

Evaluating the Care Certificate (ECCert): a Cross-Sector Solution to Assuring Fundamental Skills in Caring

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List of Abbreviations

CATI: Computer Assisted Telephone Interviewing

CC: Care Certificate

CIFR: Consolidated Framework for Advancing Implementation Science

CIS: Common Induction Standards

CQC: Care Quality Commission

DoH: Department of Health

ECCert: Evaluation of the Care Certificate

ESF: European Social Fund

HCA: Health Care Assistant

HEE Health Education England

HSCSW: Health and Social Care Support Workers

LETBs Local Education and Training Boards

NHS: National Health Service

NMC: Nursing and Midwifery Council

NVQ: National Vocational Qualification

PPI: Public and Patient Involvement

RA: Research Assistant

SCSW: Social Care Support Workers

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Executive Summary

Background

There are now more than 1.3 million people employed in the unregistered health and social care workforce (Department of Health, 2013). According to the Cavendish Review (Department of Health, 2013) annual turnover of support staff in the NHS is estimated at 14% and in social care at 20%; this indicates that up to 300,000 new workers enter the health and social care support workforce each year. We know from observational studies that on wards these people effectively make up the frontline of care (Kessler et al., 2010; Schneider et al., 2010). It follows that their competence to respond appropriately to patients' or residents' needs will greatly influence the quality of care.

The Cavendish Review (Department of Health, 2013) called for the introduction of a Certificate of Fundamental Care – now called the 'Care Certificate' – and recommended that all new care workers should achieve the Care Certificate before working unsupervised in order to improve the safety and quality of care provided. The Care Certificate is expected to form part of training for new recruits. On average this training takes 12 weeks of blended learning and covers 15 fundamental topics in health and social care (Allan et al., 2014).

The evaluation of the pilot in 29 sites (Allan et al., 2014) found that the content of the Care Certificate met with little disagreement and only minor modifications were recommended. However, the delivery of the Care Certificate was left to employers, and take up has been variable, so a representative picture of its adoption by providers of adult health and social care is needed to understand whether a truly national standard is being achieved. A robust evaluation is needed to investigate whether it is having the desired effect on the confidence and skills of the workforce.

Study Aims

The research aimed to evaluate the effectiveness of the Care Certificate in achieving its intended outcomes of improved experience of induction, training and job readiness for care workers, improved care for patients, and improved training provision and career development pathways offered by care organisations. The aims of the study were to:

- Assess how successfully the Care Certificate meets its stated objectives to improve induction training and enable support workers feel better-prepared to provide high quality care;
- Consider variations in implementation across the full range of CQC-registered health and adult social care services and organisations; and
- Explore areas for improvement in order to meet its objectives better.

Methods

Telephone Survey

We conducted a national telephone survey with staff who have responsibility for training or induction of care staff in care organisations. A representative stratified sample was selected through the CQC Care Directory (CQC, 2016) which contains details of registered managers, and allows filtering by regulated activities, service type and region. Survey

questions focused on the approach to implementation and delivery of the Care Certificate training, the impact of the Care Certificate on the organisation, care workers and care recipients, and the challenges of implementation.

Interviews and Focus Groups at Care Sites

Further in-depth evidence about the implementation of the Care Certificate was collected through semi-structured interviews and focus groups at ten care sites. These methods were used to explore the experience of taking the Care Certificate training, perceptions of its impact on staff practice, and barriers and facilitators to successful implementation and outcomes.

Focus Groups with Patients and Carer Representatives

As part of our Public and Patient Involvement activity, seven focus groups were conducted with patients and carers from diverse backgrounds. The aim of these was to include the views and perspectives of patients and carers, specifically on the principles of the Care Certificate and general impressions of care provided in a variety of care settings.

Results

Telephone Survey

Of the 401 organisations that took part in the telephone survey, 352 (87.8%) had implemented the Care Certificate into their routine induction for new care staff and the uptake was significantly higher for health service organisations than for social care organisations.

The perception that the Care Certificate was a compulsory requirement from the CQC was the main driver for organisations who had implemented it. For those organisations that had not implemented it, reasons for this were that their staff were already sufficiently qualified and trained, or that their existing induction training was sufficient in covering the standards. Other organisations stated that they had not implemented it due to barriers related to a lack of capacity, resources and leadership to support implementation. A small number of organisations reported that they were avoiding recruiting staff without care experience so that they could avoid the need to implement the Care Certificate.

There was considerable variation in the way that the Care Certificate training was being delivered, to whom, and over what period. Multiple training delivery methods were most frequently used, combining computer-, classroom- and clinically-based approaches. However, the Care Certificate was delivered using computer-only methods or online learning in one tenth of organisations. Furthermore, when organisations employed new starters who had an existing Care Certificate, 21.3% required these care workers to fully repeat the training within their organisation and 28.5% required these staff to partially complete the training. The need to repeat the Care Certificate was frequently reported to be due to perceived inconsistencies in implementation and uncertainty about the quality of the training in other organisations.

The majority of organisations perceived a positive impact of the Care Certificate on the care organisation, care staff and care recipients. However, health organisations consistently reported more positive responses than social care organisations. Managers reported a

number of perceived positive outcomes for care workers including being better prepared for their role, providing a sense of achievement and confidence boost, and benefitting from peer discussions and reflections on their role and practice.

The main challenges to implementing the Care Certificate identified through the telephone survey were lack of interest from care workers, lack of resources (funding, time, and staff for backfill) and the need for relatively high levels of literacy.

Interviews and Focus Groups at Care Sites

Ten health and social care organisations took part in further in-depth exploration of the experience of implementing the Care Certificate and the perceived impact. Interviews were conducted with a total of 24 managers, training leads and trainers at these sites. Focus groups or interviews were completed with 68 care workers, of whom 48 had completed the Care Certificate and 20 had not.

For people who had completed the Care Certificate, the reported benefits included knowledge and understanding that was immediately applicable to the working environment, greater confidence, empathy and self-reflection, and a step towards career progression by some.

While the implementation process had been initially difficult for some organisations, the Care Certificate was widely accepted as essential preparation for work in the health and social care and as a vehicle to promote greater standardisation and consistency of care within and between organisations. Its breadth of coverage and flexibility is seen as a strength, enabling training to be used in different settings and to be adapted to meet the existing induction and training within organisations.

The flexibility and adaptability of the Care Certificate means that it is being delivered in many different ways across settings. Whilst large organisations have assimilated the Care Certificate into existing training schemes, smaller organisations have had to assign responsibility for implementation to managers or external trainers.

The variation in how the Care Certificate training is delivered has led to uncertainty over the quality of training received by care workers in other organisations, and in turn devalued the Care Certificate. Portability between care organisations was not evident. National accreditation of the Care Certificate and professional registration of its holders could strengthen its perceived value. Furthermore, integration with National Vocational Qualifications and other relevant learning is needed to acknowledge prior learning when embarking on the Care Certificate. More formal recognition of the attainment of the Care Certificate through the formal presentation of certificates could benefit the motivation of care workers and the support from organisations to complete the training.

Foremost among barriers to implementation is the time commitment imposed by the Care Certificate which disproportionately affects smaller organisations, and acts as a disincentive to both prospective trainees and care managers. Successful implementation could be achieved through planned and comprehensive integration of the Care Certificate across the organisation, which was supported by existing organisational infra-structure and organisational leaders. Mentoring, buddy systems and group teaching were identified as mechanisms that facilitated learning and development on the Care Certificate.

Conclusions

The uptake of the Care Certificate has been good, and it is widely welcomed as providing a standardised approach to improving the care skills of those new to care. However, there is a proportion of smaller care organisations where the Care Certificate has not been implemented, largely due to lack of resources and capacity. For these organisations, the size of the undertaking is too much, to the extent that some avoid recruiting new staff without experience.

For those who have fully implemented the Care Certificate, they report that it has increased staff confidence, skills and knowledge and provided a standardised and basic foundation for new recruits to their care organisation. However, the use of the Care Certificate as a transferable qualification to support the movement of care staff between organisations was not widely reported. Most organisations required new recruits who had completed their training elsewhere to repeat some or all of this training, and this was often related to scepticism about the quality of any prior training and the lack of external validation of this training.

There has been considerable variation in how the Care Certificate is being used, ranging from substantial group-based programmes involving a combination of teaching approaches and activities to brief online courses completed individually. This inconsistency between organisations in their delivery of the Care Certificate has undermined the credibility and portability of the Care Certificate, leading to calls for greater regulation and standardisation in its provision. However, this flexibility also has benefits as it has also facilitated a bespoke and site-specific approach to training.

Organisational size, leadership, capacity and resources were major factors in determining the effectiveness of Care Certificate implementation. Where organisations had the resources to devote particular staff to develop the training or assimilate it into their existing induction programmes, then the potential benefits of the Care Certificate were most likely to be reported. This is reflected in the larger number of health organisations consistently reported more positive responses towards the Care Certificate than social care organisations.

Effective implementation of the Care Certificate appeared to include the following features:

- Assimilation of the Care Certificate into existing training and induction programmes.
- Blended, holistic, practical and participatory approaches to training delivery as outlined in the Care Certificate mapping document
- A broad scope of delivery, extending beyond newly recruited care workers to established personnel.
- Peer support and mentoring for Care Certificate candidates.
- Adaptation of materials and assessments to support care workers facing literacy or language barriers.
- The provision of regular updates and assessor training

The following features were associated with less effective implementation:

- A 'one dimensional' approach to Care Certificate implementation and delivery that was inflexible and unsupported.

- Didactic rather than participatory approaches to training delivery.
- Lack of supervision and assessment of standards
- Lack of peer support and mentoring for care workers
- Inadequate resourcing, in terms of materials, assessors, care worker time and backfill for training.

1 STUDY AIMS

1.1 Study Aims

The research aimed to evaluate the effectiveness of the Care Certificate in achieving its intended outcomes of improved experience of induction, training and job readiness for care workers, improved care for patients, and improved training provision and career development pathways offered by care organisations. In doing so it explored the processes through which these outcomes are achieved and how different approaches to the implementation of the Care Certificate impact on these processes and outcomes. Specific aims of the study were to:

- Assess how successfully the Care Certificate meets its stated objectives to improve induction training and enable support workers feel better-prepared to provide high quality care;
- Consider variations in implementation across the full range of CQC-registered health and adult social care services and organisations; and
- Explore areas for improvement in order to meet its objectives better.

1.2 Study Objectives

To meet study aims, we adopted a two-staged mixed methods approach. In Stage 1, a telephone survey of a large number of care organisations was conducted to achieve the following objectives:

1. To quantify the uptake of the Care Certificate by different care organisations and their staff
2. To examine patterns of uptake across settings and identify characteristics of low and high adopters
3. To assess the wider impact on training provision offered by care organisations.
4. To develop a taxonomy of approaches to the implementation of the Care Certificate across the range of care organisations

In Stage 2, semi-structured interviews and focus groups were carried out at a range of care sites to gain more in-depth insight into the implementation and effectiveness of the Care Certificate. These qualitative approaches were used to achieve the following objectives:

5. To investigate the experiences of care workers who have completed the Care Certificate and their perceptions of its impact on their practice
6. To evaluate the impact of the Care Certificate on patient experience
7. To identify the characteristics of successful implementation defined in terms of uptake, experiences and outcomes

8. To explore barriers and facilitators to achieving Care Certificate objectives in a range of care organisations

1.1 Structure of the Report

The remainder of the report is structured as follows:

Chapter 2 describes the background to the study including the current context relating to the health and social care workforce, the training and development needs of unregistered care workers, the policy and practice background leading to the introduction of the Care Certificate, a review of external training providers of the Care Certificate, and the literature to date on the Care Certificate implementation.

Chapter 3 provides an overview of the design and methods adopted in the study, although these are described in detail in Chapters 6 and 7, and Appendix 5.

Chapter 4 describes the approach to Public and Patient Involvement (PPI) taken during the planning, design and conduct of this study. This includes a description of the PPI members of the project management team and their role during the project, and the wider PPI engagement through a series of focus groups with patient and carer groups. A summary of the PPI focus group results are presented in this chapter, though the full detail of this work is described in Appendix 5.

Chapter 5 describes how our work addressed issues of equality and diversity, both through the methods adopted and through the findings and their implications.

Chapters 6 and 7 describe in detail the methods and results from the research study. Chapter 6 provides the detailed methods and results relating to the telephone survey in stage 1 of the research. Whilst Chapter 7 moves onto the stage 2 methods and results relating to interviews and focus groups at study sites.

Chapter 8 provides a summary of the key findings, bringing together the results presented in Chapter 6 and 7. This chapter also makes recommendations on areas for improvement and highlights the strengths and limitations of the study.

Chapter 9 draws some conclusions from the research of the research and indicates areas where future research is needed.

Chapter 10 describes the dissemination plans for the research, which are listed in full in Appendix 7.

2 BACKGROUND

2.1 Introduction

Health care assistants and social care support workers play an increasingly key role in frontline care provision both in terms of their numbers as well as in the roles they perform (Unison, 2016), it is therefore important to acknowledge this by investing in their training, development and support. These unregistered care workers now make up over 1.3 million frontline staff delivering the bulk of hands-on care in hospitals, care homes and the homes of individuals needing care (Department of Health, 2013). Furthermore, it is predicted that the number of people that will be working in this sector may rise to over 2.2 million in the UK by 2020 (National Careers Service, UK, 2016), with over 300,000 new workers entering the health and social care support workforce each year (Department of Health, 2013). These growing numbers are partly due to the demographic trend of an ageing population with increasing need for care and support among individuals, as well as increasing numbers of people admitted to care organisations (Unison, 2016). For example, Skills for Care (2017) predicts that if the adult social care workforce grows proportionally to the projected population growth of those aged 65 years and over between 2016 and 2030, an increase of 31% (500,000) jobs would be required by 2030. It is also due to the replacement of higher paid registered staff such as nurses with lower paid unqualified staff who are increasingly required to take on the complex tasks formerly performed by these registered staff (Unison, 2016). Unregistered care workers are usually the main point of contact for those in receipt of care (Kessler et al., 2010; Schneider et al., 2010), and approximately 60% of their time is spent delivering direct and indirect care, nearly twice that of registered nurses. (Unison, 2016).

Accompanying these trends have been demands for the improved delivery of frontline care services that is both person-centred (Brooker, 2007) and compassionate (Department of Health, 2012). A new vision and strategy, 'Compassion in Practice', has been developed (Department of Health, 2012) which highlights the values and behaviours that should underpin care and which creates better outcomes and well-being for patients and staff alike. Similarly, a person-centred approach has been adopted as a core standard in the National Services Framework for Older People (Department of Health, 2001) as an alternative to traditional task centred approaches which are thought to promote client passivity and depersonalise the care giving process (Rothera et al., 2008). In spite of these trends, in recent years, the way people are cared for has been put under the spotlight with a series of reports highlighting concerns about poor care, a lack of privacy, dignity and respect, and a failure to treat people with compassion (Farenden, 2013). These issues of poor care were recently highlighted by the serious failures in care identified at Winterbourne View (Bubb, 2014) and Mid-Staffordshire NHS Foundation Trust which led to a major inquiry (Francis report, 2013), and recommendations including common training standards and a code of conduct for care workers.

2.2 The Skills Gap

Skills for Care (2017) regard the adequate training of care workers to be crucial in improving the standards of care they provide. Benefits are seen to include:

- Quality service - completing qualifications leads to highly skilled and competent workers providing high quality care and support.

- Safety - training and qualifications in the key areas of health and safety provide reassurance about workers confidence and competence.
- Value for money - qualification achievements give considerable added value and assist workforce planning in the organisation.
- Retention - workers who receive structured learning and development feel valued and supported and are more likely to remain in their post.

In spite of these perceived benefits, poor quality carer provision persists and is often attributed to a 'skills gap' within the frontline care workforce with relevant training often being absent or inadequate and marked by a tendency to focus on tasks and mandatory competencies (Arthur et al., 2017). Although investments in staffing and work environments are pre-requisites for high-quality care (Maben et al., 2012) and are a means of better utilising existing staff at minimal cost, historically care workers have been viewed as the 'untrained workforce' (Edwards, 1997). This has led to an assumption that they are without training needs with primary reliance tending to be on personal experience and past employment in a similar setting (All Party Parliamentary Group, 2009). For example, Skills for Care (2017) found that less than half (48%) of the adult social care workforce had a relevant qualification. Furthermore, even when training is provided, it may not always go on to impact on practice in frontline care due to such things as the style and delivery of training, the innate characteristics of participants and the context in which they work (Grol and Grimshaw, 2003). Explanations for these barriers to knowledge transfer and utilisation can be broadly categorised using the Consolidated Framework for Implementation Research (Damschroder et al., 2009). This synthesises constructs influencing the effectiveness of this implementation and includes the domains of context; process; intervention characteristics and individual characteristics.

Context

Inadequate funding is a significant barrier to improving levels of training with service providers often finding it difficult to afford this training as well as paying for staff replacement costs (Arthur et al., 2017). This is exacerbated by the high annual turnover of care workers which is estimated to be around 20% in social care and 14% in the NHS (CSCI, 2008). Within the adult social care sector, Skills for Care (2017) estimates turnover to be around 27.8% which equates to approximately 350,000 leavers over the year. Turnover has increased steadily, by a total of 4.7 percentage points, between 2012/13 and 2016/17 (Skills for Care, 2017). High staff turnover not only serves to diminish the continuity of care, which is a key feature of person centred care, but also dilutes the skill levels of the remaining workforce and further reduces incentives for employers to invest in staff training (Schneider, 2016). Budgetary constraints can have other negative impacts on service provision,. Commissioning practices which put cost before quality can have a similarly negative impact.

Another contextual issue is the lack of adequate regulation. There has been a lack of regulatory requirements stipulating the level of training and core competencies which care staff must receive. The Council of Deans for Health (2013) noted that while there are an increasing number of initiatives in training and role development for care workers, there are problems of variability in access and quality and poor communication between employers and education providers. This situation is compounded by the fragmentation and mixed economy of training provision that can be delivered in-house or through external providers including independent or not-for-profit organisations, and educational institutions (Burrow et

al., 2017). As with the mixed economy of care provision, while this fragmentation can potentially promote choice and innovation, it can also give rise to problems of coordination which is exacerbated by the poor regulation of trainers themselves as well as of the training they provide. Furthermore, the care environment and organisational culture (Ravasi and Schultz, 2006) must also be receptive and characterised by adequate resourcing and leadership (Argyle, 2012) and corresponding clarity on how good practice should be implemented (Brooker, 2004). Research suggests that these criteria are often unfulfilled thus hindering the transferral of learning back to the practice setting (Bowers, 2008).

Individual characteristics

The low status and pay awarded to the care workforce (Hughes, 1962) also serves to diminish workforce development and career progression through lowering motivation and morale and increasing staff turnover. For example, in spite of recent pay rises as a result of minimum wage legislation, a care worker employed within the independent sector is likely to earn £15,000 a year which is roughly half what a registered nurse can expect to receive (Skills for Care, 2017). Furthermore, some would argue that this low pay fails to attract staff of the right calibre due to such things as the lack of innate qualities like empathy, respect and dignity in the caring relationship, characteristics essential to being a good care worker (Crawford et al., 2013; Onyett, 2012). Some argue that this compassion cannot be acquired through training leading to calls for values-based recruitment (Onyett, 2012). Others feel that this can be learnt (Crawford et al., 2013) leading to the corresponding advocacy for a greater focus on compassionate care in relevant training (Pryce-Miller and Emanuel, 2014). Whilst some suggest that the provision of training may increase the likelihood of workers moving on, thus diluting skill levels and reducing the continuity of care, others argue that the development of the skills of frontline care workers can improve both staff retention and workforce efficiency (Kessler et al., 2012). As Schneider (2016) recognises, more research is needed on the potential impact of training on care workers and their job mobility and career progression as well as into the impact of social divisions including class, gender and ethnicity on this role. Thus, there is potential to analyse what support workers can do well, develop their skills, create better career pathways, and reap savings through increased efficiency (Skills for Health, 2015). Moreover, in view of the fact that this workforce is disproportionately made up of immigrants (Hussein, et al., 2011), of particular relevance in this respect is the way in which the exit of the UK from the EU might impact upon the composition of this workforce.

Intervention characteristics

Behavioural, social and organisational theories stress the importance of external factors in the promotion of knowledge utilisation and the effective transfer of training into workplace practice (Argyle, 2012). On the other hand, educational approaches take a more individualised focus (Argyle and Kelly, 2015; Argyle and Schneider, 2016), and place an emphasis on the style and content of learning approaches adopted in order to bridge the implementation gap. Thus, in addition to the receptiveness of individual care worker and the wider work environment to training interventions, the style of training has also been found to be important in the implementation of evidence-based practice. Research has found that didactic education and standard issue protocols are least effective in promoting knowledge utilisation and that participants need to experience, discuss and reflect on problems and solutions themselves, in order for training to have an impact on behaviour (Jacques and

Salmon, 2007; Knowles, 1980). More effective methods include, interactive and hands-on education, decision support systems, audit and feedback (Arthur et al., 2017; Kolb, 2014). This is particularly the case for complex concepts such as person-centred approaches and relational care for which there is often a lack of clarity in how they should be implemented in a practical setting (Argyle, 2012). As Kirkpatrick's (Alliger and Janak, 1989; Kirkpatrick, 2006) model of training evaluation criteria observed, the impact of this training should take place on a number of ascending levels. These include, firstly, 'reactions' such as immediate levels of enjoyment and engagement, secondly, 'learning' referring to the incidence of knowledge acquisition and transfer, thirdly, 'behaviour' referring the degree to which this knowledge is utilised and fourthly, 'results', referring to the degree to which targeted outcomes occur as a result of the training.

Process

As Kirkpatrick's model demonstrates, even when training is provided, ascendance through the hierarchy of learning may not be achieved and it may not go on to impact upon the quality of the care provided (McCabe et al., 2007). Existing research into this 'implementation gap' suggests that new knowledge by itself rarely results in sustained changes in practice. (Broad, 1997). For this ascendance to be achieved, not only should the training programme be adequate, it should be preceded by learner preparation and followed by ongoing reinforcement and support (Cromwell and Kolb, 2004). For example, one study suggests that organisational features such as incentives and 'booster' sessions for participants might improve the sustainability of positive effects from communication interventions and training for frontline staff (Eggenberger et al., 2013). A supportive work environment is also required if knowledge is to be utilised. Management staff have been found to play a key role in this process and can prevent or facilitate the provision of good quality care. This has led to the widespread advocacy of multi-levelled and eclectic work-based training provision to incorporate not only care workers but also their managers and supervisors in order that they can fully understand and support the role of their staff (Argyle and Kelly, 2015; Brooker et al., 2011). In spite of this and the proven role of leadership and supervision in enhancing work performance (McDonald and Kahn, 2007), little attention has been given to the development of the skills of these leaders (Burrow et al., 2017) or in holding them accountable for effective supervision (Bowers, 2008).

2.3 Recent developments in the training of frontline care workers

In recognition of the shortcomings in frontline care provision, a number of policy developments have recently been recommended or implemented. For example, the 'Shape of Caring' review of education for nurses and care staff (Health Education England, 2015) made a number of recommendations about the care workforce, specifically: the need to value the care assistant role; widening access to enable care workers who may wish to pursue a career in nursing; and increasing the quality of education for care workers. While with regard to dementia care, the All Party Parliamentary Group on Dementia (2009) recommended responsive and ongoing mandatory training for care staff, well-informed and skilled managers, and the promotion of organisational cultures which facilitate the provision of good quality care. As such, it stressed that this training must extend beyond direct care providers and must also incorporate a wider range of personnel including managers and those responsible for commissioning services so that they are able to provide effective leadership and can make informed decisions about what constitutes good care and what is

required to provide it. These recommendations were facilitated by policy developments such as the establishment of a new regulatory body, the Care Quality Commission, responsible for regulating and inspecting all care services. While with specific regard to training, new qualification structures emerged with the new Qualifications and Credit Framework Skills for Care, reforming the existing set of National Vocational and Vocationally-Related Qualifications. Alongside these developments has been the development of a mixed economy of training provision aiming to promote choice and innovation in this provision. This has been characterised by both diverse modes of delivery spanning classroom based, practice based, online and/or blended learning approaches (Burrow et al., 2017) as well as by a diversity of providers.

2.4 The Care Certificate

In order to combat inconsistencies in this area, better integration between the workforces in social care and health care has been recommended, as well as greater regulation in the training of care worker. The Francis Report (2013), which identified serious failures in care at Mid-Staffordshire NHS Foundation Trust, suggested that such care workers should be regulated by a registration scheme and supported by common training standards and a code of conduct. Precipitated by the Francis Report (2013), the Secretary of State for Health asked Camilla Cavendish to review and make recommendations on the recruitment, learning and development, management and support of care workers in England. The resulting report, *The Cavendish Review: An Independent Review into Healthcare Assistants and Support Workers in the NHS and Social Care Settings* (Department of Health, 2013) found that these workers do not have consistent training and induction and do not have a clear status or standard job titles. It found that they often felt under-valued and lacked confidence in their abilities, and that their colleagues did not always make best use of their skills, adversely affecting the quality of care they provided. The report made recommendations (Box 1) designed to improve the training and support offered to this part of the health and adult social care workforce. The Department of Health broadly accepted the recommendations.

Box 1: The Cavendish Review Recommendations

The Cavendish Review Recommendations

Recruitment, Training and Education

1 HEE should develop a “Certificate of Fundamental Care”, in conjunction with the Nursing and Midwifery Council (NMC), employers, and sector skills bodies. This should be written in language which is meaningful to the public, link to the framework of National Occupational Standards, and build on work done by Skills for Health and Skills for Care on minimum training standards.

2 A “Higher Certificate of Fundamental Care” should also be developed, linked to more advanced competences to be developed and agreed by employers. The Department of Health should hold HEE and Skills for Care to account for ensuring that there is step-change in the involvement of best employers.

3 The Care Quality Commission should require healthcare assistants in health and support workers in social care to have completed the “Certificate of Fundamental Care” before they can work unsupervised.

4 The NMC should recommend how best to draw elements of the practical nursing degree curriculum into the Certificate; HEE, LETBs and employers should seek to have nursing students and HCAs completing the Certificate together.

5 HEE, with Skills for Health and Skills for Care, should develop proposals for a rigorous system of quality assurance for training, which links funding to outcomes, so that money is not wasted on ineffective courses.

6 Employers should be supported to test values, attitudes and aptitude for caring at recruitment stage. NHS Employers, HEE and the National Skills Academy for social care should report on progress, best practice and further action on their recruitment tool by summer 2014.

Making Caring a Career

7 HEE and the LETBs should develop new bridging programmes into pre-registration nursing and other health degrees from the support staff workforce in health and social care, working with Skills for Care, NMC and Skills for Health; and explore the Barchester proposal for a Higher Apprenticeship.

8 HEE and the LETBs should set out a clear implementation plan, with robust measures, to take forward the objective in the HEE mandate to widen participation in recruitment to NHS-funded courses: and develop innovative funding routes for non-traditional staff to progress.

9 The NMC should make caring experience a prerequisite to starting a nursing degree and review the contribution of vocational experience towards degrees so that staff with strong caring experience can undertake 'fast-track' degrees. Skills for Care should work with Higher Education Institutions to look at how care experience can be recognised in enabling people to enter social work, therapy and advanced social care courses.

10 NHS Employers, HEE and Skills for Care should work with employers to set out a robust career development framework for health and social care support staff, linked to the simplified job roles and core competences.

Getting the Best out of People: Leadership, Supervision and Support

11 Employers should allow HCAs to use the title "Nursing Assistant" on completion of the "Certificate of Fundamental Care", where appropriate.

12 Regulators, employers and commissioners in health and social care should define a single common dataset for their purposes, and commit to using it, to relieve the pressure on first line managers and other staff.

13 Trusts should empower Directors of Nursing to take greater Board level responsibility for the recruitment, training and management of HCAs, from day one.

14 The Secretary of State for Health should commission the Professional Standards Authority for Health and Social Care for advice on how employers can be more effective in managing the dismissal of unsatisfactory staff, the legal framework around this, and the relationship with referrals to professional regulators.

15 Skills for Health should refine its proposed code of conduct for staff, and the Department of Health must review the progress of the social care compact: and substitute a formal code of conduct for employers if a majority have not acted upon it by June 2014.

Time to Care

16 The Department of Health should explore with the social care sector how to move to commissioning based on outcomes; and aim to eliminate commissioning based on activity by 2017.

17 NHS England should include the perspective of HCAs and support workers in its review of the impact of 12-hour shifts on patients and staff.

18 Statutory guidance should require councils to include payment of travel time as a contract condition for homecare providers.

While the Francis Report (2013) recommendation for care worker registration was dropped, the most significant of these recommendations was the adoption of common training standards through the proposed introduction of a Certificate of Fundamental Care – now called the 'Care Certificate'. In order to improve the safety and quality of care provided, Cavendish recommended that all new care workers should achieve the Care Certificate

before working unsupervised. The Department of Health subsequently commissioned Health Education England, Skills for Care and Skills for Health (the 'Partnership') to jointly to produce a Certificate that met the following criteria:

- is applicable across social care and health – recognising the commonalities and bringing support workers in those sectors closer together;
- is portable between roles and transferable between employers – reducing unnecessary training duplication and enabling freer movement of labour;
- builds on the Common Induction Standards and National Minimum Training Standards – learning from and building on what has come before;
- builds in quality and consistency of delivery through observation and assessment in the workplace – ensuring that the Certificate is more than a tick-box exercise and is based in evidence of practice;
- maps to existing qualifications – giving the Care Certificate more currency; and
- equips unregistered care workers with the fundamental skills and knowledge to provide high quality care – improving safety, effectiveness and the experience of those receiving care.

The Care Certificate was officially launched in England in April 2015. It replaced the Common Induction Standards (CIS) and identified a set of standards that unregistered health and social care workers should adhere to in their daily working life with the ultimate aim of improving the quality of care they provide. It applies across health and social care, links to National Occupational Standards and units with a view to giving workers a basis from which they can further develop their knowledge and skills. It is made up of fifteen standards as shown below (Box 2). As such, it aims to promote: a consistent approach to staff training and induction; improvements in the quality of care provided; and better training provision and career development pathways within care organisations.

Box 2: The 15 standards in the Care Certificate

Standard	Outcomes
1. Understand your role	Understand their own role; work in ways agreed by their employer; Understand working relationships in health and social care; Work in partnership with others.
2. Your personal development	Agree a personal development plan; Develop their knowledge, skills and understanding;
3. Duty of care	Understand how duty of care contributes to safe practice; Understand the support available for addressing dilemmas that may arise out of duty of care; Deal with comments and complaints; Deal with incidents, errors and near misses; Deal with confrontation and difficult situations
4. Equality and diversity	Understand the importance of equality and inclusion; Work in an inclusive way; Access information, advice and support about diversity, equality and inclusion
5. Work in a person-centred way	Understand person centred values; Understand working in a person centred way; Demonstrate an awareness of the individuals immediate environment and make changes to address factors that may be causing comfort or distress; Make others aware of any actions they may be undertaking that are causing comfort or distress to individuals; Support individuals to minimise pain or discomfort; Support the

	individual to maintain their identity and self-esteem; Support the individual using person centred values.
6. Communication	Understand the importance of effective communication at work; Understand how to meet the communication and language needs, wishes and preferences of individuals; Understand how to promote effective communication; Understand the principles and practices relating to confidentiality; Use appropriate verbal and non-verbal communication; Support the use of appropriate communications aids/technology
7. Privacy and dignity	Understand the principles that underpin privacy and dignity in care; Maintain the privacy and dignity of the individuals(s) in their care; Support an individual's right to make choices; Support individuals in making choices about their care; Understand how to support active participation; Support the individual in active participation in their own care.
8. Fluids and nutrition	Understand the principles of hydration, nutrition and food safety; Support individuals to have access to fluids in accordance with their plan of care; Support individuals to have access to food and nutrition in accordance with their plan of care
9. Awareness of mental health, dementia and learning disability	Understand the needs and experiences of people with mental health conditions, dementia or learning disabilities; Understand the importance of promoting positive health and wellbeing for an individual who may have a mental health condition, dementia or learning disability; Understand the adjustments which may be necessary in care delivery relating to an individual who may have a mental health condition, dementia or learning disability; Understand the importance of early detection of mental health conditions, dementia and learning disabilities; Understand legal frameworks, policy and guidelines relating to mental health conditions, dementia and learning disabilities; Understand the meaning of mental capacity in relation to how care is provided
10. Safeguarding adults	Understand the principles of Safeguarding adults; Reduce the likelihood of abuse; Respond to suspected or disclosed abuse; Protect people from harm and abuse – locally and nationally;
11. Safeguarding children	Safeguard children;
12. Basic life support	Provide basic life support;
13. Health and safety	Understand their own responsibilities, and the responsibilities of others, relating to health and safety in the work setting; Understand Risk Assessment; Move and assist safely; Understand procedures for responding to accidents and sudden illness; Understand medication and healthcare tasks; Handle hazardous substances; Promote fire safety; Work securely; Manage stress
14. Handling information	Handle information
15. Infection prevention and control	Prevent the spread of infection

Although not mandatory, as of 1st April 2015, all new care workers within English care organisations were expected to attain the Care Certificate within approximately their first twelve weeks of employment or be working towards the skill sets stipulated in this Certificate. Due to the wide range of settings covered by CQC registration, implementation of the Certificate has been designed to allow for local flexibility. The partnership between Health Education England, Skills for Care and Skills for Health has avoided being overly prescriptive about the format of evidence collected to demonstrate worker competence, the training methods used, or the level of supervision required. Hitherto it has not been stipulated precisely how service provider organisations should assure the quality of their

Care Certificate programmes although guidance and standardised templates have been provided. Further questions have also emerged relating to such things as, the extent of variation in the implementation of the Care Certificate, potential barriers and incentives to implementation, how delivery methods differ and how possession of the Care Certificate, which should be transferable between employers, affects staff mobility (Trayner et al., 2015).

With a view to testing out the Care Certificate and its implementation, a pilot study was undertaken between May and September 2014. The final report (Allan et al., 2014) detailed how a total of 29 sites participated in the pilot (16 social care and 13 in healthcare). Primary research included face-to-face and telephone consultations with assessors, trainers and staff undertaking the Care Certificate. Across those sites there were 450 care workers that had undertaken Care Certificate training. In terms of delivery models, three quarters of the sites had used an in-house model with an average of 4-5 days training in a classroom setting followed by an average of 2-3 weeks work shadowing or supernumerary. There were mixed views over completion in 12 weeks, but overall it was felt it was 'about right'. Feedback from the pilot suggested that the standards in the Care Certificate are the right ones and no significant concerns were raised about the difficulty level. The most contentious area covered by the evaluation related to assessment and supervision. The areas of concerns for this included the definition of "occupationally competent" for assessors and also over potential discrepancies in assessments across centres and a potential need for greater standardisation about what constitutes acceptable evidence.

Although learning materials were considered fit for purpose, views on how portability would work in practice was a concern. Only a quarter of the pilot leads said they would be willing to accept the Care Certificate as reliable proof of a care worker's abilities. The principle of the Care Certificate was overwhelmingly welcomed by the pilot sites and the combination of theory, practical knowledge, observation and assessment were praised by most staff. However, in terms of longer term impact, most felt it was too early to see the real impact and many of the pilot sites had not yet considered any financial implications of the Care Certificate. Moreover, since its implementation, a number of further issues have emerged which were not addressed in the pilot study.

It was the purpose of the current research reported here, called 'Evaluating the Care Certificate: a cross sector solution to assuring fundamental skills in caring' (ECCert), to address these and other questions and to assess how successfully this training innovation met its objectives. This research was funded by the Department of Health Policy Research Programme.

2.5 The Evaluation of the Care Certificate

This research aimed to assess how successfully the Care Certificate has thus far met its objectives to improve induction training and enable support workers to provide high quality care; consider variations in implementation across health and adult social care organisations; and explore areas for improvement in order to meet its objectives better. In addition to the main research stages, two scoping reviews were carried out. The first review investigated external providers of Care Certificate training and the second investigated literature published on the Care Certificate between 2013 and 2017. A summary of the findings of these reviews are described below and are shown in full in Appendices 1 and 2 respectively.

Review of external training providers

There are over 3000 healthcare and social care training providers listed on the government's Skills Funding Agency. However not all of them provide Care Certificate training. Drawing on four commonly used online databases (Skills for Care, Skills Platform, Yellow Pages Online, Last Minute Learning), over 500 training providers are listed but a brief analysis of their information and websites reveals that far fewer are offering Care Certificate training.

- Skills for Care lists 98 training providers based on an 'endorsed provider scheme'
- Skills Platform lists 102 training providers on a registered user platform charging a percentage from bookings
- Yellow Pages online lists 150 training providers based on their free listing service or paid advertising
- Last Minute Learning lists 167 training providers based on a registered user platform with a quality commitment requirement

Possible reasons for fewer training providers offering the Care Certificate Training were that:

- The Care Certificate itself can only be issued by the registered manager making it more likely to be adopted as an in-house induction/ learning program.
- There are free Care Certificate workbooks and resources available from Skills for Care and Skills for Health. Other organisations offer links to those resources also.
- Many training providers have established and accredited learning programs on offer e.g. Health and Social Care Level 1 to 5 diplomas and apprenticeships

The Care Certificate training has a practical element which requires observation of the care worker/learner's practice. Whilst some training providers offer some observations of practice as part of the training, other providers are explicit about the fact that they only offer the theoretical learning and not the observation of practice. However, others sometimes state that they offer Care Certificate training but are not explicit about the fact that any certificate issued by the training provider is for 'theory only'.

The cost of externally provided Care Certificate training varies greatly, from £1.49 per module through some online e-learning providers to over £400.00 for a group of learners per day of training. Some training is advertised at over £800.00 for a group of learners including practice observations conducted by the training provider.

Review of literature on the Care Certificate

As part of this evaluation, a review of the available literature on the Care Certificate was carried out. The implementation of the Care Certificate has received limited research focus to date and it was important to scope what is currently available. The following five stages from Arksey and O'Malley's (2005) framework were used to structure the literature review:

1. identifying the research question, which is usually broad in nature;
2. identifying relevant studies, using a process that is as comprehensive as possible;

3. study selection, with the establishment of inclusion/exclusion criteria, based on familiarity with the literature;
4. charting the data, a stage that includes sifting and sorting information according to key issues and themes; and
5. collating, summarizing, and reporting the results, which provides both a descriptive and numerical summary of the data and a thematic analysis;

In accordance with these stages, the first task involved identifying the research question; this was to systematically explore and describe the breadth and depth of available research on the Care Certificate. Following this, a literature search to identify published and grey literature relating to the Care Certificate was performed by an information specialist with input from the research team. A broad free text search term of 'Care Certificate' was used. Included articles were restricted to those published in the UK between 2013 and the search date (August 2017). The 2013 start date was chosen due to the publication of the Francis Report (2013). No methodological filter was employed. Seven databases were searched. The search was conducted by an Information Specialist and resulted in 236 articles. After removal of duplicates, 99 articles from the databases and a further 20 from website searches remained. Stage 3 involved screening of texts by an expert research team (EA, LT, ZK, JS) based on predetermined criteria (see Appendix 2). The references were then imported into EndNote X7 allowing for the organisation and cross-checking of references. This process elucidated 24 relevant full text publications for final inclusion in the review. Stage 4 involved sifting, charting, and sorting information. Data from the included studies were extracted and summarized by one research reviewer using a bespoke form developed in Excel. Extracted data included where relevant; publication type, year, study design, methods, sample size, time frame, setting, topic, population, implementation factors, barriers and enablers of implementation. At this stage, a further 4 results were discarded (2 duplicates, 2 irrelevant) leaving 20 texts included in the review.

Stage 5 was then carried out which involved collating, summarizing, and reporting the results, providing both a descriptive and numerical summary of the data and analysis. Due to the general lack of research publications relating to the Care Certificate, it became difficult to numerically chart the results so a narrative descriptive analysis approach was deemed as most appropriate for the task. A narrative analysis can position characters in space and time and give order and make sense of what happened. Given the results of the literature showed mainly editorial work, this allowed for insights to be developed into how individuals experienced the introduction of the Care Certificate and how they conferred subjective meanings to these experiences. A summary of the findings is shown below, and each article summarised in Box 3:

- From 236 initial sources yielded by the electronic search, 20 were included in the final review
- The 20 articles included 13 editorials, 2 evaluation reports, 1 review, 1 news bulletin, 1 case study, 1 book review and 1 poster. Most (n=15) were from 2015, the year the Care Certificate launched.
- A series of editorials (n=11) regarding the Care Certificate appeared in the British Journal of Healthcare Assistants during 2015 from a range of stakeholders.
- The Care Certificate was generally welcomed and viewed as a positive initiative to add value to current practice and its content was viewed as applicable and relevant to the workforce. For some it was seen to be a precursor to the registration of care workers.

- Concerns were raised about the quality assurance of the Care Certificate, the need for standardisation of assessment and the risk of dilution of standards due to high-levels of staff turnover.
- Employers autonomy over implementation was often considered detrimental and likely to have a significant effect on portability; perceptions of poor or inconsistent delivery were reported resulting in lack of standardisation and variation in assessment standards
- Three quarters of employers undertaking the pilot suggest they would ask people to redo the certificate in their organisation which conflicts with the aim of a standardised certificate that is portable and transferable across care organisations.
- Further research into these issues will help elucidate the components of best practice while cross-provider working may assist with the lack of external validation leading to variation in quality and outcomes

In summary, in spite of the paucity of evidence on the Care Certificate, findings contribute to the understanding of the extent and state of the literature and demonstrated a range of stakeholder views and differing perceptions of the key issues surrounding its implementation. For example, whilst the Care Certificate set out high expectations for a single certificate spanning many different organisation structures without any ‘regulatory oversight’, concerns were expressed that the lack of implementation guidelines potentially undermines the Cavendish report recommendations for standardisation. Furthermore, the review revealed that there is very little literature on the perspectives of those implementing and those undertaking it, representing a significant gap in research, questions that this evaluation aims to address. For without in-depth research drawing on the experience of services implementing the Care Certificate, individual’s experiences of the Care Certificate and robust longitudinal data, it will be difficult to draw any firm conclusions. It will be important to keep the dialogue going across services about what works, what doesn’t and for whom in what services. A full report on the literature review can be seen in Appendix 2.

Box 3: Included studies in the ECCert literature review

Included literature	
Reference	Details
Looking back-and forward. <i>British Journal of Healthcare Assistants</i> . 2015; 9(12):581-581.	Editorial positively describing the launch of Care Certificate as a turning point in the national perception of healthcare support workers and a ‘step in the right direction’
Setting the standards for frontline care. <i>British Journal of Healthcare Assistants</i> . 2015; 9(1):38-40.	Editorial providing a description of the background to Care Certificate. A summary of the results of the Skills for Care national pilot were provided
The Care Certificate Standards: an introduction. <i>British Journal of Healthcare Assistants</i> . 2015; 9(7):322-323.	Editorial outlining the Care Certificate standards
Allan T, Thompson S, Filsak L, Ellis C. (2014). Evaluation of the Care Certificate Pilot. <i>Skills for Care, Leeds, UK</i> .	A pilot study evaluating the Care Certificate undertaken between May and September 2014 by Skills for Care with 29 participating sites.

Calkin S, Lintern S. (2013). Compulsory Care Certificate brings HCAs a 'step closer' to regulation. <i>Nursing Times</i> 109(43):3.	Editorial which welcomed the move to introduce the Care Certificate and said it moved HCAs a 'step closer to mandatory regulation'.
Cowan C. (2015). General introduction to the Care Certificate and its implications. <i>British Journal of Healthcare Assistants</i> . 9(4):166-167.	Editorial which sets out the key aspects of the Care Certificate and ponders if it may bring health and social care together, and possibly be a step closer to regulation
Cowan C. (2017). A good companion to the Care Certificate. <i>British Journal of Healthcare Assistants</i> . 11(3):122-123.	A book review of 'Fundamentals of Care' by Ian Peate. This is an optional accompanying textbook for the Care Certificate which it refers to as mandatory.
Employers NHS. (2016). Leicestershire Partnership NHS Trust: implementing the Care Certificate in Leicestershire.	The case study details how a cross service representation working group oversaw CC implementation with positive outcomes.
Gilding M. (2017). Implementing the Care Certificate: a developmental tool or a tick-box exercise? <i>British Journal of Healthcare Assistants</i> . 11(5):242-247.	An editorial describing the results of a 'day 2 Care Certificate follow up' workshop to evaluate its effectiveness in South London and Maudsley Foundation NHS Trust.
Hand T. (2015). A massive turning point for our HCAs and APs in 2016. <i>British Journal of Healthcare Assistants</i> . 9(12):582.	An editorial which reflects on the introduction of the Care Certificate which is described as having been received with enthusiasm.
Hayes C. (2015a). Challenging stereotyping and misconceptions about international HCA education. <i>British Journal of Healthcare Assistants</i> . 9(6):304-309.	An editorial which summarises the key issues surrounding migrant HCA's and how best they can be supported.
Hayes C. (2015b). Meaning-making through transformative learning for HCA education. <i>British Journal of Healthcare Assistants</i> . 9(7):354-361.	An editorial which describes the process and importance of meaning-making through transformative learning for HCA education.
Johnson K, Moulton C. (2015). Baseline review: The role of HCAs in general practice. <i>Practice Nursing</i> . 26(6):302-305.	A review discussing and detailing the role of the HCA in general practice, focusing specifically on the experience of Stoke-on-Trent
Manns J, Bryan L and Morris K. (2015). P-27 Delivery of the Care Certificate to local care homes. <i>BMJ Supportive & Palliative Care</i> . 5(Suppl 3): A10-A10.	A poster on the delivery of the Care Certificate to local care homes. The tailoring of the training could have implications for standardization and portability.
Norman K, Roche K. (2015). Mentors: supporting learning to improve patient care. <i>British Journal of Healthcare Assistants</i> . 9(3):132-137.	An editorial detailing how mentorship can be invaluable to HCAs in developing skills, knowledge, attitudes and competencies throughout their career.
Peate I. (2015). Care Certificate: not worth the paper it is written on? <i>British Journal of Healthcare Assistants</i> . 9(12):583-584.	An editorial welcoming the rationale for the CC but questioning if the Certificate in its present form has any significant value.
Pile H. (2015). Implementing the Care Certificate as positively as possible. <i>British Journal of Healthcare Assistants</i> . 2015; 9(7):324-326.	An editorial describing implementing the Care Certificate as positively as possible and specifically UNISON's recommendations.
Sprinks J. (2015). Surprise at requirement for nursing students to attain Care Certificate. <i>Nursing Standard</i> . 29(31):11.	A news report on plans that there may soon be a requirement for nursing students to attain the Care Certificate competencies.

<p>Traynor M, Corbett K, Mehigan S. (2016) Evaluating the roll out of the Care Certificate in a local health area. <i>Pharmacy Education</i>. 16(1):63.</p>	<p>An evaluation report that sought to explore the impact of the present use of the CC within a defined area of Islington and compare it with similar evaluations in other areas.</p>
<p>Wolfe D. (2015). My Care Certificate journey. <i>British Journal of Healthcare Assistants</i>. 9(9):470.</p>	<p>An editorial summarising one HCA's journey to completing the Care Certificate. This positive account highlights the gains to practice.</p>

2 OVERVIEW OF METHODS

2.1 Study Design

The study adopted a two-stage mixed-methods approach to generate both qualitative and quantitative data to address the research questions. In stage 1, a telephone survey of a large number of care organisations was conducted to quantify the uptake of the Care Certificate, analyse characteristics of early adopters, and develop a taxonomy of implementation approaches. In stage 2, site visits were carried out in a smaller number of care organisations and interviews and focus groups were conducted to gain more in-depth insight into the implementation, experience and effectiveness of the Care Certificate. A series of focus groups with patients and care workers ran alongside stage 1 of the study. Research materials are reproduced in Appendix 3 and Standard Operating Procedures for the study are in Appendix 4.

2.2 Ethical Approval

Ethical approval for the study was provided by the University of Nottingham Faculty of Medicine and Health Science Ethics Committee on 15th July 2016 (Ethics Reference No. EV08062016).

2.3 Study Methods

A brief overview of each of the methods employed is described below and illustrated in Figure 1. Detailed descriptions of the methods are provided in Chapters 6 and 7 relating to stage 1 and stage 2 of the research respectively.

Stage 1: Telephone Survey

Telephone surveys were conducted with staff in care organisations who have responsibility for training or induction of care staff. The stratified sample was selected through the CQC Care Directory (CQC, 2016) which contains details of registered managers, and allows filtering by regulated activities, service type and region. The questionnaire wording was based on the aims and objectives of the study and no standardised scales were used. Computer Assisted Telephone Interviewing (CATI) was used to conduct the survey as this was expected to achieve a much better response rate amongst the busy target sample. The telephone survey was piloted with eight care organisations, to test the survey questions, the question routing, and the most effective procedures for accessing the appropriate manager and gaining informed consent. The full list of survey questions is provided in Appendix 3, and the questions covered the following areas:

- Details of the respondent's role and their organisation
- The total number of care workers in the setting
- Awareness of the Care Certificate and whether it had been implemented
- For those organisations implementing the Care Certificate:
 - The number of staff who have already achieved the Care Certificate
 - The number currently on the Care Certificate programme
 - Who is leading on implementation of the Care Certificate, and the general approach being taken
 - How training delivery is being funded
 - Involvement/support from senior colleagues

- Reason for the decision to adopt the Care Certificate in their organisation
- Details of enrolment methods for the programme
- Details of training delivery methods (e.g. face-to-face, e-learning), design and evidence-base
- Other training/development opportunities available or planned for care workers
- Impact of Care Certificate implementation on training/development opportunities
- Impact of the Care Certificate on cross-sector working and workforce mobility
- Challenges in implementing the Care Certificate
- Impact of the Care Certificate on the organisation, care workers and care recipients.
- For those organisations not implementing the Care Certificate:
 - Reasons for non-implementation
 - Plans for implementing the Care Certificate
 - Other training opportunities for Care Workers

Participants were contacted according to a planned procedure which involved an initial phone call to the care provider to establish the name, telephone number and email of the relevant manager. This was followed by an email to the relevant manager providing them with information about the study and an invitation to participate, and a follow-up telephone call by the researcher one week later. The organisations used for the pilot study were excluded from the final sample. Interviews lasted between 5 and 30 minutes and responses were recorded directly onto a computer-based structured database.

Stage 2: Interviews and Focus Groups at Study Sites

Ten study sites took part in an interview and focus group study to provide further in-depth evidence about the implementation of the Care Certificate across a variety of settings. Interviews and focus groups with a range of different staff at each site were used to explore the experience of the Care Certificate training and implementation at these sites. Key organisational stakeholders and service leaders were identified through the initial care provider contact.

During study site visits we sought to interview a range of stakeholders including: workforce development leads, training leads/managers, HR managers, care managers, lead nurses e.g. directors of nursing, matrons. Topic guides for these interviews covered the following areas:

- Who has led the implementation of the Care Certificate in that setting?
- What the Care Certificate programme contents are and how they are delivered?
- How care staff have been enrolled on the programme?
- What does successful implementation in this setting look like?
- The barriers and facilitators to successful implementation
- The perceived impact on practice, including patient experience

Care workers who had recently achieved or were currently undergoing training for the Care Certificate were invited to attend focus groups with each group involving up to 8 care staff. Topic guides for these focus groups covered the following areas:

- The experience of the Care Certificate in that setting
- The accessibility of the programme and materials
- The perceived impact on their practice
- Barriers and facilitators to successful outcomes
- Career options for staff, post-Care Certificate

In addition, in each study site we sought to interview up to five care workers who had not completed the Care Certificate training. Non-completion of the Care Certificate by these care workers was usually because they had been in their current job role for a longer period of time and thereby not eligible as new starters, or because of other factors preventing their ability to access the training. For these participants, interviews were undertaken individually rather than in focus groups to allow for a fuller elicitation of interviewees' perceived barriers to access. Topic guides for these interviews were similar to those for care workers who had engaged with the Care Certificate training, covering:

- Perceptions of the Care Certificate in that setting
- The accessibility of the programme and materials
- The perceived impact on practice
- Barriers and facilitators to successful outcomes.

Focus groups with Patient and Carer Representatives

To include the views and perspectives of patients and carers, specifically on the principles of the Care Certificate and general impressions of care provided in a variety of care settings, we conducted a series of seven focus groups with patients and carers. These focus groups were conducted at the same time as the telephone survey in stage 1 of the study. Topic guides for these focus groups covered the following areas:

- What are considered the most important element of care?
- Experiences of care from care workers
- Any improvements that could be made to care delivery
- How might these improvements be implemented into practice?

2.4 Study Analysis

Analytical methods for the telephone survey, the interview and focus group study at care sites, and the focus groups with patient and carer representatives are described in detail in Chapters 6 and 7, and Appendix 5 respectively. Triangulation procedures were used to bring together the analyses of the telephone survey and the interviews and focus groups, to provide a more complete picture of the implementation and experience of the Care Certificate. Methodological triangulation can enhance the validity of research by increasing the credibility and dependability of interpretations (Lincoln and Guba, 1985) by exploring the

convergence, complementarity and dissonance of research findings based on different data collection techniques (Erzerberger and Prein, 1997). The techniques for a methodological triangulation protocol described by O’Cathain et al (2010) and Farmer et al (2006) were used. After the analyses of the telephone survey and the interviews and focus groups had been conducted separately, the findings from each method were listed and compared to assess whether the two sets of findings agreed (convergence), partially agreed or silent (complementarity) or contradicted each other (dissonance).

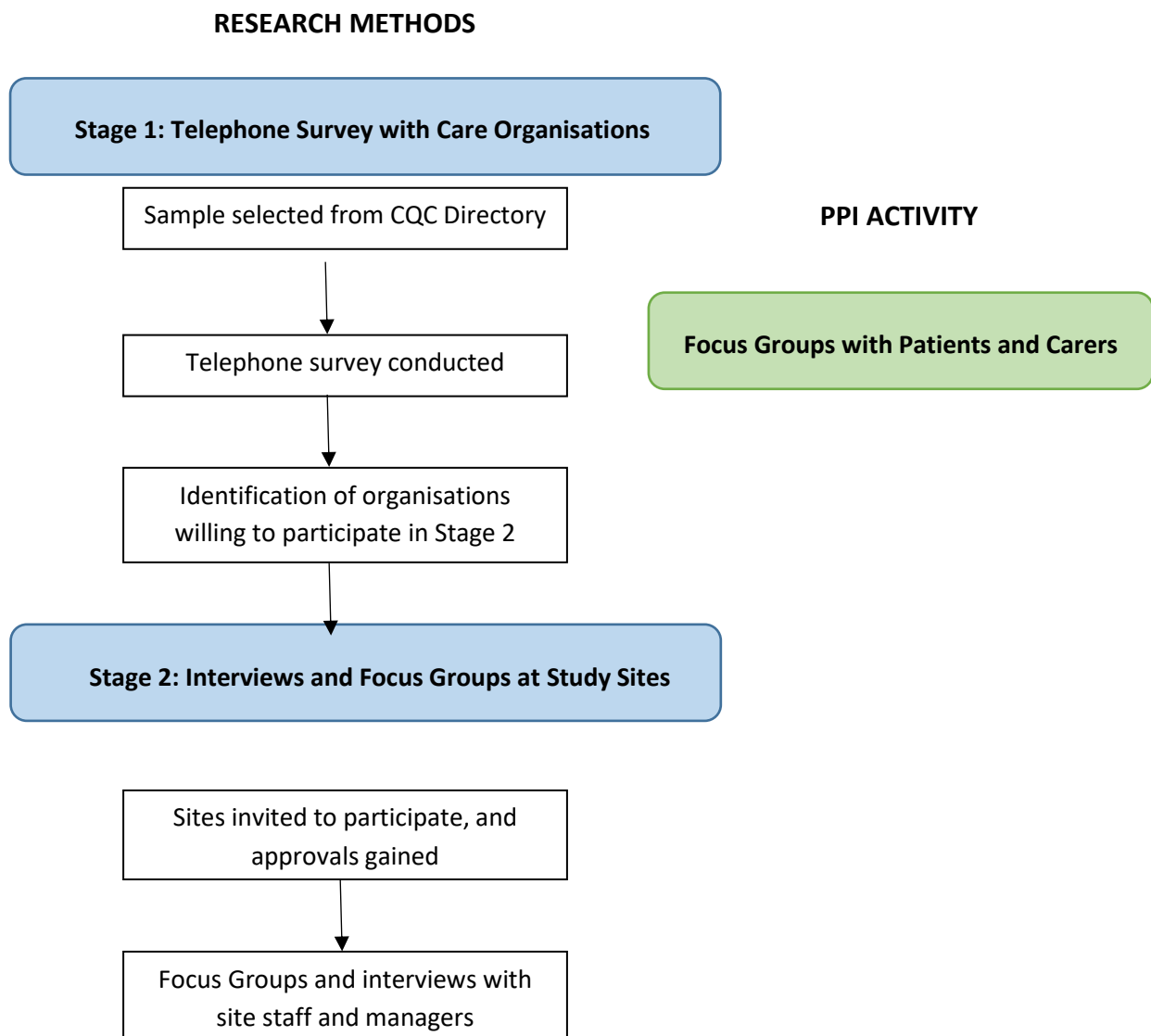


Figure 1. Overview of ECCert Study Methods

3 PATIENT AND PUBLIC INVOLVEMENT IN THE RESEARCH

Patient and public involvement (PPI) in research helps to improve the overall quality of research, by ensuring that it focuses on issues relevant to the wider stakeholders outside the research community. It is key to the promotion of a collaborative research approach with strong links to practice and the 'real world'. As one of the key aims of the Care Certificate and its evaluation was to improve frontline care provision, we recognised the importance of including the views and perspectives of patients and carers throughout the project. As Staniszezwska et al (2011) recognise, it is important to record details of this involvement in order to facilitate, the replication, appraisal, interpretation and synthesis of studies as well as to promote a collective understanding of what works, for whom, why, and in what context. With these aims in mind, further details of PPI approach taken in this study are described in this chapter.

We took a broad approach to PPI within this study, involving representatives from a wide set of stakeholder groups in the planning, conduct and dissemination of the research. This group was purposefully designed to include patients, carers, care workers and training providers to ensure that a broad set of voices and perspectives could be included in the study. Throughout all PPI activities for this project, support to PPI representatives was provided by the senior researcher, Dr Elaine Argyle.

In planning our research, The East Midlands PPI Senate provided some initial input from experienced patient and carer representatives, and we have had feedback from a care worker on the methods proposed. Feedback from these PPI representatives has broadly supported the methods but highlighted the following: the need to capture the views of care workers who had not completed the Care Certificate yet; potential difficulties in collecting views from patients during case study visits, particularly if patients lacked mental capacity; and the importance of timely results to feed rapidly into further developing practice. This feedback informed our decision to manage the project within an 18-month timeframe, and helped us to reconsider the most appropriate procedures for collecting the experiences of patients and care workers who had not completed the Care Certificate.

During the conduct of the research study, involvement was achieved was through the inclusion of PPI representatives in the project management team and advisory groups. The recruitment of PPI representatives (patients, carers and care workers) to the study team was made via the East Midlands PPI Senate and other local networks. Although the initial process of PPI recruitment was slow, as news about the evaluation spread, the number of PPI representatives grew to incorporate a range of individuals with complementary and diverse backgrounds but who all had a keen interest in the Care Certificate. The process of recruitment was more reactive and less proactive than first anticipated, with some initial recruits withdrawing due to other commitments while others joined the team several months into the project after finding out about the evaluation from various sources. Levels of involvement also varied widely between members with most of the active members of the PPI group being people with a professional interest in Care Certificate training. The background of longstanding members included an NHS HCA who had undertaken the Care Certificate and was now taking a nurse apprenticeship; a former nurse who designed and delivered her own Care Certificate training for an external training provider; and a paid and unpaid carer who had completed the Care Certificate. More recent recruits to the PPI team included a nurse trainer working for the NHS and an owner/manager of a training agency.

Although attempts were made to recruit more general members of the public to the PPI roles within the project team, those representatives who came forward were people who had experience of care giving or care work themselves.

The practical knowledge and experience provided by these PPI members was crucial to the success of the project, in grounding it in the frontline experiences of carers and care workers and their trainers as well as in the process of network building. PPI members attended project management meetings, helped to refine the focus of research questions and materials such as questionnaires as well as assisting in the interpretation of the results and in the dissemination of project material. They also provided specialist expertise and insights for example through informing the project team about different Care Certificate materials that were freely available and through writing a report on external Care Certificate training provision.

In order to have input from a wider group of patients and carers, a further way in which PPI involvement was promoted in this project was through running a series of focus groups with patient and carer groups in the community in order to elicit their views on frontline care and the Care Certificate specifically. It was felt that such groups would potentially yield more accurate information on individuals' relevant experiences of care organisations than the accounts of current patients and carers. Much research has highlighted the reluctance of service users to express their true view on the services they receive due to such things as the fear of negative repercussions and a sense of loyalty to staff (Argyle, 2003). Therefore, focus groups were conducted amongst patient and carer representative groups outside of actual care settings. The focus groups explored participants' perceptions of frontline care and the training that paid carers received with particular reference to the Care Certificate. Topic guides for these focus groups broadly covered the following areas:

- What are the most important elements of care?
- Your experiences of care from frontline care workers
- Any improvements that could be made to care and how these improvements should be implemented into practice.

With a view to identifying groups that were 'hard to reach', access was gained through liaison with a number of relevant agencies including the ENRICH network and through the Public Face bulletin which is published by the PPI Senate of the East Midlands Academic Health Science Network. It was initially planned to run five groups but due to the unanticipated high levels of interest and the wish to incorporate as many views as possible, seven groups were conducted. These involved a total of 56 participants from diverse ethnic and social backgrounds. All participants had experience of receiving care or of providing it in a paid or unpaid capacity. Ethnic minorities were highly represented in these groups with three groups consisting of a high proportion of people of African-Caribbean's heritage, African women, and people with English as a second language, primarily Eastern Europeans. This composition was reflected in group discussions with ethnic minority issues featuring fairly prominently. Similarly, two of the groups were made up of carers of people with dementia, leading to a prominence of the issues of dementia care in the focus group discussion, although other groups often referred to dementia related themes as well.

The involvement of individuals in the PPI focus groups was facilitated by the payment of travel expenses and a £20 shopping voucher to each participant. While it became clear that

for some these vouchers were a main reason for their participation, other groups were unwilling to take the vouchers or said they would donate them to charity. This was either because they felt that they were a waste of valuable resources which should be used in care provision or because the opportunity to express their views on frontline care was seen as reward in itself. A summary the findings of the focus groups is described here, but the detailed analysis and findings are presented fully in Appendix 5.

All groups had strong views on the context of frontline care and its role in facilitating or impeding knowledge transfer and utilisation following training amongst care workers. With regard to the inner context, most commonly cited was the lack of time given to care workers to perform their role which could lead to inadequate and task-centred care and undermine care workers' ability to communicate both with clients and colleagues. Some thought that this lack of time could be integral to workplace cultures and reinforced by managers and by wider contextual issues. These contextual issues included levels of resourcing, commissioning practices and the generally poor working conditions of care workers giving rise to recruitment problems and significant staff turnover.

In spite of the significant impact of contextual issues on care workers, their individual characteristics were also felt to be important. These included their age and ethnicity with a preference being expressed for more mature staff and with some advocating the need for ethnic matching in order to meet the needs of different ethnic groups. Others felt that positive results could be achieved through training and appropriate attitudes which should incorporate common sense, compassion and commitment. The ability to communicate and the continuity of care workers for each client was also thought to be important. However, it was recognised that these individual characteristics could be affected by contextual issues such as poor working conditions leading to high levels of staff turnover and recruitment problems. While respondents thought that care workers should be better paid on the one hand, they also thought that they should not be doing the job for money alone.

Most respondents had no prior knowledge of the Care Certificate but, after it was described to them, they thought that it was a positive development and provided a good basic grounding in frontline care. In doing so it helped to standardise the caring role, ensure that care workers were of the right calibre and enhance the sense of self-worth and achievement. For those that expressed a view, 'communication' was seen as the most important care standard. However most felt that all standards were equally important and interconnected with many believing that the generic focus of the Care Certificate was preferable to a more specialised approach. Nevertheless, a few felt that a more specialised focus would be desirable especially with regard to dementia.

Three subthemes emerged around the theme of process. These included the scope of delivery of the Care Certificate, the need to balance theory and practice and incorporate participatory approaches in this delivery and the perceived need for the greater recognition and regulation of Care Certificate training. As such, most felt that training should be broadened to include longer established care workers, managers and other members of staff within each care organisation in order to extend the reach and influence of the training. The second theme related to the need to balance theory and practice in Care Certificate training through such things as the greater incorporation of user perspectives, the elicitation of client feedback and the inclusion more generally of care receivers and the community into the training process. In addition, and in accordance with adult learning theory, participatory

approaches were favoured over more didactic techniques and the inclusion of regular updates and workplace assessments were also advocated. Finally, there was a perceived need for the greater recognition and regulation of Care Certificate training which some groups felt should be made mandatory.

4 EQUALITY AND DIVERSITY ISSUES

This chapter describes how our work addressed issues of equality and diversity, as requested by the funding programme for this research. The main way through which the diversity of population was addressed was through the PPI focus groups as described in Chapter 4 and Appendix 5. Focus groups were run with a diverse range of patient and carer groups in order to reflect the diversity of the population and their contrasting views and experiences of frontline care,. The seven groups who took part were drawn from a wide variety of backgrounds and located in both urban and rural settings. Of the 56 participants in these groups, 44 were women and 12 were men and several were populated by specific ethnic minority groups. They included:

Box 4: PPI focus group participants

GROUP		Total number of participants
1	An African-Caribbean elders community group (3 men and 6 women)	9
2	A frail, older people and palliative care PPI group (4 women)	4
3	Community based support group for African asylum seekers (11 women)	11
4	A self-help group for carers (4 men and 3 women)	7
5	A group for dementia carers affiliated to a national charity (1 man and 2 women)	3
6	An independent group for dementia carers (12 women and 1 man)	13
7	A drop in-centre group for people with English as a second language (6 women and 3 men)	9

The data yielded from these diverse groups help to reflect the corresponding diversity of the UK population as a whole. For example, many of those with experience as unpaid carers spoke of the inequities they experienced as a result of this role and the belief that the emergence of care in the community had led to cut backs on supportive services:

“If you put it out to the community, what you are actually doing is putting it out to mugs like us. And we are doing the nursing and the personal care and we aren't costing them a penny, we are doing it for free, whereas if you are doing it in a hospital, you have got the running costs of the hospital, you have got the staff costs.” (PPI focus group 4)

The service fragmentation taking place as a result of community care (Argyle et al., 2017) was also seen in a negative light, giving rise to difficulties in identifying and accessing appropriate support:

“We don't get information, nobody signposts you. The Alzheimer's Society were good at first but then with the cut backs from their point of view we could no longer have these meetings in their premises and so we have been going for 4 years as a self-support group.” (PPI focus group 6)

Others spoke about issues of ethnicity within care provision with some advocating the use of ethnic ‘matching’ between the care worker and care recipient:

“If you're going to have a caring service then you have people from all backgrounds so when you have a Caribbean person, you try and get the closest person to that background to serve them, it might be difficult but it is what's needed.” (PPI focus group 1)

This need for ethnic matching was seen by an African asylum seeker and former care worker to apply not just to ethnic minorities but also to the ethnic majority:

“I was thinking again in the care homes, where most of the residents are white and most of the carers are foreigners you know, whether the service users actually had a say in the diversity and all this. Because some of them, especially because they are elderly, most of them are fixed in their ideas and they find it difficult, having this coloured person taking care of them and that thing. I am not sure that even the home, the home owners are actually taking their own concerns into consideration.” (PPI focus group 3)

Members of the project management team also had a wealth of diverse and relevant experience within care organisations with seven members being qualified nurses and with two members being qualified and experienced as social workers. Due to the stratified random sample adopted, a similarly diverse and representative range of respondents was aimed for in the stage 1 telephone survey and stage 2 interview and focus groups study. Thus 401 participants took part in the survey, drawn from an initial sample of over 1200 care organisations. From these survey respondents, eight study sites were selected and visited and a further 2 sites were interviewed over the phone. Although a £20 voucher was offered to care workers taking part in these visits, as with survey response rates, those willing to participate in these visits were also low. Furthermore, most of those who were willing to take part tended to be relatively local to the university where the study was based which is perhaps attributable to its regional influence.

Consequently, it is possible that relatively high non-response rates to the survey and to site visit invitations may have compromised the representative nature of participants.

Nevertheless, it is clear that the focus of this evaluation will potentially help to improve the experiences of those giving and receiving frontline care whose voices have tended to be excluded from debates about this care (Arthur et al., 2017). By drawing on the perspectives of care workers themselves, the evaluation and the recommendations arising from it aimed

to improve their experiences by enhancing their career development, self- awareness and self-esteem. As a former care worker stated:

“I felt they were practically looking for cheap labour, because you had just come into the country, you are a student and you just wanted some human, so no much, you are not supposed to know anything, they could just take anybody and I am happy there is a certificate now.” (PPI focus group 3)

In addition, by examining the process of Care Certificate training, this project highlights good practice and effective modes of delivery as well as ways in which this delivery can best respond to the diverse needs of care workers. While through the identification of barriers and facilitators to knowledge transfer and utilisation following Care Certificate training, this study has aimed to improve the outcome of this training with potentially positive implications for those in receipt of this care:

“It is about the standard of the person, but the point is the Care Certificate can be made to make sure these people are the right people, that is the important thing. I know that may reduce the amount you are down, and you are down for people, there are still more jobs available and whatever, but the right people are then looking after your loved ones.” (PPI focus group 4)

This has been particularly the case for older people and other vulnerable groups who have traditionally been disadvantaged within the health and social care system as well as within society more generally. Finally, in promoting the more effective implementation of Care Certificate training, the project has recognised and addressed the diverse needs of care organisations in this process, encouraging the more effective use of their limited resources with potentially positive implications for the health and social care sector as a whole.

5 TELEPHONE SURVEY

This chapter describes the detailed methods and results relating to the telephone survey in stage 1 of the research.

5.1 Methods

Telephone surveys were conducted with staff in care organisations who had responsibility for training or induction of care staff.

5.1.1 Sampling Strategy

The sample was randomly selected from organisations listed in the CQC Care Directory (CQC, 2016). This directory contains details of registered care organisations and their managers, and allows filtering by regulated activities, service type and region. This database is publicly available under the Open Government Licence. A total of 30,311 relevant CQC-registered care organisations (hospitals, social care organisations and independent providers) were identified from the initial sampling frame. The sample was stratified by region (North, Central, South East, South West) and type of service (Health Care, Social Care and Domiciliary Care), and proportionate selection was used to ensure that the sample in each strata was proportionate to that of the total population.

Probability sampling was used to randomly select the sample of care organisations to fit the stratified sampling frame. A sample size of 400 gave a margin of error of 5%, i.e. for each of the reported survey results we could be 95% confident that the total population's score would fall within +/- 5% of that of the population. With a total of 400 providers planned to be interviewed and, assuming a 50% response rate along with the possibility of inappropriate organisations remaining within the final sampling frame, 4.0% of the total population in the CQC database were selected to be approached for telephone interview (n=1203).

A number of inclusion criteria were specified for the population of providers. These classifications are below.

Classifications

Supra-regions

- North: North East, North West, Yorkshire and The Humber
- Central: East Midlands, East of England, West Midlands
- South: South East, South West and London

Type of service

- Health care: NHS organisations, independent healthcare
- Social care: social care organisations
- Domiciliary: any organisation within the other two domains (health care or social care) which provide domiciliary (home-based) services

Of the providers listed in the CQC database, organisations were excluded if they did not provide any one of the following activities regulated by the CQC:

- Accommodation for people needing nursing/personal care
- Accommodation for people needing treatment for substance misuse
- Treatment under the MHA
- Nursing care
- Personal care
- Treatment of disease/disorder/injury

Advice was taken from a member of the PPI group that organisations solely delivering some specific services would not employ sufficient numbers of non-registered care staff for the purposes of the study. These included services such as transport, slimming, dental, and remote clinical advice.

NHS healthcare organisations

The CQC database registers organisation by the geographic location of the management of activities which are regulated by the CQC. For a number of large organisations, in particular NHS Trusts, this means that multiple sites within the same organisation are registered within the database.

In order to ensure that these sites could be treated as independent sampling units, advice was taken from the project steering group with regards to Care Certificate training processes within NHS trusts as well as learning from a previous NIHR HS&DR funded study (the CHAT study), and a pilot with a small number of organisations (n=10), including two sites from two NHS Trusts. It was found that the implementation between sites within the same NHS organisation differed sufficiently for these to be treated as independent sampling units.

CQC Dataset

The database of care providers was retrieved on 08/06/2016 from the CQC website¹, which provided data from the CQC database as at 01/06/2016. The total number of providers registered on this date was 50,001. Meanwhile there were a total of 30,311 organisations providing the type of services meeting the inclusion criteria of the study. There were 7 organisations with an unspecified location. Table 1 shows the total population of included care organisations stratified by region and service type, with percentages.

¹ CQC Data Directory <http://www.cqc.org.uk/content/how-get-and-re-use-cqc-information-and-data#directory>

Table 1. Number (percentage) of care organisations in the population by region and service type (n=30,331)

		Service Type		
		Number (%)		
		Domiciliary	Health	Social Care
Region	Central	2832 (9.3%)	1269 (4.2%)	5260 (17.3%)
	North	2148 (7.0%)	1321 (4.4%)	4531 (14.9%)
	South	3490 (11.5%)	2260 (7.5%)	7173 (23.7%)

Using this stratification, a target sample of 1203 organisations was drawn from the population, equating to 4.0% of the total population as shown in Table 2. These 1203 organisations provided the sample who were approached to take part in the telephone survey.

Table 2. Number (percentage) of care organisations in the target sample by region and service type (n=1203)

		Service Type		
		Number (%)		
		Domiciliary	Health	Social Care
Region	Central	112 (9.3)	51 (4.2)	209 (17.4)
	North	85 (7.0)	52 (4.3)	180 (15.0)
	South	139 (11.6)	90 (7.5)	285 (23.7)

Figure 2 shows how the final sample size was obtained from the initial population obtained from the CQC database.

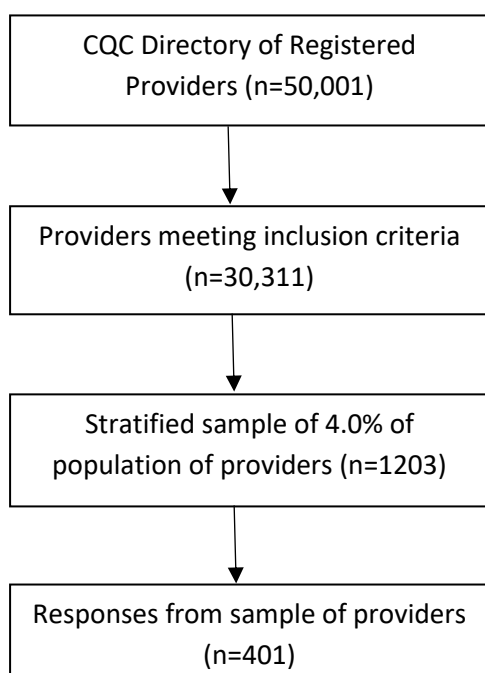


Figure 2. Flow Diagram of Population to Final Telephone Survey Sample

5.1.2 Telephone Survey Procedure

1203 organisations were initially contacted from the CQC database. Research Assistants (RAs) worked systematically through the list of contacts, each RA starting at a different part of the list. Figure 3 depicts each stage of the process of contacting, arranging and conducting the telephone survey with participants. These stages were not necessarily distinct and could overlap (e.g. stages 2 to 4 may occur over the course of one telephone contact). Full details of the contact procedures for the telephone survey are detailed in the standard operating procedures for the study (Appendix 4).

The process involved the researcher obtaining the key contact's details and introducing them to the study and the purpose of the telephone survey. The researcher recorded the routes taken to obtain contact, methods and volume of calls required in order to identify and engage with the most appropriate person for the interview. Name, job title, telephone number, email address were recorded onto the database. If the contact was willing to take part in the survey, the RA arranged a mutually convenient time for the interview and recorded this in the Telephone Survey Contact Log. After obtaining the key contact's details, the RA emailed the participant with a letter of invitation and the participant information sheet. The researcher followed up a week later with a phone call in order to confirm receipt of the email and to book a suitable time for the telephone interview to take place. If the participant was not available at the agreed time, the RA was required to call again on another occasion with a view to rearranging the interview. All new arrangements were recorded in the Telephone Survey Contact Log and appointment diary. In the unlikely event that a participant was unable to

complete the interview once the RA had made all reasonable attempts to complete the interview at the mutually agreed time, or where a mutually agreed time was not possible, the RA thanked the participant for their interest in participating in the study, where possible, before discontinuing. The RA noted the inability to complete the interview in the telephone survey contact log and telephone survey interview log. All organisations were contacted up to a maximum number of five times before being removed from the sample.

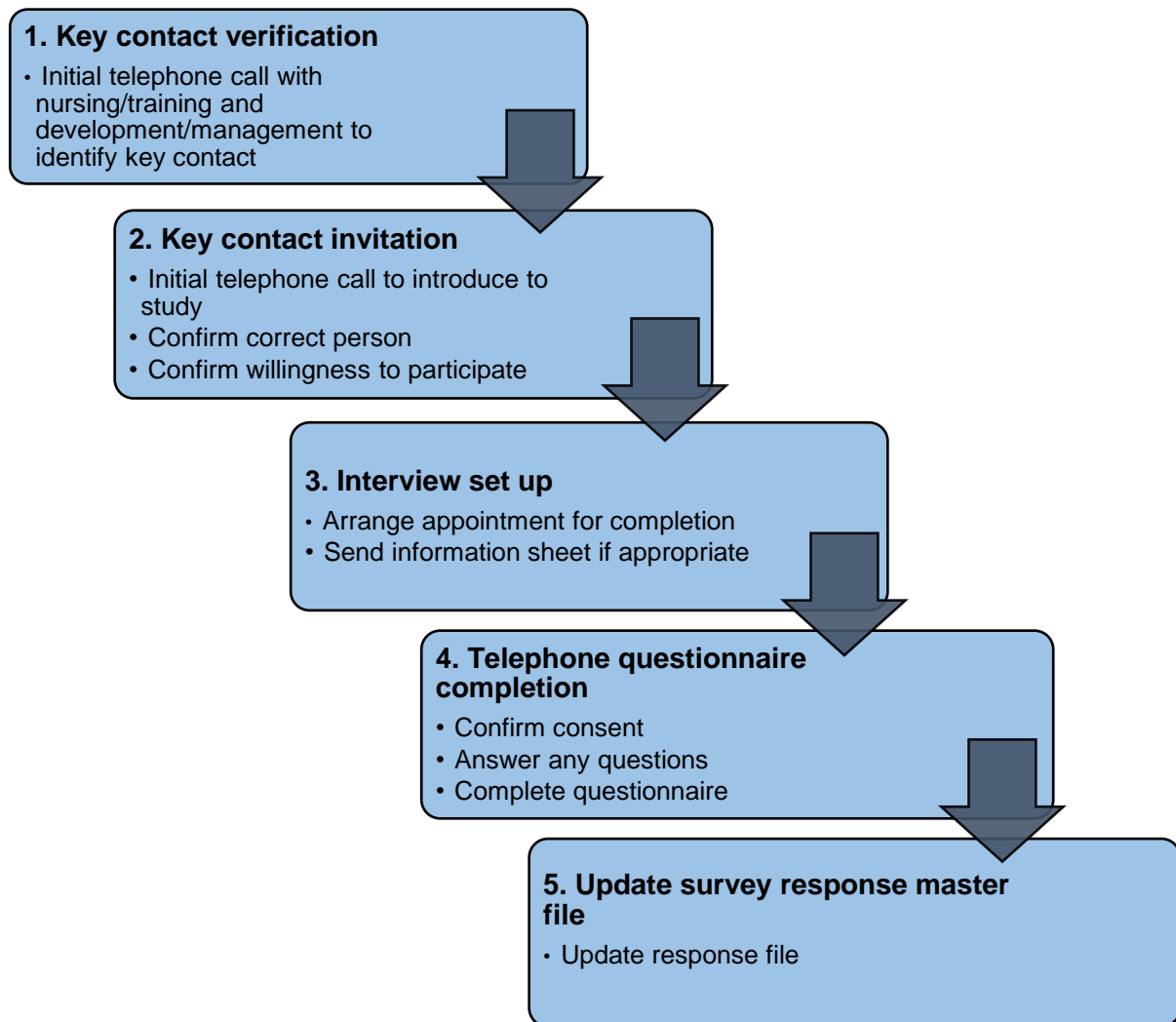


Figure 3: Telephone Survey Flow Chart

Participants wishing to take part in the telephone survey were firstly asked to confirm whether or not they had received the participant information sheet. If so, participants were asked if they were clear about the aims of the study and had any questions. At this point, any questions were answered before proceeding with the telephone survey. Each RA

formally introduced him/herself, the research study and the purpose of the telephone survey, including information relating to response confidentiality and anonymity as outlined at the start of the Telephone Survey Interview Log (see Appendix 4). The RA explained to the participant that the interview would take no longer than 15 minutes. The RA recorded all items as required on the Telephone Survey Interview Log, including interview disruptions and recommencement. The RA conducted the telephone interview in a secure room, which was quiet and where they could not be disturbed.

As long as the participant was willing to continue, the RA began with the interview by ascertaining verbal consent for the interview from the participant and confirming that all responses would be strictly confidential and anonymous. The RA explained that they would guide the participant through the interview and that if there was anything that the participant would like to say which was not covered there would be an opportunity to share this at the end of the interview. Each RA was familiar with the Telephone Survey Questionnaire in order to direct the flow of conversation with the participant and elucidate the essential data required from the activity. During the interview the RA completed the Telephone Survey Interview Log as appropriate and noted down all relevant details. At the end of the interview the RA asked if there was anything else in relation to the Care Certificate and training which had not already been covered and that the participant wishes to mention. The RA would record any other comments which the participant wanted to be recorded. The interview finished with the RA thanking the participant for their time and telling the participant that this marked the end of the interview. The RA asked the participant if they had any final questions before completing the call. The RA informed the participant that they were free to contact them if the participant thought of anything else he/she wanted to be recorded with their responses.

5.2 Analysis

5.2.1 Data Cleaning

The survey data was initially checked and cleaned and all analyses were conducted using SPSS version 22. All CQC codes for the participating organisations were checked against their details from the CQC database and amended if inconsistent. Additional columns were created within the database in order to include the region in which the organisation is located and the sector in which it belongs.

The classification of care organisations from the CQC database was compared with the self-report of respondents. This highlighted a discrepancy relating to organisations classified as providing domiciliary care services within the CQC database. Using the CQC classifications of service type, there were only 2 domiciliary organisations amongst the final survey sample. However, based on the survey responses, 74 respondents described themselves as organisations providing domiciliary care services.

Further checks were conducted on a random sub-sample of 15 survey respondents which the CQC classified as being social care services but who self-reported to be domiciliary services in the telephone survey. These checks involved internet searches for the organisations to verify which type of care services they offered. Where organisations had no website, their CQC inspection reports were examined to provide details of the services

provided. Of these 15 organisations, 14 were verified as providing domiciliary services only (providing just home-based care) and 1 organisation described itself as providing both domiciliary and a small amount of residential care. From this, it was concluded that the domiciliary sector category within the CQC database was unreliable.

5.2.2 Survey Weighting

The planned weighting approach was to use inverse sampling weights based on the survey responses for the nine categories described in section 6.1 above, based on the 3 x 3 table of Region (Central, North, South) and Service Type (Health, Domiciliary, Social).

However, as the original assumptions about the population percentages for each of the sectors based on the CQC database were found to be inaccurate, the planned sample weightings based on these percentages were not able to be used. Therefore, to allow survey responses to be accurately weighted based on representativeness of the population, the domiciliary and social care service categories were combined into one single category representing social care in both residential and domiciliary settings (see Table 3).

Table 3. Number (percentage) of care organisations in the population by region and service type - revised (n=30,331)

		Service Type	
		Number (%)	
		Health	Social Care
Region	Central	1269 (4.2)	8092 (26.7)
	North	1321 (4.4)	6679 (22.0)
	South	2260 (7.5)	10663 (35.2)

The final sample for the telephone survey is presented in Table 4, stratified by region and service type, with Social Care representing the combined categories of residential and domiciliary social care services.

Table 4. Number (Percentage) of Care Organisations in the final sample by region and service type - revised (n=401) and unweighted

		Service Type	
		Number (%)	
		Health	Social Care
Region	Central	8 (2.0)	91 (22.7)
	North	7 (1.7)	73 (18.2)
	South	14 (3.5)	208 (51.9)

Proportional weights were applied to the data such that the sample was representative of the 30,331 CQC care organisations in terms of both region (North, Central, and South) and Sector (Health and Social care, the latter category representing a composite of both social and domiciliary care). As can be seen in this 3 x 2 matrix (Table 5) sample weights ranged from 2.54 to 0.68, with North/Health the most under-represented category in the dataset (and hence having the highest weight applied), whilst South/Social was the most over-represented category.

Table 5. Survey Weightings

		Service Type	
		Health	Social Care
Region	Central	2.12	1.18
	North	2.54	1.21
	South	2.14	0.68

Notes. All weightings to 2 dp.

5.2.3 Survey analysis

The survey data were largely analysed using descriptive methods to provide a breakdown of the survey responses by sector and region. In addition, binary logistic regression models were used to examine the relationship between whether the Care Certificate was implemented and the following variables: sector (health & social); region (north, central and south); and number of unregistered care staff, after adjusting for each of these variables. For this analysis the implementation of the Care Certificate variable was recoded into a binary measure with the 3 'don't know' responses removed (to give a remaining sample size of 398).

5.2.4 Qualitative analysis

Although the telephone survey largely consisted of closed questions, there were a number of open-ended questions about participants' experiences of using the Care Certificate, how it had been implemented and feedback that they have received. Thematic analysis was used to analyse these open ended, free text questions. The analytical technique was guided by Burnard's (1991) method of analysing qualitative data from interviews that developed out of grounded theory.

5.3 Results

From our sample from the CQC database of 1203, 70 organisations were either not contactable on telephone, had ceased operating, or did not meet the survey criteria (i.e. did not provide healthcare) leaving a valid sample of 1133. A total of 401 participants took part in the telephone survey, representing a 35.4% response rate. The responses to survey questions are shown below. All frequencies and percentages reported are weighted. Some of the frequencies reported do not add up to 401 because of the weightings applied.

5.3.1 Survey Respondents and their Organisations

The telephone survey respondents had a variety of roles within their care organisation, but the majority described their role as either the Unit Manager or Care Certificate Lead (Table 6).

Table 6. Survey Respondents' Role

	Number of organisations	Percentage of organisations
Unit Manager	180	45.0
Care Certificate Lead	54	13.5
Care Worker Trainer	26	6.6
HR Manager	18	4.4
Lead Nurse	9	2.3
External trainer	3	0.8
More than one role	22	5.5
Other	73	18.1
Missing	15	3.7
Total	400	100

Two-thirds of respondents were working within the independent sector (66.3%), whilst 18.2% worked for public sector care organisations and 12% in the voluntary sector. Over two-thirds of respondents (68.3%) stated that their organisation had multiple sites. Of those organisations with multiple sites, 67% of respondents reported that there was a degree of autonomy in the training provision between sites.

Participants were asked to estimate how many unregistered care staff were employed by their organisation. There was variation by service type, with the majority of social care organisations (61.3%) reporting between 1 and 49 unregistered care staff, whilst nearly half of health organisations (44.6%) reported over 250 unregistered care staff (Table 7).

Table 7. Estimated Number of Unregistered Care staff in the Organisation (% response)

Number of Unregistered Care staff	Frequency (%)		
	Total Sample	Health Organisations	Social Care Organisations
None	21 (5.2)	0 (0)	21 (6.3)
1 - 49	233 (58.1)	27 (41.5)	206 (61.3)
50 - 249	68 (17.0)	9 (13.8)	59 (17.6)
250 +	68 (17.0)	29 (44.6)	39 (11.6)
Don't know	8 (2.0)	0 (0)	8 (2.4)
Missing	3 (0.7)	0 (0)	3 (0.9)
Total	401 (100)	65 (100)	336 (100)

5.3.2 Training for New Unregistered Care Staff

All but one respondent reported that their organisation had an induction period for newly appointed care staff. When asked about the length of that induction period, this ranged between one day and six months, but the median length of induction was 20 days.

87.8% of the sample had implemented the Care Certificate into their training provision for new staff. There was some variation by service type, with 95.4% Health organisations implementing the Care Certificate compared with 86.3% of Social Care organisations (Table 8).

There was a significant difference in whether those from the health or social care sector were likely to implement the Care Certificate (OR = 4.44, 95% CI 1.09-18.00, p=0.04) suggesting that those in the health sector were more likely to implement the Care Certificate than those in the social care sector. Further binary logistic regression models examining differences by region and number of care workers in the organisation, showed that there

were no statistically significant differences between these variables. Examining the relationship between region (North, South, Central) and the whether the Care Certificate was implemented, neither central nor southern care organisations significantly differed from those in the north with respect to implementation of the Care Certificate.

Table 8. Frequency of Care Organisations that have implemented the Care Certificate

Implemented the Care Certificate	Frequency (%)					
	Total	North	Central	South	Health	Social care
Implemented	352 (87.8)	94 (88.7)	110 (88.7)	148 (86.5)	62 (95.4)	290 (86.3)
Not Implemented	46 (11.5)	12 (11.3)	13 (10.4)	21 (12.4)	3 (4.6)	43 (13.1)
Don't Know	3 (0.6)	0 (0)	1 (0.8)	2 (1.2)	0 (0)	3 (0.8)
Total	401 (100)	106 (100)	124 (100)	171 (100)	65 (100)	336 (100)

5.3.3 Reasons for Implementing the Care Certificate

Those organisations who had implemented the Care Certificate were asked to describe the main reasons driving the implementation in their organisation. Their responses were analysed qualitatively using a thematic approach. Three themes emerged:

Compulsory Requirement

The vast majority of reasons for implementation were related to external factors and a perceived element of compulsion. The most common reason given was that it was a “CQC requirement” with more than 25% of respondents stating that the reason for introducing the Care Certificate was because that it was either a “legal requirement”, “mandatory” or “compulsory”. Examples of responses were as follows:

“They were told that they had to do it, the government said we had to do it.”

“One of those legislations that is thrown at you.”

Positive Influence on Practice

The second theme relates to benefits to improved practice and standards of care. For these respondents, the primary reason that they believed that the Care Certificate had been implemented was to promote best practice or to establish a minimum standard of care. These participants viewed the Care Certificate in a positive way, believing themselves to be active participants in a drive to improve quality rather than as passively accepting something that had been forced upon them.

“To ensure best practice.”

“To provide good quality care.”

Pragmatic Solution

A third theme that emerged was seeing the Care Certificate as a practical way to ensure basic training is given to staff that are new to care. These respondents felt that it was helpful to introduce individuals who were new to care to some of their basic responsibilities.

“(It) gives staff the basics, in the past anyone could go into care.”

The misconception that the Care Certificate is compulsory has not been reported previously. A number of stakeholder organisations do address this question in their guidance on the Care Certificate (e.g. UNISON, 2015; TGMG, 2017) and give clear advice that although it is not mandatory and does not form part of legislation, the CQC does expect to see induction programmes that meet the Care Certificate Standards. The CQC itself states that it “expects providers to induct, support and train their staff appropriately. In our guidance for providers on how to meet the regulations, we are explicit about our expectation that those who employ health care support workers and adult social care workers should be able to demonstrate that staff have, or are working towards, the skills set out in the Care Certificate, as the benchmark for staff induction” (CQC, 2015). So, although highly recommended and monitored during inspections, they do not go so far as to make the Care Certificate itself a requirement with any legal or statutory grounding stating that “the use of nationally recognised good practice, such as the Care Certificate, is one good way of helping to demonstrate this to CQC”.

The Care Certificate is not mentioned in the current regulations, although the relevant CQC Guidance to Providers on how to meet the regulations does refer to the Care Certificate Standards. More specifically, Regulation 18(2)(a) of the Health and Social Care Act (2008) Regulated Activities Regulations 2014² states that “Persons employed by the service provider in the provision of a regulated activity must receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform”. The associated CQC Guidance³ states “Providers must ensure that they have an induction programme that prepares staff for their role. It is expected that providers that employ healthcare assistants and social care support workers should follow the Care Certificate standards to make sure new staff are supported, skilled and assessed as competent to carry out their roles.”

5.3.4 Reasons for Not Implementing the Care Certificate

Those organisations who had not implemented the Care Certificate were asked to describe the main reasons for non-implementation in their organisation. From the 46 responses to this question, five clear themes emerged as to the reasons for not yet implementing the Care Certificate.

² <https://www.legislation.gov.uk/ukdsi/2014/9780111117613/regulation/18>

³ <http://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-18-staffing#guidance>

Sufficiently Trained Staff

The first theme that emerged related to the belief that care staff already had adequate qualifications and therefore did not need to complete it. For these respondents, their staff had existing qualifications that could be mapped onto the Care Certificate and therefore they felt that this would meet the CQC standards for training and induction:

“We only take on staff with qualifications and none have required the Care Certificate.”

Existing Induction Covers Standards

The second theme emerging was from organisations that believed that the induction that they were already running for their staff was adequate and did not need changing into the Care Certificate. They felt confident in the quality of their existing package and that it covered the required Care Certificate standards, with some stating that their induction had been endorsed by the CQC at their last inspection:

“There is an existing induction that already covers Care Certificate standards.”

No New Starters

A third theme related to organisations not having implemented the Care Certificate purely because they had not taken on any new staff since its introduction. The tone of these answers was positive, that they would implement it if required.

“Not required yet as there have been no new starters.”

Lack of Capacity

Some of the responses to this question were less positive and related to problems that respondents had found when trying to implement the Care Certificate in their setting. For some respondents, they felt that they did not have enough time or resources to implement the Care Certificate. The specific challenges included having staff or resources to deliver the training package, as well as having sufficient staff to provide backfill to those being released to complete the training. For small organisations in particular, the implementation, the delivery, and the completion of the Care Certificate was an additional workload that they could not resource.

“It is too great a workload.”

Others had found that a lack of organisational support and leadership was hindering their ability to implement the Care Certificate. A number of organisations described how they did not have a named person to take on and lead the implementation, or sufficient support to help with the administrative aspects:

“There is no lead and not enough staff for the administration.”

For two respondents, the organisation had made the decision to avoid recruiting staff who had no previous care experience so that they did not have to implement the Care Certificate. Despite this leading to challenges with recruitment, with a smaller pool to recruit from, this was seen as preferable to implementing the Care Certificate by these organisations:

“We decided that the Care Certificate is such a lot of work that we now have a policy of only employing staff with experience so that we do not have to do it.”

Putting off Staff

A number of respondents expressed concern that the Care Certificate was too challenging for staff. They felt that many of their staff went into Care work because they wanted to focus on physical tasks rather than paperwork, and that the requirements of the Care Certificate could put off people with the potential to be good care workers from joining their organisation.

“We are concerned it will put staff off. They go into care because it is physical and not to do paperwork.”

5.3.5 How the Care Certificate has been implemented

The following section relates to questions that were only asked to participants who had stated that the Care Certificate had been implemented in their organisation (n=352).

The implementation of the Care Certificate was largely being led by unit managers or training leads in the organisations surveyed. There was some variation in this by service type, as shown in Table 9, with health services reporting that training leads were implementing the Care Certificate in 40.3% of healthcare organisations, compared to 22.4% of social care organisations where unit managers typically took the lead (49.3%). Furthermore, funding for the Care Certificate training was more likely to be ring-fenced in health service organisations (61.2%) compared to social care organisations (48.9%).

Table 9. Implementation lead within the Care Organisation

Lead role	Frequency (%)					
	Total	North	Central	South	Health	Social care
Unit Manager	156 (44.3)	34 (36.2)	62 (56.4)	61 (41.2)	13 (21.0)	143 (49.3)
Training Lead	90 (25.6)	35 (37.2)	18 (16.4)	36 (24.3)	25 (40.3)	65 (22.4)
Care Manager	31 (8.8)	6 (6.4)	8 (7.3)	17 (11.5)	0 (0)	31 (10.7)
External trainer	3 (0.9)	1 (1.1)	0 (0)	2 (1.4)	0 (0)	3 (1.0)
Other	64 (18.0)	12 (12.8)	21 (19.1)	30 (20.3)	24 (38.7)	40 (13.8)
Missing	8 (2.3)	6 (6.4)	1 (0.9)	2 (1.4)	0 (0)	8 (2.8)
Total	352 (100)	94 (100)	110 (100)	148 (100)	62 (100)	290 (100)

Question only asked to those who had implemented the Care Certificate (n=352)

A wide range of delivery methods were reported to be used for Care Certificate training, and these showed some variation by service type and region (Table 10). Of particular note is the relatively high proportion of organisations using computer-only delivery in the South region (14.2%) compared to the Central and North regions (4.5% and 9.6% respectively).

Table 10. Training Delivery Methods for the Care Certificate

Delivery Method	Frequency (%)					
	Total	North	Central	South	Health	Social care
Multiple methods	125 (35.5)	34 (36.2)	32 (29.1)	58 (39.2)	31 (50.0)	93 (32.1)
Computer and Classroom	75 (21.3)	17 (18.1)	26 (23.6)	31 (20.9)	10 (16.1)	64 (22.1)
Classroom only	78 (22.2)	21 (22.3)	34 (30.9)	23 (15.5)	9 (14.5)	69 (23.8)
Computer only	34 (9.7)	9 (9.6)	5 (4.5)	21 (14.2)	5 (8.1)	30 (10.3)
Clinical only	32 (9.1)	10 (10.6)	11 (10.0)	12 (8.1)	5 (8.1)	27 (9.3)
Simulation only	3 (0.9)	0 (0)	1 (0.9)	2 (1.4)	2 (3.2)	1 (0.3)
Missing	5 (1.4)	3 (3.2)	1 (0.9)	1 (0.1)	0 (0)	6 (2.1)
Total	352 (100)	94 (100)	110 (100)	148 (100)	62 (100)	290 (100)

Question only asked to those who had implemented the Care Certificate (n=352)

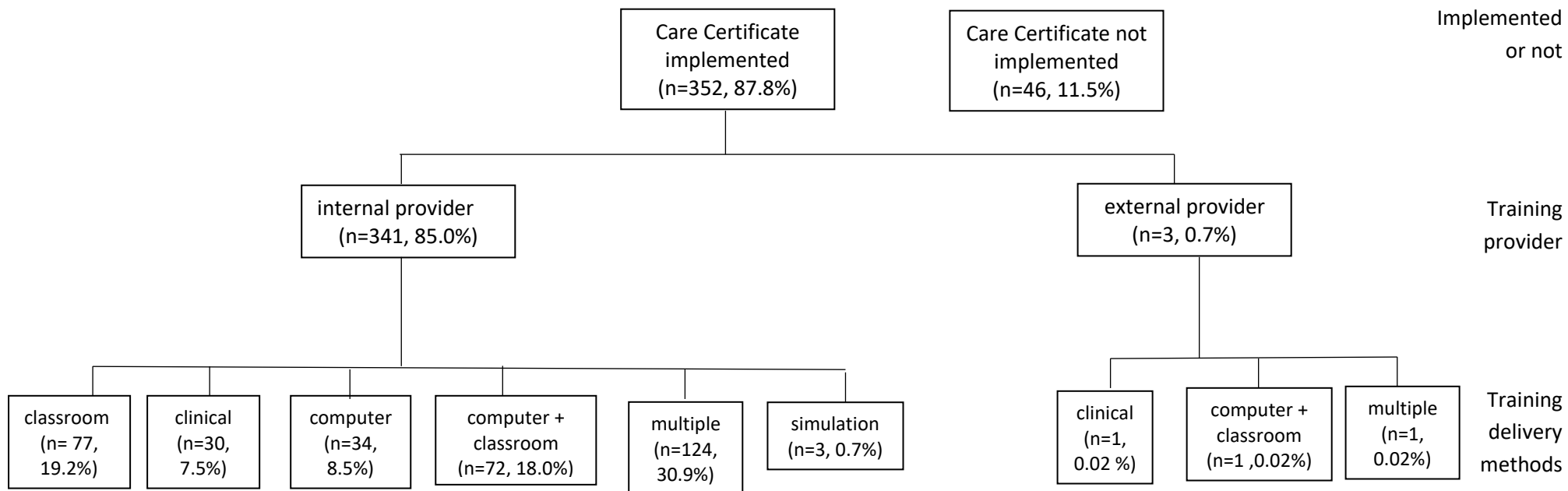
Based on the responses described above, a taxonomy of approaches to the implementation of the Care Certificate was developed, which is presented in Figure 4. This depicts the different types of implementation approach followed by care organisations, based on type of training provider (internal or external) and methods of training delivery (classroom, computer, clinical, simulation, combination of classroom and computer, and combination of multiple methods). This shows that the most frequently adopted implementation approach is the use of multiple methods of training by an internal training provider (n=124, 30.9%)

The length of time to complete the Care Certificate ranged from 2 weeks to 9 months, but the median was 12 weeks to completion.

Participants were asked to consider the main factor in determining who receives Care Certificate training in their organisation. The majority (62.3%) reported that new starters were the main recipients, but job role in relation to care duties was also an important factor (17.5%).

The mean number of employees who had already completed the Care Certificate was 65.5. However, a wide range of responses was reported (from 1 to 7000) with the median response being 6 employees per organisation. When asked how many of these trained care workers were still working within the organisations, the mean number falls to 13.9.

Figure 4. Taxonomy of Care Certificate implementation approaches (n=401)



Just over one third (34.1%) of survey participants reported that they had employed care workers who have completed the Care Certificate elsewhere. Of these (n=120), 46.1% (n=55.3) said that new staff did not have to repeat the Care Certificate if it had been completed elsewhere. However, 49.8% said that new care staff did have to repeat some of the Care Certificate even if it had been completed with a previous employer. Of these organisations, 21.3% stated that new employees had to fully repeat the Care Certificate, whilst 28.5% said that new employees with the Care Certificate had to partially repeat some of the competencies.

5.3.6 Outcomes of the Care Certificate

5.3.6.1 Perceived Impact of the Care Certificate

Participants were asked to rate the impact of the Care Certificate on their care organisation, on care staff and on care recipients. A five-point scale was used: very negative, negative, neutral, positive and very positive. The majority of respondents perceived that the Care Certificate had had a positive or very positive impact on their organisation (65.0%) (Table 11). However, this was even higher in the Health service organisations at 78.8%, compared to Social Care organisations of whom 62.1% reported a positive or very positive impact.

For the impact on care staff a similar pattern emerged, with 63.9% of the total groups of respondents reporting a positive or very positive impact. But breakdown by service type revealed a distinction, with 83.9% of health service organisations rating the impact as positive or very positive compared to 60.0% of social care organisations.

The impact on care recipients was perceived with more neutral responses (39.2%), although the majority, albeit smaller, saw a positive or very positive impact (54.8%). Once again, a difference by service type was reported with a larger number of health organisations reporting a positive or very positive impact on care recipients (67.7%) compared to social care organisations (51.7%).

Table 11. Perceived Impact of the Care Certificate

Impact on...	Frequency (%)						
	Very Negative	Negative	Neutral	Positive	Very Positive	Missing	Total
Organisation	0 (0)	25 (7.0)	86 (24.3)	203 (57.6)	26 (7.4)	13 (3.6)	352 (100)
Care Staff	1 (0.3)	15 (4.3)	98 (27.8)	202 (57.3)	23 (6.6)	13 (3.6)	352 (100)
Care Recipient	1 (0.2)	3 (0.7)	138 (39.2)	173 (49.2)	20 (5.6)	8 (9.0)	352 (100)

5.3.6.2 Workforce Mobility

The majority of participants (63.1%) reported that the introduction of the Care Certificate had not affected workforce mobility and turnover. However, there was a difference between health and social care service types, with 41.9% of health organisations reporting that workforce mobility had been affected, compared to only 32.1% of social care organisations (Table 12).

Table 12. Has the Care Certificate affected workforce mobility?

Response	Frequency (%)					
	Total	North	Central	South	Health	Social care
Yes	119 (33.8)	27 (28.7)	35 (31.8)	57 (38.5)	26 (41.9)	93 (32.1)
No	222 (63.1)	61 (64.9)	73 (66.4)	88 (59.5)	36 (58.1)	186 (64.1)
Missing	11 (3.1)	6 (6.4)	2 (1.8)	3 (2.7)	0 (0)	11 (3.8)
Total	352 (100)	94 (100)	110 (100)	148 (100)	62 (100)	290 (100)

In an open-response question, participants were asked how mobility had been affected. For many respondents, they felt that it was too early to be able to answer this question or that they simply did not know. For those who did answer this question, their responses were mixed.

Many saw the Care Certificate as providing evidence of an individual's ability to provide care which could be taken with the individual care worker to other potential employers. Some were very positive about it being an asset to a person's career despite it not being a formal qualification, and that it gave individuals confidence in their abilities. They felt that as it covered many different domains, it could be relevant to many care settings and the word "portable" was used on many occasions. Some also reported that the Care Certificate training acted as a platform that led on to other training and therefore promoted care workers in their ability to progress their careers. Rather than promoting mobility across organisations, this career progression was often in the same organisation as employers were keen to retain staff that they were investing in. So the Care Certificate was promoting internal mobility and progression within an organisation.

"The skills are portable from organisation to organisation. It does not just limit you to one role."

"The Care Certificate has allowed more training, which has allowed career progression."

For several respondents, the Care Certificate training provided an opportunity to gauge competency, either spotting excellent new care workers or noticing staff for whom care was unlikely to be the right career choice. Being able to spend time with staff, observing their

practice and reading their work was for some an opportunity to notice talent that can be nurtured within the organisation and may not have been noticed otherwise.

“Five people have left care because they didn’t want to do it but they probably would not have been suitable for care work anyway.”

In contrast, some reported that inconsistent implementation and basic content of the Care Certificate meant that they did not think staff could move between care organisations with it. There was evidence of a variety of implementation inconsistencies which has the potential to undermine the value of the Care Certificate reported by other participants.

“Not transferrable due to lack of consistency.”

“We interviewed someone who claimed to have completed it online in 1.5 hours.”

Others felt that it had affected workforce mobility but in a negative way: that staff had left due to not wanting to complete the Care Certificate training or that it had become difficult to recruit staff as people did not want to have to do it.

“It is more difficult to recruit staff as employees are not interested in doing the qualification.”

5.3.6.3 Training Opportunities

Participants were asked whether the Care Certificate had impacted on the range of other training opportunities available to care staff. For the majority of respondents (65.4%) there had been no perceived impact. However, 27.3% of organisations thought there had been an impact on the range of training opportunities offered. An open-response question on how training opportunities had been impacted revealed both positive and negative perceptions. Four themes emerged from participants’ responses.

Increased Training Opportunities

A large number of respondents reported that the Care Certificate had increased the range and variety of training opportunities available to care staff. Their induction training had been enhanced by additional training units from the Care Certificate and further training opportunities had also been identified by organisations for further development of care staff.

“It has helped develop other sessions which are in the Care Certificate, which were not in the induction before.”

Increased Motivation of Care workers

Many respondents described how completing the Care Certificate had encouraged care staff to continue with their further development through attendance on other courses and gaining further qualifications. Completing the Care Certificate increased their confidence and motivation as individual learners.

“[Staff are] more confident and willing to go on training.”

Better Identification of Training Needs

Organisations were also able to identify the training needs of new staff more readily, which opened doors to further training. The use of the self-assessment workbook was particularly noted by respondents as facilitating this.

“Training needs can be analysed from the self-assessment part.”

Restricting other Training Opportunities

Some respondents described a more negative impact of the Care Certificate on other training opportunities. This was specifically related to the time and funding required to complete the Care Certificate, which meant that there were fewer opportunities for further training.

“It is time consuming and expensive to undertake other training and in particular training everybody.”

5.3.6.4 Care Workers’ Views on the Care Certificate

Participants were asked what feedback they had from staff who had participated in the Care Certificate training. As most of the respondents were managers or senior staff, only a few had actually completed the Care Certificate themselves and taken part in training. Very few organisations reported that they collected feedback systematically, and therefore their responses described here were generally anecdotal and observational.

What Care Workers Liked:

It was observed that staff liked being able to learn, building on existing knowledge and gaining a better understanding of their role, particularly those who were new to care. Care workers felt more prepared for the reality of their new working environment.

“They feel that they know more about what they can and can’t do in their role.”

Many respondents described how staff saw the Care Certificate as a tool for development that can lead on to other training or opportunities. For staff that have few qualifications or who have not been in education for many years, completing the Care Certificate can be a confidence boost. The sense of achievement and satisfaction gained from achieving the Care Certificate was also thought to boost the relationship between staff and managers.

“It’s a sense of achievement and confidence to go further to complete more training.”

“(They) feel valued that the company is investing a lot of money in them. Creates a good working relationship between the manager and employee.”

Finally, it was described how care staff enjoyed the dedicated time given to discuss and share ideas about their work. They were felt to have benefitted from peer support in this process and an opportunity to explore the nature of their role.

“It gives the opportunity to meet new people who going into the same workplace and the opportunity to exchange ideas.”

What Care Staff Didn't Like

Overwhelmingly, issues around time were the main theme here, either lack of time to complete it whilst still working or a pressure to complete it within a 12-week time frame. Many also described that staff often had to complete the Care Certificate in their own time which then had the effect of staff finding it an extra pressure and being resentful about it.

“Difficult to keep the candidates' interest as they are doing it in their own time.”

Other issues that arose were related to content: that there is too much paperwork, the content is repetitive, some is irrelevant, and that it can be challenging for individuals with English as a second language or who struggle with academic work. Many respondents cited “written work” as an issue for their staff and an element that they disliked.

“(They dislike the) written work, [lack] motivation to put pen to paper.”

5.3.7 Challenges of Implementing the Care Certificate

Participants were asked what the main challenge in implementing the Care Certificate in their organisation was. Nearly a quarter (23%) stated that lack of care worker interest was the main challenge, followed by lack of funding to support the implementation (17.3%). These responses saw some variation by region and service type (Table 13). Of particular note is a higher response to the challenge of lack of funding and lack of time in the central region (25.5% and 20.9% respectively) and the challenge of backfill for staff in the health service (11.3%) and the north (10.6%).

An additional open-response question was asked to participants who had implemented the Care Certificate, to provide more detail on the reported challenges of implementation. Responses to this question fell into four broad categories.

For a significant proportion of the respondents, they felt that there had been no problems implementing the Care Certificate. For those that did describe challenges, three clear themes emerged, whilst others also described the innovative ways that they had tried to overcome these challenges.

Practical issues of time, staffing, resources

A large number of respondents described the practical problems they had faced in implementing the Care Certificate. These included finding time to complete the workbook and difficulties in getting staff observed and assessed due to senior staff availability and shift patterns. In organisations where the service users required a high level of care, it was difficult to prioritise time for completing the workbook and many describe staff having to do it

in their own time. Challenges related to shift patterns, such as trying to assess staff who worked nights, was also mentioned as an organisational issue. One respondent cited that the printing costs of a large workbook with many pictures were a financial challenge for a small organisation.

“Poor pay, staff shortages, operating beyond capacity of the care workers we have, too much pressure on organisations to complete Care Certificate.”

“Hard for staff to find the time to complete it once they are working”

“Backfilling hours can be issue alongside financial needs, observational element of the Care Certificate, bank staff.”

Table 13. Main Challenges in Implementing the Care Certificate

Challenge	Frequency (%)					
	Total	North	Central	South	Health	Social care
Lack of care worker interest	81 (23.0)	28 (29.8)	15 (13.6)	38 (25.4)	16 (25.8)	65 (22.4)
Lack of funding	61 (17.3)	16 (17.0)	28 (25.5)	18 (11.9)	9 (14.5)	52 (17.9)
Lack of time	50 (14.2)	7 (7.4)	23 (20.9)	20 (13.3)	4 (6.9)	46 (15.9)
Backfill for staff	25 (7.1)	10 (10.6)	8 (7.3)	8 (5.1)	7 (11.3)	19 (6.6)
Lack of organisational support	12 (3.4)	1 (1.1)	5 (4.5)	6 (4.2)	2 (3.2)	10 (3.4)
Lack of trainers	8 (2.3)	2 (2.1)	1 (0.9)	5 (3.2)	2 (3.2)	6 (2.1)
Inadequate facilities	4 (1.1)	1 (1.1)	2 (1.8)	1 (0.5)	2 (3.2)	2 (0.7)
Other	92 (26.1)	21 (22.3)	24 (21.8)	47 (31.9)	20 (32.3)	72 (25.0)
Missing	19 (5.4)	8 (8.5)	4 (3.6)	5 (4.6)	0 (0)	18 (6.2)
Total	352 (100)	94 (100)	110 (100)	148 (100)	62 (100)	290 (100)

Content of the Care Certificate

A further common theme related to the content of the Care Certificate. Some felt that the content was too basic, others that it is too complicated, that it was not relevant to their work environments or that it was a challenge for those with literacy issues. Barriers concerning literacy and language issues were mentioned by several respondents as preventing care

workers from engaging with Care Certificate materials. Some care workers had difficulties with literacy making the Care Certificate programme difficult to understand.

“The content is too demanding for carers who are in care to care and not do.”

“People with English as a second language need more time and support.”

Lack of Care Worker Interest

Finally, many respondents replied that engaging staff with the Care Certificate was the main challenge. Some of this can be explained in terms of the above issues of time, ability and organisational structures but some felt strongly that not having a formal qualification or a financial incentive was a problem. Some managers also described that new starters wanted to care and not do written work and that having to complete the Care Certificate had put them off working in the care sector.

“Very difficult to find the time to do it. Two staff started it but left care altogether as they couldn’t cope with it.”

Innovative Practice to Overcome the Challenges

It is notable that some organisations that took part in the telephone survey had developed innovative schemes and ways of encouraging staff to complete the Care Certificate that may be worth wider consideration. One organisation described having a ceremony to celebrate the achievements of those that have completed. This had the effect of recognising the achievement of care workers and celebrating the work they had completed. Another organisation offered a £100 bonus on completion of the Care Certificate but interestingly had not yet found that this had the desired effect, and they were still finding it a struggle to encourage staff to complete the Care Certificate.

There were several examples of schemes whereby Care Certificate ‘buddy’ or ‘mentor’ schemes had been developed, or specific Care Certificate workshops were delivered to enable staff to get through the content in a structured way. Such systems offer extra support that would seem to be valuable in light of the many responses that are concerned about staff struggling with the content or finding the time to complete it.

5.4 Summary

The telephone survey with care organisations was completed by respondents from 401 care organisations and gives an insight into the uptake of the Care Certificate and implementation approaches adopted by care organisations. It provides evidence on the impact of the Care Certificate and challenges to implementation, which are further explored in the Stage 2 Interview and Focus Group Study in Care Sites (Chapter 7).

A significant proportion of the care providers surveyed were positive about the Care Certificate and this must be seen as an achievement in such a short space of time. The care sector suffers from major challenges in terms of staffing and staff turnover, funding and significant time pressures and yet it has found the capacity and enthusiasm to try out the Care Certificate in nearly 90% of the organisations surveyed. For the majority this has been a positive experience. However, for a small proportion, implementing it has been a challenge

that has left them feeling disillusioned and disheartened. For this group, trust in the usefulness and authenticity of the Care Certificate has been eroded. Managers from social care organisations consistently reported more negative experiences and outcomes compared to health care managers who participated. The key points that are made in this chapter may be summarised as follows:

1. 87.9% of care organisations had implemented the Care Certificate into their routine induction for new care staff and uptake was significantly higher for health service organisations (96.7%) than for social care organisations (86.2%).
2. The key implementation driver for care organisations was the perception that the Care Certificate was compulsory and a requirement from the CQC.
3. For those organisations that had not implemented the Care Certificate, this was because their staff were already sufficiently qualified and trained to not need to complete the training, their existing induction training covered the skills set out in the Care Certificate, or they had not yet taken on new staff since the introduction of the Care Certificate but would implement it if new staff were taken on.
4. Non-implementing organisations described a number of barriers that had prevented them from implementing the Care Certificate including lack of capacity, resources and leadership to support implementation.
5. A small number of organisations reported that they were avoiding recruiting staff without care experience so that they could avoid the need to implement the Care Certificate.
6. Multiple training delivery methods were most frequently used, usually involving a combination of computer-, classroom- and clinically-based approaches. This approach was used by nearly a half of all health organisations and just over one quarter of social care organisations.
7. These blended learning approaches can have the practical benefits of overcoming limitations of time and space whilst maintaining the benefits of interaction to enhance learning (Garrison and Kanuka, 2004). Incorporating the theories of experiential learning (Kolb, 2014) and situated learning (Lave and Wenger, 1991), adding some work-place application through clinically-based training is likely to achieve better learning outcomes.
8. For one in ten organisations, the Care Certificate was delivered using computer-only methods or online learning.
9. Where organisations had employed new starters who had received the Care Certificate through previous employment elsewhere, half of them did not require these new starters to complete the Care Certificate again, 21.3% required these staff to fully repeat the training within their organisation, whilst 28.5% required these staff to partially complete the training.

10. The majority of organisations perceived a positive impact of the Care Certificate on the care organisation, care staff and care recipients. However, health organisations consistently reported more positive responses than social care organisations.
11. Many viewed the positive impact that the Care Certificate could have on care staff being able to move between employers with evidence of their abilities to provide care. However, others believed that workforce mobility would not be helped by the Care Certificate due to inconsistencies in how it had been implemented in organisations. Some also believed that the Care Certificate had negatively impacted on recruitment, as potential employees did not want to complete it.
12. Whilst some organisations reported that the Care Certificate had increased the training portfolio offered by organisations, as well as the motivation of care staff to take up these opportunities, others felt that the impact had been negative by restricting other training through lack of time and funding.
13. Positive aspects implications of the Care Certificate included being better prepared for their role, providing a sense of achievement and a confidence boost, and benefitting from peer discussions and reflections on their role and practice.
14. The main negative for care staff was the amount of time the Care Certificate took and pressure to complete it within 12 weeks, which often led to it being completed in their own time. Many providers seemed to believe that it must be completed within this time frame and found this increased the pressure on organisations and individual care staff.
15. Lack of care worker interest was reported as the main challenge to implementing the Care Certificate across all regions and both sectors. Practical issues, such as lack of funding, time, and staff for backfill, were also widely reported. The content of the Care Certificate materials, and reliance on reading and writing, was a barrier for a number of care staff.

6 INTERVIEWS AND FOCUS GROUP STUDY IN CARE SITES

This chapter describes the detailed methods and results relating to the interview and focus group study conducted in 10 care organisations in stage 2 of the research.

6.1 Introduction

The telephone survey described in Chapter 6 allowed us to capture a picture of Care Certificate implementation across England. However, more in-depth qualitative data was needed to shed light on the findings generated in stage 1 of the research. For those care workers completing the Care Certificate there may be a direct effect on their skills and career pathways. In addition, their learning should benefit patients and clients in receipt of care. Managers, trainers and supervisors of staff in the employing organisations are likely to have a critical overview of the impact of the Care Certificate. It was therefore important to include the views of these key stakeholders in our investigation. Therefore, the study included the views and perspectives of key stakeholders and care workers through a series of focus groups and semi-structured interviews within organisations which had and had not fully implemented the Care Certificate.

6.2 Methods

6.2.1 Participants

A range of sites were approached to take part in the interview and focus group study to explore in-depth the effects of Care Certificate adoption. These sites were selected from those organisations who had expressed an interest during the telephone interview in stage 1 of the study. Sites which expressed an interest in taking part in the second phase of the project (n=29) were approached with a view to including some where Care Certificate implementation was not far advanced. The final selection of sites was based on their telephone survey responses relating to the following criteria: sector, method of Care Certificate delivery, region. Thus a purposive sampling approach was adopted to maximise variation and to achieve a spread of implementation approaches across the range of care organisation types and regions. We also included some sites where the Care Certificate had not been widely implemented, in order to compare these with other 'early adopter' sites. At each site, that semi-structured interviews were sought with up to 3 managers or trainers, and around 8 Care Certificate recipients or potential recipients (care workers) were interviewed individually or in focus groups. There was, however, flexibility in these numbers depending on the opportunities available during each site visit. Potential interviewees were chosen because of their knowledge about the development, training, performance or retention of entry-level care workers, and included workforce development leads, training leads, human resources managers, social care support worker managers and lead nurses such as Modern Matrons. These organisational stakeholders and service leaders were identified through the initial care provider contact made from the CQC database during the stage 1 telephone interviews.

Ten sites participated in stage 2 of the study incorporating a total of 92 participants: 24 manager-level stakeholders; 48 care workers who had completed the Care Certificate; and 20 who had not completed the Care Certificate. Site participants were drawn from ten sites as shown in Table 14. All sites were running Care Certificate training, with the exception of 4 and 10, both small care homes, which had already implemented the training but were not currently providing it due to a lack of perceived need. A total of eight focus groups were run across the sites. Focus groups with care workers were not conducted in sites 1, 4 and 6, where care worker numbers did not enable a focus group approach to be used, nor were focus groups run on sites 9 and 10 which the researchers did not visit in person.

Table 14. Participants per site.

SITE	Number of training sessions observed	Number of care workers with CC in focus groups or interviews	Number of care workers without CC in focus groups or interviews	Number of Stakeholders interviewed	Total number of participants per site
1	2	1	2	3 (1 service manager, 2 trainers)	6
2	3	7	11	3 (2 trainers, 1 manager)	21
3	2	12	0	4 (2 trainers, 2 managers)	16
4	0	0	3	1 (1 manager/owner)	4
5	2	8	0	3 (1 manager/owner, 1 trainer, 1 learning and development manager)	11
6	0	1	1	2 (1 director/franchise owner, 1 care manager)	4
7	2	7	1	3 (3 trainers)	11
8	1	10	1	2 (ward managers, 1 trainer)	13
9	0	2	0	2 (2 unit managers) – phone interviews, not site visits	4
10	0	0	1	1 (Unit Manager) - phone interviews, not site visits	2
TOTALS	12	48	20	24	92

A brief description of each site is provided below:

1. A social care and learning disability site that is part of a national provider which is run by a charity organisation. Participants included: 1 service manager; 2 Care Certificate trainers; 2 care workers without the Care Certificate and 1 care workers with the Care Certificate.
2. A social care and learning disability site that is part of a national provider which is run by a charity organisation. Participants included: 7 care workers with the Care Certificate; 11 care workers without the Care Certificate but had previous experience as a Care Certificate Assessor; 2 Care Certificate trainers and 1 Unit Manager.
3. A social care and learning disability site that is part of a national provider run by a charitable organisation. Participants included: 12 care workers with the Care Certificate; 2 Care Certificate Trainers and 2 Unit Managers.
4. A single site Dementia specific care home. Participants included: 3 care workers without the Care Certificate; 1 Unit Manager.
5. A domiciliary care organisation that is part of a national provider which is run by a charity organisation. Participants included: 8 care workers with the Care Certificate; 1 Unit Manager; 1 Care Certificate Trainer and 1 Learning and development manager.
6. A domiciliary care organisation providing care mainly to older people, part of a national chain. Participants included: 1 care worker with the Care Certificate and previous experience as a Care Certificate assessor; 1 care worker without the Care Certificate but had previous experience as a Care Certificate Trainer; 1 Director of Services and 1 Unit Manager.
7. An NHS acute hospital. Participants included: 7 care workers with the Care Certificate; 1 care worker without the Care Certificate and 3 Care Certificate Trainers.
8. An NHS acute hospital. Participants included: 1 care worker without the Care Certificate; 10 care workers with the Care Certificate; 2 Ward Managers; 1 Matron; 1 Care Certificate trainer.
9. A social care and learning disability site that is part of a national provider which is run by a charity organisation. Participants included 2 Unit Managers; 2 care workers with the Care Certificate.
10. An independent social care organisation providing care mainly to older people. Participants included: 1 Unit Manager and 1 care worker without the Care Certificate.

6.2.2 Procedure

Sites were contacted initially via telephone in order to confirm their willingness to participate. Interested organisations were sent the participant information sheet and followed up a week later to arrange the study site visit. Site visits were planned to coincide with training activities where possible in order to support the collection of observational and documentary data, and to facilitate the arrangement of interviews and focus groups. Where it proved impossible to

find a suitable time for a visit, telephone interviews were arranged. In each study site, one to one semi-structured interviews were conducted with the key stakeholders. Focus groups or semi structured interviews were conducted with the care workers. Interviews and focus groups were conducted in the most convenient location for the research participants and were approximately 30 minutes in length. They were audio recorded with the written consent of participants.

The interview schedule included the following questions (full scripts are in Appendix 3):

For care workers who have taken or are taking the Care Certificate

- The experience of the Care Certificate in that setting
- The accessibility of Care Certificate programme and materials
- The perceived impact on practice
- Barriers and facilitators to successful outcomes
- Career options for staff, post-Care Certificate

For care workers who have not taken the Care Certificate

- Perceptions of the Care Certificate in that setting
- The accessibility of Care Certificate programme and materials
- The perceived impact on practice
- Barriers and facilitators to successful outcomes

Stakeholders including trainers and managers

- Who has led the implementation of the Care Certificate in that setting?
- What the Care Certificate programme contents are and how they are delivered
- How care staff have been enrolled on the programme
- What successful implementation in this setting looks like
- The barriers and facilitators to successful implementation
- The perceived impact on practice, including patient experience

6.2.3 Analysis

Interview data was transcribed verbatim and coded. NVivo version 11 was used to store and manage the data which was coded to identify emergent themes. The qualitative data was analysed using a framework method (Gale, 2013) drawing out themes concerning the impact of the Care Certificate and the facilitators and barriers to the implementation of the Care Certificate. We followed several broad phases: familiarisation with the data, generating initial codes, searching for themes, reviewing themes and defining and naming the themes. Upon the initial reading of the transcripts, main ideas, meanings and any preliminary ideas were noted. Several readings of the transcripts were carried out in order to account for any new insights and emerging concepts. Reflexive memos were written.

A list of emerging themes was created in order to look for connections between them; the initial order of the themes was chronological. Members of the research team confirmed that the themes chosen were a valid representation of the data. The emerging concepts were later given more abstract names. The transcripts were constantly referred to in order to ensure the connections were reflective of the transcripts from which they were derived. A table of the master list of themes was then created and ordered coherently; these themes

were structured into superordinate and subordinate themes. To illustrate each theme, quotes from participants were collated.

In order to maximise the credibility and trustworthiness of the analysis, a number of validity and reliability checks were carried out. Participant validation was done at the end of each interview, when a summary of the responses was given to the interviewee to confirm the researcher’s understanding of the findings. To promote reliability, two researchers independently coded the qualitative data and then compared the number of matching codes for agreement. Refinement of coding continued until both researchers agreed.

Themes and categories from the data were further organised and presented using the Consolidated Framework for Implementation Research (Damschroder et al., 2009). This is a synthesis of implementation theories. It lists constructs which influence implementation effectiveness within the following domains: individual characteristics; implementation process; context (inner and outer); and intervention characteristics.

6.3 Findings

The findings described below provide a combined analysis of the themes across the study sites. Individual summaries of each study site are presented in Appendix 6. In addition, using a Framework Analysis approach provided a matrix of themes by study site, which is also shown in Appendix 6, indicating from which of the study sites the themes emerged from. The analysis identified 18 themes, which are presented in Table 15, along with the framework categories relating to the research questions and CIFR domains. These themes are discussed below in the context of the research objectives relating to i) the impact of the Care Certificate; and ii) the barriers and facilitators to implementation using the CIFR domains as a framework for these. The themes are illustrated using key quotes which characterise the thematic qualities of the data.

Table 15: Themes relating to the Impact and Implementation of the Care Certificate

Framework Categories	Themes	
Impact of the Care Certificate	A basic foundation for those entering the care sector	
	Greater confidence, knowledge and understanding	
	Fostering empathy, compassion and reflective practice	
	Career progression and standardisation	
Barriers and facilitators to implementation related to the 5 CIFR domains		
	<i>1. Intervention characteristics</i>	Adaptation of the Care Certificate
	<i>2. Outer Context</i>	Portability
		Accreditation of prior learning
		Quality assurance and registration
	<i>3. Inner Context</i>	Logistics of Implementation

	Peer support
	Completion and recognition
4. Individual characteristics	Motivation to learn
	Literacy
	Prior experience
5. Implementation process	Size and infrastructure
	Organisational support
	Scope
	Recruitment

6.3.1 Impact of the Care Certificate

Four themes emerged from the data concerning the impact that the Care Certificate was perceived to have on care workers and care organisations.

6.3.1.1 A basic foundation for those entering the Care Sector

An important aim of the Care Certificate is to provide a basic foundation in care and an introduction to the employing care organisation. As such, most study sites regarded it as a positive tool for setting up care workers with the minimum standards to work within the health and social care sector, ensuring that they are delivering a high standard of care at all times:

“I feel like it has made everyone more aware and conscious of requirements for care, the minimum standards shall we say. It is a benchmark now that we can measure not only new staff off but also existing staff.” (Study site 6- Stakeholder)

“It captures everybody's learning styles that you've got, you know visual and they've got the workbooks to do so they've got revision and then you've got the practical stuff as well so it appeals to everybody's learning styles.” (Study site 5- Key Stakeholder)

Participants usually acknowledged that while the Care Certificate can be important for staff with previous experience and knowledge, it is generally more valuable for those completely new to care. This can include staff from other countries who may be unfamiliar with care conventions in the UK.

I don't think it's been as impactful for the staff that we've recruited that have already got existing experiential knowledge and qualifications, but for the ones that are completely green, for want of a better phrase, I think it has been very helpful.” (Study site 8- Stakeholder)

This was echoed by care workers themselves, who felt assured that they were working to the standards set out in the Care Certificate, which provided a firm and comprehensive foundation for their work. Care workers who completed the Care Certificate appreciated its potential for generalising to other work domains:

“Yes, not only that, if you're going to work in the adult sector, you might come across a child visitor and they might need something, and you've been trained to cover all bases.” (Study site 7- care worker with the Care Certificate)

“I think it's good because I feel like without it there wouldn't be a standard necessarily put in place. I think that immediately you get to know what's expected from the job and without it I think your knowledge would be limited.” (Study site 5- care worker with the Care Certificate)

Nevertheless, there was flexibility in its delivery depending on the levels of experience of care workers, with ‘self-assessments’ determining existing knowledge levels being commonly used with new care workers before they commenced training, so that this training could be tailored to meet their specific needs. This was found to be useful by an employee who was new to the health and social care sector:

“I made it clear that I'd never been in the industry before, so she went through a lot more in detail, because some of the others had been in the industry, so when they came in, they had more knowledge.” (Study site 1- care worker with the Care Certificate)

6.3.1.2 Greater confidence, knowledge, and understanding

The introduction of the Care Certificate was felt to have improved care workers understanding of the care sector. Interviewees told us that it provided the care workers with an understanding of the bigger picture:

“there seems to be an increased awareness amongst the support worker staff of rationales for carrying out certain therapeutic interventions with patients.” (Study site 8- Key Stakeholder)

Participants also told us that it increased care workers' skills and confidence:

“I think, from when we implemented the Care Certificate training in 2015, the confidence of people when they were leaving the training room ... is higher now because they're going away with more tools in their box if you like.” (Study site 5- Key Stakeholder)

This confidence meant that care workers were not only able to apply their own skills more readily and appropriately, but were also able to challenge others if necessary.

“They feel confident to challenge, to ask questions and most do feel very proactive in obtaining the Care Certificate and engaging managers about their development during that time.” (Study site 2- Stakeholder)

One of the biggest advantages of taking the Care Certificate expressed by care workers from the various organisations was the growth in knowledge which could be applied to different care settings and possibly developed further through additional qualifications:

“They've got a better knowledge of the standard of care that is acceptable, [they may] go on to... NVQ level 2 or QCS level 2s and 3s.” (Study site 6- care worker with the Care Certificate)

People who had completed the Care Certificate felt that the knowledge and understanding gained was immediately applicable to the working environment:

“It's given me more knowledge, 100% and it's made putting it into practice quite simple as well when I have actually gone to my placement where I work, putting into practices easily transferred from the training that I have just done.” (Study site 2- care worker with the Care Certificate)

This was true for people working with specific client groups, such as people with autism, as well as those working in a variety of other areas. This reflects how the Care Certificate training was adapted to particular settings, with nearly all sites reporting some adaptation of the Care Certificate format. For example, as a stakeholder stated on a social care and learning disability site:

“It is like the safeguarding unit, we deliver a full safeguarding training we don't sort of budget just to service the Care Certificate, we go into more detail than the Care Certificate is requiring to make sure that the needs of the new workers are fully met to meet our needs.” (Study site 2- Key Stakeholder)

6.3.1.3 Fostering empathy, compassion and reflective practice

Some participants felt that the knowledge and understanding gained through the Care Certificate fostered greater empathy in care workers. Thus one stated that they had *“learnt people's different points of view.”* (Study site 5- care worker with the Care Certificate) and another said:

“Well if you are more understanding to them they will kind of understand you more.” (Study site 9 – care worker with the Care Certificate)

Individuals who had not completed the Care Certificate could also see its potential benefits and its potential to broaden one's understanding:

“Because you can see from their perspective and put yourself in their predicament.” (Study site 1- care worker without the Care Certificate)

Compassionate care is an important objective, and there is some evidence from our interviews that the Care Certificate helped participants to understand what this means in practice:

“You just take your time and just do what you feel is best.” (Study site 9 – care worker with the Care Certificate)

Empathy is closely aligned with reflection and self-awareness. Reflection was explicitly encouraged by the approach to training and the assignments given in most sites. Consequently, care workers agreed that the learning process generated by the Care Certificate promoted a reflective approach to their practice:

“Just how you approach a situation, you might approach it the way you did before ... reflect on it ...try it this way ... you develop as a support worker basically.” (Study site 3 – care worker with the Care Certificate)

This was endorsed by trainers on two social care sites:

“It may have made them think more, think, about how they do things, and what impacts on people, and the people who use our service.” (Study site 1- Stakeholder 1).

“I think the biggest thing that it provides, the people that I have taken through the Care Certificate, it really enforces reflective practice, so as they are going through things and they are looking at the standards and they are having to think about how these standards relate to the working practice within the service.” (Study site 2, Key Stakeholder)

6.3.1.4 Career progression and standardisation

We have already reported one participant’s view that doing the Care Certificate could motivate people to undertake further training and development. We heard directly from some care workers that this was their ambition. For example, as a care worker with dyslexia said:

“I did tell them that things are going to hold me back with the dyslexia, and the knowledge, but I will gain the knowledge from the training courses, and along the way, from other staff. So, as it stands now, I have been here a year and two months, that I'm a stand-in senior, and I'm a moving and handling instructor.” (Study site 1- care worker with the Care Certificate)

This quotation shows that taking the Care Certificate was seen as a springboard to further development despite a specific learning need, and its successful completion gave this individual the confidence to undertake new responsibilities at work.

Moving from the individual benefits to an organisational perspective, key informants recognised that the Care Certificate as could serve as a common currency in workforce training and qualifications:

“It's about consistency isn't it, everyone's working ... the same.” (Study site 2 – Stakeholder)

It seems that the Care Certificate is also a mapping and assessment tool for key stakeholders to assess the competencies of their employees:

“It actually provides a structure on which you can identify why they are not meeting standards.” (Study site 2- care worker without the Care Certificate)

Most of the participants from care organisations felt that the Care Certificate offers a minimum standard for workforce development. Therefore, its implementation ensures that there is a *“benchmark of understanding”* (Study site 8- Key Stakeholder) and the provision of uniformity in training standards and, ultimately, delivery of care:

“I think it is good that we are all going to be like held to the same accountability as well in the sense that each person will be following the same routine, the same

procedures, the same practices rather than one carer might be, have their opinions on things and another carer might have their opinions, you all should be working from the same sort of thing.” (Study Site 2, care worker done CC)

Many felt that these characteristics were enhanced by participatory modes of training taking place in a classroom setting which allowed care workers to meet colleagues working in different settings and discuss relevant issues. Participants told us that it was also enhanced by the mixing of practical and classroom based approaches so that learning can be applied:

“You have got two weeks training and then two weeks of shadowing and then you will be on your placement.” (Study site 2- care worker done the Care Certificate).

Participants recognised the need for standards to be enforced, monitored and maintained, in order to be effective:

“Perhaps looking at an external body such as City and Guilds or Skills for Care, who would almost drop in and say ‘I would like to inspect your Care Certificate records.” (Study site 2, stakeholder 2)

Therefore, our participants saw the potential of the Care Certificate to raise standards of care across the board. They largely welcomed its introduction and supported its purpose as a means to prepare the unregistered workforce to deliver good quality care with regard to the fifteen standards. Those participants with direct experience of undertaking the Care Certificate reported positive outcomes for themselves and for their patients and clients. Some also regarded it as a springboard for career development. Few negative voices were heard. At the same time as seeing it as an overall improvement, there was recognition that the Care Certificate was not being delivered consistently by different organisations. In the next section, we turn to the reasons for this, by examining the barriers and facilitators to implementation.

6.3.2 Barriers and Facilitators to Implementation

We used the Consolidated Framework for Implementation Research (CFIR; Damschroder et al., 2009) to help organise our data and to draw inferences and associated recommendations. The CFIR is an overarching typology designed to promote implementation theory development and testing. The CFIR has five major domains: intervention characteristics, outer setting, inner setting, characteristics of the individuals involved, and the process of implementation.

“The CFIR specifies a list of constructs within general domains that are believed to influence (positively or negatively, as specified) implementation, but does not specify the interactions between those constructs. The CFIR does provide a pragmatic organization of constructs upon which theories hypothesizing specific mechanisms of change and interactions can be developed and tested empirically.”(2009, 3)

Here, we apply the CFIR to summarise the findings from our interview study in a way that is meaningful for service development and improvement.

INTERVENTION CHARACTERISTICS

Care Certificate training covers 15 standards concerning the delivery of care. These are intended to provide a holistic and transferable overview of the health and social care sector. One theme that emerged from our interview data concerned its content, specifically the tension between breadth and depth of the topics covered. Another was the adaptability of the Care Certificate to specific settings. Its broad range of topics was valued by many participants because this means that care workers are well equipped to work across different care settings and thus different client groups.

6.3.2.1 Adaptation of the Care Certificate

Participants described how they had adapted the Care Certificate training to suit their own needs within their specific care organisation. This adaptation describes the “*bespoke and specific*” changes made to the Care Certificate to meet local needs as expressed by a key stakeholder in study site 1. For site 3, the Care Certificate was merged with the induction programme that “*mirrored*” its competencies:

“When the Care Certificate first came out Skills for Care only released the criteria didn't they? So, I took the criteria because it was either explain, describe or it was demonstrated, so it's obviously observations and knowledge. So, I took all of that and I produced a knowledge workbook from that aspect of it and we also produced an observation workbook from that so the staff were given the knowledge workbook, it's the same sort of principle, but it wasn't the Skills for Care one because it didn't exist at that time.” (Study site 3- Key Stakeholder)

This merging Care Certificate training with existing induction training was a very common approach amongst care sites. It was adopted for pragmatic reasons in that it was seen to be the most time efficient and cost-effective way of approaching implementation. Similarly, some organisations, such as sites 3 and 8, have merged Care Certificate training with apprenticeships:

“For those who are aspiring to do, take advantage of those apprenticeship courses sponsored by our Trust working alongside other colleges and possibly universities we make it clear that the Care Certificate is part of it, so that gives them an incentive that - yes they have to complete the Care Certificate if they want to progress or have a say level 2, level 3 or level 4 apprenticeship levels if you like.” (Study site 8- Key Stakeholder)

It seems that organisations that have adapted the Care Certificate felt that the original material was too long and complex and could be simplified and shortened to make it easier to complete. This process of simplification was usually carried out by a centralised training team with the relevant expertise to carry out this task thus reducing the burden on local training providers within care organisations:

“They've also simplified everything for us, so everything's in a folder, everything's ready to go when a staff starts, and they can actually go through the certificate quite quickly now.” (Study site 1- Key Stakeholder)

Moreover, in some sites, the Care Certificate training was adapted once again by local staff in order to suit their specific needs. For example, a trainer in site 5 described how she had changed the format of the Care Certificate training provided by her organisation's central training team in order to streamline its delivery:

“When I first started delivering the Care Certificate the way it came across and set it out was the portfolio that you've seen, and the way the training was designed was we do a section or a slide and then the carers go to their portfolio and write in it before we move on to the next slide, and it took too long. So you'll see how I adapted that and I gave them the portfolio, we talked through the Care Certificate, they'd got all the information in the handbook anyway, and then they do the portfolios outside of this induction.” (Study site 5- Key Stakeholder)

As a result of these local adaptations, there was often a relative autonomy in Care Certificate delivery between the different sites of large care organisations.

In addition to the adaptation of the Care Certificate in order to reduce its perceived complexity, there has been the adoption of a tailored approach by a few organisations who felt that the Care Certificate lacked the level of detail required for working with clients within their organisation. They have therefore adapted the amount of time and detail invested into aspects of the Care Certificate training in order to meet the specific needs of their organisation and its clients.

“What we have found in our organisation is that, for instance 'fluids and nutrition', standard 8, we prefer to deliver the food safety certificate with staff rather than, it is just not deep enough, the standard is not deep enough.” (Study site 2- Key Stakeholder)

Some standards were highlighted by others as being of particular relevance to certain organisations. For instance, a participant in site 2 thought that:

“Safeguarding, communication, health and safety are big areas because of the nature of the job we do to care.” (Study site 2- care worker done the Care Certificate)

Particular interests were reflected in expressed needs for greater detail on some topics with some organisations feeling the need to:

“Go into more detail than the Care Certificate is requiring to make sure that the needs of the new workers are fully met to meet our needs. Sometimes these units we go deeper than the expectation of the Care Certificate.” (Study site 2, Key Stakeholder)

It was also suggested by some that certain Care Certificate standards need to be merged together in order to reduce the completion time:

“OK. So in terms of recommendations obviously we have talked about the standard itself. About amalgamating those safeguarding ones, I would like to

actually have some clarity on basic life support.” (Study site 6- 2 Key Stakeholders)

Similar merging was apparent in the delivery of the Care Certificate which, to maximise its relevance to each practice setting, usually combined both practical and classroom based approaches so that learning could be applied:

“You have got two weeks training and then two weeks of shadowing and then you will be on your placement.” (Study site 2- care worker done the Care Certificate)

A relatively small proportion of the organisations involved in our site visits used the Care Certificate training in its original format and simply downloaded this from the Skills for Care website. This approach was more likely to be taken for pragmatic reasons by smaller sites due to the lack of appropriate support from a dedicated training team within their organisation, and the cost of printing for these smaller organisations could be an issue. Those that adopted this approach found the Care Certificate training to be:

‘Very engaging and it captures everybody’s learning styles that you’ve got, you know visual and they’ve got the workbooks to do so they’ve got revision and then you’ve got the practical stuff as well so it appeals to everybody’s learning styles.....’ (Study site 5- Key Stakeholder).

Therefore, for the majority of care organisations that took part in Stage 2 of the research there was an individualistic approach to implementation involving the adaptation of the Care Certificate to meet organisational needs. Even within large organisations where the training was designed and developed by a centralised team, individual sites within these organisations also adapted this to suit their specific needs. While this flexibility could be a positive aspect of implementation as it facilitated a bespoke and site-specific approach to training, it is possible that variations in implementation could lead to an undermining of the credibility and portability of the Care Certificate. The problems of transferability and credibility of Care Certificate are addressed below as an aspect of the outer setting.

OUTER SETTING

For Damschroder and co-authors “the outer setting includes the economic, political, and social context within which an organization resides, and the inner setting includes features of structural, political, and cultural contexts through which the implementation process will proceed. However, the line between inner and outer setting is not always clear and the interface is dynamic and sometimes precarious.” (2009, 5) Here we take the outer setting to be the interface between a given provider organisation and the wider environment of health and social care, with all its governance and regulations.

6.3.2.2 Portability

The Care Certificate was intended to be portable between organisations, dispensing with the need to repeat the training. However, we found that the varying patterns of implementation

undermined confidence in its transferability and organisations differed widely as to whether they accepted a Care Certificate completed somewhere else. Some organisations required new recruits who held the Care Certificate to fully or partially repeat the training, while others considered it to be fully portable and in one site (site 3) stakeholders had conflicting opinions on this issue. When recruiting care workers, most organisations carried out thorough checks on the candidate in order to be assured that their Care Certificate training was valid with no important gaps in their knowledge. “Self-assessment” forms were usually used for this process. Sometimes this checking process was extended to existing staff:

“Existing staff who we didn’t have a record of induction for, we asked them to do the Care Certificate as well.” (Study site 2- Key Stakeholder)

Thus, tailor-made assessment procedures have been developed by many organisations as ways of identifying staff competencies and looking for development needs. In relation to appraising individuals’ competencies, two related issues emerged; accreditation or equivalence of prior learning, and quality assurance of Care Certificates.

6.3.2.3 Accreditation of prior learning

A further area of confusion has been over the accreditation of prior learning with some key stakeholders feeling that they had received no guidance on whether employees with existing qualifications such as NVQs still needed to complete the Care Certificate training:

“I think staff with experiential knowledge and skills and that have already got an existing vocational qualification should be, kind of, opted out.” (Study site 8, Key Stakeholder)

Similar confusion was apparent over whether the Care Certificate training exempted care workers from all or part of other vocational qualifications.

6.3.2.4 Quality assurance and registration

Many saw a need for external validation of the Care Certificate implementation, as it was felt that this would help to ensure its quality was maintained with subsequent implications for its credibility:

“I think it will be good to know what the plans are, if there are any, from the Government or I don’t know from the Health Education England or whoever is directly making the decisions suggested, what they plan to do with the Care Certificate in terms of the accreditation and its standardisation of implementation.” (Study site 8- Key Stakeholder)

For example, a stakeholder from site 2 observed how a carer had downloaded the Care Certificate from the Skills for Care website and put her dogs name on it in order to prove how easy it was to gain such a Certificate. In order to address these issues stakeholders said they wanted:

“People to come round and check and see how people are delivering it, the quality of the training and also the records that people keep.” (Study site 2-Key Stakeholder)

For some these issues of quality assurance and credibility were compounded by the fact that care workers were not required to be on a register, in contrast to health professionals such as nurses:

“If you're going to ask people to do fairly intrusive things to other people, then I think they need to be professionally registered. You wouldn't expect a doctor or a nurse or a dentist or a physiotherapist to do any of these things without being registered to do it, so why should we be doing a lot of the same things that they do.” (Study site 8-care worker not done Care Certificate)

With regard to the outer setting, and given the differences between employment settings for the care worker workforce, our interviewees felt that the credibility and acceptability to employers of the Care Certificate was relatively weak:

“They just don't feel it's beneficial to them. Whereas with an NVQ you get a proper qualification, it doesn't really mean anything much to them.” (Study site 4- manager)

“It's not accredited nationally. It's at level 1 ... so I have Support Workers coming to the training and they would say this is actually an insult to me because I have a level 3 or level 4, whatever qualification they have, relevant to health and social care and yet you know you are asking me to complete this which is very basic.” (Study site 8-trainer)

This could be improved by the creation of a systematic framework of certification and accreditation that is widely-accepted, quality-assured and integrated with other qualifications.

INNER SETTINGS

6.3.2.5 Logistics of Implementation

With regard to the inner setting, most of the participating sites had experienced initial 'teething problems' when the Care Certificate had been initially implemented. These problems were usually related to the logistics required to bring about the internal changes for implementation combined with the perceived lack of resources to facilitate this. For example, a care home manager had felt overwhelmed with the paperwork and mistakenly thought that she would have to take responsibility for the workplace assessments performed by all staff undertaking the Care Certificate within her work setting:

“I for one was quite concerned that I couldn't put enough time in to my staff's training on the Care Certificate, and sign it off. We are extremely busy people.” (Study site 1 – Key Stakeholder)

These pressures were particularly acute for smaller organisations that lacked the support of a centralised training team and other resources to support their capacity to implement and deliver the Care Certificate.

“We're quite lucky, because we have a dedicated training team, and we've got a dedicated trainer that does our training, and she actually leads on the Care Certificate.” (Study site 1 – Key Stakeholder)

Time constraints were reported to be a major consideration affecting Care Certificate candidates. Although the CQC recommendation is to have the Care Certificate completed within 12 weeks, many organisations have found this completion time to be unachievable. Such problems were particularly apparent for those working in home care, on night shifts or peripatetically, all of which made workplace observations and assessments difficult:

“We have to logistically plan the supervision so we can capture all the performance and that can be quite challenging within 12 weeks believe it or not. Especially in domicare, as we say we are not in a fixed place, people having to go out, having to find people so we tend to do it in three months but it sometimes does spill over ok, sometimes I would say we definitely get everyone done within four months.” (Study site 6 – Key Stakeholders)

A lack of time to complete the Care Certificate was also a demotivating factor for some care workers. This was due to *“protected time not being recognised as being a necessary”* (Study site 8- Key Stakeholder), for example, as well as to its subsequent impact on care workers work-life balance:

“You are doing it on your day off, it's like finding the time to do it, if you have children still at home and things, and if you can't get other staff to cover you while you are coming here, really it is the aspect of time.” (Study site 1 – care worker not done the Care Certificate)

“People don't want to do it, it interferes with their family life and that, you know, I think there's an assumption that carers are, like, dedicated to the cause, but they're here because it fits in with their families.” (Study site 4 - Key Stakeholder)

On the whole, it therefore seems that there are aspects of the inner, organisational setting that conflict with the Care Certificate implementation, Specifically, lack of time for care workers completing the Care Certificate and also lack of time for assessment by mentors and managers.

6.3.2.6 Completion and recognition

Related to these logistical issues were problems of non-completion. For example, a trainer in site 8 expressed frustration at the high incidence of non-completion within her organisation and the absence of organisational guidelines or sanctions to be utilised when dealing with this:

“That's one of the biggest issues, and that's been an issue, not just for Care Certificate training by the way, it's an issue for all the other training and then the completion. How many people have completed?” (Study site 8, Stakeholder)

Moreover, in practice, some care workers who had completed their Care Certificate training were not even aware of this fact. Indeed, it was common practice amongst the organisations visited to keep completed workbooks and certificates locked in the site office rather than to return them to the care worker. In order to address these issues some advocated the explicit recognition of the fact that the care worker had completed the Care Certificate training through such things as annual workplace presentation ceremonies. This could help to

enhance care workers' motivation and engagement in the training as well as increase the awareness of the Care Certificate more generally, as some participating care workers and trainers had no knowledge of it.

6.3.2.7 *The availability of peer support*

It emerged from the site visits that organisations which have excelled at the implementation of the Care Certificate usually appointed a responsible individual to assist the trainee with any problems faced during completion. In some places, care workers were assigned a 'buddy', who may be a senior care worker or a longstanding staff member (Site 2- Stakeholder). By offering peer support, any problems could be addressed at an earlier stage and rates of non-completion could be reduced.

Furthermore, most organisations had taken a group-centred approach whereby the Care Certificate had been delivered in group settings which had meant that care workers relied upon their peers for support and discussion, as expressed by some care workers:

"I don't know how much that's to do with the training stuff or with the fact we're in groups because we can actually say explain that again, or in a group say what have you got for this sort of thing." (Study site 2- care worker done Care Certificate)

As a consequence of the opportunities for interaction and networking provided by classroom based training, most participants expressed a preference for this approach instead of distance learning approaches.

INDIVIDUALS' CHARACTERISTICS

A number of individual characteristics relating to implementation also emerged. Key factors in the take up of the Care Certificate were: individual motivation to learn, literacy levels and prior experience, both personal and work-related.

6.3.2.8 *Motivation to Learn*

Participants frequently reported that an individual's motivation could be a facilitator and barrier towards the successful implementation of the Care Certificate. One key stakeholder from an NHS organisation felt that the way in which this training was responded to was down to the individual:

"Having run an NVQ centre myself, you know, you'll always get people that will drag their feet and not really prioritise it, and maybe just work through it to tick the box, and then you get other people who put their heart and soul into it, and really make something of it, and this programme is very similar in that respect, where it's got that looseness around it where people can, you know, put all or nothing into it really."
(Study site 8- Stakeholder)

As described by this stakeholder, some candidates showed a keen interest to complete the Care Certificate and reap its potential benefits:

*“I found it positive learning about things that we didn't particularly work with because we didn't know about it and we gained knowledge on different areas didn't we?”
(Study site 3 - care worker completed Care Certificate)*

Some spoke of the way in which the certificate would help them achieve their ultimate career goal. For example, participants in site 8 had aspirations to be a mental health nurse, a clinical psychologist or an NHS manager. Thus, our participants perceived both intrinsic and extrinsic rewards from taking the Care Certificate. By contrast, participants on other sites had fewer career aspirations and were less enthusiastic about undertaking the Care Certificate. Different reasons were given for this:

“I am a bit too old now I think and I will probably soon be retiring anyway in another couple of years so I don't think it would be worth putting me through it.” (Study site 4- care worker without the Care Certificate)

Family responsibilities were also a consideration:

“People don't want to do it, it interferes with their family life and that, you know, I think there's an assumption that carers are, like, dedicated to the cause, but they're here because it fits in with their families.” (Study site 4- Stakeholder)

Some also felt that the perceived lack of credibility of the Care Certificate and the absence of direct financial reward on completion were further factors contributing to their lack of motivation.

6.3.2.9 Literacy

While many care workers were in fact graduates or had proven academic ability, some of our interviewees considered themselves to be 'un-academic'. Hence, the Care Certificate might not necessarily suit their learning style, as expressed by one Key Stakeholder:

“Anybody that does hands-on work, how much do you think they like sitting down doing paperwork?” (Study site 3- Key Stakeholder)

Nevertheless, it did emerge from the data that some of the employees had minor learning difficulties, such as dyslexia, and making suitable adaptations for this was seen as normal:

“That has not been an issue so far because we do actually have a few carers who would maybe struggle in that department so we do have a few writing and reading challenges. But...we have got voice recorders and things.” (Study site 8, Key Stakeholder)

As a result of these adaptations, none of the care sites felt that literacy problems would form a significant barrier to undertaking Care Certificate training:

“It hasn't actually caused them any problems because they haven't had to do any writing as such, so it doesn't have to be an issue. I mean you can, when I've assessed candidates before, we've done like you're doing here, dictaphone or whatever in the past, so you know there's ways round it.” (Study site 6, Key Stakeholder)

Most experienced trainers or departments that provide adult education would be accustomed to addressing minor learning difficulties. They evidently took individual needs of this kind into account in the delivery of the Care Certificate by using verbal communication and voice recorders.

6.3.2.10 Prior experience

Maturity and 'life experience' were seen as desirable characteristics that helped people entering the care professions. The Care Certificate was thought to be particularly beneficial to overseas staff with little experience of working in the UK and to younger people whose experience tended to be limited:

"I think the Care Certificate, in terms of, you know, giving them those very basic, you know, broad skills, just helps them to bridge that gap a little bit. It doesn't fully prepare them, because time and experience does that, but I think, you know, for those initial stages it definitely does help those care-naive people." (Study site 8, Stakeholder).

Many care workers undergoing the Care Certificate training also reported that they had care experience which was advantageous. Thus, the possession of relevant knowledge and skills that could easily be transferred was helpful. Care workers also reported a wide range of previous work experience outside the care sector - including building and construction, personal training and service sector working. This variety was felt by stakeholders to be beneficial as it enriched the skills available to the employing organisation.

IMPLEMENTATION PROCESS

The study sites were selected to represent a range of sectors (NHS, voluntary, private) and different sizes of organisation. We also sought to include both sites that used external trainers and those that had their own training department. The features that determined our selection of study sites also tended to be associated with different approaches to the implementation process. Most importantly, the size of the organisation appeared to affect who delivered the training, and how candidates were supported through the process. Who was seen as a suitable candidate for the Care Certificate also varied from organisation to organisation; we consider this aspect in terms of the 'scope' of implementation. Finally, we explored what effects on recruitment and retention were believed to be associated with the Care Certificate.

6.3.2.11 Size and infrastructure

In large care organisations, their infrastructure and resources benefitted the implementation of the Care Certificate, allowing a more considered and planned approach. One example of a large organisation's approach to the implementation process is described here:

"There were lots of steering groups set up, and lots of preparatory work. ... the organisation had employed a project manager who was an ex-university lecturer. We have very close links with a local University, and so she ran lots of workshops around

the whole organisation, in order to get as many people's views as possible, in terms of how we felt as managers, and people that were supporting the process, how we felt that it would best work for the county. And so that went on for several months, and all that fed into the implementation project, and then the roll out.” (Study site 8- Key Stakeholder)

It emerged from the data that organisations with larger infrastructures often had specialist trainers for the Care Certificate which was perceived to be beneficial in the process of implementation:

“[Name] is our trainer and she does all the training to do with Care Certificate, and also guides our staff on filling in the Care Certificate, and to be quite honest now, I believe they find it a quite straightforward process.” (Study site 1-Key Stakeholder)

A planned and comprehensive approach to implementation is reflected in the system established in one organisation which runs several care homes:

“The company has five homes, so they start with a two-day induction at their own individual homes. That's followed up by five days of training here where they get taught, - is it 26 or 27 subjects, in total over the five days. So it is the mandatory, or it used to be classed as the mandatory stuff, included, so your health and safety, fire safety, food hygiene, moving and handling, health and safety generally, infection control.” (Study site 3- Key Stakeholder)

Clearly, the adoption of robust organisation-wide initiatives through existing training departments helped to facilitate implementation. A different approach to implementation was taken by organisations that commissioned external training companies to deliver the Care Certificate. For example, the smallest participating study site, a single care home, reported the use of an external trainer. This was judged to alleviate the burden of implementation on the home manager as well as motivating care workers to learn:

“I think having somebody from outside does help motivate people..... they're ex nurses that have retired and go on and have their own business. And every six weeks without fail, they come here, and they go through everybody's work, and we have a bit of an engaging session, if you like, and the girls really appreciate that. I think they probably get a bit bored with me.” (Study site 4 - Manager)

Generally, it appears that those organisations which have succeeded with Care Certificate implementation are those which adopted a structured and systematic approach, whether this is driven by a department of the same organisation or by an external partner.

6.3.2.12 Organisational support

Key stakeholders mentioned the need support from their senior managers for Care Certificate implementation:

“We have looked for co-operation from our own work site managers and senior teams.” (Study site 2- Key Stakeholder)

Such supportive arrangements were in place for the majority of sites visited, most of which had specialist training teams, and appeared to contribute to successful implementation. However, it is possible that these sites are not representative, for the fact that they were willing to take part in the study suggests that they have resolved any major difficulties presented by the transition to Care Certificate implementation.

6.3.2.13 Scope of delivery

In line with the Department of Health and Social Care recommendations, the majority of the participating organisations had initially implemented the Care Certificate for new starters as it was considered to be *“mandatory for all new staff to complete”*. (Study site 9, Deputy Manager). Thus, while some of the larger organisations told us that, when the Care Certificate was new, it was just available: *“for the Healthcare Assistants on the wards”* it has since been introduced to wider groups including *“OT Assistants, Physio Assistants, Imaging Assistants.”* (Study site 7- Three Key Stakeholders):

“It’s to all new starters, support staff, clinical support staff. We have quite a comprehensive set of work books that they work through clinically, and with their mentor, and then it’s backed up with an introduction to the Care Certificate.” (Study site 8- Key Stakeholder)

For example, on a visit to site 2, it was found that a newly recruited area manager was taking part in the training along with a wider group of care workers as part as his introduction to the organisation. Many stakeholders also felt that there was a need to make the Care Certificate available to all care workers regardless of their experience or qualifications.

“We have had everybody who has started since April 15 has done it or is doing it. Also, all Team Leaders, most of the Junior Team Leaders, I’ve done it myself and quite a few of the staff who have asked to do it.” (Study site 9, Deputy Manager)

The main reason for this broadened delivery was to achieve consistency in the delivery of care and to avoid the dilution in standards potentially resulting from making the training available to only a small proportion of the workforce. The rationale here was the need to address workplace ‘cultures’ and to challenge bad practice often engrained in these cultures, and this process is enhanced by the inclusion in the training of a broad range of staff including those at a more senior level.

“Yeah, everybody should have it whether you have been in the place 7 or 10 years, I think they should still have the opportunity to do it.” (Study site 5- care worker done the Care Certificate)

The picture emerging from site visits is that successful implementation of the Care Certificate with new recruits led to it being extended to other members of staff, because it is seen as a suitable induction process for a wide range of personnel.

6.3.2.14 Recruitment

When asked whether the Care Certificate would have any sustained effect on staff recruitment and mobility, most sites felt that it was too early to be certain whether or not this

was the case. However, it was generally felt that no significant impact had so far been experienced. With regard to recruitment it had neither attracted nor diverted applicants to care work with most recent new care workers already expecting to undertake some form of work induction and associated written work. Similarly, with regard to staff retention, no impact had yet been experienced since the launch of the Care Certificate. Moreover, possibly due to its perceived lack of credibility and portability, as compared to more established qualifications such as the NVQ, some doubted if it would ever have any significant impact on staff mobility. However, given the general levels of high turnover in care settings, one stakeholder expressed concern over the money spent on Care Certificate training when staff often left following completion (site 4). In view of the perceived high quality of the Care Certificate training they provided, another organisation said that they felt that their staff were vulnerable to be 'poached' by other care organisations once they had completed it. Consequently, they were considering a 6-month post-completion 'tie in' for these staff (site 2):

"We have invested in people and bear in mind we are leaving ourselves open here because somebody could come here, come for two weeks training, we have invested in them, have this Care Certificate and then after 3 or 4 weeks leave and join another organisation with the training. It does leave us open, if somebody wanted to be as ruthless as that." (Study site 2- Key Stakeholder)

6.4 Summary

Sites taking part in this research included a mixture of organisations from the social care and health care field, and the majority of these organisations had implemented the Care Certificate. All had strong views on the process of implementing the Care Certificate and, while this process had been initially difficult for some, these transitional issues had now been largely resolved. Since only sites expressing a willingness to be visited by the researchers took part in this evaluation, the views we report are not necessarily representative of the experiences of all care organisations. There is likely to be a bias in our data towards sites where implementation was perceived to be at least moderately successful. Nevertheless, the themes emerging from the visits are likely to be issues that affect care organisations across the country. The key points that are made in this chapter may be summarised as follows:

1. The Care Certificate is widely accepted as essential preparation for work in the health and social care.
2. Its main function is seen as a standard-setting tool promoting consistency of care within an organisation.
3. It is regarded as useful for experienced and registered staff as well as for people new to the care sector.
4. Its breadth of coverage is seen as a strength, enabling training to be used in different settings.
5. People who had completed the Care Certificate felt that the knowledge and understanding gained was immediately applicable to the working environment.

6. Its benefits to trainees included greater confidence, empathy and self-reflection and it was seen as a step towards career progression by some participants.
7. Other care workers had little interest in undertaking the Care Certificate due to a lack of time or career ambition as well as to the perceived lack of credibility of the training as compared to more established qualifications such as NVQs.
8. The Care Certificate is being delivered in many different ways in different settings.
9. Large organisations appear to have assimilated the Care Certificate as a key element within existing training schemes. For smaller organisations, external trainers and project managers take responsibility for implementing the Care Certificate.
10. All but the smallest organisations interviewed had adapted the training to meet organisational needs or to include particular areas of specialism. As a result of this, there was often a relative autonomy in training provision between the sites of large organisations.
11. Portability has yet to be achieved, and candidates did not mention this as an incentive.
12. National accreditation of the Care Certificate and professional registration of its holders could strengthen its perceived value.
13. Integration with National Vocational Qualifications and other relevant learning should seek to give credit for prior learning when embarking on the Care Certificate.
14. Completion rates could benefit from formal recognition of the attainment of the Care Certificate.
15. Foremost among barriers to implementation is the time commitment imposed by the Care Certificate; this has proportionately greater impact on smaller organisations.
16. The time commitment could present a disincentive to prospective trainees as well as managers.
17. Mentoring, buddy systems and group teaching were identified as mechanisms that facilitated learning and development on the Care Certificate.
18. The proposition that poor literacy might present a barrier for some was not supported by our data.
19. Successful implementation could be achieved through planned and comprehensive integration of the Care Certificate across the organisation.
20. The study sites were selected to generate a breadth of experience; however, participation was voluntary so our sites may be biased towards places where implementation has been relatively successful.

7 KEY FINDINGS

7.1 Uptake of the Care Certificate

Nearly 90% of care organisations surveyed had implemented the Care Certificate into their routine induction for new care staff. However, the uptake was significantly higher for health service organisations (96.7%) than for social care organisations (86.2%) (Chapter 6.3.2).

For the small proportion of organisations that had not implemented the Care Certificate, a number of different reasons for this were cited. These included: staff were sufficiently qualified and trained; existing induction training covered the Care Certificate skills; a lack of capacity, resources and leadership had prevented implementation; concern that it will impact on recruitment. A small number of organisations reported that they were avoiding recruiting staff without care experience so that they could avoid the need to implement the Care Certificate (Chapter 6.3.3).

7.2 Improvements following the Care Certificate

The main objective of the Care Certificate was to improve induction training and promote the provision of high quality care, particularly for care staff employed as care assistants in hospital, care homes and domiciliary work.

In spite of the fact that initial transitional problems were reported by some, most had overcome these challenges and felt that the Care Certificate had made a generally positive impact on their organisations, staff, and those in receipt of care (Chapter 6.3.6.1). In accordance with this, many participants including managers, trainers and care staff reported improved care skills for those new to care due to the introduction of the Care Certificate (Chapter 7.3.1.1). They reported that it increased staff confidence, skills and knowledge and provided a standardised and basic foundation for new recruits to their care organisation (Chapter 7.3.1.2). These benefits were particularly apparent when the training adopted a participatory and interactive classroom based format. In contrast to online learning environments, this format allowed new staff to meet their colleagues and discuss and reflect upon their learning and its potential application to the workplace (Chapter 7.3.2.7). It was also facilitated by the encouragement of care staff to take responsibility for their own learning and to feel 'ownership' of the training they undertook through such things as the returning of Care Certificates and workbooks to them (Chapter 7.3.2.6). Similarly, the existence of groups of peer learners, supportive colleagues, senior care staff and organisational cultures were seen to be important in the utilisation of learning within the workplace (Chapter 7.3.2.12) and this led to recommendations by some participants for the adoption of a broader scope in the delivery of Care Certificate training to incorporate care leaders and longer standing staff (7.3.2.13).

A secondary objective of the Care Certificate was to offer a transferable qualification to support the movement of care staff between organisations, while providing a foundation for further training and development of care workers. This portability is potentially advantageous both to care workers and to care organisations as it can reduce the time and cost spent on duplicating training. However, the generally high staff turnover in care organisations and the risk of staff being 'poached' once training is completed can reduce the incentives of managers to promote this portability which they may not regard as being in their interests. In

accordance with this, we found that the Care Certificate was rarely used as a fully portable, standardised training certificate and that most organisations required new recruits who had completed their training elsewhere to repeat some or all of this training, often requiring them to complete a 'self-assessment' in order to identify knowledge gaps that needed filling (Chapter 6.3.6.2 and Chapter 7.3.2.2). This requirement to repeat Care Certificate training appears to be related to scepticism about the quality of the prior training as well as by a lack of standardisation in the way in which this training has been implemented and by a lack of external validation of this training (Chapter 7.3.2.4).

The impact of the Care Certificate on further training opportunities was not yet clear and mixed views were reported. For some organisations, the Care Certificate had increased the training portfolio on offer to staff and provided more depth to existing induction activities. It had also increased the motivation of care staff to take up these opportunities. However, others felt that the Care Certificate had led to restrictions on other training opportunities through a lack of time and resources (Chapter 6.3.6.3).

7.3 Variation in Implementation of the Care Certificate

The study found considerable variation in how the Care Certificate is being used which varied with sector, organisational size and internal resources (Chapter 6.3.5 and Chapter 7.3.2.11). Multiple training delivery methods were most frequently used, usually involving a combination of computer-, classroom- and clinically-based approaches to enhance learning through interaction (Garrison and Kanuka, 2004) and experiential learning (Kolb, 2014). However, in one tenth of organisations computer-only methods of delivery were used, which can often lack the interactive and experiential features experienced elsewhere. There was also variation between organisations in who the Care Certificate was delivered to, ranging from: all new starters no matter what their previous experience or qualifications were, to all new starters with gaps in knowledge and experience. Finally, the time frame over which the Care Certificate was completed varied considerably, ranging from 2 weeks to 9 months (Chapter 6.3.5).

On one hand these variations in implementation led to an undermining of the credibility and portability of the Care Certificate leading some to recommend the need for greater regulation and standardisation in its provision (Chapter 6.3.6.2 and Chapter 7.3.2.4). On the other hand, this flexibility could be a positive aspect of implementation as it facilitated a bespoke and site-specific approach to training (Chapter 7.3.2.1). Where organisations had their own learning and training departments or external providers, and the Care Certificate could be assimilated into their existing portfolio of induction and mandatory training, adoption was relatively straightforward. In contrast, in small care organisations resourcing issues meant that the responsibility for training and development usually fell to the manager who had to assimilate the implementation of the Care Certificate into their long list of other tasks and roles leading them to feel overwhelmed and to perceive the Care Certificate in a negative light.

7.4 Barriers and Facilitators to Implementation

Perceptions and attitudes held by the leaders of care organisations towards the Care Certificate seemed to be crucial. Thus, in the survey, over one quarter of participants believed the Care Certificate to be mandatory, and this led to the perception that it had been forced upon them (Chapter 6.3.3). This perception was particularly prevalent amongst participants who perceived the Care Certificate in a negative light. In contrast, a number of study participants felt that it should be mandatory, and also believed that regulation of care workers would be a positive development (Chapter 7.3.2.4). Without a leader who recognised the importance of staff training and development, and a manager who had a dedicated role to oversee staff training and development, implementation of the Care Certificate was often a low priority (Chapter 7.3.2.12). The motivation and ability of individual care workers to undertake training was also reported as a factor influencing the implementation (Chapter 6.3.7 and Chapter 7.3.2.8).

In general, organisational size, leadership, capacity and resources were major factors in determining the effectiveness of Care Certificate implementation (Chapter 7.3.2.11). Where organisations had the resources to allocate specialist staff to develop the training or assimilate it into their existing induction programmes, then the potential benefits of the Care Certificate were most likely to be reported. This is reflected in the larger number of health organisations which consistently reported more positive responses towards the Care Certificate than social care organisations (Chapter 6.3.6.1).

One of the frequently report challenges raised by our respondents in the telephone survey was the lack of staff time and associated costs of backfill (Chapter 6.3.7). The perception that the Care Certificate had to be completed within 12-weeks placed additional pressure on organisations and staff, who frequently completed it in their own time (Chapter 7.3.2.5). In addition, the time and availability of assessors to complete staff assessments was also highlighted, especially for night workers, bank workers and those who were peripatetic or worked in domiciliary care settings (Chapter 7.3.2.5).

Other barriers to implementation included concerns over the portability and credibility of Care Certificate training provided by other organisations (Chapter 6.3.6.2). This was often attributable to a general lack of awareness, the absence of clear sanctions for those failing to complete the training within the allotted timeframe and confusion over the accreditation of prior learning and the Care Certificate (Chapter 7.3.2.4).

Effective implementation of the Care Certificate appeared to include the following features:

- Adaptation of the Care Certificate into existing training and induction programmes.
- Blended, holistic, practical and participatory approaches to training delivery as outlined in the Care Certificate mapping document
- A broad scope of delivery, extending beyond newly recruited care workers to established personnel.
- Peer support and mentoring for Care Certificate candidates.
- Adaptation of materials and assessments to support care workers facing literacy or language barriers.
- The provision of regular updates and assessor training

The following features were associated with less effective implementation:

- A 'one dimensional' approach to Care Certificate implementation and delivery that was inflexible and unsupported.
- Didactic rather than participatory approaches to training delivery.
- Lack of supervision and assessment of standards
- Lack of peer support and mentoring for care workers
- Inadequate resourcing, in terms of materials, assessors, care worker time and backfill for training.

7.5 Discussion

The results emerging from this study have aimed to address how successful the Care Certificate has been in improving induction training and making support workers feel better prepared and more valued, thereby improving the quality of the care which they provide. Furthermore, it aimed to consider the variations in the implementation of the Care Certificate across the full range of CQC-registered health and social care services, and explore how the Care Certificate can be refined in order to meet its objectives better.

To begin with the present findings have shown significant variations in patterns of implementation across health and social care organisations within England and the facilitators and barriers of successful implementation. In particular, the results have highlighted how successful the Care Certificate has been in improving induction training and making support workers feel better-prepared and more valued, thereby reportedly improving the quality of the care which they provide. There seems to be significant variations in patterns of implementation across health and social care organisations. These variations have been attributed to the lack of guidance by governing bodies and higher management within care organisations. The subsequent impact has been that there has been limited awareness of the Care Certificate, which has inevitably undermined its credibility. Remarkable variations have been observed in the approaches taken towards delivering the Care Certificate. It has been revealed that some organisations prefer to adopt didactic education and standard issue protocols for delivering the Care Certificate whereas others prefer methods such as, interactive and hands-on education, decision support systems, audit and feedback, social influence strategies, patient led strategies and rules and incentives (Arthur et al., 2017; Kolb, 1984). The qualitative findings have supported the view that participants need to experience, discuss and reflect on problems and solutions themselves, in order for training to have an impact upon their behaviour and practice (Jacques and Salmon, 2007; Knowles, 1980). Experiential methods of training (Arthur et al., 2017; Kolb, 1984) have mostly been favoured in the present study by those organisations which have openly welcomed and implemented the Care Certificate training. Educational theories and practice such as the COM-B model of capability, opportunity and motivation (Michie et al., 2011) should further be considered in the design of Care Certificate training materials, whether delivered through classroom, blended or online methods.

The Care Certificate training was introduced to all new care staff working within English care organisations, which covers a wide range of settings covered by CQC registration. Thus, the implementation of the Certificate has been designed to allow for local flexibility and also portability within different care settings. However, data from the present study revealed that the employees who come to a new care organisation with the Care Certificate already completed frequently required re-complete either parts of the Care Certificate or the entire

training. To provide better assurances about the quality of a Care Certificate gained from another organisation, key stakeholders feel that there is an urgent need for external verification and guidance.

Generally, organisations who have faced fewer problems in implementing the Care Certificate are much larger in organisational capacity and structure and have supportive team members who are assigned to delivering different elements of the Care Certificate training, as supported by previous research (Schneider, 2016). Smaller and less well-resourced organisations, often in the social care sector, have felt less well-supported in the general process of implementing the Care Certificate and have felt that the process could have been less complex with better guidance from Skills for Care or the CQC. Many of the organisations who reported a negative experience in implementing the Care Certificate were under the misconception that the Care Certificate is compulsory. A number of stakeholder organisations do address this question in their guidance on the Care Certificate (e.g. UNISON, 2015; TGMG, 2017) and give clear advice that although it is not mandatory and does not form part of legislation, the CQC does expect to see induction programme that meet the Care Certificate Standards. The CQC itself states that it “expects providers to induct, support and train their staff appropriately. In our guidance for providers on how to meet the regulations, we are explicit about our expectation that those who employ health care support workers and adult social care workers should be able to demonstrate that staff have, or are working towards, the skills set out in the Care Certificate, as the benchmark for staff induction” (CQC, 2015). So although highly recommended and monitored during inspections, they do not go so far as to make the Care Certificate itself a requirement with any legal or statutory grounding stating that “the use of nationally recognised good practice, such as the Care Certificate, is one good way of helping to demonstrate this to CQC”.

Moreover, there are debatable perspectives on the scope of delivery of the Care Certificate in the present study with some organisations believing that the Care Certificate training should be open to all care staff whereas some believe it should only be made available for those new to the care sector. Organisations with the latter belief feel that the Care Certificate should be offered to all those working within the care sector in order to ensure uniformity in training standards and thus delivery of care as initially proposed by the Care Certificate (Cavendish Report, 2013). The delivery of care is dependent to some extent on the individual's ability to take on new training and complete it sufficiently. These differences are influenced by factors such as learning difficulties and an individual's motivation to learn (Hughes, 1962).

The Care Certificate training has been shown to offer numerous benefits to the individual and the organisation. It has been noted in the present study that the Care Certificate provides care workers with a basic foundation to work within the health and social care sector, alongside a growth in knowledge and confidence and therefore the opportunity to progress in their career. The present findings are in line with the aims of the Care Certificate (Cavendish Report, 2013; Trayner et al., 2015) and suggest that the Care Certificate has a lot of potential to benefit the health and social care industry. The implementation of the Care Certificate is still fairly new within health and social care organisations. The variations in the implementation of the Care Certificate, potential barriers and facilitators to implementation, differences in mode of delivery, and its worth as a portable qualification have been addressed in the present research but there still remains a need for further long term

exploration of the Care Certificate training in relation to behaviour change in care workers following the training and the impact on care recipients.

It is clear from the evidence so far that the Care Certificate was generally welcomed and viewed as a positive initiative to add value to current practice. In terms of content it was viewed as applicable and relevant to the workforce. Significant concerns were raised about reducing the amount of work within the Care Certificate as well as the need for external verification and guidance. Further research into operational and strategic aspects of implementation will help elucidate the components of best practice. Cross-provider working may assist with the lack of external validation leading to variation in quality and outcomes. The lack of implementation guidelines undermines the Cavendish report recommendations for standardisation. Whilst the Care Certificate reinforced high expectations, a single certificate to span many different organisational structures “optionally” without any “regulatory oversight” and giving employers complete control and autonomy over implementation was considered detrimental and likely to have a significant effect on portability. Even at this early stage concerns were clear about perceptions of poor delivery at different sites, tailored certification resulting in lack of standardisation and variation in assessment standards. Three quarters of employers undertaking the pilot suggested they would ask people to redo the certificate in their organisation, which directly conflicts with the aim of a standardised certificate which is portable and transferable across roles and organisations. These issues could be alleviated by the greater standardisation of the Care Certificate portfolio to include a more substantial body of evidence. This would help to enhance its value both to the individual and to the employer as well as contribute to regulatory oversight. However, without in-depth research drawing on the experience of services implementing the Care Certificate, individual’s experiences of it, the impact it has had on behaviour change in practice and robust longitudinal data, it will be difficult to draw any firm conclusions. It will be important to keep the dialogue going across services about what works, what doesn’t and for whom in what services.

7.6 Areas for improvement in order to meet the Care Certificate’s objectives

For care organisations and other training providers:

- The use of a ‘clear workforce development plan’ (as initially recommended by Skills for Care) which sets out the learning journey for each care worker. This should include which elements of the Care Certificate should be refreshed when joining a new organisation, how this should be undertaken and how they overlap with NVQ Health and Social Care Level 2 and other care qualifications.
- The adoption of a broad scope of delivery for Care Certificate training, not just incorporating newly recruited care workers, but also wider groups of workers within the organisations including managers and other care leaders. This will help to promote uniformity of standards thus enhancing care delivery and helping to impact upon workplace culture and challenge any bad practice engrained within this culture.
- The mode of delivery should also be broad including assets based, participatory and experiential approaches and incorporating both practical and classroom components

which facilitate the transfer of learning into everyday practice. This can include such things as “discussion, observation, question and answer sessions etc.” and the alternating of theoretical and practical components with input from instructional designers and behaviour change models.

- The encouragement of care staff to ‘own’, value and be aware of their continued professional development through regular mentoring, through the availability of a network of peer support and trained assessors and through the provision of ring-fenced funding for their further development
- The explicit recognition of Care Certificate completion within care organisations through such things as annual certificate presentation or graduation ceremonies.
- Clear guidelines on timeframes for completion and on any sanctions for non-completion within these timeframes. This should include a pro-rata completion rate for part time staff and a ‘step on step off’ option if a break in training is required.

For external bodies including Skills for Care and the Care Quality Commission:

- In view of the pros and cons of the flexible approach to implementation often adopted by care organisations, the adoption of a ‘mediated flexibility’ or tailored approach to this implementation should be encouraged including the promotion of an adapted rather than ‘one size fits all’ approach coupled with measures to promote and maintain consistent standards.
- Measures to maintain standards and consistency could include the greater regulation and external validation of Care Certificate training including that provided by external trainers. Consideration should be given to developing a network of independent assessors that can visit organisations do the observations (e.g. like NVQs) as many managers struggle to find time to do this element.
- Refreshed and updated guidelines on the implementation of the Care Certificate, incorporating greater clarity on a number of aspects of Care Certificate provisions: including the accreditation of prior learning (e.g. NVQs) against the Care Certificate, and the time frame within which the Care Certificate should be completed, acknowledging that for some care staff a 12-week completion would be unrealistic.
- Guidance and support for small care organisations on how they can implement the Care Certificate standards, alongside other mandatory training. This could take the form of buddy/mentor schemes with other local organisations, local workshops and the development of a network of independent assessors and advisors.
- Provide clear alternatives to printing out materials/workbooks, as printing costs are hard for small organisations to absorb, and alternative materials and/or support for care staff for whom English is a second language or who have low levels of literacy. Given the ownership of mobile devices consider whether some materials could be delivered via new technologies.

- Review the content of the Care Certificate to consider, for example, additional standards on palliative care and mental health

7.7 Strengths and limitations of study

This study is the first to explore the experiences of a wide range of health and social care organisations and staff relating to the implementation of the Care Certificate.

The main limitation of this study is that the sample may be more favourably disposed to the Care Certificate and hence responded in a more positive way than those who did not participate. Many organisations approached for the telephone survey chose not to take part due to a lack of time or the lack of availability of an appropriate person to speak to. Some were also non-contactable due to outdated contact details on the CQC database. The relatively high non-response rates to the survey and to site visit invitations may compromise the representative nature of participating sites. It is likely that those sites accepting the invitation to take part in the survey or a site visit may not be representative of all care organisations, as they may be relatively well set up with their Care Certificate training provision and keen to show it off to researchers. Similarly, organisations that have not implemented the Care Certificate may be under-represented within the study results.

Another limitation is the ongoing validity of the results due to the changing nature of workforce development in the health and social care sector. Care Certificate training and the broader context of care provision is constantly changing possibly rendering some of the findings of this research outdated within a short period of time. Whilst the Care Certificate is still in its early stages of implementation and it was too early to definitively determine its impact on career development and staff mobility. Further ongoing research will therefore be required to assess the longer-term impacts of the Care Certificate on care workers and care organisations.

8 CONCLUSIONS AND FURTHER RESEARCH

In the ongoing debate on the implementation gap in frontline care, deficiencies in the training and expertise are often suggested (Department of Health, 2013). This debate has been mostly characterised by a lack of clarity on the key elements of good practice and how it can be practically achieved. Due to the widespread introduction of the Care Certificate training, more clarification was required on how organisations have responded to the introduction of the Care Certificate training and how they have implemented the Care Certificate training within their organisations. The findings presented here have explored the implementation approaches adopted by health and social care organisations across England. Although most organisations had a lack of awareness and guidance on the implementation of the Care Certificate training, their feedback on this training was mostly positive, although their focus on the significance of external verification from governing bodies upon the implementation of the Care Certificate work suggests the need for further research on these issues and their impact on the portability of the Care Certificate training.

In relation to the aims of this research, the following conclusions can be drawn:

- Where the Care Certificate has been implemented, it is meeting its stated objectives of improving induction training and enabling support workers feel better prepared to provide high quality care. For those who have fully implemented the Care Certificate, they report that it has increased staff confidence, skills and knowledge and provided a standardised and basic foundation for new recruits to their care organisation.
- There are considerable variations in implementation across the full range of CQC-registered health and adult social care services and organisations. There is a proportion of smaller care organisations where the Care Certificate has not been implemented, largely due to lack of resources and capacity. For these organisations, the size of the undertaking is too much, to the extent that some avoid recruiting new staff without experience. Where the Care Certificate has been implemented, a variety of methods, length and intensity of training are being delivered, ranging from substantial group-based programmes involving a combination of teaching approaches and activities, to brief online courses completed individually. This inconsistency between organisations in their delivery of the Care Certificate has undermined the credibility and portability of the Care Certificate.
- A number of areas for improvement are recommended in order to meet the objectives of the Care Certificate. These include: adopting measures to maintain consistency between organisations such as external validation; clarity on the accreditation of prior learning against the Care Certificate; additional guidance and support for small organisations to encourage them to implement the Care Certificate; provision of alternatives to printed materials and workbooks; guidance on the use of participatory and experiential learning approaches to facilitate the transfer of learning into practice; the use of presentation ceremonies and awards within organisations to celebrate and recognise Care Certificate completion.

Future research should consider the direct impact of the Care Certificate on those in receipt of care. In addition, more detailed examination of behaviour change following training and the improvement in care practice following different training techniques would highlight the advantages of specific practices and techniques. This will serve to enhance understanding and awareness of the Care Certificate and its implementation which, in turn, will help to promote its credibility.

9 DISSEMINATION PLANS

9.1 Introduction

A major focus of this evaluation of the Care Certificate is to maximise its impact through a comprehensive process of dissemination. Research impact is defined by Research Councils UK as the contribution that research makes both academically as well as economically and socially. Aspects of this impact can be instrumental through such things as influencing policy, practice and behaviour, conceptual through the contribution to the understanding of relevant issues and capacity building through such things as skill development. The process of dissemination adopted here will aim to incorporate all of these levels by promoting understanding of the Care Certificate and its implementation as well as by making recommendations on how this implementation can be improved, ultimately helping to improve the safety and quality of frontline care and the experiences of those giving and receiving it. The largely practice-based focus of this evaluation is well suited to meeting these aims and this is enhanced by the experiences of the project management team most of whom combine professional experience in the health and social care sector with relevant academic expertise. This team has prior experience of working together to deliver related projects including the NIHR HS&DR-funded CHAT study (Arthur, et al., 2017), a study into Healthcare Assistants working 12-hour shifts funded by NHS England (Thomson and Hare Duke, 2015) and the 'Inside Out of Mind' research-based play which has been used to train at least 1,500 HCAs (Argyle and Schneider, 2016).

This expertise is further enhanced by the contribution of the PPI and advisory groups who also have a range of relevant experiences and skills which can be drawn upon in the process of dissemination. Their involvement in this process as well as in the evaluation more generally has been central to ensuring that a collaborative approach is adopted involving a two-way exchange between researchers and research users. This process of knowledge exchange and collaboration is further facilitated by the engagement of wider user groups in the evaluation through such things as patient and carer focus groups, the inclusion of the views of interested groups and networks and the elicitation of the interest of the general public. Project dissemination and communication more generally are key to these processes.

9.2 Communication plan

Issues of communication are central to both the process and outcome of the dissemination process. Therefore, this project has identified all interested parties and the means and frequency of communication between them and the project. In order to determine the appropriate level of response, the list of project stakeholders shown below is categorised in accordance to the amount of power they have and how significantly they will be impacted by the project as well as by how much interest they have in this project. Thus those with the highest interest and power will require most attention while those with low interest and power will require the least attention.

Table 16: ECCert communication plan

Message	Audience	Aims	Channel(s)	Timing	Responsibility
HIGH POWER-HIGH INTEREST					
To consult and keep informed about the project	Project team and project management group	To manage closely, consult and collaborate	Meetings, email, in person, phone	Meetings every eight weeks and ongoing emails and phone calls as required	Project team
To consult and keep informed about the project	Advisory group	To manage closely, consult and collaborate. They require 28-days-notice to approve research outputs from the project	Meetings, email, in person, phone	Meetings every 6 months, ongoing emails and phone calls as required	Project manager and PI
HIGH POWER-LOW INTEREST					
To keep informed about the project	University of Nottingham, Nottinghamshire Healthcare NHS Trust, DoH Policy Research Programme	To be kept satisfied and to obtain ethical approvals	Meetings, email, in person, phone	As required	Project manager and PI
LOW POWER-HIGH INTEREST					
The reactive and proactive provision of information about the project	Project participants, patients, carers and other interested groups	A two-way process in order to elicit, maintain and respond to interest in the project	Meetings, email, in person, phone, dissemination activities	As required	Project team, project management group and advisory group
LOW POWER-LOW INTEREST					
The proactive provision of information about the project	The general public and policy 'customers'	To elicit interest in the project	Dissemination activities	As required	Project team, project management team and advisory group

9.3 Stages of dissemination

Project dissemination will be made up of two stages. The first stage of dissemination has already taken place and has focused on introducing the project and participant recruitment. Outputs so far have included conferences and other presentations (e.g. Argyle et al., 2017a), journal publications (e.g. Argyle et al., 2017b), as well as website entries and blogs (e.g.

Argyle, 2017c). However, for logistical reasons much of the dissemination will take place after the end of the study and the submission of the final report. This second stage of the dissemination process will focus on project findings and recommendations emerging from these and it will be flexible allowing for further themes and outlets to emerge. A full list of dissemination activities and outlets is provided in Appendix 7. It is not always possible to specify the source and timing of dissemination activities as they are often dependent on issues outside researchers' control such as acceptance via peer review and the timings of conferences. Therefore, the details of dissemination shown in Appendix 7 are intentionally broad and it is not expected that all of these dissemination activities will be achieved. Activities appearing in bold will be given priority by the research team and will take place immediately after acceptance of the final report.

Dissemination outlets will be diverse and will potentially include academic journals, blogs, conference presentations, meetings, press releases, seminars, tweets and website links as well as a leaflet and poster summarising findings to be distributed to participating organisations and made available via the project website. Furthermore, there may be an opportunity in the future to co-produce and pilot a good practice guide for distribution to project stakeholders and local networks of care providers and receivers.

In the light of the above discussion, overall aims of the dissemination process are as follows:

- To promote understanding and awareness of the Care Certificate and its implementation and to share ways in which this implementation can be enhanced through providing guidelines, giving practical examples of good practice and encouraging reflection, planning and evaluation in this implementation.
- The eclectic and multi-levelled approach to dissemination aims to enhance and extend the impact of the project and to incorporate economic, social and academic dimensions. For by focussing on different audiences, topics, outlets and modes of presentation, it will implicitly and explicitly recognise and address the similarly eclectic barriers and facilitators to workforce development in frontline care.
- To maximise the impact of study findings by extending their reach beyond academic and professional audiences to incorporate care workers themselves who can be difficult to reach via conventional modes of dissemination. They are nevertheless key to the successful implementation and establishment of the Care Certificate and to the efficient and effective provision of frontline care more broadly.
- To facilitate the process of implementation and help to address the lack of standardisation in this process between different care organisations around the country. This in turn will help to promote the potential portability of the qualification between different care organisations with some care workers currently having to repeat this training when changing jobs.
- Related to this lack of standardisation has been a lack of awareness of the qualification with implications for its credibility and the subsequent motivation of staff to engage in it. The dissemination process will help to address this issue of awareness, will aim to elicit public interest and to provide support and guidance to those organisations which have struggled with implementation.

10 REFERENCES

Allan, T., Thompson, S., Filsak, L., and Ellis, C. (2014) *Evaluation of the Care Certificate Pilot*, Leeds: Skills for Care

Alliger, M. and Janak, E. (1989) Kirkpatrick's levels of training criteria: thirty years later, *Personnel Psychology*, 42: 331-341

All Party Parliamentary Group on Dementia (2009) *Prepared to Care: challenging the dementia skills gap*, Alzheimers Society: London

Argyle, E. (2003) [Caring and Resources in Older Age](http://etheses.whiterose.ac.uk/5445/), White Rose eTheses online, <http://etheses.whiterose.ac.uk/5445/>

Argyle, E. (2012) Person-centred dementia care: problems and possibilities, *Working with Older People*, 16 (2): 69-77

Argyle, E., Kelly, T., Gladman, J. and Jones, R. (2017) The effective ingredients of social care support at home for people with dementia: a literature review, *Journal of Integrated Care*, 25(2): 110-119

Argyle, E; Khan, Z; Simpson, K. and Thomson, L. (2017a) ECCert: Evaluating the Care Certificate, *British Society of Gerontology Annual Conference*, University of Swansea, 5-7 July 2017

Argyle, E., Thomson, L., Arthur, A., Maben, J., Schneider, J. and Wharrad, H. (2017b) Introducing the Care Certificate Evaluation: Innovative practice, *Dementia*, <https://doi.org/10.1177/1471301217723498>

Argyle, E. (2017c) Introducing the Care Certificate Evaluation, *Dementia Day to Day*, <https://idea.nottingham.ac.uk/blogs/posts/introducing-care-certificate-evaluation:16.2.17>

Argyle, E. and Kelly, T. (2015) [Implementing person-centred dementia care: a musical intervention](#), *Working with older people*, 19(2): 77-84

Argyle, E. and Schneider, J. (2016) [Research-Based Theatre in Dementia Knowledge Transfer: Views from the Frontline](#), *Journal of Mental Health Training, Education and Practice*, 11(2): 102-111

Arskey, H and O'Malley, L. (2005) Scoping studies: towards a methodological framework. *International Journal of Social Research Methodology, Theory and practice*, 8:19-32

Arthur, A., Aldus, C., Sarre, S., Maben, J., Wharrad, H., Schneider, J.M., Barton, G., Argyle, E., Clark, A., Nouri, F. and Nicholson, C. (2017) Can Healthcare Assistant Training (CHAT) improve the relational care of older people? A developmental and feasibility study of a complex intervention. *Health Services and Delivery Research*, 5(10): 1-202.

Bowers, B (2008) A trained and supported workforce in M. Downs and B. Bowers, *Excellence in Dementia Care: research into practice*: 414-437

- Broad, M. (1997) Overview of transfer of training: from learning to performance, *Performance Improvement Quarterly*, 10(2): 7-21
- Brooker, D. (2004) What is person centred care in dementia? *Reviews in Clinical Gerontology*, 13 (3): 215-222
- Brooker, D. (2007) *Person-Centred Dementia Care: making services better*, Jessica Kingsley Publishers: London
- Brooker, D., Argyle, E., Scally, A. and Clancy, D. (2011) [The Enriched Opportunities Programme for people with dementia: a cluster randomised controlled trial in ten extra-care housing schemes](#), *Aging and Mental Health*, 15(8): 1008- 117
- Bubb, S. (2014). Winterbourne View - Time for Change. Report by the Transforming Care and Commissioning Steering Group. <https://www.england.nhs.uk/wp-content/uploads/2014/11/transforming-commissioningservices.pdf>
- Burnard, P. (1991) A method of analyzing interview transcripts in qualitative research, *Nurse Education Today*, 11(6): 461-466
- Burrow, S., [Bradshaw](#), T., [Mairs](#), H., [Pusey](#), H. and [Keady](#), J. (2017) Student experiences of taught part-time study on a post graduate dementia studies programme: findings from an electronic questionnaire survey, *The Journal of Mental Health Training, Education and Practice*, 12(6): 383-394
- Cavendish, C. (2013) *The Cavendish Review: An Independent Review into Healthcare Assistants and Support Workers in the NHS and Social Care Settings*, London.
- Commission for Social Care Inspection (2008) *See me not just the dementia*, CSCI: London
- Council of Deans of Health (2013). *Healthcare support workers in England: Five proposals for investing in education and development to deliver high quality, effective and compassionate care. A Working Paper.*
<http://www.educationandemployers.org/Data/Sites/8/codhncsw5proposalsforinvestingineduc&devforhighqualitycare.pdf>.
- CQC (2015). CQC's position on the Care Certificate.
https://www.cqc.org.uk/sites/default/files/20150318_one_page_cqc_position_care_certificate.pdf (accessed 30.11.2017)
- CQC Care Directory. <http://www.cqc.org.uk/content/how-get-and-re-use-cqc-information-and-data#directory> (accessed 16.08.2016)
- Crawford, P., Brown, B., Kvangarsnes, M., and Gilbert, P. (2014) The design of compassionate care, *Journal of Clinical Nursing*. Discursive paper, 23, 3589-3599, doi: 10.1111/jocn.12632.
- Cromwell, S. and Kolb, J. (2004) An examination of work environment support factors affecting transfer of supervisory skills training to the workplace, *Human Resource Development Quarterly*, 13(4): 449-71

- Damschroder, L., Aron, D., Keith, R., Kirsh, S., Alexander, J., and Lowery, J. (2009). Fostering implementation of health services research findings into practice: a consolidated framework for advancing implementation science. *Implementation Science*, 4(1): 50
- Department of Health (2001) *National Services Framework for Older People*, HMSO: London
- Department of Health (2012) *Compassion in Practice. Nursing, Midwifery and Care Staff. Our vision and Strategy. Author: NHS Commissioning Board Chief Nursing Officer and DH Chief Nursing Adviser*, HMSO: London
- Department of Health (2013). *The Cavendish Review: An Independent Review into Healthcare Assistants and Support Workers in the NHS and social care settings*, HMSO: London
- Edwards, M. (1997) The nurses' aide: past and future necessity. *Journal of Advanced Nursing*, 26: 237- 45.
- Eggenberger, E., Heimer, I. and Bennett, M. (2013) Communication skills training in dementia care: a systematic review of effectiveness, training content, and didactic methods in different care settings. *International Psychogeriatrics*, 25: 345- 58
- Erzerberger, C. and Prein, G. (1997) Triangulation: Validity and empirically based hypothesis construction. *Quality and Quantity*, 31, 141-154
- Farenden, A., (2013). *Compassionate Care*. National Professional Advisor (Nursing). Care Quality Commission: United Kingdom
- Farmer, T., Robinson, K., Elliott, S. J., and Eyles, J. (2006). Developing and implementing a triangulation protocol for qualitative health research. *Qualitative health research*, 16(3): 377-394.
- Francis Report (2013) *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*, HMSO: London
- Gale, N. K., Heath, G., Cameron, E., Rashid, S., and Redwood, S. (2013) Using the framework method for the analysis of qualitative data in multi-disciplinary health research. *BMC medical research methodology*, 13(1): 117
- Garrison, R. and Kanuka, H. (2004) Blended Learning: uncovering its transformative potential in higher Education, *The Internet and Higher Education*, 7 (2): 95-105
- Grol, R. and Grimshaw, J. (2003) From best evidence to best practice: effective implementation of change in patients care, *The Lancet*, 362, 9391: 1225-30
- Health Education England (2015) *Shape of caring: a review (Raising the Bar) of the future education and training of registered nurses and care assistants*, Lord Willis HEE www.hee.nhs.uk/sites/default/files/documents/2348-Shape-of-caring-review-FINAL.pdf
- Hughes, E.C. (1962) Good people and dirty work, *Social Problems*, 10, 3–11. doi:10.1525/sp.1962.10.1.03a00010

- Hussein, S., Stevens, M., Manthorpe, J., and Moriarty, J. (2011) Change and continuity: a quantitative investigation of trends and characteristics of international social workers in England. *British Journal of Social Work*, 41: 1140–1157
- Jaques, D. and Salmon, G. (2007) *Learning in groups: a handbook for face-to-face and online environments*, Routledge: New York.
- Kessler, I., Heron, P., Dopson, S., Magee, H, and Swain, D. A. J. (2010) *The Nature and Consequences of Support Workers in a Hospital Setting*. SDO Report 08/1619/155. 1619-155_V01.pdf
- Kirkpatrick, D.L. (2006) Seven keys to unlock the four levels of evaluation, *Performance Improvement*, 45(7): 5-8
- Knowles, M. S. (1980) *The modern practice of adult education: From pedagogy to andragogy*, Cambridge Books: New York.
- Kolb, D. A. (2014) *Experiential Learning: Experience as the Source of Learning and Development*. Pearson: New Jersey.
- Lave, J. and Wenger, E. (1991) *Situated Learning: Legitimate Peripheral Participation*. Cambridge Press: Cambridge
- Lincoln, Y. S., and Guba, E. G. (1985) *Naturalistic inquiry* (Vol. 75), Sage
- Maben, J., Adams, M., Peccei, R., Murrells, T. and Robert, G. (2012) Poppets and parcels': the links between staff experience of work and acutely ill older peoples' experience of hospital care, *International Journal of Older Peoples Nursing*, 7: 83- 94
- McCabe, M. Davidson, T. and George, K. (2007) Effectiveness of staff training programmes for behavioural problems among older people with dementia, *Aging and Mental Health*, 11(5): 505-509
- McDonald, I. and Kahn, K. (2007) Respectful relationships, *Future Age*, 6(2): 12-16
- Michie, S., van Stralen, M. M., & West, R. (2011) The behaviour change wheel: a new method for characterising and designing behaviour change interventions, *Implementation science*, 6(1): 42.
- National Careers Service. (2016). *Helping you take the next step*. England, United Kingdom. 2016.
<https://nationalcareersservice.direct.gov.uk/advice/planning/jobprofiles/Pages/healthcareassistant.aspx>
- O’Cathain, A., Murphy, E., & Nicholl, J. (2010). Three techniques for integrating data in mixed methods studies, *BMJ*, 341, c4587.
- Onyett, S. (2012) Creating a culture to deliver compassionate care, *Nursing Times* 03/04/12, 108(14): 45
- Pryce-Miller, M. and Emanuel, V. (2014). Developing compassion in pre-registration education. *Nursing Practice: Review Compassion*, *Nursing Times*, 110(37), 10.09.14

Ravasi, D. and Schultz, M. (2006) Responding to organizational identity threats: exploring the role of organizational culture, *Academy of Management Journal*, 49 (3): 433-58

Rothera, I; Jones, R; Harwood, R; Avery, A; Fisher, K; James, Shaw, I. and Waite, J. (2008) An evaluation of a specialist multi agency home support service for older people with dementia using qualitative methods, *International Journal of Geriatric Psychiatry*, 23: 65-72

Schneider, J., Scales, K., Bailey, S. & Lloyd, J. (2010) *Challenging care: the role and experience of healthcare assistants in dementia wards*, Report for the National Institute for Health Research Service Delivery and organisation programme, HMSO: London

Schneider, J. (2016) Paid carers: a new research challenge, *Aging and Mental Health*, 21(7), <http://www.tandfonline.com/doi/full/10.1080/13607863.2016.1156049>

Skills for Care (2017) *The state of the adult social care sector and workforce in England*, September, 2017, Skills for Care: Leeds

Skills for Health (2015). *The Healthcare Support Workforce: Working Paper 1*, <http://www.skillsforhealth.org.uk/images/resourcesection/reports/The%20Healthcare%20Support%20Workforce.pdf>

Staniszewska, S., Brett, J., Mockford, C., and Barber, R. (2011). The GRIPP checklist: Strengthening the quality of patient and public involvement reporting in research. *International Journal of Technology Assessment in Health Care*, 27(4): 391-399. doi:10.1017/S0266462311000481

TGMG (2017) Frequently Asked Questions about the Care Certificate. <https://carecertificate.co.uk/faq/> [accessed 27.10.2017]

Thomson, L. and Hare Duke, L. (2015) *The Impact of 12-hour shifts on Health Care Assistants*. NHS England Publication Gateway Reference 04030. <http://www.england.nhs.uk/6cs/wpcontent/uploads/sites/25/2015/09/hca-12h-shifts-interview-study.pdf>

Traynor M, Corbett K, Mehigan S. (2015). *Project report: Evaluation of the Roll Out of the Care Certificate in Islington*, Community Education Provider Network (CEPN) A report commissioned by HENCEL and produced on behalf of Middlesex University

UNISON (2015) *Introducing the Care Certificate*, <https://www.unison.org.uk/content/uploads/2015/04/On-line-Catalogue23121.pdf> [accessed 27.10.2017]

Unison (2016) *Care on the cheap: A Unison survey of clinical support workers*. Unison: London.

11 APPENDICES

Appendix 1 – Review of external providers

Appendix 2 – Literature Review on Care Certificate

Appendix 3 – Research documents

- Participant information sheet
- Consent form
- Focus group/interview schedules x 4
- Survey questionnaire

Appendix 4 – Standard Operating Procedures

- Phone survey flowchart
- Site visit flowchart
- Phone survey timings
- Site visit timings
- Survey interview log
- Site visit contact log and flowchart
- Site visit guidelines

Appendix 5 – PPI focus group findings

Appendix 6 – Study site summaries

Appendix 7 – Dissemination table

APPENDIX 1: Desk-based Review of External Care Certificate Training Providers

Sources of training provision

There are over 3000 healthcare and social care training providers listed on the government's Skills Funding Agency. However not all of them provide Care Certificate Training. Using four commonly used online databases (*Skills for Care, Skills Platform, Yellow Pages Online, Last Minute Learning*) a spread sheet of 55 training providers was created. Whilst these platforms list over 500 training providers combined, a brief analysis of their information and websites reveals that far fewer are offering Care Certificate Training.

- Skills for Care lists 98 training providers based on an “*Endorsed provider scheme*”
- Skills Platform lists 102 training providers on a *registered user platform* charging a percentage from bookings
- Yellow Pages online lists 150 training providers based on their *free listing service* or *paid advertising*
- Last Minute Learning lists 167 training providers based on a *registered user platform* with a *quality commitment requirement*

Possible reasons for fewer training providers offering the Care Certificate Training include:

1. The Care Certificate itself can only be issued by the registered manager making it more likely to be adopted as an in-house induction/ learning program.
2. There are free Care Certificate workbooks and resources available from Skills for Care and Skills for Health. Other organisations offer links to those resources also.
3. Many training providers have established accredited learning programs on offer e.g. Health and social care level 1-5 diplomas and apprenticeships

Some **Local authorities** are listed as Care Certificate training providers in their regions. However, they appear to only offer Care Certificate training to their own employees. Local authorities also use approved external training providers via a tendering system or bulk purchase of online training packages. Evidence is not always available online as to whether a local authority is providing an in-house Care Certificate induction program or an approved external training provider. Examples of councils who show Care Certificate details on their websites include Peterborough, Slough and Devon.

NHS Trusts offer Care Certificate training through in-house workforce development departments whereby the Care Certificate is offered as part of induction training. The use of approved external training provider partners does also exist, for example, NHS Trusts may use Care Certificate training and resources from Skills for Health which is a not-for-profit organisation funded through the European Social Fund (ESF).

Structure and Method of Care Certificate training delivery

Many care providers have established workforce plans that include blended learning programs including face-to-face training, distance learning, online training or free workbooks. This can be from a range of sources such as in-house training and external provision.

As part of training feedback JoCo Learning and Development Ltd learners are asked what their preferred learning style is. Responses show that care workers prefer face-to-face training (over 90%), Distance-learning courses ranked second, and online training ranked as the least preferred. Whilst online training is the cheapest training, this method should be balanced with learner preference to be most effective. It is not clear that care providers or training providers consistently check learning preferences of workers as part of workforce planning.

The Care Certificate Training has a practical element which requires observation of the care worker/learner's practice. This element ensures that learners have the knowledge, skill and competence to do the job in line with standards. Some training providers are explicit about the fact that they offer training in the theory/knowledge aspect of the Care Certificate only. In addition, some training providers offer some observations of practice as part of the training. Care providers do need to be careful as training providers can sometimes state that they offer Care Certificate training but do not emphasise the fact that there are observations of practice that should be done to complete the standards. They are sometimes not explicit about the fact that any certificate issued by these training providers is for 'theory only'.

E-Learning

There are popular e-learning platforms who have established pricing models that are difficult to rival, one example is Social Care TV (SCTV (www.social-care-tv.co.uk) offering accredited online training from as little as £1.49 per course.

Their platform allows the senior member of an organisation to set up an account for free and then buy credits to access a training course once. Each course is made up of several modules consisting of a video clip followed by multiple choice questions assessing the learner's knowledge. On completing the course, learners receive a certificate showing their score. Their Care Certificate offering consists of a portal to Skills for Care workbooks and other free resources created by SCTV.

Cost of Care Certificate Training

Cost of Care Certificate training varies greatly. Online Care Certificate training appears to be the cheapest method of training starting at £1.49 per module (Standard) online. Face-to-face training is the most expensive, often costing over £400.00 for a group of learners per day of training. Some face-to-face training is advertised at over £800.00 for a group of learners but in this case included practice observations conducted by the training provider. It requires careful scrutiny by care managers to know what learning outcomes are achieved by the different training approaches at these different prices.

Pricing also varies for specialist subjects such as First Aid (including CPR, AED), Moving and Handling, and Medicine Management. These subjects form part of the Care Certificate standards and are also referred to as 'Mandatory Training' under Health and Safety legislation. Online learning packages may range from £19.99-£40.00 + VAT.

Distance learning can cost £25+ VAT for a theory workbook. However, there does not appear to be many Care Certificate Distance Learning courses available. This could be for several reasons relating to the high cost of development of Distance Learning materials and the availability of the free workbooks from Skills for Care and Skills for Health. Distance Learning appears to be more viable for Regulated Qualification Framework (RQF). For example, '*Preparing to Work in Adult Social Care Level 2*', *BTEC 'Health and Social Care' Level 1* etc⁴.

Skills for Care and Skills for Health provide free workbooks and presentations. Many care providers use these free resources to provide their own training. However, they may not factor in the hidden cost of using these materials such as the print costs of a workbook which could be £10.00 in colour, staff time, managerial time for practice observation and assessment, and any CPD activity to support the internal provision. Costs can soon mount up. The 'DIY' cost of achieving the Care Certificate should be compared with package deals by training providers particularly if the care provider lacks understanding and knowledge of the Care Certificate or observation and assessment skills.

Observation and Assessment

The observation of practice element of the Care Certificate was designed to be undertaken by the manager or other 'competent' staff. There is no qualification required for one to assess. The assessor only needs to be competent in the standard for which the observation of practice relates. Some further investigation would be useful to find out how often and how effectively the observation and assessment element of the Care Certificate is completed when care organisations use external providers for their Care Certificate training. Reasons include:

- Assessment resources for guidance were included with the free resources from Skills for Care and Skills for Health. Resources indicate that a range of assessment methods can be used to support the completion of the Care Certificate but no training was provided.
- There is a need for some level of skill required to effectively conduct observations, assessment and make valid judgments of performance. At the moment, assessor qualifications are needed for the RCF assessor roles but not for the Care Certificate standards.
- There have been events and resources released after the launch of the Care Certificate to assist staff in the understanding of assessment the assessor role. Example [here](#)
- Training providers are offering Care Certificate Assessor training indicating a gap in skill and knowledge. Assessor training costs from £80 - £200 per session and may be 3 - 6 learning hours.

⁴ QCF (Qualification and Credit Framework) has now closed and Ofqual have introduced one framework for all qualifications from GCSE to vocational. QCF has been replaced by the RQF (Regulated Qualification Framework). All qualifications are now built on RQF and are subject to these conditions. A useful PDF outlining these changes can be found [here](#)

Identifying Care Certificate Training

Some of the Care Certificate standards can be mapped onto existing training. Courses such as 'Equality, Inclusion and Diversity' have been part of the previous standards. Some courses such as 'Health and Safety' are mandatory. There are some challenges around the identification of Care Certificate training provision because of poor mapping, different terminology.

External training providers sometimes advertise training as 'mandatory' and 'non-mandatory' courses. These courses could be mapped to Care Certificate Standards but because this is not always stated explicitly care providers may purchase training that they do not necessarily need at that time.

Care providers as employers also continue to provide 'induction training'. The content of induction varies from place to place. There is the risk that an organisation's own induction program is already meeting the standards but because they have not mapped it to the Care Certificate standards they may duplicate training unnecessarily.

Many training providers have chosen to only deliver QCF/RCF standard training for example, Diplomas, BTEC, Apprenticeships. Employers may choose to complete an in-house induction program that cover the Care Certificate standards sufficiently and progress staff straight on to QCF learning programs e.g. Beacon Education Partnership

Learning Hours

Whilst the Care Certificate standards are regulated, there is no regulation around the how training is delivered. The benefit of this is flexibility and choice to suit care services and individual learners. It does however mean there is a great variation in duration and quality. Learning hours for Care Certificate training can range from 1hour per standard (module) to 6hours per standard (module).

In some cases, training in 13 modules is covered in 7.5 hours of training. An example of this is available [here](#).

Funding for Care Certificate Training

For private care providers funding must come from within the organisation. Local Authorities are required to make budgetary provisions for workforce development. Due to funding cuts, some Local Authorities have reduced the training offered to care providers in their locality and have focussed on in-house training. Workforce development departments within some Local Authorities have been reduced and some are expected to include income generation in their remit to sustain the provision of learning and development activities.

NHS trusts must make their own budgetary provisions, however there have been some examples of additional funding being secured. E.g. All 22 NHS Trusts in Kent, Surrey and Sussex are aiming to achieve the Skills for Health Quality Mark, thanks to funding and support from Health Education England (HEE). The Skills for Health Quality Mark, delivered

through the National Skills Academy for Health, covers all the face-to-face training courses offered by a provider, ensuring that this learning and development is of an excellent standard and fully meets the needs of the sector. The Quality Mark requires three different courses to be assessed. In the case of Kent, Sussex and Surrey, one of these courses is the Care Certificate training, and the other two could be other frequently delivered courses, to be chosen by each Trust.

One training provider 'Care Training Solutions' state that they may be able to access Grants and bursaries to assist with training costs. It is not clear whether this includes funding the Care Certificate. It is unlikely to cover the Care Certificate. Traditionally funding streams have been available for QCF/RCF training.

APPENDIX 2: Scoping Review of the Literature

Background:

Following the Francis Inquiry (2013) into Mid-Staffordshire NHS Foundation Trust, and the identification of serious challenges in health and social care settings, Camilla Cavendish was tasked by the Secretary of State to review and make recommendations on the recruitment, learning and development, management and support of health and social care support workers (HSCW's). The final report, "The Cavendish Report: An independent review into Healthcare Assistants and Support Workers in the NHS and Social Care Settings" (2013) found that roles were often inconsistent and many were frustrated by what they felt was a lack of recognition. The Cavendish report made 18 main recommendations. A key recommendation was the introduction of the Certificate of Fundamental Care – the "Care Certificate" which has now been developed and piloted by Health Education England, Skills for Health and Skills for Care. The Cavendish report also recommended the Care Quality Commission should require all support workers to complete the Care Certificate before working unsupervised.

The Care Certificate is aimed at healthcare assistants and care support workers and consists of 15 standards. Each standard has a series of outcomes and assessment criteria. All assessment criteria must be satisfied before the Care Certificate can be awarded.

We performed a scoping review to give an overview of the available literature on the Care Certificate. We utilised methods used in the framework by Arskey and O'Malley (2005) and where relevant incorporated the later suggested amendments by Levac et al (2010) and Daudt et al (2013). Scoping reviews provide an overview of the literature by mapping the key concepts in the evidence base of a research area and can be useful to help identify the gaps in knowledge (Arskey and O'Malley, 2005)

Arskey and O'Malley (2005) use May et al's (2001) definition of a scoping study, "To map rapidly the key concepts underpinning a research area, the main sources and types of evidence available, and can be undertaken as standalone projects in their own right, especially where an area is complex or has not been reviewed comprehensively before". The framework they developed identified 4 main reasons for conducting a scoping study: 1) to examine the extent, range and nature of research activity; (2) to determine the value of undertaking a full systematic review; (3) to summarise and disseminate research findings; and (4) to identify research gaps in the existing literature. All four reasons were relevant to our research. The implementation of Care Certificate has received limited research focus to date and it was important to scope what is currently available.

Methods:

Arskey and O'Malley's framework includes six stages although the sixth is described as optional: (1) identifying the research question, which is usually broad in nature; (2) identifying relevant studies, a process that is as comprehensive as possible; (3) study selection, with the establishment of inclusion/exclusion criteria, based on familiarity with the literature; (4)

charting the data, a stage that includes sifting and sorting information according to key issues and themes; (5) collating, summarizing, and reporting the results, which provides both a descriptive and numerical summary of the data and a thematic analysis; and (6) a consultation exercise, an additional, parallel step involving key stakeholders to inform and validate study findings.

The first stage of the framework involved identifying the research question. We decided to keep this broad and therefore the aim of our scoping review was to systematically explore and describe the breadth and depth of available research on the Care Certificate.

Following this, Stage 2 of Arskey and O'Malley's framework involved identifying relevant studies. A literature search to identify published and grey literature relating to the Care Certificate was performed by an information specialist (EY) with input from the research team. The free text search term used was broad "Care Certificate" and results were restricted to UK, and commenced from 2013 to the search date (August 2017). This date was chosen due to the publication of the Francis Report (2013). No methodological filter was employed. Seven databases were searched: MEDLINE, EMBASE, PsycINFO, CINAHL, BNI, ISI Web of Science, Google Scholar and further 5 websites searching generated in discussion with our expert panel: NIHR (www.nihr.ac.uk), *Health Services and Delivery Research (HS&DR)* www.journalslibrary.nihr.ac.uk/hsdr/#/, Skills for Care <http://www.skillsforcare.org.uk>, Skills for Health <http://www.skillsforhealth.org.uk/> and United Kingdom Homecare Association www.ukhca.co.uk.

This was followed by forward citation and grey literature searches? The search conducted by a librarian team member resulted in 236 resources and after removal of duplicates, 99 resources from the databases and a further 20 from website searches. (See Table 1 and 2).

Stage 3 involved screening of texts. Levac et al (2010) recommend assembling, "a suitable team with content and methodological expertise". An expert research team (EA, LT, ZK, JS) independently screened the titles, abstracts and full texts based on the criteria outlined in table 1. The references were imported into EndNote X7. The use of online software management tool allowed us to organise and cross check our references. This process elucidated 24 relevant full text publications for review.

Results:

The 24 full text papers were imported into endnote for stage 4 of Arskey and O'Malley's framework. This stage involved sifting, charting, and sorting information. Data from the included studies were extracted and summarized by one research reviewer using a bespoke form developed in Excel. Extracted data included where relevant; publication type, year, study design, methods, sample size, time frame, setting, topic, population, implementation factors,

barriers and enablers of implementation. At this stage, a further 4 results were discarded (2 duplicates, 2 irrelevant) leaving 20 texts for review.

Stage 5 of the framework involves collating, summarizing, and reporting the results, which provides both a descriptive and numerical summary of the data and analysis. The 20 studies included (13 editorials, 2 evaluation reports, 1 review, 1 news bulletin, 1 case study, 1 book review and 1 poster), most (n=15) were from 2015, the year the Care Certificate launched. It appears a series (n=11) of editorials regarding the Care Certificate appeared in the British Journal of HealthCare Assistants during 2015 from a range of stakeholders.

Due to the paucity of literature on the Care Certificate and the breadth of literature, it became difficult to numerically chart the results. A narrative descriptive analysis ensued as most appropriate for the task. A narrative analysis can position characters in space and time and give order and make sense of what happened. Given the results of the literature showed mainly editorial work, this would allow for insight into how individuals experience the introduction of the Care Certificate, either first or third-hand, and how they confer subjective meanings to these experiences.

The first reference regarding the Care Certificate was a web editorial to the Nursing Times Website (Calkin and Lintern, 2013). The Royal College of Nursing chief executive and general secretary, Peter Carter welcomed the move to introduce the Care Certificate and said it moved HCAs a “step closer to mandatory regulation”. He further went on to say, “We have long highlighted the variations in training received by healthcare support workers, and the resulting variations in the level of care received by patients, and this Care Certificate will hopefully do much to alleviate these concerns”.

In 2014, a pilot study of the Care Certificate was undertaken between May and September 2014 by Skills for Care. The final report (Allan et al., 2014) detailed how a total of 29 sites participated in the pilot (16 social care and 13 in healthcare). Primary research included face-to-face and telephone consultations with assessors, trainers and staff undertaking the Care Certificate. Across those sites there were 450 support workers that had undertaken Care Certificate training. In terms of delivery models, three quarters of the sites had used an in-house model with an average of 4-5 days training in a classroom setting followed by an average of 2-3 weeks work shadowing or supernumerary. There were mixed views over completion in 12 weeks, but overall it was felt it was about right. Feedback from the pilot suggests the standards in the Care Certificate are the right ones and no significant concerns were raised about the difficulty level.

The most contentious area covered by the evaluation related to assessment and supervision. The areas of concerns for this include the definition of "occupationally competent" for assessors and also over potential discrepancies in assessments across centres and potential

need for greater standardisation about what constitutes acceptable evidence. Learning materials were considered fit for purpose. Views on how portability would work in practice was a concern. Only a quarter of the pilot leads said they would be willing to accept the Care Certificate as reliable proof of a support workers abilities. The principle of the Care Certificate was overwhelmingly welcomed by the pilot sites and combination of theory, practical knowledge, observation and assessment were praised by most staff. In terms of longer term impact, most felt it was too early to see the real impact. Many of the pilot studies had not yet considered any financial implications of the Care Certificate.

In 2015, a number of editorials from a range of stakeholders appeared in the British Journal of Healthcare Assistants. Starting with an introduction from the editor (Looking back and forward, 2015) who described the launch of Care Certificate as a turning point in the national perception of healthcare support workers. A "step in the right direction" and how the "proper way forward is registration for support workers", his positive introduction sighted the implementation of the Care Certificate as something to be "welcomed not feared".

This was followed by an editorial providing a description of the background to Care Certificate and process to development (Setting the standards for frontline care, 2015). A very brief summary of the results of the Skills for Care national pilot were provided. The details of the pilot were described; consisting of 29 organisations across health and social care with a further 85 employers testing the certificate, involving over 1000 support workers. Additionally, 80 organisations and individuals responded directly to members of the working partnership and Skills for Care received 155 responses to an online survey. The Care Certificate Standards were clearly laid out in a further editorial (The Care Certificate Standards, 2015).

Feedback from the pilot were largely positive and indicated draft proposals were appropriate in content and process. The editorial also detailed the background and importance of the Care Certificate and 15 key standards, the "stepping stone" nature of the qualification as a foundation for a career pathway and the portability and transferability of the Care Certificate across roles within the same employer and between different employers was emphasised. In terms of supporting the roll out, details were provided of the generic guidance documentation and learning materials to support employers which are made available to download free from the skills for health website. No information was provided about any perceived barriers or enablers.

Editorial to the Care Certificate by Chrissy Cowan (Associate practice educator) sets out the key aspects of the Care Certificate and welcomes the idea of standardising basic training across health and social care and ponders if it may perhaps bring the two branches together, and possibly be a step closer to regulation (Cowan, 2015).

A short editorial by Tanis Hand, Professional lead for Health Care Assistants and Assistant Practitioners, RCN reflects further on the introduction of the Care Certificate (Hand, 2015). The implementation of the Care Certificate is described as having been received with enthusiasm. Furthermore, she describes how organisations have developed their inductions to incorporate the standards and new opportunities for experienced workers to mentor, assess and educate new colleagues. The editorial emphasises the year has been a turning point for HCA's and that much more is to come. Tanis Hand touches on Lord Willis's Raising the Bar report (Willis, 2015) about valuing health care workers and enabling them to enter the nursing profession by taking account of their prior education and experience.

A short editorial by Catherine Hayes, Principal Lecturer at University of Sunderland summarises the key issues surrounding migrant HCA's and how best they can be supported (Hayes, 2015a). In particular, how best might education be tailored to support those joining the UK HCA workforce from a range of international settings, cultures and context. This editorial further emphasises the need for HCA educational pathways to identify diversity and to capitalise on the, "inherent value based intentionality that drives professionalism".

A further editorial by Catherine Hayes, Principal Lecturer at University of Sunderland describes the process and importance of meaning-making through transformative learning for HCA education (Hayes, 2015b). The Francis Report (2013) and the Cavendish Review (2013) both highlighted the need for interaction with patients at any level to be compassionate—and compassion is founded in the need to matter. To matter necessitates meaning-making and this is where the core connection between the need for transformative learning and change can be clearly situated. The encouragement and facilitation of change via critical self-reflection and meaning-making through the Care Certificate offers an opportunity for HCAs to feel valued in relation to the central role they play in the UK healthcare workforce.

Although not detailing the Care Certificate, an editorial by Kay Norman (2015), Senior lecturer nursing, Open University (Norman and Roche, 2015) details how mentorship can be invaluable to HCAs in developing skills, knowledge, attitudes and competencies throughout their career, not only when completing a formal educational course.

A short editorial by Ian Peate, Professor of Nursing at Gibraltar Health Authority detailed the background to the introduction of the Care Certificate (Peate, 2015). The rationale for the CC has been widely welcomed however, he questions if the Certificate in its present form and how it is currently being administered really have any value? Peate (2015) argues that whilst Health Education England, Skills for Health and Skills for Care in their guidance use the words 'should' and 'must' with regards to standards and their assessment, there are no checks in place to ensure that employers are adhering to the spirit of the Certificate. Skills for Health say the certificate 'is voluntary, but it is seen as a sign of best practice', there is no regulatory body or statute underpinning the Certificate, or the Code. So, for support workers, the outcomes of failure to comply lie instead with the autonomy of individual local employers. Consistency

should be considered essential in order for the Certificate to be universally transferable and credible.

A short editorial by Helga Pile, National Officer and Healthcare Support Worker Lead, Unison describes implementing the Care Certificate as positively as possible and specifically UNISON's recommendation (Pile, 2015). Whilst most of the literature has focused on the background of the Care Certificate or operational aspects, this report focuses on conversations with stakeholders about how to monitor and evaluate the impact. Pile (2015) emphasises what the Care Certificate can achieve will depend on how well it is implemented. This raises the issue that the programme places a lot of the "how to" at the employer's discretion.

UNISON recommend a number of both strategic and operational commitments for positive implementation. Strategic level commitments include; appointment of a board level champion of the Care Certificate, commitment to working with the local trade unions to deliver the Care Certificate programme, public recognition for staff "graduating" from the Care Certificate e.g. an award ceremony, public commitment from employers that the Care Certificate is the first stage of ongoing investment in training. At an operational level, UNISON recommends; at least some of the training to be delivered face-to-face, agreement on selection, support and training for assessors, development of an assessment protocol, integration with assessment for vocational qualifications, temporary rotations for staff who cannot demonstrate all the standards in their current role, extended timescales for part time or night shift workers, agreed systems for quality assurance and validation, including regional or sub regional collaboration with other employees. Essentially the key concerns of UNISON relate to the lack of external validation for training and assessment, lack of accreditation for the Care Certification and that the certification process is non-mandatory and the code of conduct voluntary.

A short editorial by Wolfe (2015) summarises one HCA's journey to completing the Care Certificate. This positive first-hand account highlights the gains to practice of new and up-to-date knowledge and enhanced skills. Whilst the author is an experienced HCA already, and it was only a mandatory trust requirement for new HCAs to complete the Care Certificate, the author felt completing it allowed her to support new HCAs more robustly. This is the only published first-person account of a carers experience of completing the Care Certificate.

Following the implementation of the Care Certificate, South London and Maudsley Foundation NHS Trust introduced a "day 2 Care Certificate follow up" workshop to evaluate the effectiveness. An editorial described the results (Gilding M, 2017). A total of 38 care workers and 32 clinical supervisors attended and feedback collated from a "tabletop" exercise, group discussions and course evaluation forms. results of the evaluation exercise showed overwhelming reports of inadequate support. Significant variations were identified in accessing protected time, team support and supervision. The South London and Maudsley

experience suggests systemic barriers impacting on care worker's achievement of the Care Certificate. The lack of implementation guidelines undermines Cavendish (2013) recommendation for standardisation. Giving employers complete control over implementation was considered seriously detrimental and likely to lead to poor delivery.

The series of editorials featured in the Journal of Healthcare Assistants provide an insight into how a range of stakeholders perceive the impact of the Care Certificate at an early introduction stage. In general, it is clear that many welcomed the introduction of the Care Certificate which was seen as a positive move towards a more skilled workforce, improving the image of caring, and building minimum standards of training. However, concerns were arising about the perceived challenges of lack of external validation and accreditation. Most of the literature focused on the background of the Care Certificate or potential operational aspects. Little attention was given to operational and strategic aspects and stakeholders views about how to monitor and evaluate the longer-term impact of the Care Certificate.

A review by Johnson and Moulton (2015) discusses and details the role of the HCA in general practice, focusing specifically on the experience of Stoke-on-Trent. In total 42 out of a possible 48 staff members took part. The review took place prior to the introduction of the Care Certificate but clearly mapped the service within the geographical area and will potentially provide a basis to cross reference findings with the proposed introduction of the Care Certificate. It was clear that ensuring staff are valued and supported with career frameworks will continue to help ensure HCA's can deliver compassionate, competent and high quality, patient-centered care.

The Nursing Standard published a brief news report (Sprinks, 2015) expressing surprise that under plans being developed by Health Education England (HEE) there may soon be a requirement for nursing students to attain the Care Certificate competencies within the first year of their pre-registration programmes. A mandate developed by HEE by the department of Health for April 2015-March 2016 states the HEE will build into contracts with HE institutions guarantees nursing students attain the Care Certificate if they have not already. Howard Catton, RCN Head of Policy was quoted as saying, "It would leave us with a contradiction; a certificate mandatory for nursing students but not for HCA's". This furthermore highlighted the issue regarding implementation aspects of the Care Certificate and specifically accreditation for the Care Certificate and that the certification process being non-mandatory and code of conduct voluntary. This appears to be in conflict with the Cavendish Report (2003) recommendation to bridge the gap between HCA's and registered nurses.

An evaluation report (Traynor et al., 2016) on the roll out of the Care Certificate in Islington Community Education Provider Network (CEPN) was commissioned by HENCEL and produced by Middlesex University. The evaluation sought to explore the impact of the present use of the CC within a defined area and compare it with similar evaluations in other areas. The researchers wanted to build on existing ideas of what it is that works regarding the use of

the Care Certificate to further improve performance for other support workers. The valuation approach was a realistic evaluation (Pawson and Tilley, 1997). This allows a focus on context, mechanism and outcome.

Four organisations were invited to participate and the sample at each site were from the following groups: manager, assessor, trainers, staff undertaking the certificate, mentor/supervisor. Stage 1 involved telephone interviews and stage 2 involved detailed discussions with individuals responsible for implementing and evaluating the Care Certificate. Although participation was low, overall findings showed that the CCH has been active and effective in promoting the Care Certificate. Only three assessors were interviewed and it did not appear they were prepared for the role of the assessor at the time interviews took place. They were not able to provide detailed answers or comment on the assessment guidance or assessment documentation. Two HCA's were interviewed, they were both very positive and both expressed an interest further in more in-depth training. Five managers were interviewed, all of which were positive and committed to invest in training. Concerns were raised regarding the assessment aspects and who signed off the assessments. Managers felt quality assurance was preferred as an in-house process but conflict with portability was noted, it was felt new staff would be required to repeat an organisations induction regardless.

A particular area of progress in Islington was the development of a 2 day programme commissioned by Whittington health and delivered by City and Islington College. Originally this was planned to dovetail with Whittington Health's induction programme and the Care Certificate content to cover only 5 of the 15 standards with the others being covered at induction. However, with the CEPN's commitment to having a cross-sector CC and rolling this out queries occurred about the suitability across all organisations. Trainers felt the issue of quality assurance would be addressed by processes from the organisation providing the training however they felt portability was a problem without accreditation.

The key concerns of training managers could be summarised as variation in the understanding of the assessment requirements and capacity issues regarding management of the process. Most participants felt the documentation to help with assessment from Skills for Health and HEE were not fit for purpose and didn't provide sufficient clarity. The issue of quality assurance in light of the lack of a national regulator or accreditation body was an area of huge concern. Concerns included whether or not it was being properly delivered when there is no regulatory or external body checking it. Concerns were raised as to whether a genuine high threshold for competence from every provider would be effected by pressures of recruitment and needing to get more people through the door, this would also further raise the question of portability.

Attempts to compare this experience with pilots in other settings e.g. GOSH (Great Ormond street) and Bart's Health were not possible due to delays with roll out. However, information provided by GOSH expressed concerns about the lack of national level quality assurance and the implications this would have for portability whilst information gained from Bart's expressed some concern about the role of the assessor, who would be best suited and concerns over nurse assessors being taken away from clinical work which was already under pressure.

Leicestershire Partnership NHS Trust (LPT) reported (Employers NHS, 2016) on their experience implementing the Care Certificate in Leicestershire. LPT employs over 5,500 staff and serves a population of one million. The case study details how LPT implemented the Care Certificate. A cross service representation working group was set up to oversee the implementation of the Care Certificate to support and develop health care support workers. Additionally, to ensure consistency across the region, a portfolio of evidence was developed in partnership with University of Leicester Hospital Trust. LPT adopted a team approach to supporting the care worker's with a cross-section of staff observing the practice. A key challenge was ensuring they had enough assessors in place. As a result of the pilot the trust saw a range of positive outcomes. As a next step, they hope to implement a designated mentor for each team to oversee and sign off portfolios. It is expected this role will be fulfilled by a qualified nurse.

The idea of a cross-service implementation strategy and cross-section representation of staff observing the policy may be a solution towards great national concerns over variation in quality and outcome. More longitudinal research will be needed to evaluate this is practice and compare to other methods of assessment.

A poster (Manns et al., 2015) on the delivery of the Care Certificate to local care homes detailed the experience of St Christopher's hospice. With funding from the Local Educational and training board (LETB), Health Education South London (HESL) a "hospice" version of the Care Certificate had been rolled out to 12 local care homes. The project included funding to train a nominated member of staff from each care home as a fully qualified assessor achieving the Level 3 QCF Certificate in Assessing Vocational Achievement (CAVA). This will facilitate care homes to be part of the delivery of vocational qualifications for their own staff ensuring future training and educational needs are addressed through a recognised accredited route. However, the tailoring of the Care Certificate to different organisations could threaten the standardisation of training and have implications for future portability.

A book review of "Fundamentals of Care" by Ian Peate was included in the British Journal of healthcare Assistants (Cowan, 2017). This is an optional accompanying textbook for the Care Certificate considered accessible and detailed. However, it refers to the Care Certificate as mandatory, demonstrating significant confusion over the award.

Conclusion:

This scoping review reveals a paucity of robust evidence on the Care Certificate. Nevertheless, these findings proved useful as they contributed to our understanding of the extent and state of the literature and demonstrated a range of stakeholder views and what they perceived as key issues surrounding the implementation of the Care Certificate.

Importantly, the study revealed to us that there is very little literature on the perspectives of services implementing the Care Certificate, and people's experience of it. This lack of attention to people's voice represents a significant gap in research. It became apparent that, in-depth research drawing on the experience of services implementing the Care Certificate and individual's experiences of the Care Certificate would be required in order to draw conclusions.

Initial perspectives from early pilots are starting to become available. It was clear from the evidence so far that the Care Certificate was generally welcomed and viewed as a positive initiative to add value to current practice. In terms of content it was viewed as applicable and relevant to the workforce.

Significant concerns were raised about the quality assurance of the Care Certificate, the need for standardisation of assessment and the risk of dilution of standards due to high levels of staff turnover. Further research into operational and strategical aspects of implementation will help elucidate the components of best practice. Cross –provider working may assist with the lack of external validation leading to variation in quality and outcomes.

The lack of implementation guidelines undermines the Cavendish report recommendations for standardisation. Whilst the Care Certificate set out high expectations, a single certificate to span many different organisation structures “optionally” without any “regulatory oversight”, giving employers complete control and autonomy over implementation was considered detrimental and likely to have a significant effect on portability.

Even at this early stage concerns were clear about perceptions of poor delivery at different sites, tailored certification resulting in lack of standardisation and variation in assessment standards. Three quarters of employers undertaking the pilot suggest they would ask people to redo the certificate in their organisation which conflicts with the aim of a standardised certificate which is portable and transferable across roles and organisations.

Without in-depth research drawing on the experience of services implementing the Care Certificate, individual's experiences of the Care Certificate and robust longitudinal data, it will be difficult to draw any firm conclusions. It will be important to keep the dialogue going across services about what works, what doesn't and for whom in what services.

References:

1. Looking back--and forward. *British Journal of Healthcare Assistants*. 2015;9(12):581-581.
2. Setting the standards for frontline care. *British Journal of Healthcare Assistants*. 2015;9(1):38-40.
3. The Care Certificate Standards: an introduction. *British Journal of Healthcare Assistants*. 2015;9(7):322-323.
4. Allan T, Thompson S, Filsak L, Ellis C. (2014). Evaluation of the Care Certificate Pilot. *Skills for Care, Leeds, UK*.
5. Arskey, H and O'Malley, L. (2005). Scoping studies: towards a methodological framework. *International Journal of Social Research Methodology: Theory and practice*. 8:19-32
6. Calkin S, Lintern S. (2013). Compulsory Care Certificate brings HCAS a "step closer" to regulation. *Nursing Times* 109(43):3.
7. Cowan C. (2015). General introduction to the Care Certificate and its implications. *British Journal of Healthcare Assistants*. 9(4):166-167.
8. Cowan C. (2017). A good companion to the Care Certificate. *British Journal of Healthcare Assistants*. 11(3):122-123.
9. Daudt H, van Mossel C and Scott, S. (2013). Enhancing the scoping study methodology: a large, inter-professional team's experience with Arskey and O'Malley's framework. 13:48
10. Department of Health. (2013). The Cavendish Review: An independent review into healthcare assistants and support workers in the NHS and social care settings. London, UK.
11. Employers NHS. (2016). Leicestershire Partnership NHS Trust: implementing the Care Certificate in Leicestershire.
12. Francis Report. (2013). Mid Staffordshire NHS Foundation Trust public inquiry. Executive Summary (Vol. 947). London, UK.
13. Gilding M. (2017). Implementing the Care Certificate: a developmental tool or a tick-box exercise? *British Journal of Healthcare Assistants*. 11(5):242-247.
14. Hand T. (2015). A massive turning point for our HCAs and APs in 2016. *British Journal of Healthcare Assistants*. 9(12):582.
15. Hayes C. (2015). Challenging stereotyping and misconceptions about international HCA education. *British Journal of Healthcare Assistants*. 9(6):304-309.
16. Hayes C. (2015). Meaning-making through transformative learning for HCA education. *British Journal of Healthcare Assistants*. 9(7):354-361.

17. Health Education England. (2015). Raising the Bar: Shape of Caring: A Review of the Future Education and training of Registered Nurses and Care Assistants.
18. Johnson K, Moulton C. (2015). Baseline review: The role of HCAs in general practice. *Practice Nursing*. 26(6):302-305.
19. Levac D, Colquhoun H and O'Brien K. (2010). Scoping studies: advancing the methodology. *Implementation Science*. 5:69
20. Manns J, Bryan L and Morris K. (2015). P-27 Delivery of the Care Certificate to local care homes. *BMJ Supportive & Palliative Care*. 5(Suppl 3): A10-A10.
21. Mays N, Roberts E and Popay J. (2001). Synthesizing research evidence. In: Fulop N, Allen P, Clarke A, Black N, editors. *Studying the Organisation and Delivery of Health Services: Research methods*. London: Routledge; 2001. pp. 188–219.
22. Norman K, Roche K. (2015). Mentors: supporting learning to improve patient care. *British Journal of Healthcare Assistants*. 9(3):132-137.
23. Peate I. (2015). Care Certificate: not worth the paper it is written on? *British Journal of Healthcare Assistants*. 9(12):583-584.
24. Pile H. (2015). Implementing the Care Certificate as positively as possible. *British Journal of Healthcare Assistants*. 2015;9(7):324-326.
25. Smith-Robbie A. (2015). 0189 The Care Certificate – evaluating the impact and benefits upon service user experience, participant performance and professional development. *BMJ Simulation and Technology Enhanced Learning*. 1(Suppl 2): A25-A25.
26. Sprinks J. (2015). Surprise at requirement for nursing students to attain Care Certificate. *Nursing Standard*. 29(31):11.
27. Traynor M, Corbett K, Mehigan S. (2016) Evaluating the roll out of the Care Certificate in a local health area. *Pharmacy Education*. 16(1):63.
28. Wolfe D. (2015). My Care Certificate journey. *British Journal of Healthcare Assistants*. 9(9):470.

Tables:

Table 1: search strategy

Resources

The Trust Library will develop a strategy & conduct searches for the following databases/websites: MEDLINE; EMBASE; PsycINFO; CINAHL; BNI; ISI Web of Science; Google Scholar

Website searching generated in discussion with our expert panel to include: · NIHR www.nihr.ac.uk · Health Services and Delivery Research (HS&DR) www.journalslibrary.nihr.ac.uk/hsdr/#/ · Skills for Care <http://www.skillsforcare.org.uk> · Skills for Health <http://www.skillsforhealth.org.uk/> · United Kingdom Homecare Association www.ukhca.co.uk

Search Terms:

1. The primary search will identify published and grey literature relating to the Care Certificate
2. The secondary search will identify literature on Healthcare assistants and training and development

HCA terms	Training and Development Terms
health-care assistants	
health care assistants	Training and development
healthcare assistant	Professional development
unregistered carer or nurse	Standards
non registered nurse	Competencies
nursing auxiliary	
auxiliary nurse	
nursing assistant	
orderly or orderlies	
Nurse aide	
Frontline carer	
Support worker	
Domiciliary care	
Care assistant	
Home carers	

Paid carers	
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Limitations

- Limit by date from 2013
- UK focus

Table 2: Resources and Number of Results

Resource	Time Coverage	Search Interface	# of Hits
PSYCINFO	1806 to present	Ovid	0
HMIC	1979 to present	Ovid	3
CINAHL Plus with Full Text	To date searched	Ebsco	151
Web of Science	To date searched		0
BNI	1992 to present	HDAS	44
Medline	1946 to Present	Ovid	8
Pubmed	To date searched		10
Embase	To date searched	Ovid	8
Google Scholar	To date searched		584 – 12 selected
		Screened first 200 ordered in priority of relevance to find 12 unique references	
Subtotal			236
Duplicates or screened papers			137
Total (for Screening) in Endnote Library			99

Table 3: Total Records Full Text from Website Search

Resource	Time Coverage	# of Full Text or links
NIHR	To date searched	1
Health Services research and delivery	To date searched	0
Skills for Care	To date searched	56 results. 5 selected
National Skills academy	To date searched	56 results. 1 selected
Skills for Health Academy	To date searched	46 results. 4 selected
UK Homecare Association	To date searched	27 results. 9 selected
Subtotal		186
Duplicates or screened papers		166
Total (for Screening) Full Text Papers		20

Acknowledgments:

Evidence search: Care Certificate. Emma Young. 08/06/2017. Nottinghamshire Healthcare NHS Foundation Trust, Library and Knowledge Services.

Table 4: Included studies

Looking back--and forward. <i>British Journal of Healthcare Assistants</i> . 2015;9(12):581-581.
Setting the standards for frontline care. <i>British Journal of Healthcare Assistants</i> . 2015;9(1):38-40.
The Care Certificate Standards: an introduction. <i>British Journal of Healthcare Assistants</i> . 2015;9(7):322-323.
Allan T, Thompson S, Filsak L, Ellis C. (2014). Evaluation of the Care Certificate Pilot. <i>Skills for Care, Leeds, UK</i> .
Calkin S, Lintern S. (2013). Compulsory Care Certificate brings HCAS a "step closer" to regulation. <i>Nursing Times</i> 109(43):3.
Cowan C. (2015). General introduction to the Care Certificate and its implications. <i>British Journal of Healthcare Assistants</i> . 9(4):166-167.

Cowan C. (2017). A good companion to the Care Certificate. <i>British Journal of Healthcare Assistants</i> . 11(3):122-123.
Employers NHS. (2016). Leicestershire Partnership NHS Trust: implementing the Care Certificate in Leicestershire.
Gilding M. (2017). Implementing the Care Certificate: a developmental tool or a tick-box exercise? <i>British Journal of Healthcare Assistants</i> .11(5):242-247.
Hand T. (2015). A massive turning point for our HCAs and APs in 2016. <i>British Journal of Healthcare Assistants</i> . 9(12):582.
Hayes C. (2015). Challenging stereotyping and misconceptions about international HCA education. <i>British Journal of Healthcare Assistants</i> . 9(6):304-309.
Hayes C. (2015). Meaning-making through transformative learning for HCA education. <i>British Journal of Healthcare Assistants</i> . 9(7):354-361.
Johnson K, Moulton C. (2015). Baseline review: The role of HCAs in general practice. <i>Practice Nursing</i> . 26(6):302-305.
Manns J, Bryan L and Morris K. (2015). P-27 Delivery of the Care Certificate to local care homes. <i>BMJ Supportive & Palliative Care</i> . 5(Suppl 3): A10-A10.
Norman K, Roche K. (2015). Mentors: supporting learning to improve patient care. <i>British Journal of Healthcare Assistants</i> . 9(3):132-137.
Peate I. (2015). Care Certificate: not worth the paper it is written on? <i>British Journal of Healthcare Assistants</i> . 9(12):583-584.
Pile H. (2015). Implementing the Care Certificate as positively as possible. <i>British Journal of Healthcare Assistants</i> . 2015;9(7):324-326.
Sprinks J. (2015). Surprise at requirement for nursing students to attain Care Certificate. <i>Nursing Standard</i> . 29(31):11.
Traynor M, Corbett K, Mehigan S. (2016) Evaluating the roll out of the Care Certificate in a local health area. <i>Pharmacy Education</i> . 16(1):63.
Wolfe D. (2015). My Care Certificate journey. <i>British Journal of Healthcare Assistants</i> . 9(9):470.

Excluded studies

Reasons for exclusion - duplicates
Traynor M, Corbett K, Mehigan S. (2015) Evaluation of the roll out of the Care Certificate in Islington community education provider network. A report commissioned by HENCEL and produced on behalf of Middlesex University, School of Health and Education.
Traynor M, Corbett K, Mehigan S. (2015). <i>Project report: Evaluation of the Roll Out of the Care Certificate in Islington Community Education Provider Network (CEPN)</i> A report commissioned by HENCEL and produced on behalf of Middlesex University. 2015.
Reasons for exclusion - Not relevant
Infinite in your variety. <i>British Journal of Healthcare Assistants</i> 9(9):425-425. (http://web.b.ebscohost.com/ehost/pdfviewer/pdfviewer?vid=0&sid=3b7635a0-b6d6-49f0-a603-679c1c39ac92%40sessionmgr103)

Smith-Robbie A. (2015) 0189 The Care Certificate – evaluating the impact and benefits upon service user experience, participant performance and professional development. *BMJ Simulation and Technology Enhanced Learning*. 1(Suppl 2):A25-A25
(http://stel.bmj.com/content/1/Suppl_2/A25.1)

Participant Information Sheet

07.06.2016

Research Project Title: Evaluating the Care Certificate: A Cross-Sector Solution to Assuring Fundamental Skills in Caring (ECCert)

Invitation

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. One of our team will go through the information sheet with you and answer any questions you have. Talk to others about the study if you wish. Ask us if there is anything that is not clear and please take time in deciding whether or not you wish to participate in the project.

What is the purpose of the project?

The project aims to examine the different approaches that care organisations have taken to Care Certificate training for new health and social care support workers and how these approaches impact on the improvements to care.

Why have I been invited to participate?

You have been invited to participate because you work in a care organisation providing health or social care, or you are a patient or carer representative in a Patient Participation Group. We will be asking care organisation managers responsible for staff training provision to take part in telephone surveys. We will be inviting Health Care Assistants, Social Care Support Workers and relevant Health and Social Care Managers to attend interviews and focus groups about their experience of the Care Certificate. And finally, we will also be running focus groups with patients/carers recruited through patient participation groups to explore their experiences of care.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a consent form, or verbally give consent. If you decide to take part, you are still free to withdraw at any time and without giving a reason. However the information collected so far cannot be erased and may still be used in the project analysis.

What will happen to me if I agree to take part?

If you have been asked to participate in a telephone survey, this will be arranged to take place at a mutually convenient time and will last around 15 minutes. If you have been invited to take part in an interview or focus group, these will last between thirty and sixty minutes and one of the researchers will contact you to arrange the location and time of the interview or focus group.

Health Care Assistants and Social Care Support Workers, patients and carers taking part in focus groups or interviews will receive a £20 gift voucher in return for their participation as well as travel expenses incurred in order to take part in the research.

What are the possible disadvantages and risks of taking part?

There are no identified disadvantages or risks associated with participation in this study.

What are the possible benefits of taking part?

The information we get from your participation in this study will contribute to the future development in the training provision for Health Care Assistants and Social Care Support Workers within care organisations.

What happens when the research study stops?

The information given to us by you and other participants will be analysed and we will produce a report.

What if something goes wrong?

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. The researchers contact details are given at the end of this information sheet. If you remain unhappy and wish to complain formally, you should then contact study sponsor, Shirley Mitchell, Head of Research and Innovation, Nottinghamshire Healthcare NHS Foundation Trust, Duncan MacMillan House, Porchester Road, Nottingham, NG3 6AA, tel. 0115-9691300 ext. 11903, email shirley.mitchell@nottshc.nhs.uk.

Will my taking part in this project be kept confidential?

We will follow ethical and legal practice and all information about you will be handled in confidence. If you join the study, some parts of the data collected for the study will be looked at by authorised persons from the Institute of Mental Health who are organising the research. They may also be looked at by authorised people to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty.

All information which is collected about you during the course of the research will be kept **strictly confidential**, stored in a secure and locked office, and on a password protected database. Any information about you which leaves the institution will have your name and address removed (anonymised) and a unique code will be used so that you cannot be recognised from it. All research data will be kept securely for 5 years. After this time

your data will be disposed of securely. During this time all precautions will be taken by all those involved to maintain your confidentiality, only members of the research team will have access to your personal data.

What will happen to the results of the research project?

The results of the study will be presented in a written report to the project sponsors. We will also seek to develop publications and conference presentations about the project findings. You will not be identified in any report, publication or presentation. We will also provide details of the findings to your care organisation if it is requested.

Who is organising and funding the research?

This research is being organised by the Institute of Mental Health (a partnership between University of Nottingham and Nottinghamshire Healthcare NHS Trust) and is being funded by the Department of Health, Policy Research Programme (DoH PRP).

Who has reviewed the project?

All research within this organisation is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by the Faculty of Medicine and Health Sciences Research Ethics Committee.

Contact for further information

Dr Louise Thomson, Institute of Mental Health, University of Nottingham Innovation Park, Triumph Road, Nottingham. NG7 2TU. 0115 7484298. Louise.Thomson@nottingham.ac.uk OR

Dr Elaine Argyle, Institute of Mental Health, University of Nottingham Innovation Park, Triumph Road, Nottingham. NG7 2TU. 0115 7484298. Elaine.Argyle@Nottingham.ac.uk

CONSENT FORM

Draft version 1.0: 31/05/2016

Title of Study: Evaluating the Care Certificate: A Cross-Sector Solution to Assuring Fundamental Skills in Caring (ECCert)

Department of Health, National Institute of Health Research (DH NIHR)

Study ID – PR-R14-0915-12004

Name of Researchers: Louise Thomson, Elaine Argyle, Kate Simpson, Zaynah Kahn

Name of Participant:

Please initial box

1. I confirm that I have read and understand the information sheet version number 1.0 dated 07/06/2016 for the above study and have had the opportunity to ask questions.
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. I understand that should I withdraw then the information collected so far cannot be erased and that this information may still be used in the project analysis.
3. I understand that relevant sections of my data collected in the study may be looked at by the research group and by other responsible individuals for monitoring and audit purposes. I give permission for these individuals to have access to these records and to collect, store, analyse and publish information obtained from my participation in this study. I understand that my personal details will be kept confidential.
4. I understand that any interview/focus group may be audio recorded using a digital recorder and that anonymous direct quotes from the interview/focus group may be used in the study reports.
5. I understand that all data will be anonymous and confidential with the exception of information being revealed during interviews/focus groups which is of concern and may need reporting i.e. potential risks to another person or to myself.
6. I agree to maintain the confidentiality of focus group discussions.

7. I understand that information about me recorded during the study will be kept in a secure database. If the data is transferred it will be made anonymous. Data will be kept for 7 years after the study has ended and then securely destroyed.

8. I agree to take part in the above study.

Name of Participant Date Signature

Name of Person taking consent Date Signature

2 copies: 1 for participant, 1 for the project notes.

Focus Group Schedule: Patient and Carer Representatives

Introduction:

- Introduce focus group facilitator
- Explain the aims and purpose of the study and give a brief description of the interview structure.
- Ensure Participants have read the information sheet and understand that participation is voluntary and they are free to withdraw at any time
- Discuss digital recording of the interview and confidentiality
- Opportunity for participant to ask any question
- Complete the consent form and give a copy to participant, or obtain verbal consent and record it

Questions and Topics:

- What are the most important element of care
- Their experience of care from HCAs/SCSWs
- Any improvements that could be made to care
- How should these improvements be implemented into practice

In case of distress:

If the participant becomes distressed during the interview, ask the participant if they would like to stop the interview and offer the participant the contact number for the staff counselling service for their organisation.

If a participant reveals information which is of concern and may need reporting i.e. potential risks to another person or to themselves, you should discuss this with the PI at the earliest opportunity and where appropriate report accordingly.

Short Debrief:

The interviewer will now explain the interview is now officially over and there are no more questions. They will state when the project will be ending and that if after this date, it gets published that we will let them know. The volunteers will be thanked for their participation, and asked if they would like to have a more in depth debrief, for example if what has been discussed has made them feel particularly emotional. Even if they decline the debrief at the time, it will be reinforced that we can arrange for one if on reflection they feel they would like to talk to someone. The interviewer will ensure that participants are not left distressed, and we can signpost them to individuals with expertise in this topic area if they require extra support.

Interview/Focus Group Schedule: HCAs/SCSWs who have/are undertaking Care Certificate Training

Introduction:

- Introduce interviewer/focus group facilitator
- Explain the aims and purpose of the study and give a brief description of the interview/focus group structure.
- Ensure Participants have read the information sheet and understand that participation is voluntary and they are free to withdraw at any time
- Discuss digital recording of the interview and confidentiality
- Opportunity for participant to ask any question
- Complete the consent form and give a copy to participant, or obtain verbal consent and record it

Questions and Topics:

- The experience of the Care Certificate in that setting
- How accessible the Care Certificate programme and materials are
- The perceived impact on practice
- Barriers and facilitators to successful outcomes
- Career options for staff, post-Care Certificate

In case of distress:

If the participant becomes distressed during the interview, ask the participant if they would like to stop the interview and offer the participant the contact number for the staff counselling service for their organisation.

If a participant reveals information which is of concern and may need reporting i.e. potential risks to another person or to themselves, you should discuss this with the PI at the earliest opportunity and where appropriate report accordingly.

Short Debrief:

The interviewer will now explain the interview is now officially over and there are no more questions. They will state when the project will be ending and that if after this date, it gets published that we will let them know. The volunteers will be thanked for their participation, and asked if they would like to have a more in depth debrief, for example if what has been discussed has made them feel particularly emotional. Even if they decline the debrief at the time, it will be reinforced that we can arrange for one if on reflection they feel they would like to talk to someone. The interviewer will ensure that participants are not left distressed, and we can signpost them to individuals with expertise in this topic area if they require extra support.

Interview/Focus Group Schedule: HCAs/SCSWs who have/are not undertaking Care Certificate Training

Introduction:

- Introduce interviewer / focus group facilitator
- Explain the aims and purpose of the study and give a brief description of the interview/focus group structure.
- Ensure Participants have read the information sheet and understand that participation is voluntary and they are free to withdraw at any time
- Discuss digital recording of the interview and confidentiality
- Opportunity for participant to ask any question
- Complete the consent form and give a copy to participant, or obtain verbal consent and record it

Questions and Topics:

- Perceptions of the Care Certificate in that setting
- How accessible the Care Certificate programme and materials are
- The perceived impact on practice
- Barriers and facilitators to successful outcomes

In case of distress:

If the participant becomes distressed during the interview, ask the participant if they would like to stop the interview and offer the participant the contact number for the staff counselling service for their organisation.

If a participant reveals information which is of concern and may need reporting i.e. potential risks to another person or to themselves, you should discuss this with the PI at the earliest opportunity and where appropriate report accordingly.

Short Debrief:

The interviewer will now explain the interview is now officially over and there are no more questions. They will state when the project will be ending and that if after this date, it gets published that we will let them know. The volunteers will be thanked for their participation, and asked if they would like to have a more in depth debrief, for example if what has been discussed has made them feel particularly emotional. Even if they decline the debrief at the time, it will be reinforced that we can arrange for one if on reflection they feel they would like to talk to someone. The interviewer will ensure that participants are not left distressed, and we can signpost them to individuals with expertise in this topic area if they require extra support.

Interview/Focus Group Schedule: Key Organisational Stakeholders/Service Leaders

Introduction:

- Introduce interviewer/focus group facilitator
- Explain the aims and purpose of the study and give a brief description of the interview/focus group structure.
- Ensure Participants have read the information sheet and understand that participation is voluntary and they are free to withdraw at any time
- Discuss digital recording of the interview and confidentiality
- Opportunity for participant to ask any question
- Complete the consent form and give a copy to participant, or obtain verbal consent and record it

Questions and Topics:

- Who has led the implementation of the Care Certificate in that setting
- What the Care Certificate programme contents are and how they are delivered
- How care staff have been enrolled on the programme
- What successful implementation in this setting looks like
- The barriers and facilitators to successful implementation
- The perceived impact on practice, including patient experience

In case of distress:

If the participant becomes distressed during the interview, ask the participant if they would like to stop the interview and offer the participant the contact number for the staff counselling service for their organisation.

If a participant reveals information which is of concern and may need reporting i.e. potential risks to another person or to themselves, you should discuss this with the PI at the earliest opportunity and where appropriate report accordingly.

Short Debrief:

The interviewer will now explain the interview is now officially over and there are no more questions. They will state when the project will be ending and that if after this date, it gets published that we will let them know. The volunteers will be thanked for their participation, and asked if they would like to have a more in depth debrief, for example if what has been discussed has made them feel particularly emotional. Even if they decline the debrief at the time, it will be reinforced that we can arrange for one if on reflection they feel they would like to talk to someone. The interviewer will ensure that participants are not left distressed, and we can signpost them to individuals with expertise in this topic area if they require extra support.

Telephone survey with identified member of staff with organisational responsibility for the training of care staff

Have you received and read the study information sheet? Yes/no

Do you have any questions? Yes/no

Do you confirm that you consent to take part in this telephone interview and you understand the reasons for it? Yes/no

Please confirm your name and title

Brief explanation of purpose of the study:

We are looking at the level of uptake of the Care Certificate by different organisations; the challenges of adopting the Care Certificate and why some organisations choose not to adopt it; and for those organisations where the Care Certificate is in place, their experience of implementation.

Have you any questions? Yes/no

Request permission to audio-record (if applicable) Yes/no

1. **Which of the following options best describes your role in relation to the training of care staff in your organisation?** Unit manager/Care Certificate lead/ care worker trainer/external trainer/HR manager/lead nurse/other (please tick all that apply)
2. **Could you give an estimate of how many unregistered care staff are employed by your organisation?** (eg. unregistered health care workers, social care support workers, HCAs) – prompt if necessary 1-49, 50-249, 250 plus
3. **Organisation details:** domiciliary care/care home/community/day care/health care/acute care/other
4. **Sector:** voluntary/ independent sector/ public sector/other (please specify)
5. **Are there multiple sites within your organisation? Yes/no. If yes, is there a degree of autonomy in training provision between sites? Yes/no/don't know**
6. **Do your newly appointed care workers have an induction period? Yes/no. If yes, how long is the induction in days? How many days are your care staff supernumerary during this training? (clarify if necessary)**
7. **Has your organisation implemented the Care Certificate?** [e.g. through some training for new staff] Yes/no/don't know

Following questions for those who HAVE implemented the Care Certificate

8. **What were the reasons for your organisation implementing the Care Certificate?** [capture as free text]
9. **How many weeks on average does it take to complete your Care Certificate training programme?**
10. **What is the main factor that determines who receives Care Certificate training?** Job role/new starters/employee choice/length of service/staff availability/funding/managers discretion/organisational policy/other (please specify). Do you have anything further to add about this....
11. **How many are currently on the Care Certificate training programme? Approximately how many care staff within your organisation have already achieved the Care Certificate?..... Are these people all still working within the organisation and if so, how many?.....**
12. **Do you think that the introduction of the Care Certificate has affected workforce mobility?** Yes/no. **If so, how?** (eg cross sector working, staff turnover)
13. **Who is leading on the implementation of the Care Certificate and making day to day management decisions around it?** Unit manager/training lead/HCA trainer/care manager/external provider (please supply name of external provider) Other (please specify)
14. **How is Care Certificate training funded? Is that funding ring fenced within your organisation?** Yes/no/don't know
15. **Do you use a care competency workbook within your Care Certificate training?** Yes/no. **If yes, were these introduced post Care Certificate implementation?** Yes/no
16. **How is the Care Certificate training delivered?** Mainly computer based (online)/mainly classroom based/combination of online and classroom delivery/mainly in the clinical or caring environment/simulation/other
17. **Have you employed care workers who have completed the Care Certificate elsewhere?** Yes/no. **If yes, did they have to repeat the Care Certificate competencies within your organisation?** No/yes, partially/yes, in full/don't know
18. **What other training opportunities are made available to care workers? Has the implementation of the Care Certificate impacted on the range of these opportunities?** Yes/no/don't know. **If so, how?** *Free text response*
19. **What do you see as the challenges in the implementation of the Care Certificate?** Lack of funding/lack of trainers/lack of backfill/lack of organisational support/inadequate facilities/lack of carer interest/other (please specify)
20. **Is your Care Certificate training evaluated?** Yes/no/don't know **If yes, how is it evaluated?..... What do participants like about it.....What don't they like about it....**
21. **In your view what has been the impact of Care Certificate training on the**

i) organisation very negative/negative/neutral/positive/very positive. Please expand on this.

ii) care staff very negative/negative/neutral/positive/very positive. Please expand on this.

iii) care recipient very negative/negative/neutral/positive/very positive. Please expand on this.

22. Is there anything further you would like to add?

Thank you so much for agreeing to take the time to take part in this survey.

Telephone survey with identified member of staff with organisational responsibility for the training of care staff (version for those who have not implemented the Care Certificate)

Have you received and read the study information sheet? Yes/no

Do you have any questions? Yes/no

Do you confirm that you consent to take part in this telephone interview and you understand the reasons for it? Yes/no

Please confirm your name and title

Brief explanation of purpose of the study: We are looking at the level of uptake of the Care Certificate by different organisations; the challenges of adopting the Care Certificate and why some organisations choose not to adopt it; and for those organisations where the Care Certificate is in place, their experience of implementation.

Have you any questions? Yes/no

Request permission to audio-record (if applicable) Yes/No

1. **Which of the following options best describes your role in relation to the training of care staff in your organisation** Unit manager/Care Certificate lead/care worker trainer/external trainer/HR manager/lead nurse/other (tick all that apply)
2. **Could you give an estimate of how many unregistered care staff are employed by your organisation?** (eg. unregistered health care workers, social care support workers, HCAs) prompt if necessary 1-49, 50-249, 250 plus
3. **Organisation details:** domiciliary care/care home/community/day care/health care/acute care/other
4. **Sector:** voluntary/ independent sector/ public sector/other
5. **Are there multiple sites within your organisation?** Yes/no. **If yes, is there a degree of autonomy in training provision between sites?** Yes/no/don't know
6. **Do your newly appointed care workers have an induction period?** Yes/no. **If yes, how long is the induction in days? How many days are your care staff supernumerary during this training?** (clarify if necessary)
7. **Has your organisation implemented the Care Certificate?** [e.g. through some training for new staff] Yes/no/don't know

Following questions for those who HAVE NOT implemented the Care Certificate

8. **Which of the following options are the reasons for your organisation opting not to implement the Care Certificate?**
 - i. Lack of senior/managerial staff to lead on this?

- ii. Lack of time for Care Staff to undertake training
- iii. Uncertainty about the approach to take
- iv. Not considered necessary/staff already have competencies
- v. Lack of funding/resources
- vi. Lack of knowledge about the Care Certificate
- vii. Other [capture as free text]

9. **Do you have care staff who have already achieved the Care Certificate elsewhere? Yes/no/don't know. Are these people all still working within the organisation and if so, approximately how many? Yes/no/don't know (n=?)**

10. **What other training opportunities are made available to care workers? *Free text***

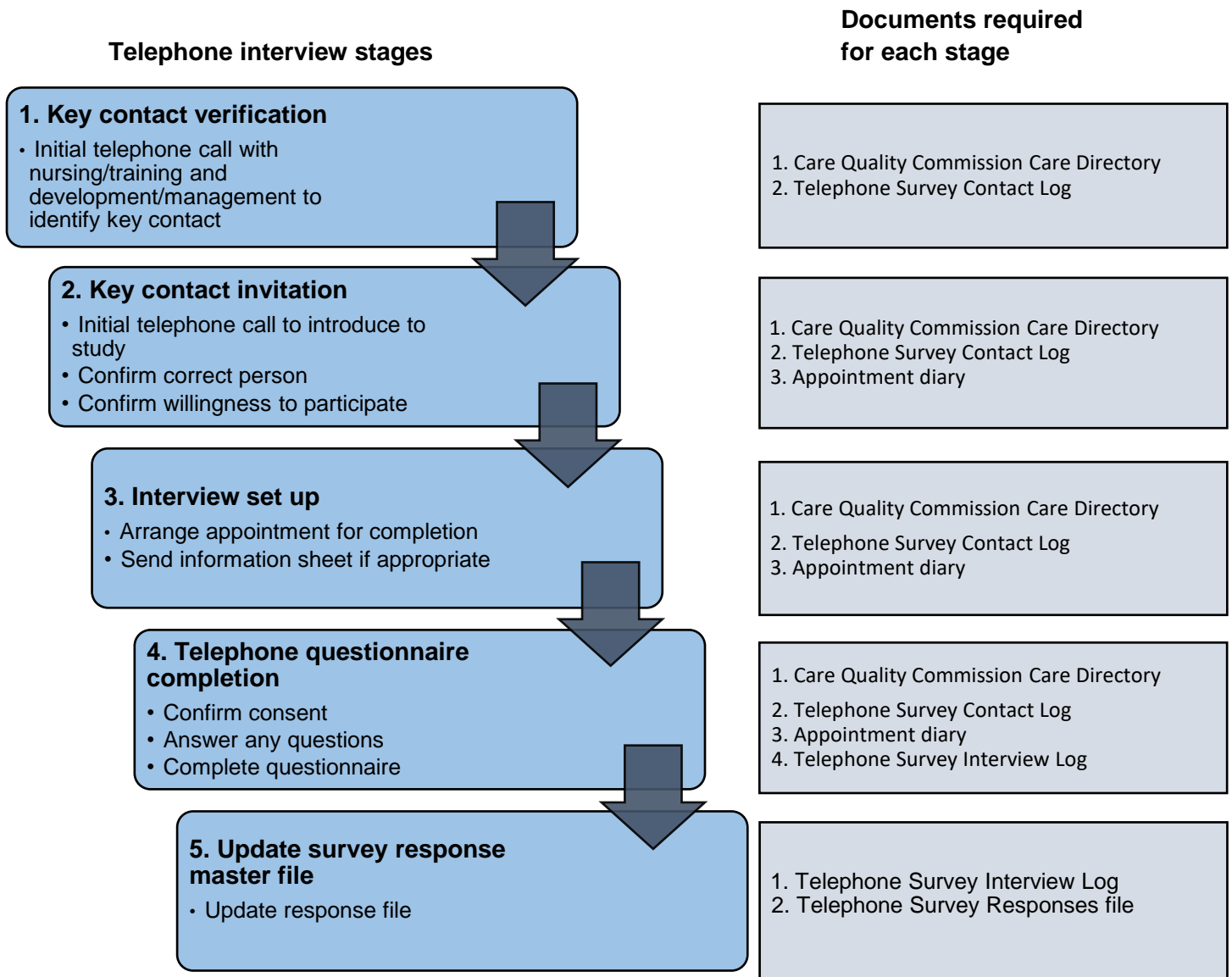
11. **Are you planning on implementing the Care Certificate? Yes/no/don't know. If yes, when? If not, what would encourage your organisation to do this?**

12. **Is there anything further you would like to add?**

Thank you very much for your time

APPENDIX 4: STANDARD OPERATING PROCEDURES

ECCert SOP: Telephone Survey Flow Chart

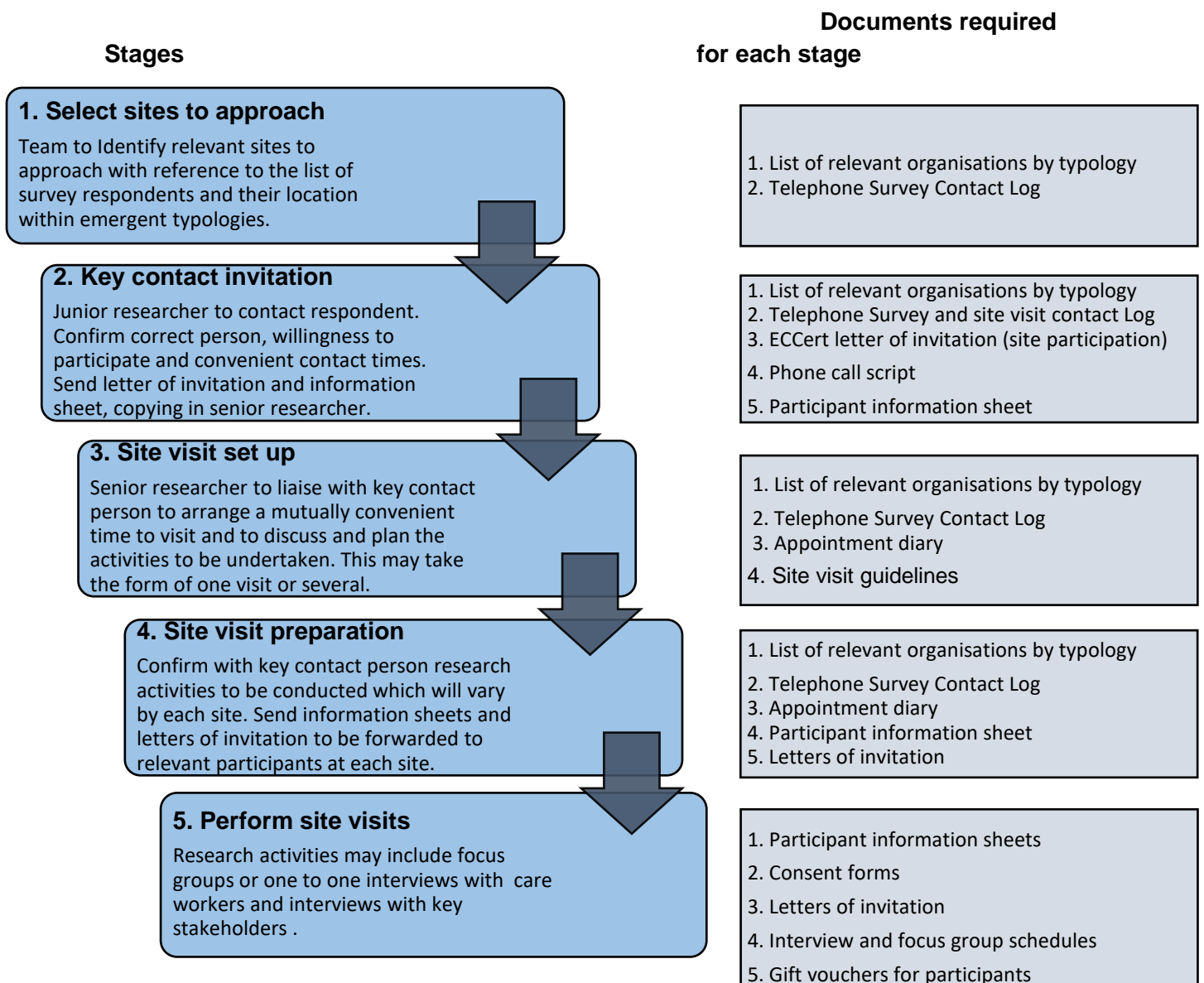


Key Documents:

- Care Quality Commission Care Directory
- Telephone Survey Contact Log
- Appointment diary
- Telephone Survey Interview Log
- Telephone Survey Responses file

NB: The flowchart identifies each stage of the process but these stages are not necessarily distinct and may overlap (e.g. stages 2-4 may occur over the course of one telephone contact).

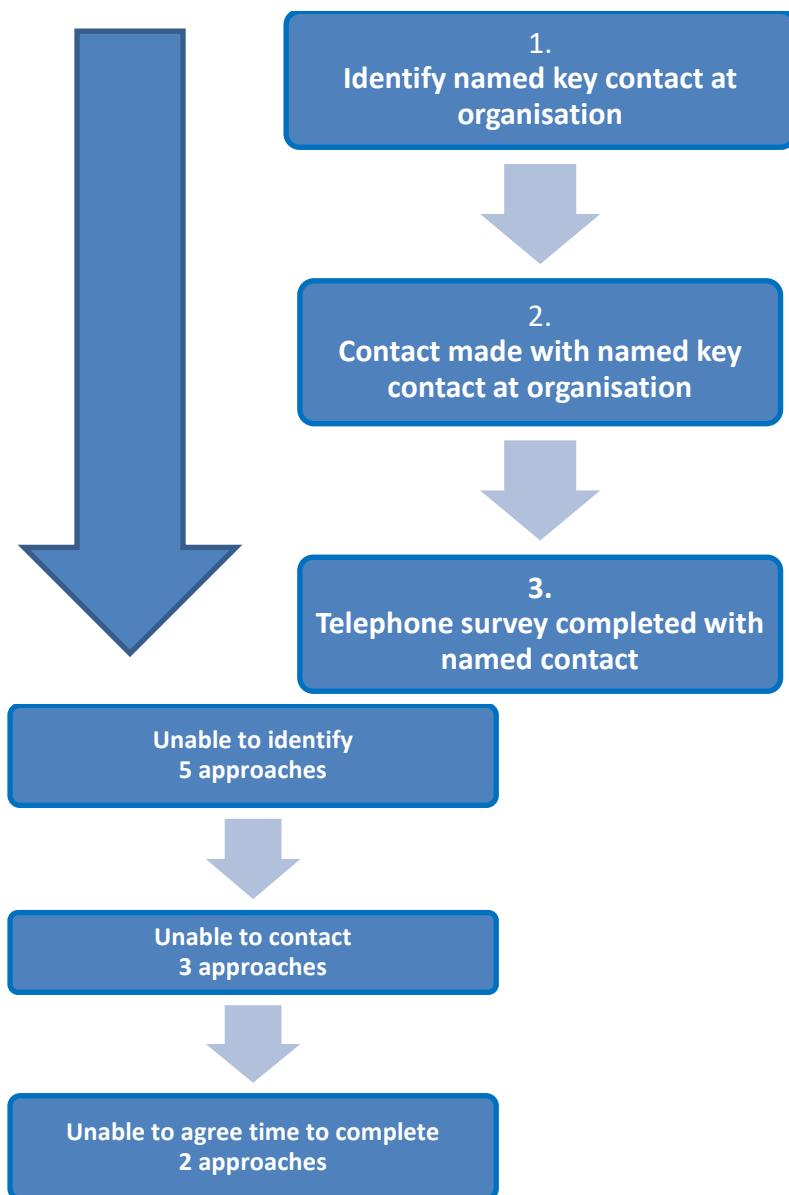
ECCert SOP: Site Visit Flow Chart



Key Documents:

- List of relevant organisations by typology
- Telephone survey contact log and site visit contact log
- Appointment diary
- Participant information sheet
- Consent forms
- Letters of invitation (for site participation, interviews or focus groups with care workers/managers/patients and carers reps)
- Interview and focus group schedules (for patients and carers reps, care workers with the Care Certificate, care workers without the Care Certificate, key stakeholders)
- Phone call script
- Gift vouchers for participants (carer workers)
- Site visit guidelines

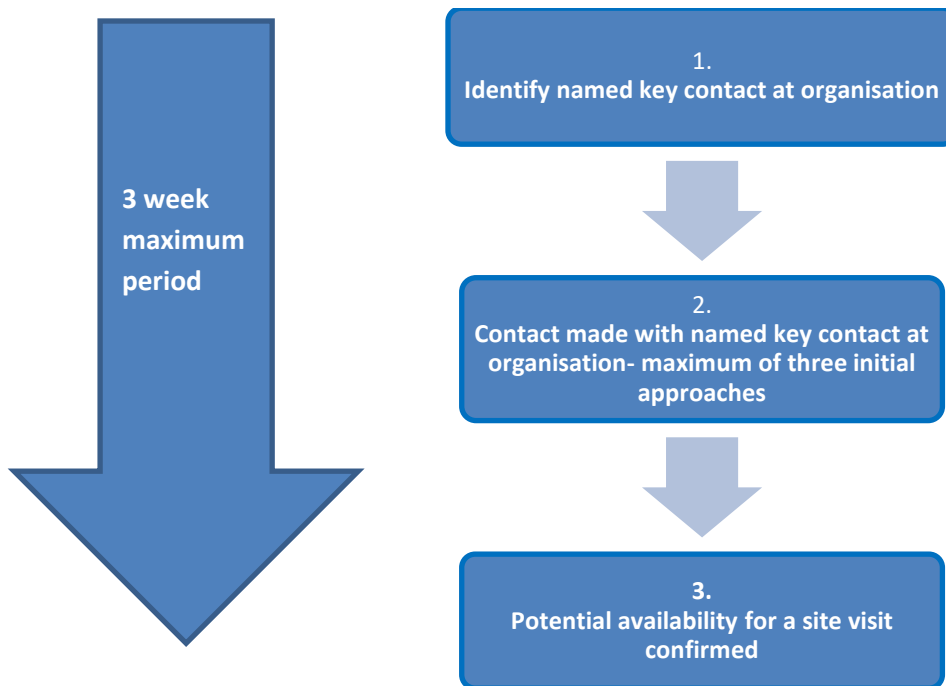
ECCert SOP: Telephone Survey timings



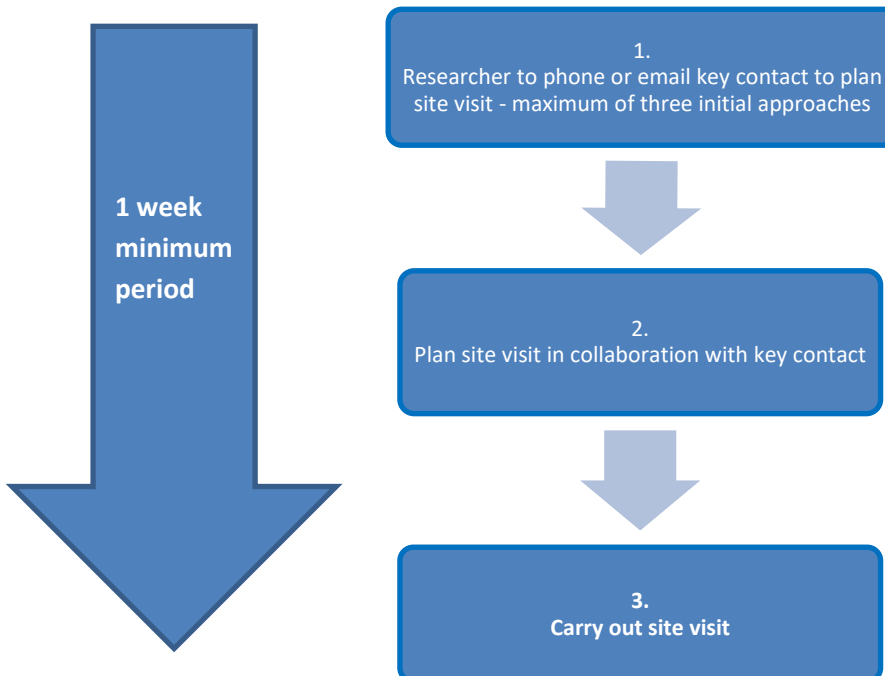
From the time of first attempt to contact, the administrator should continue to make contact with the organisation for a minimum period of three weeks (15 working days), unless questionnaire is completed or further approaches are declined in the meantime. This is to give sufficient time to identify the correct person, make direct contact and arrange an interview within the confines of the interviewee's availability. The contact at the organisation can request no further contact from the administrator/researcher at any time. Therefore, the fastest the telephone survey may potentially be completed is one day. The fastest the administrator/researcher may end contact with an organisation is 3 weeks (15 working days) from initial approach. Following completion of an initial 3-week period, the administrator may, at their discretion, cease to pursue a response from an organisation, noting the reason for cessation of contact.

ECCert SOP: site visit contact timings

Primary contact



Secondary contact



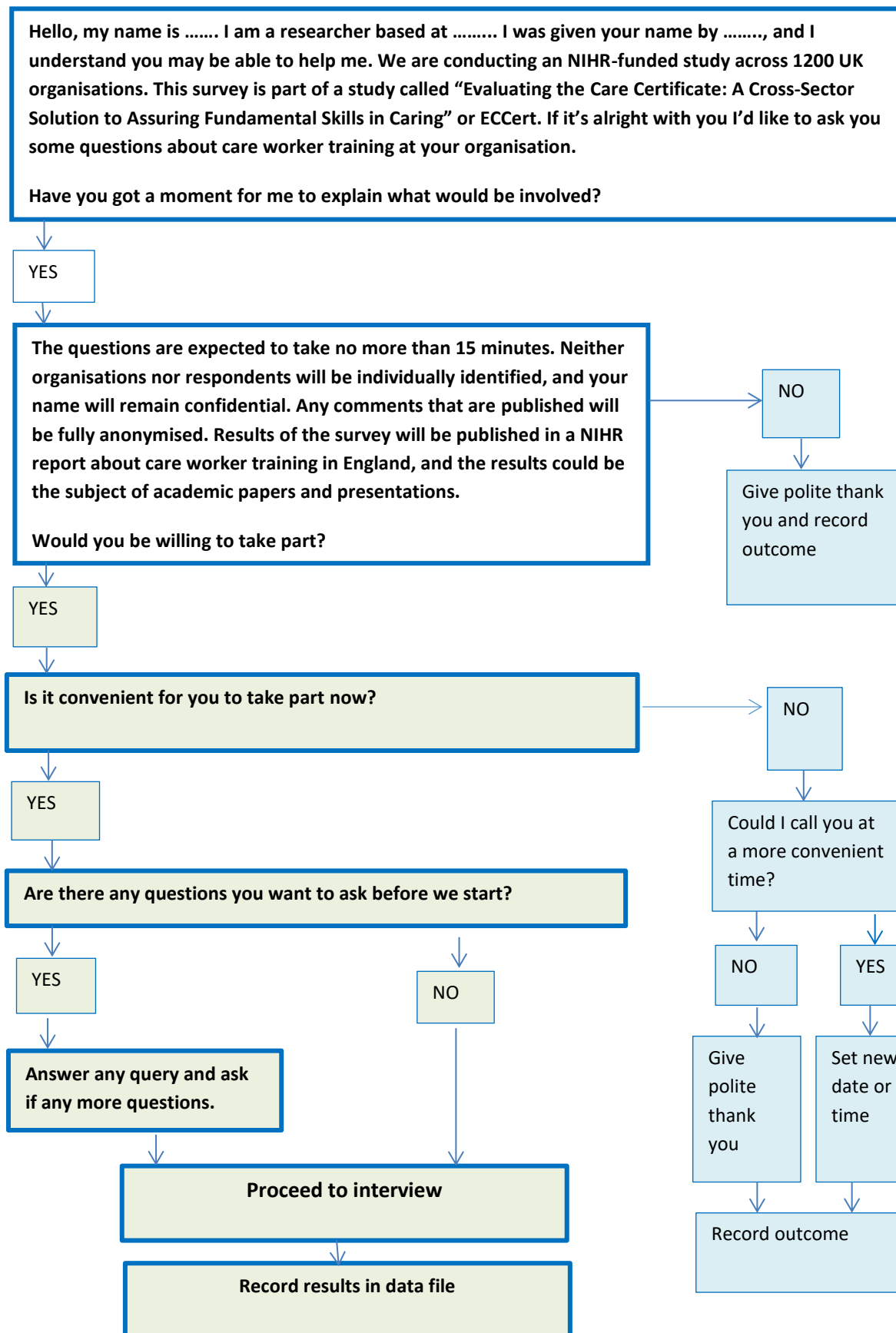
In order to arrange site visits, primary contact will be made to the key contact of the selected site, this respondent will usually be the survey respondents taking part in stage 1 who, at the time, expressed a willingness to take part in stage 2 of the project. For the primary contact, from the time of first attempt to contact, the researcher should continue to make contact with the organisation for a maximum period of three weeks (15 working days) and for maximum of three attempts. This is to give sufficient time to locate the correct person while also avoiding the risk of subjecting this person to unnecessary harassment. In this respect, it is important that the respondents are willing participants as a high degree of cooperation with them is needed in order to perform a site visit. For the secondary contact the researcher will make a maximum of three initial approaches to the key contact person and go on to plan and implement the site visit. This secondary process will take a minimum of one week but, in most cases, is likely to take longer.

SOP ECCert: Telephone survey interview log

*To be stored separately from interview response data

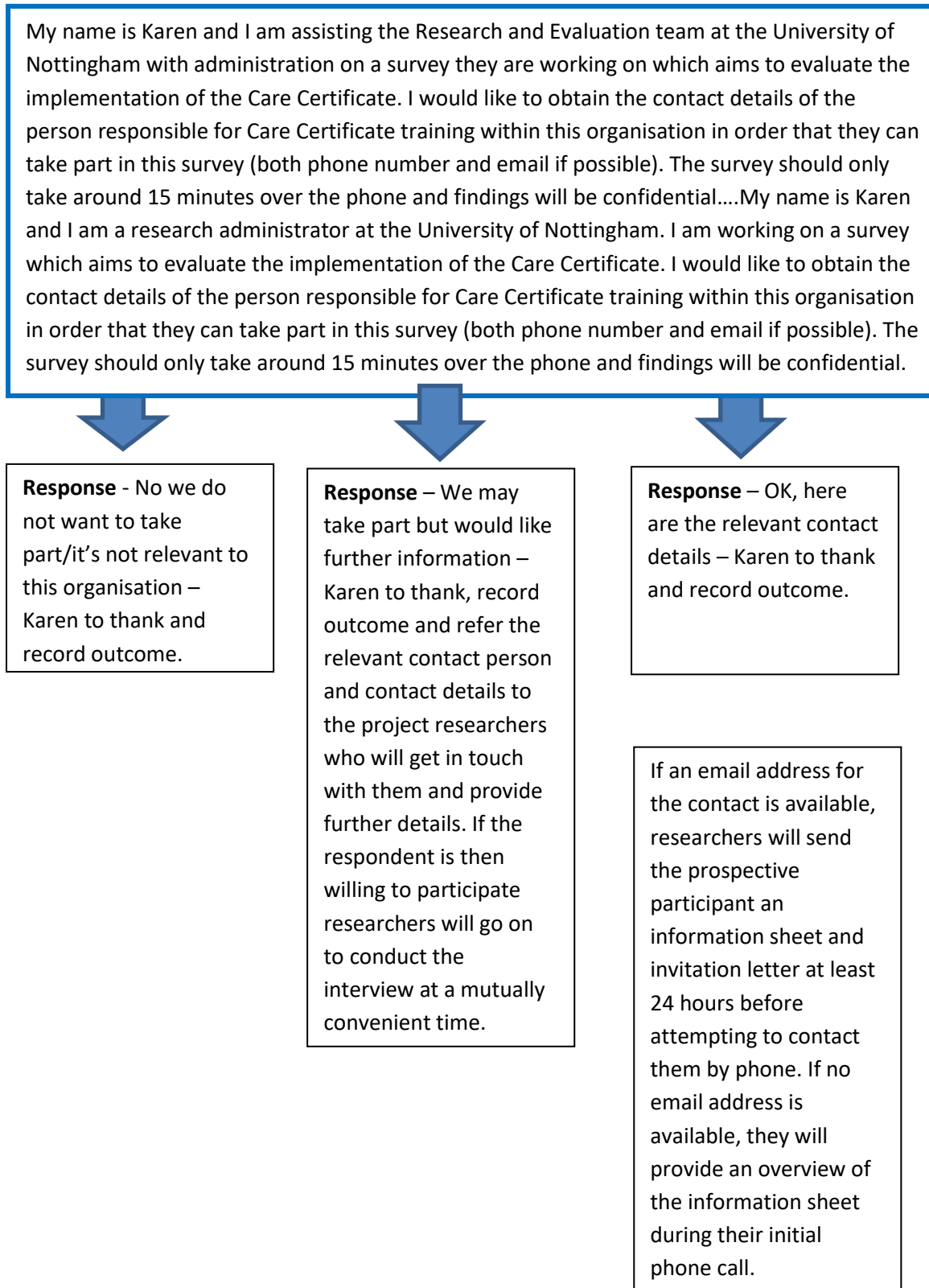
Researcher information	
Researcher name:	
Interviewee information	
Name:	
Job title:	
Tel. no.:	
Organisation name:	
Organisation UIC (Unique Identifier Code):	
Consent obtained to	
...interview:	YES/NO Date obtained: DD/MM/YYYY
...re-arrange date/time:	YES/NO/NOT APPLICABLE New date/time: hh:mm DD/MM/YYYY
...re-contact later:	YES/NO
Interview completion information	
Attempts to complete:	<i>(if greater than one)</i>
Interview completion date:	DD/MM/YYYY <i>(if different from consent date)</i>

ECCert Telephone interview process flowchart.



ECCert initial survey contact flowchart

Here is a rough guide on making initial contact with care organisations. Obviously this approach will vary according to the size of the care organisation and initial responses given:



Site visit guidelines

Site visits to participating care organisations will be arranged at a mutually convenient time and their duration will range from less than a day up to three days depending on the research opportunities available. Participating care workers will be given a shopping voucher. Visits will include some or all of the following:

Interviews with key stakeholders

One to one interviews with up to three key stakeholders such as the survey respondent, workforce development leads, training leads/managers, HR managers, HCA/SCSW managers and lead nurses. Where possible these will take place during the site visit but if this is not possible they can be conducted over the phone at a mutually convenient time. The following areas will be covered:

- Who has led the implementation of the Care Certificate in that setting
- What the Care Certificate programme contents are and how they are delivered
- How care staff have been enrolled on the programme
- What successful implementation in this setting looks like
- The barriers and facilitators to successful implementation
- The perceived impact on practice, including patient experience

Focus groups with carers who are undertaking or have achieved the Care Certificate

Frontline care staff who have recently achieved or are or are currently undergoing training for the Care Certificate will be invited to attend a focus groups with each group involving up to 8 care staff. If a focus group cannot be arranged these will be substituted by one to one interviews. The following topics will be covered:

- The experience of the Care Certificate in that setting
- How accessible the Care Certificate programme and materials are
- The perceived impact on practice
- Barriers and facilitators to successful outcomes
- Career options for staff, post-Care Certificate

Interviews with carers who have not taken the Care Certificate

We will interview up to five HCA/SCSW staff who have missed out on the Care Certificate. This may be because they have been in their current job role for a longer period of time and thereby not eligible as new starters, or because of other factors preventing their ability to access the training. Topic guides for these interviews are likely to be similar to those for HCAs/SCSWs who have/are engaged with the Care Certificate training, covering:

- Perceptions of the Care Certificate in that setting
- How accessible the Care Certificate programme and materials are
- The perceived impact on practice
- Barriers and facilitators to successful outcomes.

Other informal research opportunities

For example, sitting in on a training session.

INTRODUCTION

The ultimate goal of workplace learning is that it not only has an impact on the behaviour of trainees but it also that this behaviour has a positive organisational impact (Kirkpatrick, 2006). For those undertaking the Care Certificate this impact will relate to the experience of care receivers. It is therefore important to include the views and perspective of patients and carers, specifically on the principles of the Care Certificate and general impressions of care provided in that setting. With this goal in mind, in addition to eliciting the views of staff working within care organisations, the evaluation also included the views and perspectives of patients and carers through a series of focus groups with pre-existing groups in the community.

METHODS

Seven groups were involved in the groups incorporating a total of 56 participants. 44 were women and 12 were men. Participants came from diverse ethnic backgrounds with 3 participating groups catering specifically to ethnic minority groups including African-Caribbean elders, African asylum seekers and Eastern Europeans. The other 4 participating groups were aimed at carers, particularly those involved in unpaid dementia care although many of the participants in these groups also had experience of receiving care themselves or of working as a carer in a paid capacity. Groups were identified and accessed via email circulars and requests for help place in newsletters such as 'Public Face'. As an incentive to involvement, it was highlighted that the groups would give participants the chance to provide anonymised feedback on their experiences and perceptions to the Department of Health. Further incentives were provided by the fact that each participant would be given a £20 voucher. For some groups it was clear that this was their main reason for getting involved in the project, where as other groups said that they would donate the voucher to charity. All focus groups were run by two researchers, one who ran the group (EA) while the other took notes (ZK or KS). They took place in the group's usual meeting place, lasted around 40 minutes and were audio recorded subject to the written consent of participants. At the start of the group, participant information sheets, consent forms and project leaflets were distributed and researchers gave an introduction to the project and answered any questions about it before commencing the focus group itself.

Focus groups took a flexible format in order to respond to each group but topic guides were also used in order to maintain some structure and these were drawn from areas which were identified in the protocol as in need of exploration:

- What are the most important element of care
- Their experience of care from HCAs/SCSWs
- Any improvements that could be made to care
- How should these improvements be implemented into practice

A fuller schedule was then composed and piloted in consultation with the wider project management group and PPI representatives. An outline of the finalised schedule is shown below:

- What is your experience of care from HCAs and/or other frontline unregistered care workers? (eg. settings and type of care given)
- Do you have any awareness of the recently introduced Care Certificate?
- Distribute the list of 15 Care Certificate standards and use as a prompt for the following questions.
- What do you feel to be the most important elements of care? (prompt if necessary)
- What have been the positive and negative aspects of care?
- Could improvements be made to the care provided and if so what improvements?
- How do you think that these improvements could be implemented in practice?
- What do you think the barriers and facilitators to this practical implementation would be?
- Do you have anything more to add on any of the issues discussed?

Qualitative data gathered was subjected to a thematic analysis. Stages included familiarisation with the data, generating initial codes, searching for themes, reviewing themes and defining and naming the themes. Themes and categories from the data were developed and refined using the Consolidated Framework for Implementation Research (Damschroder et al., 2009) which is a synthesis of implementation theories listing the constructs which influence implementation effectiveness within the following domains:

- intervention characteristics
- context (inner and outer)
- individual characteristics
- process

NVivo10 was used to store and manage the data and identified themes were agreed as an authentic representation of the data by members of the team.

GROUP	PPI group description	Total number of participants
1	An African-Caribbean elders community group (3 men and 6 women)	9
2	A frail, older people and palliative care PPI group (4 women)	4
3	Community based support group for African asylum seekers (11 women)	11
4	A self-help group for carers (4 men and 3 women)	7
5	A group for dementia carers affiliated to a national charity (1 man and 2 women)	3
6	An independent group for dementia carers (12 women and 1 man)	13
7	A drop in-centre group for people with English as a second language (6 women and 3 men)	9

FINDINGS

All groups engaged fully with the group discussion and the format of these discussion was iterative and adapted to respond to the reactions of the group. For example, it was originally planned to adopt a form of 'Q Sort' method when asking participants to prioritise the relative importance of Care Certificate standards, in which cards for each standard were arranged by the group in order of importance. However, after the first group it became clear that this exercise may be problematic due to such things as sight problems and disagreements between the group members. However, this question was nevertheless a stimulus for discussion in all the groups and was therefore retained but without the ranking exercise. Shown below is an outline of the themes emerging from the groups.

Summary of Themes by Group

GROUP	Themes by Framework Category				
	Inner context	Outer Context	Individual characteristics	Intervention process	Implementation process
1	Time		Age and ethnicity Common sense, compassion, commitment Continuity	Communication Other standards Genericism V specialism	Theory and practice
2	Culture and leadership	Flexibility and consistency The wider context		Views on training Communication Genericism V specialism	Scope
3	Time	Flexibility and consistency	Age and ethnicity Common sense, compassion, commitment	Views on training Other standards	Scope Theory and practice Recognition and regulation
4	Time Culture and leadership	Flexibility and consistency The wider context	Common sense, compassion, commitment Continuity	Views on training Other standards	
5		The wider context		Genericism V specialism	Theory and practice
6		Flexibility and consistency The wider context	Common sense, compassion, commitment Continuity	Communication Genericism V specialism	Theory and practice Recognition and regulation
7		The wider context			Recognition and regulation

Inner context

Contextual issues were felt to be very important in shaping frontline care provision and could form a barrier or facilitator to the implementation of learning in the workplace. These included resourcing, leadership, staffing levels and cultural and environmental issues within the workplace.

Time

When discussing inner contexts relating to the workplace and the role of care workers, lack of time was most commonly referred to as a barrier to putting learning into practice:

“What they've done is allocated say for instance 15 minutes to an individual but what they haven't taken into consideration is travelling time to get to the next client, so in fact it's either that person they're seeing is going to have less than their 15 minutes or the next person that they're going to see is going to have less because they're going to arrive late and that again.” (PPI group 1)

The link between lack of time and poor care practice was further illustrated by one respondent who gave a specific example: of a client who had been left on the floor by her home carers as her supervisor had told her to move on to her next job:

"They said to them, "go to your next job and leave that, we will phone an ambulance", and that is true. And this is a major provider, a nationwide provider. It is just not acceptable is it?" (PPI group 4)

The link between time and the ability to communicate were also alluded to:

"There are times when you have to write reports, for instance before handover, to make sure that the next person reads your notes about how the day has gone and what's been done, but sometimes because of that issue of time, that isn't done and mistakes are made." (PPI group 3)

Some thought that lack of time was integral to some workplace cultures:

"If you don't do it fast the way they like it you are not coming back, especially if maybe you are a part time worker. You know that they will say oh we don't want that person she is too slow." (PPI group 3)

"The people who care will follow the others who don't care, it is for the simple reason they have not got the time to do the job properly." (PPI group 4)

Culture and leadership

Issues of organisational culture and leadership were particularly referred to by group 4 whose members felt that care workers needed to feel valued and supported by their organisation rather than being scapegoated when things go wrong. As such they felt that care workers were generally well-meaning people working within a system that was underfunded and the criticisms they raised about the care they received were not about individual care workers but the organisational cultures and wider contexts in which they work. Thus one thought that the impact of Care Certificate training could be undermined by this workplace culture:

"So your Care Certificate, if it is with a bad company it is going to be a bad service, as simple as that, you know. And it is about dignity for the patient, the staff. You create it with your staff, your staff will create it with the patient." (PPI group 4)

Related to this issue of culture and time limitations was that of leadership and its role in preventing or facilitating good practice.

"I think it is down to the management of these places. The staff are willing...they probably do care very much but they haven't got the time to care, they are so restricted on time they are in and out, they have gone "where has that time gone?" (PPI group 4)

One respondent specifically referred to the role of managers in impeding knowledge transfer and utilisation in the workplace setting:

"And it is the same with providing certification to say that you are trained up to a certain level. It doesn't matter how well you are trained, if the management want you to do the work to a lower standard than you have been trained to, then you can't blame the carer. It is the management regime and there is a lot of bullying in management, there is very little leadership in management these days." (PPI group 4)

Another referred to the tier of manager within the workplace who they felt held prime responsibility for the facilitation of this knowledge transfer by frontline staff:

"I have talked to top managers, NHS and all the rest of it, and they want it to work properly, but when it comes down to the under-managers who are looking after the teams and whatever, they have a different agenda." (PPI group 4)

Enlarging on this issue, a respondent in group two spoke of the detrimental impact of the removal of a tier of 'seniors' in a specialist dementia homecare service who had previously well supported carers in 'crisis' situations giving flexibility to the care provided:

"When you are dealing with people with dementia, each day, each minute almost is, can be a crisis and you come across different things all the time and these care workers need support as well which they got. Then they removed the seniors because somebody in the council decided they were going to wipe out a whole tier." (PPI group 2)

The fact that this respondent attributed negative developments in care provision to the 'council' illustrates the role of wider contextual issues on this care.

Outer context

Flexibility and consistency

With regard to this wider context, most groups referred to external forces on the provision of frontline care and its impact on the flexibility and consistency in this provision:

"When I attended the implementation of the National Dementia Strategy which was produced in 2009 I attended the workshops organised by the strategic health authority at that point and the one thing that all of us lay people in the room along with the professionals, the one thing we said we wanted was flexibility because flexibility particularly if you have got dementia." (PPI group 2)

"I was on a, we called it the lay improvement panel. It was a thing set up by the county council that I was asked to be on and they were the ones that were issuing the care to people and without being unkind they really had not got a clue. We kept saying this half an hour fixed time at half past 9 is not what you need. You also need consistency, you need the same person going in". (PPI group 2)

Related to this issue of consistency was that of high staff turnover which while being linked to the individual characteristics of frontline carers and the inner context of the workplace is also linked to the wider context due to the nationally low pay given to frontline carers

"All these care services, are always crying out for new people, and the turnover is horrendous, simply because they are on basic pay." (PPI group 4)

"There is no money there, it doesn't have kind of respect or anything, people just come in and go, come in and go." (PPI group 3)

"Retention is not brilliant in these jobs because the pay is not fantastic for the amount of work that they do. People want no bed blocking and people want them at home as much as they can, carers are absolutely vital for that and unfortunately, they are not paid back for it, they are a lifeline." (PPI group 6)

This low pay was exacerbated by the poor working conditions and recognition often associated with frontline care, in spite of the high levels of responsibility that they often held:

“They have to clock in when they go and clock in when they come out, just to make sure, and then they don't get paid in-between stops.” (PPI group 4)

“It is getting increasingly difficult to get people to care for people who are out in the sticks. Getting people to care for people in an urban setting where they go ABCD quite quickly but you live out in the sticks a bit and it is not so good. It is not so good.... There is no consistency.” (PPI group 2)

“They are like District Nurses in the community with what they do, they give out drugs, they do personal care, they do meals, they do so much, they are like District Nurses that care for people. A District Nurse would be on band 6 and 7, they will be on minimum wage or living wage, depending on their age.” (PPI group 6)

The wider context

In relation to this, some respondents advocated the need for specialist service provision particularly for dementia care services with two speaking in positive terms about a local specialist dementia home care service received by their parents:

“People came from all over the country when we were there. We were so, so, so fortunate.” (PPI group 2).

In addition, wider inadequacies in the resourcing and coordination of service provisions, ‘bed blocking’ and ‘false economy’ of service cutbacks were commonly referred to:

“My view is that they've attempted to put the care into the community, the unfortunate thing was they didn't quite realise what it actually takes to give the care in the community.” (PPI group 7)

“If you put it out to the community, what you are actually doing is putting it out to mugs like us. And we are doing the nursing and the personal care and we aren't costing them a penny, we are doing it for free, whereas if you are doing it in a hospital, you have got the running costs of the hospital, you have got the staff costs.” (PPI group 4)

As a result of these issues and the general lack of awareness of services arising from the wider context of welfare pluralism, many participants joined support groups as a means of compensating for these inadequacies:

“We don't get information, nobody signposts you. The Alzheimer's Society were good at first but then with the cut backs from their point of view we could no longer have these meetings in their premises and so we have been going for 4 years as a self-support group.” (PPI group 6)

“I have got the church family, I have got my own family and I have got the Alzheimer's family and between us we got through it.” (PPI group 5)

As it has been seen in this section, contrary to phenomenological perceptions of care workers practice and the corresponding belief that they had full control over this, this was challenged by many, with all groups discussing at length, the impact of contextual issues on this practice.

Individual characteristics

In spite of the perceived significance of contextual factors on the role of frontline carers, their innate characteristics were also seen to be important.

Age and ethnicity

Some respondents thought that care workers should be mature and experienced in their role:

“A lot of them are just employed and they're just put into something that they don't really know about and some of them are very young but because they're young obviously they've got no experience.” (PPI group 1)

“I think one of the experiences I've had is that whilst they don't mind whichever sex, someone who I've seen said what they would not like is a younger female looking after them as a male because it was like having my granddaughter looking after me and I felt uncomfortable with a young person looking. So it's down to the age again, a more mature woman would have gone down better for them.” (PPI group 1)

Issues of ethnicity were also discussed particularly by group 1 and group 3 which were composed exclusively of participants from an ethnic minority background. Some people in these groups advocated the ethnic matching of care worker and care receiver including for those of a white British background:

“If you're going to have a caring service then you have people from all backgrounds so when you have a Caribbean person you try and get the closest person to that background to serve them, it might be difficult but it is what's needed” (PPI group 1)

“I was thinking again in the care homes, where most of the residents are white and most of the carers are foreigners you know, whether the service users actually had a say in the diversity and all this, because some of them, especially because they are elderly, most of them are fixed in their ideas and they find it difficult, having this coloured person taking care of them and that thing, I am not sure that even the home, the home owners are actually taking their own concerns into consideration.” (PPI group 3)

Common sense, compassion, commitment

Others felt that such matching would not only be practically difficult and that better results could be achieved through training and through the attitude and approach of the care worker which should include 'common sense':

“Because for me, I would say that's to do with training because I've had English carers, I've had African carers, I've had Polish carers but it's all to do with common sense and respecting people's home and what their needs are.” (PPI group 1)

Compassion and commitment were also felt to be important characteristics in frontline carers:

“I think personally you are a born carer. I know that people don't think this way but you are a born carer and if caring is not in you then do not go into caring.” (PPI group 6)

“Sometimes you tend to wonder are you just doing this to pay the bills or do you actually enjoy it.” (PPI group 3)

“If the carers aren't natural carers, if they don't want the job, they are forced to do the job by the Job Centres, they shouldn't be in the job, there is no care aspect there.....People who want to do it as a vocation, that is what it should be. They have got it in their heart, they are naturally caring people.” (PPI group 4)

As such the personal characteristics of the care worker were seen to be crucial by most groups and that they had to be innately 'caring' in order to do their job properly and for some participants, no amount of relevant training could promote this 'caring' disposition.

“Caring is in the nature and you can give them a Care Certificate, you can give them the training, but if it goes in one ear and out the other it is a waste of time.” (PPI group 4)

Continuity

Links were also made between continuity of care and the ability to communicate with clients:

“You need the same person because if you don't get the same person every day, you have to keep telling them what to do. A new person's going to come in and not know what to do.” (PPI group 1)

“Continuity of carer is a massive thing because they need the same carer or a small team of carers so they build up a rapport and then the carers get to know them.” (PPI group 6)

“Having a different care person coming in to see to that person changes destabilises that individual and just confuses them.... the routine is disrupted.” (PPI group 1)

The impact of continuity of care on the quality of communication and care more generally, highlights the way in which the characteristics and performance of care workers are not necessarily innate but are mediated by contextual factors such as organisational practices and the demands of the job rather than their caring attitude and commitment:

“They come and go because they come and realise how hard it is and I also think within maybe 2 or 3 years of doing the role, no matter how good they are, it is like nursing, they get burn-out and they can do it no more because they have given their all and I think they get burn-out.” (PPI group 6)

“I think it all boils down to how much time that person could be really caring but they've only been allocated 15 minutes for a call.” (PPI group 1)

Similarly, some stated that due to poor working conditions and recruitment problems employers cannot afford to be particular over who they employ and are not always able to get the 'right' people for the job:

“You are employing people of a lower standard, because anybody worth their salt would not put up with it, they wouldn't do it.” (PPI group 4)

Low pay was also cited as having an impact on care worker motivation. On one hand it could increase staff turnover and potentially lower the calibre of those willing to do the job, while on the other hand it could ensure that only those with a sense of 'vocation' would be willing to do it.

Intervention characteristics

Views on training

Although most had no prior knowledge of the Care Certificate, most who expressed a view felt that its introduction was “a step in the right direction” (group 4) or a ‘good basic grounding’ (group 7). Some felt the benefits arose from its role in improving care workers understanding of their job:

“We have not heard of the Care Certificate but we did value the fact that those ladies and gentlemen had been trained.” (PPI group 2)

“By understanding that role you understand that as you evolve so that's the training as well and that also then reinforces improvement.” (PPI group 3)

These benefits were thought to be particularly apparent to care workers from overseas who were not always familiar with standard practices in the UK:

“I thought the training was good because like when I came into the country I didn't understand different things like commode and like so with the training I was able to know what those things were.” (PPI group 3)

“These people are sent in alone, they are untrained, they don't know what they have got to do, they are so confused when they get there, and they have to learn by trial and error.” (PPI group 4)

Training was also regarded as helping to standardise the caring role and ensure that newly recruited care workers were of the right calibre:

“They are doing the minimum wage, there is like that so if they get standardised like this, get a certificate.” (PPI group 3)

“It is about the standard of the person, but the point is the Care Certificate can be made to make sure these people are the right people, that is the important thing.” (PPI group 4)

Some participants including those who had experience of working as care workers felt that they were employed as cheap labour and felt a low sense of personal worth as a result of this with negative implications on their work performance. Proper rather than tokenistic training would help to address this issue and increase this sense of worth as well as greater recognition and reward for the work they do.

“I felt they were practically looking for cheap labour, because you had just come into the country, you are a student and you just wanted some human, so no much, you are not supposed to know anything, they could just take anybody and I am happy there is a certificate now.” (PPI group 3)

Communication

After being shown the Care Certificate standards in the focus groups, the issue of communication was most commonly felt to have prime importance. This included good communication with care receivers:

“It's communication that is key because they can still hear you and it's you showing that dignity and respect to them so that is very important that you communicate irrespective of the response you're getting back from them.” (PPI group 1)

“Gentle communication. I think as well, it is nothing that costs money or anything, it is just to smile at them as you are walking past them or just say hello as you are walking past.” (PPI group 6)

It was felt that this communication distinguished good quality and person-centred care from that which was task centred and impersonal:

“When you are talking about dementia, giving someone a drink, putting a cup of tea down and saying there is a cup of tea for you is not any use, because they do not know that is cup, they will just leave that. You have got to give it to them and encourage them to drink.” (PPI group 6)

The ability to read client communication was part and parcel of this:

“They need to be able to read the signs and act accordingly, not talk to them like children.” (PPI group 6)

As well as communication with other staff and care workers both verbally and in writing:

“I worked in the health service for about 40 years looking after the patient's interests in the health service and nearly all the complaints that we investigated both in primary care and in secondary care were lack of communication between the health professionals and the relatives of the person that died or the patient if the patient was still alive.” (PPI group 2)

“I don't know how many people know about a care plan, you know, the care plan should be in the individual's home, the carer who is in the home should know about what the care plan consists of.” (PPI group 1)

Other standards

In addition to communication which incorporated verbal, non-verbal, para-linguistic and written forms and applied not only to communication between staff and clients but also between staff, a few thought that other standards had prime importance.

“The issue of equality and diversity is also an important one. You also notice a lot more foreigners coming using services and things like that and just being aware that their cultures are different and obviously treating everyone in an equal way.” (PPI group 3)

The African-Caribbean elders group felt that there was a need for greater awareness amongst care workers of their dietary needs in the ‘fluids and nutrition’ standard. For example, their cultural preference for hot rather than cold milk on their cereal. Cultural sensitivity in communication was also felt to be required for African-Caribbeans who are less reserved than those in the UK and care workers need to recognise this in their interactions with them through such things as saying ‘good morning’ and having an understanding of the patois of their mother tongue which they often return to if they are confused or agitated:

“When people have got dementia for example, or mental health, they go back to their mother tongue, for example, if they have people from some parts of the Caribbean that speak Patois which is a broken language which if someone can't understand, it sounds as though you're speaking goboldy gook.” (PPI group 1)

This group also felt that ethnic minorities were diverse and should not be ‘lumped together’ as one group. The standard of ‘understanding your role’ was also felt to be important by group 3:

“Understanding the role, when you understand what you are there to do and your role to whether is the care giver, you are then, it gives you that understanding of what is expected of you, what the person who expects you to do as well, so a lot of time that involves training as well which helps you to understand your role, the training you get and the amount of times you get it.”. (PPI group 3)

While a participant in group 4 felt that working in a person-centred way was most important:

“When I look at these standards, it depends how you interpret it, I have got number five, work in a person-centred way. If the whole system is about the person and their whole experience, that encompasses everything to me. Whether it be understanding their role, their dignity, their safeguarding, they are looking towards the care of the individual, so it is person-centred isn't it?” (PPI group 4)

With regard to standards which were perceived to be missing, cultural awareness was cited by group 1 and the duty to 'whistle blow' if faced by concerns on the quality of care provided was referred to by group 7. Related to this were issues about the context of care such as the need for adequate staffing levels which are not explicitly referred to in the standards (group 2).

Genericism versus specialism

Nevertheless, most groups felt that all of these standards were equally important and 'comprehensive' and 'interconnected':

“None of those stand on their own because they have got to be able to pick up infection quickly and alert communicate to the right people, they have got to be able to sometimes handle delicate information and if they cannot do that right then they cannot do anything else etc. I cannot see that you can remove any of them.” (PPI group 2)

Linked to this perspective was the view that the generic focus of the Certificate was preferable to a more specialised approach:

“As a nurse, I wasn't trained to just look after one specific ... you adapted to each person, you took your training and met everybody's needs ... matter who was in the next bed you treated everybody as an individual but you learned their ways.” (PPI group 1)

On the other hand, some felt that different care standards should apply to different work settings:

“My concern is that you are trying to do one thing for people whose jobs are very different.” (PPI group 2)

In relation to this perceived need for specialism, a respondent in group 2 referred to the need for a division between health and social care provision due to the different domains of knowledge in these two areas:

“There are two separate things here, there is health standards and social awareness standards and I think that should be split into 2 to be quite honest.” (PPI group 2)

The perceived need for specialism was particularly expressed in relation to dementia care. Thus, many participants taking part in the groups were dementia care workers and they felt that staff working in this area should have comprehensive training on this issue which was not necessarily achievable within a generic certificate format (also group 3):

“I think dementia caring should stand alone personally and that is because I am very precious about it. But I think it should stand alone, like nursing you decide to go into theatres or you decide to go into orthopaedics, I think as carers you decide to go into dementia and you decide to go into a dementia care home because that is your passion.” (PPI group 6)

“I know over the years mum has had some lovely carers, but they are not dementia trained and presumably for other illness's they need to be.” (PPI group 5)

“I think there are more people expected to keep the dementia sufferer at home for as long as possible and so that means that there are going to be more carers becoming involved, so I think they definitely need to be aware of it.” (PPI group 6)

Delivery and implementation

With regard to the delivery and implementation of the Care Certificate, three main themes emerged.

Scope

Firstly, in view of the significant impact of contextual issues on the role and performance of care workers, several suggested that Care Certificate training should be delivered more broadly and not just to newly appointed care staff but also to longer established staff who may will play an important role in guiding newly appointed care workers and in setting the culture of the organisation. It was also suggested that managers and supervisors and other members of the staff team should receive the training in order to enhance their awareness of frontline caring as *“when you have lived it, you know it”*.

“The home owners, some of them should be trained, I know it’s a business, but I think something should be implemented to say they should get the training to know what is expected and how to recruit workers and how to monitor, not just because it’s not, it’s not, to them it’s a business but we are dealing with people, so there should be some kind of accountability from them to say you are dealing with people, you should know how they should be handled and what to expect, you know what’s expected.” (PPI group 3)

As such it was recognised that it was not just care workers that had an impact on the wellbeing of clients with groups 3 and 4 giving the example of the central role of hospital cleaners in maintaining this wellbeing. This accords with previous research which suggests that care innovations should adopt an eclectic approach and a multi-levelled and broad scope of delivery if barriers to implementation.

Theory and practice

The second theme pertained to the need to achieve the right balance between theory and practice in the training received. Several commented that there would be a greater incorporation of user perspectives into the training through such things as the elicitation of client feedback on their levels of satisfaction with the care received (group 3) and the inclusion of care receivers and the community more generally in the training process:

“I think that the training ought to be practical as well, so I think having individuals from the community as being part of that training, giving experience and setting real life scenarios so people understand.” (PPI group 1)

It was also felt that training should have both a knowledge based and practical element and incorporate participatory rather than didactic methods:

“I think they need to have hands-on, they need a practical as well as the theory and they need to be reviewed regularly and then you could check, you know, when you have done the training and they go back to do the practical, if you could check that they’ve registered, they’ve took it in.” (PPI group 1)

“One of the best things in a way is actually to be with dementia patients, you know a little bit like if you were doing your teaching certificate you actually go and work in a school, you are in a school aren’t you for six weeks.” (PPI group 5)

This accords with adult learning theory which suggests that such participatory approaches are more likely to lead to knowledge transfer and utilisation than more traditional methods. In addition, due to the perceived importance of practical training and the constantly “changing” nature this care practice, some stressed the need for regular updates and ongoing workplace observations:

“I think they should be observed in the workplace as well, I think it is alright in a classroom situation, there are lots of academic people out there that have not got a clue about one to one care and I think they should be regularly observed within their workplace on an ongoing basis.” (PPI group 6)

Recognition and regulation

The third and final theme emerging from the discussion on ‘process’ and delivery was the need for greater recognition and regulation both for frontline carers and for the training they receive. Thus two groups (3 and 5) spoke of the need for a national organisation which should implement a proper career structure, better pay for those working within the care sector in order to ensure better delivery of training and care:

“I was thinking if they have governing bodies for carers, it will give, it will lift the profile of the caring profession, because it’s actually like you say a very hard job and it takes a lot, it’s not getting the respect that it needs and they are taking care of the most vulnerable in society, so if they have a governing body, have a set of rules, it will help, it will place some responsibilities on also the home owners and all the agencies and it is standardised.” (PPI group 3)

It was also suggested by members of group 7 that not only should care workers be regulated but that Care Certificate training should be made mandatory, partly due to the huge responsibilities of frontline carers as well as due to the possible low levels of motivation if employers to provide this training:

“Agencies in general I think, they wouldn’t want their staff (to do training) if there was a cost and also if they’ve got to do it in their works time, because a lot are just about money. Even though the workers themselves would probably love to do it and they might not want them to have the knowledge to go forward because they night want to keep them...it could do with being a legal requirement.” (PPI group 7)

“It’s not like working in Tesco, when you’re dealing with people’s lives is it? If you make a mistake, you make a mistake that could lead to death, so it should be regulated.” (PPI group 7)

Another in group 6 felt that carers achievements should be better rewarded and recognised not only through financial incentives but also through the explicit recognition that carers had achieved the Care Certificate serving to enhance their sense of achievement and pride in their role:

“I think it should be built up, I think they need the training first and then the reward as they get more and more experienced, there should be better pay. They get 5 p extra you know, those have the NVQ level 2.” (PPI group 6)

While as the vast majority of focus group participants had not heard of the Care Certificate, some felt that its better exposure to members of the public would increase awareness and subsequent credibility of the training.

SUMMARY

Groups taking part in this research included participants from a wide range of social backgrounds and geographical locations and all participants had experience of receiving care or of providing it in a paid or unpaid capacity. Ethnic minorities were highly represented in these groups with groups 1, 3 and 7 being specifically aimed at African-Caribbeans, African women and people with English as a second language, primarily Eastern Europeans. This composition was reflected in group discussions with ethnic minority issues featuring fairly prominently. Similarly, the fact that two of the groups were aimed specifically at dementia care workers (groups 5 and 6) was reflected in the prominence of the issue of dementia care although groups not specifically devoted to this issue also often referred to dementia related themes.

All groups had strong views on the context of frontline care and its role in facilitating or impeding the knowledge transfer and utilisation of frontline carers. With regard to the inner context, most commonly cited was the lack of time given to care workers to perform their role which could lead to inadequate and task centred care and undermine care worker's ability to communicate both with clients and colleagues. Some thought that this lack of time could be integral to workplace cultures and reflected and reinforced by managers and by wider contextual issues such as levels of resourcing, commissioning practices and the generally poor working conditions of frontline carers giving rise to recruitment problems and significant staff churn and turnover.

In spite of the significant impact of contextual issues on frontline carers, their individual characteristics were also felt to be important. This included their age and ethnicity with a preference being expressed for more mature care workers and with some advocating the need for ethnic matching in order to meet the needs of different ethnic groups. Others felt that good results could be achieved through training and through the attitude and approach of the care worker which should incorporate common sense, compassion and commitment. The ability to communicate and the continuity of care worker for each client was also thought to be important although it was recognised that these individual characteristics could be affected by contextual issues such as poor working conditions leading to high levels of staff turnover and recruitment problems. Thus while respondents thought that care workers should be better paid on one hand, on the other, they thought that they should not be doing the job for the money.

Most respondents had no prior knowledge of the Care Certificate but they also thought that it was a positive development and provided a good basic grounding in frontline care. In doing so it helped to standardise the caring role, ensure that care workers were of the right calibre and enhance their sense of self-worth and achievement. For those that expressed a view, 'communication' was seen as the most important care standard. However most felt that all standards were equally important and interconnected with many believing that the generic focus of the Care Certificate was preferable to a more specialised approach. On the other hand some felt that a more specialised focus would be desirable especially with regard to dementia.

Three main themes emerged around the theme of process. These included the scope of delivery of the Care Certificate which most felt should be broadened to include longer established care workers, managers and other members of staff within each care organisation in order to extend its reach and influence. The second theme related to the need to balance theory and practice in Care Certificate training through such things as the greater incorporation of user perspectives, the elicitation of client feedback and the inclusion more generally of care receivers and the community into the training process. In addition, and in accordance with adult learning theory, participatory approaches were favoured over more didactic techniques and the inclusion of regular updates and workplace assessments were also advocated. Finally, there was a perceived need for the greater recognition and regulation of Care Certificate training which some groups felt should be made mandatory.

APPENDIX 6: SITE VISIT SUMMARIES

SITE	TRAINING SESSIONS OBSERVED	HSCSW DONE CC	HSCSW NOT DONE CC	STAKEHOLDERS (all interviews)	TOTALS
1	2	1	2	3 (1 service manager and 2 trainers)	6
2	3	7	11	3 (2 trainers plus 1 manager (not recorded))	21
3	2	12	0	4 (2 trainers, 2 managers)	16
4	0	0	3	1 (1 manager/owner)	4
5	2	8	0	3 (1 manager/owner, 1 trainer, 1 learning and development manager)	11
6	0	1	1	2 (1 director/franchise owner and 1 care manager)	4
7	2	7	1	3 (3 trainers)	11
8	1	10	1	2 ward managers, 1 trainer (over the phone)	13
9	0	2		2 Unit Managers (over the phone)	4
10	0	0	1	1 Unit Manager (over the phone)	2
TOTALS		48	20	24	92

Summary of Themes by Study Site

SITE	Themes by Framework Category				
	Intervention characteristics	Outer Context	Inner Context	Individual characteristics	Implementation process
1	Adaptation of the Care Certificate	Quality assurance and registration	Logistics of Implementation Completion and recognition	Motivation to learn Literacy	Size and infrastructure Organisational support
2	Adaptation of the Care Certificate	Portability Accreditation of prior learning Quality assurance and registration	Logistics of Implementation Peer support	Literacy	Organisational support Scope Recruitment
3	Adaptation of the Care Certificate	Portability	Logistics of Implementation Peer support	Motivation to learn Literacy	Size and infrastructure Organisational support
4	No adaption	Quality assurance and registration	Logistics of Implementation	Motivation to learn Prior experience	Size and infrastructure
5	Adaptation of the Care Certificate	Accreditation of prior learning	Logistics of Implementation Peer support	Prior experience	Scope
6	Adaptation of the Care Certificate	Accreditation of prior learning	Logistics of Implementation	Literacy	Organisational support
7	Adaptation of the Care Certificate	Portability	Logistics of Implementation	Literacy	Organisational support Scope Recruitment
8	Adaptation of the Care Certificate	Portability Accreditation of prior learning Quality assurance and registration	Logistics of Implementation Peer support Completion and recognition	Motivation to learn Literacy Prior experience	Size and infrastructure Scope
9	Adaptation of the Care Certificate	Portability Quality assurance and registration	Logistics of Implementation	Literacy	Organisational support Scope

10	No adaptation	Portability	Logistics of Implementation	Motivation to learn Prior experience	Size and infrastructure Recruitment
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SITE 1

OVERVIEW

A social care and learning disability charity which is part of a chain. Newly appointed care workers followed a 12-week induction period. They were supernumerary for 2 weeks with training adopting a structured and self-directed approach, given to new starters and delivered in classroom and work setting. Care Certificate training was implemented to follow CQC requirements. It is evaluated through feedback forms and supervision. Other training opportunities are available. The manager and learning development team make management decisions around Care Certificate training which is delivered in classroom and clinical environments. Although there were logistical problems to begin with such as obtaining assessors, most thought that the training had improved the knowledge and performance of frontline care workers.

THE VISIT

A session on behaviour training and mental health was observed. It took place in one of the organisations care homes, was led by an internal trainer and the group consisted of 7 staff including 5 care workers and 2 managers. They were all established members of staff and all knew each other. The session was informal with an open seating plan and much participation from care workers who related issues raised to their own experiences. It was not possible to run a focus group but 1-1 interviews took place. The training session was not run specifically as part of Care Certificate training and most of those present were not taking and had not taken the Care Certificate. In addition, part of a first aid training day was also observed which combined the instructor talking through a power-point presentation, practical exercises followed by a test. 11 students were in attendance all care workers and all but one women. Most were long standing members of staff and there was a lot of group discussion.

CARE WORKERS PERCEPTIONS

Interestingly, most care workers were not aware of the Care Certificate and didn't know that they had done it even if they had. Apparently, the Care Certificate had seamlessly merged into existing training provision and care workers were not given a certificate on its completion as it was kept by the organisation. The one care worker spoken to who was aware of the Care Certificate was very positive about his experiences of taking it and said he had got a lot of support in completing it due to his dyslexia and felt that it would facilitate his career advancement.

STAKEHOLDER PERCEPTIONS

According to the manager there were logistical problems when the Care Certificate was first introduced and she felt overwhelmed by the workbook material and also thought that she would have to 'sign off' care workers who were doing it. However, with support from the training team these issues were resolved and senior care workers were now able to do the signing off. The first trainer was not aware of the Care Certificate (she lived in Wales). The second trainer had been involved in its development as part of the training team and was generally positive about it with the certificate having been merged into

pre-existing training although she felt that training for Care Certificate assessors should be mandatory. Both trainers felt that greater awareness of the Care Certificate was needed amongst care workers and the public more generally.

SITE 2

OVERVIEW

A social care and learning disability charity which is part of a multi-site chain. Training lasts from 3-6 months and is mainly given to new starters who spend the first 2 weeks in classroom based training. Care Certificate training was implemented after piloting in January, 2015 as it was felt to be an improvement on existing training. It is evaluated through feedback forms. Other training opportunities are available and care workers are given their certificate but not the folder which they have to pay £4 for to cover photocopying costs. Care Certificate training had merged into existing training thus avoiding repetition and they have designed their own course for Care Certificate assessors and provide 3 yearly updates on training. Sixty care workers have so far completed the training. Out of those 60, 55 are still there. Although there is cross site uniformity the unit manager is responsible for some training decisions. Positive things are the opportunities it gives for the verification and validation of care workers experience and quality assurance. It also encourages reflective practice, provides structure to the induction process and is tied into the 6-month probationary period, helping to identify what support is needed by the new employee. On the negative side is the amount of workload it adds for staff and the fact that there aren't enough assessors means it's often hard to identify opportunities for assessment opportunities, especially if the care worker is peripatetic.

THE VISIT

A training session on safeguarding adults was observed. It took place in the organisations Head Office, was led by an internal trainer and the group consisted of 7 care staff and 1 area manager who had only joined the organisation three days previously and therefore did not know each other well. The session was formal with participants sitting round a table, reading course literature and listening to the trainer. As this was a Care Certificate training session, it was not possible to speak to care workers who were not taking or had not done it but we did run a focus group during the lunch break. Trainers were extremely helpful and one to one interviews were carried out with 3 of them. We were also given access to course materials. The same group was also observed in visit 2 taking a session on food hygiene. The trainer was the same as visit 1 as was the format which was fairly didactic. 2 people were interviewed on this visit, a newly appointed care worker who hadn't been in the last group and who was taking the Care Certificate and a senior support worker who had not taken the Care Certificate but who assessed those who were. She was happy to give her contact details in case she could be of further assistance to the project. A third and final visit also took place in order to follow up emergent themes. This was to see a group of ten newly recruited care workers attending the first day of their induction – 2 already had NVQs at level 3.

CARE WORKER PERCEPTIONS

All the care workers spoken to were new to the organisation and undertaking the Care Certificate training. All were positive about the training and felt that it gave them a good introduction to the organisation. It also gave them a chance to network with future colleagues. All care workers felt that Care Certificate training was tailored and relevant with a good coverage. All preferred the classroom setting,

which they thought allowed discussion and the opportunity to hear about others' experiences. They liked the fact that the material was accessible through online bar codes, they expressed that the reading and written work can be overwhelming at times and the modules have been broken down and simplified. The knowledge acquired could be related to everyday life and it is portable and can allow progression within the organisation. However, it was commented that rather than spending their first 2 weeks in a classroom, training may be improved by a 'sandwich' arrangement with 1 week in the classroom, 1 week in the work setting followed by another week in the classroom. This would better enable them to apply their learning to their future practice setting. However, it was recognised that there may be logistical problems with this arrangement. A care worker doing Care Certificate said he had autism and had received a lot of support in the Care Certificate training which he had found to be a positive experience. During the third visit, the group of care workers spoken to had not yet started taking the Care Certificate and while some thought it would be a valuable experience, others thought that they may struggle to find the time to complete it. One also felt that the training should also be delivered to a wider group than just newly recruited care workers who themselves may not be able to have much of an impact on established working practices within their workplaces.

STAKEHOLDER PERCEPTIONS

Stakeholders were very positive about their experiences of the Care Certificate and felt that it seamlessly merged and built upon existing training provision as well as validated care workers work experiences. They had a lot of support from the training team in implementing the training as well as from Skills for Care. However, they felt that the Care Certificate training they provided was of better quality than that provided by some other organisations and this had implications for the transferability of the Certificate for new care workers who had acquired it elsewhere – they usually asked such care workers to repeat the training. Concern was also expressed that the Certificate could be freely downloaded from the Skills for Care website. They therefore felt that there should be more consistency and quality control in Care Certificate provision. Due to the perceived high quality of their own Care Certificate training they thought it would make care workers attractive to other employers and liable to be 'poached'. Ideas of a post-training 6 month 'tie in' were therefore being considered. In addition, a trainer felt that Care Certificate training should be standardised and accredited across all organisations as well as adequately funded due to the issues of 'time and cost'. In addition, she pointed out that although City and guilds provide guidance on the accreditation of prior learning, there should be more guidance on this.

SITE 3

OVERVIEW

The organisation had multiple sites and provided residential care for people with learning difficulties and said they adopted a blended approach to care worker training. Apparently newly recruited care workers have a 2 day induction at the care home then 5 days in head office covering 23 subjects, followed by 2 weeks of workplace shadowing to reflect and a subsequent 12 weeks to do Care Certificate training. Some went on to do apprenticeships and diplomas. The organisations centralised training team lead the Care Certificate although they said there was a degree of autonomy in how individual sites implemented it. It was felt that the Care Certificate training did not have an impact upon staff recruitment, staff turnover or workforce mobility.

THE VISIT

The two visits took place at the organisations head-quarters where care worker training took place. Two focus groups were held with different groups of care assistants who had just started the Care Certificate training and were new recruits to the organisation. In the first group 4 of the 9 care workers didn't want to take part in a focus group and those that did were very quiet. In the second group all took part and were more talkative. Two trainers were also jointly interviewed as well as two managers who were each interviewed separately. During the observed training sessions, seats were arranged in a semi-circle with care workers and a trainer all doing the Care Certificate and an introductory safeguarding session. The sessions were generally interactive involving discussion and group-work.

CARE WORKER PERCEPTIONS

Both focus groups were generally positive in the views expressed about the Care Certificate as it made them reflect on their role and feel more valued. The main downside was the time it took to complete. Participants felt that it was daunting to complete it at first due to the immense amount of written work and felt that it would have been useful to have sessions to complete it within during their work shifts. However, on the whole, the participants felt that the Care Certificate training has provided them with better knowledge, a better outlook and inevitably the ability to deliver a better standard of care. The participants also felt the Care Certificate Training was useful in that it potentially allowed them to move across sectors and organisations. Moreover, it was added that the Care Certificate training provides a general overview of the care sector, an opportunity to reflect upon practice, to think outside the box, helps to develop as a support worker and most importantly, the Care Certificate training links to NVQ level 3. When questioned about the barriers of the Care Certificate training, participants felt that staffing levels can be a hindrance to successful implementation of the Care Certificate training.

Participants provided possible improvements, which could be made to the Care Certificate Training:

- The Care Certificate training could be adapted to be more organisation specific- more generic and then tailored to each organisation's needs.
- The questions need to be reconsidered as some are repetitive and the terminology can be complex.
- On the whole, the Care Certificate training was considered to be a very useful qualification as it allows you to identify your own weaknesses and allows you to monitor your own progress.

STAKEHOLDER PERCEPTIONS

There was some disagreement amongst stakeholders on the portability of the Care Certificate. The trainers said that they do accept Care Certificate training from different organisations, providing they have adequate documentation. In contrast, the head of care didn't think that the Care Certificate was usually transferable between organisations and would normally ask new care workers to repeat it. He felt that there was an initial lack of clarity on how it should be implemented and the skills for care workbook was initially daunting. He felt that it had no impact on recruitment, that it could be time consuming, especially the assessment component and that it should have a more generic focus with site specific specialist modules 'bolted on'. Nevertheless, all felt that the training was generally a step in the right direction but that more support and guidance should have been provided by Skills for Care to facilitate the process of implementation.

SITE 4

OVERVIEW

This was a small privately owned residential care home for people with dementia in a rural area of the East Midlands. The home catered for 14 residents with dementia and unlike most of the other sites visited currently had a poor CQC rating 'requiring improvement' over all areas of performance. The owner of the home was also the manager and owned one other home private home many miles away in Grimsby which she said was much better supported in the implementation of the Care Certificate than the one we visited. Although the home had officially implemented the Care Certificate, no staff there were currently undertaking or had it. The manager said that the implementation process had been chaotic and that she paid £40 for the books but then realised she could have downloaded them for free. They use the Skills for Care workbook. Although the manager leads the training and assessments an external trainer is also used.

THE VISIT

The manager had forgotten about our visit and a training session was not going ahead as originally anticipated and was in the midst of a crisis following an unfavourable CQC inspection. As a training session was not run as had been initially planned the researcher spoke to all staff present including the manager/owner, two care workers and a cook/care worker, none of whom had done the Care Certificate training. We offered to carry out a second visit should the opportunity arise but the owner did not respond to this invitation.

CARE WORKER PERSPECTIVES

Of the 3 care workers, none had the Care Certificate and all had or were thinking of doing a NVQ in care which they thought had greater credibility. No current employee has completed the Care Certificate Training. And none were keen on doing the Care Certificate due to out of work commitment/lack of ambition or motivation. One asked if the NVQ would be transferable to the Care Certificate

STAKEHOLDER PERCEPTIONS

The manager thought that the Care Certificate lacks the credibility of the NVQ and the name itself does not inspire confidence although she does find that staff are motivated by an external trainer who visits every 6 weeks. She has led the implementation of the Care Certificate but feels that there is poor staff engagement, the staff do not feel that it is beneficial to them and/or they are not interested in developing their career – 2 were currently doing it and a further 3 started doing it then left. The manager also added that once she had invested £120 pounds on the Care Certificate training resources for employees to complete and the staff had left before completion.

SITE 5

OVERVIEW

The organisation is part of a national chain of domiciliary care providers and the original survey respondent was based at the organisations main HQ in the South of England and she helped us to arrange a visit at a local branch of the organisation. All newly recruited home care workers attend initial training at the HQ which lasts about a week this incorporates mandatory training and Care Certificate training. Training includes classroom and practical methods, a workbook and assessment by peripatetic supervisors. It was explained that care workers would undertake a 12 week training programme, the

Care Certificate, mandatory training, workplace observation, introductory visits, spot checks, supervision, yearly reviews, team meetings and specific training. All training is evaluated by eliciting participant feedback. Apparently the same Care Certificate training was used by all branches and it was devised nationally although there may be some variations due to local requirements – there were a total of 86 branches within the chain.

THE VISIT

Two visits took place at the regional headquarters. During the first visit, the training session observed was an afternoon session lasting from 2-4.45. 5 female new starters were sat round a table while a trainer gave out workbooks and presented the session which was an introduction to the subsequent mandatory training they would receive. They were given a p46, an employee handbook and a Care Certificate portfolio incorporating 53 questions. The trainer started the session by talking through the 6 Cs – care, compassion, competence, communication, courage, commitment. Although they had only just met, all care workers participated well during the session. A focus group with the 5 care workers was run during a break in the afternoon session and the trainer and manager were interviewed together at the end of the session. During the second visit the same trainer ran a morning session for a different group of three new home care workers running from standard 8 of the Care Certificate. The trainer said that she adapted the training times to fit the need of the group and the group finished earlier than expected at 11.15 am. During a break in the session the 3 care workers took part in a focus group.

CARE WORKER PERCEPTIONS

In the first visit, all five care workers had just started taking the Care Certificate before they started their job as home care workers. 2 had no prior experience and 3 had experience as paid or unpaid care workers. Regarding the Care Certificate standards, one felt that 'equality and diversity' was most important, another 'working in a person-centred way'. They all felt that the material was relatively easy to cope with and accessible and they said that support was available if required either by phone, email or in person. They liked the mode of delivery as they felt that being in small groups facilitates discussion and provided networking opportunities and was far preferable to learning online. Regarding career progression one participant who also worked as a dinner lady said that she wanted to take a health and social care induction course in addition to the Care Certificate. They felt that the only barriers to putting their learning into practice was when a client refused to let them in the house or refused care. In the second visit 2 of the 3 newly appointed care workers had previous experience of care work, - one looking after her daughter who has a learning difficulty and the other through prior employment as a care worker. The third was an English literature graduate who had a deferred place on a PGCE course at the university of Lincoln. They all thought the Care Certificate training to be useful as it introduced them to the job and the organisation and gave them an idea on what to expect. They thought that all the care standards were equally important and interlinked and they felt the generic focus of the standards was useful as it helped to promote a 'joined up' approach and helped to promote consistency and continuity of care. Their main recommendation was for it to be rolled out to all care workers regardless of their length of service – in this respect they thought that working alongside a care worker who had not done the Care Certificate training may be a barrier to putting their learning into practice.

STAKEHOLDER PERCEPTIONS

A joint interview was held with the session trainer and the owner and regional manager during visit 1. They found no problems with literacy and language use amongst care workers although support was available if there were. Although still in its early stages they do currently accept the Care Certificate done elsewhere and use the CQC guidance as a form of self-assessment. Their training covers a lot and has also added extra safeguarding and dementia training leading care workers to come out with a good and broad-based level of understanding. However apart from care worker feedback, its impact on care workers and clients is difficult to quantify. All care workers get given a copy of their Care Certificate. With regard to recommendations on the future development of the Care Certificate they felt that a more practical component could be useful—A lot of people come into home care without understanding what its really about - it can be messy and invasive and the Care Certificate doesn't give a real insight into this and a more practical introduction is needed. It does however give people a basic understanding of care and it helps if care workers are older with prior life experiences. The trainer was interviewed individually during visit 2. She said that there were plans for the Care Certificate training to be rolled out to longer standing care workers. She wasn't aware of how the Care Certificate had developed from head office but felt it worked well. Although training was centralised from head office, local adjustments were made according to the client group. She had also made adjustments to the delivery of the module – initially care workers filled in their workbooks during the sessions but this was too time consuming and they now do their workbooks in their own time. She thinks that the Care Certificate can lead on to the NVQ.

SITE 6

OVERVIEW

This was a local franchise of a national company providing domiciliary care, mainly to older people. The director said that the company had 200 regional offices nationwide and that he had established this branch in 2014. Another branch of the organisation had taken part in the survey. The training lead of the national organisation had made relevant adaptations to simplify original Care Certificate documentation and the regional franchise had received support in this process from an external training provider. Nevertheless, the transition to Care Certificate had been relatively smooth. With regard to the transferability of the Care Certificate between different organisations a 'self-assessment' would be carried out to ensure that there were no gaps in the care worker's knowledge. care workers are not given the Care Certificate and its kept in the office. It was not thought that the Care Certificate had affected recruitment although some have had literacy issues and support is given through this through the use of such things as voice recorders to avoid the need for writing.

THE VISIT

The location visited was the head-quarters of the regional franchise where admin and staff training took place. The care manager had asked its care workers to volunteer to be interviewed by us but the response was poor and we finally interviewed the franchise owner/director, the care manager (the directors son), a trainer who also worked as a care worker and who hadn't done the Care Certificate and an assessor who worked as a care worker and who had done the Care Certificate. We invited the organisation to contact us should further care workers volunteer to be interviewed in the next few weeks but they did not. As such, as with other domiciliary care providers, it is often difficult to see groups of care workers unless they are in a training session or at a meeting.

CARE WORKERS PERCEPTIONS

Both the care workers spoken to had other roles, one as a trainer who had not done the Care Certificate and the other as an assessor/supervisor who had done the Care Certificate. Due to their broad roles both were able to talk extensively about training provision for care workers. They thought the Care Certificate was beneficial to new members of staff who currently got the training as it helped to identify gaps in knowledge during their 12 week probation period. It also gives them a good grounding in the principles of 'best practice' and acceptable standards of care. As such the assessor/supervisor thought it was 'the way forward'. However, she also felt that there was inadequate detail within the standards on 'managing finances' which was important aspect of the care worker role which could involve shopping etc. She felt that this was particularly the case due to social trends which meant that families were less involved than previously with home care workers filling the gaps. Although the trainer/care worker did not have the Care Certificate she had the A1 assessor award and many other relevant qualifications. The care worker/trainer felt that the standards were too generic and adult and child safeguarding could be merged. The trainer also felt that there was a lack of clarity on certain issues such as the accreditation of prior learning for the Care Certificate and whether regular updates are necessary.

STAKEHOLDER PERCEPTIONS

According to the director, they had received support in the implementation of the Care Certificate through an external trainer, the national franchise and an online portal. They had also consulted with an external trainer. He felt that there were some grey areas for example not enough information given on CPR in the standards and child safeguarding was not relevant but thinks it's been 'a good thing by and large'. It was expressed that the Care Manager had led the implementation of the Care Certificate training and then cascades it to the supervisor. Care Certificate would be accepted if completed from elsewhere but a self - assessment tool would still be used to help address gaps. The Care Certificate has had no impact on staff turnover/ recruitment but it was believed that the Care Certificate is useful as the customers need to feel comfortable that the staff have a qualification to look after their loved ones.

The care manager reported logistical problems in planning observations and supervisions for the Care Certificate training due to the peripatetic nature of home care workers work. He feels that the Care Certificate has been a generally positive development as it has made people more aware of the fundamental components of good care although he feels that there should have been more guidance from skills for care in the process of implementation. The Care Manager and Supervisor have led the implementation of the Care Certificate. Guidance and support from head office was provided in the form of resources, which were felt to be too generic and were adapted to meet the needs of the organisation. Employees generally complete the Care Certificate Training within 3 or 4 months. The assessment process was felt to be difficult due to the nature of domiciliary care. It was felt that the knowledge element was easier than the practical element due to this very reason. The Care Certificate standards were felt to be much better than common induction standards. Standard 10 and Standard 11 could be incorporated into one standard. The Care Certificate training is evaluated in appraisals throughout the 7 month probationary period. There has been a great burden on the supervisor due to the lack of clarity on how to implement the Care Certificate and the need to adapt the Care Certificate. The Care Manager felt that the Care Certificate had an impact upon practice as the employees work in a more person centred way, privacy & dignity and communication are also embedded into the observations. It was felt that the Care Certificate training did not have an impact upon recruitment but has helped with staff retention as staff feel more supported. On the whole, the care manager felt that the Care Certificate Training works well for the organisation!

SITE 7

OVERVIEW

This was the first NHS site visit and access had to be cleared with the organisations Research and Development Department. The organisation provides Care Certificate training for all newly recruited health care assistants as well as to other frontline workers such as assistant therapists. The training is usually run once a month with experts in the field contributing to it and takes place in their training centre which is in the grounds of one of their hospitals. There are usually between 8-12 people in the group. The Care Certificate was implemented in April 2015 and merged in with existing training. This development was led by the sites training team and was supported by material from skills for care, course focus groups and conferences including the M and K conference. Assessors are normally experienced care workers on the ward. The Care Certificate done elsewhere is usually accepted but it has to be checked first. The Care Certificate has had a few teething problems but it has generally gone well and apparently attracted care workers to the job. All standards are important and time staffing levels and organisational culture can be a barrier. The first day involves a corporate induction followed by a further 8 days including portfolio and workbook preparation, codes of conduct, e-learning and hands on exercises.

THE VISIT

During once visit to the site two training sessions were observed and a focus group was run with the 7 of the care workers taking part in this as well as interviews with one apprentice who was doing work experience and not doing the Care Certificate as well as 3 of the sites trainers. All 7 care workers were doing the Care Certificate Training as part of their induction. 3 of the care workers had previous work experience within the care industry but had not previously completed the Care Certificate. Observed sessions included bed bathing and mouth care with involved discussion, practical demonstration and hands on practice.

CARE WORKERS PERCEPTIONS

Care workers felt that the Care Certificate gave a good grounding in care and also thought that the generic design was advantageous as it was flexible and enhanced confidence as well as being a good refresher for existing staff. All care workers felt that the Care Certificate training resources were not daunting but were in fact accessible and easy to understand, which made the care workers feel well supported.

They made a number of recommendations regarding it implementation. These included the inclusion of unpaid care workers in Care Certificate training, the provision of regular updates and the promotion of greater awareness of the Care Certificate.

STAKEHOLDER PERCEPTIONS

Stakeholders thought that the Care Certificate had promoted consistent approaches to standards, professionalism and that it had improved every year since started. It was also perceived to attract people into healthcare and although some care workers may struggle to do it, there's lots of support available to them if they want it, especially from the sites lead trainer who had been a major force and facilitator in the local implementation of the Care Certificate. However, on the negative side, there have been problems arising from a lack of standardisation in the process of implementation, especially with regard to the

training provided by the NHS professional bank that they have to use to access extra staff – lovethenhsa.nhsp.uk.

SITE 8

OVERVIEW

This was the second NHS site involved in the evaluation. The survey participant and lead Care Certificate trainer had a keen interest in the training and had recently completed a dissertation on the impact of this training on the compassion of care staff. She was consequently very enthusiastic about getting involved in the evaluation and was central to arranging our access to the site which was in the far South of England. Care Certificate training is normally given to newly recruited frontline care workers who were nominated by their recruiting manager to take the course. Apparently those completing the training elsewhere could be exempted from some or all of the training following a self- assessment exercise - those with relevant experience were only required to attend 1 days initial classroom session and those without did 3 days. The work done can also be incorporated into an apprenticeship although this potential transition was not available to bank staff. Those completing Care Certificate training also had the opportunity to go on to train as assessors themselves if they chose to do so. The NHS Trust ran the training once a month for all newly recruited care workers and the trainer usually didn't know who or how many would be attending.

THE VISIT

Prior to the visit, phone interviews were carried out with 3 stakeholders and 1 care worker. The arrangement of the site visit itself was fairly long and complex, not only due to the need to arrange the HRA clearance required for an NHS site visit but also due to the fact that no training took place in August. In addition, the venue of the training was changed at the lastminute from its usual location in the Trusts training centre to community centre in another part of the county. Due to the unfamiliar location, several care workers were late to the session which was set to run from 9am to 3pm. Ten care workers were eventually in attendance. They were from diverse backgrounds including five from overseas including the Phillipines, Canada and Eastern Europe and 3 were graduates. They also had widely varying ranges of relevant experience. Although few of the staff knew each other this was a very lively and participatory session which introduced them to the Care Certificate and incorporated lots of groupwork and icebreaking exercises.

CARE WORKER PERCEPTIONS

All the care workers appreciated the fact that the training took place in a classroom setting as it gave them the chance to meet each other and share their experiences. Concerns were also expressed by some on the time it might take them to complete the Care Certificate workbook but reassurance on this was given by the trainer. Some thought the training delivery should be broadened to include other staff as this would impact on workplace culture. Although they didn't know if the training would impact on staff turnover, some thought that it would help them in their career plans which included training to be a mental health nurse, a clinical psychologist or to become an NHS manager. After being shown a video of the Staffordshire enquiry, the Francis report and the Cavendish review, there followed much discussion of the relative merits of care worker registration. One care worker firmly believed that this should happen, especially in view of the increasing responsibilities held by care workers and thought that the focus of the Cavendish review on training rather than on this registration had served to 'water down' the

recommendations of the Francis Report. However, another participant pointed out that the registration of doctors and nurses had not impacted on their bad practice in Staffordshire. Whistleblowing was also discussed at length with one care worker stating that she had been disciplined for insubordination when reporting a senior colleague while working with another employer.

STAKEHOLDER PERCEPTIONS

The lead trainer for the Care Certificate said that the Care Certificate training for this NHS site was not launched until January, 2016 after being piloted and developed by a project manager. She was a huge advocate of the training but did report problems in rates of completion including none attendance and non-completion with no clear pathways for sanction from human resources. Related with this was a lack of staff engagement, awareness and support. This was exacerbated by a perceived lack of credibility and low-level credit and a lack of clear guidelines on standards. The Care Certificate was potentially accepted when done elsewhere but checks needed to be done. She felt that more stress was needed on palliative care. Stakeholders had nevertheless received much support in the process of implementation from a number of sources including the South West Consortium in Bristol, sessions by Skills for Care, M and K conference sponsorship etc. She asked the researcher to write a testimonial regarding her involvement but was informed that this could only be done if it was not made public due to the need to keep confidential the identity of sites participating in the evaluation.

SITE 9

OVERVIEW

A social care and learning disability site that is part of a national provider which is run by a charity organisation. A social care organisation providing care to individuals with learning disabilities. The survey participant also known as the Training manager for the organisation was very optimistic about the implementation of the Care Certificate and its further impact upon the organisation and the care staff. She was consequently very keen to get involved in the evaluation. Care Certificate training is normally given to newly recruited frontline care workers who were nominated by their recruiting manager to take the course, however existing staff have also completed the Care Certificate. Apparently those completing the training elsewhere could be exempted from some or all of the training following competency checks.

THE VISIT

N/A – phone interviews only

CARE WORKER PERCEPTIONS

Two care workers who had completed the Care Certificate held very positive views about the Care Certificate. Generally it was felt that the Care Certificate was a positive thing, which if implemented correctly could work really for the organisation and the staff involved. Further to this, it was felt that all of the standards of the Care Certificate were equally important and by learning these standards, it generally led to a growth in the care worker's knowledge; a greater awareness of their role; aided career progression. In particular, care workers felt that it worked really well as the organisation had provided them with the adequate support and resources to learn and excel. In terms of recommendations, it was felt that the Care Certificate needed simplifying and the booklet requires simplification. Moreover, it was

felt that there was a need for more supportive networks to guide and supervise the implementation of the Care Certificate.

STAKEHOLDER PERCEPTIONS

The two Deputy Managers felt that the Care Certificate had worked really well for their organisation, initially it was felt that problems were experienced in implementing the Care Certificate but by adapting the Care Certificate to the needs of their organisation, this did not create further obstacles. It was further expressed that they had received adequate support from steering groups and some websites such as Skills for Care. The scope of delivery of the Care Certificate was generally to new starters but some staff have asked to do the Care Certificate as well. care workers who came with an existing Care Certificate were checked for their competencies in line with an assessment tool in order to avoid them completing the Care Certificate again. Moreover, the problems expressed about the Care Certificate were that it was time consuming and requires external verification in order to enhance its credibility. On the whole, it was felt that the Care Certificate was a good introduction for those new to the care sector but did require improvements in order to work efficiently.

SITE 10

OVERVIEW

A family run, residential care home, catering for private and non- private residents. This organisation has implemented the Care Certificate but not used it as all care workers currently hold an NVQ Level 3. The organisation has been awarded a Beacon status which is the highest level achievable at the Gold Standard Framework.

THE VISIT

N/A – phone interviews only

CARE WORKER PERCEPTIONS

One care worker without the Care Certificate shared their views about the Care Certificate and its potential. Generally it was felt that the Care Certificate was a positive thing, which if implemented correctly could work really for the organisation and the staff involved. Further to this, it was felt that all of the standards of the Care Certificate were equally important and by learning these standards, it would result in a growth in the care worker's knowledge; a greater awareness of their role and aid career progression.

STAKEHOLDER PERCEPTIONS

The Training manager reported that there had been no new starters within the organisation and existing staff already hold an NVQ Level 3. Hence, they have not felt the need to implement the Care Certificate. Generally, it was felt that the Care Certificate was a positive thing, which if implemented correctly could work really for the organisation and the staff involved. Further to this, it was felt that all of the standards

of the Care Certificate were equally important and by learning these standards, it would result in a growth in the care worker's knowledge; a greater awareness of their role and aid career progression. On the whole, it was felt that the Care Certificate was a good introduction for those new to the care sector but did require improvements in order to work efficiently.

APPENDIX 7: DETAILS OF DISSEMINATION PLAN

MODES OF DISSEMINATION ALREADY UNDERTAKEN (FIRST STAGE)			
Conferences/presentations	Academic journals	Professional journals	Websites and other
ENRICH event, IMH, 24/2/17 (project introduction)	"Dementia: the international journal of social research and practice" – accepted 23/6/17	Nursing Times, 9/11/16 (project introduction)	IMH website and newsletter (project introduction and ongoing updates)
Nursing and Residential Care conference, Brighton, 20/3/17 (project introduction)			IDEA blog (project introduction) 16/7/17
British Society of Gerontology conference, Swansea, 5/7/17 (project introduction– poster and symposium)			Leaflet distributed to participating sites, meeting venues (project introduction) eg M and K conference on innovation and role developments of healthcare support workers – 15/11/16
			ENRICH network via email (project introduction) 24/1/17
			Public Face newsletter (project introduction) 2/9/16
			Completion and submission of the interim report to the Department of Health Policy Research Programme 13/1/17

DISSEMINATION OPPORTUNITIES (SECOND STAGE) – This phase will extend beyond the end of the official end date of the project on the 31st October and will include diverse modes of dissemination. It is not always possible to specify the source and timing of dissemination activities as they are often dependent on issues outside our control such as acceptance via peer review and the timings of conferences. Therefore the details shown below are intentionally broad and it is not expected that all of these dissemination activities will be achieved. Activities appearing in bold will be given priority by the research team and will take place immediately after report submission.

Health Services Research UK Symposium, July, 2018	Dementia	Nursing Times/Nursing Standard/Community Care/Nursing and Residential Care – overview of findings	Skills for Health/Care
National Care Forum Annual Conference, May, 2018	British Journal of Healthcare Assistants	Health Service Journal	Social Care Online
School for Social Care Conference	Working with older people	Health Education England News	Nottinghamshire Healthcare newsletter
Care Homes Conference	Journal of mental health training education and practice	Caring Times	Dissemination opportunities identified by participating organisations
Dementia Congress, November, 2018	Age and Aging	Care Talk	NHS Employers – Events, News, blogs www.nhsemployers.org/
Margaret Butterworth Care Home Forum, SCWRU, KCL	Aging and Mental Health		NHS Confederation www.nhsconfed.org
Skills for Care Annual Conference, March, 2018	BMC Health Services Research		UNISON – Helga Pile

Jane Cummings – CNO; CNO Summit	Human Resources for Health		Poster/leaflet/research summary sent to participating organisations
British Society of Gerontology Annual Conference, July, 2018	Journal of Health Organisation and Management		The investigation of further funding opportunities to assist with dissemination
Division of Occupational Psychology Annual Conference, January, 2018 RCN Research Society	Journal of Care Services Management		Linda Hardy, Workforce Development Officer, Adult Services, Doncaster Council Floor 3 Civic Office, Waterdale Doncaster, DN1 3BU Phone: 01302 737619
University of Salford, exhibitor sponsorship package: http://www.salford.ac.uk/onecpd/media-pack	Health Education		Brian Burke, Sheffield teaching Hospital, HEE South Yorks regional excellence centre/Learn to Care National Committee (tracey.cooper@leeds.gov.uk/Vince Ion, TrueBlue Consultancy 07796 888573, HEE Leeds
Westminster forums and PSSRU in York and Kent	Health Services Research and Policy		Executive summary to Sustainability Partnership Trust organisations via Julian Eve.

[Recommended Twitter accounts](#)

Alzheimer's Society - twitter.com/alzheimerssoc
Alzheimer's Association - twitter.com/alzassociation
Cure Alzheimer's Fund - twitter.com/CureAlzheimers
Dementia UK - twitter.com/DementiaUK
Dementia Friends - twitter.com/DementiaFriends
Carers UK - twitter.com/CarersUK
Carers.org - twitter.com/CarersTweets
Age UK - twitter.com/age_uk
Independent Age - twitter.com/IndependentAge
Young Dementia UK - twitter.com/YoungDementiaUK
Mental Health Foundation - twitter.com/MHF_tweets
Care UK - twitter.com/careuk
Alzheimer's Disease International - twitter.com/AlzDisInt
Alzheimer's Research UK - twitter.com/ARUKnews
Dementia Carer (blogger) - twitter.com/DementiaCarers
NBFA Assisting the Elderly - twitter.com/theNBFA
Friends of the Elderly - twitter.com/FriendofElderly
Sue Ryder Care - twitter.com/Sue_Ryder
MIND charity - twitter.com/MindCharity
BRACE Alzheimer's charity - twitter.com/AlzheimersBRACE
NHS - twitter.com/nhsdirect
- twitter.com/NHSChoices
BUPA - twitter.com/BupaUK
- twitter.com/BupaHealth
BMI Healthcare - twitter.com/BMIHealthcarePR
- twitter.com/BMIHealthcare
Nuffield Health - twitter.com/NuffieldHealth
Pru Health - twitter.com/PruHealth
Ramsay Health - twitter.com/ramsayhealthUK
Reader's Digest - twitter.com/rdigest
Good Housekeeping Mag - twitter.com/GHmagazine
Yours magazine - twitter.com/yoursmagazine
Prima magazine - twitter.com/PrimaMag
The Oldie magazine - twitter.com/OldieMagazine
Community Care - twitter.com/CommunityCare
Enable Magazine - twitter.com/EnableMagazine
Boots Web MD - twitter.com/BootsWebMD
Patient.co.uk - twitter.com/patientuk
BBC Radio 3 - twitter.com/BBCRadio3
BBC Radio 4 - twitter.com/BBCRadio4
Smooth Radio - twitter.com/smoothradio
IDF50 (I don't feel 50) - twitter.com/idf50
Saga - twitter.com/SagaMagazine
50Connect - twitter.com/50connect
Caring UK Magazine - twitter.com/CaringUK

AARP Mag - twitter.com/AARPMag
Best Mag - twitter.com/BestMagTweet
Bella Mag - twitter.com/bellamagazineUK
Woman's Own Mag - twitter.com/WomansOwn
Radio Times - twitter.com/RadioTimes

Relevant websites for link-building possible partnerships and affiliations.

Alzheimers Research UK - www.alzheimersresearchuk.org/
Alzheimers Society - <http://www.alzheimers.org.uk>
Fisher Center for Alzheimers Research Foundation (America) - <http://www.alzinfo.org>
Young Dementia UK - www.youngdementiauk.org/
Dementia UK - www.dementiauk.org/
Dementia Friends - www.dementiafriends.org.uk/
AT Dementia - www.atdementia.org.uk/
Mental Health Foundation - www.mentalhealth.org.uk/
Care Base UK - www.carebase.org.uk/
Care UK - www.careuk.com
Dementia Care - <http://www.dementiacare.org.uk/>
Carers Trust – www.carers.org
Alzheimer's Disease International – www.alz.co.uk
Alzheimer's Association – www.alz.org
Alzheimer's Disease Scotland - www.alzscot.org
Dementia Carers - <http://www.dementiacarers.com/>
NBFA Assisting the Elderly - <http://www.nbfa.org.uk/>
Independent Age (advice and support) - <http://www.independentage.org/>
Friends of the Elderly - <http://www.fote.org.uk/>
Research Institute for Care of the Elderly - <http://www.rice.org.uk/>
Sue Ryder Care - <http://www.sueryder.org/>
The Cinnamon Trust - <http://www.cinnamon.org.uk/>
Royal Voluntary Service (helping elderly) - <http://www.royalvoluntaryservice.org.uk/>
Mental Health with Seniors section - <http://www.mind.org.uk>
Brain Research Trust - <http://www.brt.org.uk/>
Cure Alzheimers Fund - <http://curealz.org/>
BRACE – Funding Research into Alzheimers - <http://www.alzheimers-brace.org/>

Medical

NHS – internal system and external website/information to the public
(<http://www.nhs.uk/Pages/HomePage.aspx>)
BUPA – internal system and external website/information to the public/members
(<http://www.bupa.co.uk/individuals>)
BMI Healthcare - internal system and external website/information to the public/members
(<http://www.bmihealthcare.co.uk/>)
Nuffield Health – internal system and external website/information to the public/members
(<https://www.nuffieldhealth.com/hospitals/news>)

Pru Health – internal system and external website/information to the public/members
(<https://www.pruhealth.co.uk/medical/>)

Ramsay Health – internal system and external website/information to the public/members
(<http://www.neurologicalservices.co.uk/news--events/latest-news.aspx>)

Online Diagnosis Pages – (eg. Patient.co.uk/seniors_health)

Additional Websites

Age UK - www.ageuk.org.uk

IDF50 (I don't feel 50) – www.idf50.co.uk

Later Life – www.laterlife.com

Pensioner's Forum – www.pensionersforum.co.uk

Saga – www.saga.co.uk

Silver Surfers – www.silversurfers.net

Seniority – www.seniority.co.uk

2young2retire – www.2young2retire.com

50connect – www.50connect.co.uk

Go 60 - <http://www.go60.com/>

Wired Seniors/Seniors Search - <http://www.wiredseniors.com/seniorssearch/>

Yahoo section - <http://www.wiredseniors.com/seniorssearch/>

Senior directory - <http://www.senior.com/>

Online blog - http://dementiacarer.com/home/?page_id=27

Online blog - <http://betterlife.jrf.org.uk/>

Other

Women's Institute - <http://www.thewi.org.uk/>

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