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# What Can we Learn from the Innovation of The Care Certificate?

*An Online Witness Seminar*

*14th March 2023*

Edited by Jill Manthorpe and Carl Purcell

September 2023

# Contents

# Introduction

## The Care Certificate

The Care Certificate was developed by Health Education England, Skills for Care and Skills for Health in response to The Cavendish Review that followed the public inquiry led by Robert Francis QC into abuse and neglect in Mid Staffordshire NHS Trust. Her Review exposed the variable (sometimes there was none) training and induction of the estimated 1.3 million health and care support workers who deliver the bulk of hands-on care for people in care homes, people's own homes and hospitals. The Care Certificate (referred to as the Certificate in Fundamental Care in the Cavendish Review) was introduced in April 2015 and sets out 15 standards that cover the knowledge, skills and behaviours that all new health and care support workers are expected, although not required, to attain or be working towards in their first 12 weeks of employment. It was described as 'the first practical attempt to apply a common framework of occupational standards and competences across the entire field of health and social care' (Payne, 2014 in iCroner) However, concerns were voiced at the time of implementation about its lack of formal accreditation, and risks of inconsistency. Payne observed 'This is a fundamental weakness as it calls into question whether the changes required to implement the Care Certificate are worthwhile'.

## Witness Seminars

Historical perspectives are vitally important to effective policymaking and the development of services for the public. A failure to learn from the past often leads to bold claims about 'new' ideas and 'radical' reforms which invariably just reinvent the wheel and fail to avoid past mistakes. Over recent years 'witness seminars' have provided an important means to try to improve our understanding of key events or a particular period of policy development within the bounds of living memory. Witness seminars typically bring together researchers, policymakers, people undertaking or affected by policies and other key individuals that have studied or played a more direct role in the development of particular policies, new social movements or service innovations. Contributors address a particular subject from their own perspective, drawing on their memories or records of the time.

## The Supporting Innovation in Adult Social Care (SASCI) Project

Innovation or doing things differently is often seen as a solution to problems. Adult social care might seem to be an area where new approaches will naturally flourish (with competition between providers, different people paying, choice over types of care and provider and so on). Yet, while there are many innovations and good evidence that some benefit people using care services, they do not always spread rapidly and often do not become mainstream.

Compared to other parts of society, little is known about innovation in social care and why good ideas spread or otherwise. Many organisations and people offer to help with innovation but not much is known about what they do and how they do it, or what works. The SASCI research programme has been set up to draw together experiences of innovating or changing things in adult social care to let others know what might help.

As part of the programme this webinar considered the key themes of evidence and values, the roles played by political leaders and other key influencers, and how and why innovations spread and are sustained. More specifically its examined:

- Why was the idea of a Care Certificate accepted by government?
- Who were the key influencers and what did they do?
- Why was it not mandatory for everyone to undertake the Care Certificate?
- Why was no external Quality Assurance built in?
- Why has the Care Certificate spread and lasted?

## Reflection from Sandra Paget

Listening to the witness seminar and reading over the transcript the thing I took away was that a really good initiative had come along and was endorsed, but then didn't receive the impetus to make it prestigious. I had some care after an accident in early 2020. All the women were very pleasant friendly, good people and I used to talk to them quite a lot about their job. It was disappointing to hear that several of them were undertaking the Care Certificate online but were not being paid for the extra work. Thinking back to care I received in an orthopaedic hospital several decades ago, it struck me that the care these staff were providing in my home required the same skills as those of the nurses in the hospital. These skills ought to be valued and staff caring for people in their own homes should receive greater recognition and support for this skilled work.

*Sandra Paget is involved in the SASCI project as a member of the public and is a member of the Lived Experience Reference Group.*

# Participants

### Jill Manthorpe CBE (Chair)

At the time of the seminar Jill was Professor of Social Work at King's College London and Director of the NIHR Policy Research Unit in Health and Social Care Workforce, based in the Policy Institute. She was made CBE in the Queen's Birthday Honours List 2022 for services to social work and social care research. She works closely with several social care and health sector employers to link research, policy and practice and is a member of the SASCI research programme leading the workforce theme. Jill is also a member of the Social Work History Network committee and a Trustee of a major care provider charity.

### Carl Purcell (Organiser)

Carl is a Research Fellow in the NIHR Policy Research Unit in Health and Social Care Workforce, having previously worked in local government. His research interests include the development and implementation of health and social care policy across Children's and Adults' services. He is a member of the Social Work History Network. Carl is a member of the SASCI project team.

# Witnesses

### Andy Tilden OBE

Andy retired as Director of Operations at Skills for Care in March 2021 having spent the previous year as Interim Chief Executive Officer (CEO). His role covered leadership and management, standards, the Care Certificate, learning qualifications and apprenticeships, recruitment and retention, workforce innovation and regulated professionals. He also had oversight of Affina OD a separate company within the Skills for Care group. Andy has been working in and around social care since the late 1970s. He initially qualified as a teacher and has worked as a residential care worker, a trainer and manager in the NHS, and as a lecturer. He qualified as a social worker in 1984 and worked in juvenile justice, child protection and learning disability services. He served 3 years as a Fellow of the National Institute for Health and Care Excellence (NICE). Andy is now Vice Chair and trustee of the Royal College of Nursing (RCN) Covid Foundation, a trustee of Community Catalysts and a Non-Executive of Training Now which is part of the Agincare group. He is a Fellow of the Royal College of Occupational Therapists and in 2021 was awarded an OBE for services to social care.

## Angelo Varetto

Angelo is Head of National Occupational Standards, Qualifications and Apprenticeships at Skills for Health. He has a background as a registered nurse and is the lead for the Care Certificate at Skills for Health. He was a member of the small team set up in early 2014, comprised of experts from Health Education England, Skills for Care and Skills for Health, that developed the standards that make up the Care Certificate. Additional resources developed by Angelo and his colleagues to support the implementation of the Care Certificate included the guidance for assessors, the workbooks, the workbook presentations, the self-assessment form and later the e-learning resources.

## Louise Thomson

Louise is Associate Professor at the University of Nottingham in the Faculty of Medicine and Health Sciences. She is Course Director for the University's MSc in Occupational Psychology and a registered Practitioner Psychologist and Chartered Psychologist. Her research focuses on the effectiveness of interventions in reducing sickness absence and improving job retention; mental health at work; the implementation of evidence-based practice by health care professionals; and healthy and safe working conditions for healthcare staff and patients. Louise led the Evaluation of the Care Certificate commissioned by the NIHR and which reported in 2018.

*Audience participants were drawn from adult social care stakeholders including providers and people using social care and support services.*

# Seminar Transcript

## What Can we Learn from the Innovation of The Care Certificate?

### Online, 14th March (2pm-4pm)

**Jill Manthorpe:** I'd like to extend a warm welcome to everybody who's joining us this afternoon and to our speakers in particular, as we focus on the Care Certificate. If you go into work in adult social care, or indeed parts of the NHS, most people have the Care Certificate, they know what it means, but we've been surprised by the limited amount of research that's been done on it, with the exception of our colleague here Louise Thompson, who's going to present on the large evaluation study that was undertaken a few years ago. In many ways this lack of consideration of the Care Certificate reflects, I think, the inverted triangle of social care training, that there are many studies of professional qualifications, but very few studies covering people working in frontline services.

Myself, Jill Manthorpe, and my colleague Carl Purcell from King's College London, are part of an ESRC funded study of innovations in social care. This is the SASCI project, led by Juliette Malley from the LSE. Our public advisor, Sandra Paget, is also welcome and indeed we welcome other members of the research team.

One innovation that we have been interested in is the Care Certificate, I won't ask how many participants in this event have got the Care Certificate, although it would be interesting to find out, but perhaps participants are working with people who have this award, or have commissioned it, or have been pondering its content over time. I have been curious about the Care Certificate as an innovation for some time partly because it's something that actually happened wholescale. While there is a great deal of talk in adult social care about innovation intentions, particularly around training and support, not everything gathers the momentum that the Care Certificate achieved. So who better to start our witness webinar by talking about this than Andy Tilden, largely because Andy is a great repository of wisdom and history of social care, and was there in many of the conversations that happened at the

start of the millennium and before about this innovation that ended up being called the Care Certificate. Andy, we asked you to reflect on that time, to tell us about your abiding memories of the Care Certificate as it started.

**Andy Tilden**: I think it was the former Prime Minister David Cameron who said, 'I was the future once', and I feel like I'm part of history now. I joined the predecessor of Skills for Care at the end of 2000, the organisation was then called TOPSS (Training Organisation for the Personal Social Services) England. It was the training organisation for what is now called adult social care and the government of the time had set up different training organisations by sector. In April 2000 we produced the first and in fact the only workforce strategy for social care called *Modernising the Social Care Workforce* (TOPPS, 2000). This followed a widescale public conversation, consultation, and importantly it received Ministerial endorsement from two central government departments, Education and Health. Malcolm Wicks, MP, the Minister for Lifelong Learning at the Department for Education and Employment, as did John Hutton, MP, the Minister for State at the then Department of Health. And they did so because at the time there was a big conversation, as there is now about the skills needs of, UK PLC, or more precisely of England PLC, and so they wanted us to develop a training strategy. Our strategy also received support from trade organisations, the Local Government Association, the Association of Directors of Social Services, people drawing on care and support, and carers' groups. All of those groups were represented on TOPSS England Board and its workforce committee at the time. So the strategy had widescale support, and it recognised that workforce competency was the responsibility of the learner, of the worker, of the employer, and also of government. And indeed the strategy talked about the funding of that being a joint responsibility so it recognised that perhaps an employee should fund 3%, employers 15%, and then the government would fund the rest. So there was some detailed thinking about how skills levels could be raised.

As the strategy emerged, there was a view that we needed to think about induction, and so TOPSS England developed Common Induction Standards and the Foundation Standards with the thinking that, within the first six to ten weeks of a worker's job, they needed to know A, B and C, and then within the first six months they needed to learn some more, and be competent in some more skills. It is important to say that there needs to be a recognition that this wasn't to be the only induction, because clearly induction is workplace specific and indeed it's specific to the people who draw on care and support as well, so there's elements of induction that will always be very individual. But the feeling then was that workers were moving around in the sector, they were learning stuff,

but they were changing jobs and having to relearn it again, and there was a mantra at the time that, you know, learn something once, use it many times, and that followed on from induction into the qualifications at the time, which were National Vocational Qualifications.

So the underpinning principles of this workforce strategy, which I think are relevant to the Care Certificate, are the need for employers' confidence in the competence of their workforce, the need for employees' confidence in their own knowledge and skills. Although we've learnt over the years, people have said that social care is not a skilled sector well, hopefully, everyone on this call knows it is skilled. It's just not got the qualifications or accreditation next to it that we might want. And the third underpinning area concerned service users, which is the language of today, and it's amazing isn't it, that 23 years ago, that there was a seen to be a need for service users' confidence in the quality of services they were receiving. So it was about employers, it was about employees, and it was about people who draw on care and support, wanting staff to have induction, wanting to have Foundation Standards, and wanting to have a workforce strategy to meet those needs. This means there was already an updated version of those Induction Standards in place in 2013, when Camilla Cavendish came on the scene and I'm sure other folk will mention and talk about that.

I can remember at the time, and I met with Camilla Cavendish on a number of occasions, having some real mixed feelings. I was incredibly pleased that the Coalition government was starting to have a developmental view about health and social care, and that was good, even though there were concerns about that. But there were some other concerns that the underpinning evidence appeared to be predicated on health, and didn't take into account what already existed in social care. It was driven by ideology and some might say dogma, that we needed to integrate and that meant almost not looking at what went on in social care, but actually starting something afresh. So that's what we tried to do, and my colleague Angelo from Skills for Health who is going to follow on from me, will recall the time when we sat down with NHS colleagues, having an absolute willingness to get this done and work together, but struggling sometimes on working practices within social care, which were different to working practices in health and indeed the language within social care was very different from that in health. Taking just two examples, the word 'supervision' means very different things in social care than it does in the healthcare sector, or it did at that period. And 'management of medication' for social care workers was something very different to the 'management of medication' within health services. These are just two examples, but there were numerous examples where we

almost felt like we were trying to deal with integration from very much bottom up or from initial working practices up.

So it wasn't a kind of easy process, we got there though, and what we presented government with, I seem to remember at the time, was a continuum of three different models, there was the least interventionist, most cost-effective model of a Care Certificate, which is the one that we have now, at one end of the continuum. At the other end of the continuum we presented a model which had awarding organisation accreditation, albeit with employer sign off; an employer, should deem that their worker is competent, but also alongside that goes an awarding organisation sign-off. Now that was the one that the planning group, from memory, really favoured, but it was the one that government didn't favour, and it became obvious that saving money and going for the cheapest and the less interventionist model was the one that it wanted, despite the wealth of evidence that we and others kept putting government way. So we are where we are. With hindsight, and the fact that we know that if you give someone good induction, if you give someone good learning and development they stay in that work, and we know that if we give people good learning and development that's accredited and recognised, organisations don't have to go through that hoop again and again and again. And certainly, before I left Skills for Care, we were hearing of people who had undertaken the Care Certificate, but because their new employer was not particularly happy with the sign off from their previous employer organisation, they were going through elements of the Care Certificate again.

**Jill Manthorpe**: Thanks Andy, it is great to learn how it seemed from the inside, because clearly most of us are from the outside. I wanted to ask about how did you get there, was it face-to-face meetings, how did you all work together?

**Andy Tilden**: Well there was a mass of roadshows, at the time TOPSS England was split up into nine regions, and each of those had different committees, and there was a whole roadshow of events around the country, and also national events through the trade organisations. Within social care in England there were five big trade organisations that covered, I don't know what the percentage is now of the workforce, but they covered a large chunk of the workforce, and we had carers' groups as well. It just seemed to be an endless round of events looking at what was common, what employers wanted, what people who drew on care and support wanted from an induction. And then having to separate out what was clearly workplace specific, and what was generic that could be put together into a certain a set of standards really. And, in a way, that process was replicated by Angelo in health.

**Jill Manthorpe**: Just lastly to take chair's privilege again, what about the use of evidence, you said you were providing evidence, who collected that, or was it a real reflection from being close to practice and close to services?

**Andy Tilden**: I know we paid for consultants to take that work forwards, so there was a whole series of events, consultant-led events, that took that kind of first-hand information from employers, from people who drew on care and support from carers' groups forward.

**Jill Manthorpe**: We think of the world now as being quite consultant driven, so it's interesting to think they were operating in another century. I'm going to pause to see if anybody's has any comments or questions. Ian Kessler, from King's College London's Business School, do ask your question.

**Ian Kessler**: Thanks Andy, because I'm more familiar with the Care Certificate in health, it is interesting to have that prehistory of it in social care in 2000. I suppose in health and the Cavendish Report, it came off the back of the Francis Report on Mid Staffordshire , which may be why there was that emphasis and aligning with what was going on earlier in social care. I was wondering about two points. Cavendish recommended a higher Care Certificate, which never really took off, and I wondered whether there was a view in social care on that, and whether any of your earlier Common Induction Standards reflected different levels of induction. And secondly whether TOPSS collected any evidence or data to tell us to what extent these Common Induction Standards were actually being adopted by social care providers?

**Andy Tilden**: On the latter question yes, a lot of data was collected, not just by TOPSS England, but by the Care Quality Commission's predecessor, the CSCI (Commission for Social Care Inspection, the previous regulator that only covered social care). They were very much aligned with that process. Within social care we'd had the induction and foundation standards, I suppose we were always keen that people undertook the learning that reflects the job that they're doing, so higher standards great, if it reflects the work that you're doing. This was very much a competency thing, so that this was about getting recognition for the greater skills you're undertaking now, although now there's other ways in which people can undertake learning to take them onto the next step. I mean the thing that I always used to bang on, talk about, was that at the time if you wanted to be a sergeant in the police you sat the sergeants' exam when you were a constable, you just did it. And that demonstrated you had got the knowledge to go onto the next step. I was very much in favour of that, so you undertake the knowledge that will get you onto the next step, but you can only prove you can do the next step if you're in that particular

post. I wasn't convinced that Camilla Cavendish understood that, or got that right, and there seemed to be bigger drivers afoot than the evidence that we were was putting to her, so yes, I can say these things now because I'm retired [all laugh].

**Jill Manthorpe**: Ian, would you like to follow up on that?

**Ian Kessler**: Thanks, just a quick follow-up question, so when there was an attempt to collect data, or evidence on the use of Common Induction Standards, what was that finding, that they were being adopted, or were there still problems getting them accepted amongst social care providers?

**Andy Tilden**: Yes, the latter, because I think we always recognised this would need a large concerted push to help employers go from the current position to one where skills were recognised, but also where money was involved, where employers had to pay for qualifications for their workforce. Also where workers had to commit and undertake them, and we see that a bit in apprenticeships now, they had to commit towards their own learning and development as well. So it wasn't, absolutely a perfect system, but it felt like we were on the way to something.

**Jill Manthorpe**: Thanks for that Andy. I know from our own work that the Care Certificate was very much taken up by people running and working in learning disability services. Do you think that reflected their appetite for this, or how do we explain that there are people who are 'super adopters' of new things? Were they involved in the, formulating the innovation so it really met their needs, or was it just 'happen chance'?

**Andy Tilden**: No, it wasn't 'happen chance', there were key players on the TOPSS England board that worked for organisations, James Churchill from ARC which used to be, the Association of Residential Care, and other learning disability organisations, and indeed there was the Learning Disability Awards Framework, LDAF, which was specific. I think there were many other groups that supported people with specific needs, that probably felt they should have had similar thinking, around mental health as an example.

**Jill Manthorpe**: Great, so I'm just going to see if anybody else would like to build on this conversation, or take it in another direction, I see Rob Newby (from Skills for Care) that Andy has referred to you, is there anything you'd like to add there, or provide a different perspective, and just explain what you were doing around the millennium and this time?

**Rob Newby**: Thank you Jill. I joined Skills for Care ten years ago just at the point that the Care Certificate was being brought to fruition. I don't think I can add onto what Andy has said, but my involvement with the Care Certificate is still continuing, with Angelo and the ongoing kind of governance and guardianship of the Care Certificate from its inception right through to now, so there may be other things as the conversation progresses and we get sort of closer to today where I can come back.

**Jill Manthorpe**: Rob, Ian mentioned the way in which the innovation is sometimes hung on the hook of the Cavendish report which is on the hook of the Francis inquiry into Mid Staffordshire Hospital, is that something that still resonates with people? Do they talk about it as being the Francis report did this, and so on, as a sort of series of, you know, logical steps or do you think all of that has disappeared in the midst of time?

**Rob Newby**: I think it depends very much on who you talk to. I think those of us closer to policymakers and interacting with the Department (of Health and Social Care) would still refer back to its origins. I think if you were to speak to people now who undertake the Care Certificate and who are joining the sector about where it has come from and how it has grown up this has been lost over time, because we're talking 10, 12 years ago now. So perhaps there isn't the understanding always about where these things have come from, and it's only those of us who are still talking in policy spheres that maintain that link back.

**Jill Manthorpe**: Great, Dawn Grant has now got her hand up.

**Dawn Grant**: I support the Care Certificate at the moment, nationally. We ran a network event, The Care Certificate Celebration Day, in December 2022 which linked with the Care Quality Commission (CQC) where we referred to where the Care Certificate came from, especially for anyone new joining the network. I think it's really important that people actually know what it's for, what that hard construction of the framework looks like, and how you implement it in the workplace, to still bring those two things together, because I think it's very important for people to understand why you put your staff through the Care Certificate, because it's a very valid part of induction, but people do still struggle with it timewise, etc. I'm sure we'll come onto that at a later date, but the CQC has updated their position statement on the Care Certificate, so there's guidance there for employers, why the CQC would be looking for it as part of an inspection. And going back to what Ian Kessler was saying, I linked with Ian in 2015 as part of our local network in North West London, where we were rolling out the Care Certificate, and that was very, very much health orientated. But certainly, we have grown a network which includes Skills for Care, locality leads as well. And always

we are trying to make sure that we represent across health and social care, it's very important to cross-pollenate and to support everybody in their areas. While I don't have a history on this subject before 2013 certainly since then I have definitely been a champion for the Care Certificate.

**Jill Manthorpe**: In terms of an innovation, do you think we underplay the importance of regional networks? We often think of something like the Care Certificate at national level with a national report and so on, but you're describing quite an interest in and a way of keeping things going regionally or sub-regionally.

**Dawn Grant**: Yes, Kay Fawcett and myself set up the Care Certificate leads network in 2019, just before the pandemic, but previously it was very much driven by Health Education England local networks, which would be talking about what current incentives would be to support staff, whether that's pre-apprenticeship, pre-recruitment, and training and development. I think local networks are really crucial, that they're able to feed into the national picture, and certainly we have upwards of 700 people on the Care Certificate network now, with 300 of them who are registered on the NHS Futures site, so that's a very live area where people from health and social care can go to get questions answered, have their own discussions offline, to be able to support what those, sometimes continuing, issues can be around the Care Certificate, both local and national.

**Jill Manthorpe**: So we have heard about a very interesting example going back to what Andy was saying about a form of integration that is perhaps overlooked in all the current debates of integration and indeed integrated care systems and so on. Thanks very much Andy, I thought it was great to hear from somebody who was on those conversations ten years ago and more, particularly presenting that history.

We're now going to turn to Angelo who's got some slides so that's great (see Appendix 1). While we are setting up Tony, a former GP, is recalling on the chat how he worked for Health Education England in from 2014 to 2018 setting up this work and viewed the Care Certificate developments as an incredibly helpful thing in providing a standard for unqualified staff.

Angelo, you've been working on this area for many, many years, so it's really great to have you here.

**Angelo Varetto**: Thank you Jill, and thanks for inviting me to take part in this. I've known Andy going back to the 1990s, before he was at TOPSS England, and in the days when I was very involved in ACTAN (Association of Care

Training and Assessment Networks) and as Andy said, as Skills for Health and Skills for Care, we worked very closely together right from when I started at Skills for Health in 2005, around apprenticeships in health and social care, the National Vocational Qualifications (NVQs), etc. So, over the intervening years, up until the Mid Staffs report, and then subsequently the Cavendish Review, we'd worked on a number of projects. The Cavendish report was published in 2013, and like Andy, I was involved in some of the conversations that took place with Camilla (Cavendish) at the time. I think everybody, in health particularly, was trying to deal with the fallout from Mid Staffs, not just from a practical point of view, but as a health professional, just how it makes you feel. How something like Mid Staffs could have happened. In 2013, we were working with Skills for Care to develop national minimum training standards for health and care support workers. This, along with the Code of Conduct for health and care support workers, were commissioned by the Department for Health as part of a piece of work where DH was thinking about the possibility that there may be voluntary regulation for support workers. As you know, that didn't happen, but we ended up with the minimum training standards, and the Code of Conduct. Ten years on the Code of Conduct is still one of the most downloaded documents from the Skills for Health website. However, the minimum training standards I don't think anybody remembers apart from myself. The Cavendish Review and the development of the Care Certificate replaced the Minimum Training Standards. In terms of developing the Care Certificate Standards there was a small team of people who worked together, myself, Kay Fawcett as Dawn has mentioned, and Fazeela Hafejee from Skills for Care. And we were the little team that worked particularly on the technical development of the standards and reported into the governance group that Andy sat on, which then reported up to Department of Health, and then Camilla and the Secretary of State - now the Chancellor, Jeremy Hunt. What we didn't want to do was start from scratch, although as Andy said there was a view that the Care Certificate would be 'new' standards. We did the very early stages of the work of scoping what might be included, in the Care Certificate. It was very apparent that we already had a lot of the content, it was in the Common Induction Standards, it was in the core units that were shared between health and social care, which were in the NVQ/diploma.

What we wanted to do was to take that and make it into something that would become the Care Certificate. We did a lot of scoping work, looking at what we had, looking at how we could write it up. In the meantime, I think it was actually Jeremy Hunt who came up with the title of Care Certificate, and I can remember Andy and I at the time were thinking that might be a challenge because the QCF (Qualification Curriculum Framework) had been fairly recently launched and the term

'certificate' had very particular connotations around the size of a regulated qualification. I'll come onto what Andy was touching on earlier around why it didn't become a qualification, in a little bit. The Care Certificate stuck as a title.

One of the other things which we spent quite a lot of time on was which roles it should apply to? Which support worker roles? As Andy said, Camilla's view was that support workers were support workers, but what she was really thinking of was healthcare support workers that work in a hospital. While I think she did go to see some adult social care provision, her experience that informed her thinking and the majority of the conversations and the things that she saw were in health, in the NHS. Even this wasn't straightforward because there are lots of healthcare support workers who work in very different environments, in Ambulance Trusts, needle exchanges, GP surgeries, support workers who work with allied health professionals, rather than nurses.

The other big debate at the time was whether the Care Certificate would apply to personal (family) carers. It was decided at the time that it wouldn't apply to them, and there was a statement published. Basically, what we came back to was a view that the Care Certificate would be done by anybody who can achieve all of the standards, we didn't want to describe a particular job role because we knew that job titles and job roles vary between employers, so it'd be really hard to kind of come up with a definitive list. We had some examples in the guidance we produced, but we didn't want to be that prescriptive. It was, if you can make it work and you want to use it, use it. I know one of the groups that were absolutely considered outside of the scope were support workers working for Ambulance Trusts, people who work in ambulances, but actually we now know through experience that a lot of Ambulance Trusts did adopt it and actually do it as part of their induction with their new support staff.

As Andy said, there was a very clear steer, but the content of the standard had to be applicable to health and social care, and Andy's absolutely right that the challenges were around language, and in some instances, application. There was a huge amount of debate, because Camilla wanted the Care Certificate to include first aid training, because she couldn't believe that health and social care workers weren't first aiders, but, as Andy mentioned money was the barrier. I can remember at the time there was a piece of work to actually calculate how much it would cost the public purse to train every single support worker as a first aider and the cost was enormous. So, we ended up with basic life support as the compromise. In health that was easily adopted, because everybody did it anyway. But in adult social care it was much more of a challenge. There were organisations on the steering group who were really against the

inclusion of basic life support in the standard, because their view was that if a service user needed to have basic life support the role of their support worker was to actually dial 999, not to actually do the basic life support themselves. Issues raised at the time were over employer liability, insurance, and all those things.

The other thing, which was a challenge I think for all of us, was the very clear steer from Camilla around eating and drinking, and that was very much based on her experience of the care that her father had received in hospital, or should I say the poor care that her father had received in hospital. She was absolutely insistent that for all support workers the Care Certificate, the minimum training standards for induction, would include supporting people with eating and drinking. As we know there are lots of support workers who don't do that work, it's not part of their daily job, but she was absolutely insistent on that. We had to address it through the guidance and try to come up with ways of trying to say to people, look, be creative, be innovative, in order to allow your support worker to demonstrate they meet the standard.

What we hadn't anticipated was how much more people wanted to include over and above the content we actually tested. We field tested, and I actually still have the slides from all of this, so across 29 sites, 530 new starters, this was around November 2014, we had lots of people who wanted additional content in the standards. They wanted things like oral hygiene, they were all really valid things to want, but they were very context specific, they weren't things that applied to every new starter across health and social care. It was actually as big a job managing what stayed out of the Care Certificate, as what we actually ended up including.

We received the feedback from the pilots as Andy said, and we drafted up the final version of the standards.

As Andy said, we went through huge amount of debate, there were very strongly held views about things like assessment, and as Andy said, whether assessment would be done in the workplace, how they would be assessed, who they would be assessed by, would it be a qualification, and so on. Even down to who would issue the Certificates, would they be issued centrally, would we have a register of all the healthcare support workers that had achieved the Care Certificate - the management of that would have been enormous. And quality assurance, how would we ensure the consistency of the assessment? As Andy said, without any doubt money was a very big factor in this, the cost of creating a national qualification and the discussions that went into that and how that would be paid for, not just in terms of the relevance of the qualification, but how

would, the training be paid for, who would actually deliver the training, and if it's a regulated qualification it's much more likely that people will use a training provider, an independent training provider or a Further Education (FE) College. And then the cost associated with that, so the view was that quality assurance would be left up to the employers to work through themselves. As Dawn said, even in the very early days we started to see for example, down in the South West, Health Education England, and social care employers, and health employers, coming together on a regional basis to start to iron out some of the issues around how were people being assessed, how would employers have confidence in how other employers had taught and assessed the Care Certificate. And that evolved over time, over the past nine years or so into what Dawn and Kay run now.

And, of course the big question, how would we get employers to adopt the Care Certificate if it wasn't mandatory. We had quite a lot of conversations with the CQC around whether they could produce a statement that would give the impression that meeting the Care Certificate standards was required, without actually saying it was mandatory. And so CQC came up with the guidance statement which, as Dawn mentioned, has recently been revised.

All these resources were published, some of them are very obvious like the standards themselves, guidance, etc, but one of the big issues that we were aware of at the time was, particularly for small and medium employers, how were they going to actually implement the Care Certificate? We knew that in health, for example, NHS training departments would pick these things up and would get on with it. What we recognised, particularly for adult social care, was that was going to be a real challenge. So we worked with commissioners, through Skills for Care, to develop the workbooks, and the presentations that went with the workbooks for employers to use. What we were trying to do was to give everybody what they needed to roll it out. There were also mapping documents, at the time, mapped to the qualifications, we also mapped to the old common induction standards, so that people could see where it transitioned. We also published the certification template, as the decision was taken that employers would issue the certificate themselves. Again, a lot of work went into what the logo and the branding would look like. It's amazing, how these very simple things actually take up huge amounts of time and effort. As I said all those documents were published on the 1st of April, there was a big national launch event which strangely, I can't remember why, I wasn't able to attend, but I know it was very well attended in London.

And my final thoughts, about things that we didn't anticipate, the good and the bad, such as Care Certificate badges were massively popular, employers were constantly asking for them, which was great, they were circulated through Health Education England. What I don't think any of us anticipated was that the Care Certificate would be as widely and as quickly adopted as it was. I don't know what it was about it, but it really did get traction, maybe it was guilt over Mid Staffs that made people adopt it, but they did. The fact that we put a lot of work into making it as accessible for employers, dealing with employers' enquiries, we had Frequently Asked Questions, we had dedicated email boxes that were dealing with enquiries, so yes. One of the not so good things, was that within weeks of the workbooks being available, was that completed workbooks with all the answers were being sold on eBay. We also had the obvious things like some training providers making false claims around their training and the Care Certificate, that it was endorsed by Skills for Health, or Skills for Care, or Health Education England, which wasn't the case. Or that people could achieve the Care Certificate through doing e-learning, which absolutely wasn't the case, because you have to be assessed in the workplace. And then, we used to get a lot of enquiries from support workers who were leaving their employer, going to a new employer, and their current or their original employer wouldn't let them take the copies of their Care Certificates, their portfolios, their workbooks, and that was, you know, really distressing to be dealing with. It doesn't happen so much now. Unfortunately, other than suggesting they submit a subject access request, there isn't very much that we can do about it.

We do still regularly review the standards, since they've been launched, like when GDPR was introduced the relevant standard's been updated, we've tried to keep them up to date in terms of terminology. And, eight years on I'm still around, still doing it, and the Care Certificate has been the success it has been, brilliant, thanks to people like Dawn and Kay in Health Education England and now Rob and team in Skills for Care. Thank you.

**Jill Manthorpe**: Thank you Angelo for that, that was incredibly illuminating and great to have your perceptions, what a shame you couldn't go to the launch, I hope it was that you had something better to do ... Dawn did you have a point here?

**Dawn Grant**: I was saying thank you to Angelo because it's nice to be reminded of that grassroots start, and still that it's still very valid today. Apart from the apprenticeship, which not everyone accesses, the Care Certificate is the main form of training and development for support workers coming into to their role, so it definitely has gone from strength to strength, we

continue to have issues such as people saying that they aren't able to take their training records elsewhere, unfortunately. But I think hopefully throughout the next year we'll be looking at much more of a transferable portfolio for support workers completing the Care Certificate, where it can be seen by whoever needs to access the completion, because it does continue to be a problem. And I know one of the issues is quality assurance, and we have tried several times over the last five years to look at what quality assurance we have got in regions, not nationally, but that is still quite a tricky area to navigate, to get that standardisation for the quality assurance part anyway.

**Jill Manthorpe**: That's a really good point, and it's interesting I think from both Andy and Angelo was the fact that some of these things were very predictable weren't they, the problems don't go away and, as Angelo's reminded us, the Care Certificate didn't start from nothing. There was quite a lot of preparation behind something that appeared to be innovatory when it was delivered, so it was interesting to hear all the sheer trudge of development, and I'm sure many of us will want to know what price they were getting on eBay, a completed workbook. From the online chat Tony has offered his view that the Care Certificate met a huge and unrecognised unmet need, was this the case in social care as well as in health?

**Angelo Varetto**: I can't speak for social care, Rob or Andy are much better placed really. I think in health, in the early 2000s, there was an attempt through something called the NHS University, launched by the Labour government, to have a standardised induction. I think what we found (which was not a surprise to any of us who'd been around the NHS for a long time) was that induction was hugely variable, and there were people who were spending two days doing statutory mandatory training, and then being put on a ward or clinical setting, and then other places where people were doing a proper two weeks of induction, including lots of skills training, etc, etc. And in terms of unmet need, I think there was the extra recognition, so up to the introduction of the Care Certificate, induction was just induction, it was what you did when you started a new job, and suddenly, and for a huge number of people who'd come into health and social care as support workers, the Care Certificate was the first time that they had something where they actually got proper recognition for the learning and the assessment that they had done. And I think that's a big plus for it, there will always be employers who do very, very good things, and I think what the Care Certificate did was to encourage all employers to try and do something. As I said, just the Certificate, the badges, people really, really wanted them, and were very proud at the fact they'd achieved the Care Certificate. I mean there were even discussions about getting the Care Certificate made part of that

professional training, nurse training for example, although the view was that everything in the Care Certificate was covered by nurse training. Also, lots of employers put all their existing support staff through it as well not just new ones.

**Dawn Grant**: Can I just come in there Angelo about the badges. We now have badges for supervisors, so we've grown associate educator networks across health and care, where support workers actually assess support workers, and so now instead of the original blue badge it's now a green badge with the word supervisor. The word supervisor was chosen mostly because we didn't want the wrong connotation of what an assessor was, so it's growing all the time, which is fantastic.

**Jill Manthorpe**: Andy what did you want to add here?

**Andy Tilden**: I think it's positive that it's meeting a clear need within health, and, this is my personal view, that it was a recognised need before the Care Certificate in social care, but, as Angelo alluded to, we had to put stuff in the Care Certificate that took people away from their current working practices. This may be the price that we paid for an integrated approach, but I've yet to see real benefits of that integration on the ground. I think it's absolutely valid we try and form services around people who draw on care and support across health and social care, but I don't see the Care Certificate has pushed integration any further forward, because the experience in a hospital ward is very different to the experience of supporting someone in their own home, for example. I'm probably less excited, but there we go.

**Jill Manthorpe**: There is much to learn from adding the word integration, or an integrated approach, which doesn't always reflect two complete sides. The third in our presentations this afternoon is from Louise Thompson from the University of Nottingham talking about the evaluation that was commissioned around the Care Certificate. (see slides). The full evaluation report is available with a summary on the Institute of Mental Health website.

So welcome Louise and thank you for accepting this invitation to build on what our fellow presenters have been saying.

**Louise Thomson**: Thank you firstly to Jill and Carl for the invitation to talk about the evaluation, which I undertook with a number of other colleagues. As you can see from this slide we were commissioned in 2016 by the NIHR Policy Research Programme to see how successfully the Care Certificate had been meeting its objective to improve induction training for support workers, but also to consider the whole issue of implementation and the

variations across implementation around those different settings that both Andy and Angelo have referred to. As you know, there was obvious concern that the variation could potentially be an issue, and there was interest in finding some evidence about what that variation is and what might be kind of driving it, what might be the facilitators to help organisations implement the Care Certificate where they were finding it challenging. We were asked to explore areas for improvement to enable the Care Certificate to meet its objectives more effectively. We started in 2016 and the report was published in 2018 with a summary report.

Our research used two main different methods, a large telephone survey with managers in 401 care organisations, we made sure that we weighted those by the kind of split based on CQC data, so we were trying to capture different sized organisations, making sure those different kinds of organisations, ranging from domiciliary care to Ambulance Trusts as Angelo mentioned, were all included in that survey, to see who was using it, what kind of use they were making of it, how it had impacted on their training, and how they approached implementing and adopting the Care Certificate. We followed that up with some in-depth case studies with ten organisations, with interviews and focus groups with both managers and workers within those organisations. Again, this was split between health and social care organisations. While we wanted to investigate the experiences of staff who'd done the Care Certificate we also wanted to hear the experiences of those who had already been working in the organisation for a while and hadn't done the Care Certificate, to ask about the impact on patient experience, what helped organisations to implement and adopt the Care Certificate, and any barriers and facilitators to achieving its objectives.

In terms of our main findings, the main thing is that, as Angelo said, there was a massive response to and a very quick update of the Care Certificate. In our telephone survey 87.8% of the organisations we spoke to had implemented the Care Certificate in some way. It was interesting hearing what Angelo said about this - the CQC kind of saying it was required but it wasn't mandatory, because this definitely came across in the responses when we spoke to managers. They definitely perceived that it was mandatory, so that obviously really, really worked in getting a lot of organisations to take it up. They also saw that there was a need, as I think Tony's mentioned a couple of times, that it really filled a gap, it filled a need that was maybe particularly in healthcare organisations. And I think with all the resources that were provided with the Care Certificate, organisations could see it was a pragmatic solution to getting some start of a standardisation of an induction training for people who were new to care.

In terms of the survey responses, reasons for not implementing the Care Certificate in their organisation, a lot of respondents said that they just didn't have enough new starters, that actually they had a fairly stable workforce, people were sufficiently trained already based on existing induction, and that meant there wasn't the demand, there wasn't the need in their particular organisation. Obviously, that may have changed, and it would be interesting to see what other impact workforce policies or other workforce labour shortages may have had on the demand, thinking of Brexit in particular. Among reasons for not implementing was just the basic inability to deliver it in terms of lack of capacity, this was particularly in social care organisations. As other speakers have said, healthcare organisations with a learning and training department could easily pick this up and deliver it, that wasn't a big issue, but for small independent sectors, particularly social care organisations, this would fall onto the manager's lap and they just felt that they didn't have capacity to deliver it. Also some felt that it put new staff off joining, if there was a requirement to engage, so that was something else we heard from managers. When we asked about whether the Care Certificate had been positively received, there was a very positive response, 63.9% said that it had had a positive impact on staff, and 54.8% said it had had a positive impact on patients. But there were definitely more positive responses from healthcare organisations that we surveyed, compared to social care, so our findings definitely reflect those of the previous speakers in terms of their expectations about the level of need, and the level of resources and capacity to deliver it.

In terms of the interviews with ten organisations, we found some stories about how and why organisations found that it had had a positive impact for them. They perceived a need for this basic foundation of knowledge for those who were completely new to caregiving, so for those who hadn't done any care work before, it really did allow a kind of minimum standard for them, and this meant that it gave people greater confidence knowledge and understanding. So care workers told us that they felt more confident having been through it, that it allowed them to much more easily put in place practices that they'd learnt in the Care Certificate. And because they were being supervised, they were being kind of assessed, and they were being kind of checked to see whether what they were putting into practice was good for them, it enabled them to feel confident that they were developing themselves.

It also helped foster empathy, compassion and reflective practice. One of our key stakeholders said that it reinforces that process of reflective practice, so staff are going through things and they're looking at the standards, and having to think about how the standards really relate to working practice, and that just that very act of encouraging that reflective

practice was seen to be a benefit of the Care Certificate. Some thought it was good to have that, and although it didn't fully achieve a standardisation, some perceived that there was some element of standardisation through it, and it did allow you to potentially to progress your career, and think about how you might want to progress your career beyond taking the Care Certificate, so it opened up the opportunity to discuss about training and further training for care workers as well.

But there were challenges to the Care Certificate, as we've heard, and variation in the delivery of the training definitely came through in our findings. There were some organisations, nearly 10%, who used only e-learning computer based delivery, although the majority used a combination of different methods - a little bit of e-learning followed by more practice based sessions, but there was quite a lot of variability. And we also found issues with transferability, as previous speakers have said, we heard quite a lot of cases of managers, in fact nearly half of managers who employed care workers with existing Care Certificates said that these new employees had to repeat part or all of the Care Certificate when they joined their organisation, so it wasn't as transferable and portable as it had intended to be, not back in 2017, 2018 anyway. When we asked why there was the need to repeat elements of the Care Certificate, this was because of those perceived inconsistencies and its implementation, and uncertainty about the quality assurance around the training in other organisations, fears that it had been a two hour e-learning programme rather than the two weeks, more extended induction.

This last slide summarises some of the findings we found around barriers and facilitators to implementing the Care Certificate. Some of them acted as both barriers and facilitators, for example, the adaptation of the Care Certificate, some really liked that and saw it as absolutely as a facilitator, as they could adapt bits of it, they could take some materials and put their own little spin on them or add to them, and that really helped organisations to see how they could use it. For others that was a source of concern around quality assurance, as they were not sure what type of Care Certificate training a new staff member had done. This led to issues around portability. It was interesting, hearing Angelo and Andy's descriptions of the policy background, and the policy drivers in terms of portability, accreditation, and quality assurance. Because these were all issues that came up in our evaluation, so existing staff, if you didn't have a record of induction, you know, were definitely asked to do all of it again, even if they said they'd previously done it. There was an issue around accreditation of prior learning, so where people have had lots of experience working in care roles but not actually done the Care Certificate, there wasn't really an option opt out and that was frustrating for some of the organisations we spoke to. But quality assurance and

registration were also big questions, people wanted to know if there would be a register, how would they be assured of its quality, and even at the time we were hearing about the good things happening in the South-West region where that community of Care Certificate leads was providing an example of ways that that quality assurance could be supported.

In terms of the setting, within the organisations themselves, there were issues of implementation related to the logistics, such as having enough time to develop and put people through training in the Care Certificate, and then to sign it off. Particularly within the smaller organisations, completion and recognition were issues for any training, not just the Care Certificate, being sure how many people have completed it and keeping a track of who'd done which bits, and which bits had been signed off as being assessed. And the availability of peer support was important, so where organisations were doing it really well there was often a chance to not just reflect on how you were doing with the Care Certificate, but also to share experiences, and having group activities to support each other to share examples of things that were challenging, or things that were helpful for their own practice. So having that kind of peer support and that group-based work was also beneficial to organisations. Moving onto those individual characteristics, some of the things we heard about that might have been acting as barriers or facilitators in terms of the Care Certificate were people's own motivations to learn, and some said in interview or focus groups, that they weren't really interested in career development, they wanted jobs that fitted around their family life and were doing a job which was easy to fit around life and didn't really want to develop a career beyond what they were doing. I think, making it as part of that bigger development pathway was not necessarily a motivation for them. We also heard about issues around literacy, and although there were materials for people who had voice recorders that people used to help with literacy, having people with writing and reading challenges, or for whom English was a second language, did lead to some issues in implementation.

Lastly on this theme, around prior experience, there was a feeling that the most valuable thing was prior experience in care, and some people felt that was the most important thing so the Care Certificate was useful for people with no prior experience, but supporting them in gaining that experience in a supervised way was really critical. And the implementation process, which really kind of ties a lot of these factors together, there was a lot of preparatory work to do, people said there was a need for a sufficient size in infrastructure, and so, as I said previously, those organisations that were small, that didn't have people with learning and development roles, those were the organisations that found it most

challenging. They also needed organisational support, so if you had a manager or managers who were really supportive of this initiative they really ran with it, and implemented it, and adopted it, much quicker. Having that kind of high-level organisational support was an important driver as well. The scope of delivery in terms of whether everybody should do it, or just those new staff in different kinds of roles, was a question, so for those organisations who had to think through who are we going to make do it and who are we going to put in reserve, and who are we going to say doesn't need to do it, this challenged them sometimes.

There was a definite concern, and I think Angelo alluded to this, about managers not giving the Care Certificate, there was a concern that managers described to us about giving new people really good intensive training for two weeks then getting the Care Certificate, but then leaving with this portable Care Certificate. This was one of the barriers that prevented people investing a lot in it, or at least giving these Care Certificates out at the end of the course and it was interesting to hear that that is something that still can happen even now. Just to summarise and bring things together, our evaluation had a number of overarching findings, but certainly the evidence that we were able to gather showed that, where implemented, the Care Certificate had really improved induction training and enabled care workers to feel better prepared and that made them feel more confident as well. However, that implementation was very much driven by organisational size, their capacity, and their resources, and having a very supportive leadership. Where those things were in place there was more effectiveness in terms of implementation. Those smaller care organisations were where we saw the Care Certificate struggling to be implemented, it was largely due to lack of resources and capacity. And whilst the flexibility and adaptability of the Care Certificate meant that it was a benefit for some people, it meant that they could use it in an appropriate way for their particular organisation, that also did then make other people question what kind of Care Certificate did people have when they were new to their organisation. So that variation in Care Certificate delivery led to uncertainty about the quality of training, and, in turn, raised questions about quality assurance that we've heard the other speakers talk about. This is a whistlestop tour of our findings really, and I hope it was of interest and of use to you and I am happy to answer any questions.

**Jill Manthorpe**: Huge thanks for that Louise, it was great to have that summary of the report which is available on your website. We have time for some questions, or indeed observations about what the evaluators found, which, I agree with Louise, did chime in with a lot of what Andy and Angelo said. If anybody would like to follow-up with discussion, please do put your hand up or speak up.

**Carl Purcell**: I was interested in what you were saying about it wasn't overly centralised and obviously this has advantages and disadvantages, so I wondered whether, on balance, you think that was what's helped to make it stick, the fact that it wasn't too prescribed, there wasn't a complete framework coming down from the top, and actually that flexibility allowed people to take it on. I'm also interested in the way that the regional groups have come together to maybe make it more relevant to themselves.

**Louise Thomson**: You referred to the sticky ideas concept, Carl, and I think that initial stickiness was very much for those people who really needed it probably, which were the health organisations, maybe where there wasn't a standardised kind of induction. That was very much a good lever and allowed people to think, 'yes I can adapt it in this way and I have the resources to do that'. So I think that was a really key part of it, and I suppose having those kinds of suggestions about having that regional approach and having those kind of regional connections to share those innovations, to share how we can make it work for us, was a way for organisations to build on that initial stickiness, to get greater traction and get greater confidence about how it was being delivered and what was being delivered, and understand where the good providers were and share good practice. So I think that kind of peer support between organisations was really critical and moving it onto that next stage.

**Jill Manthorpe**: Thank you for that Louise, you have drawn our attention to the greater interest in this from the NHS and the greater ability of the NHS to take it on, as opposed to social care. Dawn would you like to comment here?

**Dawn Grant**: Talking about stickiness, I think it did become unstuck in a lot of places, I will be honest, and over the last maybe three years we find ourselves regularly going back to the beginning with a lot of organisations that want to reinvigorate it, they want to look at what maybe was put in place eight years ago, and maybe reflect a better process now, so yes in a lot of places it did become unstuck, but more and more people are interested now because of the national health care support worker award of 2020. I know Louise you were talking about job vacancies and not enough members of staff going through to make a cohort, but in the NHS now we're quite the other end of that, because there is such regular recruitment going on, and it coincides with, you know, the start date and induction, you know, for those big organisations that have been able to create it as such. I think with a lot of the resources now being improved, we have even more e-learning for healthcare resources that are applicable for health and social care. Indeed we worked together with social care to create an assessor

suite of resources, so the assessors have the support they need to be able to ensure that support workers get a robust introduction to the Care Certificate, to get it signed off. So yes, I think the network certainly does hold things together, without a doubt, and we have those meetings once every two months with a two hour slot, attended by health and care organisations. We're really pleased that we still are able to have that joint approach and be able to help people out no matter what background, wherever they're working, which is fantastic. And we've got a new video that I can share. We've found a lot of people were deselecting themselves from completing the Care Certificate, so we wanted to do an inclusive video for people when they're first in their role so they understand what the Care Certificate is, what it means to them, but also what it means to the organisation and the patients and service users who they're going to be working with. It hasn't been officially launched but I'm happy to share it if people would like.

**Jill Manthorpe**: Thank you for that Dawn. We've got a question here that may be appropriate for Andy, Angelo or Louise, asking what role did the findings from the evaluation play in the continuation or the evolution of the Care Certificate in social care, Louise, was there any stickiness in policymaking around this subject?

**Louise Thomson**: We certainly had meetings towards the end of the project in which Kay Fawcett was involved with and Angelo and others, but we then handed over the report to the NIHR so it might be better for Angelo or Andy to say what happened next.

**Jill Manthorpe**: Andy, were you there at that time to hear about the evaluation?

**Andy Tilden**: Yes, I was there at that time but I was going to give Rob the opportunity to comment if he wishes. I felt that it was a great report, it was a report for government, no, from my point of view, it was for government to undertake the next steps, because I think as you know, people would have picked up, this wasn't how TOPSS England, later Skills for Care in the beginning wanted that sort of certificate to kind of roll out, because all the policy came from the health point of view, from Cavendish. And I get that, and I understand why, but some of the disconnect within social care which employers were telling us all the time, was because they were being asked to do stuff which they simply do not do. It took them away from their everyday working practices, because the way the Care Certificate was created as I've alluded to, was to help with integration rather than reflect the kind of workforce at the time, but Rob's probably in a better position to kind that conversation forward.

**Jill Manthorpe**: So Rob, just putting you on the spot.

**Rob Newby**: That's absolutely fine, and you're absolutely right Andy, it was a report for government really the evaluation report. In terms of how it's influenced things since then, there hasn't been, other than as Angelo said, the sort of update in terms of legal changes and legal requirements, there haven't been any major revisions to those 15 standards since they were first designed, and they still sit there as they were. And the issue of how this has sat with the social care workforce has been very different to how it has often landed with the health workforce. So much so that over the last two or three years, and certainly when we were looking at supporting the Department (DHSC) with the work on the White Paper reform (People at the Heart of Care, DHSC, 2021), we've reached a stage where it commissioned a research project into looking at options to solve the issues around portability, around content and so on, which has resulted in them now tendering for designing a specification for a qualification which is out there now. This is interesting, you know, given how Andy started this afternoon with the three options that were first proposed to government at the beginning, so we seem to have come full circle. The difficulties with the social care workforce haven't gone away, they're still there, and in the system, although the Care Certificate is working well, for care workers we've got 71% take up of the Care Certificate across their role, so it isn't that people aren't doing it. But it's about how appropriate it is, and what's the portability, and all those other things that are hard to fix with the system as it stands. That I think is part of the reform programme now within the Department and one the current administration, the current Minister, is trying to solve.

**Jill Manthorpe**: How interesting to think when we talk about the current minister it's still in the context of references to Jeremy Hunt (now Chancellor of the Exchequer) whose budget is tomorrow. Angelo did you want to add anything here about the conversations we've just been having?

**Angelo Varetto**: As Rob said, I don't think anybody is pretending it's all been marvellous. I think the reality is there will be employers in the NHS as well who've struggled with implementation around some of the standards which I mentioned in my main slot around supporting people with eating and drinking, etc, which really don't fit comfortably everywhere. Other than what happened within the Department with the evaluation report, the link was shared. Certainly, from my perspective, we were more interested in how's it going, is the stuff working that we've put out there, do we need, more information. E-learning for health was very new at the beginning of the Care Certificate so there were lots of e-learning providers vying for space in the area. I don't think the evaluation report directly impacted things, it probably did indirectly, and we could track back and look at some of the feedback that was in that report, there are

things that have absolutely kind of been addressed, but it's probably more by accident than design.

**Jill Manthorpe**: Great, thank you. We're beginning to draw this session to a close. We've covered so many areas and it's been such a rich picture of an innovation that happened and is still here, even though it probably is evolving as we've heard. So I'm going to offer the last chance to comment before I turning to our speakers to say a few words. Andy, your last thoughts, what do you think of this as an innovation?

**Andy Tilden**: I just want to take us back to the year 2000, and for us to ask the question, do patients and do people who draw on care and support now have greater confidence in the workers, the new workers in particular that are supporting them, so has it achieved that aim with patients and people who draw on care and support, do employees feel now that their skills are being recognised and they're being valued, because they've got the Care Certificate? As Rob said, 70% plus in social care have this, and do employers have the confidence in the competence of those people with a Care Certificate? I think we've seen evidence from Angelo and from Louise that that might not be the case. So the jury's out from my point of view.

**Jill Manthorpe**: Well thank you Andy, Angelo what do you think by way of summary of an innovation that happened?

**Angelo Varetto**: A couple of things, following what Andy's just said and Ian Kessler's comments in this meeting drawing on his involvement in another piece of work within the NHS, focused on support workers induction and recruitment which is going to report fairly soon. I've been involved in vocational education and training now for, gosh, 30 years, and I don't think there is a silver bullet, whether it's qualifications, whether it's statutory regulation, there will always be instances where things don't work out. I think as I said earlier, I'm amazed at how successful it has been, certainly in terms of health. And on a personal level it's one of the pieces of work that I'm most proud of, in a very long career. I joined the NHS in 1984 and been involved over the last 20 odd years in a huge amount of policy driven work, and this is one of the bits that I am most proud of.

**Jill Manthorpe**: Thank you Angelo, a really lovely note to end on that reflection, that it has had some particular traction in the NHS and in other parts of social care. So Louise if there was anything you want to add, perhaps as a summary?

**Louise Thomson**: I suppose this wouldn't come as a surprise but as a researcher I'd say we need some more evidence about what's working, and why is that working, and for whom is it working. I think that would have to be very context specific evidence, and as Andy raised, asking if it is making a difference for our service users, has it made a difference, and that is the critical question. It's interesting there are still issues around portability, around quality assurance, but actually to what extent it makes a difference for those ends users would be interesting to find out.

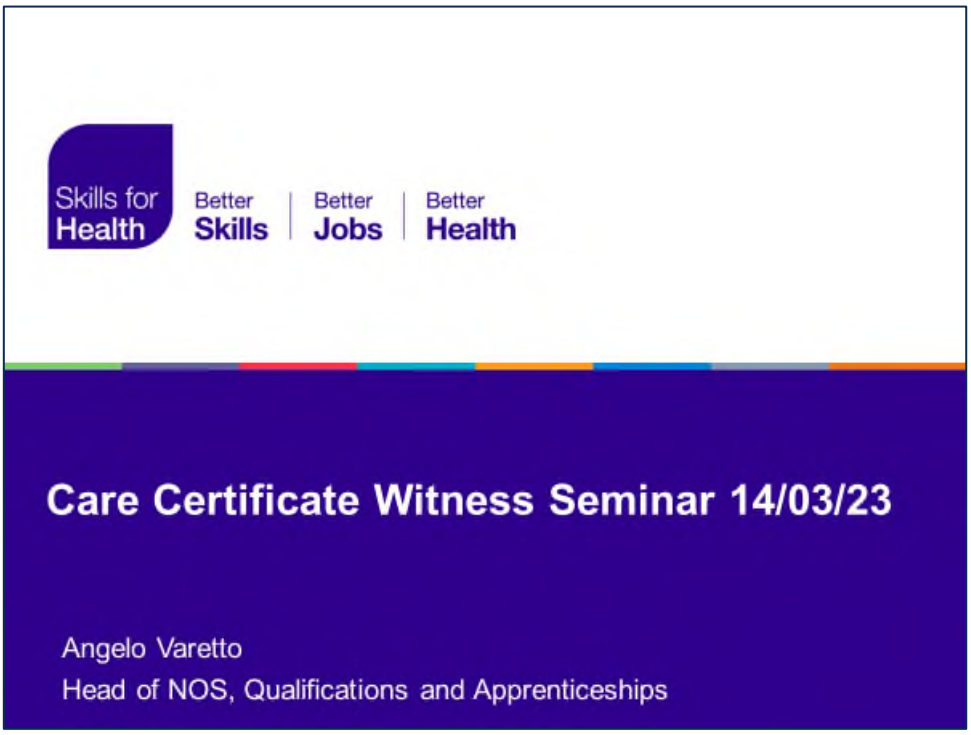
**Jill Manthorpe**: It's lovely to have a research webinar ending with a call for more research [all laugh], and Dawn, obviously drawing on a lot of experience, and what would you like us to think about as a take-home message?

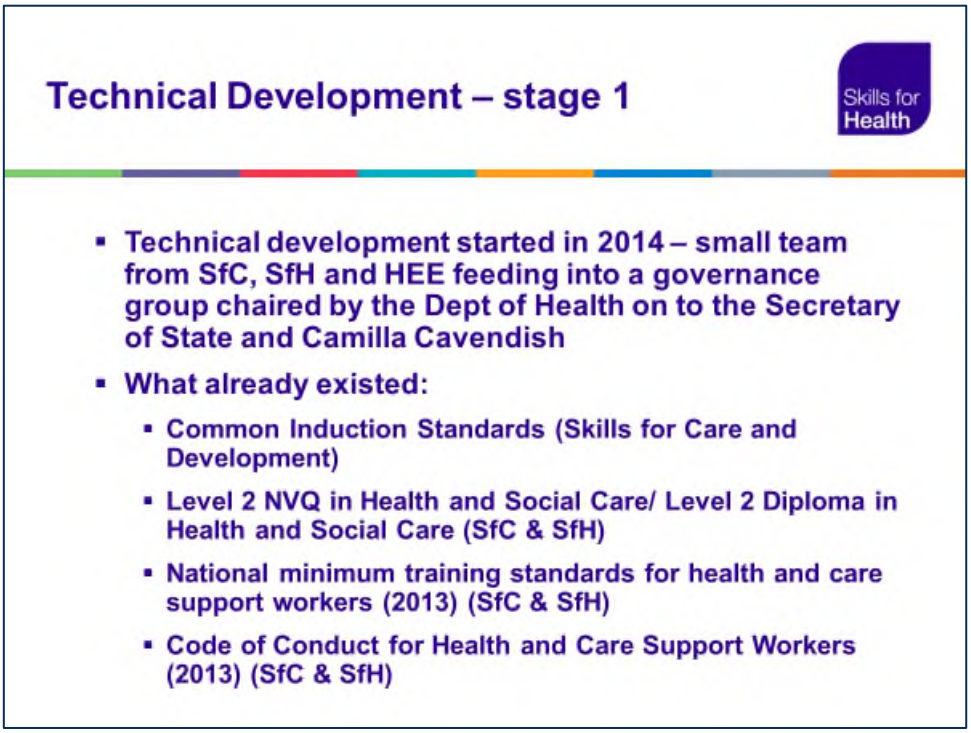
**Dawn Grant:** I was just going to say, there's a very large audience if you wanted to find out those top level answers to your questions, we do have a way to speak to quite a large group of people if that's something that you would like to follow up, because certainly it would be good hear to hear that collectively, so happy to follow up with anyone afterwards (dawn.grant2@outlook.com).

**Jill Manthorpe**: Thank you. What we have been doing, using today's research language, is talking about a theory of change, the context, what works for whom, and so on and so forth, and at what cost and with what outcomes. The innovation of the Care Certificate has been implemented on rather a shoestring, and we probably could have spent all afternoon talking about the costs that are incurred even if there's no central allocation.

Thank you to those in the chat for saying this has been an interesting webinar, we very much look forward to seeing you at another webinar in this series. The next witness webinar will be on social worker registration and regulation, which was a little bit more of a 'hot potato' I think than the Care Certificate. If anybody would like a Certificate of Professional Development for attending today, we'll happily send you that if you email your details to Carl. I'd like to thank very much Andy, Angelo and Louise, and Carl in particular for helping with this, and the wider SASCI team. Do keep an eye on the SASCI website to which we'll be adding more information about adult social care innovation. Again thank you to everybody.

## Appendix 1 – Slides used by Angelo Varetto



## Technical Development – stage 2

- Title – Fundamentals of Care to Care Certificate
- Which health and adult social care support worker roles were in scope of the Care Cert?
- The standards had to be applicable across health and social care
- There was a clear steer that certain areas of care must be covered e.g. eating and drinking and basic life support
- Managing what was excluded became as much a challenge as what was included
- Field tested across 29 sites and 530 new starters end of 2014
- 15 standards finalised for publication on 5th April 2015

## Technical Development – wider considerations

- Assessment models
  - How would learners be assessed?
  - Who would assess?
  - Where would assessment take place?
- Certification model
  - Who issued the certificates?
- Quality Assurance
  - How would consistency of teaching and assessment be assured?
- How would we encourage employers to adopt the Care Certificate if it wasn't mandatory?

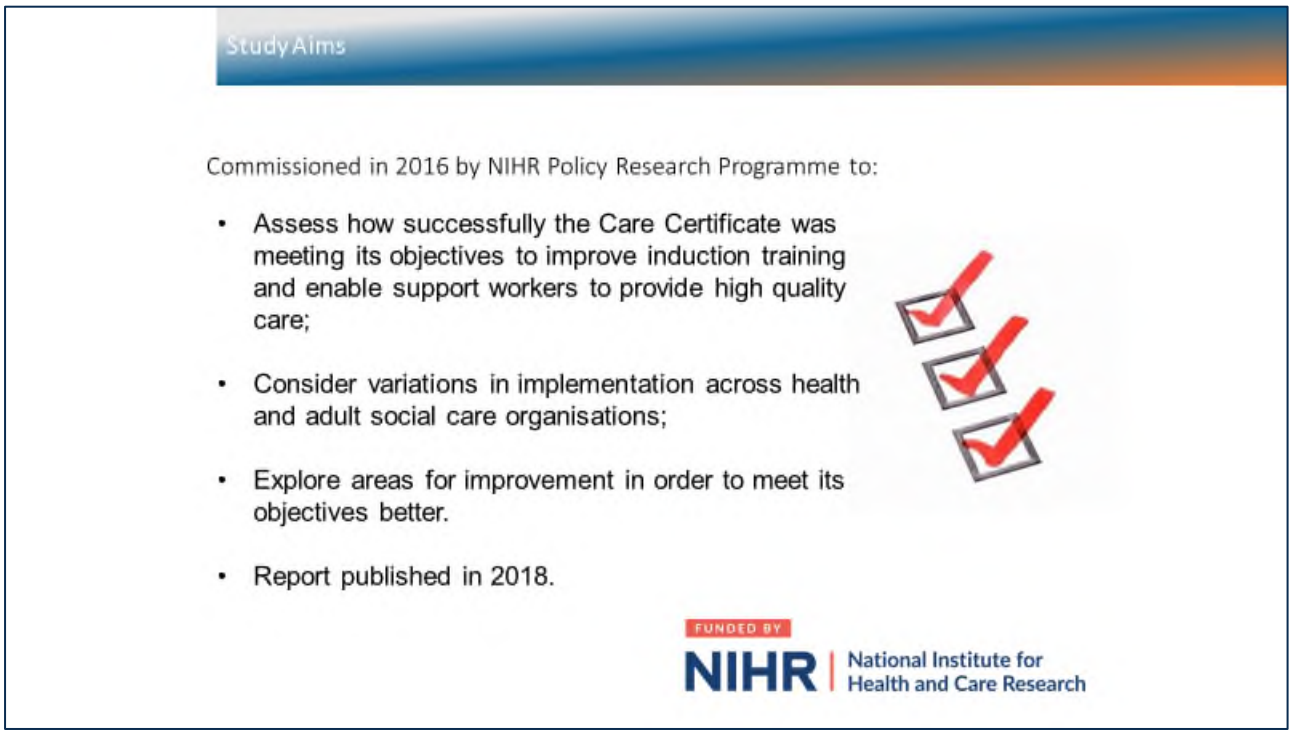
## Technical Development - resources

- On 1st April 2015 the following were published:
  - Care Certificate Standards
  - Care Certificate Guidance
  - Care Certificate Assessor Guidance
  - Care Certificate Workbooks
  - Care Certificate presentations
  - Care Certificate mapping document
  - Care Certificate Self Assessment Tool
  - Care Certificate certification template

## Technical Development – final thoughts

- What we didn't anticipate (good and bad):
  - Massive popularity of the Care Certificate badges
  - How widely and quickly it would be adopted
  - Completed workbooks/ answers being sold on E-bay within weeks of launch
  - False claims from some training providers
  - Some employers preventing support workers taking their certificate, portfolio's/ workbooks with them when they went to a new employer
- Regularly reviewed the standards and related documents since launch
- That we would be where we are 8 years later

## Appendix 2 – Slides used by Louise Thomson

## Study Methods

Stage 1: Telephone Survey with Managers in 401 Care Organisations

- To quantify the uptake of the Care Certificate
- To examine patterns of uptake across settings
- To assess the impact on training provision offered
- To develop a taxonomy of implementation approaches

Stage 2: Qualitative Interviews and Focus Groups in 10 Care Organisations, with 24 managers and 68 care workers

- To investigate the experiences of unregistered care staff
- To evaluate the impact on patient experience
- To identify the characteristics of successful implementation
- To explore barriers and facilitators to achieving Care Certificate objectives

## Telephone Survey

- From 401 responses with managers, 87.8% had implemented the CC
- Main drivers for implementation:
  - Perceived to be compulsory
  - Positive influence on practice
  - Pragmatic solution

- Reasons for not implementing
  - Sufficiently trained staff / existing induction / no new starters
  - Lack of capacity
  - Puts new staff off joining
- Overall, the CC had been positively received by survey respondents
  - 63.9% - CC has had a positive impact on staff
  - 54.8% - CC has had a positive impact on patients
- More positive responses by health care organisations than social care

## Key Themes: Positive Impact of the Care Certificate

- Interviews in 10 Organisations with 24 managers and 68 Care Workers
- Four qualitative themes relating to the positive impact of the CC
  - A basic foundation for those new to care
  - Greater confidence, knowledge and understanding
  - Fostering empathy, compassion and reflective practice
  - Career progression and standardisation

## Challenges to the Care Certificate

- Variation in delivery of Care Certificate training
  - 56.8% used a combination of different methods
  - 22.2% used classroom-based delivery
  - 9.7% used computer-based delivery only


- Care Certificate was not widely transferable
  - 49.8% managers who had employed care workers with an existing Care Certificate said these new employees had to repeat part or all of the Care Certificate

- Need to repeat Care Certificate was due to:
  - perceived inconsistencies in implementation
  - uncertainty about the quality of the training in other organisations

## Barriers and Facilitators to Implementing the Care Certificate

| Intervention Characteristics | Outer Setting | Inner Setting | Individual Characteristics | Implementation Process |
|---|---|---|---|---|
| Adaptation of the Care Certificate | Portability<br>Accreditation of prior learning<br>Quality assurance | Logistics<br>Peer support<br>Completion & recognition | Motivation to learn<br>Literacy<br>Prior experience | Size and infrastructure<br>Org.l support<br>Scope<br>Recruitment |

## Summary

- Where implemented, the CC had improved induction training and enabled care workers feel better-prepared to provide high quality care.
- Organisational size, leadership, capacity and resources were major factors in determining the effectiveness of Care Certificate implementation.
- There was a proportion of smaller care organisations where the Care Certificate has not been implemented, largely due to lack of resources and capacity.
- The flexibility and adaptability of the CC meant that it was being delivered in many different ways across settings and there had been considerable variations in implementation.
- Variation in CC delivery led to uncertainty over the quality of training in other organisations, and in turn devalued the CC and reduced portability.

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