



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, School of Health and Education

by

Michael Traynor
Kevin Corbett
Sinead Mehigan

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Background

The rise of support workers

Support workers have nearly always worked alongside qualified nurses. In the past student and auxiliary nurses have carried out a great deal of the direct patient work (Allen, 2001) but today much of that work is done by a growing number of Health Care Support Workers (HCSWs), also known as Health Care Assistants (HCAs). The health service has relied on these workers partly for demographic reasons, when it has been difficult to recruit enough nurses, but more obviously because these workers are not only cheaper to employ, but quicker and cheaper to train (Traynor, 2013). It was the combination of the new higher level training for nurses brought in by Project 2000 (National Audit Office, 1992) in the 1990s and a government concerned with reducing healthcare costs that led to a policy and managerial focus on 'skill-mix' (Car-Hill et al., 1992) and the rise of the support worker. Since then the role of support workers has received much policy attention. Reports which have examined their work have found variability and flexibility in their use, ambiguity in the attitudes of nurses towards them (Kessler et al., 2010) and unevenness in their preparation for practice (NHS Education for Scotland, 2010).

Added to this the 2010s saw a series of highly-publicised scandals in which support workers were implicated alongside nurses. The first reports of systematic failures of care at Stafford Hospital appeared (BBC News, 2010), along with harrowing tales of nurses' apparently cruel behaviour. This was followed by undercover reporting showing cruelty to patients by support workers (BBC Panorama, 2011), and a report of the Ombudsman (Health Service Ombudsman, 2011) detailing a series of stories of poor nursing of older people.

These problems brought to the public's attention the variability and often low level of training provided to health care support workers who are responsible for delivering care to vulnerable groups of patients.

The Francis Report into failures at Mid Staffordshire made seven recommendations specific to health care support workers. These concerned four areas:

- Strengthening identification of Healthcare support workers (HCSWs) and other nursing staff in the workplace
- Registration of HCSWs
- A national code of conduct for HCSWs
- A set of common national standards for the education and training of HCSWs

As a response to the Francis report, the Secretary of State for Health commissioned the Cavendish review on the support workforce in the NHS and social care

(Cavendish, 2013). This review focused on: recruitment, training, supervision, support and public confidence. The report's author claims that its guiding principles were 'to try to reduce complexity and bureaucracy; and to go with the grain of what the best employers are already doing' (page 5).

The 'Certificate of Fundamental Care': Care Certificate

In November 2013, the government issued a formal response to the Francis report and to the subsequent reviews. While not agreeing to pursue registration for the 1.3 million support workers in health and social care settings (the majority in local authority employment), it did request Health Education England to work with Skills for Care, Skills for Health and other stakeholders to consider how the 'Certificate of Fundamental Care' proposed by Cavendish, (now known as the Care Certificate), could be developed. The Cavendish report envisages that student nurses and HCSWs would complete the certificate together (page 55). It has come to be focussed in its initial use almost entirely with the support workforce, though there are local moves to map the Care Certificate with year 1 of pre-registration nurse training.

The above organisations developed 15 Care Certificate standards requiring attitudinal, legal and technical care information input. A key intention was that the certificate be 'applicable across health and social care, and be portable/transferable from sector to sector' (Skills for Health et al., 2014a, p. 2). The Care Certificate is primarily aimed at Healthcare Assistants, Assistant Practitioners, Care Support Workers and those giving support to clinical roles in the NHS where there is any direct contact with patients or people who receive care and support (Allan et al., 2014: p. 2).

Its aim was to offer a structured and consistent approach to the preparation of support workers within healthcare and adult social care settings. Cavendish's recommendation was that only after completing the Certificate should support workers be allowed to work unsupervised. If support staff are successful in completing the Care Certificate programme, it is suggested that the care they deliver will be of a sufficient quality to provide evidence to employers and the public that they have the right skills, knowledge and behaviours to perform their role to a consistently high standard. Significantly, the Care Certificate was intended to be complemented by a code of conduct for employers. In the spirit of reducing complexity, the Certificate was also intended to remedy a situation where 'Lack of faith in the system has led to costly duplication, as employers develop their own in-house courses, and retrain new staff irrespective of what training they have had elsewhere' (page 7).

The Care Certificate, therefore, while becoming compulsory for the support workforce is not overseen by either a professional regulator or by an accredited national body. This seriously compromises the ambitions of those who see the Care Certificate as a portable and quality assured qualification similar to professional registration. The recently published Shape of Caring review (Willis 2015) sets out a vision for a more nationally consistent recording system for the support workforce.

HEE should work with the care sector to develop or use an existing e-portfolio tool that will allow signed-off competencies to be recorded electronically on a national database for care assistants, across both the health and social care sectors. All competencies held within the database will be achieved at nationally accepted standards (which are quality assured on a regular basis) so that they are truly transferable and accepted by all health and social care organisations; reducing the duplication of unnecessary education and training. (Summary report page 6)

Nevertheless, Skills for Health and Health Education England are clear about the status of the Care Certificate:

The Care Certificate **IS** the shared health and social care training and education which must be completed and assessed, before new HCSW/ASCWs can practice without direct/ line of sight supervision in any setting. This may be done in a phased approach, as each HCSW/ASCW meets an individual standard their supervisor may allow them to practice without direct/ line of sight supervision against that standard. Therefore a HCSW/ASCW who has not yet successfully completed the certificate must be supervised directly and always be in the line of sight of the supervisor. Indirect/ remote supervision of the HCSW/ASCW will still be required following award of the certificate. (Skills for Health et al., 2014b, p. 3)

Any local implementation can only operate within a national policy context and, in the case of the care certificate, the inconsistencies outlined above are likely to have an effect at local level.

Care Certificate pilot project

In the Spring and Summer of 2014 the Care Certificate was introduced as a pilot in 29 sites across England (<http://www.nhsemployers.org/your-workforce/plan/education-and-training/care-certificate/care-certificate-pilot>). The pilot was evaluated by Skills for Health (Allan et al., 2014). One of the recommendations of the evaluation was that this approach to development be rolled out and that Local Education and Training Boards (LETBs) should act as co-ordinators to ensure cross-provider networking within the healthcare sector.

A review of the evaluation of the original pilot project suggests that there are several factors that might contribute to the success of the programme, in certain contexts. For example, the provision of a common preparation programme, and the possibility of sharing teaching and assessment resources have been seen as positive. The possibility of having a transferable/portable award has also been seen as being of benefit, though seen as problematic by many Care Certificate pilot leads. The evaluation also draws attention to what might not have worked in certain contexts, for example concerns about consistent standards of assessment across organisations led some managers in pilot organisations to state that they would not accept the transferability of this award. The evaluation as a whole gives an idea of

what has worked, in terms of possible outcomes although as the evaluation was undertaken very shortly after the pilot commenced it is recognised that there is scope to look at longer-term impacts. Underpinning the development and implementation of this programme is an assumption about the value of education, which is that an individual's performance in practice is related to how they have been prepared and assessed.

Aims of this evaluation

Given the findings of the national pilot evaluation, the aims of this proposed evaluation are to:

1. Explore the impact of the present use of the Care Certificate within a defined area – Islington CEPN - in one LETB, Health Education North Central and East London (HENCEL),
2. Compare it with similar evaluations in the HENCEL area and
3. Build on existing ideas of what it is that works regarding the use of the Care Certificate to improve performance of support workers.

We are particularly interested in gaining a better understanding of what is it about the programme that increases the possibility of consistency in the level of practice performance of support workers, that is, what 'works' in the local context to promote such performance consistency, and secondly, whether this local context-specific approach could work elsewhere. We are also interested in exploring the degree to which the findings of the original evaluation also apply within Islington CEPN and in the other pilot sites in North, central and east London.

Study design and data collection

Our evaluation approach is similar to that developed by Pawson and Tilley called *realistic evaluation* (Pawson and Tilley 1997). It assumes that real causal relationships emerge around new programmes or developments (such as the Care Certificate) and that key local participants have special relevance for the evaluation of such initiatives. This assumption enables a focus on the real world links between *context*, *mechanism* and *outcome*. The *context* for the Care Certificate comprises those local conditions which are relevant to its implementation and operation as a programme of training. *The mechanisms* at play include the local means by which the implementation of the Care Certificate occurs within the dedicated human, fiscal and stakeholder resources, thereby creating new capacity, processes and relationships between stakeholders/providers. *Outcome* comprises the anticipated and unanticipated consequences of its implementation, resulting from the activation of different mechanisms in different contexts. Our realist approach does not stipulate any single outcome measure for assessing the successful delivery of such a development (Pawson and Tilley 1997).

Based on the above approach our evaluation has had two overlapping phases. The first comprised data collection within sites in Islington. The second involved a comparison between this data and the findings of similar evaluations carried out at Barts Health and Great Ormond Street Hospital for Children NHS Foundation Trust and the dissemination of the findings of the whole project.

Phase one of the study drew on the design of the national pilot evaluation, as far as possible within the scope of available resources, in order to facilitate comparison.

After having obtained ethical approval from Middlesex University a list of participating organisations was requested from the Islington CEPN Task and Finish Group all of which comprise the specific local participants who have a special relevance for the successful implementation of the Care Certificate and hence for our evaluation. With the advice of the Task and Finish Group we selected 4 organisations to invite to participate. We then contacted the relevant manager to explain the project and to seek permission to conduct the evaluation. In each site we planned to sample from the following groups:

- the manager or other person with lead responsibility for the Care Certificate
- an assessor/assessors
- a trainer/ trainers (both within the organisations and external providers)
- staff undertaking the Certificate
- a supervisor(s)/mentor(s)

The aim of our sampling approach was to select participants and organisations which represent as wide a range of variation as possible in terms of type of

organisation, professional background, and if appropriate, regarding the support workers, demographic characteristics. We aimed to include both social care and healthcare providers.

We planned to collect data on the mechanisms associated with the implementation of the Care Certificate, specifically those enabling factors and outcomes within the following four themes (taken from the national pilot evaluation): expectations of the Care Certificate, delivery models, progress, challenges, outcome and impacts. The schedule of questions provided in the national evaluation was used as a starting point for the development of a data collection tool, however, given the early stages of preparedness in most organisations involved in our evaluation, we departed from this schedule in many cases. We also included as data the issues discussed at the CEPN meetings.

An interview schedule, based on the above, was used in telephone interviews with our sample. These interviews were arranged in advance after our participant information sheet was sent to all respondents and took between 15 and 40 minutes. One interview was held in person. With the permission of participants we audio recorded all interviews and these were transcribed by a member of the project team. The identity of the organisations and participants was protected and no identifying details are included in this report.

The data was approached as described above by the evaluation team with a view to answering the evaluation questions, within the overall framework of Pawson and Tilley's *realistic evaluation* (Pawson and Tilley, 1997).

Phase two involved discussions with those individuals responsible for implementing and evaluating the Care Certificate pilots carried out at Barts Health and Great Ormond Street Hospital for Children NHS Foundation Trust; identifying enabling factors and barriers to success of the programmes at each site as well as other key features; developing a detailed analysis of similarities and points of divergence between these settings; developing a site sensitive model of implementation and delivery of the Care Certificate that appears to lead to the most effective outcome, with important contextual features clearly identified. This comprises a separate section of the overall report.

At the end of the evaluation we will organise a dissemination event where the results will be shared with key stakeholders from the organisations involved and from HENCEL. Part of the aim of the event will be to create a forum where next steps in the roll-out of the Care Certificate can be explored.

Procedure

Once funding for the project was confirmed in December 2014 we obtained ethics approval from the School of Health and Education at Middlesex University. After this we made application for approval from Whittington Health and applied to the NHS Health Research Authority to determine whether the project met their definition of research. The project was registered on Whittington Health's Quality Improvement

Project Register and a Data Processing Agreement was signed. We attended meetings of the CEPN from December 2014 in order to become acquainted with the challenges and progress of the Care Certificate and to start to make contact with potential informants. These meetings were crucial to the progress of the evaluation.

Findings

Part 1: the interview study

Table 1: Participants

	General Practice	Care Home	Local Authority	Whittington Health	Training org
Care Certificate Participants	2				
Assessors	2	1			
Managers of organisations involved or considering involvement	3	2			
Trainer or manager of training				1	1
Total	11 (some of the above are included in two categories)				

All participants were assured of anonymity, however numbers were low. In order to protect anonymity some of the presentation of findings omits contextual material. Overall findings indicate that the CCG has been actively and effectively promoting the Care Certificate across the range of sectors where support workers are employed. Those involved in these organisations have responded positively though it is clear that their degree of readiness varies.

Assessors

Three assessors were interviewed, two from GP practices and one from the care home sector who was a manager of one home. In addition one assessor from a GP practice declined to be interviewed as they had not yet engaged with the Care Certificate. In the care home the manager who was a nurse said they would be undertaking assessments while in the GP practices the main assessor would be one of the practice nurses. Therefore all interviewed assessors from these sectors were qualified nurses.

Assessors were asked about their preparedness for acting as Care Certificate assessors and their views about the fitness for purpose both of the assessment documentation and how they believed assessment would be achieved in the workplace. It is clear that not all assessors were prepared for their role at the time the interviews were undertaken and perhaps because of this, said they could not comment on the guidance and assessment documentation or gave very unspecific responses.

Yeah, I haven't seen the guidance as its not been sent to us. I know they've [HCAs] got the workbook, but the guidance hasn't been sent out to us yet.

(Care home)

Have you had a chance to look through the assessor's guidance document?

Not really, I had some emails, have come from Whittington Health, which I have to print and look through it, but then, the healthcare assistants have been coming to me and said you will be my assessor and after all, I got involved that we need to sit down and talk and discuss what it involves.

So what do you think of the guidance for assessors.

I don't know. The information comes through from the Whittington. I'm just working flat out, so no time at all, you know?

Have you had any specific preparation to be an assessor?

I haven't.

(GP Practice 1)

Confidence about the assessor role varied:

Because I think the document has not been provided to us yet. But if I had it - I mean, I'm a nurse myself and have been working in the care industry for a while - so I think I feel confident that I'm able to support the staff and their development and things like that.

(Care home)

Do you feel confident that the evidence required for those assessments is adequate to make a judgement?

No, I think it's adequate and, obviously what I'm doing, evaluations and we work very closely with [HCA], just so she's got support. I think it might be slightly difficult if someone was working quite separately but I think if you work in a place where you've got on-going support, I think it's perfectly fine.

Would you say that you've got any learning and development needs to support you as an assessor?

No, and I think me and my colleague, we just had a mentor update last week, so no, I think we're quite OK.

(GP Practice 2)

Would you say that you've got any learning and development needs to support you as an assessor?

Well, on my behalf, I would say that I will be assessing, mentoring them, but nothing has been done, there's nothing yet in paper.
(GP Practice 1)

Lack of preparedness and speed of implementation therefore can be seen as—if not barriers to implementation—then challenges to thoughtful and fully optimised implementation.

There were a number of enabling factors to implementation. Assessors in GP practices reported that the practice managers and GPs were supportive of the scheme and of the need to provide the support required to the practice nurse in their role as assessor. Similarly in the care home, once a decision had been made at senior level to participate then there was no reason not to proceed. As suggested in the interviews with GP practice managers, the care home sector is clearly giving careful attention to the issue of skill mix and any training that is able to extend the responsibility and skills of support workers is likely to be welcomed. In addition, individual support workers themselves, as we have found from previous research, tend to be enthusiastic about any opportunity to enhance their responsibility and perceived standing among their colleagues. According to the care home manager:

It's a big help and it's a big boost of morale; it's not just only for them, I mean carers, they know, it will give them an awareness to understand that it's not just only doing personal care and activities, there is more they can do, and they spend a lot of time with the residents so their role is as important as the nurse, and, for them, it's given more understanding and awareness of what we're doing, and it's giving a meaningful purpose, and, again, it's another way of a career booster, so someone was thinking, well I could take the path of becoming a nurse or becoming something, so it's another career booster for them... and I think, if this training is made available to [more support workers], it will boost up a lot of confidence and a lot of standards in nursing homes.
(Care Home)

In addition the same assessor/manager believed that the support workers from her care home gained a particular encouragement from attending Care Certificate training that involved other workers from different sectors (this point was also made by a support worker from a GP practice):

From the feedback I got - actually my staff felt really proud – when they came, they said, 'oh, we were the only staff from an nursing home, my God, this is really nice, thank you, thank you'. So they were in an environment with staff in the hospital and, you know, when you think you work in nursing home, you're not that important? But, for them, it's got them to realise that, actually, you are equally as important as anybody

who works anywhere else.
(Care Home)

Care Certificate participants

Two HCAs, both from GP surgeries participated in the evaluation. One had heard about the Care Certificate from the CCG Nursing and Organisational Development Manager and had requested to attend. The other had been asked to attend by her practice manager. Both expressed a personal keenness for involvement in training and spoke of practice settings that were facilitative for them to attend. When asked to talk about the content of the Care Certificate, each participant emphasised a different aspect. One focussed on the practical skills and in particular being shown how to take blood pressure recordings using a manual device while the other focussed on more ethical issues. Both commented on attending the training alongside support workers from other settings:

Well, I learned - to be honest, most of it was just background to HCA, telling us about our dos and don'ts; when to stand up and say 'No'; competency first, to be able to do something; I learned about how to use the manual blood pressure machine but then most of it was relevant to people working in hospitals, I think they achieved more. So for us, [at] the GPs, I think they need to change it in a way that is both for GP practices and district nurses and everyone who works outside the hospital.
(HCA GP Practice 1)

It was very good to be honest to tell the blood pressure, because normally we use electronic one and it was quite interesting for me to learn to get the pulsation and everything.

So was any of it not relevant to what you do in your job?

No, everything was relevant for my job and, to be honest, everything was good, yes.

So were the other healthcare support workers – were they from different types of work?

I think it's quite different because we have different duties to do so in surgery, you would do completely different duties to what you would do in the hospital, but, for me, the blood pressure, pulsation and respiration is the thing you can do everywhere, even in the hospital, GP Practice, everywhere. Maybe that's why they are teaching us how to do it.

And was it useful to you to be doing this training alongside other people who work in hospitals?

It was quite interesting because we just find out what is the difference between you working in the GP surgery delivering care and working in the hospital and just going to do the care for the patient, even if it is in the hospital or in the GP surgery, we just care about the patient whether we are seeing them here or in the hospital.
(HCA GP Practice 2)

Both participants were clear about the assessment process. The process of demonstrating competence was familiar to both:

Luckily, we have a practice nurse here so she normally, well, helps me through and the doctors as well, so they normally assess me on my day to day progress and then they need us to do kind of coursework we were given and we have a period as to when we have to hand it in and then, they will assess and see, but then the competency, we have to do ourselves with someone.

And is it clear, from what you've been given, what you have to do?

Yes, it was quite clear. It was quite clear. They gave us some booklets of things we have to do, things we have to fill in, things we need to research, things we need to practice on.

And when you've finished that, you'll sit down with [practice nurse] and she'll do the assessment?

Yes, or the doctors, cause I work with some doctors as well, one to one. Cause I normally do dressings, stuff like that.

So will the doctors be involved in assessing the care certificate?

They can do but I'm not sure if it has to be a nurse, cause things like the health checks, the OSCEs¹ as they call them – it would be a doctor who worked with me, so like spirometries², it would be a doctor who worked with me, but for wound care, it's the nurse, wound care, spirometry as well, part of it.

(HCA 1)

I completed with the nurse here – for me it was very easy to do it, to be honest, because most other courses in there, I done it already in the hospital, because I used to work there in the last year here and it's quite easy for me to complete this folder and I just take 3 hours sitting with the nurse and we complete it together and she was happy with all the

¹ 'OSCE' – observed/objective structured clinical examination: common modes of clinical assessment for many health professionals.

² Objective scientific measures of lung function used to assess a patient's response to medication for asthma and obstructive airways disease.

answers and the questions and everything I did.
(HCA 2)

When asked to identify the good things about the Care Certificate, the participants responses tended to differ from those of the practice managers who focussed on the increased range of tasks which they believed the training would enable their support staff to be responsible for. The HCAs both identified input about the scope of practice and the limits of their role as good things about the Care Certificate:

We learned a lot about the history; we learned that we actually have the right to say 'no', cause you think, yeah, cause you're a healthcare assistant, you're not supposed to say no - whatever they tell you, you have to do. I learned that I have to cover my back as well; I have to be competent and feel comfortable to do what I have to do, not just do it cause I've been asked to, and also, to fill in my competence kind of folder which I created now, which I think is very helpful, cause then at least I have a kind of backup to what I do and someone will stand up and say, yeah, I signed this off; she is competent to do this, in case of anything, of course.

(HCA 1)

The good thing is many carers, they have been working without the certificate; maybe they are thinking they [are] doing the right things and ... maybe they are doing duties that they don't have to do, even in the hospital or the medical practice, and this is the main [reason that it] is good for every healthcare to do the course, so they know about their duties, what they have to do for patients and everything because ... and maybe you don't need to do these duties now and make a mistake ... and look after patients properly and that is a good thing.

(HCA 2)

Both ended by expressing an interest in further more in-depth training which they believed that their practices would support. The Care Certificate appeared to be an opportunity for support workers to develop or re-visit certain clinical skills and to consider the scope and parameters of their role.

Managers

We undertook interviews with five managers who were not assessors: one from an NHS trust, one from a private sector company providing care home services and three from General Practice. (The care home manager interviewed was an assessor and her views have been included above). In addition we made notes from conversations with others in similar positions from different sectors (Local authority care sector) at CEPN meetings.

We asked the practice managers why they had taken up the Care Certificate. Two spoke about their intention to make more use of skill mix within their practices:

Well, the changes in primary care and how we make our money, involves a lot of sort of work that healthcare assistants can do, so we're finding that, although the workload is increasing, some of it can be, the doctors can be supported by healthcare assistants, so that's why we, we sort of decided to skill up two members of our team to take that on.
(GP Practice manager 1)

A third practice manager pointed to new requirements from the practice's insurers who had placed restrictions on the indemnity for non-registered workers. This manager believed that in future all HCAs would be required to have some accreditation and thought that completion of the Care Certificate could be a first step in that direction. All three managers identified the support and guidance from the CCG Nursing and Organisational Development Manager as facilitating this take-up. Even though all managers were supportive of the scheme, there was some lack of familiarity with the details and implications of the Care Certificate and a reliance on the CCG for information about it. When asked about their view of the fitness for purpose of the guidance documents from Skills for Health and Skills for Care, none had familiarity with these documents. Regarding their view of the suitability of the content of the Certificate, not all had a clear idea of this though they had received feedback from the attending HCAs. A similar picture emerged regarding arrangements for assessment,

That was a secondary thought really, I would think. We have two full-time nurses here: one is a lead practice nurse and we assumed that she would, in fact, be the assessor for the healthcare assistant – it turns out that she actually needs to do some sort of assessor's course as well, or refresher course, which we also weren't expecting – it wasn't that we didn't realise it at the time – but I don't think that's a showstopper, and, also, we just assumed that the lead nurse who worked with the healthcare assistant anyway, on a day to day basis, would undertake that work for us.
(GP Practice manager 1)

In the care home sector, the senior manager we spoke to told us that the organisation had heard about the Care Certificate national initiative and had made the decision to adapt all training and induction for support workers to be in line with the standards of the Certificate.

In one practice, both the manager and participating HCA spoke of the involvement of doctors in the assessment as the practice medical staff clearly played a role in teaching and supervision of HCAs:

Well, to be honest, our practice nurse has been doing it, but I think, if I was to do it again, and certainly with [our second HCA], as she progresses through the care certificate, we may do it slightly differently, because you also have to consider the strengths of the person who's assessing them and what their tasks are, and often, it may not be related – I mean, we have doctors who specialise in diabetes who do a lot of our

chronic disease management here, so it would be more appropriate for them to actually perhaps, look at how the healthcare assistants do things and mentor them in that, and so, I think that possibly, it's assumed that the nurses do everything but, actually, in some cases, they don't, so I think perhaps, making that clear in the beginning would be good.
(GP Practice Manager 3)

All the practice managers expressed commitment to invest in this training, in terms of the opportunity costs of staff training and assessment time:

What about the resource implications – was that an issue, that she wouldn't be in the surgery for a particular amount of time?

Well, of course, that's always an issue when we lose clinicians to training, but that's part of, I mean that's what the doctors have to do, that's what the nurses have to do, we have to lose time for them and for the healthcare assistant, we didn't think twice about that really, that is just part of how we have to run.

And would that be true about the time it would take your nurse to do the assessment?

It will, yes, yes. We realise they're going to have to block off some clinical time to do that and, of course, the healthcare assistant has got some work to do outside and again, after that, but, maybe we didn't look into that as closely as we may have done, but as I say, that hasn't stopped the show rolling... But qualifications for healthcare assistant and training for all the nurses to update – they're always updating their training – we just see that as part of their jobs and the roles in the practice, so it hasn't had a great impact, as we say, on the working and running of the practice, cause we understand these things have to be done for the other clinicians and we don't see why the healthcare assistant is really any different.
(GP Practice Manager 2)

When asked for further comments about the Care Certificate, most managers expressed an interest in further training for this grade of worker, returning to what had been—at least one of—the original motivations for involvement:

Maybe there could be a second part to the Care Certificate so that those 2 days that [our HCA] went on, it could have been an introduction or foundation care certificate, I don't know and then have maybe have another, I don't know, 3 or 4 days where they look at certain areas in more depth because it's really difficult to get them on courses cause there's usually nothing available so I think it really keeps them motivated as well, knowing they're not just stuck doing new patient checks or BPs [measuring blood pressures].

So it's skills training.

Yes, I think so, especially with the shortage of nurses. I think it's really important to make sure our HCAs can expand in their roles and can do what they're able to do. HCAs nowadays, they're allowed to do a lot more things: they can do spirometry, they can do diabetic checks, even ECGs and I just think there's not enough courses out there to help them, support them in moving forward as an HCA.
(GP Practice Manager 2)

Regarding assessment, the care home sector manager expressed disagreement regarding the requirement for the Care Certificate assessment to be finally signed off by a qualified nurse or similar qualified person. This was on the grounds that some of the organisation's provision does not involve nursing care or qualified nursing staff, along with a belief in the principle that arrangements should be simple for organisations to engage with in a sustainable way—be 'self-managing systems'.

That one I don't agree with and, for some of my services, I simply won't do it, purely because there are a number of services – we have four services which are not providing nursing care, and therefore, the registered manager is not a qualified nurse and there is no need for the information to be signed off by a qualified nurse.
(Care Home Organisation Manager)

This informant's preference was for the registered manager of any service to be 'having the final sign-off'. Regarding the perceived necessity for training for assessors, they believed that those members of the organisation with previous NVQ [National Vocational Qualification] training would find the process familiar and will have developed a relevant skill set. Regarding quality assurance the belief was that this should be a matter for individual organisations rather an overseeing body, as organisations such as care homes are legally obliged to do this. A strong preference was expressed for self-sufficiency in this area, despite the possible negative implications for portability. In terms of resources, we learnt that this organisation wishes training such as the Care Certificate to be 'candidate led' with responsibility for ensuring compliance and completion placed upon the new employee within a 3 month probationary period. The Care Certificate workbook (released in April 2015 by Skills for Health) has already been made available to all staff within this organisation.

The only way of making this sustainable is that all of it becomes provided in house. This is the only sustainable way it can work.

In terms of acceptability of a Care Certificate obtained within another organisation (given this scenario), it was felt that all new staff would be required to complete this organisation's induction process regardless. Nevertheless, evidence of having obtained the Certificate would be weighed alongside the normal process of recruitment.

Care Certificate Trainer

Originally the main area of progress with the Care Certificate in Islington was a two-day programme commissioned by Whittington Health and delivered by City and Islington College starting in July 2014 and continuing monthly since then. This development however revealed some of the inherent concerns in the Care Certificate regarding the key issue of portability. Originally conceived to dovetail with Whittington Health's induction programme, the Care Certificate content was intended to cover only 5 of the 15 Care Certificate standards, the others, it was thought, being included at induction. However, with the CEPN's commitment to providing a single cross-sector Care Certificate and the roll out of this format to organisations other than Whittington Health, it was inevitable that questions began to be asked about its suitability across organisations and sectors. This is reflected upon by the trainer responsible for developing the programme:

Yes, [the training] was based on 5 standards, [Whittington Health] identified which 5 standards they were and we based it around those had been covered elsewhere. What I realised in coming to the wider group [CEPN meetings] is that some of other users do not have the induction programme as broad as the Whittington so I think that there's a need now... I think some of them have been quite clear about they don't really perhaps seen the need for the OSCE³ assessments – it's not something that they would want – they would be more interested in covering the 15 standards, so that's something that we would be looking to do in the future, cause right now, people are piggybacking off this and feeding into it, but it doesn't solve the whole issue; you're just getting 5 standards on day 1 and day 2 is given to OSCE, so I think what we need to have is another day where the other users can tap into – perhaps not the Whittington because they have a robust induction system whereby they will get the assurance that the other standards are covered. So we haven't actually had a conversation with the other.

When you say 'the other', who do you mean?

Oh, I mean in terms of GPs and the care homes – this brief was just originally to deliver to Whittington HCAs, so the assumption was that everybody who attended our two day study programme had already received the induction programme and were proficient in the first 5 standards.

Regarding the issue of quality assurance, the organisation providing the training has its own processes which are followed. However, quality assurance is not the same as portability. A course can be quality assured and still fail to be portable in the sense of having accreditation:

³ 'OSCE' – observed/objective structured clinical examination: common modes of clinical assessment for many health professionals.

We observe some of the sessions. I will observe the session and I have one of the other managers come in and sit down and observe some of the different aspects of the sessions from the start, the interim, the end, and it's evaluated at the end, so we observe, we quality assure through lesson observations, and we've got obviously the sign off from the client to say that it meets the requirements, the objectives that they set it out to. It's currently non-accredited as you know, it's deemed a study day, and the delegates receive a certificate from the college of attendance for the two days. We have qualified nurses that deliver the OSCE assessments... so that is being quality assured by, actual nurses deliver that, so it's not just, you know, qualified health and social care trainers who would, we've got qualified senior nurses that deliver that and then we actually observe the participants carrying out the taking of the measurements and then they're asked a range of questions to check their knowledge and their understanding... based on the quality assurance, we do make changes and feed back in one on one to the trainers about what we observe: we give them a grade and then, if there's anything we feel that they need to change, they do raise that with us and we do get to see the slides in advance and have an input, you know, even in some of the activities and the tasks....

We asked about the perceived impact on participants and the employers and this trainer's response echoes those from managers and, to a certain extent, from HCAs themselves:

I think one of the main things is that they are made to feel valued, the care assistants, they are made to feel that their role is important and they are coming across other people who do similar things in other settings and it makes them that their employers are— some of them have never engaged in this level of training before and it's something that they value and the retention is quite high; I don't think we've had anyone who's turned up for day one, not turn up for day two, the feedback has been extremely positive in terms of what they've learned and so they've learned more about their practices, validating why they do what they do, and I think they just had that validation that perhaps they hadn't had before, and there's this strong sense of, I think they feel appreciated, that's how I'd summarise it, by the employer.

Part of our evaluation involved identifying lessons that participants in this pilot would pass to others. The key lesson that the trainer has is for more careful planning that involves all potential stakeholders with consideration for all stages of the Care Certificate process. The speed of introduction has also been apparent in the comments of managers presented earlier in this report.

...in terms of the advice, I think it's maybe seeing the wider picture – I mean, we didn't see the wider picture; we were given a specific brief, so I didn't really realise that was just part of the sum, but then, had we had a fuller brief, and then maybe we would have asked more questions about

the portfolios, but I just had the impression that they had assessors [in place]... so you've got delegates who come to the two day training programme, have gone away, amassed a lot of evidence and they haven't had any feedback - I don't think they were given very detailed advice as to what should or shouldn't go into the portfolio but we weren't involved with that. Moving forward, we can help rectify that: we can be very specific with the delegates as to what should go in and be specific with the people who will be assessing them, and then we will provide some assistance in advising the Whittington on how to assess the forty [portfolios submitted] and, I think that maybe, perhaps looking back, it was all quite rushed and I think that, yes, to some extent, it's out of our hands, cause we've been given a contract to deliver two days - those two days have been prescribed, right up until May – and they decided to give the Whittington some of their places to others, which is fine, but I think that if we had gone back to the drawing board and said to them, ok, this is what we're doing for the Whittington - and I think it all happened so fast.

At CEPN meetings the topic of how to quality assure the care certificate was also discussed. The intention was for the person responsible for managing the Care Certificate at Whittington Health to examine in detail the fifteen modules with the training organization and decide the kind of evidence required against each element so that there would be a standard around each module irrespective of which organisation the participants are from. The intention was that this would also help those who are assessing. The intention was also to check a sample of assessment documents for consistency. From this would emerge the content for a training day for mentors and 'grandparents' who sign off the HCAs, in order that all are clear about expectations and evidence required for trainees to attain each of the module standards.

Training manager

We interviewed one manager/co-ordinator of training and assessment. Three major issues emerged: the comprehensiveness of the training provided to HCAs outside Whittington Health, uneven understanding of the assessment requirements and capacity issues regarding overall management of the process.

Initially Whittington Health, in collaboration with City and Islington College devised a program for their own support workers that would coordinate with existing induction for these workers. When the training was opened to workers in other organisations who had not received the same induction, an inconsistency emerged which had not been anticipated. Other participants have discussed this. It appears that as of April, 2015 there is still some degree of uncertainty:

The last couple of programmes that I ran, we had taken on some of the GPs' [support workers] – I think it was a little bit difficult for them, because how we did it in the hospitals, this was basically a bespoke programme for

healthcare assistants in the hospital and the community, but mostly in the hospital, so, what we did was looked at what our healthcare assistants did - from within their mandatory training – and looked to see what Cavendish had recommended, so we identified that they already covered 5 of the standards but I found, with involving the GPs recently, that it wasn't that sort of clear cut – yes, they do this as mandatory training – so I think it's been a little bit more difficult from that point of view because our programme doesn't cover all of the 15 standards, so basically, it's bridging the gap between what they do mandatory and what Cavendish recommended, but I'm not sure, I'm not as clear on that with regards to what the care homes and what the GPs do.

Dealing with this problem appears to be at an early stage:

I think probably now that Islington and outside of the wider organisation, we have discussed maybe just covering all 15 of those standards and maybe changing how our HCAs do their training, so rather than doing those standards as their mandatory - e-learning and face to face modules – maybe they could do them all in the one go and that way, they're covered, so yes, all of the 15 standards could be in four study days or whatever, and that way we know that everybody that's completed the programme has covered all of them.

So is that something you're actively considering or is it just an idea?

Yes, it is an idea, it is something that we have discussed...

We asked most participants whether they considered the documentation from Skills for Health/Care and HEE fit for purpose. It emerged that the mechanics of physically adapting the documentation consumed resources and that they were not seen as providing sufficient clarity:

Did you think that those documents were clear, and were they useful?

I think when we first got the documents to work with, we had to format them ourselves, because they all came with all that 'draft' written across them and it was really, really hard to remove that - in fact, it took hours of work to get that off, plus there was nowhere to sign anything, so we inserted the signature boxes ourselves, so when they came, they didn't have anything like that, it was just a plain document but we changed them and formatted them.

In terms of the actual content of the 15 standards, was that clear or ambiguous?

I think the way to be assessed and how they're assessed is open to interpretation and I do think that hasn't been very clear and has caused some confusion for both healthcare assistants and assessors, reflected in

some of the emails and the conversations that I have with people, so they're not really completely sure how to go about meeting the standards because it's just a document which has been given to them with no further explanation.

The documentation was seen as one cause of a time-consuming confusion that resulted in the approach to assessment:

When [HCAs] are given it, I think the way that they're assessed is quite difficult and does cause confusion for people and I think that's reflected in some of the portfolios that I've had returned – you know, some people have just signed off the bare essentials, so this workbook has just been signed off, or some people have provided a folder that's got loads of different certificates in it, but nothing is linking into the various standards, so there isn't a document that necessarily links the evidence to the assessment standards.

The feeling was that the degree of difficulty varied across sectors:

I think, in the hospital environment, people are more familiar with assessing, so they find it a little bit easier. I think most of the issues with assessments are really coming in from care homes and the GPs, from the point of view, who the assessor is, how do they assess, what do they assess.

The small number of assessors from these sectors who participated in this evaluation did not generally talk of uncertainty about assessment, though it could well be that others were uncertain about how to implement this. There was clarity about the level of qualification and specific training needs of assessors.

The assessors are allocated by the manager of the nominating person that has nominated them to the programme and we have said that it should be an RGN and, because we do have a lot of our staff with mentorship qualifications, we have said that it would be somebody that has that qualification, but, because they don't have the same level of qualification in the care homes and GPs, we have said that it would be an RGN.

Lack of clear guidance in advance has led to uncertainty about the assessment requirements which in turn has required remedial action, further use of scarce resources and possibly some stress for participants:

I have met with the practice development nurses in the community, I've brought some of the portfolios with me and I have explained to them, as best I can, with the lack of documents – cause it's the linking of the evidence basically, I think people just don't understand and how to go about assessing the person, because the guidance isn't there.

So what do you about that – do you devise a way of doing it, on the hoof with them?

I have done that, I've tried to in the classroom, with the healthcare assistants themselves, put it across to them – I've brought samples of what looked to be the better examples of portfolios – and I have asked the trainer to focus a lot more on this, to reassure people that this isn't anything that should cause you so much stress and take up all of your time and cause you to worry.

This informant felt that it was too soon to be specific about the benefits of the scheme to patient care however, like others, they believed that attending the Care Certificate has raised the morale of participants:

I think, and from their feedback, they seem to be more team players, networking with staff outside of their units, because a lot of our healthcare assistants, they don't do any training, apart from their mandatory training, and they don't come out of their departments either, so I think from a networking point of view, it's been a positive experience. I think they feel more valued.

Their final point, already referred to above, is that this work represents a major impact on workload, particularly with the problem-solving work involved. Given the backlog of portfolios (a point made by one participating HCA who had received no feedback of an early submission) it appears that the overall coordination of the Care Certificate is barely sustainable at present.

NHS training manager

This interview, unlike others, included discussion of contextual factors to the local launch of the Care Certificate that may have enabled or hindered its uptake across NHS organisations in the borough. The interview also raised a number of issues with the Care Certificate that few other participants discussed. A possibility emerged that not all NHS organisations in the borough may have been aware of the set up of the CEPN, nor of other key decisions in respect of the Care Certificate. It was suggested that urgent attention to clinical work can take priority within NHS trusts. The range of work done by the CEPN was seen as unclear and suffering from mission-creep by some. There was a lack of clarity about the mission of the CEPN or at least communication could have been better and this underpinned an apparent hesitancy to engage with the Care Certificate:

So if we'd been clearer at the start that the LETB's intention longer term was that these [CEPNs] would be the means for the disbursement of large chunks of the workforce development budget - that would have focussed my mind quite clearly about it... the LETB model is let 100 flowers bloom: you know, everyone comes to the table, everyone gets a voice, that's a really refreshing approach in contrast to the command and control we used to have from SHAs, in terms of education and training. But that

means that I'm unclear, within the organisation, who they need to have at those meetings.

More positively, the overall approach to the range of CEPN work, that includes the promotion of the Care Certificate, was seen as well managed:

I think, at a personal level, having [Community Matters] to drive it forward, was a masterstroke because [they have] balanced, quite carefully I think, the consultant's role in terms of moving a development forward, with the need for the stakeholders to take ownership for what's going on in that development, and that's been a very, very useful payoff. So I think that's been masterful in getting lots of people to the table, getting them having conversations, but giving them the ownership of the decisions.

One specific provider's approach to participating in the Care Certificate was cautious:

So [two of our HCAs] will attend the May course just to reassure us that what needs to be covered off for us in our type of trust, is being covered off, in terms of the 15 standards. Our care support workers are in a very, very different context to those in an integrated care organisation like the Whittington and I need to be reassured that they're being adequately prepared for every area of practice.

This caution is against a backdrop of an awareness of unresolved issues regarding the principle of the Care Certificate:

I was at a [workforce planning] meeting - the Healthcare professionals education steering group - the other day, and there was quite a big discussion about the care certificate and expressions of concern around that once individual provider organisations are certificating this for themselves, there is a danger that they will start to reorient the qualification towards their particular needs and you could end up with something that isn't terribly portable. And, secondly, when we think about rolling it out so that all 15 standards are being covered in terms of direct teaching, what that might look like, so it does cover every element of practice in terms of health and social care. You know, it's such a broad spectrum you could end up with teaching interventions at such a level of generality that they might well end up being meaningless.

Key questions about assessment had been considered in this provider:

In terms of the internal assessment, I think that's the nub of the issue. The [senior staff] gave some consideration to this matter. I gave them some options which included: a do nothing option; ask the current nurse mentor to do this work; get the manager - of the new staff who's going to join the team - to do the assessment; or to recruit a team that would look uncannily like an NVQ team... What I suspect we'll do is try to get the

signing off of the standards overseen by the manager that the new care assistant will be joining, and they will have the responsibility, over the 12 weeks, of making sure that the assessment is completed. There's a virtue in that, in so far as the manager will then have that member of staff on their team, so they've got a vested interest in making sure that individual is competent, and there will be specialist elements against the 15 standards they will need to source in terms of the assessment, but ultimately, the responsibility will lie with the manager.

If there is possibility to approach the Care Certificate only in terms of meeting a requirement with the least disruption then this manager was aware of the imperative to approach it in a more fully useful manner:

We're looking genuinely to make a difference in people's practice through encouraging learning in whole range of settings... it would be very easy just to meet the regulation. The danger is, that with this workforce in particular, they have been promised the opportunity for development. There have been countless reports, one after the other, saying that the support workforce is vital to the delivery of care; we need to invest in their development. If we do again, a simple kind of sticking plaster action like this which is just about getting bums on seats, then I think, politically, it's a really unhealthy position. So the bureaucrat in me thinks, this is a simple exercise, just getting people into a room, ticking them off, getting them back into practice, getting them ticked off there and then everything's hunky-dory and I put in my report which says our compliance is 98%. Realistically, if you think about Francis, if you think about Cavendish, you think about the Shape of Caring stuff that's just come out, it's more complicated picture and we would be missing a trick if we didn't include the genuinely education elements that need to be considered in this exercise.

Similarly, the issue of the preparation of assessors, in the context of reducing workforce education budgets and increasing clinical demands, was seen as one that raised difficult issues:

Our business can't currently tolerate that level of training [made up of days and half days off-site]. So whilst, on the one hand, I'm thinking there is a need for some support in this regard, I'm not sure commissioning an FE College to deliver a programme is necessarily going to be the best way of doing it cause I can't see how I'm going to release my managers to go and do that. But that doesn't mean that they don't have learning needs in this area, cause I think they do, and even if we had said, we'll choose our mentors [to be assessors], I still think it's a different process and I still think there's different techniques around this stuff and making the comparison with the old NVQ type assessment,

Finally we returned to the issue of quality assurance in the light of the lack of a national regulator or accreditation body underpinning the Care Certificate.

No-one is going to check that it's being properly delivered within an NHS provider: there's no awarding body; there's no regulatory authority coming to see it; we're not going to be 'Ofsted' about it; all those kind of ways in which you measure the quality of an educational intervention. We get to issue the certificates. Now, I would go on record saying that our [organisation] will be diligent in making sure that we're only signing off those people who are genuinely competent, but recruitment is a hot topic for any NHS provider organisation and getting bodies into spaces is a critical issue, so whether we can be reassured that there is genuinely high threshold, in terms of competence, for each and every provider in terms of the care certificate, is a difficult question, and the fact that there will be lots of people issuing those certificates, making it a cluttered market, where the portability of that is going to be difficult to assess.

The role of the Care Certificate Task and Finish Group meetings

Between December 2014 and April 2015 we attended Task and Finish group meetings where the Care Certificate was the focus of discussion and planning. The emphasis of the meetings was on dealing with issues that arose since the implementation began. This group appeared to be a crucial forum for discussion, clarification and decision-making as key players—from Whittington Health, from other local trusts, the care home sector, the college providing the training, local authority and others—were in attendance. This was particularly important due to the speed and complexity of implementation because, as has already been discussed, unanticipated problems emerged and needed prompt cross-sector remedial action.

The group could also discuss other related policy implementation such as the promotion of apprenticeships.

Where attendance was consistent, progress could be made and shared decisions developed. When attendance was uneven and new members attended or key players were absent, misunderstandings could arise. One such area that emerged early in the process concerned the brief given to City and Islington College for the Care Certificate training and its applicability to other areas. A later issue was the confusion over vocabulary used to describe the Care Certificate assessors. Both of these issues were effectively addressed in subsequent meetings.

The group was also a venue where the vision for an integrated Care Certificate was promoted with the group's chair reinforcing a view of the benefits of this approach whenever the problems arose. Not all problems however, related to portability of content: some related to the scale, complexity and need for consistent procedures, around assessment for example. The group appeared effective when working together to develop solutions. Some solutions, however, were constrained by the policy context, for example those proposed to meet the challenge of standardised quality assurance for delivery and (particularly) assessment across organisations

and sectors. National regulation or accreditation would have addressed this issue more effectively.

Part 2: comparison with other pilot schemes

In late January 2015 we made contact with the individuals responsible for introducing and evaluating similar pilots of the Care Certificate in other London settings: Great Ormond Street Hospital (GOSH) and Barts Health. Unfortunately the lead from Barts Health was not available to provide an update in March/ April.

GOSH: When the GOSH Lead practice educator was contacted in late January, we learned that the pilot had been delayed and had not yet started. An update in April revealed the following:

This trust has completed planning for its implementation of the Care Certificate and plans to start sessions in May 2015. It has been decided to develop a version with content focussed on the client group that characterises this hospital. Our informant believed that the future of the Care Certificate would be one of customised content, and was concerned about the lack of national level quality assurance for the scheme. This has implications for the portability of the scheme. In their implementation registered nurses will act as assessors though senior health care support workers are being prepared to act as supervisors.

Barts Health introduction of the Care Certificate Pilot (as of 28th January):

Barts Health designed and implemented three programmes based on their existing 5 day programme for their Health Care Assistants (HCAs). Like Whittington, when designing the care certificate input they first examined their existing programme to see which of the dimensions and competencies it already covered and built on this.

Their evaluation is being carried out with Himmerton and East London Foundation Trust (ELFT) and in particular the community section of this mental health trust. They set up a project steering group across these two organisations.

The program was delivered from October to December 2014 as a four-day program. Their own program usually included an extra skills day but they removed this from the new shared program so that each organisation could tailor this for their own needs at a later date. They will reinstate this day for their own HCAs. They included reflective sessions at the end of each day.

Barts Health have a large number of new HCAs and the first program was delivered to 40 HCAs. ELFT delivered to 3 new HCAs and from late November to mid-December, Himmerton delivered this to their staff using the program developed by the group at Barts Health.

In terms of paperwork they started with the national competency document and added space for input from assessors and the HCA participating in the course and

for signatures beside each dimension. Their program includes all 15 dimensions. Their process comprises 3 meetings between assessor and candidate. Early feedback suggests that many are failing to complete these assessments.

On 12/13th February they are evaluating the first wave of the programme including ward managers and facilitators in this.

Initial feedback: The programme is running very well with positive feedback. Some existing facilitators are concerned about aspects of the programme as run in dementia services. One suggestion is that some aspects of the assessment be completed in the classroom via reflection. In common with the present evaluation, the implementation of the pilot was very speedy and some staff have not been as well prepared for their assessor role as they could have been given more time. The Barts Health team intended to engage a project lead for this but this was delayed. Their plan, in late January, was to assess as much as possible in the classroom in order to take the pressure away from clinical areas. Initially they planned to use existing nurse mentors as assessors but this was proving difficult as nurses in these roles are already under pressure with other work. Their proposal is to involve senior band 3 HCAs with assessment of their junior colleagues, with a system of key and support assessors. It was hoped that such an approach could provide developmental opportunities for staff in these grades. Other trusts have apparently employed this approach in an attempt to share the pressure of assessment, though this is not considered in Islington.

Discussion

From its inception, the Care Certificate set ambitious expectations. These concern the scale of the challenge to induct the nation's support workforce in health and social care, estimated at over 1.3 million workers with the great majority of these employed by local authorities (Cavendish, 2013) and the desire for the development of a single certificate across health and social care and different organisational models within this, all within the national context of a highly stressed and recently reorganised health service, and also by design, without any national regulatory oversight.

With the above in mind, the experiences reported in Islington, despite highly motivated individuals promoting and implementing the scheme, are not totally unpredictable.

Initially some concern had been anticipated about the willingness of small organisations, such as individual GP practices or individual care homes, to participate and invest in the learning and development of what are in essence professionally unqualified members of the workforce. However, this appears not to be the case (bearing in mind the limitations of this evaluation), and as such, is an unanticipated finding. If training budgets are constrained, attention to the skills level of healthcare and other support workers appears to be a priority for many organisations, large and small. Coupled with this, the offer of the Care Certificate,

carefully promoted and facilitated by CCG links, appears to have been welcomed in these sectors. In addition many of these 'small' organisations are themselves part of larger groups or networks where strategic decisions may be taken. It is worth noting that there was scepticism about the feasibility of an integrated or nationally coordinated scheme from a care home sector informant, with an expectation that the Care Certificate would eventually be delivered in-house. It is also worth noting that few managers and participants made reference to the original drivers for the scheme, namely the Francis and Cavendish reports with their focus on ways to improve and assure the standard of patient/client care delivered by assistant grade workers.

There were differences of view regarding responsibility for the completion of the Care Certificate across different organisations. One training manager in an NHS organisation believed that the responsibility should lie with the manager of the individual support worker because they would be motivated to have the skills and knowledge of their team assured. In the care home sector, the view was that the support worker themselves should be given responsibility to complete the Care Certificate standards in order to successfully complete their probationary period.

The small number of participants of the Care Certificate included in this evaluation considered their involvement to be positive, as did their managers, while assessors reported variable levels of preparation for their role. A pinch point appears to be the examination and quality assurance of portfolios and 'signing off' of these at Whittington Health. It was not clear whether this was a problem of limited resource or of lack of anticipation. One HCA told us about her disappointment at not receiving feedback for her promptly completed assessment documents.

Under the leadership of Community Matters, Islington has persevered with a commitment to an 'integrated' certificate, in the sense of implementing the Certificate within a diverse range of providers. To date those organising and delivering the certificate have been one step ahead of requirements and have sometimes addressed implementation questions and problems as they arise 'just in time' for delivery. The Task and Finish group shows a strong commitment to integration which has proved to be a unifying and motivating force and it seems that the group has developed a good working method with the right people around the table. The involvement, to take one example, of City and Islington College has meant that the decision to offer different levels of training to Care Certificate Assessors with and without formal mentorship training could be agreed and implemented with minimal delay. The maintenance of this forum after the end of the pilot would represent a lasting benefit of this locally integrated approach and may be the only way that the commitment to integration is sustained.

Limitations of this evaluation

The chief limitation of this evaluation is the lack of response from those approached to participate. Our original sampling scheme was not achieved in the Care Home, and Local Authority sector particularly, despite strenuous and continued efforts to engage individuals from these areas. It was particularly disappointing not to gather data from the Local Authority as the Care Certificate clearly represents, numerically

at least, a significant challenge in that sector. Our findings therefore are in danger of presenting only a partial picture. Nevertheless, a strong picture emerged from the interviews we carried out coupled with intelligence gained from the Care Certificate Task and Finish group meetings attended. Better participation may have added detail to our overall findings but we believe would not contradict them. One finding was of NHS and Local Authority personnel under considerable pressure and this is consistent with an apparent inability to respond to our invitations to contribute to the evaluation.

Factors enabling the pilot implementation:

1. Up-skilling the support workforce is on the agenda of many providers because they are already looking for ways to re-profile their workforce to manage increased workflow while minimising increasing costs. They see the Care Certificate as part of that process.

2. Generally workers in assistant grades are highly motivated to take up training that can expand their role and responsibility.

3. Individuals in the CCG who already appear to have good relationships with the sectors that they deal with have promoted the Care Certificate in a targeted way within these sectors and facilitated involvement with it.

4. There is commitment within the CCG and Community Matters to the high-quality implementation of the Care Certificate across the borough and to use it to develop networking and collaboration across sectors and organisations

Factors inhibiting the pilot implementation:

1. The speed of required implementation coupled with competing agendas for individuals within the NHS, and Local Authorities particularly, led to a lack of readiness as well as implementation issues that were not adequately anticipated.

2. The pilot implementation appeared to not include a strategy for adequate and sustainable resource allocation for the coordination and quality assurance of the Care Certificate training.

3. A commitment to integrated cross-sector training in Islington may well have long term benefit and be consistent with the intention of the scheme, but it has led to some initial concerns about portability.

4. The initial guidance documents from HEE, Skills for Health/Skills for Care appear not to have been useful for those evaluation participants who attempted to work with them, risking disengagement and inconsistency.

Recommendations

A dedicated, adequate and sustainable resource needs to be available to coordinate and quality-assure the continuing implementation of the Care Certificate.

Clear attention needs to be given to the design of the Care Certificate so that it meets the requirements for HCAs from different organisations and sectors. This may involve extending its length from two days and developing a system of accreditation of prior learning to accommodate differing induction and CPD in different organisations.

Clear and specific guidance concerning assessment needs to be developed from the latest national documents, agreed to be feasible by all sectors involved, and disseminated across all participating organisations in Islington, along with support for assessors.

Guidance and other documentation from HEE/Skills for Health/Skills for Care needs to be easily usable by local organisations.

Terminology regarding the Care Certificate and the various roles involved needs to be agreed across organisations and disseminated well.

An effective forum for continued discussion across organisations and sectors needs to be maintained to deal with emerging problems and issues and could be essential if an integrated approach is to be maintained.

Appendix 1. Interview schedules for Care Certificate study

(based on questions used in the National Pilot Evaluation)

Overall coordinator for the CEPN

How has the Certificate been implemented in practice?

- _How have employers in different settings (health/social care; large/SME/micro/individual; acute/primary care; residential/domiciliary/day care; urban/rural; different geographies/LETBs; statutory/PVI) implemented the Certificate?

_To what extent does the Certificate appear portable?

- _How was the quality of learning and development assured?

- _What has been the impact of the Certificate on (a) learners (b) employers (c) people who use health and social care services?

- _What are the opportunities for delivering the Certificate across localities/organisations?

The manager or other person with lead responsibility for the Care Certificate in particular organisations

Why did your organization get involved/not get involved in the Care Certificate/not get involved in the Care Certificate?

What is your view of how it is being organised here?

What are the strengths and what do you think could be changed?

Who will be assessors in your organization?

How will you decide who to send?

- _To what extent does the Certificate appear portable?

- _How effective is the guidance for implementation?

- _Who has provided learning for the Certificate (e.g. in-house versus external learning providers)?

How has the Certificate been assessed in different settings?

- _Are there any learning and development needs for assessors?

- _How was the quality of learning and development assured?

- _How long did the necessary learning and development take to complete? How does this compare to prior arrangements for induction?

- _What have been the issues arising and how have any challenges been overcome?

- _What were the resource implications of undertaking the Certificate for employers?

- _What has been the impact of the Certificate on (a) learners in your organization and (b) people who use your services?

An assessor/assessors

- _To what extent did Assessors feel they understood the outcomes required in the Assessor Framework document?

- _To what extent did Assessors feel they were confident that they were able to

make a judgment of the HCSW/ ASCW against the assessment requirements?

- _To what extent did assessors feel that the assessment requirements meet the outcomes i.e. did assessors feel confident that the evidence required was sufficient/ too much/ too little to make a judgment that the HCSW/ ASCW had met the standard?

How has the Certificate been assessed in different settings?

- _Are there any learning and development needs for assessors?
- _Is the guidance for assessors fit for purpose?
- _Can all performance evidence be collected in a real workplace or has some of it had to be collected using simulation (some requirements may need to be simulated)?

Assessment Evidence:

- _To what extent did existing documents/ systems meet the requirements for recording evidence and assessment decisions?
- _To what extent did new documentation/ systems need to be produced to record evidence and assessment decisions?

A trainer/ trainers (both within the organisations and external providers)

Framework content:

- _Is the content of the Care Certificate framework fit for purpose in its current form?
- _To what extent is it universally applicable to the employers and occupations currently within scope (healthcare assistants and adult social care support workers)?
- _If not, what were the specific challenges and for which roles?
- _Were there any areas in the Technical Framework document from Skills for Health etc. where it was difficult to interpret the outcomes or the standard to be met?
- _To what extent did Assessors feel they understood the outcomes required in the Assessor Framework document?
- _To what extent did Assessors feel they were confident that they were able to make a judgment of the HCSW/ ASCW against the assessment requirements?
- _To what extent did assessors feel that the assessment requirements meet the outcomes i.e. did assessors feel confident that the evidence required was sufficient/ too much/ too little to make a judgment that the HCSW/ ASCW had met the standard?
- _To what extent is HCSW/ ASCW version of the Framework understood by workers from different backgrounds and with differing educational standards?
- _Does the workbook provide sufficient coverage of the learning required?
- _Are the questions set clear and unambiguous?

Staff undertaking the Certificate (2-3 in each organisation)

How did you hear about the Care Certificate training?

How was it delivered? E.g. in Induction or separate sessions or both?
How relevant was it for your particular job? Was some content irrelevant?
How were you assessed?
Was it clear what you needed to do in order to be assessed?
What were the good things about the Care Certificate?
What would you change?

A supervisor(s)/mentor(s)

We plan to collect data on enabling factors and outcomes within the following themes (taken from the pilot evaluation):

Can you tell me about local and organisational expectations of the Care Certificate?

Can you tell me about delivery models and how effective you think they have been?

Can you tell me about progress with the Care Certificate to date?

What would you say have been the main challenges in implementing the Care Certificate?

What would you say have been the main outcome and impacts, both intended and unintended?

Appendix 2. The Care certificate standards

1. Understand Your Role
2. Your Personal Development
3. Duty of Care
4. Equality and Diversity
5. Work in a Person Centred Way
6. Communication
7. Privacy and Dignity
8. Fluids and Nutrition
9. Dementia and Cognitive Issues
10. Safeguarding Adults
11. Safeguarding Children
12. Basic Life Support
13. Health and Safety
14. Handling Information
15. Infection Prevention and Control

(Skills for Health et al., 2014a)

Table 1. Overview of evaluation

CONTEXT	MECHANISM	QUESTIONS	INFORMATION REQUIRED	DATA SOURCE	DATA TYPE
Support workers (SWs) employed and working in health care settings	SW Undertake Care Certificate programme (two taught days plus access to other learning materials) and are taught, supervised and assessed in specific practice area	<p>What factors enable support workers to successfully complete the Care Certificate programme?</p> <p>What factors enable employers to support their support workers to successfully complete the Care Certificate programme?</p> <p>What evidence is there to demonstrate that standards achieved are consistent and transferable across areas?</p> <p>What is required to ensure that successful participants continue to demonstrate consistent levels of performance, as measured by the programme?</p>	<p>A. Enabling factors</p> <p>B. Outcome evidence</p>	<p>A maximum variation sample from each of the following groups within health sector:</p> <p>A. the manager or other person with lead responsibility for the Care Certificate</p> <p>B. assessors</p> <p>C. trainers (both within the organisations and external providers)</p> <p>D. staff undertaking the Certificate</p> <p>E. supervisors/mentors</p>	Qualitative Quantitative
Support	SW	What factors			

<p>workers (SWs) employed by and working in social care settings</p>	<p>Undertake Care Certificate programme (two taught days plus access to other learning materials) and are taught, supervised and assessed in specific practice area</p>	<p>enable support workers to successfully complete the Care Certificate programme?</p> <p>What factors enable employers to support their support workers to successfully complete the Care Certificate programme?</p> <p>What evidence is there to demonstrate that standards achieved are consistent and transferable across areas?</p> <p>What is required to ensure that successful participants continue to demonstrate consistent levels of performance, as measured by the programme?</p>	<p>A. Enabling factors</p> <p>B. Outcome evidence</p>	<p>A maximum variation sample from each of the following groups within social care sector:</p> <p>A. the manager or other person with lead responsibility for the Care Certificate</p> <p>B. assessors</p> <p>C. trainers (both within the organisations and external providers)</p> <p>D. staff undertaking the Certificate</p> <p>E. supervisors/mentors</p>	<p>Qualitative Quantitative</p>
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