Driving Impact

From social worker to social care trainer, I entered this career from a strong value base. Like many of my colleagues, the people/professionals we were before 'trainer' influences our approach. A commitment to professionalism provides a moral foundation to serve our communities, and thus have an impact in our work. However, there is often a disconnect between training and impact which has always both intrigued and frustrated me. This compelled me to undertake a doctorate to understand what limits us, and explore if there is a better way of working in social care education.

My research shows that most external training providers (ETP) within the health and social care sector want to have a good impact in their work. Most are value driven and consider quality a driving force.

However, what does impact mean?

To some, impact means developing the programme to include local policies and procedures, to others it means having an active role post training to improve the impact of learning interventions.

Perhaps it hinges on how the ETP position themselves: either as 'training provider' or as 'workforce development', each position is distinctly different. Training is a single point of delivery, whereas workforce development requires a much more strategic and integrated approach.

However, it is very difficult to cultivate impact as an ETP for the following reasons:

- it costs more to deliver impact
- care providers are unwilling to pay extra when there are cheaper options that tick a box
- it's challenging to influence practice post training
- there is a distinct lack of policy to facilitate incentives for impact
- large care providers already have a developed quality system in place which they would argue already measures impact (although questionable!)
- many just don't value it, which is evident in commissioning processes that often fail to recognise the full cycle of learning and development, and instead focus disproportionately on delivery.

There are many factors working against, rather than for impact. For example, providers are required to complete annual mandatory training, with often pre-defined learning outcomes. However, services are very diverse, with learners all starting at different levels. There is no requirement (or funding mechanism) to undertake an organisational needs analysis. We are commissioned instead to meet compliance requirements.

Many see the role of the ETP as delivering training NOT to impact practice. For many ETP's this causes a significant disconnect.

The environment in which social care training is delivered does not foster conditions where providers can grow capability in impact work. Resource restraints, poor expectations, and profit driven mentality limits our impact. As a result, much funding is wasted ticking boxes.

However, there is hope, as the recent pandemic caused a digital explosion across health and social care training. The uptake of these new technologies has been necessary to survive the radical changes in the market, but it has also provided new opportunity to engage, collaborate and reach situated practice in new ways without breaking the bank.

Workforce learning theory suggests that much of the learning happens at a practice level, often when there are tensions in practice. People learn when they see things work in practice. So how then can an ETP impact practice at that point?

Some of the ways that ETP's can cultivate impact using technology include:

- providing access to resources on mobile applications (needed for deskless communities)
- providing more flexible content to improve accessibility
- using collaborative tools to foster peer learning
- using 'Flipped Learning' between sessions to deliver a practice based activity
- undertaking initial assessment and using technology to target specific content to keep it relevant
- data reporting – using tech not only to report on achievement but also activity post training.

Measuring Impact

The tool that is used most frequently to measure impact is the Kirkpatrick Model. Most ETP's are very good at delivering levels 1 and 2. However levels 3 and 4 are much harder as an external provider.

Level 1 evaluation immediately after the training to determine the learner's reaction to it

Level 2 use assessment methods to identify if there has been learning.

Level 3 gather data on behaviour changes in the workplace

Level 4 ascertain the impact on the business.

However, the Kirkpatrick model is limited as it assumes that there is a relationship between each part, that the reaction to training will impact on the learning, that the learning will impact on the behaviour change, and that the behaviour change will in turn impact on outcomes for the client. It assumes a causality that increased learning will be the sole determinant of behaviour change, and ignores other factors which

might play a critical role in behaviour change such as supervision and mentoring, or the introduction of new tools. It's far from a perfect model.

Important Steps

- Where working with regulated services, always make sure that impacts identified are specifically linked to the KLOE's (see examples below).

- Use 'Reverse Engineering'. In the process of Organisational Needs Analysis, instead of asking what training do you need, ask instead what are you trying to solve? These are sometimes known as Level 4 impacts. Not everything needs training, and a customer will always value your honesty.

- Document the ONA process or development plan, as this can help to meet KLOE outcome: **E2 How does the service make sure that the staff have the skills, knowledge, and experience to deliver effective care and support?**

- At the Needs Analysis stage, try to gage the strengths of the organisation, as the learning experience is bi-directional. The ETP develops most of its capability and 'power' from learning across multiple boundaries.

- Then define the expected behavioural impacts (see examples below). These are sometimes known as Level 3 impacts.

- Set up a survey to monitor the Level 3 impacts. This can be self-reported post training using a simple survey tool. However, this does need to be actively managed, otherwise you risk low return rates. Analysis of data is also essential to ensure incremental improvements.

- The Level 4 impacts need to be reported by the organisation. These should be part of existing quality systems. However, it's the ETP's role to link the Level 3 and Level 4 (in discussion with the service), then provide tools and resources post training to improve the impact.

Getting client buy in for impact work can be challenging. It's important to highlight the benefits of collating this data for inspections, for cultivating a learning culture, for evidencing return on investment and most importantly for improving the wellbeing of the individuals they support.

Some of the things you could do is ask the provider to:

- audit MCA assessments before and after training
- complete audits of the social environment before and after training (a bit like a DCM style audit)
- measure incident reporting, and safeguarding alerts before and after training

- complete competency assessments before and after specific training.

What can be done to improve impact?

If you are going to the bother of measuring impact, you should take active steps to cultivate it. Here are some examples:

- ignite and inspire learners by delivering highly engaging and relevant training
- use experts by experience to connect learners to meaningful experiences that aid retention and improve impact
- explain to all stakeholders the expectations post training.
- Introduce a new tool, as tools turn action to activity, and become a platform in which best practice can be enacted. They are a framework for recording discussion, and cross team engagement.
- provide specific guidance to providers on how to make the most of the training post training, which can include what questions to ask informally (often straight after the training) or formally through supervision.
- provide a crib sheet to evidence learning and impact.
- provide memory aids to prompt people in busy environments, such as visually engaging infographics.

The bigger picture

There are cross sector challenges that training can support; below are only a few. Tackling any of these will lead to a return on investment. However, it is for the ETP to explain how this could be achieved through whole system approaches.

Potential impacts from training:

- reduction in falls – mortality rates can be high, leading to deaths which impact on bed occupancy rates .There are substantial health related costs to the NHS (Conducting falls prevention research in a care home setting, 2020)
- reduction in infection outbreaks. In the recent pandemic, bed occupancy rates have plummeted ('2020 UK Care Homes Trading Performance Review', 2021)
- reduction in incidences of challenging behaviour. The excess annual cost associated with agitation per resident with dementia is £1,125.35 (Panca et al, 2019). A study delivering person centred care in dementia training (WHELD study) showed that it was cheaper to deliver training, as it directly reduced the number of incidences of challenging behaviour (Ballard et al., 2018)
- reduction in organisation type safeguarding concerns. A recent publication by Local Government Association (2020) reviewed recent Safeguarding Adult Reviews and highlighted that there were several poor practice areas that led to failings in safeguarding. Several recommendations are made on how training in these areas can strengthen practice (Analysis of Safeguarding Adult Reviews, 2019). Examples of this include legal literacy, making

safeguarding personal, risk assessment, mental capacity assessment and interagency working.

Some examples of impact work

Course outcomes	Tier 3 impacts	Tier 4 impacts	
		KLOE	**other**
Communication skills in dementia Identify ways to assess the communication strengths and abilities of the individual with dementia. State how dementia can impact on communication skills. Identify other factors that might influence the individual's ability to communicate. Describe a range of communication strategies that could be adopted at different stages of dementia. Describe techniques to overcome the barriers to communication. Describe how information about an individual's life history can strengthen communication 6j. Apply active listening skills Explain how assumptions and beliefs influence effective communication.	Have used a range of assessment methods to identify communication needs. Have reported and /or recorded on changes to communication abilities. Have reported and/or recorded identified communication barriers. Have made changes to the social environment to improve communication e.g. adapting to and working with different realities . Have adjusted and amended the structure and pace of communication with someone living with dementia. Reframed challenging behaviour as method of communication, enabling a different response. Have made referrals to allied health e.g. sensory services to enhance communication aids,	Effective E1.1 Effective E2.2 Effective E5.2 Care C1.1 Care C1.2 Care C1.3 Care C3.2 Safe S2.7	Reduction in incidences of behaviors of concern.

Explain how challenging behaviour is a form of communication. Explain the role of mouth care in supporting communication.	dentist to support fitting of dentures. Have drawn on life history to understand behaviour in context. Have included people more in conversations. Listened more mindfully to what people are saying .		
Dementia Environment Describe how changes to the brain effect the way an individual navigates an environment. Describe how to adapt the environment to minimise difficulties related to sensory impairment. Explain how good design promotes self-identity and self esteem. Identify what home means to a person. State the factors associated to design that can support orientation.	Have raised awareness of the impact of the environment on the person with dementia and support tasks. Have made changes to the environment to support sensory needs. Have made changes to improve familiarity and support identity. Have made changes to the environment so that the person can participate. Have made changes to improve way-finding. Have made changes to the environment to support nutrition. Made changes to the environment to support sleep.	Effective E1.3 Effective E2.2 Effective E3.3 Effective E6.1 Effective E6.2 Effective E6.3 Effective E6.4 Care C3.1 Care C3.5	Reduction in Falls. Reduction in incidences of behaviors of concern.

	Have provided more access to the outdoors. Have discussed in own team the possible use of assistive technology.		
Mental Capacity Act State the main principles of the act. Define the term mental capacity. Explain who is affected by the provisions of the act Identify when it is appropriate to undertake assessment of capacity. State the key roles in the assessment process. Describe best practice in recording and defensible decision.	Have been able to recall the five principles. Have been able to identify where Best Interest applies. Have carried out supported decision making. Have recorded consent to care and treatment in daily records. Have reported and/or challenged where someone's rights have been overridden.	Effective E2.2 Effective E7.2 Effective E7.3 Effective E7.4 Effective E7.5 Effective E7.7 Care C2.1 Care C2.2 Safe S2.1 Safe S2.2 Safe S4.4	Reduction in safeguarding concerns.

Documenting and evidencing impact is a critical part of the ETP’s role but does require a significant amount of work before and after training to get right. Getting stakeholders on board is an important part of the process. Engaging digital technology is the only way to make this cost effective. Finally, it is important to remember not to try to measure impact without first cultivating it.

References

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