

**Policy Research Programme
Summary Final Report Form**

For office use only:

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IMPORTANT

The maximum character limits shown in this form include both printing and non-printing characters such as spaces and carriage returns.

This form must be completed after your full final report has been approved. Completion of this report is required for release of final payment. **Please note that this summary may be placed in the public domain.**

1. Project Details

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

Project Duration:
(months) 18

Original Contracted End Date: 31 October 2017

Start Date: 01 May 2016

Revised Contracted End Date: n/a

2. Grant Holder's Details

Title: Dr

Surname: Thomson

Forename: Louise

Department: Division of Psychiatry and Applied Psychology, Institute of Mental Health

Role in project:

Institution: University of Nottingham

3. Keywords

Please provide up to eight keywords that relate to the research undertaken in this study (**maximum 200 characters**).

Care Certificate, Health Care Assistant, Support Worker, Training, Workforce, Induction, Care Standards

4. Executive Summary

Please provide a structured summary which outlines the aims and objectives of your work in relation to the questions being addressed, the research design, the methods of investigation and your findings and conclusions. In addition, please describe the expected influence/impact of your work on the relevant policy field, service providers and wider stakeholders, and on current practice. Please ensure that this is a comprehensive, stand-alone summary of your work **(maximum 10,000 characters)**.

Background

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. When it was launched in April 2015, the delivery of the Care Certificate was left to employers and adoption by care providers has been variable.

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 objective 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 a representative stratified sample of staff who have responsibility for training or induction of care staff in care organisations. 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

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.

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. 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 prior training.

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.

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 24 managers, training leads and trainers. 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 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 and confidence 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.

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. This inconsistency between organisations 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 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.

Impact of the findings

For care organisations and training providers, these include:

- The use of a 'clear workforce development plan' which sets out the learning journey for each care worker.
- The adoption of a broad scope of delivery for Care Certificate training, to include wider groups of workers.
- Training should include participatory and experiential approaches, incorporating both practical and classroom components.
- The explicit recognition of Care Certificate completion within care organisations through certificate presentation ceremonies.
- Clear guidelines on timeframes for completion including a pro-rata completion rate for part time staff.

For policy-makers and regulators, these include:

- Measures to maintain standards and consistency such as an external validation system or a network of independent assessors.
- Refreshed and updated guidelines on the implementation of the Care Certificate providing clarity on the accreditation of prior learning (e.g. NVQs) and the time frame for completion.
- Guidance and support for small care organisations on how they can implement the Care Certificate standards.
- Providing alternatives to printing out materials/workbooks.

5. Lay/Plain English Summary

The Department of Health actively encourages the dissemination of research to the public and it is therefore essential that you make the content of your summary and the implications of your research accessible to lay persons. Please provide a plain English summary of objectives, findings, and conclusions of your research, avoiding both technical terms and undefined acronyms (**maximum 2,000 characters**).

The 'Care Certificate' was introduced in April 2015 as a new training programme that all new care workers (Health Care Assistants and Social Support Workers) should achieve before working unsupervised.

This research aimed to evaluate the effectiveness of the Care Certificate in achieving an improved induction and training so that care workers are better-prepared to provide high quality care.

We carried out a national telephone survey with 401 staff who have responsibility for the induction of care workers in care organisations. We also interviewed 68 care staff and 24 managers at 10 different care organisations to get a more detailed understanding of their experiences of the Care Certificate training.

We found that the uptake of the Care Certificate has been good, and it is widely welcomed as providing a standardised approach to improving the care skills and confidence 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.

The Care Certificate was not widely used as a transferable qualification to support the movement of care staff between organisations. Most organisations required new recruits who had completed the Care Certificate elsewhere to repeat some or all of this training due to scepticism about the quality of any prior training.

There has been considerable variation in how the Care Certificate is being used which has undermined the credibility and portability of the Care Certificate, leading to calls for greater regulation and standardisation in its provision.

Organisational size, leadership, capacity and resources were major factors in determining the effectiveness of Care Certificate. Where organisations had the resources to devote particular staff to develop the training or adapt it into their existing induction programmes, then the potential benefits of the Care Certificate were most likely to be reported.

6. Details of Patient and Public Involvement in the Research

The Department of Health supports the development of an evidence base for patient and public involvement (PPI) in research and is therefore keen for researchers to record, learn from and share their experiences of PPI in research.

Please provide a structured summary that:

- Details the PPI undertaken in this research project;
- Describes how, if at all, this has differed from what had originally been planned and why;
- Considers what impact, if any, PPI in the project has had on any aspect of the research process and outcomes;
- Reflects on the key lessons learned (both challenges and successes) from the process of PPI in this project.

If you did not have any PPI in the project, please explain why (**maximum 2,000 characters**).

One way in which PPI involvement has been achieved was through their inclusion in the project management and advisory groups. 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.

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 care work. 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 writing a report on external Care Certificate training provision.

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 on the principles of the Care Certificate.

In order to further broaden its impact, the project team compiled a list of individuals and organisations who have expressed an interest in the project since its commencement. It also engaged in the ongoing and widespread publicising of the project in accessible formats in order to promote further interest, awareness and feedback.

7. Addressing Equality and Inequality

As set out in the DH Research Governance Framework for Health and Social Care 2005, research and those pursuing it should respect the diversity of human culture and conditions and take full account of ethnicity, gender, disability, age and sexual orientation in its design, undertaking and reporting. It is particularly important that the body of research evidence available to policy makers reflects the diversity of the population. Please describe how this was addressed in the planning and delivery of your research, and what contribution your research will make to informing policy to tackle inequalities in health and/or social care. If diversity was not explicitly considered in this piece of work, please explain why **(maximum 10,000 characters)**.

A main way in which issues of equality and inequality were addressed 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. It was felt that such groups would potentially yield more accurate information on their relevant experiences of care organisations than those with current patients and carers due to the fact that the groups were not being carried out within these organisations. 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. Focus groups explored participants' perceptions of frontline care and the training that paid carers received with particular reference to the Care Certificate.

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, including 44 women and 12 men. 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 carers (groups 5 and 6) was reflected in the prominence of the issue of dementia care although even groups not specifically devoted to this issue also often referred to dementia related themes.

Their involvement was facilitated by the payment of travel expenses, where appropriate and through giving a £20 shopping voucher to each participant. While it became clear that for some, these vouchers were a main reason for their participation, unexpectedly, 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. 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.

All groups had strong views on the context of frontline care and its role in facilitating or impeding knowledge transfer and utilisation 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 their 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. These include levels of resourcing, commissioning practices and the generally poor working conditions of care workers giving rise to recruitment problems and significant staff churn and turnover.

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. 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. Others spoke about issues of ethnicity within care provision with some advocating the use of ethnic 'matching' between the care worker and care recipient. This need for ethnic matching was seen by some to apply not just to ethnic minorities but also to the ethnic majority.

Due to the stratified random sample adopted, a similarly diverse and representative range of respondents was aimed for in the survey and site visit component of the study both in terms of sites involved and the staff interviewed. Thus 401 participants took part in the survey, drawn from an initial sample of over 1200 care organisations. From these survey respondents and in order to elicit the views of managers, trainers and care workers, a representative selection of 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 and its aim to promote the more effective and equitable implementation of the Care Certificate 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). For drawing on the perspectives of care workers themselves, the evaluation and the recommendations arising from it aimed to improve their experiences through such things as enhancing their career development, self-awareness and self-esteem.

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, this study has aimed to improve the outcome of this training with potentially positive implications for those in receipt of this care. 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.

8. Key Publications and Presentations by the End of the Project

Please list here any publications which have resulted from this piece of work, including those currently in press. This should include journal articles, conference proceedings, press releases and all publications in the lay and scientific press, including website links to published articles if appropriate. **Please note that it is a contractual obligation to provide 28 days notification prior to submission of any publication relating to this study and that this condition is without time limitation.**

Author(s)	Title	Reference/Further Details
Thomson, L., Argyle E., Khan Z., Arthur A., Maben J., Wharrad H., Schneider J., Guo B., Eve J.	Evaluation of the Care Certificate: new national training standards for the health and social care s	Presentation at HSRUK Conference, 4-5 July 2018, Nottingham.
Thomson, L., Argyle E., Khan Z., Schneider J., Wharrad H., Maben J., Arthur A.	Evaluation of the Care Certificate: new national training standards for the health and social care s	Presentation Division of Occupational Psychology Conference, 10-12 January 2018, Stratford-upon-Avon.
Thomson, L., & Argyle, E.	Evaluating the Care Certificate: a cross-sector solution to assuring fundamental skills in caring.	Poster at CLAHRC Wessex Ageing and Research Conference, 25 April 2018, Southampton.
Argyle, E., Thomson, L., Arthur, A., Maben, J., Schneider, J. and Wharrad, H.	Introducing the Care Certificate evaluation.	Dementia: the international journal of social research and practice. http://journals.sagepub.com/epr
Argyle, E., Khan, Z., Simpson, K., Thomson, L.	ECCert: evaluating the Care Certificate.	British Society of Gerontology conference, Swansea, 5-7 July 2017 http://eprints.nottingham.ac.uk/id
Thomson, L., Argyle, E. & Khan, Z.	ECCert: Evaluating the Care Certificate.	Nursing and Residential Care Conference, 20 March 2017, Brighton