Evaluation of the Care Certificate Pilot

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# Acknowledgements

Sincere thanks are offered to everyone that has contributed to this evaluation and especially to the staff at the pilot sites, all of whom have been extremely helpful and generous with their time.
Executive Summary

Introduction

1. This is the draft final report from the evaluation of the Care Certificate pilot undertaken between May and September 2014. The main purpose of the evaluation has been to assess the effectiveness, fitness for purpose and potential impact of the Care Certificate’s content, assessment processes and certification. It has been based on a programme of primary research with 29 providers of healthcare and adult social care services from across England (the ‘pilot sites’). The primary research has included face-to-face and telephone consultations with pilot leads, assessors, trainers, staff undertaking the Care Certificate and staff in supervisory roles.

2. The evaluation is one component from a suite of activities and data sources, including a wider consultation exercise across both the healthcare and adult social care sectors, that will be used to inform the final content of the Care Certificate.

Overview of the Care Certificate Pilot

3. A total of 29 sites have participated in the Care Certificate pilot: 16 operating in adult social care and 13 in healthcare. Three adult social care sites withdrew from the evaluation partway through, so the sample, particularly for the face-to-face consultations in July and August 2014, was 26 sites.

4. Across those sites combined, just over 450 Support Workers have undertaken Care Certificate related training during the evaluation, 55% of whom work in adult social care and 45% in healthcare. Whilst the number of Support Workers involved has varied significantly by site, the average in healthcare (16 Support Workers per site) and the average in adult social care (19 Support Workers per site) are similar.

5. Of the 26 pilot sites that began their delivery of the Care Certificate during the evaluation period, over a third started later than planned (usually by a few weeks). This was mainly due to delays in the recruitment of new staff, leading five sites to pilot the Certificate with existing Support Workers rather than new recruits.

6. Delivery of the Care Certificate was still very much in progress at the time that the face-to-face evaluation visits were undertaken (late July and throughout August). Only 2% of the Support Workers had completed the Certificate at the time of their face-to-face consultation.
Delivery Models

7. In-house delivery of the Care Certificate, i.e. where the classroom based training, on the job supervision and assessment is carried out by employees of the pilot site, has been the most common approach during the pilot. Three quarters of the sites have adopted an in-house model.

8. Approximately one in four of the pilot sites have used a combination of in-house and external provision and one site has outsourced all delivery (with the exception of observation based assessment). In the vast majority of cases, the delivery models used for the Care Certificate are the same as those used for previous Support Worker induction programmes at the pilot sites.

9. The length of time that Support Workers have spent in a classroom setting has ranged from 2 to 10 days, with an average of 4-5 days (note that this refers not only to the training that is associated directly with the standards in the Certificate, but also includes corporate/organisation specific training). The classroom based training has typically been followed by a period of work shadowing which has lasted, on average, 2-3 weeks, after which, in most cases, Support Workers have been permitted to work in a supervised or supernumerary capacity.

10. The recommended completion timeframe of 12 weeks for new starters was the subject of much debate during the evaluation. Whilst there are strong views amongst some pilot leads that 12 weeks is too long, and equally strong views that it is not long enough, the most common opinion was that it is about right.

11. Ten of the pilot sites intend for some or all of their Support Workers to use the evidence gathered for the Care Certificate to count towards an accredited qualification. Other sites are not averse to this but had not given it detailed consideration at the time of the evaluation.

Content of the Care Certificate

12. Feedback from the pilot sites suggests that the standards in the Care Certificate are, overall, the right ones. Whilst potential omissions and suggested amendments were put forward, these mainly centred on role or organisation specific content. The majority of consultees are satisfied that the Care Certificate in its current guise provides adequate coverage across a generic Support Worker ‘footprint’.

13. No significant concerns have been raised about the difficulty of the Care Certificate. Whilst Support Workers new(er) to the sector were more likely to say that they had
found it difficult than those with previous experience, the general consensus was that it had been pitched at a level which was neither too difficult nor too light touch.

14. For reasons that include the types of service the provide and the types of staff they are putting on the Care Certificate (and plan to in the future), questions were asked at the pilot sites about whether all 15 standards should be obligatory in order for the Care Certificate to be achieved.

Assessment and Supervision

15. Assessment and supervision have been amongst the most emotive topics covered by the evaluation. Whilst no consultees said that they were opposed to the concept of Support Workers being formally assessed, and all can recognise the benefits, there are issues relating to assessment, and more broadly to supervision, that require further consideration before a national roll-out can take place.

16. The first is around the definition of “occupationally competent” for assessors, although in reality most sites are happy with this and it was only a relatively small minority that questioned it.

17. The second centres on whether sites have different standards for assessment and sign-off. If they do, then there is a risk that workbooks which at one site would be considered incomplete could, at another, be signed-off. The same applies to on-the-job assessment. A nationally endorsed ‘assessment handbook’ which gives examples of acceptable evidence, would be warmly welcomed as a way of helping to reduce the risk of large variations in practice from site to site (some variation will always exist without external standardisation).

18. The Technical Document and the Healthcare Support Worker and Adult Social Care Worker Document give mixed messages about whether a Support Worker can work unsupervised only after having completed all 15 standards, or whether a phased approach is allowed. Universally across the pilot sites, a phased approach would be preferred (and some consider it essential).

19. Some domiciliary care providers, and live-in care providers who contributed to the evaluation in writing, have significant concerns about the practicalities of ‘line of sight’ supervision and workplace assessment in their service areas.

20. A national Care Certificate template, which can be printed off and given to Support Workers as a hard copy upon successful completion, will be welcomed when the Care Certificate is launched nationally.
Learning Materials and Draft Guidance

21. All sites have used a workbook to support their delivery of the Care Certificate and, in the vast majority of cases, this has been the primary learning material issued to Support Workers. Delivery has also been supported by videos or online films, case study examples, role plays and interactive exercises. The evaluation did not find any evidence which indicated that a particular combination of materials resulted in a better or more engaging induction.

22. At just over half of the sites, the previous induction workbook has been used as the basis for the Care Certificate workbook, with amendments made to allow for evidence collection and the inclusion of Care Certificate standards that weren’t previously covered. Wording changes have also been made to ensure that the workbooks accurately reflect the Care Certificate framework documents.

23. At the remainder of the pilot sites (just under half), staff have developed new workbooks to deliver the Certificate, sometimes because their previous Support Worker induction materials were relatively brief and sometimes because they simply thought it was easier to start from scratch.

24. There is an argument for a national workbook to accompany the Care Certificate to encourage standardisation (although there are also arguments against this). It may also be appropriate to develop an online repository onto which pilot sites can upload learning materials that they have used during the Care Certificate pilot. These would be available to sites that haven’t been involved in the pilot but who wish to prepare for their own delivery of the Certificate.

25. Although first impressions have often not been positive due to their length, there is general agreement that the framework documents are in fact very useful and broadly fit for purpose.

Portability

26. Staff at all the pilot sites understand and are supportive of the concept of a portable Care Certificate and recognise that it could generate cost savings and boost Support Worker morale.

27. However, views on how portability will work in practice paint a different picture. A quarter of the pilot leads said that they thought the Certificate was, in part at least, portable, i.e. they would be willing to accept it as reliable proof of a Support Worker’s abilities, but most were less convinced.
28. The reasons for this centred on the absence of any (mandatory) independent quality assurance of the Care Certificate (apart from the role played by the system regulator), the related point of standardisation and a view that the scope of a Support Worker’s role, and the skills and knowledge they require, can vary quite substantially across different service areas.

29. Consequently, the vast majority of the pilot leads (both in healthcare and adult social care) reported that if they recruited a Support Worker with a Care Certificate from another organisation, they would require them to redo at least part of it again, although that may well be in a ‘fast track’ format. At six sites, Support Workers would be required to do all of the Care Certificate training, supervision and assessment again.

**The Potential Impact of the Care Certificate**

30. The principle of the Care Certificate has been broadly welcomed by the pilot sites and they can see how, across both the healthcare and adult social care sectors, it has the potential to add value to what currently exists. The combination of theory, practical knowledge and workplace application; the focus on observation and assessment; and the recognition that it gives to the Support Worker workforce were all praised by staff at the majority of the sites.

31. When asked about impact, pilot leads spoke of potential improvements to the reputation of their organisation, increases in the number of Support Workers achieving accredited qualifications and improvements in retention. But in each case the number of pilot leads saying this was relatively small, mainly because it is still too early for them to talk about impact with any certainty. Half said they thought the Care Certificate could lead to an improvement in quality of care, although this is likely to be a short term improvement, generated by new Support Workers having a greater breadth of knowledge and skill earlier in their career, rather than longer term change.

32. Concerns over costs (covered in a separate study, although clearly not yet considered in detail by many of the pilot sites) and the practicalities of ‘line of sight’ observation and workplace assessment in certain service areas were seen as the main issues that need to be resolved.

33. Most of the new Support Workers interviewed for the evaluation had little to compare their early experiences of the Care Certificate against. However, those that did repeatedly said that it was “more comprehensive”, “more detailed” and just generally “better” than the induction training they had received previously in the sector. They
felt confident that the Certificate would prepare them well for their new roles and that the supervisory/mentoring arrangements would be helpful.

**Recommendations for a National Roll-out**

**Recommendation #1: Timeframes**
The fact that the majority of pilot sites are broadly satisfied with the 12 week timeframe leads to the recommendation that this should not be changed. However, the draft guidance should acknowledge that part-time Support Workers and those on low hours contracts may need longer to complete the Care Certificate.

**Recommendation #2: The 15 standards**
The development and roll-out of the Care Certificate should proceed with the current set of 15 standards. However, the Department of Health and its partners should note the issues raised by providers about content, and the interpretation of content, as explained in Chapter 4 of the main report.

**Recommendation #3: Addressing issues, concerns and misunderstanding**
Prior to the Care Certificate being introduced, it is suggested that a series of master classes or road shows be run which address the most common uncertainties currently associated with the Certificate, including the expectations that will (or will not) be placed upon employers to review the competencies of Support Workers (new and existing) that have undertaken the Certificate. These sessions should also give sites the opportunity to discuss their plans for delivery, assessment, learning materials etc, which the evaluation evidence suggests will be highly valued.

Also on this topic, given the positive response that the *Piloting the Cavendish Care Certificate* briefing paper has received, it should be used as part of the national roll-out, (prior to which references to the pilot and the evaluation of the pilot should obviously be removed).
Recommendation #4: Assessment handbook and national workbook

A nationally endorsed version of the ‘assessment handbook’ from Chapter 5 of the main report is likely to be welcomed and it is therefore recommended that consideration be given to developing one over the coming months. Note that the evaluators are not endorsing the answer book cited in Chapter 5 as a blueprint for a national document (although in practice some or all of it may be suitable for wider use) but rather the concept that has been adopted.

Consideration should also be given to developing a national Support Worker workbook for the Care Certificate which will be available to employers and publicised as part of the national roll-out.

Recommendation #5: Clarity on working unsupervised

Ensure that the text on unsupervised working that currently appears in the Technical Document is replicated in all other relevant guidance materials. This is also a topic that should be covered at the proposed master classes (see Recommendation #3).

Recommendation #6: Sharing resources

Depending on the action taken in response to Recommendation #4, consider developing an online repository onto which pilot sites can upload learning materials that they have used during the Care Certificate pilot. It would be important to make it clear that these materials are not nationally endorsed, nor have they been quality assured externally.

Recommendation #7: Cross-provider networking

Cross-provider networking on the Care Certificate should be encouraged. LETBs are obvious candidates to take this forward in a co-ordination capacity on the healthcare side. Further consideration is required as to how it should be managed in adult social care. Skills for Care Area Networks may be an appropriate channel.
1. Background

1.1 Introduction

This is the draft final report from the evaluation of the Care Certificate pilot. The evaluation was undertaken between May and September 2014 and was based on a programme of primary research with 29 providers of healthcare and adult social care services from across England.

The Care Certificate has been designed to provide clear evidence to employers, patients, people who receive care and support and the general public that healthcare support workers and adult social care workers have the right skills, knowledge and behaviours to perform in their role to a consistently high standard. It builds on, and will ultimately replace, the Common Induction Standards (in adult social care) and the National Minimum Training Standards (in healthcare) and specifies what new Support Workers must know, be able to do and the standards of behaviour that are expected of them. These behaviours are underpinned by the Chief Nursing Officer's six Cs: care, compassion, competence, communication, courage and commitment.

This report provides an independent evaluation of the implementation and delivery of the Care Certificate pilot and identifies relevant topics which the Department of Health, Health Education England, Skills for Health and Skills for Care should give further consideration prior to a national roll-out.

1.2 A summary of the context

In the wake of the Francis Inquiry, and following the identification of serious challenges in some other health and social care settings in 2013, Camilla Cavendish was asked by the Secretary of State to review and make recommendations on the recruitment, learning and development, management and support of healthcare assistants and social care support workers, ensuring that this workforce provides compassionate care.

The Cavendish Review obtained input from staff and patients in organisations that employ Support Workers and looked in particular at recruitment, training, supervision, support and public confidence. The ensuing report – The Cavendish Review: An Independent Review into Healthcare Assistants and Support Workers in the NHS and Social Care Settings – was published in July 2013 and found that the preparation of

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1 Referred to collectively in this report as ‘Support Workers’
2 http://www.midstaffspublicinquiry.com/report
Support Workers for their roles within care settings was often inconsistent. It also suggested that the public image of this workforce is outdated, that Support Workers receive insufficient attention when decisions are taken about values, standards and quality of care, and that many are frustrated by what they feel is a lack of recognition from managers, employers and/or commissioners.

The Cavendish Review made 18 recommendations. Amongst these was the introduction of the Certificate of Fundamental Care – the ‘Care Certificate’ – which has been developed in its pilot form by Health Education England, Skills for Health and Skills for Care. The Cavendish Review also recommended that the Care Quality Commission should require Support Workers to have completed the Care Certificate before they are allowed to work unsupervised.

### 1.3 The Care Certificate

The Care Certificate is primarily aimed at Healthcare Assistants, Assistant Practitioners, Care Support Workers and those giving support to clinical roles in the NHS where there is any direct contact with patients or people who receive care and support. Other roles in health and social care such as caring volunteers, porters, cooks or drivers that have direct contact with patients and people who receive care and support could also undertake all or some of the Care Certificate.

The Care Certificate, in its pilot form, comprises 15 standards, summarised below. Within each of the standards is a series of outcomes (an average of between three and four per standard) and assessment criteria (an average of between three and four per outcome)\(^4\). Support Workers, supported by a mentor/supervisor, must satisfy all of the assessment criteria in order to be awarded the Care Certificate.

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

The Care Certificate is intended to be the start of a career journey for Support Workers and as such should be only one element of the training and education that will make them ready to practice within their specific sector. It is not designed to replace employer induction specific to the environment in which practice will take place, nor will it focus on the skills and knowledge needed for specific settings.

Each Support Worker starting in a new role that is within the scope of the Care Certificate is expected to have completed the training, education and assessment relating to the Certificate within the first 12 weeks of their employment.

1.4 Evaluating the Care Certificate pilot

The Care Certificate pilot has taken place between May and September 2014 and has involved 29 pilot sites – 16 from adult social care and 13 from healthcare – the characteristics of which are provided in Chapter 2. Approximately 70 other healthcare sites across England have also been trialling some or all of the Certificate over the same timeframe. Collectively referred to as ‘field testing sites’, these have been outside the scope of the formal evaluation.

The main purpose of the evaluation has been to assess the effectiveness, fitness for purpose and potential impact of the Care Certificate’s content, assessment processes and certification. Under each of these topics, a series of key questions were provided in the evaluation brief. These are summarised at Appendix A and provided the basis for the research tools that have been used during the study.

The evaluation has been delivered through two main phases of activity:

- **Phase 1**: during June 2014, the lead member of staff for the Care Certificate pilot in each of the 29 pilot sites was consulted on their expectations for the pilot and the Care Certificate more widely, delivery models, early progress (where delivery had started), anticipated or early challenges, outcomes and impacts.

- **Phase 2**: during July and August 2014, the evaluators visited 26 of the 29 pilot sites (or, in four cases, undertook in-depth telephone consultations where visits were not practicable). Through these visits, feedback on the Care Certificate was gathered from pilot leads, assessors, trainers (internal to the pilot sites and external providers), staff undertaking the Certificate, supervisors/mentors and, at four of the sites, patients and people who receive care and support.

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5 The three sites that were not included in Phase 2 had not been able to proceed with delivery to a point where an evaluation visit was worthwhile.

6 This only occurred where the pilot sites could only make a small number of consultees available on the scheduled day of the visit and it wasn’t possible within the evaluation timeframes to re-arrange.

*Evaluation of the Care Certificate Pilot*
A more detailed explanation of the evaluation methodology, which includes the number of consultees involved at each site, is provided in the accompanying annex document.

Note that this evaluation is one component from a suite of activities and data sources that will be used to inform the final content of the Care Certificate. A wider consultation exercise across both health and social care has also taken place, the aforementioned field testing has been run and employers have been invited to provide their views via written submission.

1.5 Terminology

Pilot sites: the 29 organisations that have piloted the Care Certificate and which have participated in the independent evaluation.

Support Workers: to ease readability, this report uses the term ‘Support Workers’ to refer collectively to those staff that have undertaken the Certificate at the pilot sites. Where appropriate, a more precise definition of individuals’ roles is provided, as is clarification on whether reference is being made to adult social care workers or healthcare support workers.

Pilot leads: the member of staff with operational responsibility for the Care Certificate pilot within each site that has participated in the evaluation.

Learning materials: workbooks, textbooks, information packs and other materials that pilot sites have used to support their delivery and assessment of the Care Certificate.

Draft guidance: documents produced centrally (e.g. by Skills for Care or Health Education England) that give information about the Care Certificate. Primarily these include the following:

- Care Certificate Framework Assessor Document
- Care Certificate Framework Technical Document
- Care Certificate Framework Healthcare Support Worker and Adult Social Care Worker Document

1.6 A note on the timing of the evaluation

Many of the pilot sites began their delivery of the Care Certificate pilot some weeks later than planned. The impact of this, from an evaluation perspective, is that it was very rare
for any of the Support Workers to have completed the Certificate at the point that they, or other staff in their organisation, were consulted.

Whilst this hasn’t influenced the evaluation’s main conclusions and recommendations, it does mean that the findings on assessment and the actual (rather than anticipated) outcomes and impacts of the Certificate are less robust than they would be had more staff been through the full Certificate process at the time of the visits.

1.7 Differences across adult social care and health

At various points in the report, differences in the views of adult social care staff and healthcare staff are highlighted. Where the findings do not distinguish between the two sectors, it should be assumed that there are no discernible differences.
2. Overview of the Care Certificate Pilot

2.1 Pilot site overview

A total of 29 sites have participated in the evaluation of the Care Certificate pilot: 16 from adult social care and 13 from healthcare. As shown in the table below, large employers account for a significant proportion of the sample (due in part to the prevalence of NHS trusts amongst the healthcare sites) and there is a reasonably equal split between public and PVI sector organisations. Each English region is represented, although in some cases only by one provider. Note, however, that neither the main evaluation findings, nor the recommendations proposed in this report, are geographically specific, i.e. there is no suggestion that the under-representation of some regions has been in any way detrimental to the evaluation.

<table>
<thead>
<tr>
<th>Pilot Site Profile: Full Sample</th>
<th>Pilot sites</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Size</strong></td>
<td></td>
</tr>
<tr>
<td>Large (250+ employees)</td>
<td>22</td>
</tr>
<tr>
<td>Medium (50 – 249 employees)</td>
<td>4</td>
</tr>
<tr>
<td>Small (1 – 49 employees)</td>
<td>3</td>
</tr>
<tr>
<td><strong>Sector</strong></td>
<td></td>
</tr>
<tr>
<td>Private, voluntary or independent sector</td>
<td>16</td>
</tr>
<tr>
<td>Public sector</td>
<td>13</td>
</tr>
<tr>
<td><strong>Geography</strong></td>
<td></td>
</tr>
<tr>
<td>London</td>
<td>6</td>
</tr>
<tr>
<td>National</td>
<td>6</td>
</tr>
<tr>
<td>South West</td>
<td>4</td>
</tr>
<tr>
<td>East Midlands</td>
<td>3</td>
</tr>
<tr>
<td>East of England</td>
<td>3</td>
</tr>
<tr>
<td>North West</td>
<td>2</td>
</tr>
<tr>
<td>South East</td>
<td>2</td>
</tr>
<tr>
<td>North East</td>
<td>1</td>
</tr>
<tr>
<td>West Midlands</td>
<td>1</td>
</tr>
<tr>
<td>Yorkshire and Humber</td>
<td>1</td>
</tr>
<tr>
<td><strong>Urban and rural profile</strong></td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>15</td>
</tr>
<tr>
<td>Both rural and urban</td>
<td>10</td>
</tr>
<tr>
<td>Rural</td>
<td>4</td>
</tr>
</tbody>
</table>

Source: ekosgen. Note that the urban and rural figures are based on pilot leads’ classifications. Adult social care sites with national operations have been classed as both rural and urban. Where percentages do not sum to 100% this is due to rounding.
2.2 Adult social care pilot sites

A profile of the adult social care sites that participated in the evaluation is provided in the table on the following page. National data, using a July 2014 extract from the National Minimum Dataset for Social Care\(^7\) (NMDS-SC) is included in the table for comparison purposes, the key points from which are:

- **Service area:** all of the adult social care pilot sites provide domiciliary and/or residential care. As a result, community care\(^8\), day care and live-in care providers are not represented, nor are Individual Employers (IEs). One IE was originally included in the sample, but for personal reasons was forced to withdraw.

- **Size:** Large organisations are overrepresented in the adult social care sample, as they are across the evaluation sample as a whole. Large organisations account for over half of the adult social care pilot sites, but only 1% of adult social care employers nationally (and 8% of national employment in the sector\(^9\)). Note, however, that it was necessary to oversample on large employers in order to obtain a meaningful sample of Support Workers for the evaluation.

- **Sector:** PVI organisations account for the vast majority of the adult social care sites (15 out of 16), whereas nationally a third of all adult social care employers operate in the public sector.

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\(^7\) NMDS-SC is an online database which holds data on the adult social care workforce. It is a primary source of workforce intelligence for the ASC sector and holds information on around 25,000 establishments and 700,000 workers across England.

\(^8\) One of the healthcare pilot sites would consider themselves to provide community care.

The composition of the adult social care sample was influenced by various factors, not least timescales, the relatively small size of the overall pilot and the aforementioned need to oversample on large employers. Given the significant diversity that exists within the sector, it would have been extremely difficult to have achieved either the optimum group of employers for the pilot, or a group that was entirely representative of the adult social care sector. It should also be noted that feedback on the Care Certificate has not been limited to the evaluation. Field testing and employer consultation exercises have also been undertaken which have obtained input from employers in all parts of the adult social care and healthcare sectors, together resulting in a broad and comprehensive evidence base.

Geographically, the majority of the English regions are represented in the evaluation sample (see the following table) although as above, the evaluation findings and recommendations are not location specific. Note also that whilst six sites are classified as ‘national’ and have a presence in various parts of the country, only one site from each organisation was visited. Two of these sites were in Yorkshire and one was in the North East, giving the evaluation sample a broader geographic coverage.
### Geographic Profile: Adult Social Care

<table>
<thead>
<tr>
<th>Pilot Sites</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td>No.</td>
<td>%</td>
</tr>
<tr>
<td>National</td>
<td>6</td>
</tr>
<tr>
<td>East Midlands</td>
<td>2</td>
</tr>
<tr>
<td>East of England</td>
<td>2</td>
</tr>
<tr>
<td>London</td>
<td>2</td>
</tr>
<tr>
<td>South West</td>
<td>2</td>
</tr>
<tr>
<td>North West</td>
<td>1</td>
</tr>
<tr>
<td>South East</td>
<td>1</td>
</tr>
<tr>
<td>North East</td>
<td>0</td>
</tr>
<tr>
<td>West Midlands</td>
<td>0</td>
</tr>
<tr>
<td>Yorkshire and Humber</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>16</strong></td>
</tr>
</tbody>
</table>

Source: ekosgen (pilot sites) and NMDS-SC (sector). Note: NMDS-SC does not include a ‘national’ classification.

### 2.3 Healthcare pilot sites

There isn’t a healthcare equivalent of the NMDS-SC and making a comparison between the profile of the pilot sites and the profile of sites nationally is therefore less straightforward. However, across the 13 healthcare sites (one from each of the 13 Local Education and Training Board (LETB) areas), the key points are:

- **Type**: 10 of the 13 sites are NHS acute or foundation trusts. The remainder are accounted for by a community trust, an integrated health and social care trust and a private sector provider.

- **Size**: 12 of the 13 healthcare sites are large employers (250+ employees). One is medium sized employer (50 to 249 employees).

- **Geography**: all nine English regions are represented in the healthcare sample.
### Geographic Profile: Healthcare

<table>
<thead>
<tr>
<th>Pilot Sites</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>London</td>
<td>4</td>
<td>31%</td>
</tr>
<tr>
<td>South West</td>
<td>2</td>
<td>15%</td>
</tr>
<tr>
<td>East Midlands</td>
<td>1</td>
<td>8%</td>
</tr>
<tr>
<td>East of England</td>
<td>1</td>
<td>8%</td>
</tr>
<tr>
<td>North East</td>
<td>1</td>
<td>8%</td>
</tr>
<tr>
<td>North West</td>
<td>1</td>
<td>8%</td>
</tr>
<tr>
<td>South East</td>
<td>1</td>
<td>8%</td>
</tr>
<tr>
<td>West Midlands</td>
<td>1</td>
<td>8%</td>
</tr>
<tr>
<td>Yorkshire and Humber</td>
<td>1</td>
<td>8%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>13</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source: ekosgen. Where percentages do not sum to 100% this is due to rounding.

### 2.4 A note on participation

Three pilot sites, all in adult social care, were able to make only a very limited contribution to the evaluation (compared with the majority of other sites). The main reasons for this were a lack of manager time to dedicate to the Care Certificate pilot (due to unforeseen circumstances) and the late notification of their involvement from the organisation’s head office. These sites effectively withdrew from the pilot and the ‘true’ evaluation sample, certainly for the second phase of the work which involved the site visits, is therefore 26 rather than 29 sites.

### 2.5 Timing

Pilot sites were expected to start their delivery of the Care Certificate in or by June 2014. As shown in the table below, a significant proportion did so, although 10 sites started later and three sites\(^{10}\) were not able to start at all.

<table>
<thead>
<tr>
<th>Start date of the Care Certificate pilot</th>
<th>Social Care sites</th>
<th>Healthcare sites</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>May</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>June</td>
<td>9</td>
<td>5</td>
<td>14</td>
</tr>
<tr>
<td>July</td>
<td>2</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>August</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>N/A</td>
<td>3</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>16</strong></td>
<td><strong>13</strong></td>
<td><strong>29</strong></td>
</tr>
</tbody>
</table>

Source: ekosgen. N/A refers to those sites that withdrew from the pilot.

---

\(^{10}\)This refers to the sites that withdrew as reported under ‘A note on participation’.
Where sites started later than planned, the main reasons were as follows:

- **Recruitment and DBS**: difficulties in recruiting Support Workers per se, and difficulties in co-ordinating start dates for Support Workers that were aligned with the pilot, were the main reasons behind a late start. These delays were, in some cases, then compounded by the need to obtain Disclosure and Barring Service checks and satisfactory references (at two sites the inadequacy of the references prompted the provider to withdraw the offer of employment). As a fallback, the decision was taken in some sites to put existing Support Workers on the Care Certificate, either partially (e.g. via short refresher sessions) or in full.

- **Familiarisation and preparation**: in a small number of cases, pilot leads appear to have underestimated the amount of time it would take them to cross-reference or map the Care Certificate onto their existing provision in order to identify how many standards they already cover and where they would need to introduce new content.

### 2.6 Scale of delivery

Just over 450 Support Workers have undertaken Care Certificate related training during the evaluation, 55% of whom work in adult social care and 45% in healthcare (see the table on the following page)\(^{11}\). Whilst the number of Support Workers involved varied substantially by site, the averages in both healthcare and in adult social care were reasonably similar.

Just over a quarter of the Support Workers were expected to complete the Care Certificate by the end of the evaluation period (30\(^{th}\) September 2014). Very few Support Workers – only 2% – had completed it at the time of the evaluation visit\(^{12}\).

---

\(^{11}\) Wave 2 of the evaluation obtained the input of 87 Support Workers – 19% of the total. 84 responses to the Wave 1 Support Worker were received, although due to the fact that the survey was deliberately anonymous, it is not possible to say how many different Support Workers have contributed to the evaluation.

\(^{12}\) The data on completion excludes 16 Support Workers from a healthcare site. These Support Workers had all been in post for a number of years and had completed a short, classroom based refresher session rather than the full Care Certificate.
### Scale of delivery during the Care Certificate pilot evaluation

<table>
<thead>
<tr>
<th></th>
<th>Social Care</th>
<th>Healthcare</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Support Workers undertaking the Certificate during the evaluation</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>251</td>
<td>202</td>
<td>453</td>
</tr>
<tr>
<td>Average</td>
<td>19</td>
<td>16</td>
<td>17</td>
</tr>
<tr>
<td>Max</td>
<td>120</td>
<td>40</td>
<td>120</td>
</tr>
<tr>
<td>Min</td>
<td>2</td>
<td>4</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Social Care</th>
<th>Healthcare</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Support Workers completed the Certificate at point of the Phase 2 visit</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>11</td>
<td>0</td>
<td>11</td>
</tr>
<tr>
<td>Average</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Max</td>
<td>6</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Min</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Social Care</th>
<th>Healthcare</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Support Workers expected to complete during evaluation the period</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>79</td>
<td>17</td>
<td>96</td>
</tr>
<tr>
<td>Average</td>
<td>7</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Max</td>
<td>40</td>
<td>7</td>
<td>40</td>
</tr>
<tr>
<td>Min</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Source: ekosgen. Note: average shown is the mean.

### 2.7 Roles

At seven of the pilot sites, all in healthcare, the Certificate has been piloted entirely with existing Support Workers (five sites) or with a combination of existing and new Support Workers (two sites). This is largely for the reasons given under ‘Timing’ earlier in this chapter. These employees had, in most cases, been with their organisation for more than five years and, in some cases, more than ten years. Whilst this situation wasn’t envisaged at the outset of the evaluation, in practice it has provided an additional and very useful perspective on the suitability of the Care Certificate. It does, however, mean that the outcomes experienced by these sites to date will not necessarily be representative of those that they experience when they deliver the Certificate with new Support Workers.

At all of the other pilot sites across both healthcare and social care (excluding the three that withdrew), Support Workers new to the organisation have undertaken the Care Certificate.

Three sites – one in adult social care and two in healthcare – have put other members of staff on the Care Certificate in addition to ‘core’ Support Workers. At one site this included a member of the kitchen staff who is keen to become a Support Worker and, at another site, members of staff that assist patients at mealtimes.
This approach has given rise to some specific questions about ‘auxiliary’ support workers undertaking the Certificate. These are revisited in Chapter 4.
3. Delivery Models

3.1 In-house delivery

In-house delivery of the Care Certificate, i.e. where the classroom based training, on the job supervision and assessment is carried out by employees of the pilot site, has been the most common approach during the pilot. Three quarters of the pilot sites have adopted an in-house model, all of whom also delivered their previous induction programmes in-house. In the larger organisations, delivery of the Care Certificate has been co-ordinated by central education and training teams. At smaller sites, co-ordination and delivery has tended to be the responsibility of staff who also perform other roles, such as care home and domiciliary care agency managers.

Several benefits of an in-house approach were identified by the consultees and are summarised below. Note, however, that these are not necessarily specific to the Care Certificate, but rather relate to the induction of Support Workers per se. They are nonetheless relevant here as they provide the rationale for why the vast majority of these sites plan to continue with an in-house delivery model for the Care Certificate in the future:

- **Organisation specific relevance**: pilot leads and in-house trainers regularly reported that an in-house approach allows induction training to be better tailored to the specifics of the organisation, especially where it is delivered by staff with prior experience of ‘customer facing’ roles within that organisation.

  "The trainers are all nurses so we know they all have up to date practice knowledge." Pilot lead (hospital)

  “Our trainers have all worked here so they know exactly how we want the knowledge and skills that we are giving them [the Support Workers] to be applied in our homes.” Pilot lead (residential care)

- **Early views on staff suitability**: an in-house approach is reported to give managerial staff a better opportunity to form an early view on the suitability of new Support Workers for the demands of the role than is the case through external provision.

- **Cost**: those sites who deliver their induction training in-house tended to report that it is more cost effective for them to do so than to use an external provider. Small adult social care providers, for example, often recruit Support Workers in
small numbers and on an ad hoc basis, so using external training providers for induction is not only impractical but also has a high unit cost.

3.2 External delivery and the combined model

Approximately one in four of the pilot sites have used a combination of in-house and external provision to deliver the Care Certificate. In most cases, this is also the approach that they use for the CIS/NMTS, where some of the more standardised components of induction, such as health and safety, are delivered by an external provider.

“We’re not qualified to train basic life support and if we delivered this in-house there would be huge cost implications as we’d have to buy ‘Annie dolls’. To deliver health and safety we’d have to have an up to date licence. It’s easier to outsource these parts.”

Pilot lead (domiciliary care)

At one site, and as explained in the box below, the induction of Support Workers prior to the Care Certificate had all been done in-house, but they have now moved to a combined model.

**Combining in-house and external delivery of the Care Certificate**

An acute NHS trust in the south of England is using a combined model, with 10 of the Certificate’s 15 standards delivered in-house and the following five delivered by a local college:

1. Understanding your role
2. Your personal development
3. Duty of care
6. Communication
13. Health and Safety

This approach has enabled the pilot site to deliver a full Care Certificate programme (i.e. one which covers all 15 standards) within the lead times available for their participation in the pilot. Consultees at the site reported that it would have been difficult for them to have achieved this in the absence of a combined approach given limited availability of resources within the education unit.

At the time of writing, the college had held initial discussions with Pearson UK about endorsing the externally delivered components of the induction programme.
Only one of the pilot sites – an adult social care provider – has outsourced all of their Care Certificate training delivery (with the exception of observation based assessment) to an external provider. Induction training at this site has historically been outsourced, with the pilot lead citing a lack of in-house capacity as the main reason.

3.3 Composition of Care Certificate induction programmes

Whilst the detail of the delivery models used for the Care Certificate (e.g. overall duration and the number of days spent in the classroom) has differed considerably across the pilot sites, the fundamental components of knowledge based sessions and supervised, on-the-job learning are common to all. Examples against each of these core elements are provided in the sub-sections that follow.

Classroom based training

The length of time that Support Workers undertaking the Care Certificate have spent in a classroom setting has ranged from 2 to 10 days\(^\text{13}\), with an average of 4 to 5 days (there are no discernible differences between health and adult social care). Note that this refers not only to the training that is associated directly with the standards in the Certificate, but also includes corporate/organisation specific training. In some cases, this corporate/organisation specific training previously included topics that are now covered by the Certificate.

Three examples of classroom based delivery are provided below, covering the shortest (2 days), the longest (10 days) and one that is close to the average (4 days).

<table>
<thead>
<tr>
<th>Example 1: 2 days of classroom based training</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of organisation: Acute NHS Trust</td>
</tr>
</tbody>
</table>

**Day 1:**
- Introduction (15 minutes)
- 6 C’s and video covering Standards 2, 5, 6 and 7 (30 minutes)
- Role of HCA covering all standards with the exception of Standard 4 (30 minutes)
- Code of conduct covering Standards 1, 3, 4, 5, 6, 7 and 10 (30 minutes)
- Break (30 minutes)
- Observations covering Standards 3, 5, 6, 7, 9, 12, 14 and 15 (90 minutes)
- Lunch (45 minutes)
- Simulation (communication) covering Standards 1, 3, 5, 6, 7 and 14 (30 minutes)
- Simulation (confused) covering Standards 1, 3, 5, 6, 7, 9 and 10 (60 minutes)
- Break (15 minutes)

\(^{13}\) At one healthcare site, existing Support Workers had a 3 hour classroom based refresher course, but this was more with a view to testing out some of the content rather than replicating the delivery that will be adopted when the Care Certificate is rolled out more widely across the organisation.
- Simulation (deteriorating patient) covering Standards 1, 3, 5, 6, 7, 12 and 15 (60 minutes)

Day 2:
- Personal care covering Standards 1, 3, 4, 5, 6, 7, 9, 10 and 15 (90 minutes)
- Break (15 minutes)
- Fluids and nutrition covering Standards 1, 3, 5, 6, 7, 8 and 15 (90 minutes)
- Lunch (45 minutes)
- Bowel care covering Standards 1, 3, 5, 6, 7, 8, 9, 10, 14 and 15 (30 minutes)
- Waste management covering Standards 1, 3 and 13 (15 minutes)
- Break (15 minutes)
- Simulation and competencies (2 hours 45 minutes)

Example 2: 4 days of classroom based training
Type of organisation: Adult Social Care

Week 1:
- 2 consecutive days of classroom based training covering 13 of the 15 standards in the Care Certificate (the exceptions being Standards 10 and 11 on safeguarding)
- 1 day off
- 2 days of work shadowing

Week 2:
- 2 consecutive days of classroom based training, the first covering the safeguarding of adults and children (Standards 10 and 11) and the second covering organisation specific induction topics
- 1 day off
- 2 days of work shadowing

Example 3: 10 days of classroom based training
Type of organisation: Acute NHS Trust

Day 1: Equality, Diversity, Privacy and Dignity (which maps to Standards 3, 5, 7 and 14)
Day 2: Understand your role and personal development (Standards 1 and 2)
Day 3: Health and Safety (Standards 3, 6, 10, 13 and 15)
Day 4: Cognitive impairments/clinical patient observations (Standards 3, 9 and 12)
Day 5: Nutrition (Standard 8)
Day 6: Health and Safety/Care of the Dying and Deceased (Standards 3, 5, 7 and 13)
Day 7: Communication (Standards 4, 5 and 6)
Day 8: Assessment of the unwell patient and Basic Life Support (Standards 3 and 12)
Day 9: Assisting with personal hygiene (Standards 3, 5 and 7)
Day 10: Corporate induction
In all of the pilot sites, and as demonstrated in these examples, the standards of the Certificate are not being delivered in a sequential order, but rather are being grouped together under broader topic headings. In many cases, as in the 10 day example, several of the standards appear under more than one topic.

At this early stage in the Care Certificate’s implementation, it is difficult to comment objectively on the optimum or recommended number of days of classroom learning. The pilot leads at each of the sites visited for the evaluation appear to have confidence in their own approach and until such time that the actual outcomes and impact of the Certificate can be assessed, then it is difficult to call this into question. Perhaps not surprisingly, those sites that are at either end of the spectrum (i.e. the 2 day and the 10 day examples) were somewhat doubtful of the merits of the other’s approach, but the concentration of sites around the 4 to 5 day mark suggests (although by no means proves) that the standards are being covered in broadly equivalent depth across the majority of the pilot sites. Note once again that the number of days quoted in these examples refer to the delivery of both the Care Certificate standards and any corporate or organisation specific induction that is provided.

**On the job learning and supervision**

Following the classroom based training, or in some cases in between the classroom sessions (e.g. where they take place weekly or fortnightly), a period of work shadowing is commonplace for new Support Workers. This appears to be almost universally well received by the Support Workers consulted for the evaluation and is seen by to them to act as a very important part of their learning and development.

> “In the training room it was a lot of information to take in, but when I started my work shadowing things started to make sense and I could see why we’d been taught certain things. I started to ‘get it’.“ Support Worker (residential care)

In a small number of cases, and most notably in some of the domiciliary care sites, pilot leads reported that work shadowing is rather less beneficial. For example, at one site the pilot lead described the dynamics of work shadowing in their organisation as “all wrong” and that Support Workers had a tendency to “stand back and not get involved”. Their preference is therefore for ‘double visits’ with the Support Worker and the more experienced member of staff working jointly, rather than through a shadowing arrangement.

Where work shadowing does take place, the duration of it ranges from a few days to several weeks and is determined by a combination of the policy or historic practice of the organisation and the speed with which the Support Worker is growing into the role.
On average across the sample, the work shadowing element tends to last between two and three weeks.

Following the work shadowing, Support Workers are, in the vast majority of cases, then permitted to work in their setting in a supervised or supernumerary capacity. This element of the Care Certificate model has been subject to considerable variation in interpretation by the pilot sites and it is evident that both practice and practicalities differ significantly across the sample. For example:

- **Definition:** the word ‘supervision’ itself has been interpreted differently, from those who take it to mean very hands-on, direct supervision through to, at the other end of the spectrum, an interpretation that it means supervisors being available to Support Workers as and when needed.

  “We need more clarity about what ‘supervision’ means in the guidance. Does it mean someone has to be with them at all times? This would be unrealistic for us. Everyone is supervised and support is available when they need it, but the supervisor won’t actually be with them all the time.” Pilot lead (domiciliary care)

- **Formality:** directly linked to the previous point, the formality of the supervision element has also varied, from those (the majority of the pilot sites) who treat it very much as a formal strand of induction, through to those (the minority) where it less prescribed and can be influenced more by the Support Workers’ own assessment of where they need some further guidance.

- **Settings:** in ‘centralised’ settings, such as hospitals and residential care homes, staff reported that it can be easier for Support Workers to be directly supervised, and for them to work alongside other members of staff, than in domiciliary care. That is not to say that any domiciliary care providers suggested that direct or ‘line of sight’ supervision in their service area is less important than in others, just that from a practical perspective it can be more difficult.

- **Sign-off:** there is some confusion across the pilot sites about whether Support Workers should be supervised until such time that they have completed the Care Certificate in its entirety, or whether they can work unsupervised on specific tasks as and when the standards to which those tasks relate are signed-off. As covered in more detail in Chapter 5, where revisions to the draft guidance materials are recommended, the strong preference within both healthcare and adult social care sites is for the latter.
3.4 Review meetings

Most of the pilot sites have incorporated a series of review meetings, often fortnightly or three weekly, between Support Workers and their mentors/supervisors. These typically cover:

- A review of recent progress from the Support Worker’s perspective, e.g. what’s gone well, any arising concerns, tasks they felt they didn’t understand etc.

- Plans for additional tuition sessions, should they be needed.

- Review of the Support Worker’s Care Certificate workbook.

- Goal setting, e.g. “by the next meeting I will have completed my workbook for Standards 8, 9 and 10”.

These review meetings are well regarded by both the Support Workers and the pilot leads. Sites that already have them as part of their Care Certificate delivery model intend to continue with them in the future.

3.5 Assessment

A key feature of the Care Certificate is the requirement for Support Workers to have their knowledge and skills approved via formal assessment by an occupationally competent member of staff. Given the amount of evidence gathered on this topic through the evaluation, Chapter 5 is dedicated to assessment and associated issues.

3.6 The duration of the Care Certificate

The 12 week recommended completion timeframe for the Care Certificate was the subject of much debate during the evaluation. In summary, whilst there are strong views amongst some pilot leads that 12 weeks is too long, and equally strong views that it is not long enough, the most common opinion is that it is about right. As shown in the table below, two thirds of the pilot leads said this and in the vast majority of cases their view was shared by the other consultees in their organisation. Note, however, that these pilot leads rarely said that it would be easy for Support Workers to complete the Care Certificate in 12 weeks. On the contrary, most used words such as “stretching”, “tight” and “challenging” but they nonetheless felt that it was achievable.
### Views on the Recommended 12 Week Timeframe

<table>
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<th></th>
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<th></th>
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<th></th>
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<tbody>
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<td>%</td>
<td>No.</td>
<td>%</td>
<td>No.</td>
<td>%</td>
</tr>
<tr>
<td>Too long</td>
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<td>3</td>
<td>19%</td>
<td>5</td>
<td>17%</td>
</tr>
<tr>
<td>About right</td>
<td>9</td>
<td>69%</td>
<td>10</td>
<td>63%</td>
<td>19</td>
<td>66%</td>
</tr>
<tr>
<td>Not long enough</td>
<td>2</td>
<td>15%</td>
<td>3</td>
<td>19%</td>
<td>5</td>
<td>17%</td>
</tr>
</tbody>
</table>

Source: ekosgen. Where percentages do not sum to 100% this is due to rounding.

Five pilot leads said that 12 weeks is an insufficient amount of time for Support Workers to complete the Care Certificate. This was mainly down to the following practical considerations:

- **Sites** (namely in domiciliary care) that are providing care and support for people across a **wide geographic area** may find it difficult to complete the observation and assessment elements within 12 weeks. This is because Support Workers and assessors could, for periods of time, be working some distance from each other and it may not straightforward to co-ordinate their diaries.

- Support Workers who only work a **relatively small number of hours per week** will reportedly find it harder to complete the Care Certificate within 12 weeks than those working more hours. Later in this chapter a recommendation is made that the 12 week guideline should be amended to recognise this.

- Staff that are new to caring, and especially those who do not have recent experience of education or training, may, in the view of some pilot leads, find the pace of the Care Certificate too fast. However, and as reported in Chapter 5, it was relatively rare for any Support Workers consulted for the evaluation to say that this was the case. Naturally, some had found it more challenging than others, but few appear to have experienced significant difficulties with the pace.

In addition to the above, two of the healthcare providers recommended a duration for the Care Certificate of at least six months and ideally a year. An example of one of these (which is also representative of the other) is provided in the box on the following page and in reality points to the pilot site’s *interpretation* of the Care Certificate rather than to a genuine suggestion that its core components require six months or more to be completed. This topic is revisited in Chapter 5, where a recommendation is made for master classes or road shows to help address issues like this before a national roll-out takes place.
Duration of the Care Certificate: Example #1

Staff (including the pilot lead and the assessor consulted for the evaluation) at one of the pilot sites – a large NHS trust – are strongly of the view that a minimum of six months, and possibly a year, should be the recommended completion time for the Certificate.

The reasons behind this relate to their interpretation of the Certificate’s content and to the distinction between a Support Worker that has successfully completed an induction programme and one that is fully skilled in all aspects of the role. For example:

- The pilot lead was keen to point out that a Support Worker shouldn’t be expected to fully understand, nor be in a position to recommend significant changes to, a patient’s care and support plan until they have been in the role for several months. However, the Technical Document does not suggest that they should be able to do these things via induction training, but rather (in Standard 5.b2) that they should be able to “explain why the changing needs of an individual must be reflected in their care and support plan”\(^{14}\). This is an important distinction: Care the Certificate requires a Support Worker to understand that if an individual’s condition or circumstances change, this should be reflected in the care and support plan. It does not require the Support Worker to recommend specifically what changes should be made, nor to make them, as appears to be suggested by staff at the pilot site in question.

- The pilot lead also questioned whether Standard 2 – Your Personal Development – and in particular 2.1 (‘I will contribute to developing my own personal development plan’) could be achieved before Support Workers have had their first full performance review, which takes place around a year after they start. But in reality Standard 2 is not about a retrospective review of performance, but about planning and recording development.

Four providers felt that 12 weeks for completion of the Care Certificate was too long. Without exception, this was down to financial or logistical issues. For example:

- An adult social care provider of residential services intends to deliver the Care Certificate using an eight week model. Their current induction programme (which is based on the CIS) runs for eight weeks and the pilot lead was keen to explain that they “can’t afford to have a longer programme……it’s not financially viable”. To help ensure that Support Workers can complete the Certificate within eight weeks, they have a regular programme of structured review meetings which include setting specific short term-goals, each of which is linked to the Care Certificate workbook and assessment processes.

\(^{14}\) The Technical Document actually says “my care and support plan”, which is incorrect, and may also be causing confusion. A similar mistake is evident in 5.2c, which reads “my future wellbeing and fulfilment” rather than “their”.

Evaluation of the Care Certificate Pilot

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• A large NHS trust intends to deliver the Certificate in four weeks, the pilot lead explaining that “we have a new intake of Support Workers every four weeks and we need to have the previous ones finished before the new ones start”. However, as shown in the box below, there has to be a question mark over the extent to which the Care Certificate is genuinely being ‘completed’ under this model within a four week period.

**Duration of the Care Certificate: Example #2**

An NHS trust intends to have Support Workers complete the Certificate in four weeks. However, their model does not oblige the Support Workers to have finished all elements of their workbook within four weeks (after which time they can work without ‘line of sight’ supervision). Some elements are to be completed within that timeframe, with evidence against the other standards to be collected and signed off over the ensuing weeks. The ‘completion’ within four weeks is denoted by more senior staff on the ward (namely registered nurses) providing verbal assurances to the assessor that the Support Workers are suitably competent.

**Recommendation #1**

The fact that the majority of pilot sites are broadly satisfied with the 12 week timeframe leads to the recommendation that this should not be changed. However, the draft guidance should acknowledge that part-time Support Workers and those on low hours contracts may need longer to complete the Care Certificate.

### 3.7 Linking the Care Certification to accredited training

Ten of the pilot sites (four in healthcare and six in adult social care) intend for some or all of their Support Workers to use the evidence gathered for the Care Certificate to count towards an accredited qualification. Other sites are not averse to this (unless, as in one case, they have taken the decision at corporate level not to fund QCF qualifications for Support Workers) but rather had not given it detailed consideration at the time of the evaluation.

### 3.8 Looking to the future

Very few, if any, significant changes are being planned by the pilot sites in terms of their future delivery models for the Care Certificate. A range of minor changes are, however, either planned or are being considered, although none to an extent that they could be considered in any way commonplace. These include:
Potentially covering the standards in a different order to how they've been covered during the pilot.

Revisions to workbooks, either based on feedback from Support Workers or to incorporate elements that pilot leads have seen at other sites.

Giving further thought to how the Certificate will work for agency and bank staff.

For multi-site organisations, deciding whether the classroom based training will be undertaken centrally or separately within each site.

In the main, however, pilot leads seem generally satisfied that the model they have used during the pilot will be fit for purpose when the Care Certificate is implemented on a larger scale.
4. Content of the Care Certificate

4.1 The 15 standards

Feedback from staff at the pilot sites suggests that the standards in the Care Certificate are, overall, the right ones. That is not to say that consultees did not identify potential omissions or amendments – they did and these are covered below. However, the majority of consultees are satisfied that the Care Certificate in its current guise provides adequate coverage across what might be considered a generic Support Worker ‘footprint’.

Recommendation #2

The development and roll-out of the Care Certificate should proceed with the current set of 15 standards. However, the Department of Health and its partners should note the issues raised by providers about content, and the interpretation of content, as explained in the remainder of this chapter.

4.2 Difficulty and pitch

No significant concerns have been raised about the difficulty of the Care Certificate. Whilst Support Workers new(er) to the sector were more likely to say that they had found it difficult than those with previous experience, the general consensus was that it had been pitched at a level which was neither too difficult nor too light touch.

It should also be noted here, however, that at five of the pilot sites, all of the staff undertaking the Care Certificate were existing Support Workers, some of whom had been in post for many years. These staff were therefore asked for their views on the difficulty and pitch of the Certificate for new Support Workers, although in the main they too tended to agree that it would be suitable.

4.3 Is anything missing from the Care Certificate?

Feedback gathered during the evaluation does not suggest that any standards are evidently missing from the Care Certificate. Staff at all of the pilot sites recognise and accept that the Certificate forms (or will form) a central part of Support Worker induction, alongside which are organisation and role specific competencies that also need to be covered to provide a holistic and tailored programme.
It is also clear from the evaluation that making the Certificate any larger would not be well received in either the adult social care or health care sectors. As explained in Chapter 3, some pilot sites have voiced concerns over the feasibility of completing the Certificate within 12 weeks, and others feel that whilst it is achievable, 12 weeks is definitely stretching. Adding new standards, without taking some out or increasing the recommended timeframe for completion, would doubtless add to these concerns.

Nonetheless, staff at four of the pilot sites did recommend that one or more new standards or competencies could usefully (for their organisation at least) be added to the Care Certificate. It should be noted that there was no consistency to these recommendations, i.e. none was made at more than one site, and as such there are no differences to report by sector or service area. Even so, they are reported here for completeness, although the question can be asked, especially about the second and third recommendations, as to whether these could genuinely be considered induction topics or whether they require more specialist, role specific training.

<table>
<thead>
<tr>
<th>Suggested Additions to the Care Certificate</th>
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<tbody>
<tr>
<td><strong>New standard to cover...</strong></td>
</tr>
<tr>
<td>Dealing with aggressive behaviour and physical abuse by someone who receives care and support</td>
</tr>
<tr>
<td>Caring for people with autism</td>
</tr>
<tr>
<td>Caring for people with mental health issues</td>
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<tr>
<td>Checking blood pressures</td>
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<tr>
<td>Correctly dressing wounds</td>
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4.4 Does the Care Certificate contain anything that is superfluous?

The answer to this question varies from site to site and is influenced by two factors:

- The type of service provided by the site.
- The roles of the staff that will be expected to undertake the Certificate in the future.

Taking these in turn, and starting with the **type of service provided by the pilot sites**, the main question seems to be whether Safeguarding Children (Standard 11) is directly relevant for sites whose focus is exclusively on adults. This standard is ‘new’ for the
Certificate i.e. in the CIS and the NMTS there is a standard on ‘Principles of safeguarding in health and social care’, but it does not distinguish between adults and children.

Views differ across the pilot sites on how this should be addressed. One provider of residential care services for older adults, many of whom have learning difficulties and/or acquired brain injuries, has treated Standard 11 as ‘not applicable’ and has flagged it as such in their workbooks. Staff at other sites would question this approach and have taken the view that whilst it may not be directly applicable to their Support Workers, it is nonetheless good practice for them to have a basic awareness of child safeguarding. As such they have included it in their Care Certificate programmes and have used simulated evidence, either through one-to-one discussions or group exercises.

The second factor to consider is the roles of the staff that are expected to undertake the Care Certificate in the future. It is difficult to provide a pilot-wide assessment on this topic, because whilst few sites expect to change the core elements of their delivery models, there is a definite interest in seeing how the final version of the Certificate looks, and what that means for their delivery costs, before determining exactly who will undertake it and when.

However, the most common position at this stage appears to be that the Certificate will be aimed only at what this report terms ‘Support Workers’, i.e. Healthcare Support Workers or Adult Social Care Workers. A small minority of sites are also considering it for a range of other support roles. As per the Care Certificate FAQs, these could include caring volunteers, porters, cooks or drivers that have direct contact with patients and people who receive care and support. These sites, perhaps understandably, have asked whether people in these auxiliary support roles need to complete all elements of the Certificate given that several of the standards will be of little or no direct relevance to them.

In reality the answer to this question is already in the public domain. The FAQs make it clear that staff can complete part of the Certificate but that there will be no award for part-completion. Even so, the Department of Health and its partners should build this issue into their master classes (see Recommendation #3 later in this chapter), especially as the evaluation uncovered examples of considerable uncertainty around this issue.

4.5 Should any of the current content be changed?

The majority of the pilot sites would be broadly happy for the Care Certificate to be rolled out with its current set of 15 standards, assuming that some consideration is
given to the above point on partial completion. With this in mind, it appears that fundamental changes to the ‘high level’ content of the Certificate are unnecessary.

Views are rather more mixed on some of the specific content. As mentioned earlier, a minority of the pilot sites would like to see extra topics included, in addition to which other examples arose where sites questioned whether certain standards overlapped with one another or might be difficult to cover in a group session with people of varying experience. However, these were very much exceptions to the norm and do not form a sufficient basis for any recommendations about changing the content of the Care Certificate.

However, a closely related point, and one that staff at the pilot sites were keen to raise during the evaluation, is the interpretation of the Care Certificate’s content. The examples provided in Chapter 3, where two sites have advocated up to a year for the completion of the Certificate and another site as little as 4 weeks, highlights the issue.

It is very important not to exaggerate the prevalence of the ‘extreme’ examples in the evaluation sample. It should also be reiterated that pilot leads at the majority of sites are satisfied that 12 weeks represents a realistic timeframe for completing the Care Certificate. Even so, the point remains that as more sites begin delivering Care Certificate, the risk of variations in interpretation increases. This explains why many of the pilot sites have raised concerns about the following two issues:

- The standardisation (or otherwise) in the delivery of the Certificate across the country;
- The extent to which the Certificate, in its current guise, can be portable.

On standardisation, sites are questioning whether the Care Certificate will be taught and/or assessed in a standard or consistent way, recognising of course that some local variation or context specific delivery is both inevitable and advisable. In summary, concerns exist that while the Care Certificate provides a standardised framework for both delivery and assessment, and while it is deliberately intended to be open to interpretation, in practice that interpretation could be very broad.

This is a topic we return to in Chapter 5, which includes a recommendation for a standardised ‘assessment answer book’ and nationally produced workbook. Portability is covered in Chapter Seven, but clearly those sites who question the consistency with which the Certificate is being delivered across the country also have doubts about how portable it can be in practice.
These are difficult issues to overcome. The more standardised and prescriptive the Care Certificate becomes, the more it will be open to criticism that it does not provide sufficient flexibility for different organisations and different settings. The Department of Health and its partners should therefore acknowledge the need to manage the expectations of employers on this topic and be clear with them about the degree of standardisation that is envisaged in the delivery of the Certificate.

**Recommendation #3**

Prior to the Care Certificate being introduced, it is suggested that a series of master classes or road shows be run which address the most common uncertainties currently associated with the Certificate, including the expectations that will (or will not) be placed upon employers to review the competencies of Support Workers (new and existing) that have undertaken the Certificate. These sessions should also give sites the opportunity to discuss their plans for delivery, assessment, learning materials etc, which the evaluation evidence suggests will be highly valued.

Also on this topic, given the positive response that the *Piloting the Cavendish Care Certificate* briefing paper has received, it should be used as part of the national roll-out, (prior to which references to the pilot and the evaluation of the pilot should obviously be removed).

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15 This topic is covered in more detail in Chapter 5.
5. Assessment and Supervision

5.1 Introduction

Assessment and supervision have been amongst the most emotive topics covered by the evaluation of the Care Certificate pilot. Fundamentally, no consultees said that they were opposed to the concept of Support Workers being formally assessed. Similarly, everyone can recognise the benefits that assessment offers in terms of rigour, accountability and a formal evidence trail. As such, there is no suggestion that assessment should not feature in the Care Certificate when it is rolled out nationally.

However, there are several issues relating to assessment, and more broadly to supervision, that do require some consideration and which may warrant changes to the draft guidance materials. These are considered in the sub-sections that follow. It is important not to dilute the strength of feeling that exists around these topics. As such, clear responses are required from the Department of Health and its partners, and the pilot sites should be given the opportunity to comment on those responses in advance of a wider roll-out.

5.2 Clarifying who can assess the Care Certificate

In more than three quarters of the pilot sites, the assessors are the same people that have delivered the Care Certificate training, whilst in other sites they include registered managers and qualified nurses that are now working in education teams.

The draft guidance states that assessors should be “occupationally competent”. Staff at the majority of the pilot sites are happy with this definition and feel confident that they have identified the right member(s) of staff to fill the assessor role. For these sites, any question or concern over the definition of “occupationally competent” is a non-issue.

“It really shouldn’t need spelling out. Any site should know who is fit and able to do the assessments......if they don’t then it’s quite concerning” Assessor (hospital)

However, staff at the pilot sites who harbour the most significant concerns about standardisation and portability also tended to be the ones who questioned the definition of “occupationally competent”. The worry for them is that without some consistency or ‘minimum threshold’ in terms of the years of experience or levels of qualification that assessors hold, there is a risk that portability will be compromised. Staff at these sites...
will not have confidence in the quality or rigour of assessment that has taken place in a Support Worker’s previous employment if this is not in place.

5.3 Promoting a consistent approach to assessment

A point closely linked to who can assess the Care Certificate centres on whether sites have different quality standards for assessment and sign-off. If they do, then there is a risk that a Care Certificate workbook, for example, which at one site would be considered insufficiently detailed or complete could, at another, be signed-off. The same applies to on-the-job assessment.

Feedback from the evaluation suggests that whilst the vast majority of sites in the evaluation sample have confidence in the rigour of their own assessment processes, they have far less confidence about the situation sector-wide. In reality, it would be impossible for any authority or regulator to police the assessment of the Care Certificate to such an extent that the risk of poor practice in assessment is nullified (a point which the pilot sites generally recognise). However, there is definite interest in having further guidance on assessment and, in particular, ‘example workbook answers’ or ‘example evidence’. Many of the sites feel that this would serve one or more of the following purposes:

- Instil confidence that they are approaching the assessment of the Certificate in a comparable way to other providers in their sector;

- Promote consistency of approach across the country;

- Augment the portability of the Certificate.

One of the adult social care providers in the sample has already been proactive in this regard and has produced an ‘answer booklet’, details of which are provided in the box below.
Answer Booklet

At this site – a residential care provider – the pilot lead has taken each of the tasks from the Care Certificate and turned these into questions that the Support Workers have to answer in their workbooks. Recognising (as many sites have) that the tasks/questions do not all have definitive right/wrong answers and are therefore open to a degree of interpretation, they convened a panel of four staff – including an experienced Support Worker – to discuss what each of them considered to be acceptable responses.

The pilot lead described the variety of valid answers that was put forward as “an eye opener”. She collated them into an ‘answer book’, excerpts from which have been included on the following two pages. Going forwards, this will be used by the different members of staff that are responsible for signing off the workbooks and in doing so is designed to promote consistency across the organisation.
5.1 Understand person centred values
5.1a Describe how to put person-centred values into practice in their day-to-day work
5.1b Describe why it is important to work in a way that promotes person centred values when providing support to individuals
5.1c Identify ways to promote dignity in their day-to-day work

1. Why is it important to recognise the individuality of each client?
To be able to identify and meet their particular needs, to avoid stereotyping and to develop a relationship with the client as a person rather than a set of care requirements.

2. Describe a way in which you support a client’s/tenant’s independence
The answer should be a description of a particular way in which the carer supports a client to be as independent as possible; for example:
- giving them time and encouragement to dress themselves
- assisting them in moves rather than moving them
- encouraging them to make their own choices
- developing their confidence outside the home so they can start to do things like going shopping on their own
- teaching them to use the internet so they can use networking sites or shop for clothes

3. What could you do to treat someone in a respectful way?
Respect their dignity- closing doors whilst using toilet/ changing
Listen to them
Involve them as much as possible
Promote their independence- encouraging to do things by themselves as much as possible
Allow them “me time” in their bedroom

4. Give three examples of ways you can disrespect someone
Interrupting
Not knocking before entering their room
Ignoring them

5.2 Understand working in a person centred way
5.2a Describe the importance of finding out the history, preferences, wishes and needs of the individual
5.2b Explain why the changing needs of an individual must be reflected in their care and/or support plan
5.2c Explain the importance of supporting individuals to plan for their future wellbeing and fulfilment, including end-of-life care
6.3 Understand how to promote effective communication
6.3a List barriers to effective communication
6.3b Describe ways to reduce barriers to effective communication
6.3c Describe how to check whether they (the HCSW/ASCW) have been understood
6.3d Describe where to find information and support or services, to help them communicate more effectively

10. List the barriers to effective communication:

Noise
Hearing impairment
Sight impairment
Jargon
Foreign language
Temperature
Comfort
Medical/ health issues
Dislikes
Personality clash
Distractions
Eye contact

11. How would you reduce the barriers you have listed in the previous question?

Reduce noise- quiet area
Sit comfortably with comfortable environment and surroundings- temperature, lighting
Use simply language that is understood by all parties
Use an interpreter if needed
Address medical/ health issues primarily
Ensure the people communicating are comfortable with each other and like each other
Maintain eye contact
Reduce distractions

12. Where could you find information on communicating effectively?

Speech and language therapist
Care plan
Training
Other staff
Line manager

If you hear or witness something which makes you suspect that a client is the victim of abuse you should maintain appropriate confidentiality but you may have to pass on information to senior staff / police etc. Let the client know that you cannot keep secrets and that if you believe it is in their best interests you will have to talk to other people.

In section 1 we looked at the handling of personal information and the role of the Data Protection Act. The Act only covers information which is written down or stored on computer but you must also be aware of your duty to maintain client confidentiality when speaking to people.
**Recommendation #4**

A nationally endorsed version of the ‘assessment handbook’ from Chapter 5 of the main report is likely to be welcomed and it is therefore recommended that consideration be given to developing one over the coming months. Note that the evaluators are not endorsing the answer book cited in Chapter 5 as a blueprint for a national document (although in practice some or all of it may be suitable for wider use) but rather the concept that has been adopted.

Consideration should also be given to developing a national Support Worker workbook for the Care Certificate which will be available to employers and publicised as part of the national roll-out (this topic is covered in more detail in Chapter 6).

### 5.4 Assessment and working unsupervised

The draft guidance on when Support Workers should be allowed to work unsupervised appears contradictory and is causing confusion amongst the pilot sites. The *Healthcare Support Worker and Adult Social Care Worker Document* states, on page 3, that:

“If you have not yet successfully completed the certificate you must be supervised directly and always be in the line of sight of your supervisor.”

The implies (and has been interpreted by many of the sites to mean) that all 15 standards from the Certificate have to be successfully completed before a Support Worker can work without ‘line of sight’ supervision.

The *Technical Document* seems to contradict this and suggests that Support Workers can work unsupervised on specific tasks once the standard in the Certificate to which they relate has been signed off (page 3):

“This [completing and assessing the Certificate] may be done in a phased approach, as each HCSW/ASCW meets an individual standard their supervisor may allow them to practice unsupervised against that standard. Therefore a HCSW/ASCW who has not yet successfully completed any standard of the certificate must be supervised directly for this standard and always be in the line of sight of the individual providing supervision.”

It is the latter of these standpoints with which the pilot sites are much more comfortable. Pilot leads repeatedly said that it is impractical for them to have Support Workers ‘in the line of sight of the individual providing supervision’ until such time that the Certificate has been completed in its entirety. Were this to be enforced, it seems likely that it would it be contravened.
“If I have to supervise staff [i.e. ‘line of sight’ supervision] until they complete the Certificate it will put me out of business. There’s no way I can do it. We give them the training they need, but then they have to be able to work independently. It would double my costs to send two people out to every visit.” Pilot lead (domiciliary care)

Recommendation #5

Ensure that the text on unsupervised working that currently appears in the Technical Document is replicated in all other relevant guidance materials. This is also a topic that should be covered at the proposed master classes (see Recommendation #3).

5.5 The suitability of workplace assessment and ‘line of sight’ supervision in certain settings

One of the more significant issues uncovered by the evaluation concerns the practicalities of ‘line of sight’ supervision and assessment in domiciliary care settings. Put simply, there are notable concerns amongst some of the domiciliary care providers in the sample about the following:

- **The cost implications** of providing ‘line of sight’ supervision for Support Workers until such time that they have completed the Certificate.

- **Privacy and intrusion** issues associated with non-care staff (or care staff not known to the person who receives care and support) coming into a home and observing what can often be quite personal procedures taking place.

- Linked to the above, the need to obtain **approval from the person who receives care and support** for an assessor to enter the home and undertake a workplace assessment. This can be particularly problematic in situations where the recipient of the care has dementia or other conditions affecting their recollection of having previously given consent.\(^{16}\)

It is difficult to predict the extent to which these issues would arise following a wider roll-out of the Care Certificate, but there is no reason to assume that they would be limited to the pilot sites. Skills for Care has engaged domiciliary and other social care providers further through a consultation exercise which is reported on separately.

\(^{16}\) Live-in care providers also wrote to the evaluation to express similar concerns, however live-in carers are not currently in scope for the Care Certificate, unless they are in a regulated setting, which is atypical.
5.6 **Practicalities and delays in assessment**

With the exception of domiciliary care, there is broad agreement that the assessment processes for the Care Certificate *should* work reasonably well in practice. The ‘should’ is important though, as in almost of the pilot sites, very few Support Workers had actually completed the Certificate and, as such, very few sites had been through the process of signing off all 15 standards.

Clearly however, and as might be expected, there are some practical considerations which are affecting the promptness with which assessment and sign-off can take place. The most prevalent of these relates to the Support Workers and their assessors working different shifts. The same is also true of Support Workers and their mentors. In both cases Support Workers, albeit in small numbers and in isolated examples, voiced concerns about whether they would be able to complete the Care Certificate within the recommended timeframe as a result.

These are local level issues which need to be resolved by individual sites rather than through national changes to the Certificate. They are nonetheless worth noting as there is the possibility that they will resurface when the Certificate is implemented on a larger scale.

5.7 **Introducing a ‘national Certificate’**

A national Care Certificate template, which can be printed off and given to Support Workers as a hard copy upon successful completion, will be welcomed when the Care Certificate is launched nationally. In the intervening period, consideration is required as to how to recognise the achievements of Support Workers that have participated in the pilot.

5.8 **Time limiting and re-assessing the Care Certificate**

This topic was not raised regularly during the consultations and the findings presented here should therefore be seen in that context. However, an issue which, for a minority of the pilot sites in both healthcare and adult social care, is seen to potentially jeopardise the portability of the Care Certificate is the absence of any requirement for it to be re-assessed after a specific period of time. The pilot leads at these suggested they would become less trusting of the Certificate as an endorsement of an applicant’s skills and abilities the longer the time that had elapsed since they completed it.

“If they completed it ten years ago but there’s nothing which shows that they have been assessed since, then it won’t carry much weight with us.” Pilot lead (residential care)
There are at least two pilot sites in the sample – one in adult social care and one in healthcare – that have introduced new measures on this topic. One has incorporated the standards from the Care Certificate within Support Workers’ performance management processes, meaning that their capabilities against each standard are revisited each year. The other site intends to re-assess Support Workers against each of the standards on a set frequency, which at the time of the evaluation visit had still to be confirmed.

Staff at these sites (and others) would advocate some re-assessment of the Care Certificate, although there was no consistency in their feedback about how often this should take place (annual, biennial etc).
6. Learning Materials and Draft Guidance

6.1 Definitions

**Learning materials:** documentation and other materials that the pilot sites have used to support their delivery of the Care Certificate during the pilot. This includes workbooks, online resources, case studies, role plays and interactive exercises.

**Draft guidance:** documents produced centrally (e.g. by Skills for Care or Health Education England) that give information about the Care Certificate. These are:

- The Care Certificate Framework: Technical Document
- The Care Certificate Framework: Assessor Document
- The Care Certificate Framework: Learner Document

6.2 Learning Materials

**Workbooks**
All sites have used a workbook to support their delivery of the Care Certificate and, in the vast majority of cases, this has been the primary learning material for Support Workers.

The workbooks are usually in hard copy and are structured around the Care Certificate’s 15 standards. They typically include explanatory text, knowledge based question and answer sections and sections for recording observational evidence. Whilst they have broadly similar content, they vary in terms of style and formatting.

Extracts from two of the pilot sites’ workbooks are provided on the following pages. Note that these have not been selected necessarily to represent good practice, although in terms of both content and presentation, they appear to be fit for purpose.
Workbook Example (healthcare). Included with the permission of the pilot site.

Standard 1 – Understanding your role

Employers rights and responsibilities

There are many laws that protect us at work and ensure that we are treated fairly by an employer. At the same time, everyone who works has to take care that they behave well in work, looking out for their own and other people’s safety, and are reliable and trustworthy.

There are a number of laws and regulations which have been written to protect you at work; they also protect your colleagues and the patients you will work with. As is usually the case, with rights go responsibilities, so these laws also tell you what you are expected to do and how you should behave at work.

The most important of these laws are described below under four main headings:

1. Workplace Regulations: Laws that keep everyone safe and reduce hazards and manage risks.
2. Employment Conditions: Outlines the duties, rights and responsibilities of employers and employees.
3. Equal and Fair Treatment: Ensuring that people have equal access to opportunities and that the diversity of the workforce is valued.
4. Working with Children: Additional requirements that result from work undertaken with vulnerable people including children and their families.

Code of conduct

You have been issued with a code of conduct for support workers. Following the guidance set out in the Code of Conduct, will give you the reassurance that you are providing safe and compassionate care and a high standard, and the confidence to challenge others who are not. This Code will tell the public and people who use Health and care services exactly what they should expect from Healthcare Support Workers and Adult Social Care Workers in England.

As a healthcare support worker or adult social care worker in England you must:

1. Be accountable by making sure you can answer for your actions or omissions.
2. Promote and uphold the privacy, dignity, rights, health and wellbeing of people who use health and care services and their carers at all times.
3. Work in collaboration with your colleagues to ensure the delivery of high quality, safe and compassionate healthcare, care and support.
4. Communicate in an open and effective way to promote the health, safety and wellbeing of people who use health and care services and their carers.
5. Respect a person’s right to confidentiality.
6. Strive to improve the quality of healthcare, care and support through continuing professional development.
7. Uphold and promote equality, diversity and inclusion.

1.1a List your main duties and responsibilities (see job description)

1.1b As well as working to the Cavendish Certificate Standards and your Code of Conduct, who other acts do you need to know about?

1.2a Describe your employment rights and responsibilities

1.2c Why is it important that you work within your job description and follow employment rights and responsibilities?
### Additional materials and e-learning

Whilst the workbook is the key resource, the pilot sites have also used videos or online films, case study examples and role plays or interactive exercises to support their delivery of the Care Certificate. The use of PowerPoint slides is also very common.

There is no evident pattern to show which types of materials are used by which types of providers. Neither is there any evidence to suggest that a given combination of materials results in a better or more engaging induction. Role plays and interactive exercises, however, have evidently proved to be very useful and were reported to provide an excellent platform for group discussion and debate.

At one adult social care site, the Care Certificate has been delivered almost entirely through e-learning. An overview of this approach and the associated learning materials is provided on the following page.
Delivering the Care Certificate through e-learning
Type of organisation: residential care (large)

Overview: Support Workers work through a series of online modules that have been mapped to the Care Certificate standards. Each Support Worker has access to the system through their own account from which they can access the modules and see their progress. Line managers also have an account and can view the progress of their team. At the head office, staff can access the system and view the status of induction training across the company.

Learning materials: Each module has a video or interactive exercise for Support Workers to watch or complete. There are also written exercises. The exercise on safeguarding, for instance, gives the example of a letter that a care home resident has written to a relative and asks a series of questions about how the person writing the letter might be being abused. The answers to these questions are documented by the Support Workers in their workbooks (hard copy).

Assessment: Knowledge based assessment is undertaken through online tests at the end of each module. The observational assessment is undertaken by line managers who log into the system to sign off to record the Support Workers as competent against each task.

Sequencing: Support Workers must work through the modules sequentially. Only when they have completed a module (i.e. viewed the learning materials and passed the necessary knowledge based and observational assessment) does the system allow them to progress to the next one.

Strengths: Staff across the site were positive about the e-learning approach and highlighted the following strengths:

- It places the onus on the learner to complete the training and gather observational evidence.
- All Support Workers use the same learning resources, helping to ensure consistency across a large organisation.
- The record of completion provides an audit trail which can be accessed from head office.
- The system allows line managers to see if staff are falling behind and where they might need additional support.

“It’s changed the way I manage people. I can see when they might be having issues and can support them.” Line manager and assessor

Weaknesses: Staff at the pilot site did not criticise any aspect of the e-learning approach. It is, however, costly. The cost incurred by the company to develop the system is in excess of £150,000, which would clearly be beyond the reach of many organisations in the sector.
6.3 How suitable are existing learning materials for the Care Certificate?

At just over half of the pilot sites, the pilot leads and those delivering induction training have amended their previous (i.e. pre-Care Certificate) workbooks to be suited to the Certificate. The extent of the amends has varied, with some sites making minor changes and others more substantial revisions. The most common amendments include:

- **New content**: components of the Care Certificate that were not previously covered by the CIS/NMTS have been added to the workbooks. In some cases these components were already being covered during the organisation specific elements of induction, so for those sites it has been less about developing new content and more about collating it all into one workbook.

- **Wording changes**: a range of minor wording changes have been made to ensure that the workbooks fully reflect the requirements and content of the Care Certificate.

- **Evidence collection**: adding spaces/pages for Support Workers to record evidence and for assessors to sign it off.

> "We previously had boxes in the workbooks for supervisors to tick when staff had been observed. They still use the tick boxes but they also write in comments about the evidence that they have seen." Pilot lead (domiciliary care)

At the other pilot sites (just under half), staff have developed new workbooks to deliver the Certificate, sometimes because their previous Support Worker induction materials were relatively brief and sometimes because they simply thought it was easier to start from scratch. The Certificate framework has typically been used as the basis for the new workbooks, with the detail under each of the standards amended to form knowledge based assessment questions or for gathering observational evidence. Site specific information has also been included where appropriate.

Aside from delivery aids (i.e. PowerPoint slides and exercises), it is rare for additional learning materials to have been developed to accompany the workbooks. Pilot leads often said that the workbooks were already quite big and they felt that giving Support Workers any additional materials would have been counterproductive. The evaluation did however find examples of a learning log for Support Workers which acts as a diary of their development, and an assessment answer booklet (see Chapter 5), which, whilst not Support Worker focused, has nonetheless been very well received.
6.4 Is there a need for nationally produced learning materials?

Those sites which would advocate a greater degree of standardisation in the delivery of the Care Certificate would welcome the introduction of a Support Worker workbook, produced centrally, which all sites are obliged to use (or, at the very least, are obliged to use as the basis for their own local version). This is, however, not a unanimous view, with numerous pilot leads in both healthcare and adult social care strongly of the opinion that they should be allowed to use learning materials that best meet their needs and circumstances.

The risk of not having nationally produced materials is that as more sites begin to deliver the Certificate, the variety that exists in the learning materials being used across the country will increase, and, for some people at least, the portability and value of the Certificate could be compromised. The argument against having nationally produced materials is that it gives the impression of a ‘one size fits all’ approach which may not be sensitive to the requirements and contexts of individual sites. A more practical solution may be to develop a national workbook and to make efforts to sell its merits to sites across the country, but not to make the use of it obligatory (see Recommendation #4).

Another important consideration is the amount of time across the country that will potentially go into the design of workbooks, assessment books and other associated documentation as more sites prepare for their delivery of the Care Certificate. This adds weight to the case for national materials and also introduces the possibility of a ‘repository’ where materials developed during the pilot can be uploaded onto a public website so that new sites can use them as reference material as they make their own preparations for delivery. The question here would be whether the introduction of a national workbook and a repository for site-level examples are mutually exclusive.

**Recommendation #6**

Depending on the action taken in response to Recommendation #4, consider developing an online repository onto which pilot sites can upload learning materials that they have used during the Care Certificate pilot\(^7\). It would be important to make it clear that these materials are not nationally endorsed, nor have they been quality assured externally.

6.5 Draft guidance

**Suitability of the Care Certificate Framework documents**

The three Care Certificate framework documents (technical, assessor, Support Worker) have been widely used by the pilot sites, although the use of the technical and assessor

\(^7\) Similar tools exist for the teaching profession, e.g. [http://www.sparklebox.co.uk/](http://www.sparklebox.co.uk/)

*Evaluation of the Care Certificate Pilot*
documents has been considerably more widespread than the Support Worker document. This is for two reasons:

- In most cases, the workbooks contain the key elements of the Support Worker framework document and it therefore seemed unnecessary to issue both.

- Around a quarter of the pilot leads said that the length of the Support Worker framework document could be “off-putting” or “daunting” for new Support Workers and that they would rather issue it later in the process (if at all) than at the outset.

When asked for feedback on the framework documents, the responses from consultees highlighted the following consistent themes:

- **First impressions:** the large majority of consultees, and in reference to all three of the framework documents, remarked that on first inspection they did not appear especially reader friendly. Comments were often made along the lines of them being long and text heavy.

- **Repetition:** the three framework documents contain much of the same (or very similar) content and this was seen by a minority of consultees as justification for producing one overall document that could be issued to different audiences. Whilst understandable as a concept, this would seem ill advised in practice given that each document is aimed at a specific cohort and has been tailored with that cohort in mind.

- **Content and relevance:** whilst first impressions of the framework documents tended not to be especially positive, it is also clear that in most cases, a closer read has led pilot leads, assessors and indeed Support Workers to change their view. It is still the case that concerns exist about the length of the documents, but alongside this is a general acknowledgement that they contain a level of detail which is commensurate with what the Care Certificate has been introduced to achieve. Where consultees said that they would like more detail, this was generally with regard to having sight of completed workbooks or assessment guidebooks, rather than more content being added to the framework documents per se.

“I initially thought it was too detailed but then when I got onto the ward I realised that I needed all that detail.” Support Worker (hospital)
Changes to the Framework documents
Elsewhere in this report suggestions are made for minor changes to the Care Certificate framework documents. However, the evaluation has not found sufficient evidence to justify recommendations for wholesale changes to the content, nor has it found evidence to suggest the format or layout of the content should change.

Yet by continuing with the current framework documents (with the aforementioned recommendations incorporated), it would seem likely that feedback along the lines of the ‘first impressions’ point outlined above will continue to arise. The positive way in which the Piloting the Cavendish Care Certificate briefing paper has been received should therefore be noted (see Recommendation #3). This document has only been available to adult social care sites, but was variously described as “valuable”, “easy to read” and “a really good overview of the information you need to know”. One pilot lead commented that their internal staff briefings on the Care Certificate had been based on this paper because it provided such a clear overview.
7. Portability

7.1 What is portability?

Portability in this context refers to the notion, as stated in the Care Certificate FAQs document, that “once the Care Certificate is completed it is portable and therefore does not have to be retaken”. The inference here is that the Certificate should act as a recognised stamp of approval that a Support Worker, with the necessary local or role specific training, has the knowledge and skills to deliver care to an appropriate standard and with the necessary compassion and dignity. As such, Support Workers who have completed the Care Certificate should not need to redo it if they move to a new employer.

7.2 The difference between portability theory and practice

Staff at all the pilot sites understand and are supportive of the concept of a portable Care Certificate and recognise that it could:

- Generate cost savings for employers as they would not need to put new Support Workers who had already obtained the Certificate on as full an induction programme.

- Be morale boosting for Support Workers as they would not need (to the same extent as now) to re-cover topics or tasks against which they had already demonstrated their abilities.

However, feedback from the pilot sites on how portable they expect the Certificate (based on its current design) to be in practice paints a different picture. The pilot leads at a quarter of the sites (including both healthcare and adult social care sites) said that they thought the Certificate was, in part at least, portable, i.e. they would be willing to accept it as reliable proof of a Support Worker’s abilities. Pilot leads at the other sites, accounting for three quarters of the total, were less convinced, the reasons for which are outlined in the following sub-sections.

Quality Assurance

The absence of any independent quality assurance of the Care Certificate, apart from that required by the system regulator, and the variability that could therefore arise in both training and assessment, places significant limitations on the extent to which pilot leads will accept its portability. Put simply, with a few exceptions where sites are already working in partnership on the Certificate, there is evidently only limited trust in
the training and supervision that takes place in other organisations. This goes far beyond some sites’ preferences for “doing things our way” and reflects a more deep seated scepticism over how effectively (or otherwise) the induction of Support Workers is currently undertaken across the country. Most pilot leads are therefore somewhat reluctant to accept that a portable Care Certificate is a realistic ambition in the short term.

“It should be portable and HCAs shouldn’t have to redo it, but at the moment I would have concerns about how in-depth the training had been at other places.” Pilot lead (hospital)

Unless there was something to give me assurances that the assessment was being approached in a similar way everywhere, then I wouldn’t really trust it.”

Pilot lead (residential care)

Standardisation
A point related to quality assurance is that of standardisation. There was a common view across pilot leads that the absence of a national workbook and an assessor’s handbook would reduce the extent to which they would recognise the Care Certificate as a reliable endorsement of knowledge and skills. A recommendation on this topic has been made in Chapters 5.

Transferability between settings
The Care Certificate is aimed at Support Workers across a broad range of healthcare and adult social care settings. Perhaps not surprisingly, the portability of the Certificate across very different settings was therefore called into question by several of the pilot leads.

“Portability would only work across similar settings....if someone got their Certificate working in a residential home, I don't think it would be very relevant to a ward in this hospital.”

Pilot lead (hospital)

This is an understandable concern, but equally it should not be seen as a criticism of the Care Certificate per se. The Certificate is designed to equip staff with a broad base of knowledge and skills that applies, in some capacity, to Support Worker roles in all healthcare and social care settings. Where a Support Worker is moving between settings that are very different, it is to be expected that a greater degree of role or organisation specific training would be required than if they were moving between two organisations providing very similar services. In theory at least, the Certificate should act as an indication to a new employer that the Support Worker understands and has demonstrated the fundamental concepts of the role and should therefore be in a good position to take on board and apply the new organisation/role specific requirements.
7.3 Current plans for inducting Support Workers with a Certificate

The vast majority of the pilot sites (both in healthcare and adult social care) reported that if they recruited a Support Worker with a Care Certificate from another organisation, they would require them to redo at least part, and, in six pilot sites, all of the Care Certificate training again. Note that the pilot leads who said they would require Support Workers to undertake the majority or all of the Certificate again were also those that were most concerned about the issues of standardisation in delivery and assessment.

“All new staff would go through our induction process even if they’d done the Certificate somewhere else. It’s completely different working with people with learning difficulties to working with older people; or working in a residential home compared with domiciliary care.”

Pilot lead (residential care)

However, the following points of detail are important here:

- In most cases, pilot leads reported that the induction of staff already holding a Care Certificate, and especially those with accredited qualifications and prior experience in the sector, would be done in something of a ‘fast track’ format. This might begin with verbal or written question and answer sessions, plus observed practice, either in the workplace or in a simulated environment. The Support Workers’ performance in these tasks would then determine which elements of the Care Certificate need to be formally retaken.

- The above is happening now with CIS and NMTS based inductions, so the introduction of the Care Certificate does not look set to represent a major change in this regard.

- Pilot leads often said that they trusted the quality of Support Worker induction programmes in organisations local to them more than they did in organisations elsewhere in the country. This was often because they knew the trainers or had worked in the organisations themselves. Portability on a local level therefore seems more likely than nationally. Also, the extent to which the Care Certificate would have been retaken if someone was moving from a local provider might be less than if they were coming from further afield.
Assessing whether a Support Worker should retake the Care Certificate

One of the adult social care pilot sites is in the process of implementing new software which they will use to assess the knowledge of new Support Workers. The intention is that this will help to reduce the amount of unnecessary retraining that takes place by testing and evidencing the knowledge which Support Workers already have (in doing so, it will also show where their knowledge needs to be improved). Support Workers will still be required to evidence that they are competent in practice, but the software aims to help their employers verify their knowledge in a cost and time efficient way.

7.4 Enhancing portability through working in partnership

Two of the LETB areas have co-ordinated local programmes of cross-organisation planning and knowledge sharing during the Care Certificate pilot phase. Both plan to continue this during the period between the end of the evaluation and the national roll-out of the Care Certificate. These local programmes have included:

- Round table discussions on delivery models.
- Comparisons of learning materials (with a view to local standardisation).
- Sharing information on how assessment and sign-off will be approached by the different organisations involved.
- Cross-site observations, where staff from one site visit another to observe the delivery of Support Worker induction training.

Whilst the evaluation has not looked in any depth at these models, anecdotal feedback on them is very positive. It also suggests that initiatives of this kind will help to promote the portability of the Certificate at a local level.

Only one adult social care example of this kind was uncovered through the evaluation. This involved a pilot site in London who made contact with another pilot site in the same region and arranged a meeting to compare approaches and learning materials. Both sites had found this very useful and remarked that, with hindsight, they wished they had done it earlier in the pilot, as both were able to take ideas from the meeting as to how they might modify their own materials.
Recommendation #7

Cross-provider networking on the Care Certificate should be encouraged. LETBs are obvious candidates to take this forward in a co-ordination capacity on the healthcare side. Further consideration is required as to how it should be managed in adult social care. Skills for Care Area Networks may be an appropriate channel.
8. The Potential Impact of the Care Certificate

8.1 Added value

No-one that has been consulted for the evaluation would argue against the concept of more comprehensive and more structured induction training for Support Workers. In that regard, the principle of the Care Certificate is broadly welcomed and the pilot sites can see how, across both the healthcare and adult social care sectors, it has the potential to add value to what currently exists.

Views on added value at an organisational level, whilst still clearly positive overall, are more mixed (this is likely to be influenced in part by the fact that most of the providers already see themselves as being strong on Support Worker induction). On the plus side, a majority of sites in both healthcare and adult social care identified the following elements of added value that the Care Certificate offers (or could) over the CIS and the NMTS:

- The combination of theory, practical knowledge and workplace application. The quotation below reflects the sentiments of a great many consultees on this topic.

  "It helps them [Support Workers] to understand what they need to do in their jobs and how, but also why, and that's really important." Pilot lead (community care)

- The workplace observation and assessment elements of the Care Certificate, whilst not without challenges, are widely seen as a step forward.

  "Managers will have to see knowledge being applied and will have to sign it off. Assuming that people don’t pay lip service to it, then this should reduce the risk of bad practice. But if they can just ‘tick a box’ and say they’ve signed someone off, then it won’t." Pilot lead (private sector healthcare provider)

- More generically, the Care Certificate has the potential to raise the profile of the Support Worker workforce, to provide greater recognition for the work that they do and make inroads into some of the issues that Cavendish raised in her review.
The pilot leads at six of the sites, however, said that for their organisation, the Care Certificate either offered no added value or they could not yet say but were doubtful about it. The reason for this, consistent across all six of the sites (which include both healthcare and adult social care), was that they were already delivering what they considered to be a very comprehensive induction programme for Support Workers that covered all, or the vast majority, of the Care Certificate’s standards and included structured programmes of supervision and observation.

“The added value of the Certificate depends where you’re starting from.....you can always make improvements but we’re providing a programme which looks very much like the Certificate anyway.” Pilot lead (community care)

It has not been within the scope of the evaluation to assess existing induction programmes, but the pilot leads at all bar one of the sites felt that their previous programmes for Support Workers were at least ‘good’. The vast majority agreed with the hypothesis that the added value of the Care Certificate would, or could, be greater amongst organisations whose previous approaches to Support Worker induction were less thorough.

Linked to added value, and a topic which arose regularly during the consultations, is whether or not the Care Certificate can have a positive impact on (what many pilot leads perceive to be) variable levels of quality and rigour in Support Worker induction training across the country. Despite the incorporation of formal assessment requirements, and not losing sight of the significant added value that many consultees think the Certificate will have, the general consensus is that poor quality training will not be significantly reduced by its introduction.

However, this is not the issue that the Care Certificate has been introduced specifically to address. So whilst some pilot leads would question whether enough priority is being given to eradicating poor quality training across the country, they also acknowledge that the Care Certificate is well placed to introduce greater consistency in how Support Workers are prepared for their roles.

8.2 Impacts for the pilot sites

At the time of the evaluation, most pilot leads could envisage some, although primarily modest, positive impacts for them as an employer that would arise from the introduction of the Care Certificate. These are summarised in the table below, and cover a range of areas that include reputation, staff morale and progression to accredited qualifications.
Impact of the Care Certificate for Pilot Sites

<table>
<thead>
<tr>
<th>Impact</th>
<th>Pilot Sites</th>
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<tbody>
<tr>
<td>Improve the reputation of the organisation as a good place to work as a Support Worker</td>
<td>7</td>
</tr>
<tr>
<td>Increase the number of Support Workers who go on to achieve accredited units from the QCF</td>
<td>5</td>
</tr>
<tr>
<td>Improve the overall level of morale amongst Support Workers</td>
<td>4</td>
</tr>
<tr>
<td>Help to attract Support Workers to apply for vacancies</td>
<td>3</td>
</tr>
<tr>
<td>Improve the retention of Support Workers</td>
<td>3</td>
</tr>
<tr>
<td>Enable them to identify Support Workers that are less suited to the role at an earlier point</td>
<td>1</td>
</tr>
</tbody>
</table>

Source: ekosgen. Staff at the pilot sites could cite more than one impact.

As proportions of the overall sample of 29 pilot sites, these numbers are relatively small. However, it is very important to note that they are likely to increase over time. Pilot leads were very keen to stress that they were, at the time of the evaluation, still in the very early stages of delivering the Care Certificate and were still to form a definitive view on its longer term impact. This was especially the case amongst those organisations that had exclusively put existing Support Workers on the Certificate.

Negative impacts of the Certificate were cited with less regularity, but there was nonetheless clear consistency in what they are (or will be):

- Costs and resources;
- Logistics and practicalities.

Each of these is covered in the following sub-sections.

**Costs and resources**

Note: the cost impacts of the introduction of the Care Certificate have been researched and reported upon through a separate study. The findings below are based on the feedback gathered through the external evaluation of the Care Certificate and not the other study, although clearly the two should be considered in parallel.

All of the pilot leads noted that there will be some one-off or start-up costs associated with the introduction of the Care Certificate. These cover the design and printing of new workbooks, assessment documentation, the time associated with the re-design of PowerPoint slides etc, but they were not seen by the pilot leads as being prohibitive or unmanageable.
It should also be noted here, however, that relatively few of the pilot sites had given any detailed consideration to the cost implications of the Care Certificate. This was due largely to the fact that the Certificate might be subject to change prior to national roll-out, although estimating the cost of induction activity seems not to be especially commonplace across the pilot sites, especially those operating in adult social care.

In terms of ongoing costs and resourcing considerations, the main issues cited during the evaluation were:

- **Additional training time:** most sites have increased (or will do in the future) the amount of classroom based time included in Support Worker inductions. Tuition costs (especially where external training providers deliver some or all of the training), room hire and associated overheads will all increase.

- **Assessor/supervisor time:** marking workbooks and undertaking assessments will, for the vast majority of sites, take up more time through the Certificate than it does currently.

**Costs of the Care Certificate**

The vast majority of pilot sites have not yet considered the cost impacts of the Care Certificate. However, one adult social care provider has given detailed consideration to these issues, far more so than any other provider in the evaluation sample, and harbours significant concerns about the additional financial outlay that they will face. These have conveyed to the Department of Health and its partners as part of the separate study that has given more detailed consideration to costs.

It is very difficult to predict the extent to which their concerns will be representative of a) other providers in the pilot sample; or b) employers in the sector more widely, given that they appear to be the only pilot organisation that has looked in depth at the financial aspects of the Care Certificate.

**Logistics and practicalities**

The supervision and assessment requirements of the Care Certificate for certain providers, most notably those providing domiciliary care, were flagged as a potentially difficulty.

These issues have been covered under ‘Assessment and working unsupervised’ and ‘The suitability of workplace assessment and ‘line of sight’ supervision in certain
settings’, both in Chapter 5. To avoid repetition the key points are not reiterated here, although the following quotations further highlight the issues.

“Routine can be vitally important for some service users, particularly those with learning difficulties. Changes to the members of staff involved in home visits, with assessors and supervisors coming in, could be very upsetting and unsettling for these clients.”

Pilot lead (domiciliary care)

“I’d need to get agreement from service users that someone else (the assessor) can attend. The first visit might say yes, the second one might say no in which case I’m hanging about for an hour. The next one may have said yes, but have forgotten about it, and then it depends what is happening that day as to whether the right situations will arise for me to observe. I can end up wasting a lot of time.”

Assessor (domiciliary care)

8.3 Impacts of the Care Certificate for new Support Workers

Most of the new Support Workers interviewed for the evaluation had little to compare their early experiences of the Care Certificate against. However, those that did repeatedly said that it was “more comprehensive”, “more detailed” and just generally “better” than the induction training they had received previously in the sector. This is, of course, not solely a reflection of the Care Certificate. As previously noted, pilot leads at almost all of the sites said that they already had good quality Support Worker induction programmes in place, and some have made relatively few changes as they have transitioned to the Certificate, so the positive feedback from the new recruits will, to some extent at least, reflect their employer’s approach to induction per se rather than the Certificate specifically.

Even so, the feedback from new starters was very positive. They felt confident, insofar as they were able to comment at that point in time, that the Certificate would prepare them well for their new roles and that the supervisory/mentoring arrangements would be helpful. Aside from some concerns about completing their workbooks to the required standard within the timeframes available (concerns which were not uncommon but equally not especially widespread) and the short term impacts that this may have on their free time and work-life balance, there was very little that they could identify by way of negative consequences or areas for change/improvement. The comment below was made, in similar ways, by many of the new Support Workers that were consulted.

“It’s been really good…..a lot to take in but all of it so far has been relevant.”

Support Worker (hospital)
The existing Support Workers consulted for the evaluation (i.e. those that were undertaking the Care Certificate but were not new to the organisation) were asked how well they thought the Certificate would meet the needs of new starters with less experience than themselves.

Their feedback was, in the main, very positive and from the perspective of impact tended to centre on the following:

- The breadth of the Care Certificate, and its combination of theory and practice, will help new Support Workers to be **better prepared for their jobs than they would have been via previous induction practices**. Note here that few people suggested that the effect or the difference would be transformational, but it is a positive message nonetheless.

- Their knowledge and skills might enable them to **spot problems or risks earlier** (e.g. relating to a patient's condition) than new Support Workers might have done in the past.

- The Care Certificate has the potential to **raise the profile of Support Workers** across the pilot sites and to make them feel **more valued**.

Perhaps the most significant element of the feedback from existing Support Workers is that many of them made comments along the lines of, “I wish I’d had this when I’d started”.

Pilot leads and other consultees (assessors and supervisors) very much echoed the above points, highlighting as well that the opportunity to use the Care Certificate as a means to achieve an accredited qualification may well, over time, prove to be a significant component of its impact.

In terms of negative impacts for Support Workers, three points were raised, none with any particular regularity, but they should nonetheless be acknowledged. The first relates to **the suitability of the Certificate for bank and agency staff**, and whether there is a risk of tension being created between those parts of the sector in which Support Workers have the Certificate and other parts of the sector (namely bank and agency staff) where they don’t. However, this concerns seems to centre on the assumption that bank and agency staff won’t be able to achieve the Care Certificate, which at the time of writing would appear to be largely unsubstantiated.

The second negative impact also relates to a point which is addressed elsewhere in the report, namely that of certain elements of the Care Certificate **not being directly**...
relevant to all Support Worker roles. If the guidance remains that a Support Worker must satisfy all elements of all 15 standards, then some Support Workers, especially those in auxiliary roles, may face practical difficulties in completing it. The impact, it was suggested, would be the demotivating effect it could have for some Support Workers.

8.4 Impacts for patients and people who receive care and support

The ultimate intended impact of the Care Certificate for patients and people who receive care and support is a better quality of care. The summary position on this topic is that at half of the pilot sites, staff (not necessarily unanimously) felt that the introduction of the Care Certificate would have a positive impact on the quality of care. None of the consultees thought it would have a negative effect. This is a very positive message, but it also important to bear the following in mind:

- Consultees often said that as a result of the Care Certificate, Support Workers would achieve the required knowledge and skills earlier in their career than was the case through previous induction programmes. In other words, they will be providing high quality care more quickly than they would in the past. That is not to say, however, that previously Support Workers wouldn’t have achieved that level, but just that it might have taken them longer.

- Consultees were not able to be specific about which elements of care might improve or on what scale.

The second point above relates purely to timing. At the time that the evaluation consultations were undertaken, sites were still partway through the Care Certificate with their initial cohort and in some cases had not actually begun delivery with any new Support Workers, instead focusing on existing staff. It is therefore unrealistic to expect them to have definitive views on the impact of the Care Certificate, including the impact for patients and people who receive care and support.

When asked why the Care Certificate would not improve the quality of care within their organisation, two themes were common in the responses. The first was that quality of care is already at a very high level and the influence of a new training programme for Support Workers will not cause this to rise any higher. The second was that the Care Certificate is not a significant departure from the organisation’s previous Support Worker training and, as a consequence, the impact it can be expected to generate is only limited.
A total of 26 patients and people who use care and support services were consulted across four of the pilot sites. These consultations added relatively little to the evaluation overall, mainly because the consultees had very little knowledge of the Care Certificate and were not able to compare the care they had received before and after its introduction.

The consultations did, however, reveal some common themes in the feedback. These were:

- A universal agreement that formal training programmes for healthcare and adult social care staff, including Support Workers, are necessary and should be in place in every provider of care services across the country.

- Broad support for the concept of introducing a more comprehensive programme of training for Support Workers (note that the consultations did not lend themselves to discussions about any of the detail of the Certificate).

- A sense from consultees that they would feel “reassured” if the setting for their care changed (e.g. through moving ward or transferring to a different care home) and they knew that the Support Workers had all received similar training.

Perhaps most significantly, the patients and people who receive care and support were less interested in, or concerned by, the formal training that Support Workers have received and said instead that they placed more significance on the compassion and friendliness with which they went about their work. Many clearly take it as read that staff in health and care institutions have the technical skills and core knowledge to do their jobs, but it is how they do them that patients and people who receive care and support really value.
9. Conclusions

This evaluation has obtained input from 29 providers of healthcare and adult social care services across England that have piloted the Care Certificate in mid 2014. It has found strong support for the concept of adding rigour and assessment to the induction of new Support Workers and has highlighted a number of areas where the Care Certificate has the potential to add value to current practice and generate positive impacts.

The content and requirements of the Care Certificate have been interpreted in a broadly consistent way across the pilot sites and, whilst as expected some sites have recommended changes to specific points of detail, there are very few pressing issues to address in terms of the overall design. The suitability of the Care Certificate for live-in care providers and the practicalities of workplace assessments for some domiciliary care providers could, however, benefit from further consideration.

Staff in the majority of pilot sites are satisfied that the Care Certificate can be completed to the required standard by new Support Workers within 12 weeks. There are some exceptions to this, where sites have advocated a much longer timeframe, but these appear to be down to issues of misunderstanding and misinterpretation and do not warrant an increase to the recommended timeframe. That said, recognition is required that part-time Support Workers and those on low hours contracts may need longer to complete the Care Certificate.

It is very important that sites have the flexibility to deliver the Care Certificate in a way that is best suited to the needs of their organisation and the scope of the Support Worker role within that organisation. The current design of the Certificate allows this, but it should also be acknowledged that pilot leads are unsure that it will be delivered and assessed to a consistently high standard across the country. This is impacting upon the extent to which they are willing to see it as genuinely portable, although the examples of cross-provider working highlighted by the evaluation provide one route through which this could potentially be addressed.

The guidance documents produced to date have been commensurate with those expected on a pilot of this type and, whilst they have not always found favour with the pilot sites on first impressions, in most cases they are later reported to be fit for purpose. Prior to a wider roll-out there would be merit in producing an ‘assessment handbook’ and in making the Piloting the Cavendish Care Certificate briefing paper more widely available.
The pilot sites are strong advocates of supervision for Support Workers but they would nonetheless benefit from further guidance on when 'line of sight' supervision is (and is not) expected. The clear preference across the sites is that once a Care Certificate standard is signed off, a Support Worker can undertake the tasks in that standard without line of sight supervision. Currently the guidance documents could be seen to give an inconsistent message on this topic.

Overall, the evaluation concludes that the Care Certificate has been welcomed by the large majority of the pilot sites, that it can deliver a range of important benefits, and that most of the sites will be willing to deliver it on a larger scale. As would be expected with a pilot, the evaluation has also highlighted a range of issues which will require further consideration before a national roll-out takes place. Most of these are operational matters that should be relatively straightforward to address, although some are more substantial and will best be resolved through further dialogue with providers. Assuming that suitable resolutions can be found then the evaluation evidence would suggest that the Care Certificate is well placed to have a very positive impact on the induction of Support Workers in both the healthcare and adult social care sectors.
Appendix A: Evaluation Questions

**Overall implementation:**
- How has the Certificate been implemented in practice?
- How have employers in different settings (health/social care; large/SME/micro/individual; acute/primary care; residential/domiciliary/day care; urban/rural; different geographies/LETBs; statutory/PVI) implemented the Certificate?
- To what extent does the Certificate appear portable?
- How effective is the guidance for implementation?
- Who has provided learning for the Certificate (e.g. in-house versus external learning providers)?
- Are electronic methods, technology or blended learning being used and if so, which and how effective are they?
- How was the quality of learning and development assured?
- How long did the necessary learning and development take to complete? How does this compare to prior arrangements for induction?
- What have been the issues arising and how have any challenges been overcome?
- What were the resource implications of undertaking the Certificate for employers?
- What has been the impact of the Certificate on (a) learners (b) employers (c) people who use health and social care services?
- What are the opportunities for delivering the Certificate across localities/organisations?

**Framework content:**
- Is the content of the Care Certificate framework fit for purpose in its current form?
- To what extent is it universally applicable to the employers and occupations currently within scope (healthcare assistants and adult social care support workers)?
- If not, what were the specific challenges and for which roles?
- Were there any areas in the Technical Framework where it was difficult to interpret the outcomes or the standard to be met?
- To what extent did Assessors feel they understood the outcomes required in the Assessor Framework document?
- To what extent did Assessors feel they were confident that they were able to make a judgment of the HCSW/ ASCW against the assessment requirements?
- To what extent did assessors feel that the assessment requirements meet the outcomes i.e. did assessors feel confident that the evidence required was sufficient/ too much/ too little to make a judgment that the HCSW/ ASCW had met the standard?
- To what extent is HCSW/ ASCW version of the Framework understood by workers from different backgrounds and with differing educational standards?
- Does the workbook provide sufficient coverage of the learning required?
- Are the case studies/ examples used appropriate and helpful? Are there any significant omissions?
- Are the questions set clear and unambiguous?
- Is the recommended further reading comprehensive and appropriate?
• Is the presentation/design helpful?

**Learning materials:**
Employers may already have established workbooks, portfolios, e-learning or other learning materials in use to support the Induction of HCSWs and ASCWs. As part of the evaluation we are looking at how well these met the learning and development required to meet the outcomes of the Care Certificate.

• Did existing learning material provide sufficient coverage of the learning required?
• If additional learning material needed to be developed/sourced what were these?
• To what extent did the existing/new learning material meet the learning needs of the HCSWs/ASCWs?
• To what extent did the learning materials have associated assessment e.g. questions, reflective logs, space to record observations etc?
• Did learning material generate sufficient evidence that could be used to make a judgment on whether the learner had met the outcomes required?

**Assessment:**

• How has the Certificate been assessed in different settings?
• Are there any learning and development needs for assessors?
• Is the guidance for assessors fit for purpose?
• Can all performance evidence be collected in a real workplace or has some of it had to be collected using simulation (some requirements may need to be simulated)?
• If it has which elements relied on simulated activity more than others?
• Do employers have confidence that the assessment decisions are sufficiently standardised i.e. that assessment decisions would hold up if another assessor were to undertake the assessment of the same learner?
• Is the assessment proportionate/consistent? Is it asking too little/too much and are assessors across a single employer/multiple employers making the same demands on the learner in terms of evidence?

**Assessment Evidence:**
Evidence produced by the HCSW/ASCW and used by the Assessor to make the assessment judgment must be auditable. How the evidence and assessment decisions are maintained and in what form is the decision for individual employers. This could be through using the same workbook, portfolio (electronic or hard copy) that contains the learning material or in a separate form.

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