Sheffield Hallam University | Faculty of Health and Wellbeing

CPA C.I.C Community Practitioner Alliance

An Independent Analysis of the Care Homes Education and Training Evaluation (CHETE) carried out by the Community Practitioner Alliance CIC

Report produced by Sheffield Hallam University (SHU) *on behalf of* Doncaster Metropolitan Borough Council (DMBC) and NHS Doncaster Clinical Commissioning Group (DCCG)

January 2017

Authors:

On behalf of Sheffield Hallam University:

Dr Robin Lewis (Author)

Professor Shona Kelly

On behalf of Community Practitioner Alliance CIC:

Jo Cameron (Project Lead)

Rob Gorringe

Gareth Bennett

Martin Collins (reviewer)

Contact Information for the report:

Dr Robin Lewis

Senior Lecturer

Faculty of Health & Wellbeing

Collegiate Campus

Tel: (0114) 225 5858

Email: r.p.lewis@shu.ac.uk

Contents

Executive Summary

In line with the national situation, the health and social care landscape in Doncaster is changing. As a result of the modernisation and transformation agenda and key policy developments such as the Care Act (DH 2014), one of the key challenges facing any Council is ensuring a high quality workforce within the Care Home sector that is 'fit for purpose'. With ever tighter resources and a need to ensure that the care provision within the sector meets the required quality standards of the Care Quality Commission (CQC) it is vital for DMBC and Doncaster CCG to have a motivated and well-trained care workforce that can provide competent client-focused care with skill and compassion.

The purpose of this report is to provide DMBC and Doncaster CCG with an understanding of education and training practice, provision and future requirements for the Care Homes and Domiciliary Care sectors in Doncaster. This report will provide DMBC/Doncaster CCG with an 'hard' evidence base on which to make informed decisions as to what education and training in the Care Home sector should 'look like' in the future, and will help to inform the 'direction of travel' for the future provision of education and training in this sector. The focus of the study was to provide DMBC/DCCG with robust intelligence in the following areas:

- The education and training currently accessed by Care Homes and to what standard
- The awareness/ understanding the Care Homes have of DMBC/NHS Doncaster CCG quality standards in respect of the education and training of their workforce
- Details of the education and training providers that Care Homes are using to train their workforce
- The level and type of training required by Care Home staff
- The ‘gaps’ in the provision of education and training, particularly to meet new ways of working under new market demands
- The barriers that Care Homes, Domiciliary Care and their staff encounter in accessing appropriate education and training
- Understanding of the preferred methods for the delivery of education and training for care staff
- Understanding how Care Homes and Domiciliary Care teams keep up-to-date with new learning, development needs and resources

Study design

The evaluation used a mixed methods approach, which began with a rapid literature review followed by a 'face to face' survey and structured 'deeper dive' interviews. The 54 Care Homes and 2 Domiciliary care teams were initially contacted through a letter informing them of the evaluation, followed up by a telephone call or personal visit by a member of the team. Following the initial contact an appointment was made with the individual care homes to complete the survey 'face to face'.

Summary of key findings

There were a number of key Issues emerging from the data:

- Recognition on the part of the managers of the importance of having well-trained care staff throughout the care home and domiciliary care system
- Frustration with the current training system(s)
- 'Information overload' in keeping up with the various competing and occasionally contradictory demands of the commissioners and regulatory bodies (DMBC/DCCG & CQC)
- 'Decision-making fatigue' over 'wrestling' with the disparate delivery methods, quality and level(s) of training available
- 'Lack of clarity' over the choice of different courses & levels available and mapping this to the point above
- The logistical difficulties involved in sourcing and providing appropriate education & training for care staff

Recommendations

- **A CENTRAL COMMUNICATIONS HUB:** Information from regulatory bodies, commissioners, education providers and other national bodies relating to education and training, staff development and other initiatives should be filtered through a central communications hub and cascaded as appropriate to the individual care homes. This will ensure the provision of clear, unambiguous information clarifying the obligations of the Care Homes in terms of training and education from all the regulatory, compliance and contractual bodies. In addition, the cascade of new information, updates, educational provision and other network issues can be managed through the hub

- **AN 'INSTANT ACCESS' BOOKING SYSTEM:** There is a clear consensus over the need to produce a viable ‘live’ booking system for accessing all care staff training. A system which clearly states the availability of places and provides instant online confirmation of booked places. In addition, there is a clear need for increasing the capacity for provision of induction training courses. A review of current booking processes with a view to the development of a ‘live’ real time online booking system will enable managers to better identify and plan their training in line with staffing rotas and availability. The development of a 'single point of access' booking system for all care staff education and training is a longer term aspiration, however a single booking system for DMBC/DCCG courses would be a shorter term 'quick win'. The use of an online service such as 'Eventbrite' would provide a relatively straightforward way to achieve this, in addition to the cost savings that would accrue from its use

- **LOCALITY DEVELOPMENT:** The development of a two-tiered approach to networking and support. The first tier would be a local ’network of care’ providing practical and peer support within the locality, and the second tier would be a ‘network of care’ strategic level feed through the communications hub. The development of local ‘networks of care’ will enable Care Homes to support each other in a wide range of areas including pooling of staff training and education and the sharing of other resources and best practice

- **DEVELOPMENT OF CARE STAFF:** The development of and support for an agreed career pathway for all care staff is vital. The fact that the care role is seen by most people primarily as a job rather than a career is a disincentive for high quality applicants. Even worse, the role is often viewed by the media as a job with low pay, low status and few prospects. This means that staff turnover is high and the quality of applicants is often variable. The provision of a locally (in the first instance) agreed pathway for care staff to be supported and developed through the care 'system' to undertake their Registered Nurse training would be a significant step forward. Improving the care staff's skills to enable them to better meet the increasingly complex health needs of clients with chronic conditions and other co-morbidities would also form a key strand of any future training strategy. Finally the development of meaningful, practical training delivered on site within the Care Homes, which is able to flex and adjust to work around the day to day requirements of the home. The success of the Best Practice Support Team project in equipping care staff with key skills demonstrated that this approach to care staff education and training is both beneficial and cost-effective. There was some evidence that care staff are carrying out clinical 'tasks' without necessarily having the

requisite knowledge and understanding that would derive from appropriate education and training such as that just described.

- **REGISTERED NURSE DEVELOPMENT:** Alongside the need to develop and educate the unregistered care staff, there is an equally pressing need to provide post-qualification education and training for the Registered Nurses working in care homes. Given that there may be only one RN working in any given home, the need to address the sense of isolation that is often felt, and improve access to post-qualification education and training is vital. As with the care staff, the fact that the RNs are working 'outside of the NHS' means that access to any learning beyond registration funding from Health Education England (HEE) is restricted.

- **TRAINING BUDGET ALLOCATION:** Although the budget would be held within the remit of DMBC/DCCG, there should be allocated budgets for all care home providers, which will enable them to identify their specific training needs and then choose, with support and guidance, appropriate training programmes to meet those needs. It is envisaged that a portfolio of courses would be developed and provided through DMBC/DCCG and that the care homes and domiciliary care providers would choose from this portfolio according to their identified needs. DMBC/DCCG would then fulfil a quality control brief and act as a conduit for both quality control and governance. This would enable the release the funds accordingly at the request of the care home or domiciliary care provider

- **A FACILITATION 'TEAM':** This would involve the development of a team to support the delivery of induction and mandatory training for all new care staff. This would be resourced and monitored by DMBC/CCG but would also source additional funding from other outside agencies with a remit for health and social care e.g. Skills for Care. This would contribute to the development of a training network in Doncaster that assists the Care Homes and Domiciliary Care providers to get new staff ‘work ready’ in a timely manner and then supports them in identifying and realising their future training and development needs. Given the high turnover of care staff, this would be a practical and cost-effective way to ensure both the quality and the availability of the provision.

- **BEING 'SEEN' TO FACILITATE THE CHANGE IDENTIFIED BY THE CONSULTATION:** Given the degree of trust and respect from the care homes that members of the CPA team have amassed, it is vital that DMBC and DCCG are seen to act upon the findings and recommendations of the CHETE consultation. There is a clear need for the adoption of a *'you said, we did'* approach.

Introduction

This report details an independent analysis of the findings from the Care Homes Education and Training Evaluation (CHETE) project. The analysis was carried out by the Centre for Health and Social Care Research (CHSCR) at Sheffield Hallam University (SHU). This evaluation was requested by Doncaster Metropolitan Borough Council (DMBC) and Doncaster Clinical Commissioning Group (DCCG). Through a competetive tendering process, Community Practitioner Alliance CIC (CPA) was selected as the preferred provider, and commenced the Care Home Education and Training Evaluation (CHETE) project on the 25th January 2016. The original project specification of care homes was expanded at the interim report stage to include a cohort of domiciliary care providers and a DCCG commissioned service.

The purpose of this report is to provide DMBC and Doncaster CCG with an understanding of education and training practice, provision and future requirements for the Care Homes sector in Doncaster. This report will provide DMBC/Doncaster CCG with an 'hard' evidence base on which to make informed decisions as to what education and training in the Care Home sector should 'look like' in the future, and will help to inform the 'direction of travel' for the future provision of education and training in this sector.

Note

It should be emphasised from the outset that this report is a completely objective analysis of the findings; and accurately reflects the thoughts and perception of the care staff who participated in the study. The opinions presented here are solely theirs and in no way represent the views of the authors. Where direct quotes are used, these were transcribed and presented 'verbatim' within the text.

Background

In line with the national situation, the health and social care landscape in Doncaster is changing. As a result of the modernisation and transformation agenda and key policy developments such as the Care Act (DH 2014), one of the key challenges facing any Council is ensuring a high quality workforce within the Care Home sector that is 'fit for purpose'.

With ever tighter resources and a need to ensure that the care provision within the sector meets the required quality standards of the Care Quality Commission (CQC) it is vital for DMBC and Doncaster CCG to have a motivated and well-trained care workforce that can provide competent client-focused care with skill and compassion.

National Drivers

There are a number of key government documents that have an impact upon social care delivery. These documents are part of a drive nationally to transform the way in which adult social care is organised and delivered. Primarily influenced by the vision articulated within the *Five Year Forward View*, these drivers include:

- A Vision for Adult Social Care: Capable Communities and Active Citizens
- Putting People First and Think Local, Act Personal
- Working to Put People First: the Strategy for the Adult Social Care Workforce in England
- The Localism Bill
- Living Well with Dementia: A National Dementia Strategy
- Caring for our Future: Reforming Care and Support
- Framework for Enhanced Health in Care Homes

In addition, there a number of 'Vanguard Sites' for Enhanced Health in Care Homes within Yorkshire & Humber, and their experiences will provide DMBC/DCCG with much useful intelligence that can be incorporated into any future social care strategy.

Local drivers

There are in addition a number of local drivers that need to be taken into consideration. For example, Doncaster's population is predicted to rise to 312,500 by 2020. At the same time, the number of individuals *over the age of 65* is also predicted to increase to 61,200. Of these, the number of older adults with dementia is also predicted to rise to 4,300. These increases will inevitably place a great deal of pressure upon social care providers in Doncaster in order to meet this growing demand. To respond effectively to these challenges and to deliver a high quality service, DMBC/DCCG needs to develop a well-trained and compassionate care workforce. The recent Doncaster *Place Plan 2016-2021* clearly highlights the need for change and for more 'joined up thinking' with regard to adult health and social care provision. This is a theme that has clear resonance throughout this report.

The 'direction of travel' needed to deliver this significant transformation of adult social care was originally outlined in *'Our Health, Our Care, Our Say: A new direction for community services'* (DH 2006). It described a vision for the development of a personalised approach to the delivery of adult social care. This vision was introduced under the auspices of *'Putting People First'* (DH 2007). *Putting People First* also identified a number of key priorities for the health and social care workforce of the future.

These were outlined in *Working to Put People First: The Strategy for Adult Social Care Workforce in England* (DH 2009). The process of integrating adult health and social care is a complex and often frustrating undertaking.

One of the key priorities for this to be successful is the need to recruit and retain competent, compassionate care staff, and to ensure that there are clear career pathways in place for the workforce to be able to meet the various diverse roles within adult social care. The other key priority is for the workforce to be suitably developed so that the right people with the right skills, knowledge and behaviours are available to deliver high quality personalised care in this sector.

One of the key components of the national workforce strategy for people working, supporting and caring in adult social care (Skills for Care 2011) was a better understanding of the local care workforce. Following recent discussions between NHS Doncaster CCG, DMBC Commissioners and DMBC Workforce Development team it was concluded that there was a clear need to address the gaps in their awareness and understanding of the current workforce education and training environment within the Care Home sector in Doncaster.

Historically, DMBC's Workforce Development Team and more recently the commissioning team have attempted to engage with the Care Home sector through individual visits, workforce fora and other network meetings, and information about education and training developments has been communicated through these networks. Despite these efforts on the part of the DMBC workforce development team to engage with Care Home providers, a full comprehensive picture about training needs and the quality of training they are accessing has not been fully established.

Currently there remains a somewhat fragmented and incomplete picture of the training and education situation across Doncaster, both for individual care homes, domiciliary care and the care sector as a whole. There is limited information on the education and training needs of both Domiciliary Care and Care Home staff, and limited awareness and understanding of education and training taking place within the Care sector.

Given all of this, there is a need to work with the Care sector to support and shape the development of skills, understanding and expertise within the local workforce. Both DMBC and DCCG are committed to working more proactively with Care Homes in Doncaster to ensure that the care workforce is fit for purpose. In addition to the Place Plan, the publication by DMBC of the 'Care Home Strategy for Doncaster' earlier this year, marked a major step forward in this regard. One of its key tenets included a review of the education and training landscape for care staff in Doncaster.

In order to achieve this, DMBC commissioned CPA, in partnership with Sheffield Hallam University (SHU) to undertake a 'root and branch' review of Care Home education and training in Doncaster. The remit of the CHETE project was to focus upon a number of key areas that had been identified as important by both DMBC and DCCG. The focus of the CHETE study was to provide DMBC/DCCG with robust intelligence in the following areas:

- The education and training currently accessed by Care Homes and to what standard
- The awareness/ understanding the Care Homes have of DMBC/NHS Doncaster CCG quality standards in respect of the education and training of their workforce
- Details of the education and training providers that Care Homes are using to train their workforce
- The level and type of training required by Care Home staff
- The 'gaps' in the provision of education and training, particularly to meet new ways of working under new market demands
- The barriers that Care Homes, Domiciliary Care and their staff encounter in accessing appropriate education and training
- Understanding of the preferred methods for the delivery of education and training for care staff
- Understanding how Care Homes and Domiciliary Care teams keep up-to-date with new learning, development needs and resources

This will enable the authors to:

- Identify recommendations and improvements that can be made in facilitating better access to education and training for the Care Home and Domiciliary care workforce
- Identify best practice that can be shared across the care sector as a whole

The Evaluation

Aims

To provide DMBC and Doncaster CCG with an in-depth understanding of:

- Current education and training practice and provision within the Doncaster Care Home sector
- How best to meet the future requirements of the Care Home workforce in Doncaster

Objectives

- To engage and consult with each of the 54 Care Homes in the Doncaster area, and a small convenience sample of domiciliary care services
- To provide an evaluation and analysis of the project findings for DMBC and DCCG

Study design

The evaluation used a mixed methods approach, which began with a rapid literature review followed by a 'face to face' survey and structured 'deeper dive' interviews. The Care Homes were initially contacted through a letter informing them of the evaluation, followed up by a telephone call or personal visit by a member of the team. Following the initial contact an appointment was made with the individual care homes to complete the survey 'face to face'.

The survey was developed online as a partnership between SHU and CPA using Survey Monkey© software, and was piloted on a small convenience sample of 6 care homes. Following feedback from this group, the survey was modified and then retested prior to the launch. The survey was broken down into five main sections.

These were:

- Demographic details of the care home
- Care staff information
- Recruitment and retention of care staff
- Current staff training and education
- Future training requirements

The full survey may be viewed as appendix 1.The purpose of the survey was to obtain a benchmark of current training activity and future training need in all 54 of the DMBC care homes. An agreement to complete the survey was taken as consent to take part in the study. The information provided included a statement for all participants that if they wished to withdraw, they could do so at any time without detriment to themselves. It also included details of the study team and the person to whom any complaints regarding the study should be addressed (in this case, the author).

Structured 'deeper dive' interviews

At the end of the survey the participants were asked if they would be prepared to participate in the 'deeper dive' interviews and if so to provide contact details. The structured 'deeper dive' interviews were used to clarify and expand upon the findings from the first survey. They were facilitated by a member of the study team and took place at a date and time of the participant's choosing. With the participant's consent the interview data was transcribed in situ. Data collection continued until data saturation was reached. The deeper dive survey may be viewed as appendix 2.

A purposive sample of 20 Care Homes based upon the analysis of the first survey was drawn from the population of Care Homes within the DMBC area. The Care Homes were approached based upon data relating to (1) the number of residents and (2) the nature of the care provided. The interviews were based upon the findings from the survey and were designed to explore in greater depth the views of both Care Home managers and care staff on the provision of education and training.

Following the initial agreement to take part, formal consent was obtained from all participants prior to the 'deeper dive' interviews taking place. This provided the participants with the opportunity to ask questions and to consider whether or not to participate. The consent process also included information concerning the study with a statement for all participants that if they wished to withdraw, they could do so at any time. It also included details of the study team and the person to which any complaints regarding the study should be addressed (in this case, the author).

Ethics and Governance

Ethical approval for the study was obtained from the SHU Faculty Research Ethics Committee (Ref: H447). SHU Research governance protocols were adhered to throughout the study. All data was anonymised to maintain confidentiality and to ensure that no individual could be recognised in any subsequent report. Paper based data is kept securely in a locked drawer and electronic data and information relating to this research is kept on a password-protected computer on a network storage system that adheres to Home Office Standards of Data Security. This data will be kept for a minimum of seven years in accordance with SHU guidelines.

Data Analysis

The survey data was entered into SPSS v21.1 for statistical analysis. The free text from the survey and the interviews were entered into Quirkos© software for analysis.

Survey Data

The purpose of this section of the analysis was to provide a baseline of education and training 'activity' for all of the Care Homes. Using SPSS v21.1, the online survey data was cleaned and formatted. Response frequencies were calculated for each question.

Qualitative Data

The raw data from both the deeper dive interviews and the free text from the survey were transcribed and cross-checked for accuracy. Once it had been cross-checked, the data was analysed using 'Quirkos'© data analysis software. Data analysis followed the National Centre for Social Research 'Framework' guidelines (Ritchie & Lewis 2003). This approach has emerged from applied health and social policy research and analysis. It involves a systematic processing, sifting, charting and sorting of material into key issues and themes.

It also permits both within and across-case comparisons and allows the integration of existing knowledge from previous research and policy into the emerging analysis. All transcripts were analysed independently by members of the research team and the interpretation of data was also cross-checked within the team.

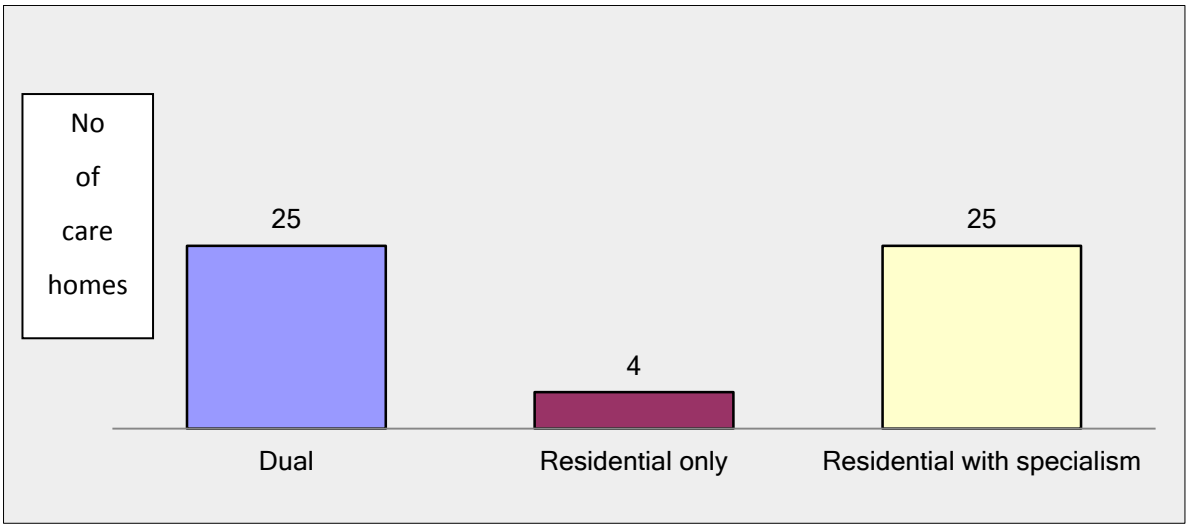
Findings

The next section of the report addresses the presentation and discussion of the findings from the two strands of the evaluation. All 54 of the Care Homes within DMBC participated in the survey giving a 100% response rate. Of the 54 homes and 2 domiciliary care providers approached, 52 completed the 'full' survey and 4 provided 'soft' intelligence only. A purposive sample of 20 care homes was identified for the 'deeper dive' survey and 49 individuals (care staff and managers) were interviewed.

Demographic details

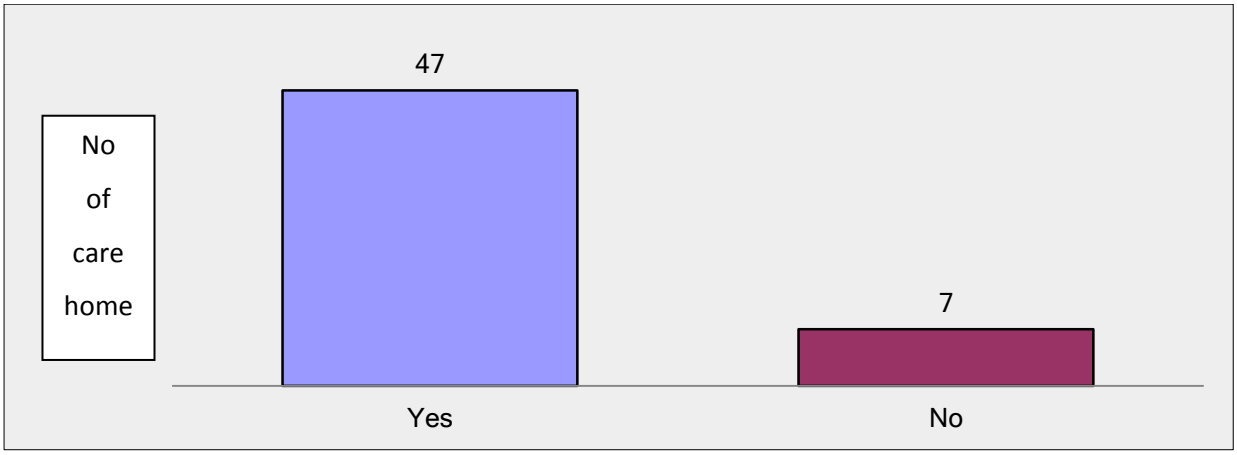
The first section will provide a summary of the basic demographic information collected by the survey. We asked each of the managers about the status of the home. In their terms, 90% of the homes were referred to as either 'dual category' or 'residential with a specialism' (dementia care/learning disability and/or elderly mental health).

Figure 1: Care Home categorisation as identified by the Managers themselves



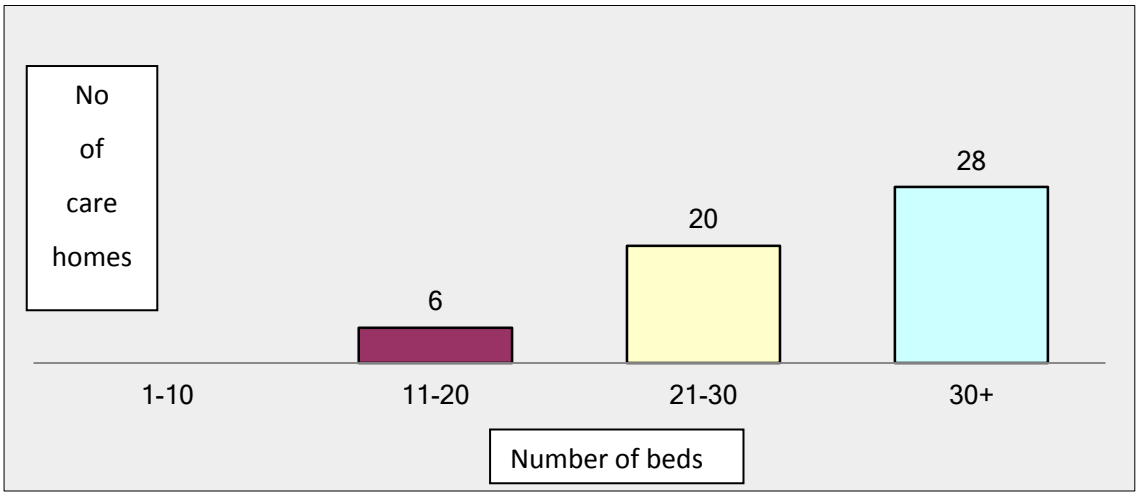
We also asked each of the homes whether they were an independent, privately owned care home or part of a larger chain or company. As we can see, over 80% of the homes were part of a larger chain. These chains included larger companies such as 'Four Seasons' and 'Runwood Homes'. The differences between the smaller, independently-run homes and the homes that were part of a larger company were quite pronounced. For example, the larger chains often insisted upon a 'companywide' response to a particular issue or regulation. This placed additional pressure upon the managers to comply not only with company policy but also any local policy requirements from DMBC/DCCG.

Figure 2: Is your care home part of a larger chain or organisation?



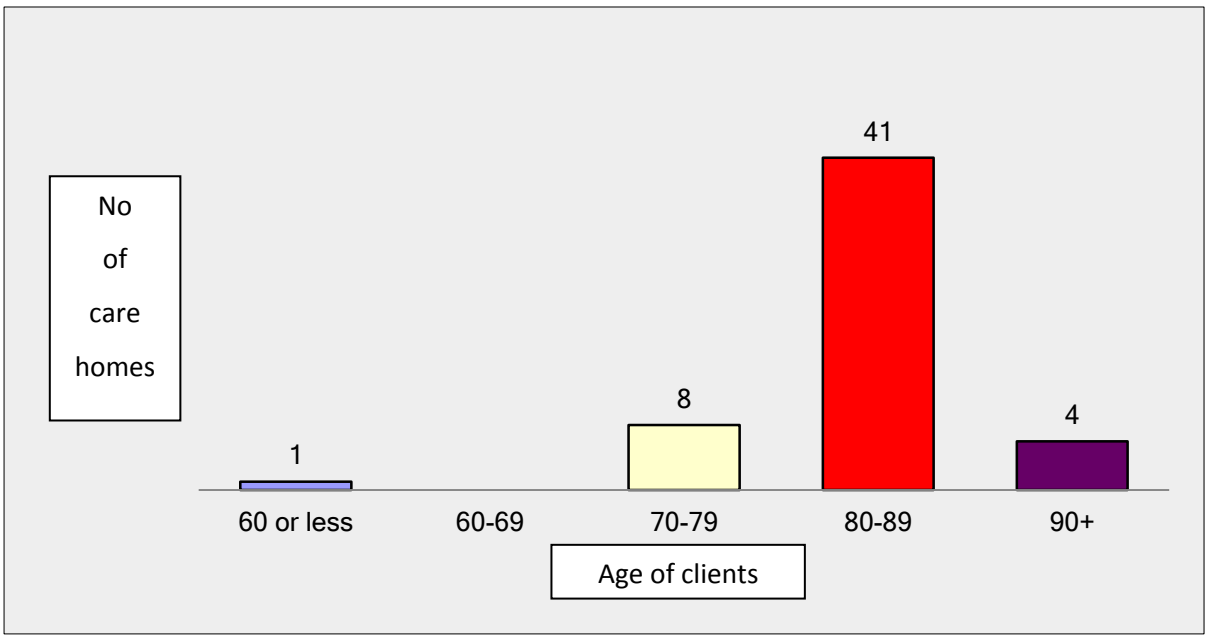
The 'economies of scale' mean that nearly 50% of the current care homes had capacity to care for more than 30 clients at any one time. Small, independent homes were very much in the minority.

Figure 3: How many beds do you have in your Care Home?



The vast majority of the clients being cared for were aged between 80-89 and this may be seen as a consequence of the fact that people are living longer, but with a greater number of co-morbidities and other chronic conditions. The number of older adults is set to increase significantly over the next decade, and this will clearly have huge implications for both the Care Home and Domiciliary Care sectors.

Figure 4: What is the average age of your clients?

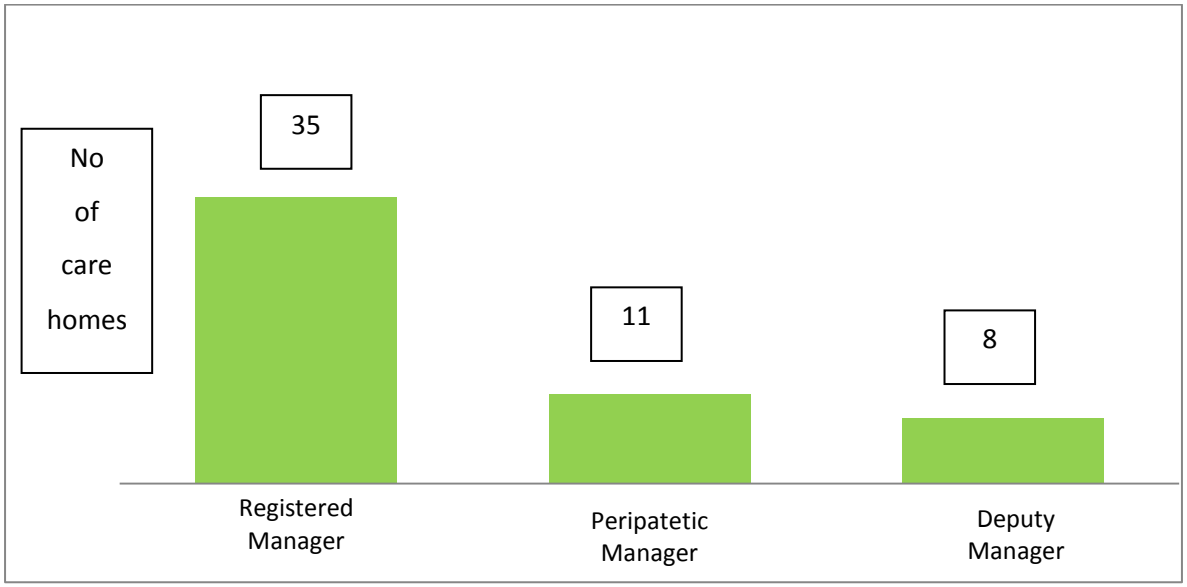


The Care Home Staff

The survey was completed with the most senior member of staff in each care establishment. The titles that were used are shown below. The majority of respondents called themselves 'Registered Manager' or a variation on that title. There were other titles such as 'owner', 'managing director' and 'peripatetic' manager.

The latter title is an interesting one and applies to managers who are there to provide cover for care homes that are part of larger chains. They are experienced managers who generally provide cover for maternity leave, long term illness and in the hiatus when a current manager leaves their post. As expected, over 80% of the managers were female.

Figure 5: What do you call yourself?



We were interested to know what qualifications the managers had to support them in their role. The role of manager is a complex and challenging one, and requires a significant degree of day to day decision-making, organisation and people skills. Although not a recognised qualification as such, a significant proportion (90%) of the respondents were CQC Registered Managers. To qualify as a Registered Manager with the CQC requires the individual to apply and then pass an interview. To be successful, the Registered Managers need to possess a high level of knowledge, skill and understanding of the care home sector. Of the other types of qualifications listed, these varied quite considerably. Interestingly, around 25% of the managers had a registered nurse qualification (RN or RMN). This tends to support the supposition that in the smaller care homes the manager/RN role is interchangeable.

Figure 6 below shows the qualifications held by the 49 managers who were registered with the CQC. As we can see, the minimum qualification was NVQ level 5, and a significant proportion held professional qualifications including social work.

Figure 6: *In addition to CQC Registered Manager*, what other qualifications do you have?

What 'qualifications' do you currently have?	
	Number of Managers (n=49)
RN (including RMN/RFN)	16
Degree (non-nursing)	7
NVQ level 5	44
CQSW (social work)	2
Assessor courses (level 5)	18

Care home staff

When asked about the different categories of staff that were employed by the care homes, there were a variety of responses. As expected, all of the homes surveyed had carers and domestic staff, and the vast majority had 'senior' carers and dedicated kitchen staff. Some of the bigger homes from the bigger chains also had maintenance staff available to them. Over 80% of the homes had some type of 'activities co-ordinator' role although this was often combined with another care role. Interestingly 60% of the homes described having Registered Nurses and this may be explained by the fact that in the smaller, independent establishments the manager role was often undertaken by a Registered Nurse (either RN or RMN).

Figure 7: Staff composition in the care homes

What types of staff do you have in your team?		
		Number of Care Homes
Manager	92.5%	49
RN	45.3%	24
Care assistant	100.0%	53
Senior carer	96.2%	51
Domestic/laundry	100.0%	53
Kitchen staff	94.3%	50
Activities co-ordinator	81.1%	43
Maintenance staff	94.3%	50

Recruitment and retention of care staff

This next section looked at the managers' views on the recruitment and retention of care staff. Anecdotally the turnover of staff in the care home and domiciliary sector has always been high, and this was clearly reflected in the responses to the survey. The findings show that 30% of the care homes had 10 or more staff leave their employment within the previous year.

The most recent National Care Forum (NCF) data published in July 2016 identified an average yearly turnover rate of ~20% in the care home sector nationally. Care staff turnover remains a significant issue for the sector as a whole, and the reasons for this are multifactorial. Given the high turnover of care staff, the need for easy access to 'work ready' care staff is clear. As a result, any delays to the start date for new staff were seen by the managers as counterproductive. The need for care staff to be 'work ready' meant that administrative issues such as obtaining DBS (Disclosure and Barring Service) clearance (formally known as CRB) were a source of frustration. In addition, the availability of training and the issues inherent in the booking system(s) meant that, more often than not, new starters were not 'work ready' on their first day. Aside from the regulatory implications, this lack of work readiness has implications for the individual member of care staff.

Figure 8: Staff turnover in the last year

How many of your staff left in the last 12 months?		
Number of staff leaving		**Number of Care Homes**
1	8.0%	4
2	18.0%	9
3	12.0%	6
4	12.0%	6
5	6.0%	3
6	6.0%	3
7	6.0%	3
8	2.0%	1
9	0.0%	0
10+	30.0%	15

There were a number of reasons that were given for staff leaving. These related to *career progression, changes to domestic and/or personal circumstances and disciplinary issues.* For example, a number of the care staff that had left in the last 12 months had used the post to gain caring experience in order to apply for nurse training or medicine. This phenomenon will become more common as the entry requirements for most nurse training courses include a period of care experience. Other domestic issues related to problems with childcare. Worryingly, another of the main reasons given by the managers for staff leaving related to disciplinary issues, leading to either dismissal or resignation.

Figure 9: Why did they leave? (multiple answers possible)

What reason(s) did the care staff give for leaving?		
		Number of care homes
Career advancement	52.0%	26
Relocation	32.0%	16
Childcare	24.0%	12
Personal/family issues	34.0%	17
Disciplinary processes	84.0%	42

From an objective point of view, the concern would be that given the constant high turnover of staff and the delays in getting new staff 'work ready', managers may feel pressurised to appoint often unsuitable candidates in order to fill a vacancy. In turn, the appointment of unsuitable staff may inadvertently contribute to the number of disciplinary issues and the high turnover of care staff. What we end up with is a 'vicious circle' in which the people that are disadvantaged the most by the high turnover of staff are the clients themselves.

The reasons for the high number of disciplinary issues are complex and multifactorial, and would clearly benefit from further investigation. However, the idea of a 'vicious circle' of unsuitable applicants may be complicated by the fact that there was clearly no shortage of applicants for each post when advertised.

Figure 10: Number of applicants for care staff jobs

How many applicants did you get for the last post advertised?		
Number of applicants		**Number of care homes**
1	5.7%	3
2	5.7%	3
3	5.7%	3
4	7.5%	4
5	11.3%	6
6	5.7%	3
7	1.9%	1
8	5.7%	3
9	7.5%	4
10+	43.4%	23

When asked how many applications they received for the last post they advertised, over 40% of the managers surveyed said that they had received more than 10 applications. Clearly some of the turnover may be attributed to the need for nursing applicants to have previous, relevant caring experience as previously identified, however given the qualifications required and the rates of pay offered for these posts, it may be reasonable to assume that a proportion of the candidates fulfil the job specification but are unsuitable for the role. This constant 'merry go round' of care staff often results in care homes turning to agencies for temporary staff cover.

Figure 11: Have you used agency care staff within the last year?

Have you used agency care staff within the last year?		
Yes	40%	20
No	60%	30

As we can see, 40% of the managers surveyed had used care staff agencies within the last 12 months. The disadvantages of agency staff include increased staff costs and a lack of continuity of care for the residents. This is particularly important for clients with cognitive impairment such as dementia or with learning disability.

Education and training for care staff

Once appointed, we were interested to learn what type of induction was provided for new care staff and of what it consisted. Most new care staff received basic training in aspects of *safe moving and handling, food hygiene, first aid, dementia awareness, health and safety, fire safety, adult safeguarding and infection contro*l. The care homes from the bigger chains (48%) also provided an induction into company policies and procedures. A small percentage (18%) of the bigger care homes also said that they provided training on medicines management for their care staff.

Figure 12: Mandatory training requirements

What is classed as' mandatory' training for each staff group in your team?							
	Registered manager	**Care staff**	**RN/RMN**	**Senior carer**	**Domestics**	**Kitchen staff**	**Maintenance staff**
Moving & handling	46	49	20	47	44	36	36
Food hygiene	45	49	19	47	42	43	33
First aid	45	48	20	47	44	40	39
Dementia	45	48	19	46	41	37	34
Medicines	44	8	20	42	2	1	2
Health & safety	47	49	21	47	48	42	43
Fire training	47	49	21	47	49	44	45
Safeguarding	47	49	21	47	49	44	43
Infection control	46	49	21	47	49	44	38

As far as could be ascertained from the 'deeper dive', there was no consistency or standardisation of the induction package. So, although 100% of new staff were described by their managers as having received an induction package, the quality, content, depth and delivery were clearly variable. It appeared as if the delivery of the induction was primarily dependent upon which members of staff were available on the new starter's first day. This meant that the delivery was often *ad hoc* and lacking in focus. The use of e-learning also meant that there was a lack of coherence in the mandatory training delivery which further fragmented the induction. As one of the more experienced care staff noted in the deeper dive, the new starters were often 'put off' right from the start by the e-learning packages they had to complete.

A key part of the project was to provide DMBC/DCCG with intelligence on the current state of education and training in the sector. We asked the managers what training and/or qualifications (if any) their care staff had undertaken and/or were currently working towards. All of the managers (100%) said that they would recognise any previous certificated education or training that a new member of care staff had undertaken. This willingness to recognise previous training may be seen at the outset as a pragmatic and sensible approach to the high levels of staff turnover.

Figure 12: Training, development and qualifications currently being undertaken by care staff (multiple answers possible)

How many of your staff have or are studying/undertaking the following?	
	Total number of care staff
Care Certificate	27
Apprenticeships	15
QCF diploma in Health & Social Care	32
NVQ (all levels)	45
Leadership qualification through DMBC	4
Clinical courses (Diabetes care/Continence care)	20

It does however create some problems for the individual care home. For example, if a member of care staff is already part of the way through a particular course such as a QCF Health & Social Care Diploma, they will inevitably wish to continue and obtain their qualification. This will make the desired aim of simplifying the education and training framework for care staff more difficult. As we can see from figure 12, there was a wide variety of different education and training being undertaken, and at a number of different levels. Again, the differing level of the courses undertaken creates another layer of complexity for the manager in ensuring that each member of care staff receives the appropriate training for their role.

Figure 13: What factors influence the training needs of your staff? (multiple answers possible)

Who decides what training is required for your home?		
Staff appraisal/PDR	78.3%	36
Company policy or directives	69.6%	32
CQC	26.1%	12
The client/family	10.9%	5
DMBC/DCCG	67.4%	31

We asked managers how they identified the training needs of their care staff. There were a number of drivers, both internal and external to the organisation. For example, all of the managers said that they used regular staff appraisal and performance reviews to identify specific training needs with individual care staff. This was reinforced in the deeper dive by the majority of the care staff who said that their PDR was used appropriately for this purpose. The managers also identified that external legal or regulatory requirements and commissioners' requests were significant drivers for sourcing training. A number also mentioned acting upon complaints or requests from clients and/or family members, which they linked to maintaining a high quality of care.

Figure 14: How do you go about finding a training course for your staff? (multiple answers possible)

How do you look for staff training courses?		
Online searches	63.0%	29
Brochures (through the post)	26.1%	12
Adverts in journals/trade papers	47.8%	22
Recommendations (word of mouth)	54.3%	25

Having identified a need, we asked the managers how they went about finding a suitable course or training programme. Given how busy the managers were, it was clear that the ability to find a training programme quickly and easily was important. Online searching and personal recommendations seemed to be the most common methods; however all the managers described struggling to find suitable, accessible education and/or training locally.

Figure 15: Was it easy for you to find a suitable training course?

Can you always find the training you want?		
Yes	13.0%	6
No	87.0%	40

Nearly 90% of the managers surveyed said they were often unable to find suitable training. This placed an additional strain upon the already stretched resources of the care home. In the main, the courses that were in most demand and most difficult to access were the clinically focused courses.

These were in order of popularity:

- 'Vital signs' measurement and interpretation for care staff
- Diabetes care (including blood glucose monitoring)
- Managing challenging behaviour in older adults
- Managing dementia
- End of Life care for care homes
- Phlebotomy and injection technique
- Continence care & urinary catheterisation
- Wound care and dressings

Having found a suitable course, we then asked them who would be most likely to provide the education or training they were looking for. As would be expected, the majority of the courses that are accessed by Doncaster care staff are provided either by DMBC/DCCG or private education providers locally. There did not seem to be a particular rationale for the choice and type of provider other than the availability of a local training place when required.

Figure 16: Which 'type' of provider do you use for staff training? (multiple answers possible)

Where would you go to for staff education or training?		
College of FE (or similar)	58.7%	27
Private provider/company	56.5%	26
DCCG/DMBC	76.1%	35

The fact that the care homes are independent businesses and not part of the NHS means that it is often difficult for their staff to access education and training provided through publicly-funded means. The education and training that HEE provide for NHS staff is not routinely available to non-NHS staff. In general, the budget for most types of education and/or training tends to come from the individual home or company. Most of the larger chains do have a corporate training budget however there are inevitably constraints upon how and where that budget is spent. Given this situation there appeared to be a degree of confusion over what external funding was available for care staff training, how to access it and what it could be used for. Under the auspices of the local Skills for Care (SfC) team, DMBC/DCCG offer free training courses and support for workforce development needs. However the means by which this support may be accessed did not appear to be widely known or understood.

Figure 17: Paying for training and education (multiple answers possible)

Who currently pays for your staff training?		
The parent company	93.6%	44
Care staff themselves	4.3%	2
The home (if independent)	70.2%	33
DMBC/DCCG	85.1%	40
SfC funding (through DMBC)	36.2%	17

In addition to the fixed costs of purchasing training, there are many other hidden costs which affect the ability of the care homes to provide training for their staff. Therefore the need to demonstrate value for money and the cost/benefit of any training is vital. There are understandable tensions that exist between the need for care homes to meet regulatory requirements and to provide suitable, appropriately delivered education and training for their care staff. There is a push of behalf of the training providers and parent companies to ensure that much of the mandatory training is delivered via an e-learning platform.

Learning styles for adults

There are a number of key issues that need to be taken into consideration when providing any education and training. These are (1) the students' preferred learning styles[1] and (2) the purpose for which the training is to be used. Both of these will help to define the pedagogical[2] approach that is used.

There is an understandable push to provide much of the mandatory training via an e-learning platform. The perceived advantages of e-learning are (1) the training can be undertaken outside of work and (2) be done flexibly at the student's own pace. E-learning removes the need for managers to provide cover for staff undertaking training, whilst simultaneously ensuring that mandatory regulatory requirements are being met. From a DMBC/DCCG perspective, there is clearly a place for e-learning however it should be used appropriately and with caution. The evidence shows that *most* adult learners prefer to learn by the use of a 'blended' approach in which a combination of teaching methods is used. These methods combine a predominantly 'hands on' approach to learning with the underpinning theory provided and contextualised 'in situ' by the facilitator. This explains why most of the care staff interviewed disliked e-learning since they find it difficult to contextualise their learning online.

From a theoretical perspective, most adult learners (particularly those who have been away from education for some time) find that 'learning by doing' with the opportunity to practice what they have learned in a safe and supportive environment is the preferred option. The presence of an experienced and supportive facilitator to help them to contextualise their learning and apply it to their own situation helps the learner to embed the learning.

Although this blended approach to learning is perhaps more time consuming in comparison to e-learning, the longer term benefits of the andragogical[3] or adult learning approach to training that accrue in comparison to e-learning or other didactic methods of teaching and learning are well evidenced. It should be emphasised here that the ability of the facilitator to help the student to contextualise their learning is a key aspect of successful adult learning. Whilst the traditional 'see one, do one, teach one' model of teaching and learning might still be in evidence; the support of suitably experienced and skilled educators is crucial.

Interestingly, the managers and care staff unanimously agreed that their preferred method of delivery would be a work-based, 'hands on' approach; however they were all clear that this was often not an option. As already highlighted, the challenges that exist for care managers in ensuring that their care staff meet all the necessary regulatory requirements often mean that e-learning is used as the default mode of delivery.

Figure 18: What are the preferred modes of delivery for training (multiple answers possible)

Ideally, how should training be delivered?		
E-learning (in staff own time)	15.2%	7
On site & 'hands on'	97.8%	45
Classroom-based lectures	8.7%	4
Classroom-based & on site	28.3%	13

[1]All learners have a preferred 'way of learning' and there are a number of validated tools available to assess these different preferences

[2]Didactic, 'chalk and talk' type teaching e.g. the traditional lecture format in which information is 'given' by an 'expert' to the learner

[3]Adult learning which uses an interactive, student-centred and problem solving approach to learning

Figure 19: What are the perceived benefits of having well-trained staff? (multiple answers possible)

What are the advantages of having well trained staff?		
Staff retention	100.0%	46
Staff morale	100.0%	46
Job satisfaction	97.8%	45
Reduced sickness and absenteeism	52.2%	24
Quality/continuity of care	100.0%	46
Shared values of organisation	95.7%	44
Seeing caring as a career	95.7%	44
Self-worth of staff	100.0%	46

Organisations need to be convinced that the benefits of having well-trained staff will outweigh the costs. The responses to the next question clearly demonstrate that the managers all appreciate and understand the benefits of having well-trained care staff. As figure 19 clearly shows, the many benefits that accrue from having well-trained staff were evident. *Staff retention, morale, increased job satisfaction* and *increased quality of care* were all highlighted. The improvements in recruitment and retention that may accrue from an increased focus upon education and training for care staff are well-evidenced and would inevitably have a positive impact upon quality of care

The managers highlighted a number of challenges to the provision of high quality training for their staff. In addition to the problems with finding suitable training that have already been underlined, and the costs involved in resourcing the training, the managers focused upon the other logistical issues involved in training. The 'time out' required for staff training and the need to provide 'back fill' for those staff were a constant headache for managers. This situation was exacerbated by the difficulties involved in accessing courses and booking places on courses in a timely fashion.

The managers all said that they needed to have had places confirmed on a training programme in sufficient time to be able to forward plan and organise cover. Unfortunately the reality was that the confirmation of places was often delayed and given at short notice, which meant that care staff were unable to take up the places as the rotas were already set. These delays often resulted in a degree of non-compliance with the regulatory requirements for mandatory training.

Figure 20: What are the challenges to providing training for your staff? (multiple answers possible)

What are the disadvantages?		
Cost	29.5%	13
Time off needed for training	56.8%	25
The need to 'backfill' to cover shifts	61.4%	27
Staff moving on to other jobs	18.2%	8
Organisation and logistics	70.5%	31

The other issue that the managers often raised related to staff retention and the 'merry go round' of care staff recruitment. The transient nature of the role, the low pay and low status afforded the role contributed to the high degree of staff turnover already highlighted. This made some of the managers reticent to invest too much time and money in their care staff. There was a genuine concern that if they trained their staff 'too well' that they would simply become a valuable 'asset' and be poached by another care home or chain with the promise of a pay rise or other inducement.

Figure 21: Ideally, what training would you invest in? (multiple answers possible)

If there were no restrictions what staff training/education would you invest in?		
Care Certificate(s)	82.6%	38
Apprenticeships	65.2%	30
QCF diploma	87.0%	40
Nurse training	67.4%	31
Specific clinical topics* (see list below)	89.1%	41

* Diabetes care/End of Life care/Managing challenging behaviour/Dementia care/Vital signs measurement and interpretation

As a final thought we asked the managers what training they would invest in if they had unlimited funds. Their wish list was generally practical and insightful. Most would like to continue to provide their newly-appointed care staff with the Care Certificate followed by the QCF Diploma in HSC (or the new Higher Care Certificate when it is available).

Interestingly apprenticeships were mentioned as an option for the early part of staff development and at the other extreme nurse training was seen as a potential career pathway for the more ambitious care staff.

The deeper dive clearly demonstrated some real impetus for developing a 'proper' career structure for care home staff. The need to move away from it simply being a job rather than a career was another recurrent theme. There were a number of clearly very capable care staff who felt trapped in their roles. They wanted to progress and develop but did not feel sufficiently confident or able to apply for their nurse training independently.

Inevitably the vast majority of the respondents discussed the need for the urgent provision of training to address specific clinical issues or other emerging topics. As previously discussed, these included *managing challenging behaviour in the older adult, dementia care, communication skills* and *technical skills* such as *venepuncture or catheterisation*.

Given the complex care needs of the majority of clients that are cared for in our care homes, it is imperative that the staff that care for them are well-trained and motivated. Their clients are amongst the most vulnerable of adults, often with challenging behaviour, and the ability to care for these individuals in a compassionate and competent manner is vital.

Summary of findings

There were a number of key Issues emerging from the data. These were:

- Recognition on the part of the managers of the importance of having well-trained care staff throughout the care home and domiciliary care system
- Frustration with the current system(s) as they stand
- 'Information overload' in keeping up with the various competing and occasionally contradictory demands of the commissioners and regulatory bodies (DMBC/DCCG & CQC)
- 'Decision-making fatigue' over 'wrestling' with the disparate delivery methods, quality and level(s) of training available
- 'Lack of clarity' over the choice of different courses & levels available and mapping this to the point above
- The logistical difficulties involved in sourcing and providing appropriate education & training for care staff in a timely manner

The remit of the CHETE project was to examine 8 specific areas of concern for education and training within the care home and domiciliary care sector in Doncaster. This summary will outline the evidence to address each of the eight issues in turn. It should be noted here that the majority of the evidence was provided by care home staff and this inevitably influences the findings. Wherever possible, the findings have been presented in such a way that they may also be applied to the domiciliary care context.

(1) The education and training that is currently accessed by Care Homes

There was clear evidence, particularly in the deeper dive, of both frustration and irritation over the current situation. For example, there was a wide variety of different programmes currently being accessed by care staff. In addition, there was no clear sense of the required level and some confusion over the different levels that the care staff were working to. The ad hoc way in which some training is accessed means that it is difficult to maintain any degree of quality control over either content or delivery.

Given the current situation, there is a clear need for the *simplification* of the education and training for care staff, and for a single agreed pathway for training. It may make sense for example to direct all care staff in the first instance towards the Care Certificate, which has been developed for health and social care for use as an induction standard. This is the national benchmark for the initial (12

weeks) phase of care staff education and training. This would then become the starting point within Doncaster for a care staff development framework, and would help to ensure consistency of quality and the transferability of knowledge and skills.

(2) The awareness and understanding the Care Homes have of DMBC/NHS Doncaster CCG quality standards in respect of the education and training of their workforce

It is clear from both the survey and from the deeper dive interviews that the managers have both an awareness and understanding of standard regulatory requirements. However, the conflicting information they receive in terms of both local and national requirements does cause some confusion.

"I don't totally understand all of the regulations … sometimes they can be very misleading as change happens constantly"

(Senior Care Staff)

Two areas of note are that the regulatory and monitoring bodies appear to offer conflicting advice in certain areas i.e. the lack of consistency over revalidation requirements for mandatory training such as moving and handling. Care Managers also experience confusing and conflicting demands from their parent company and the commissioners/regulators which detracts from the focus upon the education and training.

(3) Details of the education and training providers that Care Homes are using to train their workforce

As would be expected, there are a variety of different providers used by the care homes. The type of provider will depend upon (1) the type of training, (2) the level at which the training is required, (3) its availability and (4) cost. The proposed simplification of the care staff training and the development of a single training framework would enable a greater degree of clarity over the suitability of the provider and the level of training required.

(4) The level and type of training required by care staff

The training needs of care staff are assessed and managed using a variety of resources including annual staff appraisal, supervision, addressing legal and/or regulatory requirements and through requests from staff, clients or their families. There is however a perceived lack of consistency and agreement regarding the type, level and quality of the training required. Some clarity and direction from both DMBC and DCCG over this would be very timely. As already discussed, one way forward

would be the wholesale adoption of the Care Certificate as a starting point, with staff then progressing onto the Higher Care Certificate or its equivalent.

This would probably need some measure of support and external mentoring from DMBC/DCCG, but would address the problems that currently arise in relation to the lack of consistency in approach to education and training. DMBC/DCCG want and need a suitably trained, educated care workforce with a portfolio of transferable skills, and there is an imperative for DMBC and DCCG to work together with the care home sector to agree the way forward in this regard.

(5) The 'gaps' in the provision of education and training, particularly to meet new ways of working under new market demands

Over 90% of the respondents stated they could not find all the training they wanted using currently available resources. The responses also highlight the need to make education and training more role and environment specific, with a high bias towards on-site delivery. In addition to the mandatory training that all care staff require for their roles, there was an identified need for short courses designed for care staff on specific topics. For example, adult 'safeguarding' is an absolutely vital topic for all care staff. However as a mandatory topic it is often taught generically to all health and social care-related staff, in a way that is not always easy for the new care staff member to contextualise to the care home environment.

The increasingly complex nature of resident's health needs was also a prevalent theme highlighted by all of the respondents. The monitoring and surveillance of chronic conditions were areas of concern, as were the development of the 'softer' non-technical skills of communication, assertiveness and teamwork. There is an opportunity for care staff to increase their confidence when interacting with health & social care professionals and to assist in the appropriate monitoring of residents' health status.

Other areas highlighted as 'gaps in the market' related to the provision of care at the end of life, particularly in the care home context and the management of dementia and challenging behaviour in older adults. It was apparent that much of the training here is ad hoc and dependent upon circumstance. Where it was available it appeared to work well. For example:

"There is a fabulous dementia team within my home… and I learn things [from them] *all the time because they are always there for advice…"*

(Care Staff)

On a more practical level, there was a perceived need for support and assistance with the adoption of initiatives such as the Care Certificate, which places increased demands upon all levels of care staff over a sustained period of time.

The development of key roles such as the 'activities coordinator' role was also highlighted. This type of role has assumed greater prominence in recent years as its importance has been highlighted; there is however currently a dearth of activities co-ordinator courses available to access. The ability to formalise and standardise the activities co-ordinator role and what it entails will enable care staff to maximise the opportunities to (1) provide a high quality experience for care home residents and (2) access a meaningful career pathway for the future.

(6) The barriers Care Homes and their staff encounter in accessing appropriate education and training

The previous section discussed one of the main barriers to accessing appropriate education and training. The constantly changing care environment means that there is a constant need for new education and training to meet specific need. Dementia awareness is a huge issue at the moment and it inevitably takes some time for education provision to catch up with new initiatives. When asked specifically about other barriers, managers highlighted a number of mainly logistical issues that acted as a disincentive for education and training. For routine mandatory training these were:

- Issues with the current booking processes, which were seen as too slow and cumbersome
- A lack of transparency regarding availability of places on particular courses
- 'Fines' for staff non-attendance on some privately run courses
- The cost of the training and who should bear the responsibility for it
- Information 'overload' from multiple sources regarding mandatory training priorities

For other types of education and training the emphasis is on the word *appropriate.* There was some apparent confusion over the relationship between course 'content' and the 'level' of learning required, and in particular how this relates to the care staff and the job that they are required to do. This confusion is exacerbated by the way in which clinically-focused courses are often marketed. The content of the course for different levels of staff may appear to be similar but the *context* and *application* of the content will be markedly different between for example a diabetes study day for an RN and a new member of care staff.

On an individual level, the need for care staff to have basic standards of literacy and numeracy was also highlighted in the deeper dive interviews. Anecdotally the incidence of dyslexia (whether diagnosed or not) in care staff is predictably high, and this in itself is a significant barrier to learning. An awareness of how to 'deal with' dyslexia and how to access dyslexia support services needs to be incorporated into any training programme. Other issues such as English not always being the care staff's first language were also highlighted. The recruitment of care staff from the European Union, (as well as clients) has placed this issue into sharper focus. It is acknowledged that these are all sensitive issues and it is therefore difficult to address them in the context of group staff training. As this member of care staff stated quite candidly:

"I didn't enjoy school and didn't fit in… I left school at 14 and started work… learning doesn't come easy …"

(Care staff)

(7) Understanding of the Care Homes' preferred methods for the delivery of training

There is a need to support managers and care staff to increase their understanding of how theory relates to practice and how to ensure that the underpinning theory for any skill or activity is appropriately contextualised. In addition there is a clear need for improved mentorship to provide support for the students once the training has been completed. Support during this transitional period of skills acquisition is vital if best practice is to be properly embedded.

An understanding of basic educational theory is required, particularly with regard to adult learning styles. The need to match the learner with an appropriate learning style is vital if the learning is to be effective. Whilst individual, bespoke training would be impractical, there is clearly an approach that will suit the majority of the care staff. All of the managers expressed an overwhelming preference for training and development to be delivered within the care home environment by subject field professionals who understand the environment and its often subtle nuances.

However for entirely understandable reasons the most widely used yet least preferred delivery method was the use of online training packages. These do not suit the adult learning styles of the majority of the care staff, particularly in the light of the sensitive issues discussed in the previous point.

Shown below is a small but representative sample of some of the comments from the care staff in the deeper dive:

"I get nervous and make mistakes in front of people I don't know…being taught by people I know is much better"

"I like the training that we do which is taught in the home because I feel more relaxed and confident [there] *to ask questions… it seems to make more sense too"*

"I like to be taught by someone who knows what the job is [all about] *… and are interested in what they are teaching…"*

"The training that I have to do online I don't like but practical 'hands on' training I do like… so I can learn in my own way…"

"E-learning is boring […] *looking at a computer screen all day and not discussing it with other people…I was not raised with computers… "*

In addition to the preferred mode of delivery, the managers discussed the need for any training and development to be flexible in its delivery times in order to be inclusive of all staff within the care home. There needs to be recognition that most care staff are paid the minimum wage, have to work weekends and unsocial hours and often have other responsibilities in addition to their work. There is a clear correlation in the literature between formal and informal caring roles, in that many care staff are also informal carers for their own family members. This combination of factors means that a proportion of care staff find it difficult to study in their own time or on their days off. Anecdotally from the deeper dive managers are more often than not aware of these individual circumstances, and do try to take this into account when considering the allocation of education and training.

(8) Understanding how Care Homes keep up-to-date with new learning, development needs and resources

Care Homes access a variety of resources with no single, predominant format. Websites, email communication and onsite visits from regulators and commissioners are all methods by which information is cascaded. Regulatory requirements and standards are received from commissioners, regulators, standardisation bodies and parent companies. Although these bodies are often pursuing the same end, the overload of information presented in a variety of formats and arcane languages, means that the message is often 'lost in translation'.

As a final thought, there is much that can be learnt from the experiences of the *Enhanced Health in Care Homes* Vanguard sites. 'Connecting Care' in Wakefield involves dedicated teams of health and care professionals being allocated to support care homes in looking after the health and wellbeing of their residents. Wakefield's vanguard team aim to improve the health of older people living in care homes by streamlining primary care, health and social care professionals, specialist voluntary workers and care home managers.

Each of the care homes that are taking part in the vanguard are linked to a dedicated GP practice which works with mixed teams including community nurses, therapists, carers and other professionals to provide a flexible, efficient and responsive service that reacts to the needs of residents. The team aims to avoid ill health among residents by taking action *before* people become unwell reducing the need for reactive care and unplanned hospital admissions. *They do this by proactively monitoring residents to make sure care for potential health problems is offered as early as possible and by building the skills and confidence of the care home staff through training and education*.

Key Recommendations from CHETE

- **A CENTRAL COMMUNICATIONS HUB:** Information from regulatory bodies, commissioners, education providers and other national bodies relating to education and training, staff development and other initiatives should be filtered through a central communications hub and cascaded as appropriate to the individual care homes. This will ensure the provision of clear, unambiguous information clarifying the obligations of the Care Homes in terms of training and education from all the regulatory, compliance and contractual bodies. In addition, the cascade of new information, updates, educational provision and other network issues can be managed through the hub

- **AN 'INSTANT ACCESS' BOOKING SYSTEM:** There is a clear consensus over the need to produce a viable 'live' booking system for accessing all care staff training. A system which clearly states the availability of places and provides instant online confirmation of booked places. In addition, there is a clear need for increasing the capacity for provision of induction training courses. A review of current booking processes with a view to the development of a 'live' real time online booking system will enable managers to better identify and plan their training in line with staffing rotas and availability. The development of a 'single point of access' booking system for all care staff education and training is a longer term aspiration, however a single booking system for DMBC/DCCG courses would be a shorter term 'quick win'. The use of an online service such as 'Eventbrite' would provide a relatively

straightforward way to achieve this, in addition to the cost savings that would accrue from its use

- **LOCALITY DEVELOPMENT:** The development of a two-tiered approach to networking and support. The first tier would be a local 'network of care' providing practical and peer support within the locality, and the second tier would be a 'network of care' strategic level feed through the communications hub. The development of local 'networks of care' will enable Care Homes to support each other in a wide range of areas including pooling of staff training and education and the sharing of other resources and best practice

- **DEVELOPMENT OF CARE STAFF:** The development of and support for an agreed career pathway for all care staff is vital. The fact that the care role is seen by most people primarily as a job rather than a career is a disincentive for high quality applicants. Even worse, the role is often viewed by the media as a job with low pay, low status and few prospects. This means that staff turnover is high and the quality of applicants is often variable. The provision of a locally (in the first instance) agreed pathway for care staff to be supported and developed through the care 'system' to undertake their Registered Nurse training would be a significant step forward. Improving the care staff's skills to enable them to better meet the increasingly complex health needs of clients with chronic conditions and other co-morbidities would also form a key strand of any future training strategy.

  Finally the development of meaningful, practical training delivered on site within the Care Homes, which is able to flex and adjust to work around the day to day requirements of the home. The success of the Best Practice Support Team project in equipping care staff with key skills demonstrated that this approach to care staff education and training is both beneficial and cost-effective. There was some evidence that care staff are carrying out clinical 'tasks' without necessarily having the requisite knowledge and understanding that would derive from appropriate education and training such as that just described.

- **REGISTERED NURSE DEVELOPMENT:** Alongside the need to develop and educate the care staff, there is an equally pressing need to provide post-qualification education and training for Registered Nurses working in care homes. Given that there may be only one RN working in any given home, the need to address the sense of isolation that is often felt, and improve access to post-qualification education and training is vital. As with the care staff, the fact that the RNs are working outside of the NHS means that access to any learning beyond registration funding from HEE is restricted.

- **TRAINING BUDGET ALLOCATION:** Although the budget would be held within the remit of DMBC/DCCG, there should be allocated budgets for all care home providers, which will enable them to identify their specific training needs and then choose, with support and guidance, appropriate training programmes to meet those needs. It is envisaged that a portfolio of courses would be developed and provided through DMBC/DCCG and that the care homes and domiciliary care providers would choose from this portfolio according to their identified needs. DMBC/DCCG would then fulfil a quality control brief and act as a conduit for both quality control and governance. This would enable the release the funds accordingly at the request of the care home or domiciliary care provider

- **BEING 'SEEN' TO FACILITATE THE CHANGE IDENTIFIED BY THE CONSULTATION:** Given the degree of trust and respect from the care homes that members of the CPA team have amassed, it is vital that DMBC and DCCG are seen to act upon the findings and recommendations of the CHETE consultation. If this is ignored then that trust will be significantly eroded and difficult to regain. There is a clear need for the adoption of a *'you said, we did'* approach.

- **A FACILITATION 'TEAM':** This would involve the development of a team to support the delivery of induction and mandatory training for all new care staff. This would be resourced and monitored by DMBC/CCG but would also source additional funding from other outside agencies with a remit for health and social care e.g. Skills for Care. This would contribute to the development of a training network in Doncaster that assists the Care Homes and Domiciliary Care providers to get new staff 'work ready' in a timely manner and then supports them in identifying and realising their future training and development needs. Given the high turnover of care staff, this would be a practical and cost-effective way to ensure both the quality and the availability of the provision.

- **FUTURE-PROOFING:** Given the size and scale of the task, it is vital that the transformation of adult social care in Doncaster is carried out in a sustainable way. The CHETE project has provided evidence of the need for change, and the recommendations produced will be clinically and cost-effective in the long term. The support of DMBC/DCCG is vital in getting to a critical mass of care homes and domiciliary care providers that will 'buy into' the changes.

Conclusions

This 'snippet' from the recent Wakefield Vanguard 'Connecting Care' report very neatly sums up the 'direction of travel' for both care homes and domiciliary care providers in Doncaster:

"They do this by proactively monitoring residents to make sure care for potential health problems is offered as early as possible and by building the skills and confidence of the care home staff through training and education"

Dr Robin Lewis

Sheffield Hallam University

January 2017