Three-year evaluation of the Workforce Development Innovation Fund, 2011/12-2013/14
Final Report

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Three-year evaluation of the Workforce Development Innovation Fund, 2011/12-2013/14

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This work was researched and compiled by Holly Krelle and Michael Lawrie of ICF Consulting Services Limited

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Executive summary

The Workforce Development Innovation Fund (WDIF) is a funding stream distributed by Skills for Care. It supports innovative training and workforce development projects across the adult social care sector in England. It was introduced in 2011/12 and, since then, has supported 111 projects, distributing nearly £3 million.

In April 2014, Skills for Care commissioned an evaluation of the WDIF over the three years of its lifetime. The overall aims of this study were to assess: whether the programme met its aims; the outcomes and impacts of the WDIF; and the extent to which projects have been sustained, scaled up, and transferred to other parts of the sector.

Key findings

The WDIF has supported a range of innovative workforce development projects. Between 2011 and 2014, 15,000 people were either trained or directly benefitted from a WDIF project and the Fund has also supported the development of 143 new training courses, and 154 new training packs or resources. There is strong evidence that the WDIF has led to positive outcomes for social care staff; the organisations that were awarded the funding and people who use care and support.

The Fund supported projects with a set of varied aims, as illustrated below.
In addition to nearly £3 million of WDIF funding, the commercial, governmental and third sector organisations supported have themselves provided over £700,000 of cash and in-kind inputs into projects.

The WDIF has also successfully supported projects to develop responses to local or organisation-specific challenges, though these challenges often overlapped with wider policy issues and drivers in the sector. Funded projects focussed on:

- Increasing workforce skills and knowledge of a particular condition;
- Increasing general workforce skills or competencies; or
- Working with Individual Employers and Personal Assistants.

**Innovation in the WDIF**

Innovation, how to define it, and how to fund it, is a complex area. This evaluation framed it in terms of an ‘innovation spectrum’. This sees innovation as a dynamic process, moving from initial idea to scalability and sustainability. ‘New’ ideas (and the evaluation recognises that ideas are rarely entirely new) are only one part of innovation: piloting, improving, scaling and transferring ideas to a new setting, are as important. Each of these stages takes time and planning.

WDIF has funded projects throughout this spectrum. This is sensible, the WDIF provides a small amount of money, over a relatively short time-frame. Projects should not necessarily be expected to move from idea to fully scaled up, transferred project in this time.

**Activities funded by the WDIF**

WDIF project activities broadly fell into three categories:

- Workforce training, developing and/or delivering a new type of training for the sector (85% of projects).
- Piloting of innovative care provision, where projects focussed on delivering a new form of care to people who use care and support. Training social care staff was a component, rather than the main focus of the project (8% of projects).
- Research, generally to improve an organisation’s understanding of the care or training needs of a particular group (6% of projects).

A wide range of innovative products, including training materials (in a variety of formats including e-training, phone apps, films and workbooks), working groups, networks and databases were also developed.

**Outcomes achieved by projects**

Social care staff reported that provision was relevant to their roles, and only rarely overlapped with existing provision. In addition:
- Nearly three-quarters of staff increased their skills, knowledge and awareness;
- Two-thirds improved in their general professional competencies
- Nine in ten reported that the training met their expectations, and was useful and relevant to their role.

For organisations, WDIF projects:

- Led to changes policies, procedures, or ways of working (in a quarter of projects)
- Led to improvements (for grant-holding organisations, social care staff, and the wider sector) in awareness of a particular issue, of the social care profession, or of the grant-holding organisation (a quarter of projects).

WDIF projects also had a positive impact on people who use care and support, generally by increasing the quality of care. The evidence here was relatively anecdotal.

WDIF provides value for money; for every £1 invested by Skills for Care, there is a return of at least £1.88. This is likely to be a significant underestimate of the true benefit - the estimate only includes the benefit accrued from people attending training, within the time-frame of the project.

Sustainability, transferability and scalability

The WDIF is designed so that small amounts of funding will lead on to much bigger projects, with wider application. Reflecting this aim, WDIF projects have a high level of sustainability – around 80% of those interviewed provided some evidence that their project, or elements of their project were sustained. Levels of sustainability were particularly high among charities and Local Authorities.

There are two main models of sustainability. Projects either secure additional funding, or continue at no extra cost. These are shown below. Projects that were not sustained generally stopped because of insufficient funds.

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1 This includes employer cash and in-kind contributions as a ‘cost’ of the project.

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Around two-fifths of projects provided evidence of activities being scaled or transferred in some way. There were three main models of this. Projects either offered their training to new groups, delivered the same training but on a larger scale, or adopted a simple ‘cascade’ model where participants passed on learning within their organisations. These are illustrated below.

While levels of transferability and scalability are relatively low in comparison to sustainability, this is not unexpected, and partly reflects where projects are on the ‘innovation spectrum’. Where projects are just developing or piloting a new idea, they might not yet be ready to transfer or scale it up. This was the area where projects reported that there was the most scope for Skills for Care to improve their support.

**Programme and project management**

The majority of organisations awarded funding in the WDIF were already somewhat engaged with Skills for Care, and use their resources. Views on the application process
were mixed; where projects were less positive, they were generally less accustomed to applying for Skills for Care funding

Three main themes are evident in defining ‘what worked’ with project delivery. These related to: planning and project management; project design; and partnership working.

**Recommendations**

Based on the evidence from this evaluation, there are nine recommendations for the future.

**Recommendation 1**: Given the outcomes generated, the high level of additionality, and the return on investment, Skills for Care should continue to disburse a portion of the Workforce Development Fund made available by the Department of Health, as the WDIF.

**Recommendation 2**: The management team should ensure that the scope of the programme – in terms of the organisations and activity types funded – remains wide.

**Recommendation 3**: Skills for Care should clarify the bidding process for the Fund. In particular, Skills for Care should consider how to clarify some of their requirements, bidders (particularly from small organisations) sometimes reported misunderstanding these.

**Recommendation 4**: Skills for Care should promote the WDIF more widely to improve the uptake of the WDIF amongst organisations less well linked to Skills for Care. This could also include focussed marketing to the residential sector. Skills for Care’s partners in particular parts of the sector could also be asked to promote the Fund.

**Recommendation 5**: the WDIF programme team should identify where projects are targeting harder to reach beneficiaries and offer projects additional support, or ensure that they have allocated sufficient time and resource.

**Recommendation 6**: the WDIF programme team should provide more guidance on how to estimate in-kind contributions, and highlight to funded projects why this is important.

**Recommendation 7**: the WDIF programme team should simplify and clarify what projects should report in output tables. This could include separating out the development and delivery of training courses and resources; clarifying what ‘numbers’ means; and distinguishing between accredited and non-accredited training, and managerial and non-managerial trainees (Table A6.1).

**Recommendation 8**: Skills for Care should ask projects to be more specific about how they will sustain or scale up their projects on the initial application form. Locality Managers should highlight sustainability in early discussions. Guidance should include examples of how projects have sustained their activities after the WDIF support is finished.
**Recommendation 9:** The WDIF programme team should more actively collect any resources, toolkits and other products of the funded projects. Skills for Care should ensure these products are shared on the 'Learn from Others' web resource.
1. Introduction and methodology

1.1 Aims and objectives of the study

This study aimed to evaluate the WDIF over its lifetime, assessing whether the programme is meeting its aims, to evaluate the sustainability of outcomes achieved, and to assess the overall impact of the WDIF on innovative good practice in the social care workforce. The study will also produce case studies to share on the Learn from Others web resource.

The more specific research questions of this evaluation are as follows:

- What was the background and rationale for developing the WDIF?
- How well did programme design fit with aims, objectives and needs?
- Were the priorities set the right ones?
- How effectively has the programme responded to changes in context over the last three years?
- How effective is the process of priority setting, programme design, administration and disbursement?
- What has the programme achieved over the last three years?
- Who/how many has the programme reached?
- What innovative products and services have been developed through the support of the programme?
- How sustainable are the outputs of the programme?
- How effectively has learning been disseminated/shared elsewhere in the sector?
- To what extent have new approaches been mainstreamed?
- What has been the impact on employers, including individual employers?
- What has been the impact on the workforce?
- Is there any evidence of impact on people who use services?
- What is the additionality of the programme?
- What is the return on investment?
- Does the programme deliver value for money?
- What recommendations can be made to ensure that the programme maximises its value going forward, in terms of developing and sharing innovative good practice in social care workforce development?

1.2 Method overview

This study had two stages. The scoping stage included: analysis of all 111 projects’ self-evaluations to draw out common data on inputs, activities, outputs and outcomes...
and interviews with key programme stakeholders. Alongside this, the project also gained approval from the Social Care Research Ethics Committee (SC-REC) and ADASS. Findings from the scoping stage informed the design of the fieldwork.

The fieldwork consisted of:

- 39 interviews with project grant-holders, covering 49 projects (see Annex 2 for a list of projects; Annex 4 for the projects broken down by activity, size of project and year). All projects were contacted and asked to take part, with minimum sampling criteria used to ensure that a mix of project activity types, project size, and project year were engaged. All sampling criteria were met, apart from the number of 2011/12 projects, (seven projects contributed, instead of eight). Interviews were thematic and semi-structured.

- 68 interviews were conducted with beneficiaries, covering 33 projects. Of these, 37 interviews (from 23 projects) were with direct beneficiaries of training projects, and therefore were conducted with survey style questions. This is not a representative sample; as such, findings from the beneficiary survey and other beneficiary interviews are used to supplement findings from the grant-holder interviews to add depth and insight, rather than as stand-alone information on the Fund (see Annex 2 for a list of which projects beneficiaries are from).

- 15 of these projects were then written up into case studies showcasing best practice. These will be uploaded to the Learn from others web resource (see Annex 3 for a list of case studies).

The findings from the grant-holder interviews were analysed thematically. Coding was used to pull out key themes from the interviews and construct a coding framework that was applied across all interviews. Non-direct beneficiary/wider stakeholder interviews were analysed thematically alongside the grant-holder interviews. Interviews conducted with direct beneficiaries of training projects were also analysed thematically.

Value for Money analysis was conducted using information from all 111 projects’ self-evaluations. It compared Skills for Care’s investment to the monetary benefit from the training interventions, alongside employer cash and in-kind contributions. A full methodology is available in Annex 5.

The main methodological limitation related to the fieldwork with beneficiaries. The protocol agreed with the SC-REC meant that project researchers were unable to contact beneficiaries directly, and were instead reliant on grant-holders to chase beneficiaries. This has limited the number of beneficiaries surveyed (although a sufficient number were engaged to be included in the analysis). Given the varied nature of the activities.
of the Fund, it also became clear that many beneficiaries were able to take part in an interview, but were not doing so as a training beneficiary. Many of those interviewed as a beneficiary had, for example, contributed to the management of the project as well as benefiting in some way from the training. These individuals were still interviewed; the findings are included in the general thematic analysis, but not the analysis of survey responses.

1.3 Structure of the report

This report is arranged in eight chapters:

- Chapter 1 introduces the evaluation;
- Chapter 2 outlines the context and rationale to the Fund;
- Chapter 3 details the inputs to the Fund from Skills for Care and grant-holding organisations;
- Chapter 4 outlines findings on the activities undertaken, and the outputs achieved;
- Chapter 5 outlines findings on the outcomes of the programme, including economic analysis;
- Chapter 6 outlines findings on the sustainability, transferability and scalability of the Fund;
- Chapter 7 outlines findings on the management of the programme and individual projects;
- Chapter 8 outlines conclusions and recommendations.

These are supported by eight annexes, covering: the logic model and evaluation framework; a list of grant-holders interviewed; a list of case studies; the sampling frame for the study; a method statement for the economic analysis; a suggested new table for collecting output data; detail on the ‘Diffusion of Innovation’ theory; and the research tools.
2. Context and Rationale

Summary

- The WDIF funds innovative, small scale projects in social care. Projects should be sustainable, scalable and transferable.

- The WDIF has evolved since 2011, and Skills for Care has taken a more active role in defining the focus of projects. The WDIF has responded well to changes in context over the years. Predominantly, this is because most projects are driven by organisations themselves, in direct response to emerging challenges.

- Project aims are most commonly developed in response to a pre-existing need in the sector. Most projects had multiple aims, related to a range of fields.

- Project activities fell under three overarching themes: increasing the workforce’s skills or knowledge of a particular condition; increasing general workforce skills or professional competencies; or Personal Assistant (PA) and Individual Employer (IE) were targeted. Within these themes, the WDIF targeted a wide variety of different conditions and competencies. Social care staff’s reasons for taking part in projects reflected these overall themes.

- Most commonly, projects reported that the ‘innovative’ aspects of their projects were the learning techniques employed, or the approach taken to relationship-building. There are some limitations to these definitions.

- WDIF supports projects throughout the innovation spectrum; including those just testing out new ideas, right through to those trying to scale up, or offer training to a new group. This diversity is a positive feature. Project aims and risks will vary throughout this spectrum.

2.1 Skills for Care supports the adult social care sector by managing and distributing a number of funds

Skills for Care plays a central role in supporting the development of the adult social care workforce through the distribution of funds for training, collection and maintenance of Labour Market Information (LMI), and supporting the development of qualifications, training resources, and solutions to key workforce challenges such as poor retention rates. One of the organisation’s key roles for several years has been to manage and distribute funds through the Workforce Development Fund (WDF) and prior to that the
Training Strategy Implementation (TSI) fund. The WDF supports employers in the adult social care sector to invest in workforce development and, in particular, to gain units and qualifications from the Qualifications and Credit Framework (QCF). In both 2012/13 and 2013/14 the WDF distributed over £8.7m to employers.

In 2011/12, the Department of Health, with Skills for Care, conceived of a second fund – the Workforce Development Innovation Fund – which would distribute funding to the sector to support innovative projects which were unlikely to receive funding from other sources. As one stakeholder reported this fund was designed to provide: ‘Smallish amounts of money to encourage innovative ways of developing workforce’.

The main differences with the WDF are that the training it funds should be delivered to a new or under-resourced part of the workforce, and that outputs are not restricted to qualification units. The WDIF was also designed to fund the development of new training resources and tools, and non-training workforce development activities such as research into innovative service provision or piloting new approaches to delivery.\(^2\)

### 2.2 The WDIF supports innovative training and development activities in the adult social care sector

The WDIF aims to support innovative training and development activities in the adult social care sector. The Skills for Care website states that in the WDIF:

> ‘Innovation is defined as applying new and creative ways of working to learning and development within the workplace. Some projects may include the use of technology to support cost effective approaches to learning and development.’\(^3\)

Stakeholders and programme documentation note that projects should be:

- **Scalable.** If there is evidence of positive outcomes, the solution / approach could be scaled up to be used in a greater number of settings, or delivered to a greater number of people.

- **Transferable.** If there is evidence of positive outcomes achieved, the solution / approach could be utilised in a different context, for example, a different sub-sector, service area or geography.

\(^2\) Recently a third funding stream has been set up. This will distribute funding to Individual Employers (IEs) to spend on their own development, or on that of their Personal Assistant (PA) staff. Again this funding stream aims to channel support to parts of the adult social care workforce which find it difficult (practically) to access training or for whom other sources of funding for development activities are scarce.

- **Sustainable.** If there is evidence of positive outcomes achieved, the solution / approach could be sustained, potentially by receiving support from an alternative funder or to be supported by the employer, or through commercial sources.

Transferability and scalability are difficult to achieve in the social care sector. This is because employers from the private, voluntary and independent sector (PVI) (alongside independent employers) form the largest proportion of the overall sector. Hence, any innovations they develop (such as a new approach to training their staff) will be a competitive advantage. As a result, they may be less likely to share their learning / any products with other employers. One stakeholder compared this to the health sector, noting that innovations developed by one Trust could (theoretically) be shared with other Trusts, providers or commissioners to improve patient care. Social care organisations were reported to be more disparate, have limited links to one another, and may differ significantly from each other in how (and why) they deliver services. This fragmentation is a significant barrier to sharing knowledge and tools. It also means that publically-funded schemes (such as WDIF) are particularly important.

Funded projects should also:

- Deliver demonstrable business benefits and service quality improvements.
- Deliver tangible resources or products which are developed and tested as part of the project and provided to Skills for Care when the project ends. Stakeholders highlighted the importance of projects’ outputs being practical and able to be used by other employers, rather than simply being uploaded to a website and not used.
- Result in an evaluation report which describes the project approach and lessons learned from delivery. Along with developing scalable, transferrable and sustainable resources, the WDIF should develop a knowledge base on the sorts of investments that yield particular outcomes and the contexts / circumstances in which these outcomes are achieved. This knowledge base should inform future WDIF funding decisions as well as future investment in innovative activity in the social care sector.

The logic model for the WDIF is in Annex 1.
2.3 WDIF funding criteria have evolved since 2011/12

The design of the WDIF has been iterated over the three years of its existence. In the first year, it was seen as a subset of the wider WDF. No funding themes were identified. Instead, Skills for Care Locality Managers were asked to highlight to employers and other stakeholders that resources were available for innovative workforce development activities (which was defined quite broadly at that stage).

Over the next two years of the Fund, Skills for Care developed a set of funding themes (see Table 2.1) to shape the sorts of bids they received, as well as being clearer about the sorts of outcomes that projects should achieve. This new approach was taken – partially – to ensure that the activities supported by the WDIF reflected Skills for Care’s business plan and key Department for Health policy priorities in the sector.

The differences between the two years’ criteria are minimal, though the 2013/14 is slightly more prescriptive (for example in 2012/13 the Fund requested bids to develop, ‘Cost-effective approaches to delivering learning and development’, while in 2013/14, the Fund requested bids which would use, ‘Technology to support cost effective… learning and development’).

Table 2.1: Funding themes by year

<table>
<thead>
<tr>
<th>2012/13 Funding Themes</th>
<th>2013/14 Funding themes</th>
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<tbody>
<tr>
<td>Overcoming current barriers in commissioning, accessing or delivering training</td>
<td>Overcoming current barriers in workforce commissioning, accessing or delivering learning</td>
</tr>
<tr>
<td>Delivering or accessing skills requirements that are essential in meeting the future needs of adult social care employers, employees and people using social care services</td>
<td>Delivering improved quality for people who use services through the further development of skills, behaviours and embedding of person-centred values in the adult social care workforce</td>
</tr>
<tr>
<td>Cost effective approaches to delivering learning and development and continuing professional development</td>
<td>Use of technology in supporting cost effective approaches to delivering learning and development and continuing professional development</td>
</tr>
<tr>
<td>Skills and qualification development which support prevention and early intervention through health and social care integration.</td>
<td>Skills developments and qualifications which support prevention and early intervention through health and social care integration.</td>
</tr>
</tbody>
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### Table 2.2 Funding priorities by year

#### 2011/12 funding priorities

Skills for Care anticipated that examples might include projects that:

- Utilised new, cost effective and innovative approaches to commissioning and delivering training and development
- Undertook workforce development in new and emerging market segments
- Used Government initiatives and policies to shape workforce development strategies to ensure that training and development carried out was in preparation for meeting the needs of the future adult social care workforce
- Were leaders in supporting the development of new and emerging roles or methods to deliver services in the sector
- Innovated in relation to partnership.

#### 2012/13 funding priorities

In 2012/13 SFC highlighted the following three funding priorities:

- Emerging or hard to reach areas of the workforce, for example, Personal Assistants and individuals who directly employ their own care and support staff
- Continuing professional development for example, QCF award and certificate qualifications in specialist skills, for example, activity provision, stroke care management
- Person-centred approaches that focus on dignity and respect.

#### 2013/14 funding priorities

In 2013/14 SFC highlighted the following six funding priorities:

- Continuing professional development for example, QCF award and certificate qualifications in specialist skills, for example, dementia care, end of life care, diabetes, stroke care management, activity provision etc.
- Developing innovative approaches to the delivery and assessment of health and social care qualifications
- Continuing professional development to support registered and front line managers
- Person centred approaches that focus on dignity and respect
- Emerging or hard to reach areas of the workforce, for example, Personal Assistants and individuals who employer their own care and support staff
- Workforce development which focuses on an asset-based approach.
2.4 Project ideas are predominantly driven by organisations themselves

As it has developed, the WDIF has become more prescriptive in its themes and priorities. Despite this, it remains an open programme, offering significant scope for projects to develop a project in line with their own needs. Given that the programme aims to foster innovative solutions to workforce challenges in the sector, encouraging this bottom-up approach would seem a sensible approach – innovative ideas are likely to be fostered in response to organisational-level, local challenges (though of course these may also be reflected elsewhere). This is discussed further in section 2.7.

Reflecting this, the majority of projects developed their ideas for projects based on local issues, rather than in direct response to one of the Fund’s themes. Although there was sometimes overlap (for example, many projects were designed to meet skills requirements, or improve person-centred care), this generally indicated that both the WDIF and projects were responding to wider sector needs, rather than one to the other.

Grant holders reported that projects were developed in response to issues. These issues came from three sources:

- To meet a pre-existing need within the sector;
- They built on organisation-specific projects or issues; or,
- They were developed following suggestions from other organisations.

The majority (around three-fifths) of projects were developed to meet an already identified or pre-existing need within the sector. Some of these projects were made aware of the need through stakeholder engagement, or the organisation’s current work within the sector, while others saw the need to further drive recent policy development and/or fit in with (or challenge) Local Authority agendas (see the box below). Other organisations developed projects to coincide with the move towards greater diversity of social care delivery methods, or the integration agenda. For example, one project, building on prior work done on the integration agenda, wanted to further improve information exchange between health and social care, to contribute to a smoother overall patient experience.
Developing projects to meet local needs

One project developed a brokerage training course. Independent brokerage supports individual employers to manage their own budget independently of the council, thus avoiding council influences which may encourage them to be more risk averse, or to take the cheapest options. Prior to the recession, this was a well-resourced area (as part of wider policy encouraging increasingly personalised services), however the project team felt that local authorities are increasingly seeing independent brokerage as a challenge to their work, and there is therefore a need for independent organisations to encourage its use.

Around one fifth of projects built on previous project work or specific scoping work carried out by the organisation, and only about a tenth of projects were developed after being asked by other organisations or individuals, or because they were able to tap into other funding sources. For example, two projects (one from a charity, and one from a care home) developed their projects following feedback from CQC reports (relating to a lack of stroke awareness, and poor medicine management systems respectively).

A few projects developed their projects to coincide with a number of these factors. For example, one Local Authority had been considering their project for a while and had access to an additional £4,000 of funding. Alongside this, their local End of Life commissioner was looking for an accredited end of life care course, following the issues with the Liverpool Care Pathway.

2.5 Project aims were varied

Projects were varied, with individual projects tending to report more than one aim. These aims fall into nine categories, grouped in Figure 2.1 below.
These aims broadly fit those of the WDIF (set out in Table 2.1). For example, ‘overcoming current barriers in commissioning, accessing, or delivering training’ is covered by four-fifths of projects. Other themes are covered infrequently. For example, few projects explicitly focussed on the use of IT to deliver cost-effective training; while some projects did this, it tended to be a way of achieving or facilitating a wider aim related to improving skills in a particular area. Similarly, only a couple of projects focussed on improving health and social care integration. Though this is a big issue (attracting many projects and funding) in the health sector, it appears it is not on the radar of many social care organisations.
2.6 These aims were translated into a range of project activities

These aims led to a range of activities, delivered across the adult social care sector – in domiciliary, day and residential care. Broadly, three over-arching themes in the types of activity undertaken are evident. Within these themes, projects targeted very varied conditions, skills and competencies (Figure 2.2). A more detailed analysis of the activities undertaken within these themes is in Chapter 4.

**Figure 2.2: Project activities**

- **Increasing workforce skills or knowledge of a particular condition**
  - Autism
  - Learning difficulties
  - Dementia
  - Understanding of the mental capacity act
  - Diabetes
  - General health and wellbeing

- **Increasing general workforce skills or professional competencies**
  - Mentoring
  - Use of assistive technology, e.g. telecare
  - Administering medication
  - Leadership and management
  - Safeguarding
  - General customer service
  - Activity provision

- **Personal Assistant or Individual Employer targeted**
  - PA skills
  - IE skills, and understanding of role as an employer
  - Networking for PAs and IEs.

These themes were reflected in social care staff's reasons for taking part in a WDIF project

Most commonly, social care staff reported that they took part in training to generally increase their skills or knowledge in relation to a particular condition or group (just over half), or to generally increase their professional competencies (just over two-fifths). Just over a third also reported taking part to address a specific gap in their knowledge, skills or professional competencies. More specifically, care workers reported a desire ‘to sharpen skills’, or update knowledge, as well as to improve the quality of care that they offer.

For most, either the content and/or the style of training was new to them. Around half reported that they had never undertaken training like this before, and only a few reported that they had undertaken similar training before:
‘I had never done training like this before, had done medication training, but this generally focussed on administration rather than the processes that surround it.’

‘I had done some similar telecare training before, but have never done any coaching-style training.’

2.7 Defining ‘innovation’ can be challenging; one solution is to view it as part of a process

Innovation, how to define it, and how to fund it, is a complex area. Numerous models are available which try to understand both what ‘innovation’ is, and how it develops from an idea, through to a fully sustained programme. One way to deal with these definitional challenges is to view innovation as part of a process, with ‘innovation’ being defined differently at different stages. One useful model for this is the ‘innovation spectrum’ (Spring Consortium, for the Department of Education, 2014⁴). This frames innovation as a dynamic process, moving from the initial idea to scalability and sustainability. ‘New’ ideas (and it recognises that ideas are rarely entirely new) are only one part of innovation: piloting, scaling and improving are as important (Figure 2.3).

*Figure 2.3: The innovation spectrum (adapted from the Spring Consortium 2014)*

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Several WDIF projects provide have illustrated this process. For example, a hospice took an end-of-life training programme (developed in-house as an alternative to the Gold Standards Framework\(^5\)), and mapped it across to the QCF. They had (prior to the WDIF) developed an ‘innovative’ training programme (developing ideas), they had tested and refined this, identifying accreditation as a possible area for improvement (test and improve), and were now working with a new group of individuals (social care workers) to deliver this training, and scaling their work through a train-the-trainer programme (scale and spread).

However, most WDIF projects are unlikely to run through this entire spectrum in the course of the funding period – the funds awarded are small, and a year is a short length of time. Perhaps reflecting that, there are WDIF projects at all three stages of the spectrum. Given the limited amount of funding available in social care, this seems sensible; there would be little point in funding only the very early development of ideas, if there was then nothing available to test and scale up these outcomes. Similarly, whilst transferability and scalability are a key aim of the Fund, Skills for Care must be cognisant of the fact that you cannot scale and spread ideas, without first investing in developing them.

Projects at different stages of this model should have different rationales, aims and risks

Adopting this model has implications for the selection and monitoring of projects. Chances of failure are (probably) highest towards the start of the scale. An acceptance that some projects will not succeed is crucial to supporting innovation. In addition, it is not good practice to jump straight from fostering new ideas to scaling up and transferring. Projects need time to work through and refine their ideas, otherwise, what is developed may not be evidence based, and may not be tailored to local settings. Skills for Care may have a role in checking that, where projects intend to go from idea to scale, they have fully thought the steps to achieving this. Key questions to ask at each stage include:

- Developing ideas: Is this really a problem? Is this the right way to address this problem?
- Test and improve: Is the innovation leading to the intended outcomes? In what ways could it be improved?
- Scale and spread: Will this work in other settings, with other organisations, and in different parts of the sector? Will this work with different target groups? If so, what changes need to be made?

\(^{5}\) An established training programme in end of life care.

Three-year evaluation of the Workforce Development Innovation Fund, 2011/12-2013/14 20
Throughout, ‘newness’ should not be over-emphasised, as successful projects respond to a clear need, often tweaking or altering something which already exists. While the scope for radical improvement might be less with these projects, the likelihood of developing a successful, and implementable product is higher. Innovation isn’t just about having an idea; it’s about an idea which people and organisations will engage with, find useful, and use.

2.8 Innovation was most commonly defined by projects in terms of relationship-building and the use of new learning styles

In interviews, and in application forms, projects were asked to consider in what ways their projects were innovative. Just over half of projects interviewed thought that the relationship-building aspects of their projects were what made them different from existing products or training programmes. For example, one local authority reported that the user-led nature of their work, and the fact that it spanned several boroughs, was what made it innovative.

Similarly, around half of projects thought that it was the use of new learning techniques that made their work innovative. For example, one project (run by a care provider) felt that it was their use of ‘reflective learning’ techniques, together with their tailoring of qualifications to be relevant to junior members of staff and managers, which made it innovative. Another project thought that training that did not require IT was an innovative approach, while using coaching and mentoring (a technique that arguably not many managers are aware of) was seen as the innovative aspect of several Local Authorities’ projects.

About two fifths of projects offered some form of accredited training and making existing courses part of a QCF qualification was often viewed as an innovative aspect of projects. Another Local Authority felt that their project differed from existing projects due to the combination of short individual training courses they offered, which together led to the achievement of a Level 2 or 3 QCF qualification.

Roughly one third of projects identified the spreading of information more widely, faster or through a new medium and tackling a new subject matter/topic as what made their projects so innovative. Two charities argued that, when developing their projects, there were no other courses currently available that covered those topic areas, with the latter stating that, ‘If there was ‘off-the-shelf’ [available] we would have bought it’.

There are three key issues with projects’ definitions of innovation

There are three issues with the ways that projects described themselves as innovative. Firstly, projects rarely consider in detail why their projects are innovative. Grant-holders
would often report that their projects were innovative because they were offering a ‘new’
type of training, without exploring what was new, or unusual about it.

Secondly, and linked to this, projects often mentioned ‘new’ types of training or posts,
which were also seen elsewhere (for example, the use of coaching and mentoring, the
development of PA networks). The repeated offering of the same ‘new’ idea is not
entirely unreasonable. Social care is a fragmented sector so it makes sense to try out
new ideas in multiple locations, then transfer and scale up – as the innovation spectrum
suggests. However, there are questions where projects are funded on repeated years,
in similar sectors. For example, two activity co-ordinator projects were funded in
2012/13, and a further two in 2013/14.

Lastly, there is a question of timing; where projects were developed in response to a
challenge (and often an idea) that an organisation already faced, this raises the
question of whether the WDIF is stimulating innovation, or just providing funding for
existing ideas to be mainstreamed. The innovation spectrum also addresses this issue.
All [good] innovation develops in response to a clearly defined challenge or issue.
Where plans or ideas are already in place, this simply suggests that projects are further
along the spectrum, which is no less valid. The key for WDIF is to ensure that they are
funding the full breadth of the spectrum.
Summary

- The WDIF has invested nearly £3million in 111 projects, over three years. This funding has been awarded to commercial, governmental and third sector organisations.

- Projects were funded throughout England. Broadly, the funding reflected the distribution of the adult social care workforce.

- Projects were most often run by not-for-profit providers and Local Authorities. Not for profit providers also received the largest proportion of funding (around a quarter of the total funding - £750,000), non-provider charities and employer-led organisations the smallest proportion.

- WDIF funded an over-representation of projects in adult community care, compared to the distribution of the workforce nationally. It funded an under-representation of projects in residential care.

- Average funding award varied by organisation type. The largest average awards went to not-for-profit providers (average £45,000), and the smallest to employer-led organisations (£14,000) and Local Authorities (£19,000).

- Around a third of projects provided additional cash inputs into their projects. On average, these amounted to £3,000 per project. Additional cash contributions were most often made by for-profit providers, and least often by Local Authorities.

- Around half of organisations provided in-kind contributions (estimated from self-evaluations). However, interviews showed that almost all projects provided some form of in-kind contribution, but were unable to estimate the value of this. Even including only those projects which had assessed the monetary value of their in-kind contributions, these were larger than total cash contributions from all projects.
3.1 WDIF has invested nearly £3 million in 111 projects, over three years

The WDIF has invested nearly £3 million supporting 111 different projects between 2011 and 2014. Table 3.1 shows that the total annual amount awarded has nearly doubled between 2011/12 and 2013/14. Nearly £1.3 million was awarded in 2012/13, compared to £8.7m for the WDF, and £1m for the IEs Fund.

The mean award amount has also almost doubled between the first year of funding in 2011/12 and 2013/14. The maximum award amount has increased year on year; from £40,000 in 2011/12, to over £100,000 in 2013/14.

Table 3.1: Number and value of projects, per year

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Projects</th>
<th>Total amount awarded</th>
<th>Mean amount awarded (and range)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011/12</td>
<td>33</td>
<td>£546,816</td>
<td>£16,570 (£1,410 - £40,000)</td>
</tr>
<tr>
<td>2012/13</td>
<td>46</td>
<td>£1,282,543</td>
<td>£27,881 (£3,000 - £88,680)</td>
</tr>
<tr>
<td>2013/14</td>
<td>32</td>
<td>£1,049,086</td>
<td>£32,784 (£4,800 - £106,682)</td>
</tr>
<tr>
<td>All</td>
<td>111</td>
<td>£2,878,444</td>
<td>£25,932 (£1,410 - £106,682)</td>
</tr>
</tbody>
</table>

3.2 Projects were funded throughout England

The largest proportion of successful applications came from the Midlands, representing almost a third of successful project bids. Each other region accounted for around a sixth of total successful bids, with the exception of Eastern England, which only accounted for 7% of successful bids. These proportions largely reflect those seen across all applicants; no one geographic area was more (or less) successful at receiving funding. 45 of the original applicants were from national organisations; of these, 15 were successful in gaining funding.
The proportion of applicants (and successful applicants) appears largely to reflect the size of the workforce in each area (Figure 3.1). There are some discrepancies. For example, London and the south east (LSE) reflects a quarter of the workforce, but only a fifth of successful applicants.

**Figure 3.1: Geographical spread of projects 2011-2013 (successful applicants) compared to the size of the adult social care workforce in each geographic region (NMDS 2011)**
3.3 Funding was awarded to commercial, governmental and third sector organisations

Funding was awarded to a range of different organisation types, from the commercial, governmental, and third sector. The most common recipients for funding were not-for-profit providers (25 projects, 23% of the overall list of recipients), followed by Local Authorities (20 projects, 18%), and for-profit providers (16 projects, 14%), plus nine from Community Interest Companies (CICs) (8% in total).

Figure 3.2: Percentage of projects by lead organisation type

There is some variation in the types of organisations funded each year with, for example, not-for-profit providers particularly prevalent in 2013/14. Conversely, the numbers of employer-led or membership organisations (including training associations), for-profit providers, local authority agencies and non-provider charities, all fell between 2011 and 2014. The variation in organisations funded is a strength of the WDIF, and suggests that the Fund is successfully supporting projects from throughout the adult social care sector.
Total funding varied by organisation type

Figure 3.3 shows that by far the largest portion of WDIF funding (accounting for around a quarter of the total, nearly £750,000) was awarded to not-for-profit providers. For-profit providers, local authorities, local authority agencies and CICs all received between 10-15% of the total funding. Non-provider charities and employer-led/membership organisations received smaller quantities.

Figure 3.3: Total funding per organisation type

The average award size also varied by the type of organisation. The largest average award size went to not-for-profit providers (£45,000), and the lowest to employer-led organisations (just under £15,000).

Figure 3.4: Average funding by organisation type
3.4 There is an over-representation of projects in adult community care, compared to the distribution of the workforce

Projects were funded in adult residential, adult domiciliary and adult community care. A very small number were funded in ‘adult day’ care.\(^6\) Almost three quarters of successful applicants were from community care, while only 19% were from adult residential (excluding the category ‘other’ from the analysis) (Figure 3.5). Comparing this to the proportions of total applicants, this shows that more adult community care services put in a successful bid (51% of applicants, but 61% of successful applicants), than did adult residential services (32% of applicants but only 19% of successful applicants). The proportion of adult domiciliary and day services remained the same for successful bids compared to total applicants.

\(^6\) Over half of projects were classified as ‘other/ unclassifiable’. These included projects which did not fit in the three categories above (e.g. they were employer alliances/ partnerships), and those for which there was not sufficient information available from project MI to classify them (for example, they were run by an employer operating multiple sites, but the project description did not indicate which setting this project would be in.)
Figure 3.5 compares successful applicants to WDIF to the size of the social care workforce working in each type of adult social care service. There are clear differences; notably, there is a significant underrepresentation of the adult residential sector, and a large overrepresentation of adult community care. Whilst the categorisation of the WDIF projects is necessarily an estimate – many do not map neatly on to the NMDS categories (nearly half the projects are classified as ‘other’ and excluded from the analysis) – this is still a notable finding. It could suggest that organisations working in community care are more open to innovation, and to thinking up and piloting new ideas. It could also suggest that the adult residential sector, despite the issues it is currently facing, is not piloting much innovative activity. Skills for Care may want to consider doing more targeted marketing in the residential sector.

Figure 3.5: Spread of 2011-2013 projects by type of adult social care service (successful applicants, excluding ‘other’), compared to the size of the adult social care workforce (NMDS-SC 2012)
3.5 Employers made additional cash and in-kind contributions to their projects

Over £700,000 of employer input has been made to projects in addition to the nearly £3 million WDIF funding (see Table 3.2). This is around 40% of the WDIF award for these projects (including only those making their own contributions). This included £325,000 in additional cash contributions from the projects’ organisations, and £410,000 in additional in-kind contributions.

Only around one-third of projects (34 in total) made additional cash contributions to the WDIF fund – on average, £3,000 per project which made a cash contribution.

Around half of projects (57) reported providing in-kind contributions; 46 of which quantified this amount. Where they were provided, in kind contributions averaged £4,096 per project.

Table 3.2: Cash and in-kind contributions

<table>
<thead>
<tr>
<th>No. providing additional contribution</th>
<th>Range (all)</th>
<th>Mean (all)</th>
<th>Mean (those providing contributions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer cash contributions (lead and secondary partners)</td>
<td>In £</td>
<td>£200-£63,300</td>
<td>£2,934</td>
</tr>
<tr>
<td>As a % of SFC funding</td>
<td>34</td>
<td>2-224%</td>
<td>12%</td>
</tr>
<tr>
<td>Employer in-kind contribution</td>
<td>In £</td>
<td>£460-£105,000</td>
<td>£4,096</td>
</tr>
<tr>
<td>%</td>
<td>57</td>
<td>1-137%</td>
<td>17%</td>
</tr>
<tr>
<td>Total employer contribution (cash and in-kind)</td>
<td>In £</td>
<td>£520-£115,000</td>
<td>£6,625</td>
</tr>
<tr>
<td>%</td>
<td>63</td>
<td>4-224%</td>
<td>28%</td>
</tr>
</tbody>
</table>

7 Of which 11 didn’t quantify in-kind contributions, and are therefore not included in analysis.
Additional inputs varied by organisation type

Average additional cash contributions from the projects themselves were highest from for-profit providers. On average, these organisations provided match funding of around 25% of Skills for Care’s award, with average cash contributions of £6,800. Local authorities leveraged the lowest amount of cash contribution, at around £622 per project (Table 3.3).

Table 3.3: Cash and in-kind contributions by grant organisation type

<table>
<thead>
<tr>
<th>Contribution (in £)</th>
<th>Contribution (as a % of WDIF award)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cash</td>
</tr>
<tr>
<td>Local authority agency</td>
<td>£2,105</td>
</tr>
<tr>
<td>Provider (for profit)</td>
<td>£6,821</td>
</tr>
<tr>
<td>Provider (NFP)</td>
<td>£1,761</td>
</tr>
<tr>
<td>Other</td>
<td>£249</td>
</tr>
<tr>
<td>Employer led/membership organisation</td>
<td>£2,082</td>
</tr>
<tr>
<td>Community Interest Company</td>
<td>£7,420</td>
</tr>
<tr>
<td>Local authority</td>
<td>£622</td>
</tr>
<tr>
<td>Charity (non-provider)</td>
<td>£3,300</td>
</tr>
</tbody>
</table>

An outlier: a commercial care provider

One commercial care provider provided the majority of funding themselves. Originally estimated at £63,300, representing 224% of the original Skills for Care grant, the interviewee argued that the total contribution was likely nearer to £250,000 overall, plus staff wages. The interviewee argued that, in this case, the purpose of the Skills for Care funding was that it acted as a lever within the organisation:

‘It enabled me to have the discussions with the people that mattered…the board were happy to support a project that was part-funded, they didn’t really mind what proportion it funded.’

Around half of projects reported in-kind contributions on their self-evaluations; this is likely to be under-reported

As detailed above, around half of projects reported in-kind contributions on their self-evaluations. However, when interviewed, an additional 26 projects reported providing...
additional in-kind inputs, which they had not quantified in their self-evaluations. This meant that nearly 90% of interviewed projects made additional in-kind contributions, though only just under half of these projects were able to estimate the cash value of this. Reflecting this, the following analysis relates only to those projects interviewed (and includes information from these projects’ self-evaluations, as well as interviews with grant holders).

**In-kind contributions vary by organisation type**

Figure 3.6 shows the average in-kind contribution for each organisation type. Although only a rough estimation due to the caveats outlined above, not-for-profit providers alone, on average, provided more in-kind contributions than for-profit organisations and Local Authorities combined. Community Interest Companies also provided a similar amount of money, per project, as for-profit providers. While it may be that charities and NFPs have better skills in / more likely to record in-kind contributions, it is perhaps also unsurprising that they provided more in-kind assistance, given the nature of their organisation.

**Figure 3.6: Average in-kind contribution split by organisation type (from self-evaluations)**

<table>
<thead>
<tr>
<th>Organisation Type</th>
<th>Average in-kind Contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Interest Company</td>
<td>£10,334</td>
</tr>
<tr>
<td>Employer-led/membership</td>
<td>£1,873</td>
</tr>
<tr>
<td>LA or LA agency</td>
<td>£6,344</td>
</tr>
<tr>
<td>Provider (for profit)</td>
<td>£11,182</td>
</tr>
<tr>
<td>Provider (not for profit)</td>
<td>£19,180</td>
</tr>
</tbody>
</table>

In kind contributions were most commonly in the form of employee time and labour

Where projects identified an in kind contribution, it was mainly in the form of employer/employee time and labour (four fifths of projects). Two fifths provided additional resources, for example, room hire or the production of workbooks. Two fifths
of projects provided both employer/employee time and labour and additional resources. More specific examples of in-kind contributions included:

- One charity gave up a significant amount of time raising awareness of the National Minimum Data Set for Social Care (NMDS-SC) dataset (which organisations were required to be compliant with before they could take part in the training); hours spent on marking coursework or examination work from training; and they also took a flexible approach to training, for example one student suffered a bereavement part-way through the course so the trainers provided her with additional support to make sure that she completed it.

- One organisation grant-holder spent at least an extra week of his time on the project, putting on extra training sessions and visiting learners in their home. He also mis-calculated the price of the venues on the original bid – he wasn’t sure he could go back to Skills for Care and admit his mistake and felt that it was right his organisation paid the additional £2,000.

- One organisation also reported an important in-kind contribution as the opportunity cost of the grant-holder’s time spent in project delivery (i.e. time that she couldn’t spend delivering training and/or assessments).

**For projects interviewed, total in-kind contributions were larger than total cash contributions**

Despite only 15 organisations (of those interviewed) being able to provide an estimate of their in-kind contributions, they were still greater overall than the cash contributions recorded across all 47 projects (£147,587 and £117,695 respectively). This is even excluding all the projects who reported in-kind contributions as hours given, or those who noted a ‘significant contribution’ but provided no figures, so the actual figure is likely to be a great deal larger.

As shown in Figure 3.7, for-profit organisations provided a larger cash contribution.⁸ Local Authorities, Employer-led/membership and not-for-profit organisations usually provided a greater in-kind contribution. It is perhaps unsurprising that employer-led/membership organisations and not-for-profit organisations would provide a greater in-kind contribution, given the nature of their organisations.

Few organisations discussed what these cash or in-kind resources would have been spent on, if not on the WDIF project. Those that did, discussed how their time would have easily been taken up with other work, day to-day tasks or existing projects.

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⁸ Assuming all organisation types are equally likely to report their in-kind contributions as a cash figure.
Figure 3.7: Total cash versus in-kind contribution
4. Activities and outputs

Summary

- Most WDIF projects developed and / or delivered training. A smaller number were focussed on research and innovative provision of care services. The latter all included some element of workforce training, alongside care provision.

- There were three main methods for developing training: either developing it from scratch, altering it to make it more appropriate for a particular group, or making existing training accredited.

- Most training activities were face-to-face, though blended and e-learning approaches were also common. Coaching and mentoring was used by a few projects.

- 2012/13 and 2013/14 projects resulted in 143 new training courses and 154 new training packs or resources. Across all years, around 15,000 people were trained or benefitted from some form of professional development.

- A range of innovative products were developed. These included working groups and networks, databases and mapping documents, and training materials.

4.1 WDIF projects were primarily related to training; a small number were either research, or innovative service provision

WDIF-funded projects most commonly related to training, generally delivered in a new or innovative way. There were no patterns by organisation type. They could be sub-categorised into (Figure 4.1):

- Projects which developed new training provision, tools or resources (for example, a new module, or tool (9% of projects));
- Projects which delivered a new type of training (for example, providing an established training programme to a new group, or in a new setting (25% of projects));
- Projects which both developed new training provision, tools or resources, and then delivered it (51% of projects).

Alongside this, a few projects also related to:
• **Research** (6% of projects): For example, research to improve organisations’ understanding of the care needs of a particular community, or research into the training needs of PAs; and

• **Piloting of innovative care provision** (8% of projects): These projects were targeted primarily at people who use care and support, with training social care staff a component, rather than the main focus. This included the provision of sports-related reminiscence sessions, a two-day workshop for care home residents on ‘Cognitive Stimulation Therapy’; and workshops to improve the personal relationships between students with learning disabilities and social care staff.

**Figure 4.1: What did WDIF projects do?**
More than half of all projects designed new training, or a new training tool; around three-quarters delivered training

There were three main models of developing new training. The majority (just over half) of projects which developed training did so from scratch, building either on their own research and expertise, or through working with an external contractor. Fewer projects adapted their training from an already existing model, making it appropriate for a new audience. A couple of projects took a non-accredited training, and made it accredited (Figure 4.2).

**Figure 4.2: Examples of how projects developed training**

<table>
<thead>
<tr>
<th>Developing training from scratch</th>
<th>Tweaking existing training to make it more appropriate for one group</th>
<th>Developing existing training and making it accredited</th>
</tr>
</thead>
</table>
| • A Charity developed training on stroke for all adult social care staff.  
  • They developed a learning handbook, learning manual and workbook, powerpoint slides, activities and lesson plans. | • An employer adapted their existing introductory training for care workers to make it more appropriate for PAs.  
  • They focussed it more around practical skills such as lifting and carrying, food preparation and how to use a hoist. They also offered home-based training and training outside 9-5. | • A care provider wanted to develop its existing 'Six Steps' end of life care training programme and accredit it.  
  • Staff mapped the existing training across onto the QCF Framework, and six graduates of the programme were offered the opportunity to take the QCF-accredited version, at either Level 3 or 5.  
  • The project also trained 10 educators to become assessors. |

Around three-quarters of projects delivered training, the majority of which ran structured training activities, with a few also including workshops and events. Activities were delivered through a range of different formats; many projects used a range of different activities as part of delivery. The majority of projects included some teaching, predominately face-to-face, though a few also used e-learning or a blended learning approach.

Around a third of projects ran events, all-day workshops and focus groups. One CIC project, for example, organised a networking event with different care and advocacy organisations, to promote employment as an opportunity for people with care needs. Alongside the networking event, the project also organised a range of workshops exploring the necessary skillsets for embedding knowledge about employment support in the social care workforce.

Coaching and mentoring was offered both to improve management skills, and to encourage people more generally to use new tools or techniques. For example, one
employer’s project delivered a coaching and mentoring course to managers of care homes. The group sessions used coaching and mentoring, as well as peer support, to explore the individual development needs of the managers and to identify a particular management challenge that they wanted to address through the group sessions.

The range of training activities offered reflects the non-prescriptive nature of the WDIF, and suggests that projects have the freedom (and knowledge) to develop and use a training style which best fits the topic covered, and learning needs of participants.

A few WDIF projects were focussed on research

Around 6% of WDIF projects were focussed mainly on research (though many other projects included elements of this). The majority of these projects involved increasing the grant-holding organisation’s knowledge of a particular issue related to adult social care workforce development. For example, the Chinese Community Engagement project, run by a Local Authority, carried out a series of workshops with Chinese community members to gather intelligence on current barriers and training needs. They also collected information through a questionnaire. Based on the findings of the workshops and questionnaire, the project developed training programmes specifically for Chinese care workers, around safeguarding and autism awareness.

Research projects can appear less clearly linked to workforce development, and may appear to fall outside the scope of the WDIF. However, as highlighted in the discussion of the innovation spectrum in section 2.7, innovation often begins with research; projects need to understand the problem they are trying to address, and how to address it, before they can design a training programme to deal with it. Indeed, research, either on its own or as a component of developing training, can be encouraged by the WDIF. It is crucial to ensure that the research is not replicating something that is already known; organisations should be able to demonstrate that they have looked more widely in the sector (and academic literature) for this intelligence.

A few WDIF projects were focussed on innovative care provision

Just under a tenth of WDIF projects piloted innovative forms of care provision. For example, one CIC addressed dementia, depression and social isolation in older people through reminiscence therapy. Working with staff from local care homes in Leeds, the project involved the collection of materials to form a training pack which included photographs and individual stories of sporting memories (and memorabilia). It also developed a newspaper which focused on relevant sports in the local area. Along with some training in how to use the training pack, the resources were designed to enable care staff to better engage with the people who use care and support through the medium of sporting memories.
Where projects’ main focus was innovative care provision, this could be viewed (as with research) as moving away from the core aims of a funding stream focused on workforce development. However, while the emphasis was on the provision of new forms of care, all included some element of workforce training. This was to ensure both that staff were able to offer this new provision, and that they could continue to offer it once the intervention ended. In fact, the focus on work-based learning, to enable staff to use new techniques with clients, ensures that this is ‘innovative’ training, which fits well with the overall goals of the Fund.

4.2 The WDIF produced common project outputs

In total the WDIF 2012/13 and 2013/14 resulted in:

- 143 new training courses designed, and 727 sessions delivered;
- 154 new training packs/resources designed;
- 1,322 new qualifications/units achieved;
- 290 individual employers trained;
- 186 PAs trained;
- 312 trainers trained; and
- 13,121 social care staff trained.

Summary data collected from evaluations also showed that:

- 977 people were engaged with projects;
- 1,425 had benefitted from development in some way;
- 429 people undertook training or attended events;
- And 1,224 employers were engaged.

Projects also reported a range of specific outputs. Most commonly, these related to the production of tools, packs and resources. Around 20% of projects reported producing resources (generally linked to training courses) such as DVDs, handbooks and apps. A few projects also developed networking tools and databases (generally online, and for PAs).

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9 The numbers in this section differ from those outlined in the economic analysis. This is due to a number of exclusions made as part of that analysis – these are detailed in Annex 5.
10 Projects from 2012/13 and 2013/14 reported their outputs against standard targets, allowing for comparison and summation between projects. It was not possible to disaggregate into the categories above for 2011/12 projects, due to inconsistencies in how outputs were reported.
11 It should be noted here that the definition of ‘trained’ was quite broad, for example, one organisation reported supporting around 7,000 beneficiaries, but this was predominantly by showing them a DVD.
12 Beneficiaries were not differentiated by type.
13 Care should be taken in interpreting these numbers, as it was not always clear whether projects were treating categories as mutually exclusive.
A range of innovative products were developed

WDIF projects developed a range of innovative products or resources. Broadly, these fell into three categories: the setting up of groups or networks; establishing mapping documents or databases; and the production of training materials. The sorts of products created are outlined in Figure 4.3 below.

Figure 4.3: Innovative products developed by WDIF projects

What sorts of innovative products were produced?

- Working groups or stakeholder networks
- Databases or mapping documents
- Training materials
  - Training packs
  - E-training tools
  - Mobile phone/online apps
  - Workbooks
  - Films
  - Leaflets
  - Websites
5. Outcomes and additionality

Summary

There is strong evidence that the WDIF has led to positive outcomes for social care staff; the organisations that were awarded the funding and people who use care and support.

For beneficiaries:

- The WDIF has led to improvements in knowledge, understanding and competencies for project beneficiaries. Nearly three-quarters of participants reported increases in their skills, knowledge and awareness, and two-thirds reported improvements in their general professional competencies. This learning related both to knowledge in a particular area or topic, and knowledge around specific competencies or skills.
- 90% of care workers reported that the training met their expectations, was useful and relevant to their role.
- Beneficiaries and grant holders suggested that training worked particularly well when it focussed on embedding learning about new skills and techniques in a workplace setting, and emphasised the potential practical barriers to achieving this.

For organisations:

- For a quarter of projects, the WDIF led to improvements in organisations’ awareness and knowledge about social care issues and the social care professions. It also raised the profile of grant-holding organisations.
- A quarter of organisations also reported that WDIF funding led to changes in policies, procedures or ways of working.
- Grant-holders suggested that the involvement of managers, whole team approaches, and selecting ‘good’ providers could maximise the impact of WDIF projects.

For people who use care and support:

- The WDIF had a positive impact on people who use care and support. Around a third of grant-holders reported this, generally because their WDIF project improved the quality of care they could provide.
- However, the evidence at this level was relatively limited.
- The impact of WDIF projects was maximised where projects:
  o Ran training which supported personalisation, enabling staff to see people who use care and support as individuals, rather than simply as ‘patients’;
5.1 The WDIF generated positive outcomes for social care staff

Nearly three-quarters of projects reported some improvement in participants’ knowledge and understanding

Improvements in knowledge and understanding were the most commonly-reported outcomes of WDIF projects, with almost twice as many grant-holders reporting this as any other outcome. Staff themselves confirmed these findings (Figure 5.1):

- Nearly three-quarters of survey respondents reported that training resulted in increases in their skills, knowledge and awareness
- Around two-thirds reported that it increased their professional competencies
- Around half also felt that the training addressed specific skills or competency gaps
- Around a third reported that the training improved their productivity
- Only one person reported that it led to an increase in their wages.

**Figure 5.1: Did the training…? (Participants could select more than one answer)**
Staff increased their knowledge of specific topics or areas, and improved their skills and competencies

WDIF projects increased staff knowledge and understanding in a variety of ways. Some projects resulted in participants increasing their knowledge in a particular area or topic (for example stroke care), whereas others focussed on particular skills or competencies (for example critical thinking, or the role of mentoring). For example:

‘I work with clients who have previously suffered from stroke, so now I know what the symptoms are and how to react’ (Residential care worker)

‘I learnt to notice different emotional situations, assess mood and notice differences in the client… [as well as] ways to approach and help the client when they might not always want to explain what’s wrong’ (Residential care worker)

‘I manage a team of 21 staff and 14 volunteers, having the skill set to put formal processes in place around peer professional supervision is helpful’ (Residential care worker, following a management and leadership training course).

Staff increased their confidence

Around a third of projects increased staff confidence. This confidence took a number of forms, but was predominantly related to improved confidence in communicating with service users, for example:

‘It has increased my confidence in speaking to groups of people and delivering activities’ (Adult social care worker)

Where projects worked with IEs/PAs, confidence tended to relate to their ability to ‘recruit the right person’, or general confidence about becoming an IE.

Occasionally, staff did not report improvements in knowledge, understanding or confidence. These staff did not like the style of delivery, or they already had a good knowledge of the topic. There were few overall patterns in the types of projects which participants were less happy with; for example, even where staff were attending training because they were to, they still felt it was relevant and beneficial.

A few projects reported improvements in job satisfaction and retention; a few also reported that staff went on to take more qualifications
One organisation discussed how the knowledge and understanding gained from projects led to participants having higher job satisfaction and (potentially) increased retention; one charity’s project found that two participants moved into a stroke care specialism following the course, and anecdotally reported improvements in staff retention.

In a few cases, WDIF projects encouraged workers to go on and take further qualifications, though only one interviewee could provide evidence of this – in their project, 21 of the PAs involved went on to do more training and qualifications, including nine who went on to do an additional accredited qualification. A few care workers interviewed also reported that the training had encouraged them to take further qualifications.

**Most social care staff reported that the training met their expectations, and was useful and relevant to their role**

Around 70% of survey respondents reported that the training fully met their expectations, and just under 20% reported that it met them to a great extent. Only one individual thought it contributed little. Almost all social care workers thought that the training was relevant to the challenges they face in their workplace to a considerable or great extent. Generally, training related to people’s day-to-day roles, and addressed a knowledge area or competency for which little or no other training had been offered:

> ‘I am responsible for managing a team, and had [previously] received no training in how best to make my team perform well’ (care manager)

Indeed, grant-holders suggested that around 10% of projects specifically targeted groups who otherwise had limited access to training; predominantly low-skilled workers (and, where grant-holding organisations were from the health sector, social care workers generally), PAs and IEs.

Where training was less relevant, this was because people were already quite experienced or knowledgeable in the area:

> ‘My work already involves a lot of tele-care work. Because of this it’s not added a lot to my day to day work’ (care worker)

Where projects’ innovation is based on offering a well-established training tool or technique to a new group or in a new setting (‘scale and spread’ in the innovation spectrum (section 2.7)), it is crucial that the target group is carefully thought through to ensure that this is a new type of training for them. There is therefore a need to balance training between that which is relevant to a day-to-day role (and likely to have had some prior training in it), and that which is innovative, or addressing a new need (but which
might therefore not be as relevant, or practical). Without this balance, the training offered could be neither useful, nor innovative.

5.2 The following principles helped projects to achieve outcomes for social care staff

Outcomes for social care staff were enhanced in three main ways:

- By delivering practical training, which focuses on how staff can implement learning in a day-to-day setting;
- By offering workbooks and tools to support training;
- By enabling on-going access to networks of other training attendees.

The three boxes below highlight this learning:

**A practical context facilitates learning**

Several projects focussed on getting participants to implement ‘academic’ learning in a practical, day-to-day setting. Academic learning would be offered alongside skills or action-based sessions, designed to enable participants to implement what they had learned. In several cases, it was reported that this improved the quality of care, and created an environment where people were more willing and able to challenge poor practice. For example:

- One Local Authority’s dementia training programme reported that participants have: ‘Been able to go back and do more meaningful activities in the care homes they work in, look at things that have become normal practice, challenge them, [and] create a better environment’ (Grant-holder, Care Provider)

- In a care provider’s medicine management project, participants moved from a ‘tick-box’ appreciation of what medicine management means, to a real engagement with the issues, and a critical view on their own practice: participants revisited the Mental Capacity Act, for example, and thought about how much they really ensured informed consent in their workplaces.

Findings from the beneficiary surveys confirmed this. Slightly over a third of respondents reported that this was the most useful aspect of their training. For example, one beneficiary reported that: ‘The practical mentoring sessions [were useful] because it allowed for the application of skills’. Similarly, others highlighted that learning about how to provide different types of activity was particularly beneficial.
Tools and workbooks enhance learning

Care workers often also highlighted the tools and workbooks that came alongside training as particularly helpful, especially when trying to implement the learning back in the workplace. For example:

‘The most useful part was the 11 audit tools [used to assess how effective medicine management processes were]… they were really useful and allowed you to build on audits already in place’ (Care worker)

‘As part of the course we were asked for examples from our roles, this made the course highly relevant’ (Care worker)

The networks developed during training were an added benefit

Around a sixth of grant-holders noted that their projects developed networks between participants, helping to foster a sense of community among otherwise quite disparate individuals (for example, activity coordinators, PAs and IEs, and social care workers (particularly managers) in different residential care homes). For example, it gave them an opportunity to interact with other people doing similar types of work:

‘It [being an activity coordinator] can be quite a lonely existence and now they have a peer network’ (Grant Holder, Local Authority)

Around a fifth of care workers also said that this was the most useful element of the training - both because it facilitated discussion and knowledge transfer within the training – ‘[The group dynamic] meant that a lot of discussion took place and you heard different things from different people’ (Care worker) – and because it led to the creation of mutually supportive networks. For example, one care worker reported how useful it was to ‘have that connection’ with other people working in similar fields.
5.3 WDIF projects raised awareness of key issues in the social care sector

Around one quarter of WDIF projects were reported to have raised awareness of key issues in social care. Projects increased:

- Awareness of policy challenges;
- Awareness of the social care profession;
- The profile of organisations who benefited from grants.

These themes broadly mirror the varied activities outlined in Chapter 4. Each of these themes is discussed further below.

Projects raised awareness of policy challenges in social care

Projects raised awareness of policy issues in social care, including: the integrated care agenda, medicine management, stroke, the employability of people with care needs, IEs’ legal responsibilities, and dementia. WDIF projects tended to focus on areas that get little other attention, and which participants may not realise they lack knowledge about. For example:

‘When [learners] come on [the course] they don’t know what they don’t know… [they are] fascinated by increasing their understanding of different types of dementia and the different conditions which might present alongside… [it] increases [their] awareness and ability no end’ (Grant-holder, Care Provider).

Projects raised awareness of the social care profession more generally

Projects increased the profile of some roles in social care, particularly activity coordinators, PAs and IEs. This often happened where projects offered training related to particular job roles, or conducted research into them. Alongside this, a few projects reported raising awareness among adult social care staff of the training opportunities available to them.

Raising awareness of the grant-holding organisation

Around a fifth of projects raised awareness (with people who use care and support, social care staff, and other social care organisations) of the grant-holding organisation. These outcomes were less commonly reported as aims (see Chapter 2) and are to some extent unexpected. In particular, projects improved grant-holding organisations’ networks and partnerships with other relevant organisations in the area. For example,
two hospices ran a project together, and reported that this resulted in staff from both hospices working together to share best practice.

This improved networking could also have commercial impacts for the organisation; for example, prior to their project, one CIC provider's training was tailored predominantly to care homes, and not to PAs and IEs. The new training opened up new markets for the CIC, but also increased the availability of high-quality training for PAs and IEs themselves. The project (particularly their partnership with the local CIL) opened up new markets to them; in addition, they learnt to adapt the way they worked, becoming much more flexible in how, where and when they offer services – for example they now offer home-based training, and delivery outside the core working hours of 10-4. The timing of this (as Direct Payments begin to grow) is likely to make this a particularly beneficial move.

5.4 Around a quarter of WDIF projects resulted in changes to policies, procedures and ways of working

Around a quarter of grant-holders reported that their projects had resulted in changes in policies, procedures, or ways of working in the organisations which took part. All of these projects were training projects, 90% of which both developed and delivered training. Findings from the beneficiary survey provide further evidence of this, with around four-fifths reporting that the training they attended had changed their actions in the workplace ‘to a considerable or great extent’. This is a strong finding, and suggests that the training programmes funded by the WDIF are going beyond just raising individuals’ knowledge and understanding, to motivating them to take action, and change ways of working in the workplace.

Projects changed organisations’ (and staff’s) ways of working in two main ways:

- They altered policies and procedures (for example, introducing procedures to quality assure medicine administration; promoting more integrated working; or introducing procedures to improve the quality of end of life care – see ‘changing ways of working in care homes’ below).
- They introduced new tools or activities (for example, ‘Namaste’; Jabadeo; Care Passports; communication passports; and ways of delivering reminiscence training – see ‘introducing new tools and activities’ below).
Changing ways of working in care homes

One project introduced a medicine management system into a range of care homes. All organisations participating in the training improved their medicine management processes, with one beneficiary reporting that: ‘We could use the information and tools provided to enhance the service we deliver, and be able to monitor services better’. In particular, the training led to several organisations changing their systems for medicine quality assurance. In one organisation, prior to the training, staff were only observed once; following the training, staff are now observed three times, and evaluated every three months. Any staff member whom the organisation has concerns about are monitored monthly.

These changes in processes are supported in shifts in care workers’ competencies and attitudes to medicine management, the grant-holder reported that the training resulted in care workers questioning themselves and their ways of working. For example, ensuring that they went beyond a ‘tick-box’ approach to the ethics of clients consenting to their medication, instead, really thinking about whether or not the client understood what their medication was for, what the implications would be, and whether they wanted it now.

A care worker from a different care home, following training on dementia awareness, reported that the home now offers a specialist dementia week three or four times a year. They have also set up a memory room, to encourage reminiscence, and have done a ‘knowing me’ review. Here, staff talked to carers about clients’ personal histories; this enabled staff to have a more personal and empathetic relationship with clients.

One project supported a group of managers (each employed by different organisations) to engage in peer professional supervision. The programme aimed to support managers to stand back, and reflect on how well they engage in mentoring and supervision in the workplace. As well as improving participants’ skills in this area, seven of eight participants reporting carrying out peer professional supervision in their workplace, following the training.
Introducing new tools and activities

One Local Authority developed a number of short training courses on dementia communication skills, medication, facilitating activities, using a life story approach, and Jabadao, which, when combined, led to a QCF qualification. A key aim of the training courses was to develop a person-centred approach to dementia care as well as using movement and music – ‘It’s about non-verbal communication through movement and music’ (Grant holder). Jabadao (defined as ‘exuberant movement play’) is thought to be particularly beneficial to dementia patients because the movement increases blood flow to the brain, as well as helping to improve people’s non-verbal communication skills. As a result of the training, quite a few care home managers reported back that Jabadao is now being widely used in their care homes.

A national provider organisation worked with a charitable training provider to offer ‘open studios’ in three of their care homes. Open studios involved transforming the care home into a film studio for the day, and recreating a classic film. Part of the project involved engaging with (and training) leaders in each home, this ensured that the new activities kept being offered: ‘we’re maintaining the studios… and have them in most of the homes once every quarter… just using different musicals, getting the residents into different characters’ (Grant holder).

Even where projects’ main focus was on providing activities for people who use care and support, there were still longer-term impacts on how social care staff worked in residential homes. For example, one project, which delivered a multi-sensory dementia workshop for care home residents with late-stage dementia, found that staff taking part reported that the training which went alongside this was easily adapted into practice. Staff reported that, after the provider left, they continued to offer similar multi-sensory activities.

5.5 The evaluation identified several success factors underpinning these organisational outcomes

Projects which resulted in organisational change also changed staff behaviour. Without these shifts organisational change will only ever be ‘skin deep’, and not sustainable. Projects resulted in staff:

- Achieving ‘softer’ outcomes such as being more spontaneous, reflective, or having a general improvement in attitude, or;
- Ensuring that staff used new tools, policies and procedures.
These changes in behaviour, and in how staff thought about their role, led to shifts in the way organisations worked, and the care clients received. For example, social care staff reported that, following a WDIF project, they were:

‘More spontaneous, and go about my role in a more open way’ (Social care worker)

Others reported on improvements in management. For example, as a result of their manager attending training:

‘Some members of the team are now more positive about their role and impact in the team because the new approach to supervision highlights their contribution’ (Care worker).

Another reported that, following activity coordinator training, she was now able to tailor her approach depending on who she was working with. For example, where there was:

‘…a very shy gentleman, who needed more specialist and individual activities, the course helped her learn how to adapt to his needs’ (Care worker)

Another illustrated how the training led her to initiate changes in the wider workplace:

‘When I came back from the course I talked to my manager about the role of care staff in activities and since then there has been much more engagement’ (Care worker)

Projects also noted that involving managers in training, and delivering training to whole teams, were helpful in facilitating organisational change. For example, one local authority noted that their course required care workers to develop action plans. The effectiveness of these plans, particularly when a whole team attended training, was greatly enhanced by manager buy-in and direction. Similarly, a charity suggested:

‘The homes with the lowest level of management engagement were those that had the lowest number of staff going on to complete the activity’ (Grant holder).
5.6 The WDIF has generated outcomes for people who use care and support

Around a third of projects reported that their projects had a positive impact on people who use care and support. However, this evidence was predominantly anecdotal or inferred; the evaluation spoke to few people who use care and support, and projects themselves rarely formally collected views from them.

Most commonly, projects and care workers reported that projects resulted in improved quality of care, generally as an offshoot of improving staff knowledge and understanding. For example, one Local Authority project, looking to improve awareness and knowledge around stroke, resulted in three staff detecting irregular pulse rates, contacting GPs and getting medication changed. Similarly, another project reported robust qualitative and quantitative data around improved quality of end of life care, as a result of their newly-accredited ‘Six Steps’ programme. They showed improvements in the use of Advanced Care Plans (including conversations with individuals about them), anticipatory prescribing and the use of electronic registers. They also demonstrated a reduction in the number of people who died in hospital – this would suggest an increase in the number of people dying in their preferred place as most prefer not to be in hospital.

Around half of projects reporting improvements in service user experience did so anecdotally, with no additional evidence. For example, one interviewee reported that their integrated care programme resulted in a more seamless experience; another that it led to, ‘more person centred care’.

The evaluation identified several factors that contribute to outcomes for people who use care and support

Projects improved the care of people who use care and support by altering the way staff and residents / clients viewed each other. In particular, projects helped staff get to know clients as people, rather than simply as patients:

‘It took people away from their roles as resident and staff and made them see each other as people… we were getting feedback from residents saying they hadn’t known the person they worked with at all, but now they did’ (Grant holder, Care Provider).

This interaction worked both ways; residents were also more connected to staff:

‘You could see how residents’ confidence developed… we saw a great sense of laughter, improved communication and interaction, a sharing of wisdom and
emotion, and – importantly – being put in your place when residents didn’t like something’ (Grant holder, care provider delivering a new form of dementia provision).

Involving service users in the design or running of projects was deemed to be a key contributor to beneficial outcomes for people who use care and support. For example, one project delivered 14 training workshops on a range of topics of relevance to PAs and IEs. People who use care and support facilitated the workshops. This allowed service users to shape the content of the training, ensuring that it was relevant and of interest to learners.

Similarly, another project worked with veteran soldiers to develop an online self-aWellness and signposting tool. This tool was an interactive source of information about local support groups, community and leisure services, as well as having some interactive features to facilitate online peer support. The functionality and content of the tool was entirely shaped by the veterans:

‘We take it in its skeleton form, then get them [the veterans] to shape it, decide what images should be in there, what links should be there, what local resources could be linked to’ (Grant holder)

5.7 The additionality of the WDIF is high

Additionality is an assessment of the extent to which the outcomes and impacts outlined in this report would have happened without the WDIF. Table 5.1 below summarises the findings against each criteria. It shows that the level of additionality for the WDIF is high; most of the outcomes and impacts achieved by the programme would not have been achieved in the absence of WDIF funding. In addition, it suggests that there has been limited negative impact on other provision.

Additionality was assessed qualitatively through interviews with grant-holders and beneficiaries, with questions in each topic guide designed to assess the extent to which projects resulted in deadweight, displacement, substitution or leakage. Each interviewer then assessed the extent to which a given project met each measure of additionality, using the questions in Table 5.1 below. Given the qualitative nature of the assessments interviewers assessed whether each project was ‘low’, ‘medium’ or ‘high’. The findings from each project were then summed, with final assessments given in the table below.
### Table 5.1: Summary assessment of the additionality of the WDIF

<table>
<thead>
<tr>
<th>Measure of additionality</th>
<th>Summary of findings</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deadweight: the extent to which the project could have happened without WDIF funding</strong></td>
<td>Deadweight is assessed as low-medium. Around two-fifths of grant-holders reported that they <em>would</em> have gone ahead with their projects had they not secured WDIF funding, but on a smaller scale, or further in the future.</td>
</tr>
<tr>
<td><strong>Displacement: Is the project likely to have prevented people attending other training or provision?</strong></td>
<td>Displacement is assessed as low-medium. A few projects and project beneficiaries reported that they would have found other training, had they not attended the WDIF-funded provision.</td>
</tr>
<tr>
<td><strong>Substitution: Did the project result in organisations not offering training or provision that they otherwise would have done?</strong></td>
<td>Substitution is assessed as low. Very few projects had any issue with this. Those that did, tended to be so small they could only run a couple of projects at any one time.</td>
</tr>
<tr>
<td><strong>Leakage: Did anyone benefit who was outside the WDIF target criteria?</strong></td>
<td>None. No projects funded or project beneficiaries were outside the WDIF target criteria.</td>
</tr>
</tbody>
</table>

### 5.8 The WDIF provides value for money

A value for money analysis was carried out using information from projects’ self-evaluations, supplemented by findings from the grant-holder analysis. The analysis is informed by HM Treasury Guidance and economic impact literature.

Value for Money was assessed by calculating the increases in productivity associated with taking part in training. These increases in productivity were adjusted according to whether a beneficiary was a manager or not, and applied to all individuals who took part in training. This total benefit was assessed against the costs of the WDIF. Lastly, the additionality of the benefit was calculated, by applying the additionality reductions outlined above (Table 5.1) to the overall impact.\(^\text{14}\)

The results suggest that the WDIF has resulted in a total benefit of £15,500,000, and an additional benefit of £6,800,000. This indicates that for every £1 invested by Skills for Care, there is a return of £2.36. If the in-kind and cash contributions of employers are included, this return falls to £1.88, however this is still a positive outcome and likely to be an underestimate – see below.

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\(^{14}\) Full detail on the way in which the analysis was conducted, including the assumptions made and sources drawn on, is in Annex 5.
Table 5.2: Economic impact of WDIF

<table>
<thead>
<tr>
<th>Type of qualification</th>
<th>Type of worker</th>
<th>Number achieved</th>
<th>Total impact (£m)</th>
<th>Additional impact (£m)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualifications achieved at Level 2</td>
<td>Care worker</td>
<td>419</td>
<td>£2.4</td>
<td>£1.0</td>
</tr>
<tr>
<td></td>
<td>Manager</td>
<td>65</td>
<td>£0.4</td>
<td>£0.2</td>
</tr>
<tr>
<td>Qualifications achieved at Level 3</td>
<td>Care worker</td>
<td>233</td>
<td>£4.3</td>
<td>£1.9</td>
</tr>
<tr>
<td></td>
<td>Manager</td>
<td>258</td>
<td>£4.8</td>
<td>£1.9</td>
</tr>
<tr>
<td>Number receiving non-accredited training</td>
<td>Care worker</td>
<td>2,381</td>
<td>£3.1</td>
<td>£1.4</td>
</tr>
<tr>
<td></td>
<td>Manager</td>
<td>194</td>
<td>£0.4</td>
<td>£0.2</td>
</tr>
</tbody>
</table>

Total 3,550 £15.5 £6.8

There are a number of limitations with the analysis. These are likely to lead to an underestimation of the impact of the WDIF. Most importantly, this analysis only measures the impact of training reported in projects’ self-evaluations, not any future training undertaken with the materials. Given the high degree of sustainability (including repeat running of courses) of projects in the WDIF, it is likely that the impact is (and will be) considerably higher. In addition:

- The analysis only considers the economic impact of people attending training. It does not calculate the benefit of the development of tools or resources, research, or innovative provision.
- In many cases, it was not possible to determine what proportion of participants were managers. Where it was not possible to determine this, it was assumed that one trainee would be a manager, and the rest care workers. This is likely to underestimate the number of managers, and therefore underestimate the total economic impact, as training a manager has a higher impact than training a care worker.
- In some cases training was delivered at several levels. The number of people attaining each level was rarely identified. Where this was the case, it was assumed that everyone achieved the lower level. This will likely lead to an underestimation of impact as a higher-level qualification has a greater economic benefit.

It has not been possible to benchmark the value for money offered by the WDIF against any other programmes. This is because no other value for money assessments have been carried out in the adult social care sector to compare these results to. It is problematic comparing the value for money of this programme with assessments carried out in other sectors, given the differences in returns to qualifications and training.
between sectors. Therefore no attempt has been made to compare the value for money provided by the WDIF with any other programme.
Summary

WDIF projects have a high level of sustainability – around 80% of those interviewed provided some evidence that their project, or elements of their project, were sustained following the end of funding. Projects run by charities and Local Authorities were most often sustained.

There are two main models of sustainability, projects:

- Secured additional funding or resource, or;
- Continued to have the benefits of the training, at no extra cost.

The main barrier to sustainability was a failure to leverage additional investment. Around a fifth of projects were unable to continue part or all of their projects because there were insufficient funds to do so.

Two-fifths of projects were scaled up or transferred in some way. There were three main models, projects:

- Offered their training to new groups;
- Delivered the same training but on a larger scale, or;
- Adopted a simple ‘cascade’ model where participants passed on learning within their organisations.

The biggest barrier to transferability was a lack of capacity within organisations to deliver more training or provision. Where this happened, there was a further issue around how to quality assure any provision not offered by them. Organisations thought that Skills for Care could do more, beyond ensuring that tools are available on the Learn from Others site, to facilitate transferability and scalability.
6.1 WDIF projects are typically sustainable, at least into the short and medium-term

Around 80% of projects interviewed provided some evidence\(^{15}\) that their project (or elements of their project) were sustained in some way. This is a high level of sustainability. Indeed, Skills for Care should expect some projects not to be sustained, particularly given their innovative nature – some level of failure should be expected, reflecting the fact that most projects are trying something new.

The proportion of projects sustained in some way was highest for 2013/14 projects (around 90%), and lowest for 2011/12 projects (just over half). This may indicate that the outcomes of projects tend to be more sustainable in the short-term.

There were notable patterns by the organisation type (also see Figure 6.1):

- All projects run by non-provider charities (of a total of three projects) and all but one run by Local Authorities/Local Authority agencies (of a total of 15 projects) were sustained.
- Similarly, eight out of ten projects run by charitable providers were sustained in some way.
- At the other end of the scale, only half of for-profit providers’ projects were sustained.

This suggests that Local Authorities’ and Charities’ projects are particularly sustainable. Local Authority projects were twice as likely to report that following the project trainees taught or showed others what they had learnt. It is possible that the greater sustainability reflects a larger culture of sharing learning within local authorities, compared to other sectors.

There were no patterns by activity type, or the size of the grant-holding organisation’s additional cash input – the latter likely reflects the relative size of cash contributions in comparison to in-kind, as well as the fact that this tends to be strongly related to the organisation type, above anything else\(^{16}\). This suggests that Skills for Care should not rely on cash contribution as a proxy for long-term employer ‘buy-in’ to projects.

Grant-holder feedback on sustainability was supported by care workers, nearly all of whom thought that their training had been sustained in some way (though this will, in part, reflect biases in who responds to requests for interview; those who respond are more likely to be sustaining their work).

\(^{15}\) Evidence included projects reporting that they had (rather than planned to) offered training/provision again, or continued to use a particular tool, resource, or way of working.

\(^{16}\) For example, for profit providers had average cash contributions of nearly £7,000, Local Authorities of just over £600.

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6.2 There were two main models of sustainability

Interviews with grant-holders and beneficiaries highlighted two main models of sustainability:

- Projects secured additional funding/resource;
- Projects found a way to continue the benefits of their training, at no extra cost, either by:
  - Incorporating the training or training tool into existing training;
  - Developing a tool/resource which continued to be used, with little additional input; or
  - Sustainably changing policies, ways of working and staff behaviour.

These are summarised in Figure 6.2. Each of these models is discussed in more depth below.
Around a third of grant-holders reported that, to sustain their projects, they needed to secure additional funds

Around one-third of projects sustained their projects by securing more funds. There were three sources of additional funds:

- The grant-holding organisation itself;
- The organisation begins charging for training;
- The organisation secures additional external grants or funding.

Most commonly, organisations began charging for training. Most did this to cover costs, for example, a Local Authority’s e-learning programme is still available on their website, for a small fee, and another project continues to offer their course at a cost, with occasional discounts for those who need it. Two projects, both run by Local Authorities, took over the funding of projects themselves.

Three projects secured additional grants, or were commissioned, this included:

- One charity secured £60k of Lottery funding to build on the DVD developed as part of their project;
• A Local Authority secured funding from Health Education West Midlands to develop their training to Level 5. When this runs out they will offer the training at a cost, subsidised by the Local Authority and CCG;
• A charitable provider has had their project commissioned by several areas' Health and Wellbeing Boards.

Where training was accredited, it was more easily sustained, as individuals could claim back money from the WDF.

**Just over half of projects reported sustaining part or all of their projects, without additional funds**

Around a fifth of projects were sustained because they created a tool or resource which could continue to be used at little or no additional cost. There was variation in the extent to which projects reported (and could evidence) that such tools were actually being used. For example, a couple of projects reported that networks developed as part of their projects continued to meet. A care worker from one Charity-funded project noted that:

> ‘The support network is there for the benefits of the project to be sustained, and the employees at [the grant-holding organisation] are brilliant at supporting and helping everyone’ (Care worker)

Others provided evidence that resources developed (for example, reminiscence boxes, and a Self-aWellness tool) were still being used. Others suggested that their tools were low-maintenance, or would be updated regularly, but provided limited evidence of this happening.

Another fifth of projects reported that their projects sustainably altered policies, frameworks and ways of working in organisations. However, some projects struggled to achieve this organisational impact, particularly where an external grant-holding organisation was delivering training to multiple groups. In particular, there is a concern that initial enthusiasm following the training will drop off and practice will return to previous standards; for example care workers from one Local Authority training project reported that the training:

> ‘Got me thinking about telecare again… looking at updates and news and things… bringing it up in weekly team meetings… but then it does tend to get put on the backburner’ (Care worker).
Refresher courses, the provision of easy-to-use tools, and instigating complementary changes in policies and procedures were reported to be effective ways to encourage staff to use new techniques/learning, and reminding them to continue to do so.

**The main barrier to sustainability was a failure to leverage additional investment**

Around a fifth of projects reported that an inability to secure additional investment resulted in all or part of the training being discontinued. For example one grant-holder had to cut back on the resource intensive element of their project (one-to-one support). Whilst some projects got round the lack of funds by charging participants, this was not always an option – even where participants could later claim back the money from the WDF, a couple of projects reported that it was difficult to get participants (or their organisations) to pay up front. In addition, participants reported difficulty in covering the costs of backfill. This was a particular issue for PAs and IEs.

Other barriers to sustainability mentioned by a few projects included staff turnover and insufficient demand, or difficulty accessing target populations (particularly PAs and IEs). Capacity was also an issue, but this mainly related to the transferability and scalability of projects.

**6.3 The programme has generated scalable and transferable products**

Two-fifths of projects provided some evidence of their projects being scaled up or used with/by other organisations. A further four had made firm plans to do so, but had not yet started implementing these.

There are three main models of transferability and scalability (summarised in Figure 6.3 below):

- Organisations delivered their training to new groups, possibly by adapting or altering it. Around a fifth of organisations reported doing this. For example, one tool was adapted for the Scottish context, another was translated into Urdu. Another organisation extended their research programme from working with the Chinese community, to working with the Afro-Caribbean community.

- A simple cascade model, whereby participants return to their organisations and pass on what they have learnt to colleagues. Care workers often reported that they shared learning with colleagues and their wider team. For example, one reported that she took the documents used in the training back to her organisation, and they have now incorporated some of the material into staff inductions.
• Organisations delivered the same training or provision, but on a larger scale. Very few grant-holders provided evidence of this having happened yet. Around half of care workers did not know whether their training had been offered more widely, with about a fifth thinking it had been offered on a larger scale to a considerable or great extent. Both grant-holders and trainees were confident that projects would have wider relevance in the sector; nearly three-quarters of beneficiaries thought it was relevant to a considerable or great extent. Comments included: ‘could be delivered to PAs across the social care sector’; ‘training should be rolled out at a national level’.

Figure 6.3: Summary of scalability and transferability models

Projects which developed transferable and scalable products had several common features

The biggest barrier to transferability was a lack of capacity within the organisation. Where projects wanted to roll out their project, training or service provision on a larger scale, they were often prevented by not having the staff to do so. This is not unexpected, given the size of many of the organisations receiving funding from the WDIF. To achieve transferability, projects must therefore either find partners, adopt a train-the-trainer model, or allow (and promote) other organisations to use the tool or
training. For example, one project was made available to around seven Local Authorities (free of charge) via the Log on to Care online system. However, several projects voiced concerns about how to quality-assure any future use of their resources – many of the benefits of a tailored, well thought out training provision (often delivered in an innovative way) can/ will be lost if delivered poorly:

‘The main issue is who delivers it [the training]… we need to make sure they’re good enough. Ideally, they’d have the National Skills Academy mark… or a set of criteria they had to comply with, before they go and run with it… we need to persuade training providers that it [the training programme – based around competencies] is more than just a tick-box approach’ (Grant-holder, Care Provider).

‘[The success of roll out] depends on the course leader, I have been on some similar courses that were not well run’ (Care worker).

Linked to this is a need to design training which is flexible enough to fit the needs of other organisations, as well as targeting only those where it is likely to be of benefit. Rogers17 ‘Diffusion of Innovation’ theory highlights the importance of the ‘trialability’ of innovation - the extent to which an innovation can be refined and tailored, based on experience. It may be that, when offering the same training in a new organisation, parts of it need to be tweaked. Providers should be aware of this. This tweaking can have an added benefit of increasing organisations’ ownership of the training or tool.

Where transferability was achieved through a cascade model, evidence from the interviews suggested that the extent to which this occurs is likely to (at least partly) depend on the level of people trained. For example, one training provider reported that the best practice learned was internally disseminated, but that this was dependent on the trainees being, ‘Key decision makers within their organisations’. Similarly, a care provider, whilst taking a ‘whole organisation’ approach to training, did think through exactly who should be trained, for example, training a couple of new recruits ‘who seemed to have leadership quality’.

This links with wider evidence on what works in achieving transferability of innovations. Rogers’ model highlights the importance of an innovation clearly demonstrating relative advantage (over what existed before), and observable results. As highlighted in Chapter 5, many of these projects resulted in positive outcomes. The degree to which they will be sustained and transferred will depend on organisations’ ability to demonstrate this success, both within and/or without their organisation; having influential individuals lead this work is one way of ensuring that impact is both noticed, and trusted. This also links to the discussion of evaluation in section 7. To demonstrate

17 See Annex 7 for a summary of the theory.

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success, particularly to external organisations, projects must produce some evidence; robust evaluation, appropriate to the scale of the project, is therefore important.

**Organisations were positive about Skills for Care’s role in facilitating transferability and scalability**

Generally, projects agreed that Skills for Care are best placed to facilitate the transferability and scalability of projects. However, projects thought that Skills for Care could do what they currently do better, and could also do more. A range of issues and potential recommendations were identified.

Issues were raised with the current Skills for Care website (though projects were generally aware that it was being redeveloped). A few projects felt that it lacked some of their resources. One interviewee estimated that, ‘Only 10% of the resources we have developed are online’. More saliently, projects felt that, even where information was there, the website was ‘difficult to navigate and not engaging’. Several projects suggested that ordering projects thematically, and/or having a thematic search function would improve this.

Many projects also considered that Skills for Care needed to do more to promote and transfer products, they needed to:

> ‘Take it [a course] and make it live, show the impact that it can have…’

Several interviewees suggested more ‘live’ events such as regional conferences, held at the end of funding to share what had been delivered, would be useful.

Projects had often promoted their projects themselves. Where project grant-holders were from national organisations (for example, the Stroke Association), accustomed to promoting themselves commercially (for example, Sporting Memories, who were a CIC set up to ‘sell’ their provision), or had very strong links with Skills for Care, they tended to have the skills and contacts to achieve this. Smaller, less well connected organisations sometimes did not know how to promote their course; here Skills for Care have a role in linking them into the relevant networks, and perhaps providing some strategic advice. This was not felt to be provided currently.
# 7. The management of projects and the programme

## Summary

The majority of organisations awarded funding in the WDIF are already somewhat engaged with Skills for Care, and use their resources. Views on the application process are mixed; where projects were less positive, they were generally less accustomed to applying for Skills for Care funding.

Projects reported few issues with implementation, where they did, these were often overcome through flexibility and adaptation, including from Skills for Care.

A range of examples of good practice, relating to the planning and delivery of training were noted. Self-evaluations were generally well designed and filled in. There were a few issues with output tables and in-kind estimations.

## 7.1 Grant-holders held mixed views on the application process

### The majority of projects found out about the funding opportunity through existing links with Skills for Care

Almost all projects were either contacted about the funding opportunity by their Skills for Care Locality Managers who directed them to the Skills for Care website, or were alerted of the funding through other links with Skills for Care including via:

- Email/regular email bulletins;
- Informal conversations at Skills for Care events;
- Local networks (for example, one charity heard about it through the Care Sector Alliance Cumbria).

Only one organisation said they found out about the funding by seeing the ITT. Only one had found out about it through the Skills for Care website, though others had used the website later in the application process.

The WDIF rarely reached projects that were not already engaged with, or aware of, Skills for Care. Project stakeholders admit that the WDIF is ‘inevitably not getting to everyone’; and that it will always be more challenging to reach small and/or non-traditional employers. However, it is these employers who may generate many of the most innovative responses to training and service delivery challenges. For example, bringing training or techniques used in another sector, to social care.
Views on the bidding process were mixed

The biggest problems identified were the tight submission deadline (identified by just over a quarter of projects which answered this question) and the time-consuming nature of the application (around two fifths of projects which answered this question). In particular, several projects noted that the short timeframe did not allow them enough time to engage with stakeholders about the project. This was particularly problematic where project bids were co-written by multiple organisations. Other issues with the application process included:

- Difficulties understanding what was required. Around one fifth of organisations found the question wording unclear, had difficulties knowing how much information was required and/or found the question word count restrictive.

- Difficulties meeting application requirements. Issues included not knowing about NMDS-SC and/or some of the more technical. This was more of a challenge for small businesses. Some of the concerns reported were for requirements (such as indemnity insurance), which were not necessary to receive WDIF funding. In addition, the need to meet NMDS-SC requirements is highlighted clearly. However, given that organisations (particularly smaller ones) are struggling to understand the requirements, this suggests that greater clarity – and perhaps a ‘myth-busting’ document – are required.

Generally, the smaller the grant, the more time-consuming and difficult grant-holders found the application process. In addition, individuals were more likely to find the process time-consuming if it was the first time they had written a bid, with most reporting that it was much easier the second time round. Two organisations noted that it was particularly difficult when writing a bid for an innovative project because there is no obvious template (i.e. previous similar bid) to work from, while other organisations highlighted the time taken to conduct background research, weigh up their resources and capabilities, and develop their rationale and theory. However, other projects reported that, although time-consuming, the time spent was proportionate to the level of funding at stake.

Generally, it is to be expected that the smaller the grant (and the bidding organisation), the more onerous the grant-process will be. However, the balance of feedback suggests that the WDIF application is sufficiently simple; and strikes the right balance between being sufficiently open to be appropriate for a wide variety of projects, and bidding organisations, and providing too little guidance. The role, and availability, of Locality Managers, is key here.
Support received by Skills for Care was usually very helpful

All organisations who required help from Skills for Care reported that the individuals they spoke to for advice were very useful, and all had high praise for the Locality Managers. However, just over one fifth of projects received support after the bid was submitted, rather than during the bid process. Projects reported that this was inefficient, resulting in them effectively submitting two bids. Again, there is a need here to balance projects’ desire to minimise post-bid work, with a need to ensure fairness in a competitive process.

7.2 There were few problems with programme management, or project implementation

Few issues were reported with the programme management

WDIF projects are performance managed against the milestones set in their application. Projects’ main day-to-day contact tended to be with the Locality Managers. There were generally few problems with the performance management of projects. This included those very small organisations which accessed the WDIF. Some problems have arisen where a grant-holder was off long-term sick. Skills for Care is now addressing this by requiring that organisations provide at least two contacts.

All projects interviewed reported that the management of their projects was conducted mainly by Locality Managers, and was very helpful. One typical comment was:

‘I couldn’t fault them… they were really supportive and I always had someone to speak to’.

A couple of other grant-holders reported that they would have liked further flexibility with milestones and payment, and that they would have liked to run their project over a longer period of time. Whilst these requirements are clearly advertised at the outset of the programme, this does not mean that these difficulties were not significant, or didn’t cause limitations to the projects. If these milestones and time periods are inflexible, then Skills for Care could consider how to encourage projects to reflect clearly and critically on how likely these are to occur, at the bidding stage.

It was recognised by programme stakeholders and grant-holders that these are innovative projects, often run by quite small organisations, trying out something new. As such, it’s likely that management will need to be a little more flexible in allowing timescales to slip, and targets or milestones to change. When piloting new things it is good practice to shift modes of delivery or targets as organisations learn more about
what it is they are trying to do. In general, projects reported positively about the degree of flexibility shown by the programme management.

Some projects failed to deliver parts of their activities. Most were flexible enough to adapt their plans.

The majority of projects did not encounter many problems and activities were delivered as planned. However, around a fifth of projects failed to deliver some of their activities, or meet some of their targets. There were few common patterns to this. There was no relationship between the size of the funding awarded or the size of the organisation, and the projects not being delivered as planned.

In the majority of cases where projects faced a particular challenge or were unable to deliver a part of the project, they were able to demonstrate adaptability and either provide another form of training, make alterations to the activity, such as hold one large event instead of three smaller events, or re-direct funds to other areas of the project. Skills for Care’s flexibility in allowing this was key to success here.

**There were a number of common factors which improved implementation of projects**

Several factors which improved the delivery and implementation of projects were identified. These relate to:

- Planning and project management
- Project design
- Partnership working

The figure below summarises these factors, and boxes 1-3 provide more detail on the learning from each of these areas.
Figure 7.1: What works to improve implementation?
Best practice in planning and project management

Take advantage of the local context.

Projects found it helpful to link their work into local priorities and initiatives. For example, one Local Authority found that focusing their work on dementia, which was a local priority at the time (as the area was looking into developing dementia friendly communities), increased leverage and attention on their project.

Plan timescales

A few grant-holders felt that the quality of their projects was limited by short timescales. This was a particular challenge where projects were both developing and delivering training, and where projects were delivering a full course, rather than just a module.

Scope demand, and understand where engaging certain groups will be challenging

Roughly one-third of projects reported difficulties recruiting participants. Most commonly, the difficulties related to recruiting PAs, IEs and staff from the health sector. For example, one project aimed to recruit participants from both health and social care settings. However, training schedules in health care were set 12 months in advance (while the social care sector is generally much more flexible). Attracting participants from health care settings was thus very difficult, partly due to the short timescale of the entire project. The project was therefore oversubscribed by social care workers. It did not have a rich mix, ‘cross-fertilisation’ of participants, and it lacked input from health care workers.

Projects reported that they should have scoped out these potential risks in advance, begun to recruit earlier, considered working with a partner with good links to certain professions (for example a user-led organisation, or health partner), and potentially revise down their targets.
Best practice in planning and project management (cont.)

Consider who to target

Projects considered whether to target whole teams, or individuals, and whether to work with ‘good’ providers, or those who were struggling. Some projects suggested that whole team approaches worked particularly well at embedding practice within a setting. However, it also reduces reach, and requires training which is flexible enough to be relevant to staff of different grades. Where training is delivered to fewer individuals within an organisation (who will then cascade), providers need to ensure that they train individuals who have the influence to affect others.

Projects reported differing attitudes on whether to work with struggling providers, or those that are already engaged. Whilst the potential for benefit may be higher with those who are struggling, they may also be less able to change. One interviewee reported: ‘shape up or ship out… I’m concerned about the money being spent on failing providers… I would rather parade good practice.’

Arrange backfill

A lack of backfill could make attending training too expensive, even where training was free. This was true for PAs (which is well known), but also for some care home staff, particularly where they worked shifts. For example, one social enterprise had difficulty recruiting care home staff because the shift patterns within some care homes meant that it was difficult for care staff to take time away from the care home, due to a lack of suitable cover. This is a common problem, and should be emphasised by Locality Managers (if projects don’t themselves) during bid design.
Best practice in project design

Consider how to structure the course

Some projects reported that modular training worked well, particularly if it was flexible, allowing participants to attend at different times. A couple of projects noted the benefit of having at least two sessions, with time off in between for participants to reflect on what they learned, and (possibly) return with further questions in the next session. Setting ‘homework’ or research in this time can further engage individuals with the course – ‘no involvement, no commitment.’

Use interactive techniques, and involve participants in the design and running of projects

Interactive learning can help attendees engage with the learning. This can also encourage people to engage with material on a deeper level, for example, one project reported how the interactive elements of the sessions helped staff to empathise and understand more about how people who use care and support feel. Where using innovative or interactive methods, it is also important to consider how to get staff to relax; some training (for example, programmes that involve drama or role play) can initially be quite off-putting for some people.

Consider whether accreditation is appropriate

Accreditation can be very worthwhile, for a number of reasons. Projects reported that it made participants feel valued, and gave a strong sense of achievement: ‘They [the participants] were all really proud of themselves for completing such a big qualification.’ It also allows qualifications to be transferable, and easily understood. However, it is not always appropriate, particularly for more innovative projects. It can be ‘costly and complicated’ and can reduce the flexibility for innovative delivery.

Consider whether to require deposits to encourage attendance

A few projects noted difficulties with the commitment of participants. This included: failure to attend projects after booking a place; beneficiary drop outs; the non-completion, delayed hand-in or poor quality of coursework; and, poor attitudes from participants. Some suggested that charging, or using deposits, might be a way to ameliorate this, though there were also concerns that this would just create additional barriers for those who could not afford a deposit.
Best practice in partnership working

Work with a diverse range of partners.

Around one-fifth of grant-holders commented that working with a diverse range of people and with other organisations worked particularly well. Partnership working, co-production of projects (including training materials) and the opportunity to network and share experiences with other people, were particular aspects of the projects that were highlighted.

Where grant-holding organisations are working with a training provider, ensure that the provider is of a high-quality, and understands what is required of the training.

Projects often reported that having a good relationship with their training provider was important to a successful project. This was particularly the case where training content was innovative, or different; without a partner who fully understood what they were aiming for, this relationship could break down. For example, one Local Authority reported how the college that provided training to their Apprentice delivered training ‘too slowly, and not what was promised… the Apprentice had to start work at the Council before he had been able to undertake any training’. One way of ameliorating this was using a partner who had developed the training themselves; or one which they already had a trusted relationship with.
7.3 The provision of self-evaluations had a high degree of compliance

All WDIF projects have been asked to complete self-evaluations, with completion linked to payment milestones. Compliance with this request is high, with all completed projects from 2012/13 and 2013/14 returning this form, and all but four from 2011/2012. Projects were asked to report on the: inputs; implementation and activities undertaken; challenges and lessons learned; outputs and outcomes. Outcome reporting focussed on how projects were sustainable, scalable and transferable, and what additionality and value for money they offered. Projects reported this information to varying degrees of robustness.

From 2012, Skills for Care also began asking for common information from projects, with grant-holders asked to identify which overall Skills for Care themes, priorities and outcomes their project contributed to. They were also asked to report on common project specific outputs. These were defined at a programme level.

While compliance was high, and the use of common output measures led to some common information being collected, there were still a number of issues with the evaluative evidence requested. As discussed in Chapter 3, some projects struggled with assessing in-kind contributions, or did not try. In addition, projects often put contradictory answers in their output tables. This may relate to the fact that categories are overlapping, and not well defined.
Table 7.1 highlights the issues with current output tables. A suggestion for a new table is in Annex 6. The benefit of having these common output measures is that it enables economic analysis to be done more robustly. Where they are not filled in consistently, this means that the analysis is based on many more assumptions.

**Table 7.1: Self-evaluation output table (2012/13 and 2013/14 projects)**

<table>
<thead>
<tr>
<th>Output</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. new training courses designed</td>
<td>• Not clear what the differentiation between these is.</td>
</tr>
<tr>
<td>No. new training packs/resource packs developed</td>
<td>• Not always clear what the ‘number’ refers to, whether it is the number of times training was offered, or the number of different courses completed.</td>
</tr>
<tr>
<td>No. training courses delivered</td>
<td></td>
</tr>
<tr>
<td>No. qualifications/units achieved</td>
<td>• Not clear if this solely refers to accredited qualifications, or if it refers to the total number of qualifications, or the number of different qualifications.</td>
</tr>
<tr>
<td>No. individual employers trained</td>
<td>• Frame these separately to those on training to avoid confusion between number of attendees, and number of different courses.</td>
</tr>
<tr>
<td>No. Personal Assistants trained</td>
<td>• Not clear if this means completed training.</td>
</tr>
<tr>
<td>No. trainers trained</td>
<td>• Separate out managerial and non-managerial staff.</td>
</tr>
<tr>
<td>No. social care staff (all grades) trained</td>
<td></td>
</tr>
</tbody>
</table>

**There is limited evidence of the impact on people who use care and support**

There are likely to be several reasons why projects collected limited outcome data from people who use care and support. Predominantly, it relates to the fact that very few projects directly supported people who use care and support; evaluations, particularly for relatively small projects, are likely to focus on the direct beneficiaries (e.g. staff trained). This is compounded by the fact that the majority of projects delivered training to care workers who were not part of their organisations – it is unlikely to be feasible for them to collect feedback. Alongside this, there are more practical considerations such as the difficulty of gathering robust data to evaluate these outcomes and research ethics, particularly where participants may have conditions such as dementia.

**The impact of projects needs to be evaluated within the context of their scale, and level of innovation**

Different projects within the programme cannot be easily compared to each other; a reported increase in staff confidence in one project is not necessarily comparable to that in another. The reported increase will be a function of the measurement of success, the scale of the project, and how innovative it is.
Firstly, project impact (or lack thereof) must be evaluated within the context of the scale of the project and investment; a £5,000 project will not necessarily have the same scale of impact as a £80,000 one. Furthermore, this is not a simple relation between size and impact, small projects can reach large numbers of individuals, some projects may be targeting ‘low hanging fruit’ or easily altered behaviours, with (relatively) well established techniques. Others may be untested and innovative; but this innovation may tie them more closely to the aims of the Fund.

Indeed, the level of innovation in a project will affect its risk of failure. Innovative projects are, by their nature, trying something new – their chances of success are therefore potentially lower than those implementing something already proved. Innovation, and the risk associated with it, can be seen across two scales in the WDIF:

- **How ‘innovative’ is the project**, tool or training; is it a well-established tool, being applied in a slightly new setting, or tailored in a slightly different way? Is the grant-holding organisation accustomed to working with the target group? Alternatively, is this a very new or innovative tool, which has had little piloting work, or is working with an entirely new group?
- **How ambitious is the scope and scale?** Is it applying an innovative idea to a small, well contained, well-understood part of an organisation; or attempting large-scale culture change, or to influence external organisations? In these cases projects are trying to effect multiple outcomes, for multiple different groups of individuals, some of whom they may have very limited influence over.

Where projects are more risky, evaluation can be particularly valuable. The process of evaluation, in particular, gathering feedback from beneficiaries, can help projects to understand what elements of their project worked well, and what did not. Beneficiaries may not find a new style of training (or part of training) useful; projects need to know this. For example, one Local Authority’s project did not achieve the outcomes it had hoped for; staff, in particular, reported that the ‘innovative’ part of the project – a coaching and mentoring model added on to standard training – was ‘a bit gimmicky’ and not helpful. Self-evaluation allowed the organisation to robustly assess and identify this; they had been considering rolling out mentoring and coaching on a larger scale throughout the Local Authority, but decided not to as it was not cost-effective.

There are also management implications for Skills for Care for particularly ‘innovative’ projects; both in terms of identifying those who are at greatest risk, as well as considering what breadth and mix of projects they want within the WDIF.
8. Conclusions and Recommendations

This chapter presents the main conclusions to the evaluation, together with a set of recommendations for the future of the WDIF.

Programme design and management

*Individual projects’ aims fit with the priorities of the WDIF, though they were rarely developed in direct response to them*

The WDIF has been developed to support innovative training and development activities in the adult social care sector. Projects generally developed their plans to meet an already identified or pre-existing need within the sector, rather than in response to specific Skills for Care funding themes. Whilst many mapped onto Skills for Care’s broader themes, there were some which were rarely covered; for example, the theme around better integrating health and social care.

*Innovation in the WDIF is most helpfully viewed in terms of a development spectrum*

Innovation is not just about having an idea. That idea needs to be well-founded, addressing a specific problem; it needs to be tested, piloted and refined; and eventually (if successful) scaled up and transferred. WDIF projects sit across this spectrum. This should be expected given the relatively small scale (and timeframe) of WDIF funding – projects are unlikely to be able to move through each of these stages. Skills for Care should be funding projects at each stage of innovation – each stage of the spectrum is crucial to achieving high quality, mainstreamed innovation, and there are limited alternative funds available in social care to support the development of innovative ideas. Skills for Care should also support projects to consider, within this framework, how well-based their innovative idea is, and how they might develop it onto the next stage of the spectrum.

The more innovative a programme, the more risky it is. This risk can be defined both in terms of how new or un-tested a particular project is, and how ambitious its scale and reach is. Where projects are very high risk Skills for Care should be aware of this, and offer extra support where needed.

*Views on the bidding process were mixed; there are concerns that the project is predominantly targeting the already-engaged*

Some grant-holders were very positive about the bidding process, finding it proportionate and easy to use; others found it time-consuming and confusing. Generally, this related to how experienced projects were in applying for Skills for Care funding. Linked to this, there is a concern that the programme reach is limited. Given
that this Fund is about encouraging new and innovative projects, it is likely (and
desirable) that new organisations (including partnerships) apply for it. Though new
ideas can come from established partnerships, there may also be a role in encouraging
new ‘types’ of organisations to take part.

Innovative ideas (of course) can come from organisations already engaged with Skills
for Care, who are constantly focussed on ways to improve. However, they can also
come from those struggling (facing a significant issue may focus attention on how to
solve it) and those not engaged with Skills for Care (for example, they are a third sector
organisation, offering a particular type of training which may not currently be used in
social care).

Management (at the level of both the project and programme) has generally
worked well

Project grant-holders and Skills for Care staff were both positive about the management
of the WDIF. Where projects faced delivery challenges, they were generally provided
with enough flexibility from programme management to adapt their delivery plans. This
is important in small-scale innovative projects.

Key project challenges related to short timescales, beneficiary recruitment, and
beneficiary commitment.

Many projects struggled with the short time-frame of WDIF funding, both in terms of the
application process, and delivery. This was particularly an issue for projects trying to
deliver a whole or long course. This is to some extent unavoidable given the restrictions
of WDIF funding, though Skills for Care could ensure that ambitious projects carefully
think through how feasible they are, within the year timescale. Recruitment was
particularly challenging where participants were PAs, IEs, or from the healthcare sector.

There are a number of common factors which improved implementation

Grant-holder interviews identified a number of common factors which facilitated the
effective implementation of projects. They included:

- Planning and project management: take advantage of the local context; consider
timescale limitations at the outset; think about who to target; arrange backfill;
- Partnership working: work with a diverse range of partners; if using an external
training provider, ensure that they are competent and understand the aims of the
programme;
- Project design: consider using a modular format for training, with time for
beneficiaries to reflect on what they’ve learned; use interactive techniques, and
involve participants in the design and running of projects – this increases
ownership; carefully consider whether accreditation is appropriate; consider
requiring deposits to encourage attendance.
Self-evaluations were generally proportionate in size and complexity to the funding awarded, but there were some areas for improvement

The self-evaluations were completed by nearly all projects, to varying degrees of robustness. In-kind contributions were often not assessed, or were found to be underestimations once the grant-holders were spoken to. In addition, output tables were frequently completed inconsistently. Annex 6 includes a suggested new table for this.

Programme outputs and outcomes

The programme trained over 15,000 social care staff, and resulted in a large number of new training resources and innovative products

2012/13 and 2013/14 projects (the only years for which data is available) resulted in 143 new training courses and 154 new training packs or resources. Across all years, around 15,000 people were trained or benefitted from some form of professional development.

The innovative products developed were varied. They included training materials such as training packs, e-learning tools, phone apps and films; new training or workshops; working groups or stakeholders; and databases or mapping documents.

The programme reported outcomes for beneficiaries, organisations and people who use care and support

Social care staff who benefited from the WDIF projects reported that the training was almost always relevant to the challenges they faced, useful, and met their expectations. Alongside this, they (and grant-holders) reported that around three-quarters of projects led to improvements in their knowledge and understanding.

Organisations most commonly reported outcomes related to raised awareness either of a particular issue, of the social care profession, or of their organisation. Alongside this, they reported changes in ways of working, policies and procedures, generally supported by changes in staff behaviour. The evidence on improvements in care for people who use care and support was more limited.

Additionality of the programme is high

This reflects the aim of the WDIF to distribute funding to projects which are unlikely to receive funding from other sources. Around two-fifths of projects said that they would have gone ahead, just at a smaller scale, or more slowly, or without certain elements. Skills for Care needs to decide whether these represent value for money; it is possible that these projects carry a lower risk of failure than those which are totally new (they may already have supportive infrastructure, wider policies, etc.), and therefore are more
likely to be sustained and/or transferred than others. Skills for Care might want to balance its WDIF portfolio between highly innovative/highly risky projects and less innovative/less risky ones.

**The programme provides value for money**

For every £1 invested in the WDIF, there is a return of £1.88\(^\text{18}\). This relates to a total additional benefit of £6.8m. It is likely that this is an underestimation of the true impact of the WDIF programme, as it only considers the impact of people attending training, not the development of tools, research or innovative provision. It also only counts the number of people who attended training in the lifetime of the project, so ignores any sustained, scalable or transferable benefits.

**Sustainability, scalability and transferability**

**Sustainability of the WDIF is high**

Around 80% of projects reported that their projects (or elements of it) were sustained in some way. This is a positive finding, particularly given the innovative nature of many of the supported activities. There were two main models of sustainability; projects either continued to run or benefit from their projects at no extra cost, or they secured additional funds, either internally, by charging for provision, or by leveraging an additional grant. Where projects could not find ways to run their project at little extra cost, or they couldn’t secure additional monies, they tended to not be sustained.

Refresher courses, the provision of low maintenance tools, and instigating complementary changes in policies and procedures were all highlighted as effective ways to embed staff behaviour change.

Local Authorities were particularly successful at sustaining their projects. There is inconclusive evidence about why this is, though there is some suggestion that they are better at disseminating and sharing learning within their organisations. This is something the programme team could explore further, and, based on this, consider whether private-sector projects might require additional support to be sustained.

**Scalability and transferability of the Fund is relatively high, but not reaching its full potential**

Around two-fifths of projects were scaled up or transferred in some way. There were three main models by which this occurred; either projects offered training to new groups, delivered the same training but on a larger scale, or adopted a ‘cascade’ model, where social care staff shared learning with colleagues.

\(^\text{18}\) N.B. this figure includes the cash and in-kind contributions of grant-holding organisations as ‘costs’.
Almost all beneficiaries and grant-holders interviewed thought that their projects could be usefully scaled up or offered more widely, however there were a number of barriers to achieving this. The biggest barriers were a lack of capacity within the organisation to deliver more training or provision, together with issues around how to quality assure training or provision if taken on by another organisation. Currently, only those organisations which are large (with a national reach), accustomed to promoting themselves commercially, or have very strong (and senior) links with Skills for Care are able to effectively market themselves. Smaller, less well connected organisations struggle.

8.1 Recommendations

This chapter presents the recommendations for the programme team, and Skills for Care more widely.

Programme outcomes

**Recommendation 1**: Given the outcomes generated, the high level of additionality, and the return on investment, Skills for Care should continue to disburse a portion of the Workforce Development Fund made available by the Department of Health, as the WDIF.

**Recommendation 2**: The programme management team should ensure that the scope of the programme – in terms of the organisations and activity types funded – should remain wide.

Programme design and management

**Recommendation 3**: Skills for Care should clarify the bidding process for the Fund. In particular, Skills for Care should consider how to clarify some of their requirements, bidders (particularly from small organisations) sometimes reported misunderstanding these.

**Recommendation 4**: Skills for Care should promote the WDIF more widely to improve the uptake of the WDIF amongst organisations less well linked to Skills for Care. This could also include focussed marketing to the residential sector. Skills for Care’s partners in particular parts of the sector could also be asked to promote the Fund.

**Recommendation 5**: the WDIF programme team should identify where projects are targeting harder to reach beneficiaries and offer projects additional support, or ensure that they have allocated sufficient time and resource.

**Recommendation 6**: the WDIF programme team should provide more guidance on how to estimate in-kind contributions, and highlight to funded projects why this is important.
**Recommendation 7:** The WDIF programme team should simplify and clarify what projects should report in output tables. This could include separating out the development and delivery of training courses and resources; clarifying what ‘numbers’ means; and distinguishing between accredited and non-accredited training, and managerial and non-managerial trainees (see Annex 6 for example table).

**Sustainability, scalability and transferability**

**Recommendation 8:** Skills for Care could ask projects to be more specific about how they will sustain or scale up their projects on the initial application form. Locality Managers should highlight sustainability in early discussions. Guidance should include examples of how projects have achieved sustained their activities after the WDIF support is finished.

**Recommendation 9:** The WDIF programme team should more actively collect any resources, toolkits and other products of the funded projects. Skills for Care should ensure these products are shared on the ‘Learn from Others’ web resource.
9. Annexes
Annex 1 Logic model

**Context**
The Workforce Development Innovation Fund is a funding stream from the Department of Health, managed and disseminated by Skills for Care. It was set up to address some of the key challenges faced by the sector, including increasing demand, the rise of personalised care, and new job roles and sectors. Skills for Care also has a wider role in developing tools and resources to help develop the adult social care workforce.

**Rationale**
The adult social care workforce is changing rapidly; this change means that insight and intelligence, particularly as regards newer service areas such as PAs and IEs, is particularly beneficial. Employers best understand the needs of their workforce and service users, and are therefore best placed to develop innovative solutions to gaps in provision and knowledge.

<table>
<thead>
<tr>
<th>Inputs</th>
<th>Activities &amp; Outputs</th>
<th>Short term outcomes</th>
<th>Medium term outcomes</th>
<th>Impacts</th>
</tr>
</thead>
<tbody>
<tr>
<td>£2,878,444 Skills for Care funding, to 111 projects.</td>
<td>Development of new training tools/resources – e.g. a training course, a workbook, an app</td>
<td>Take up and use of tool/resource by host organisation and/or elsewhere</td>
<td>Participants and organisations consider the resource to be valuable, relevant to their roles and needs, and to address a gap in their skills/knowledge</td>
<td>Products, resources and provision developed are scaled up, transferred to new settings, and sustained</td>
</tr>
<tr>
<td>£325,000 cash contributions from employers</td>
<td>Provision of (already existing) training to new groups in new settings e.g. PAs or IEs trained; social care staff accessing leadership training</td>
<td>Participants and organisations consider the resource to be valuable, relevant to their roles and needs, and to address a gap in their skills/knowledge</td>
<td>Participants’ knowledge and awareness increase</td>
<td>Quality of care, user experience of care improved</td>
</tr>
<tr>
<td>£410,000 in-kind contributions from employers</td>
<td>Research into experience of and access to service provision – e.g. increases in knowledge and understanding</td>
<td>Participants apply the knowledge, skills and awareness learned in order to do their job more effectively and efficiently</td>
<td>Gaps in workforce knowledge and access to training are filled, harder-to-reach groups benefit from training</td>
<td>Improved health and social outcomes</td>
</tr>
<tr>
<td>Recipients included: providers (not for profit and profit); CICs; employer-led/membership organisations; local authorities; charities</td>
<td>Pilots of innovative provision – e.g. pilot sessions of a new activity offered, PA registers created; organisational networks created</td>
<td>The research provides improved understanding and awareness of local problems, solutions, barriers and facilitators to delivering high quality care</td>
<td>Organisations disseminate research findings within and outside their organisation</td>
<td>PAs, IEs and other harder-to-reach groups have improved and sustained access to training and development</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Findings are used to inform service design and policy</td>
<td>Areas of care lacking training material now have training material</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>The social care sector’s capacity to innovate is increased</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Organisations in the social care sector have improved connections with each other; collaborative working increases</td>
</tr>
</tbody>
</table>

Three-year evaluation of the Workforce Development Innovation Fund, 2011/12-2013/14 85
Table A1.1 Evaluation framework for the WDIF

<table>
<thead>
<tr>
<th>Element of logic model</th>
<th>Activity type</th>
<th>Indicator</th>
<th>Tool/method of evidence collection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rationale</td>
<td>All</td>
<td>■ Evidence base for whole WDIF programme&lt;br&gt;■ Evidence base for individual projects.</td>
<td>Scoping interviews; Document and MI review; interviews with grant-holders.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inputs</td>
<td>All</td>
<td>■ Skills for Care investment; employer cash and in-kind contributions&lt;br&gt;■ VFM analysis</td>
<td>Document and MI review; VFM analysis</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outputs</td>
<td>All</td>
<td>■ Project self-reported outputs (from self-evaluations), compared against target outputs (where given), including:&lt;br&gt;Training projects&lt;br&gt;– No. new products developed&lt;br&gt;– No. new training courses delivered&lt;br&gt;– No. participants attending training&lt;br&gt;– No. of qualifications completed&lt;br&gt;Research projects&lt;br&gt;– No. research reports produced&lt;br&gt;– No. of research participants consulted.&lt;br&gt;Innovative provision&lt;br&gt;– No. sessions of innovative provision offered&lt;br&gt;– No. of new tools/resources developed.</td>
<td>Document and MI review; interviews with grant-holders</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Short-term outcomes</td>
<td>Training</td>
<td>Development</td>
<td>Interviews with grant-holders; beneficiary survey; case studies</td>
</tr>
<tr>
<td>---------------------</td>
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<td>------------------------------------------</td>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Resources are being taken up and used by host organisations and/or elsewhere</td>
<td>■ Evidence of the course’s relevance to participants</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Resources are being taken up and used by host organisations and/or elsewhere</td>
<td>■ Training is developed that is perceived to fill a gap in current provision</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Participants report increases in their attitude, knowledge and skills in new topics, roles and issues</td>
<td>■ Participants share learning with colleagues</td>
<td></td>
</tr>
<tr>
<td></td>
<td>New groups of people access training</td>
<td>■ New groups of people access training</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Training provided fills a gap in current provision</td>
<td>■ Training provided fills a gap in current provision</td>
<td></td>
</tr>
<tr>
<td></td>
<td>All of the above</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Research</td>
<td>Organisations have improved knowledge and understanding of the barriers/facilitators to service provision and access.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Innovative provision</td>
<td>People who use care and support access new and innovative provision</td>
<td>People who use care and support benefit from the innovative provision</td>
<td></td>
</tr>
<tr>
<td></td>
<td>People who use care and support benefit from the innovative provision</td>
<td>Organisations improve understanding of the barriers/ issues surrounding implementation of new provision.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>All of the above</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medium-term outcomes</td>
<td>Training</td>
<td>Development</td>
<td>Interviews with grant-holders; beneficiary survey; case studies</td>
</tr>
<tr>
<td>----------------------</td>
<td>----------</td>
<td>-------------</td>
<td>---------------------------------------------------------------</td>
</tr>
</tbody>
</table>
|                      |          | ■ Participants improve their knowledge, skills and awareness of new topics, roles and issues  
■ Resources taken up beyond the initial target group/organisation.  
■ Other organisations/groups find the resource valuable and relevant. | |
|                      |          | **Provision**  
■ Participants use new knowledge/skills and awareness.  
■ Groups which previously didn’t access training, now access training  
■ Topics which lacked training materials now have training materials. | |
|                      |          | **Development and provision**  
■ All of the above | |
|                      | Research | ■ Research findings are disseminated within and/or outside the organisation  
■ Research findings are used to inform service/training design. | |
|                      | Innovative provision | ■ New services are delivered more efficiently (cost-effectiveness/ increased number of attendees?)  
■ Provision continues to run and be accessed  
■ Provision is accessed beyond the initial target group | |
<table>
<thead>
<tr>
<th>Impacts</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Improved quality of care and improved experience of care</td>
</tr>
<tr>
<td></td>
<td>Resources/tools and training courses are offered on a larger scale</td>
</tr>
<tr>
<td></td>
<td>Resources/tools and training courses are offered to new groups/organisations/to a wider audience</td>
</tr>
<tr>
<td></td>
<td>Resources/tools and training are embedded into ‘normal’ practice and sustainably implemented</td>
</tr>
<tr>
<td></td>
<td>Products (resources/tools) are downloaded from the Skills for Care website</td>
</tr>
<tr>
<td></td>
<td>Organisations report that harder-to-reach groups (PAs, IEs, ethnic minorities) access services more</td>
</tr>
<tr>
<td></td>
<td>Innovative provision continues to be offered in the long-term</td>
</tr>
<tr>
<td></td>
<td>People who use care and support report sustained improvement in the quality of their care</td>
</tr>
<tr>
<td></td>
<td>Innovative provision is offered on a larger scale</td>
</tr>
<tr>
<td></td>
<td>Innovative provision is offered to new groups or organisations</td>
</tr>
<tr>
<td></td>
<td>Employers report increased collaboration with each other (e.g. evidence of new partnerships, projects run together)</td>
</tr>
<tr>
<td></td>
<td>Improved employer productivity and efficiency</td>
</tr>
<tr>
<td></td>
<td>Increases in staff wages</td>
</tr>
<tr>
<td></td>
<td>Services offer good returns on investment.</td>
</tr>
</tbody>
</table>

Interviews with grant-holders; beneficiary survey; case studies
# Annex 2  List of grant-holding organisations interviewed

<table>
<thead>
<tr>
<th>No.</th>
<th>Organisation Name</th>
<th>Number of beneficiaries interviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Association for Care Training (2011/12)</td>
<td>0</td>
</tr>
<tr>
<td>2</td>
<td>Association for Care Training (2012/13)</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>Association for Care Training (2013/14)</td>
<td>1</td>
</tr>
<tr>
<td>4</td>
<td>Carlisle Mencap</td>
<td>0</td>
</tr>
<tr>
<td>5</td>
<td>Dudley Centre For Inclusive Living</td>
<td>0</td>
</tr>
<tr>
<td>6</td>
<td>Flexicare Altruistic Solutions Limited</td>
<td>1</td>
</tr>
<tr>
<td>7</td>
<td>Barchester Healthcare</td>
<td>0</td>
</tr>
<tr>
<td>8</td>
<td>Cambian Healthcare</td>
<td>1</td>
</tr>
<tr>
<td>9</td>
<td>Community Health International (C.H.I) Ltd</td>
<td>0</td>
</tr>
<tr>
<td>10</td>
<td>Eat that Frog (CIC)</td>
<td>0</td>
</tr>
<tr>
<td>11</td>
<td>National Association for Providers of Activities NAPA</td>
<td>2</td>
</tr>
<tr>
<td>12</td>
<td>Richmond Users Independent Living Scheme (RUILS)</td>
<td>3</td>
</tr>
<tr>
<td>13</td>
<td>Shared Lives Plus</td>
<td>2</td>
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<tr>
<td>14</td>
<td>Sporting Memories Network CIC</td>
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</tr>
<tr>
<td>15</td>
<td>St Giles Hospice</td>
<td>0</td>
</tr>
<tr>
<td>16</td>
<td>St Helens Chamber Limited</td>
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<tr>
<td>17</td>
<td>St Lukes Hospice Plymouth</td>
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</tr>
<tr>
<td>18</td>
<td>Stroke Association (2012/13)</td>
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<tr>
<td>19</td>
<td>Stroke Association (2011/12)</td>
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<tr>
<td>20</td>
<td>The London Brokerage Network</td>
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<tr>
<td>21</td>
<td>The Suffolk Brokerage</td>
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<tr>
<td>22</td>
<td>Vida Healthcare</td>
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</tr>
<tr>
<td>23</td>
<td>BCDA - Learning and Development Service</td>
<td>0</td>
</tr>
<tr>
<td>24</td>
<td>CareMatch, Staffordshire County Council</td>
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</tr>
<tr>
<td>No.</td>
<td>Organisation Name</td>
<td>Number of beneficiaries interviewed</td>
</tr>
<tr>
<td>-----</td>
<td>-------------------------------------------------</td>
<td>-------------------------------------</td>
</tr>
<tr>
<td>25</td>
<td>East Dorset District Council</td>
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</tr>
<tr>
<td>26</td>
<td>Shropshire Council</td>
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</tr>
<tr>
<td>27</td>
<td>London Borough of Newham</td>
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</tr>
<tr>
<td>28</td>
<td>Sefton Council</td>
<td>3</td>
</tr>
<tr>
<td>29</td>
<td>Staffordshire County Council (2011/12)</td>
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</tr>
<tr>
<td>30</td>
<td>Staffordshire County Council (2012/13)</td>
<td>0</td>
</tr>
<tr>
<td>31</td>
<td>Tameside Metropolitan Borough Council</td>
<td>1</td>
</tr>
<tr>
<td>32</td>
<td>West Sussex County Council</td>
<td>2</td>
</tr>
<tr>
<td>33</td>
<td>Hertfordshire County Council</td>
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</tr>
<tr>
<td>34</td>
<td>Shropshire Council</td>
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</tr>
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<td>35</td>
<td>Brighton &amp; Hove City Council</td>
<td>4</td>
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<tr>
<td>36</td>
<td>Central Bedfordshire Council</td>
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</tr>
<tr>
<td>37</td>
<td>Woodford Homecare &amp; Support Services</td>
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</tr>
<tr>
<td>38</td>
<td>Staffordshire County Council (2013/14)</td>
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</tr>
<tr>
<td>39</td>
<td>Stroke Association (2013/14)</td>
<td>0</td>
</tr>
<tr>
<td>40</td>
<td>The Orchard Trust</td>
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</tr>
<tr>
<td>41</td>
<td>RUILS</td>
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</tr>
<tr>
<td>42</td>
<td>Sheffield Centre for Independent Living</td>
<td>5</td>
</tr>
<tr>
<td>43</td>
<td>Spare Tyre</td>
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</tr>
<tr>
<td>44</td>
<td>The Forum for Health and Wellbeing</td>
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</tr>
<tr>
<td>45</td>
<td>Association for Real Change</td>
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</tr>
<tr>
<td>46</td>
<td>Dimensions</td>
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<tr>
<td>47</td>
<td>Dudley BCPC</td>
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<tr>
<td>48</td>
<td>NAPA</td>
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<tr>
<td>49</td>
<td>Sense</td>
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</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
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</tbody>
</table>
Annex 3  List of Case Studies

Full case studies will be included in the final report.

- Brighton and Hove Council
- Central Bedfordshire Council
- Woodford Homecare and Support Services
- Staffordshire County Council
- Stroke Association
- The Orchard Trust
- RUILS
- Sheffield Centre for Independent Living
- Spare Tyre
- The Forum for Health and Wellbeing
- Association for Real Change
- Dimensions
- Dudley BCPC
- NAPA
- Sense.
## Annex 4  Sampling breakdown of projects

### Table A4.1 Sampling of projects

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Sampling information</th>
<th>Sample achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Activity</strong></td>
<td>As outlined in the logic model, different activity types have different aims, objectives and outcomes. Their models of innovation, and the ways in which they are sustained, scaled up and transferred, also differ. To fairly represent the proportion and diversity of projects the evaluation will sample a minimum of: 10 training (development and provision) projects  Seven training (provision only)  Four training (development only)  Three research  Three innovative provision.</td>
<td>29 training (development and provision)  4 training (development only)  10 training (provision only)  3 research (though one was re-categorised as training following the interview)  3 innovative provision.</td>
</tr>
<tr>
<td><strong>Size of project</strong></td>
<td>There is significant variation in the size of projects (from £1,000-over £100,000) so it will be important to ensure that the evaluation captures this variation. The evaluation will speak to at least three projects under £10,000, and at least three projects over £50,000.</td>
<td>10 projects &lt;£10,000  8 projects &gt; £50,000</td>
</tr>
<tr>
<td><strong>Year of project</strong></td>
<td>The rationale and management of the WDIF has shifted since 2011, and it will be important to take account of these changes. In addition, it will be important to talk to some of the older projects to get a longer-term view. The evaluation will include at least eight projects from each year.</td>
<td>Seven 2011/2012 projects (despite putting additional resource into chasing these)  20 2012/13 projects  22 2013/13 projects</td>
</tr>
</tbody>
</table>
Annex 5  Value for Money Analysis Method

The method for assessing the economic impact of the WDIF is outlined in this annex. It sets out the assumptions around the additionality of the programme, and around monetising the outcomes, before presenting the findings.

A5.1 Assumptions

Additionality

Additionality is the difference between the outcomes achieved by participants on the programme and the outcomes which would have been achieved anyway. As detailed in the main report, no counterfactual data was available to the evaluation; the assumptions therefore come from qualitative interviews, with each interviewer assessing the four criteria for each project. Interviewers were asked to assess, for each project, for each measure, whether the impact was ‘low’, ‘medium’ or ‘high’. The overall assessment therefore combined an assessment of the number of projects reporting a particular additionality challenge, with how significant this challenge was.

- **Deadweight** – participants who would have achieved learning outcomes without the WDIF projects. Projects were asked whether or not they would have gone ahead with their training if they had not won WDIF funding. Just under half of projects reported that they would not have gone ahead at all, and just over half reported that they would have gone ahead, but on a smaller scale. Deadweight has therefore been estimated at low/medium.

- **Leakage** – did anyone benefit who was outside the WDIF target criteria? No projects identified any participants who were outside the target criteria. Leakage was therefore estimated at zero.

- **Displacement** – Is the project likely to have prevented people attending other training or provision? A few projects and project beneficiaries reported that they would have found other training to attend, had they not attended the WDIF-funded course or module. Displacement was therefore estimated at low/medium.

- **Substitution** – Did the project result in organisations not offering training or provision that they otherwise would have done? Around a fifth of projects had either a small or medium issue with substitution, often because they were so small they could only run a few programmes at any time. Substitution was therefore estimated as low.
The multiplier effect

The multiplier effect measures the degree to which an intervention ‘ripples’ out into the economy, through effects on demand in the sector and for care sector supply chain. The training provided and qualifications achieved are not expected to increase demand in the sector, therefore the multiplier effect is estimated to be zero.

Measuring impact

The project self-evaluations were not required to monetise the outcomes they achieved, or assess the value for money of the project. Therefore, there is no primary information on the monetary impact of the programme. In order to estimate the monetary impact, proxy measures from existing literature have been used to estimate the impact of the training. The proxy measures used are presented below.

For accredited training leading to a qualification

Each qualification achieved through WDIF funding is associated with an increase in productivity for the individual completing the qualification. The value of this increase in productivity was estimated for the adult social care sector in England in research carried out for Skills for Care by ICF (Economic Value of the Adult Social Care sector, 2013). The Present Value of each qualification to the employer has been used as a proxy measure of the impact of the qualifications achieved through the WDIF. The proxy measure has been multiplied by the number of qualifications achieved to get to a total impact for the qualifications achieved. This value has been netted using the additionality measures discussed above to provide an estimate of the additional monetary benefit of the qualifications achieved.

For non-accredited training or training modules

Measuring the impact of training on productivity is more challenging, as it is difficult to disaggregate the effect of training from other variables affecting productivity. There is a limited amount of research into the topic which quantifies the impact of training on employers. In 2010, the UKCES produced a literature review which covered the effect of training and skills acquisition (The Value of Skills, an evidence review). This included a selection of studies which quantified the effect of training on productivity, but the majority of these studies estimated the change in productivity from increasing the percentage of employees who received training (for example a one percentage point increase in the number of employees receiving training led to a 0.6% increase in value added, Dearden et al, 2006). There have been some studies since which have estimated the impact of providing training to employees, such as the work by Sauermann, & De Grip (2012) which indicated that a worker’s participation in training leads to a 9 percent increase in productivity, and Lopes & Teixeira (2013) which
estimated that an additional hours training for an employee increased their productivity by 0.09%.

The work of Lopes & Teixeira has been selected as the most appropriate to estimate the impact of the training delivered through the WDIF, as the studies covered in the UKCES review cannot be used due to the results being expressed as an increase in the proportion of workers receiving training, or the training being formal training. The training programme used in the Sauermann, & De Grip (2012) research is a 38 hour course, which would overestimate the length of much of the training provided through the WDIF.

The data, assumptions and method used for the calculation of the impact of this training are:

- There is no accurate measure of the productivity of a worker in the care sector, particularly one which is broken down by occupation (for example the different values of productivity for a care worker or a care manager). Therefore, annual wages have been used as the baseline measure of worker productivity in the sector (before the training took place). The wages used have been taken from data from the NMDS-SC, presented in “The state of the adult social care sector and workforce in England, 2012”. Two values have been used, the annual earnings of a registered manager in the sector (£28,152), and the annual earnings of a senior care worker (£16,711).
- There is variation in the length of training provided through the WDIF. It has been assumed that the average length of training is 2 days (14 hours). This leads to a change in productivity of 1%.
- The impact of the training is assumed to last for seven years, the same duration as the impact of a qualification lasts. The value of the increase in productivity in future years has been discounted at a rate of 3.5%, following the guidance set out in The Green Book: Appraisal and Evaluation in Central Government (HM Treasury, 2011).
- The proxy measures of the impact have been multiplied by the number of individuals completing training courses, to get a total impact for the qualifications achieved. This value has been netted using the additionality measures discussed above to provide an estimate of the additional monetary benefit of the training completed.

Limitations

There are some limitations to the calculations that have been made, making the estimation of the economic impact of the programme more uncertain. In most cases,
these mean that the estimated economic impacts are under-estimated. Overall, results are likely to be an under-estimate.

- The analysis only considers the economic impact of people attending training. It does not calculate the benefit of the development of tools or resources, research, or innovative provision.
- The monetary impacts are only calculated for those individuals already trained by projects; it does not take into account future training run using the tools and resources developed. Again, this is likely to lead to an underestimation of impact, particularly for those projects which are successfully sustained, transferred or scaled up.
- In many cases, it was not possible to determine what proportion of participants were managers. Where it was not possible to determine this, it was assumed that one trainee would be a manager, and the rest care workers. This is likely to underestimate the number of managers, and therefore underestimate the total economic impact as training a manager has a higher impact than training a care worker.
- In some cases training was delivered at several levels. The number of people attaining each level was rarely identified. Where this was the case, it was assumed that everyone achieved the lower level. This will likely lead to an underestimation of impact as a higher-level qualification has a greater economic benefit.
- A couple of project listed thousands of beneficiaries as having been ‘trained’. In reality, training in this sense tended to be that they had seen a DVD. This is likely to lead to very limited impacts in comparison to doing a learning module, therefore these were excluded.
- It is likely that the estimation of in-kind contributions is an under-estimate. All projects were asked to note this on their self-evaluation, and only around half of projects reported. However, when this was checked in qualitative interviews, the proportion providing in-kind contributions rose to nearly 100% - though many were still unable to monetise this.
Annex 6  Suggested new outputs table

Table A6.1 Suggested new table

<table>
<thead>
<tr>
<th>‘Design’ outputs</th>
<th>Designed</th>
<th>Delivered</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of new training courses(^{19})</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. of new training resources or tools (i.e. not standalone training)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of participants trained</td>
<td>Completed non-accredited training</td>
<td>Completed accredited qualification units</td>
</tr>
<tr>
<td>No. IEs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. PAs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. trainers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. social care staff (non-managers)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. social care staff (managers)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

\(^{19}\) This refers to the number of different training courses, not the number of times it was delivered. So if a Local Authority designed two new training courses on dementia, which were then offered to eight people, the numbers in both boxes would be two.
Annex 7  Rogers’ Diffusion of Innovation

Rogers’ Diffusion of Innovation\textsuperscript{20} provides a framework for understanding how innovative ideas might be adopted. The framework is detailed below, alongside questions and factors which will influence uptake in the WDIF setting.

**Table A7.1 Framework for assessing the adopting of innovation – Rogers’ Diffusion of Innovation**

<table>
<thead>
<tr>
<th>Factor</th>
<th>Things to consider and factors influencing uptake</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Relative advantage</strong> – to what extent is the idea/tool/resource perceived to be better than what it supersedes?</td>
<td>To what extent is the training or tool addressing a clearly defined gap in provision? If a project is addressing an area for which lots of other training or tools exist, it will be much harder to persuade others of the relative advantage of this. To what extent can the organisation evidence the success that their project has had? Evaluation is important here in building a persuasive case to other organisations that the tool or training is worthwhile.</td>
</tr>
<tr>
<td><strong>Compatibility with existing practices</strong> – the degree to which the innovation is consistent with the existing values and practices of potential adopters</td>
<td>Who would this training be relevant to? Projects should consider whether other types of organisation or beneficiaries are likely to face barriers to adopting/taking part in this training. Projects should think carefully about targeting training.</td>
</tr>
<tr>
<td><strong>Simplicity and ease of use</strong> – the degree to which the innovation is perceived as easy to use and understand</td>
<td>How easy is it to deliver the training? Do you need specially trained staff (in which case, consider a train-the-trainer model)? What level of staff are necessary – can it be delivered (more cheaply), by less senior staff? Consider to what extent you will need to quality assure the training. What skills and background will beneficiaries need to take part? Are there minimum requirements for it to be worthwhile?</td>
</tr>
<tr>
<td><strong>Trialability</strong> – the extent to which an innovation can be experimented on and refined based on findings. Can it be tailored to local settings?</td>
<td>How flexible is the training or tool? Consider whether the tool can be adapted or tailored to local settings (e.g. is it modular?), reflecting prior knowledge or priorities. Allowing and facilitating tailoring can increase organisations’ and beneficiaries’ ownership</td>
</tr>
</tbody>
</table>

\textsuperscript{20} Rogers (2003) Diffusion of Innovations, Simon & Shuster International
<table>
<thead>
<tr>
<th>Factor</th>
<th>Things to consider and factors influencing uptake</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(and therefore engagement) with a particular tool/ training.</td>
</tr>
<tr>
<td><strong>Observable results</strong> – how easily can an adopter see the (positive) impact of an innovation?</td>
<td>Consider how easy it is to see the benefits of training/ the tool, put systems in place to feedback success/ failure (for example monitoring of tool use/ performance).</td>
</tr>
</tbody>
</table>
Annex 8  Research tools

A8.1  Case study topic guides

Below are the topic guides for the case study interviews. Case study interviews will be held with a wide variety of people (staff, service users, PAs, IEs, colleagues), in a wide variety of different roles and relations to projects. We have therefore designed a range of topic guides. These are intentionally open and flexible; interviewers will tailor according to the individual. If we will be interviewing an individual who doesn’t fit any of the categories below, we will tailor a new topic guide. The topic guides are:

- For direct beneficiaries:
  - Staff who have attended training/used a particular tool – these are to be used together with the shorter survey questions;
  - Service users and/or staff who benefitted from innovative provision – these are to be used together with the shorter survey questions.

- For indirect beneficiaries:
  - Colleagues of staff who have attended training/used a particular tool;
  - Service users whose carers/social care staff have attended training.

Training projects

The following is to be used for the 15 projects for which we are conducting case studies. When conducting interviews, interviewers should ask the relevant set of survey questions, as well as these more in depth questions. Interviewers should bear in mind that the questions they ask will vary according to whether they are speaking to a direct or indirect beneficiary of the programme; a member of staff or an adult social care user; and which type of activity they are speaking about.

Interviewers must use (and sign) the verbal consent script to gain consent to take part, prior to starting the interview. Interviewers must also make participants aware that what they say is not completely anonymous, their comments will be attributed (though anonymously) to a particular project. At any time (including after the interview) they can ask for things they say not to be printed. They can also ask that what they say only be analysed in the cross-project synthesis (thus maintaining anonymity).

N.B. none of the projects selected as case studies were classified as ‘research’.

Background/rationale

- Why did you decide to take part in this training?
  - Explore: whether it was to address a gap in skills, in particular areas of knowledge, etc.
- How often do you usually take part in training?
  - Explore: interviewees usual access to training, level of qualification.
- Do you have any formal social care qualifications?
  - Explore what these are, and at what level.

Experience of the course

- Has the course met your objectives? What did you find most useful and why?
Explore: the content of the provision, the way it was delivered, the topic it addressed
- How relevant was the tool/course to your work?
- Was there anything you found less useful about the provision?
- How different was this training from other training you have accessed? Is there anything else similar available?
  o Explore: the content of the provision, the way it was delivered, the topic it addressed
- To what extent has the training influenced the way you work?
  o Ask for examples
- To what extent has the training influenced the way your organisation works?
  o Ask for examples
- What are the barriers and facilitators to implementing what you learnt in practice?
  o Explore: content of what was learnt, role of mentors, organisational buy-in, practicality of tools/resources

**Sustainability, transferability and scalability**

- To what extent have the benefits from this training been sustained? Is it still being offered?
- To what extent is this training/resource useful for other people in the adult social care sector?
  o Explore: who it would be relevant to, and why
- What are the barriers and facilitators to allowing people to access this tool/training more widely?
  o Explore: relevance to other people, any changes that are needed
  o Explore: role of Skills for Care, role of the grant-holding organisation
- What evidence is there for this being used more widely?
  o Explore: scale
  o Explore: with whom?
- Is there anything else you’d like to add?
Innovative provision

The following is to be used for the 15 projects for which we are conducting case studies. When conducting interviews, interviewers should ask the relevant set of survey questions, as well as these more in depth questions.

Interviewers should bear in mind that the questions they ask will vary according to whether they are speaking to a direct or indirect beneficiary of the programme; a member of staff or an adult social care user; and which type of activity they are speaking about.

Interviewers must use (and sign) the verbal consent script to gain consent to take part, prior to starting the interview. Interviewers must also make participants aware that what they say is not completely anonymous, their comments will be attributed (though anonymously) to a particular project. At any time (including after the interview) they can ask for things they say not to be printed. They can also ask that what they say only be analysed in the cross-project synthesis (thus maintaining anonymity).

N.B. none of the projects selected as case studies were classified as ‘research’.

Background/rationale
- What was your involvement with this provision?
- Why did you decide to take part?

Outcomes/impacts
- How relevant was the project to the challenges you face?
- How was this project different from other service provision?
  - Explore: content, topic, mode of delivery
- How have you benefitted from this project?
  - Explore: impacts on quality and experience of care; impact on quality of life; impact on ability to cope
  - Explore: ease of access to services etc.
- What worked well about this project?
- What worked less well?

Sustainability, transferability and scalability
- To what extent have the benefits from this provision been sustained? Is it still being offered?
- To what extent do you think other people in the adult social care sector would benefit from this provision?
- What are the barriers and facilitators to this being provided more widely?
- What evidence is there for this being used more widely?
  - Explore: scale
  - Explore: with whom?
- Is there anything else you’d like to add?
Topic guide for interviews with colleagues of people who received training

This topic guide is intended for use with colleagues of people who have received training. It is being used to provide 360 degree feedback of the benefits of a particular training intervention or tool.

Interviewers must use (and sign) the verbal consent script to gain consent to take part, prior to starting the interview. Interviewers must also make participants aware that what they say is not completely anonymous, their comments will be attributed (though anonymously) to a particular project. At any time (including after the interview) they can ask for things they say not to be printed. They can also ask that what they say only be analysed in the cross-project synthesis (thus maintaining anonymity).

Background and rationale

- What is your job role and sector?
- What is your relationship to the individual(s) who have undertaken training/used the tool?
  - Explore: are they line managers, colleagues, or someone who reports to the individual.
  - Explore: why they didn’t undertake the training themselves
- What is your understanding of the training intervention / tool?
  - Outline the training / project if necessary.
- How relevant do you think the tool/training was to addressing gaps in skills, knowledge and awareness?
  - Explore: were the gaps specific to the individual? To the wider organisation? To the sector?

Outcomes and impacts

- What impact has the training/tool had?
  - On your colleague’s skills, awareness and knowledge?
  - On you?
  - On the wider team and organisation?
- Has the training had any impact on the way your colleague behaves?
- What other factors may have influenced your colleague’s skills, awareness and knowledge?
  - Policy changes
  - Other training
  - Are these impacts greater or less than you would have expected?
  - Explore: what other factors might have impacted on the benefits noted above?
- Have there been any negative impacts of the training?
  - On your colleague?
  - On you?
  - On the wider team and organisation?
• Has your colleague shared their learning with the wider organisation? How have they done this? What more would you like them to do?

• Did the training fully address the gaps in skills, knowledge and awareness identified before?
  o If not, why not? What else might be needed?

Sustainability, transferability and scalability

• Has your colleague continued to implement the skills, awareness or knowledge learnt from the tool/training?
  o Explore: what are the barriers/ facilitators to them doing this?

• Have the benefits to yourself and the wider organisation (if any) been sustained?
  o Explore: which benefits, to what extent, and why

• Do you think you, or other people in your organisation would benefit from this training?
  o Explore: why, why not?

• Do you think people in the wider sector would benefit from this training?
  o Explore: why, why not?
  o Explore: who would benefit
  o Explore: what scale?

A8.2 Grant-holder topic guide

This is the topic guide for the interviews with grant holders. This topic guide is intentionally broad, reflecting the diverse nature of projects. The interviewer should familiarise themselves with the project before the interview, and tailor their questioning accordingly. In particular, the questions will vary according to whether the project is about training provision, training development, research or innovative provision.

Interviewers need to explain to grant holders that they would also like to speak to up to three beneficiaries of the project, but that we would like them to provide us a list of up to ten, from which we will select – in order to increase anonymity. Explain that you will send them information sheets to distribute to beneficiaries. If beneficiaries are happy to take part, then ask the grant-holder to pass their contact details on to us [N.B. that this discussion may have taken place before the full interview, in which case please remind the grant-holders].

Interviewers must use (and sign) the oral consent script to gain consent to take part, prior to starting the interview.

Background

• Establish: the interviewee’s current role and organisation; and their role over the period that they were awarded Skills for Care funding.

• Establish: the interviewee’s role in relation to the project in question. Did they:
  o Hear about funding opportunity;
- Write the bid;
- Manage the project;
- Evaluate the project.

- Establish whether the interviewee has been involved in other projects for Skills for Care? If so, what and when were they?

**Application process**

- How did you hear about the WDIF?
- How did you find the application process?
  - How time consuming was it?
  - What support did you have from colleagues?
- What support did you receive from Skills for Care in producing the bid document?
  - Refine the project delivery plan?
  - Help in shaping the outcomes of the project?
- What additional support would have been helpful?

**Rationale**

*Here, we want to understand why the project came about, and what challenge it aimed to address. In particular, we want to know why this project is different/ innovative. This will be important in our assessment of the additionality of the project.*

- What was the main challenge this project was meant to address?
  - When did this challenge emerge?
  - Why are you addressing it now?
  - Who is affected by this challenge?
  - Who will benefit from this project?
- How did you decide that this was a priority project? Did you consider any other projects?
- What are the aims and objectives of the project?
  - How were these set?
  - How do the aims relate to the challenge?
- How does this project differ from what already exists?
  - Check: do similar qualifications/ training courses already exist? Does this research exist elsewhere? Is someone else offering this service?
- What is innovative about this particular project?
- What would you have done without this funding?
  - Explore: are you aware of other funding sources?

**Inputs**

*The main purpose of this section is to help understand the additionality (particularly deadweight and displacement) of the WDIF – this is needed for the VFM/ROI analysis.*
It will also sense-check the information provided in the self-evaluations, and help to establish how robustly projects have estimated their cash and in-kind contributions.

- Did your organisation provide any additional cash input into this project?
  - Explore: Did this come out of existing training funds, was it additional money?
  - What would this have been spent on, if not the WDIF project?
- Did your organisation provide any additional in-kind contributions to the project?
  - Explore: how did you assess/estimate this?
  - What would this resource have been used on, if not the WDIF project?
- What other potential funding sources were there for this project?

**Activities and implementation**

Here, we want to clarify what activities projects undertook, we would also like to know more detail, particularly around the level of any qualifications undertaken – this will help with the VFM analysis. We also want to understand how well they were implemented, and whether any particular challenges were faced.

- What activities did you undertake with the funding?
  - Explore: how did these link with the aims and objectives?
- (if training was offered) At what level was training offered? How long did it last for?
- In the absence of this funding, which (if any) of these activities would you have undertaken?
- Were there any planned activities that didn’t happen?
- Who did you engage with in the project?
  - Explore: were there any target groups not reached?
- What worked well with delivering your project?
- What worked less well?

**Outcomes and impacts**

*Ensure this section is tailored to the activity type, and particular project you are talking about.*

**All projects**

- What were the main outcomes of the project?
  - For direct beneficiaries;
  - For wider staff within the organisation (for example, did staff share learning with colleagues; did training impact on line managers’ performance);
  - For the wider organisation (for example, opening of new markets, increased visibility);
  - For people who use care and support (for example, the provision of a new service).
• Have there been any unexpected impacts or spin-offs as a result of the investment in this project?

For training projects
• Which organisations/individuals have used the tool/resource developed?
• What impact did the project have on participants’ skills, awareness and knowledge? How has it impacted their ability to do their job? What do they do differently now to before the project?
• How successfully has the tool/training filled the gap that was originally identified?

For research projects
• What did you learn from this research project?
  o Explore: what knowledge was gained
  o Explore: who these findings have been shared with
• What impact has this had?
  o Explore whether the research has informed service delivery; if there is a new service offer as a result; whether there is any impact on the staff.
• For innovative provision
• What did you learn about how best to deliver services?
  o Explore: what about delivery worked well;
  o Explore: what worked less well
• How successfully has the provision filled the gap identified in planning (refer back to project’s aims)?

Sustainability, transferability and scalability
• To what extent have the outcomes identified above been sustained or extended?
  o Explore sustainability for staff, people who use care and support and the organisation
• To what extent have the activities identified above been sustained or extended?
  o Explore how this has taken place: are other employers using the learning or resources produced by the project?
• If extended, explore who to (outside initial target group?), and on what scale
  o Prompt to ensure evidence is provided.
• What factors contributed to sustainability?
• What factors limited sustainability?
• How have tools/training/findings from your project been disseminated more widely?
  o Explore: who they have been disseminated to
• What factors contributed to wider dissemination?
• How have the tools/training/findings from your project been transferred to other settings or contexts in the adult social care sector?
• What factors allowed this to happen?
• Do you think there’s a wider market for what you developed as part of the WDIF?
  ○ Explore: who this would be; the potential scale of it
• What barriers do you think there might be to the wider use of this work?
• What other plans do you have for further dissemination?
  ○ Explore: What resources do they need to do this?
  ○ Explore: What skills would they need to do this?
  ○ Explore What should Skills for Care’s role be?

A8.3 Beneficiary surveys

The interview should last 10-15 minutes. The interviewer should familiarise themselves with the project before the interview, and tailor their questioning accordingly. In particular, the questions will vary according to whether you are speaking to a member of staff; a PA; an IE; another adult social care user; or a representative of an organisation.

The interviewer will input results directly into survey monkey, for efficient analysis of the results.

Interviewers must use (and sign) the verbal consent script to gain consent to take part, prior to starting the interview.

Where the project is a case study, please ask the survey-style questions, in addition to those on the longer topic guide.

Background

• Which project is this part of?
• What is your job role (categories?)? (Manager/ supervisor; professional; direct care (not a PA); direct care (PA); other)
• Which groups of people who use care and support do you usually work with?
• What level is this qualification at? (Entry Level or Level 1; Level 2; Level 3; Level 4 or above; Level not known or not relevant)
• What previous training have you undertaken which is similar to this?
• Why did you decide to undertake this training? Options (tick all that apply):
  ○ Because it was mandatory
  ○ To generally increase my skills/knowledge/awareness in relation to a particular condition/group
  ○ To generally increase my professional competencies
  ○ To address a specific gap in my knowledge/awareness skills
  ○ To address a specific gap in my professional competencies
  ○ Because it was interesting
  ○ Other
Experience of the course

- To what extent has the course met your objectives? (Please rate your answer using a scale of 1 to 5 on which, 1=not at all; 2= a little; 3 = a considerable extent; 4 = a great extent; 5 = fully (Please select one only))
- What did you find most useful? Why?
- Prompts: was it the content of provision, the way in which it was delivered and/or the topic addressed?

Relevance

- To what extent has the course been relevant to the challenges you face in the workplace in your role? (Please rate your answer using a scale of 1 to 4 on which, 1=not at all; 2= a little; 3 = a considerable extent; 4 = a great extent (Please select one only))
- If the project has relevance to their role, ask how it is relevant?
- To what extent did this course address an issue/ topic for which little other training exists? (Please rate your answer using a scale of 1 to 4 on which, 1=not at all; 2= a little; 3 = a considerable extent; 4 = a great extent (Please select one only))

Outcomes

- Did the training? Options (tick all that apply)
  - Generally increase my skills/knowledge/awareness in relation to a particular condition/group
  - Generally increase my professional competencies;
  - Address a specific gap in my skills/knowledge/awareness in relation to a particular condition/group/key issue;
  - Address a specific gap in my professional competencies;
  - Improve my productivity
  - Lead to an increase in my wages
- Please rate the extent to which the training has changed your actions in the workplace (Please rate your answer using a scale of 1 to 4 on which, 1=not at all; 2= a little; 3 = a considerable extent; 4 = a great extent) (Please select one only))
- In what ways are you working differently as a result of the training?
- Please rate the extent to which the training has changed your wider team/organisation’s work (Please rate your answer using a scale of 1 to 4 on which, 1=not at all; 2= a little; 3 = a considerable extent; 4 = a great extent (Please select one only))
- In what ways has the training influenced your wider team / organisation’s work?
- If there has only been a limited impact on the work of individual or the team, why is this the case?
- What impact has the project had on the experience of service users?
Wider use

- Transferability: To what extent has this training/tool been offered to other organisations? ((Please select one of the following answers: not at all; a little; a considerable extent; a great extent; don’t know) (Please select one only))
  o (if time) Please explain your answer…

- Sustainability: To what extent do you think the benefits of this project will be sustained? (Please rate your answer using a scale of 1 to 4 on which, 1=not at all; 2=a little; 3=a considerable extent; 4=a great extent (Please select one only))
  o (if time) Please explain your answer…

- Scalability: To what extent has this training/tool been offered on a larger scale? (Please rate your answer using a scale of 1 to 4 on which, 1=not at all; 2=a little; 3=a considerable extent; 4=a great extent (Please select one only))
  o (if time) Please explain your answer…