The Cavendish Review

An Independent Review into Healthcare Assistants and Support Workers in the NHS and social care settings
6. Recruitment, Training and Education

Summary

In all the discussions about values, standards and the quality of care in the NHS and social care, the support workforce has received the least attention. As a result, there are unacceptable variations in the competence of this workforce. Yet the public needs to know that support workers can work safely, competently and with kindness.

There are pockets of excellence: organisations which recognise that this workforce is a critical resource. These organisations recruit people for their values and commitment to caring; they invest in rigorous training and development; and they ensure that training translates into day to day practice. They prioritise this in tough financial times, knowing that it improves care and staff engagement.

But overall, training is neither sufficiently consistent, nor sufficiently well supervised, to guarantee the safety of all patients and users in health and social care. In domiciliary care, we have heard of instances of staff being sent unsupervised into clients’ homes with no training.

Considerable amounts of money have been spent on a vast array of vocational qualifications and training courses without clear evidence that the training HCAs and support staff receive improves outcomes. The array of courses and providers is hard to navigate, especially for small employers. A rigorous quality assurance mechanism is urgently needed, to police a market in which it is very easy to set up as a training provider, and in which too many workers are signed off as ‘competent’ without necessarily being so.

Training should not be seen as an end in itself: what matters is that workers are competent, and kind. The best organisations are beginning to base their recruitment and training strategies around values. They are screening applicants for aptitude; they are helping them to learn why they are doing tasks, as well as how; and they are constantly refreshing the lessons learned through supervision and practice.

The support workforce is increasingly going to need to be flexible across health and social care. While the actual skills required will vary between settings, workers in both sectors are increasingly going to need to draw on similar core knowledge and approaches. A golden thread of values should run through all training in health and social care, defined by employers on the frontline.

There is now an opportunity to create a “Certificate of Fundamental Care” which will not only build on the minimum training standards called for by Robert Francis QC but will also improve the image of caring. It will reduce complexity, duplication and confusion by linking explicitly to the nursing curriculum. Eventually, it should be open to volunteers and unpaid carers, who are shouldering so much fundamental care. And it will be the foundation stone of a series of national competences which emphasise what is common to health and social care, and what is common to registered nursing and support work, rather than what is different. For the airline industry has demonstrated that common goals and a common language, training junior and senior staff together, are a cornerstone of safety.
6.1. Overview

6.1.1. At a minimum, the public needs to know that support workers are able to work safely, with the basic knowledge relevant to their job. For many workers this will mean knowing first aid, and how to lift someone properly. It may also mean understanding how to correctly dress a wound or change a catheter, both of which done incorrectly are major infection risks which can raise morbidity and create serious extra costs in the system.

6.1.2. Beyond the minimum, the public expects workers to be competent. It expects – and deserves – workers to be kind, capable, and able to communicate clearly.

6.1.3. What the public actually get is very mixed. There are pockets of excellence: but too much variation. The best organisations are trying to reduce variation with rigorous training and supervision. Many have developed their own training courses in order to set a standard. There is much which should be learned from them to raise standards and reduce duplication.

6.1.4. The airline industry trains its cabin crews together, to reduce the risk of accidents. This Review proposes a “Certificate of Fundamental Care” developed along similar lines.

This chapter considers these issues in three sections:

- The challenges
- What the best organisations are doing
- The way forward

6.2. The challenges

- The system does not currently guarantee public safety
- Qualifications and tick sheets do not always denote performance on the job
- Employers’ lack of faith in the system has led to duplication and wasted resources
- Staff do not always achieve recognised, transferable skills
- Training does not always relate to the needs of the patient/service user
- Training can reinforce professional silos rather than contribute to team-building and shared responsibility
- Caring does not always feel like a career, with clear routes to progress

6.3. The system does not currently guarantee the safety of the public

6.3.1. There are no minimum educational requirements to begin working as a HCA or support worker in the NHS or social care. Even literacy and numeracy are not always tested.

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“Only seven of us were given a literacy test before being appointed to our job. We think this is essential.” Submission to Review from group of 26 HCAs currently studying to gain a diploma (experience in group ranges from 4 to 22 years)

6.3.2. According to research undertaken at the Universities of Oxford and York into the NHS, around two thirds of acute trusts are now using numeracy and literacy tests to screen Band 2 candidates across most of their organisations. But a third do not. Most NHS Trusts theoretically require HCAs to have NVQ Level 2 on joining at Band 2, but the research found that only 39% of the trusts surveyed required Band 2s to achieve training targets before being confirmed in post.

6.3.3. In the NHS, there is very little guidance about the training needs of HCAs. The RCN has found that qualified staff are not always aware of the educational courses available for HCAs in their organisations, and that this can cause qualified staff and managers to display negative attitudes towards HCAs. In the NHS, the unfortunate coincidence of the nomenclature of vocational qualifications at Levels 2, 3 and 4 with the NHS pay bands 1-4 has exacerbated frustration among HCAs, who expect to be promoted to Band 3 if they achieve Level 3, and are disappointed when this does not occur. Since there is no national record of HCA qualifications, however, it is not possible to know the extent of this.

6.3.4. Academic research has suggested that some HCAs who know how to carry out a procedure may not fully understand the consequences of something going wrong; and that some of those who monitor a patient's observations are unable to interpret the results. This is of great concern to nurses.

6.3.5. In social care, mandatory training varies according to the specific role that a support worker is required to carry out. Most workers we have spoken to have taken mandatory courses in food hygiene, moving and handling, safeguarding, and health and safety.

6.3.6. However, the Review has also heard from home care workers whose “induction” consisted of being handed a DVD to watch at home, before going out to a client. We have heard from two care workers who claim that they were asked to pay for mandatory training out of their own pockets. One said she had quit as a result, and would never consider a caring role again.

6.3.7. The Common Induction Standards (CIS), developed by Skills for Care in 2005, are supposed to be completed by all adult social care practitioners within 12 weeks of starting a job. CIS includes three days’ training in first aid, moving and handling, infection prevention, dementia awareness, nutrition and hydration, and dignity. Guidance from Skills for Care advises that lone working should not be permitted until the CIS are completed or until competence has been assessed and a manager ‘signs off’ that a practitioner is ‘safe to leave’ to work alone.

6.3.8. However employers and Skills for Care have told us that completion of CIS is not always verified by inspectors. The United Kingdom Healthcare Association (UKHCA) told us that the guidance is “only a recommendation with no commitments on what training standards and timescales should be

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16 2011 Nurse Support Workforce Survey Initial Results: Ian Kessler, Paul Heron, Karen Spilsbury, NIHR SDO project number 10/1008/17
Recruitment, Training and Education

achieved…as a result providers have little guidance on what an agreed standard...should be”. The UKHCA suggests that HCAs and support workers should shadow more experienced colleagues “at a minimum” until the worker is regarded as safe to work independently – but again, this does not always happen.

6.3.9. Inconsistently applied rules do not guarantee patient safety. It is commonly assumed that support workers are acting under supervision. But this is not always the case.

“People talk about HCAs as though they’re fully supervised: but they’re not. That doesn’t need to be a problem. But they need to understand what they are doing and why.”

(Kay Fawcett, Chief Nurse, University Hospitals Birmingham NHS Foundation Trust)

6.3.10. The problem is particularly acute in the community because supervision is remote; no one sees what a support worker does except the service user. As community care becomes more complex, and new organisations enter the market, consistent standards will be needed to protect the public. HCAs and support workers themselves will also need the confidence and competence to meet increasing demands from commissioners and providers.

6.3.11. It is important to recognise that it is the performance of each worker that matters, not training per se. Data from NMDS-SC shows that in 2011, around 40% of those working in direct care roles in social care had no relevant qualification. But this does not mean that they are doing a bad job. Following the Health and Social Care Act 2008, the requirement that 50% of staff should have completed NVQ Level 2 was removed, in favour of one that staff should be “appropriately trained”.

6.3.12. Given what the Review has heard about the low value of some vocational qualifications (see below), it is correct to place the emphasis on staff performance, rather than qualifications. But more clarity is needed about what constitutes "appropriate" training, and whether staff are adequately supervised.

The Department of Health, in response to the Francis Inquiry, has asked the Care Quality Commission (CQC) to look at the induction arrangements for HCAs and support workers across the NHS and adult social care.

The CQC is conducting the thematic probe to obtain a baseline picture of the current situation about how well healthcare assistants support workers are prepared (through induction) to start caring for people unsupervised. If any information found suggests that there is evidence of non-compliance with one or more of the quality and safety regulations, CQC will follow this up as part of the normal inspection methodology and as such publish findings as part of the inspection report.

6.4. Qualifications and tick sheets do not always denote performance on the job

6.4.1. A bewildering array of modules, certificates and vocational qualifications have been developed by a large number of training providers chasing changing fashions in public funding. Trying to navigate this sea of courses and funding puts a huge burden on already stretched employers, who find the opaque
language of vocational training virtually unintelligible. And they feel the value of many of these courses is questionable.

“Some people gain FE qualifications without ever seeing a resident. Apprenticeships are far better because they’re based with employers.” (Care home owner and end of life specialist)

“We had staff coming with NVQ3s and they hadn’t a bloody clue.” (Domiciliary care agency)

“As a sector, we want to see a qualification which actually means something. A person can have an NVQ3 and know nothing about care.” (Care home owner)

“In our Trust we are considering not having NVQ2 as a requirement for Band 3 – we have found that it is often not worth the paper it is written on. We have found that the candidates we assess internally who don’t have NVQ2 are actually often better suited for our own competency programme for Band 2 to 3 progression than those who have completed NVQ2.” (Senior nurse educator, London Hospital)

“There is very little connection between qualifications and competence.”
(Local authority area manager in social care)

“Assessors change all the time, there’s no continuity, they’re lowly paid and not properly valued themselves.” (Domiciliary care manager)

6.4.2. The CQC told us that it frequently receives calls from social care employers seeking advice about what training to give their staff, and which are the best training providers. CQC advises employers to refer to the Skills for Care CIS, and to the units or qualifications relevant to the job role as advised by Skills for Care. However, it cannot advise on training providers, as there is no national rating of providers or quality assurance mechanism.

6.4.3. In addition, the way the market is funded can create incentives for trainers to sign off as many people as possible as quickly as possible. The Review has heard of small care homes being offered free training from providers which are supposed to ask the employers to co-fund, but which simply take government money and shorten the courses. It is a mystery why governments should have paid up for so long, with so few questions asked.

“I’m horrified at what I see out there. We teach Level 2 End of Life care in four days, over a period of a month. But I’ve seen it taught in one day: the training providers don’t think they will come back otherwise. They don’t get the funding until the person completes. People go back to the organisation and wave their piece of paper, but there’s nothing to say they’re competent.”
(Palliative care nurse)

“QCF qualifications have credit values; each credit represents up to 10 hours notional learning, dependent on learner need. As such it is hugely concerning to see QCF Level 2 qualifications of 3 credits taught and summatively assessed in a classroom in six hours. I have examples of funded programmes in London where this is happening.” (Sally Garbett, former policy advisor for QCF qualification development and training)
In too many cases, in both health and social care, staff seem to be handing in tick sheets to be signed as a record of their performance, without sufficient checks that they really understand their training. The Review heard examples of care home staff being asked by supervisors to bring in six months’ and even eight months’ worth of sheets in one go, to make the process of “sign off” easier. Training needs to be part of an ongoing process of assessment and supervision.

“I’m not sure we are testing competences as part of training. In medical training you have competency simulation tests which have to be passed. Why aren’t the competences of HCAs tested?” (Senior nurse educator, London focus group)

“There is no long term assessment of the impact training is having. The HCA may be able to demonstrate a competency at the end of the training day, but what about the following week or year? There is no follow-up.” (HCA development clinical lead, London focus group)

However good the competency booklet, there is no substitute for standing next to someone and watching them to see if they can actually do the job.

Lack of faith in the quality of some of the training on offer has led many organisations to develop their own in-house training. Some of this is excellent, but it leads to duplication, with employers retraining new staff irrespective of what they have learned elsewhere.

“We have given up on training providers except to get our staff the qualification: then we train them ourselves from scratch again. They can get the qualification but they’re not competent in practice. And the training providers aren’t competent either.” (Care home owner)

In-house training is rarely accredited: leaving support workers unable to prove what they have learned to clients, or when moving to a new employer. HCAs in the NHS express frustration at being trusted to perform tasks in one Trust that they are then prevented from doing when they move. Home care support workers particularly need to be able to reassure people using their services, who in turn should be able to verify the experience and qualifications and those looking after them.

“For a national health service there is nothing national about it. When they move from one [Trust] to another they are expected to undertake different training and assessment to achieve it.” (Focus group attendee)

This also means that the skills of individual workers depend very much on the quality of local teaching and supervision. Training is often an ad hoc mixture of tasks, not a comprehensive preparation for a role.
6.7. Training does not always relate to the needs of the patient/service user

6.7.1. Some training programmes encourage the impression that caring is a list of tasks, rather than a skill which involves compassion and the ability to adapt to someone’s needs. An HCA at one of our focus groups claimed that in her hospital the training said to “let people fall” rather than to catch them and risk injuring yourself. “This,” she commented, “goes against every caring instinct.”

“We value compassion and personal skills. But you can train that out of people if you insist too much of doing things in a certain way, feeding everyone at a certain time or taking everyone to the toilet after every meal is not respecting the individual or their dignity.” (Care home manager)

“We expect the workers to know enough about each resident’s medical condition, the appropriate therapeutic regime, awareness of the importance of appropriate medicines, their diets and allergies and of course, the crucial relevance of nutrition and hydration, as well as to keep and share appropriate records. Often, the role is one of brokerage and representation, not something which is apparent in most training programmes.” (Judy Downey, Relatives and Residents Association)

6.8. Training can reinforce professional silos rather than contribute to team-building and shared responsibility

6.8.1. Support workers and HCAs are often last in line for training, reinforcing divides between different groups.

“In terms of training we often find that we come after others; if there is online training that must be done, we often do not get the time to do it and other nursing staff are prioritised. We also find that Trusts put on training which is suitable for us as front line staff but then say “for qualified staff only”: but actually it is very important that we understand that topic.” (Submission to Review from group of 26 HCAs currently studying to gain a diploma)

6.8.2. Given their importance to patient safety, excluding them from key training may not be a sensible use of resources.

6.8.3. In addition it is clear that society is increasingly going to need a flexible workforce that can operate across the boundaries of health and social care, with more and more shared knowledge. While a huge range of different skills is required in different settings, some will need increasingly similar core skills. A community facing support worker, for example, may need to learn how to monitor vital signs; the hospital and healthcare assistant will need to learn about personalisation and discharge.

6.8.4. Social care employers increasingly feel there is a core of knowledge and skills common to both health and social care: and that these should be taught in the same way to everyone, in the same language.
6.9. **Caring does not feel like a career, with clear routes to progress**

6.9.1. Some care home owners have told us that they are directly competing for staff with local supermarkets and high street shops. Yet health and social care do not yet offer the kind of clear, simple career ladders available to staff who join Tesco, or Specsavers. A school-leaver with few GCSEs can join a high street optician as an optical technician and work their way up into administration, management, or optometry. Such commercial companies routinely train staff in customer service—something that social care organisations such as the Caring Homes Group are beginning to do. A clearer career path in health and social care would make it easier to attract and retain staff; particularly given the pay rates. At the moment, many workers are not sure they can see the way forward.

6.9.2. The concerns detailed in this section suggest that there is an urgent need for a rigorous quality assurance mechanism to link training to outcomes; for consistent national standards; and for a clearer career path. They also suggest that NVQs were too inflexible. The Qualifications and Credit Framework (QCF), the national credit transfer system for education qualification in England, Northern Ireland and Wales, has now replaced the National Qualifications Framework and is designed to provide greater control over what is learned, and how. Some social care employers we spoke to welcomed the greater flexibility offered by QCF; others felt that it was too complicated; many others had not heard of it.

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### Qualifications and Credit Framework

The Qualifications and Credit Framework (QCF) is a structure that shows how the different types of qualifications interrelate and allow credit from assessments to be transferred flexibly between qualifications.

The Office of Qualifications and Examinations regulation (Ofqual) work with the government and are responsible for regulating QCF qualifications and assessments to maintain standards.

Every unit and qualification in QCF has a credit value (where one credit represents 10 hours of learning time). There are three different sizes of qualification:

- **awards** (1 to 12 credits)
- **certificates** (13 to 36 credits)
- **diplomas** (37 credits or more).

In addition, each qualification has a level of difficulty from Entry level (Key Stage 3) at the bottom to Level 8 (Doctorate) at the top.

If a qualification includes a unit that has already been awarded, the unit already taken can be put towards that qualification. Units awarded by different awarding organisations can be combined to build up qualifications.
6.10. What the best organisations are doing:

6.10.1. The Review has heard from a wide range of organisations, some of which are leading the way in terms of their thinking about how to ensure that HCAs and support workers treat people better, consistently. This involves:

- Recruiting people with the right values, attitudes and behaviours
- Training people how to be kind and responsive as well as how to carry out a list of tasks
- Setting high minimum standards with ongoing supervision

6.11. Recruiting for values

6.11.1. Many experts interviewed by this Review have said that they do not think it is possible to train people to be caring, if they do not start off with the right attitude and aptitude. To get the right quality of care, it is therefore vital that the right people are recruited to caring roles.

6.11.2. The next three case studies describe organisations which have increased staff retention and user satisfaction by ensuring that new staff understand the reality of caring roles before they start work, and by testing their aptitude for caring. The success of these schemes suggests that in social care especially, organisations which recruit for values may start to find this an excellent way of differentiating their offer to the public.

Case study: MACINTYRE

MacIntyre is a national charity providing support and care for people with learning disabilities. Working with an occupational psychologist, they profiled high-performing staff members to identify character traits. This showed that they had a distinctive psychological profile: more empathetic and also more introverted, in the sense of being more reflective, observant and principled in the service of others. From this, they created the "MacIntyre Profile", which is used when recruiting all new staff. The approach makes no assumptions that previous experience will bring better support staff, but rather focuses on a person's predisposition to care work and more importantly, to working in a facilitative and reflective way.

MacIntyre has found that this approach has led to better staff retention, less sickness and absence and fewer performance management issues. Families of users have commented positively on the quality of care and support received.
Case study: YORK NHS FOUNDATION TRUST

York Hospitals NHS Foundation Trust noticed high attrition rates amongst HCAs three years ago, and decided to start recruiting for values rather than for training. York dropped the requirement for applicants to have an NVQ and made all potential applicants attend Open Days where talks and videos explained the job in detail. York also introduced a longer induction, and a buddy system. Since the new measures were implemented:

- turnover has been reduced from 17% to 12%
- sickness has reduced from 8% to 5%
- the "did not attend" rate for interview has dropped from 25% to 0%; suggesting that those who apply are the ones who understand and want the job.

Case study: HERMANN MEMORIAL HOSPITAL, TEXAS

This successful American hospital chain uses the Hartman Values Profile Tool in recruiting nursing staff both Registered and Enrolled. The tool is an axiological inventory (philosophical study of values) that measures a person’s capacity to make value judgements concerning the world and themselves.

Hermann Memorial states that the use of this tool has resulted in higher staff performance and increased quality of patient care; it has also reduced staff turnover by between 25% and 33%.

6.11.3. These kinds of recruitment approaches are something that all employers should be considering. Some already do it intuitively; several care home managers have described to the Review the way they ask candidates about caring experience in their own lives, and watch how interviewees interact with residents. But as Bill Mumford of MacIntyre says, thinking of caring as a “vocation” can underestimate the psychological make-up required for emotionally demanding jobs.

6.11.4. This Review welcomes the Department of Health’s commissioning of the National Skills Academy, Skills for Care and MacIntyre to produce a value-based recruitment tool for the social care sector. This has been tested by employers and has been positively received. It will be rolled out in summer 2013 and will be available to all employers in the sector on a trial basis whilst it is refined and further developed.

6.12. Training people to be kind and responsive as well as competent

6.12.1. Some patients and user groups complain that staff treat caring as a list of tasks to be achieved, whereas real caring is the ability to adapt to each person as an individual. Many organisations are exploring ways to train staff to put themselves in the shoes of others, and to actively reflect on their own practice. Here are three examples:
Case study: MACMILLAN

While patients find it hard to define ‘dignity’ or ‘respect’, they are nonetheless very aware of behaviours that signify their opposite. The Macmillan Values Based Standard has been developed through an 18 month engagement process with over 300 healthcare staff and people living with and affected by cancer across the country. It is structured around eight behaviours that can be used as indicators of service quality. These are designed to effect positive change in staff/patient relationships, to drive up performance – especially in patient experience, satisfaction and outcomes – and protect care rights. The eight behaviours are:

- Naming – “I am the expert on me”.
- Private communication – “My business is my business”.
- Communicating with more sensitivity – “I’m more than my condition”
- Clinical treatment and decision-making – “I’d like to understand what will happen to me”
- Acknowledge me if I’m in urgent need of support – “I’d like not to be ignored”.
- Control over my personal space and environment – “I’d like to feel comfortable”.
- Managing on my own – “I don’t want to feel alone in this”.
- Getting care right – “My concerns can be acted upon”.

For each of these areas, the Macmillan Values Based Standard includes an associated list of staff behaviours, leadership behaviours, and prompts to encourage staff to set themselves personal goals that challenge what they do on a day-to-day basis.

Case study: GREAT INTERACTIONS

‘Great Interactions’ is a project developed by MacIntyre that involves observing and videoing the “natural” staff who are best at building relationships with users, then using that information to develop a recruitment, training and development strategy to help all frontline staff emulate the naturals. It focuses on making staff more reflective about their practice while learning ten facilitation skills, the soft people skills, which provide a better understanding what it means to deliver personalised services centred on the individual.

Case study: BARBARA’S STORY

Guy’s and St Thomas’ NHS Foundation Trust have developed a powerful, award-winning film about Barbara, a woman with dementia. The film tracks her experiences during a hospital visit and shows how “it’s the smallest things that can make the difference”: the nurse who is kind to her is doing something that staff who are carrying out their tasks perfectly well are not. Almost every one of Guy’s 12,000 staff has now watched this film as part of an innovative training session; and reports are very positive.
6.13. Setting high minimum standards with ongoing supervision

6.13.1. The best employers in health and social care are developing longer, more rigorous induction programmes, linked to continuous professional development with high expectations. York Hospitals NHS Foundation Trust has created a two week induction period for HCAs, with a heavy focus on values, personal responsibility, care and compassion. This leads to a preceptorship (supervised training period) of one year, where every new recruit has an experienced HCA buddy and a registered nurse mentor. York is currently looking at how to get its training accredited, so that the HCA gets a recognised and transferrable qualification at the end of the first year.

6.13.2. St Christopher’s Hospice, one of the leading organisations in palliative care, runs a week – long induction in which potential staff are closely supervised, both in groups and individually, interacting with elderly people and with each other. Staff are only offered jobs if the management are in unanimous agreement about their attitude, commitment and potential. Supervision is rigorous and ongoing throughout a career.

“We do all our training ourselves. If you’re going to train someone properly you’ve got to be a role model, you go out with them and show them how to do it. When we have clients who need two carers, I go and be one.” (Deborah Holman, Advancing Practice Nurse and Social Care Project lead, St Christopher’s Hospice)

6.13.3. Lancashire Teaching Hospitals NHS Foundation Trust runs an eight-day induction before HCAs can operate in clinical areas, after which they are mentored on the wards and have

6.13.4. Heart of England NHS Foundation Trust has developed a series of online knowledge test for doctors and nurses called Virtual Interactive Teaching and Learning (VITAL). Nurses are expected to repeat the (randomised) questions until they score 100% on 14 elements of basic care. The Trust has tested this with other hospitals, and is now developing a version for HCAs, who will be expected to score 100% within six months of joining.
Within the military the role of the HCA is unique to the British Army and they are members of the Queen Alexandra Royal Army Nursing Corps (QARANC), working as an integral part of the multidisciplinary team and in close partnership with the Registered Nurses specifically to care for both civilian and military patients in the UK and overseas.

New recruits to the Army have 14 weeks basic military training. Would-be HCAs then spend a further 14 weeks on a training package where the constant emphasis is ‘the patient is the centre of their care’. “They all understand very early in their career that ‘care’ is not a list of tasks but is about communicating with and involving our patients at all levels.” (Capt Alison Game, Queen Alexandra’s Royal Army Nursing Corps)

Additionally they also mandate City and Guilds Diploma Level 2 in Clinical Healthcare Support (CHS) which all HCAs start whilst in their 14 week training programme. They are expected to complete within one year.

The Army is an accredited centre for City and Guilds. It trains its own Assessors and Verifiers within the military in order to allow HCAs to access and complete the Diploma Level 2 in CHS wherever they are required to work, and progress to Level 3 in a similar way. The military HCA career path moves on beyond Diploma Level 2 and 3 if they wish to, if they are suitable and are recommended, to Foundation Degree and Assistant Practitioner.

The military HCA has knowledge and skill sets that enable them to fully understand and apply the theory to the practice, which ensures all patients get the right care, in the right way, at the right time. By continuing to maintain both their theoretical and practical competences through their Diploma work and skills updates they are the heart of the care team within the QARANC.
6.13.5. It is striking that the Army sets high standards for its HCAs and sees them as an integral part of the team, with joint training. The army is also scrupulous about assessing its staff. For no matter how many training courses someone has passed, at the end of the day, there is no substitute for standing next to someone and observing them at work.

6.13.6. At University Hospitals Birmingham NHS Foundation Trust, members of the "Dignity in Care" team of highly trained registered nurses will periodically spend two to three hours simply observing staff practice in a single hospital bay. They will intervene to stop bad practice, but otherwise they simply report back to the Chief Nurse on the interactions they observed between staff and patients, and whether that particular ward is a good environment in which to train other staff.

6.13.7. In social care, some leading organisations are also seeking to achieve high standards of training and ongoing supervision through innovative use of technology, combined with face to face observation, to keep costs down.
Case study: HC-ONE

HC-One provides dementia, nursing, residential and specialist care for older people, with homes located throughout the UK. The company was created as part of the rescue of care homes formerly run by Southern Cross. The much-publicised demise of that operator left HC-One with a legacy of low morale among staff and its inevitable risk to service quality. But the new business has risen to the challenge and placed a culture of kindness at the heart of its work to re-engage and re-invigorate staff.

By focusing on kindness, HC-One is recognising the crucial vocational aspect of being a care professional. In the outcomes of the 2013 annual staff survey, colleagues overwhelmingly cite "making a difference to people’s lives" as the goal that is most important to them.

HC-One has created an innovative blended corporate learning programme called 'touch', to support colleagues throughout the organisation. Touch delivers a wide range of mandatory and specialist learning courses though e-learning, video, podcasts and other online formats, including ground-breaking courses in dementia care and dignity. It also blends a wide range of conventional training approaches such as workshops and supervisions.

Personal accountability is the heart of safe and kind care, and HC-One has made staff learning and development a key driver of this principle. Touch learning materials place the emphasis on what is expected of you, and on your responsibility for ensuring good practice. Personal accountability also means having the confidence to speak out if you think something is not right, and touch is supporting that.

HC-One is also using touch to promote involvement. Throughout the learning materials, case studies and scenarios are used to connect training to the everyday work experience of carers.

HC-One is using its touch learning and development platform to promote partnership working and the development of effective role models at every level. Touch learning activities are specific practical exercises that colleagues complete in the home where they work, often under the supervision of a more experienced colleague. HC-One is also developing a range of support tools for Home Managers and shift leaders to help them promote good practice and personal development within their teams.

Seven months since its launch, over 90% of colleagues are active participants and have between them completed a staggering 140,000 online courses (plus a huge number of workshops and other face-to-face training assignments). A detailed evaluation of the learning experience has been completed by more than 4,000 colleagues, who give average approval ratings over 90% across a range of measures of quality and effectiveness. In the 2013 staff survey, colleagues were asked 'what is the best thing HC-One has done for you this year?' The top answer was 'training'. As care worker Tanya Welch puts it "touch has generated great enthusiasm and is helping our work on a daily basis".


6.14.1. We have seen that the current system is not working well for many employers, especially small employers in the care sector, who struggle to navigate the minefield of funding and qualifications. It does not provide adequate safeguards for the public. Nor does it help support workers to demonstrate transferable skills. Lack of faith in qualifications, and the lack of central quality assurance mechanism, has led to duplication and wasted resources.
6.14.2. We have also seen leading employers are more ambitious for their care support staff, recruiting them on the basis of aptitude, then training them to higher standards as part of ongoing supervision and assessment and career progression. These measures seem to have the effect of increasing staff engagement and reducing attrition rates, and therefore cost.

6.15. Set a higher standard

6.15.1. The Review does not wish to place overly onerous burdens upon employers, given the harsh financial environment. There is no point making demands on employers which are not heeded or which put good, small care homes out of business. But several large care organisations, social care trade associations and NHS Trusts have told the Review that they would welcome a system of agreed national core competences for their staff, both at and beyond the minimum, to which they could then add their own modules and values. They believe that these would help to improve safety, raise the status of caring and potentially save money.

“Transferable and nationally-recognised certification would be immensely valuable both to the employee and the service provider. It would go a long way towards standardising practices and lift basic standards. It would not only reduce the cost of constantly duplicating training, but also create a national standard under which all staff would have to operate.”

(Chai Patel, Chairman, HC – One)

6.15.2. The Review concludes that the system should be more ambitious in the standards demanded of support workers, and in the support given to them. But the system should also be more ambitious in another way: it should seek to bridge the divides between health and social care, and between healthcare assistants and registered nurses.

6.16. Train the caring workforce as one workforce

6.16.1. What is striking about the training of the caring workforce is that individuals are being taught different courses, or bits of courses, in silos. Yet from the public’s point of view, it would surely make more sense to teach care workers the fundamentals of care in the same way and in the same language. Why is every care assistant not learning the best way to lift or move someone safely, from the experts? (The Review heard from one trainer who believes that many lifting and handling courses are inadequate). Why is every care assistant (to whom it is relevant) not learning the latest way of understanding dementia, from people who have figured out how to communicate this simply and powerfully? Why are healthcare assistants in the NHS not learning the same fundamentals of care jointly with registered nurses, in the same language? Nurses already learn basic life support/resuscitation, infection control, moving and handling, and other elements of fundamental care. There is no reason why that learning should be acquired by nurses and HCAs in different places, using different curriculums.

6.16.2. Training people in different places, to varying standards, is inefficient. It is also a safety risk. This is something that the aviation industry figured out long ago.
Case study: “HUMAN FACTORS”- TRAINING IN THE AVIATION INDUSTRY

In the 1970’s, US investigators discovered that more than 70% of air crashes involved human error rather than failures of equipment or weather. A National Aeronautical and Space Administration (NASA) workshop examining the role of human error in air crashes found that the majority of crew errors consisted of failures in leadership, team coordination, and decision making. Some errors stemmed from no one questioning the word of the Captain.

In 1980, United Airlines created a formal training programme which combined technical and human factors training. This started in the cockpit but gradually moved to encompass the whole “crew”: flight attendants, mechanics, dispatchers, and everyone who had a responsibility for the safe completion of the flight. This has become known as Crew Resource Management (CRM) training: it was adopted by British Airways in 1989 and is now mandatory for commercial airlines.

CRM supports the avoidance, management, and mitigating of human errors. The secondary benefits of effective CRM programmes have improved morale and enhanced efficiency of operations.

6.16.3. Airlines realised that passenger safety improved when everyone whose job had any bearing on safety shared an explicit common goal, and common training. Today, airline’s cabin crew, engineers and pilots undergo the same technical and human factors training, in the same room at the same time. This helps reduce the sense of hierarchy, and make people feel more comfortable in challenging each other.

6.16.4. There is a powerful analogy here with health and social care, where patient safety should be paramount but where training is currently fragmented. This is neatly put by Professor Martin Green:

“On something like infection control, if you get it right you get it right. When we fragment training (across the sectors), it causes problems, because everyone is not on the same page.”
(Professor Martin Green, CEO, English Community Care Association)

6.16.5. Infection control is a good example of something that should be taught effectively, in the same way, to every member of staff. In 2007, Methicillin-resistant Staphylococcus aureus (MRSA) bloodstream infections and *Clostridium difficile* infections were recorded as the underlying cause of, or a contributory factor in, approximately 9000 deaths in hospital and primary care in England. Healthcare-associated infections are estimated to cost the NHS approximately £1 billion a year. And the risk of infections is rising in social care, as more and more invasive procedures are performed.

6.16.6. The opacity of the language of vocational qualifications, and the profusion of training courses and modules, has obscured that fact that there is a simple common core of knowledge – such as infection control – that most support workers need to learn to ensure public safety. Moreover, the widespread assumption that support workers are lowly figures who cannot understand certain concepts has obscured the potential for teaching them within the clinical team, especially with nurses who ought to be setting the standards. Whether it is first aid, infection control, how to prevent a pressure sore, or how to communicate with someone with dementia, the same techniques should apply. The fact that

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41 NICE clinical guidelines, March 2012
nurses need to learn additional skills, such as medicines management, should not mean that more basic learning cannot be shared.

6.17. The "Certificate of Fundamental Care"

6.17.1. There is now an opportunity to raise standards, improve transparency, reduce duplication, raise the status of caring, and bridge divides in the system, by creating a “Certificate of Fundamental Care”. This would encompass the minimum competences that support workers in health and social care should achieve before they can start working in intimate caring roles. It should build on what nurses already learn, rather than being developed and delivered in a separate silo. It would mark a fresh start to assure public safety and raise the status of caring.

6.17.2. The “Certificate of Fundamental Care” would build on the National Minimum Training Standards (NMTS) developed and published by Skills for Health and Skills for Care, in March 2013 as part of its response to the Francis Inquiry. These suggested the minimum content that an HCA or support worker should know.

6.17.3. The Certificate should be written in plain English and be accompanied by guidance written in plain English. This is very important to reassure the public: some employers and experts who were consulted about the minimum standards complained to the Review about the bureaucracy and opaque language involved.

6.17.4. The content of the Certificate would be linked to the National Occupational Standards, with a more transparent emphasis on what most matters to patients and the public. The Alzheimer’s Society has made a strong case to the Review that dementia training should be a mandatory requirement, since providing care to people with dementia is now “a core business of healthcare and care workers”.

6.17.5. Support workers surveyed by UNISON agreed, wanting the NMTS to include compulsory training on dementia and mental health issues. The proposed minimum standards currently include dementia training as an option in the glossary. This takes account of the fact that some support workers may be working with children or in other settings where it is not appropriate. However, dementia awareness teaches dignity and communication skills which are relevant to all workers.

6.17.6. Workers who achieved these standards would receive positive recognition in the form of the “Certificate of Fundamental Care.” The term ‘fundamental care’ is more positive than ‘basic care’, which understates the skilled nature of many tasks. “Mandatory minimum”, while accurate, does not give workers the chance to feel pride in their achievements. Achieving the “Certificate of Fundamental Care” should be a badge of honour, a first step on a caring career.

6.17.7. In the NHS, the new standards present an opportunity to bring nurses and HCAs together. The NMC should help determine which elements of nursing education should be drawn across into this Certificate and taught jointly to first year students and HCAs. A few Trusts are already running joint induction for nurses and HCAs: this Certificate should be taught jointly to those groups, and wherever possible to care support workers in the same place. Ultimately, this Certificate should also be made

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43 Skills for Care/Skills for Health consultation on code of conduct for adult social care and healthcare support workers. Feedback from UNISON’s survey
available to volunteers and family carers, who shoulder so much of the caring burden – which in turn would help to promote transparency and quality.

6.17.8. Of course, the suggestion that this new training be grounded in the nursing curriculum raises questions about whether nurse training itself is fit for purpose. Concerns have been expressed to the Review, by some NHS Trusts and HCAs, about the variable quality of practical nurse education. These concerns echo the comments of the Willis Commission about student placements. The higher education partnerships being developed by University Hospitals Birmingham NHS Foundation Trust, and separately by Heart of England NHS Foundation Trust, are a sign that leading Trusts want to take greater control of the practical elements of the nursing curriculum. The views of those Trusts will be particularly relevant to the development of the Certificates of Fundamental Care. For unless practical nurse training in fundamental care is of the highest standard, the junior workforce will not have the right role models or supervision.

6.17.9. The creation of Health Education England (HEE) offers an opportunity both to improve practical nurse education, and to link this to new standards for support workers. This is the first time that a single organisation has had responsibility for all NHS staff education, recruitment, training and development. Through its mandate, HEE is committed to developing a strategy and implementation plan to improve the capability of the HCAs and support workers, working with employers and building on the NMTS. This is also an opportunity to identify the best places to train; and make training a badge of honour.

6.17.10. This Review proposes that HEE should commission the “Certificate of Fundamental Care”, building on the work already done by Skills for Health and Skills for Care. While HEE will need to work in partnership with those bodies, the NMC, and employers, it is vital that the Certificate is not commissioned by committee. However HEE must take full account of the needs of social care, as the largest workforce. Skills for Care will play a pivotal role here, and in mapping to the National Occupational Standards and the QCF. And the five main trade associations in social care will need to play a leading role.

6.18. “Higher Certificate(s) of Fundamental Care”

6.18.1. The “Certificate of Fundamental Care” would only be a first step. No induction training should exist on its own. Good employers link induction to a probationary period, clear job descriptions, supervision and continuous assessment over time. As we have seen, many good employers are now linking induction training to 6-month or year-long probationary periods after which they expect a defined level of competence to have been reached. Some NHS Trusts are also streamlining Bands 2 and 3 to try and get a more explicit, consistent relationship between banding and competence.

6.18.2. As described earlier in this chapter, there is now an opportunity to develop an agreed set of national competences in health and social care which would underpin what could be called a Higher Certificate (or Certificates) of Fundamental Care. To be fit for purpose, such a Certificate (or Certificates) would need to encompass a common core, with modules appropriate to different settings. Over time, the goal would be to develop a clearer, more integrated education offer for health and social care workers.

6.18.3. The “Certificate of Fundamental Care” should mark a fresh approach to training, with a step-change in employer involvement. The best employers, especially small employers in social care, know what
really works on the ground. But they also have little time to attend lengthy committee meetings and little patience with bureaucratic language. This Review has no interest in burdening employers with additional work for the sake of it. The process of drawing up new core competences will only be worth undertaking if employers are prepared to define what knowledge, skills and attitudes they think are most relevant to the frontline and to the future; and do not delegate this work to quangos.

6.18.4. What has been made clear, by some of the most innovative care organisations, is that training needs to embed values from the very start. While the actual skills needed will vary between settings, there should be a golden thread of values running through all training in health and social care. Workers in both sectors are increasingly going to need to draw on similar knowledge and approaches as health and social care integrate: there needs to be a shared set of language and values, drawing in health from the values expressed so clearly in the NHS Constitution.

Recommendations

Recommendation 1: HEE should develop a "Certificate of Fundamental Care", in conjunction with the NMC, employers, and sector skills bodies. This should be written in language which is meaningful to the public, link to the framework of National Occupational Standards, and build on work done by Skills for Health and Skills for Care on minimum training standards.

Recommendation 2: A "Higher Certificate of Fundamental Care" should also be developed, linked to more advanced competences developed and agreed by employers. The Department of Health should hold HEE and Skills for Care to account for ensuring that there is step-change in the involvement of best care employers.

Recommendation 3: The CQC should require healthcare assistants in health and support workers in care to have completed the Certificate of Fundamental Care before they can work unsupervised.

Recommendation 4: The NMC should recommend how best to draw elements of the practical nursing degree curriculum into the Certificate; HEE, LETBs and employers should seek to have nursing students and HCAs completing the Certificate together.

6.19. A rigorous quality assurance mechanism

6.19.1. There is no point in creating minimum standards or national competences unless there is a robust mechanism for ensuring that they produce competent workers with the right values and behaviours. Currently this does not exist. A rigorous quality assurance mechanism is needed, to weed out poor training providers, tie funding to outcomes and user feedback, and put stronger emphasis on the responsibility of the employer to ensure and demonstrate that their staff are suitably trained, backed up by assurance by CQC that fundamental training standards have been met.

6.19.2. Organisations that support registered professions, such as the NMC, RCN and RCM for nursing and midwifery, the General Medical Council and Medical Royal Colleges for doctors and the College of Social Work for social workers, set the standards for training of registered professionals and seek to

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44 The Health Care Professions Council (HCPC) is the regulator for social workers in England.
drive up the quality of the training provided. For non-registered professions, the situation is less clear-cut. Although employers are ultimately responsible for ensuring HCAs and support workers have the right training, but the sector skills councils also play a vital role by linking training standards to QCF and the National Occupational Standards\textsuperscript{45} across both health and social care.

6.19.3. HEE, as reflected in the Government’s mandate, also has a key role to play in driving up the standards of training and improving the capability of this staff group. In developing a strategy to achieve this, HEE will need to work with partners including employers, patients, service users, CQC and sector skills councils. The newly created LETBs also have a direct interest in the quality of the non-registered healthcare workforce, and a small amount of funding to secure training and development for that group. We propose that HEE develop, with LETBs, proposals for validating training.

6.19.4. It is painfully clear that staff shortages and turnover, and low fees paid by commissioners, make it very difficult for some care providers to gather staff together for training, or to provide cover for an individual so that clients receive care while an individual is training. It will be important to find a way to increase the flexibility without compromising the quality and continuity of care. This may be through imaginative use of online training and videos: but there still need to be practical, real-life observations of how staff actually perform.

6.19.5. It is the duty of employers to ensure that their staff demonstrate the right values and behaviours, and are competent to perform the tasks they are asked to do. The NHS Constitution sets out an admirable set of pledges which are simply not being put into practice in too many NHS Trusts. In social care, an equivalent “compact”, or code of conduct, is being drawn up for employers. Both of these will need to be acted upon.

6.19.6. These proposals should also take into account the Quality Mark (QM), a stamp of approval being developed by Skills or Health for the quality of delivery of training programmes. It is currently being piloted with ten education/training providers. The QM is awarded for two years, with a one year mandatory review. If pilots are successful then consideration should be given to whether it is possible to develop a single QM, with Skills for Care, for both health and social care.

**Recommendations**

**Recommendation 5:** HEE, with Skills for Health and Skills for Care, should develop proposals for a rigorous system of quality assurance for training, which links funding to outcomes, so that money is not wasted on ineffective courses.

**Recommendation 6:** Employers should be supported to test values, attitudes and aptitude for caring at recruitment stage. NHS Employers, HEE and the National Skills Academy for social care should report on progress, best practice and further action on their recruitment tool by summer 2014.

\textsuperscript{45} National Occupational Standards (NOS) are statements of the standards of performance individuals must achieve when carrying out functions in the workplace, together with specifications of the underpinning knowledge and understanding. NOS describe what an individual needs to do, know and understand in order to carry out a particular job role or function. NOS are national because they can be used in every part of the UK where the functions are carried out. NOS are developed for employers by employers through the relevant Sector Skills Councils (Skills for Health and Skills for Care).
6.20. Conclusion

6.20.1. Consistent minimum training standards are essential to protect the public. But they also provide an opportunity: to give the public a better understanding of what support workers do, and to develop training which can focus on the core of fundamental care that is common to nursing, social care and healthcare assistants.

6.20.2. Many employers are striving to recruit, train and motivate staff under considerable financial pressure. But the best organisations are showing that taking the time to develop good recruitment and training strategies, with proper oversight, can pay off. It is well known that engaged, well-supported and well-motivated staff deliver better quality care.

6.20.3. 6.20.3. Support workers are often said to be working "under supervision". But the reality, particularly in social care, is that this cannot always be the case. Workers need to be capable of acting independently and making the right judgements in what can be challenging and stressful situation. The best organisations regularly observe them on the job to ensure that standards are maintained.

6.20.4. 6.20.4. There is an opportunity to create more integrated, rigorous training across health and social care to underpin the flexible workforce needed for the future; and to build public confidence by making this transparent and intelligible.