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An Independent Training Needs Analysis (TNA) of the Social Care Workforce carried out on behalf of Cambridgeshire County Council (CCC)

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Introduction to the report:

This report details the key findings from a Training Needs Analysis (TNA) undertaken by Sheffield Hallam University and Community Practitioner Alliance CIC, on behalf of Cambridgeshire County Council (CCC). The purpose of the report is to provide CCC with an understanding of education and training practice, provision, and future requirements for the Care sector currently under their jurisdiction. This will enable CCC to make informed decisions as to what education and training in the Care sector should 'look like' now and in the future.

Background

In line with the national situation, the social care landscape in Cambridgeshire is changing. As a result of the modernisation and transformation agenda and key policy developments over the last decade such as the Care Act (DH 2014), one of the key challenges facing any Council is ensuring a high-quality workforce within the Care 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 CCC to have a motivated and well-trained care workforce that can provide competent client-focused care with skill and compassion.

The 'direction of travel' needed to deliver this significant transformation of adult social care was originally outlined as far back as 2006, 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), which 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. There are a number of key government documents that have an impact upon social care delivery. These documents were 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* published in 2014, these national drivers have since included:

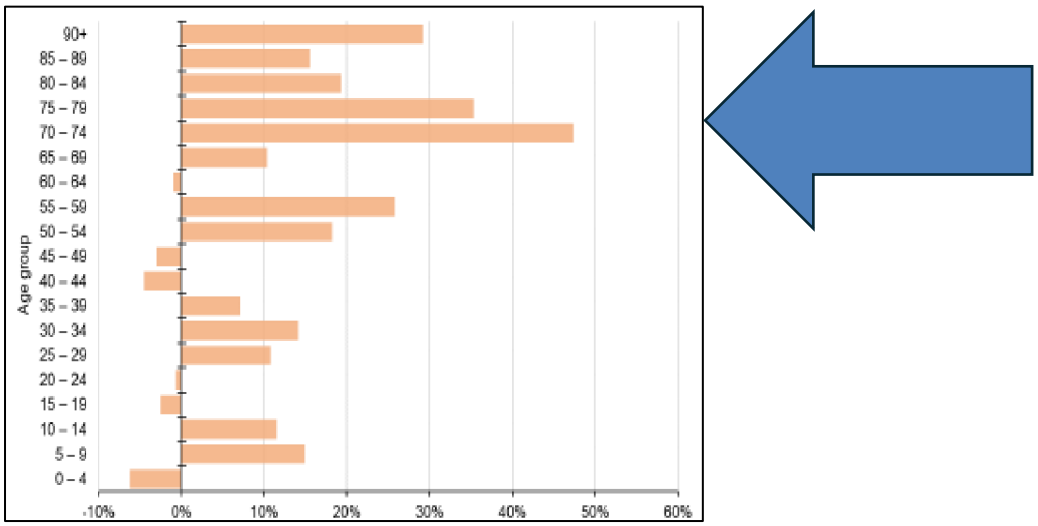
- *A Vision for Adult Social Care: Capable Communities and Active Citizens*
- *Working to Put People First: the Strategy for the Adult Social Care Workforce in England*
- *Living Well with Dementia: A National Dementia Strategy*
- *Caring for our Future: Reforming Care and Support*
- *Framework for Enhanced Health in Care Homes*

Most recently, the publication of the new Skills for Care *Workforce Strategy for Adult Social Care in England* (2024) has placed a renewed, and very welcome, emphasis upon the importance of the social care workforce. In addition, the recently published Darzi report on the NHS (2024) also emphasised the importance of providing 'joined up' health and social care, to prevent unnecessary hospital admissions, particularly in older adults.

Local drivers: CCC demographic data from the 2021 Census

There are a number of local drivers that need to be taken into consideration. According to the 2021 Census, Cambridgeshire has a population of approximately 880,000. Peterborough and Cambridge, located in the north-west and south respectively, are the two main areas of population concentration. The rest of the county is predominantly rural/agricultural in nature.

Percentage change in Cambridgeshire population by age group (2011-2021)



As we can see, the growth in the Cambridgeshire population aged 65+ is significant and is in line with the national trends. However, whilst people are living longer, they are not always living healthily. This has increased the demand for social care nationally, and the need to prevent *unnecessary* hospital admissions is key to the future of the NHS. According to the 2021 Census, Cambridgeshire's population is predicted to grow by ~17% between 2022 and 2041. At the same time, the number of individuals over

the age of 65 is also predicted to increase by ~26%. These increases will inevitably place a great deal of pressure upon social care providers to meet this growing demand. To respond effectively to these challenges and to deliver a high-quality service, CCC needs a well-trained and compassionate care workforce.

Currently there remains a somewhat fragmented and incomplete picture of the training situation across Cambridgeshire, for care homes, domiciliary care and the care sector as a whole. There is limited information on the education and training needs of care staff, and limited awareness and understanding of education and training taking place within the Care sector. Given the need to proactively work with the Care sector to support and shape the development of skills, understanding and expertise within the local workforce.

To address this, CCC commissioned a TNA in summer 2024 for all of the care and support staff employed by contracted adult social care organisations across Cambridgeshire. This was designed to identify training, skills and competencies across the local workforce. The TNA will inform a training plan including specialist training and addressing gaps in needs, with regard to local provision. The Council will use the report findings to commission training for its care sector.

Overarching Aims of the Evaluation

Cambridgeshire County Council (CCC) commissioned the TNA to gain a clearer understanding of the current training landscape for adult social care providers in the county. The overall goal was to assess the skills and training needs of care staff and managers, particularly those working with contracted care providers. This evaluation was essential to ensure that the workforce is well-prepared to meet the growing demand for high-quality, person-centred care within CCC.

Why CCC Commissioned the Report:

At the time of commissioning, there was limited information on the existing training provision for care providers. CCC sought to address this gap by identifying key areas where training was either insufficient or lacking, particularly in specialist areas such as dementia, mental health, and autism care. As the Council emphasised, *"The vision for adult social care requires a workforce with the right skills, knowledge, and behaviours to deliver high-quality, personalised care."*

What CCC wanted to find out:

1. **Identify Training Gaps:** CCC needed to determine where training was lacking across care providers, especially in complex areas like home care, mental health, and learning disabilities. The aim was to ensure that care providers are adequately trained to meet current and future challenges.
2. **Assess Workforce Competencies:** The TNA was designed to evaluate whether care staff and managers had the necessary skills and competencies to perform their roles effectively. This included assessing whether managers were equipped to handle leadership responsibilities, such as communication and fostering a positive workplace culture.
3. **Prioritise Future Training Needs:** CCC sought to prioritise future training needs to ensure that resources are allocated where they are most needed. This included leadership development, particularly for registered managers, with a focus on wellbeing and communication.
4. **Shape Future Training Provision:** The findings of the report will inform future training strategies and help CCC commission targeted training programmes. The aim is to ensure that care providers are equipped with the skills necessary to deliver high-quality care, in alignment with national standards and the Care Certificate.

Study design

Mixed methods research (MMR) is one of the standard approaches to undertaking this type of study, as it successfully combines elements of both qualitative and quantitative methods. This enables the study of complex problems such as workforce development. This type of approach allows us to gather and integrate multiple data sources, and to view a set of problems from a number of different perspectives.

For this particular TNA, a sequential, explanatory-exploratory 'mixed methods' approach to evaluation was chosen. In this two-phase design, quantitative data (the survey) is collected and analysed first, then the qualitative data (the follow up interviews) is collected and analysed to help to explain, contextualise and clarify the quantitative results.

Processes

Following the awarding of the contract to CPA, a first draft survey was developed by the team for discussion. The survey was developed online using Qualtrics© software. Qualtrics© is a recognised software package used for developing and distributing online surveys. Using feedback from the CCC team and other key stakeholders, the TNA was modified a number of times, and the final version agreed between the study team and CCC. Once the final version of the TNA had been agreed and subsequently

beta tested, a series of meetings were held with stakeholders and care providers to publicise the TNA and encourage engagement.

To expedite this, an initial e-letter explaining the TNA was sent to all care providers by email. The CCC care provider database was used to compile a 'working list' of care providers, their managers and email addresses. Alongside this, the team attended three virtual CCC care provider meetings to further raise awareness of the TNA and to encourage engagement. Following the initial email, there were a small number of email 'bounce backs' and other queries caused by incorrect and/or obsolete emails derived from the CCC database.

Once the surveys had been sent out, a reminder email was sent after 7 and then 14 days, and in addition the care providers were telephoned by the team to encourage completion, collect correct contact details and arrange a convenience sample of follow up interviews. The follow up phone calls used a structured approach, with questions developed from the initial analysis of the survey data.

Data collection

Online surveys

Phase one of the TNA began with two online surveys, followed by a number of structured telephone interviews. The Care teams within CCC were initially contacted through an introductory email, which was sent to the nominated manager of the team. This email contained an e-copy of the participant information sheet and an online consent form if required.

1.1: Manager survey

There were two different surveys: a first one for managers and a second one for care staff. The first email contained a link to the managers' survey, which was designed to provide the views of the managers with respect to teaching and learning.

1.2: Carer survey

Subsequently, another separate email was sent with an e-poster. The poster, which could be printed, provided information on the survey, and contained a QR code with a link to a separate survey for all care staff. This second survey was designed to elicit views from the perspective of the care team, as opposed to the management.

2: Structured telephone interviews

At the end of the online survey the respondents were asked if they would be prepared to participate in a further interview and if so to provide contact details. The structured telephone interviews were used to

clarify and expand upon the findings from the surveys. 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 recorded and subsequently transcribed.

3: Governance

Approval for the study was obtained from the SHU Faculty Research Ethics Committee. 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.

Completion of the survey was taken as implicit consent to participate in the study. The information provided in the email 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 should be addressed.

4: Data Analysis

4.1: Online 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© V30.00 software, the online survey data was cleaned and formatted. Basic descriptive statistics (mean/median/mode) and response frequencies were calculated for each question.

4.2: Qualitative Data

The raw data from both the follow up interviews and the free text from the survey were transcribed and cross-checked for accuracy. Once it had been cross-checked, the qualitative 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.

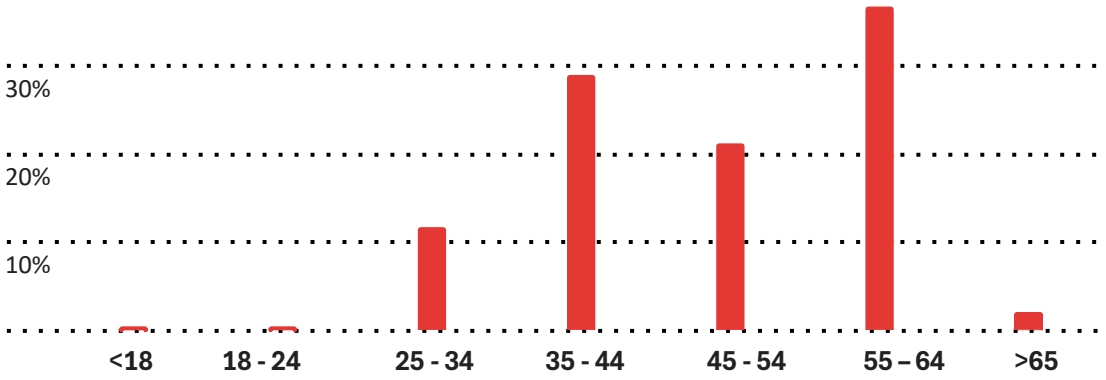
Key findings from the managers' survey:

There were 70 completed responses to the managers' survey out of approximately 170 individual manager email addresses. As already discussed, the directory of organisational contacts was incomplete and out of date and required some degree of 'data cleansing'. This gives a theoretical response rate of 40.4% which is better than would normally be expected for surveys such as this. A response rate of 20-25% would not be unusual for an online survey such as this.

Section 1

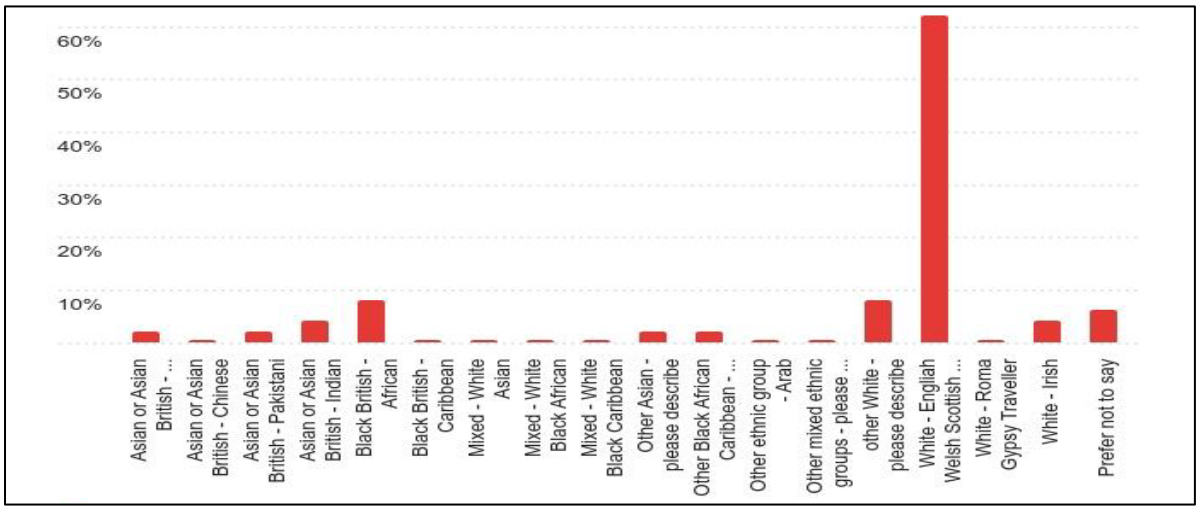
The first section outlined the demographic profile of the managers who responded to the survey. We collected basic data related to *age, gender,* and *ethnicity*. We wanted to get a sense of the general profile of the care provider management workforce.

Age and gender



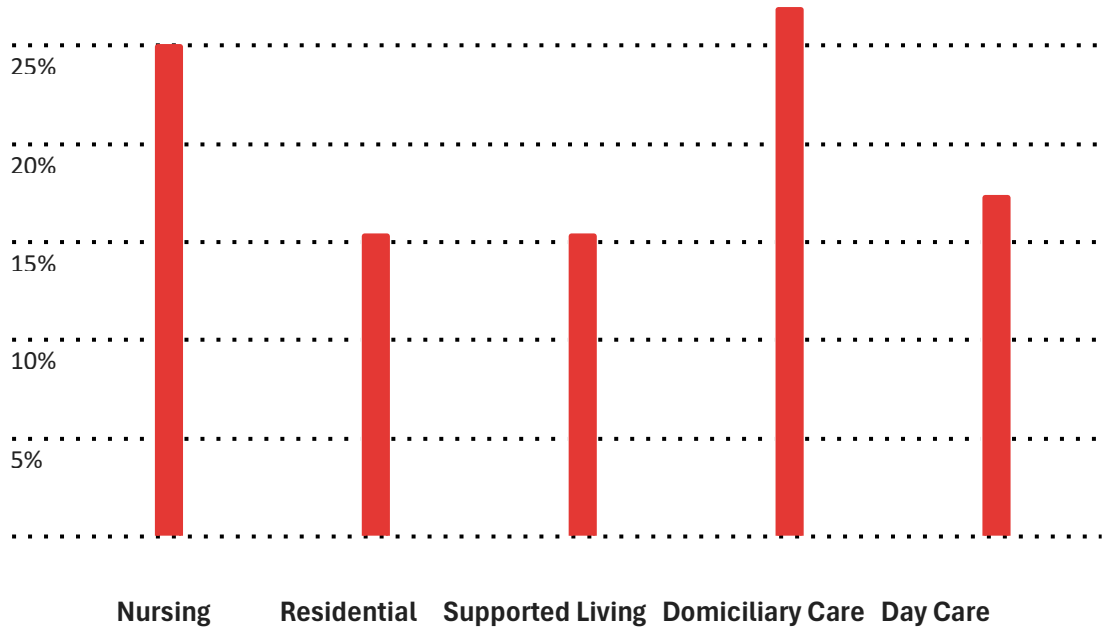
As we can see, the age profile for managers indicates a predominantly 'older' workforce with ~55% being over the age of 45. The peak age profile was between 55-64 (38%) with an average age of 53 years. Interestingly, 0.2% (2 respondents) of the respondents identified themselves as being under the age of 18, and 3% (31 respondents) as being over the age of 65. Whether these outliers are simply anomalies remains to be seen. As expected, the vast majority (84%) of the managers were female. Most of the respondents (82%) worked full time.

Ethnicity



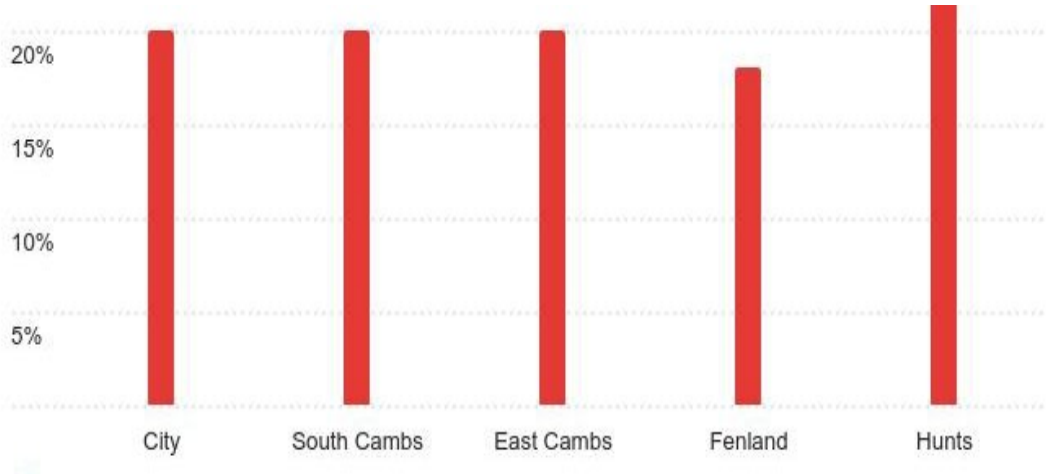
The vast majority (74%) of the respondents identified themselves as 'White'. The other significant ethnicities included 'Black British' (8%) and 'British Asian' (7%). Interestingly, 7% of the respondents chose not to identify themselves.

In what type of care environment do you usually work?



In addition to the type of care environment, we wanted to look at the various geographical areas covered by CCC. Each area is different and has its own unique characteristics and challenges. Within CCC there is a mixture of built-up urban areas such as Cambridge and Peterborough, together with much more rural, agricultural areas such as fenland

In which area of Cambridgeshire do you work?

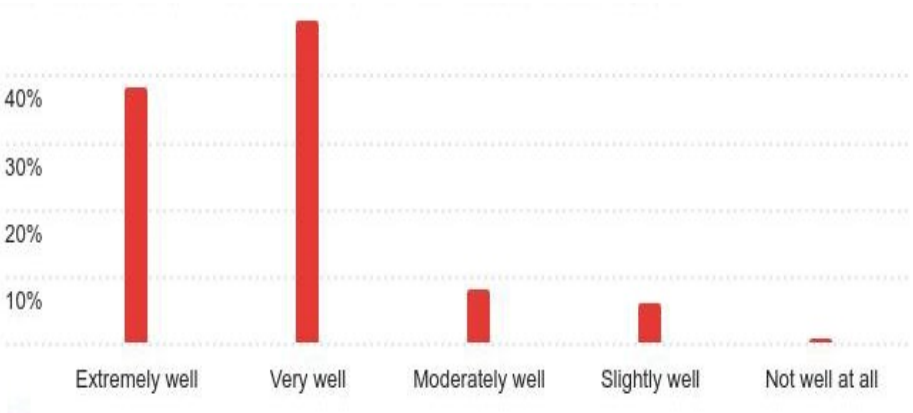


These two questions were designed to enable the cross-referencing of the overall findings (e.g. staff turnover) with both geographical area and type of care delivery. As we can see, there is a reasonable spread between the various areas covered by CCC, which should enable some tentative conclusions to be drawn, despite the small number of respondents in each area.

Section 2

In this second section, we asked managers to give their views on the roles and responsibilities involved in being a 'good' manager. We were interested to know how well prepared they felt for their role, and how this was achieved.

How well prepared do you feel, in general, to carry out your current role?



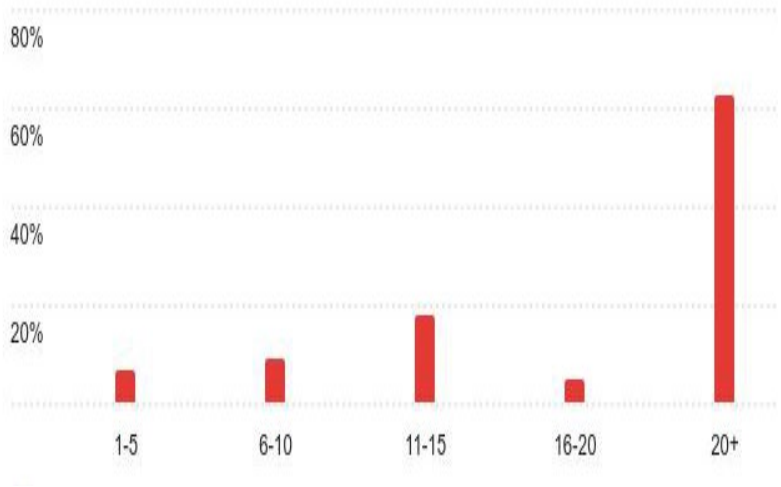
Aggregating the various positive responses indicates that a majority (~88%) of the managers felt appropriately prepared for their roles. The types of qualifications possessed by the managers varied quite

considerably, from GCSE to Degree level training. Interestingly, less than 10% of the managers listed a registered nurse qualification (RN or RMN) in their responses.

We were also interested to know how the managers felt about managing people. The role of a manager in this context is a complex and challenging one and requires a significant degree of day-to-day decision-making, organisational and people skills. The majority of the respondents were responsible for more than 20 staff.

How many staff do you currently manage?

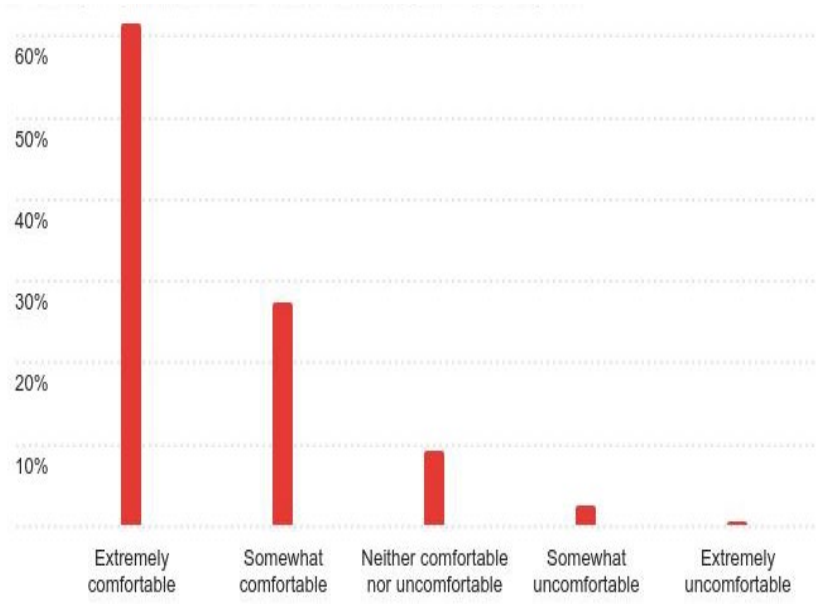
Despite often managing teams with over twenty people, it was clear that most of the respondents felt comfortable in their role, and with managing their team of people.



How comfortable do you feel in managing your team?

Managing people requires a number of different skills, including patience, empathy, good communication, consistency and fairness. We wanted to know what training, if any, the managers had been given to support them in their roles. The positive responses to the question would tend to suggest that training had been provided.

We asked the managers about their training in a number of key areas such as managing complaints, carrying out staff appraisals, supervising staff and managing conflict/difficult conversations. Given the perceived comfort with managing people shown below, the responses to the next question were rather confusing.



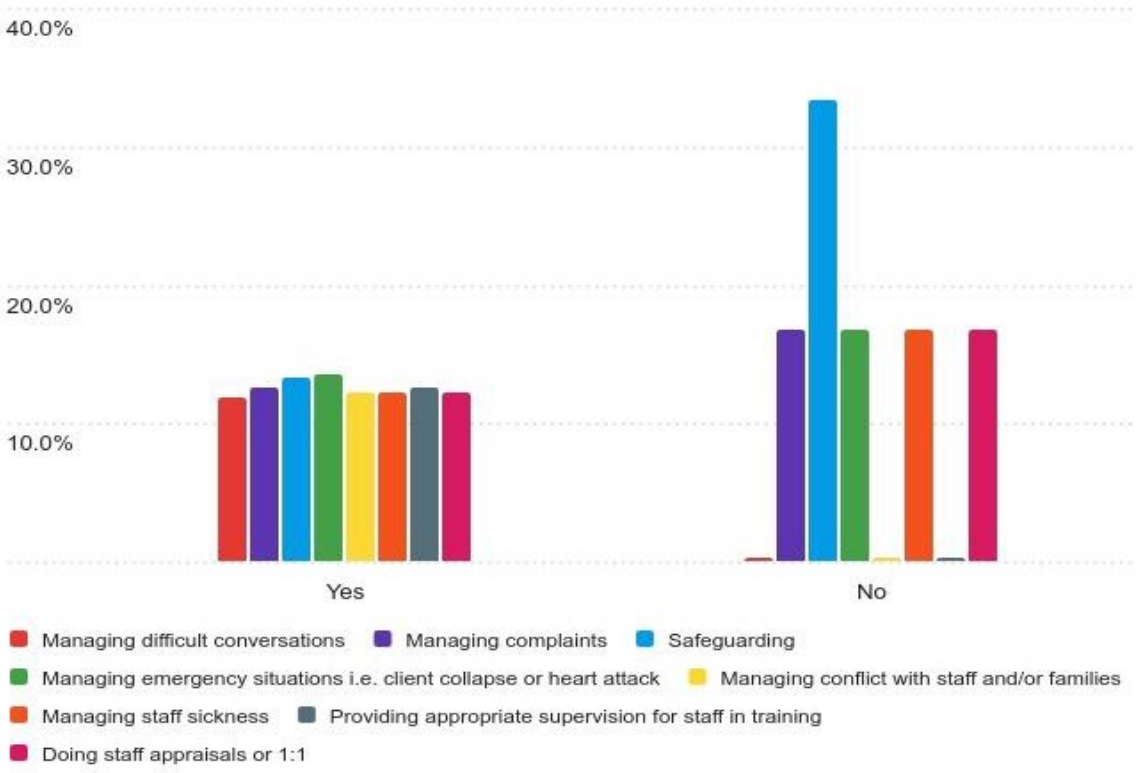
The presupposition would be that managers need training for their roles in the same way as everyone else. To be a successful manager requires the individual to be competent in dealing with the issues outlined above. Whilst confidence is not a proxy for competence, the degree of comfort with management displayed below is interesting, and merits further investigation.

What training have you had for your role as a manager?

The results show the degree to which the managers had been provided with specific management training, and, as we can see below, that much of it was not really appropriate for their needs. The appetite of care

providers to invest time and resources into the manager role is debatable, given the financial pressures 'across the board'.

Was the training appropriate for your needs as a manager?

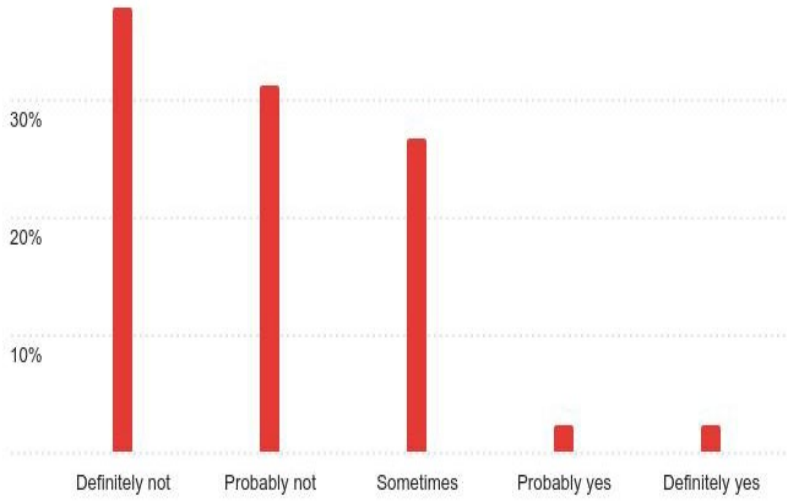


One of the main challenges here would appear to be the provision of appropriate safeguarding training for managers. Throughout the survey, the issue of safeguarding and individual safety is a recurrent theme both for managers and care staff.

Recruitment and retention of care staff

A good proxy measurement for the quality of leadership in any organisation is the degree of staff turnover. One of the most challenging aspects of the managers' role is therefore managing staff retention and recruitment; and this next section looked at the managers' views on this topic. Empirically the turnover of staff in the care sector has always been high, and this was reflected in the responses to this survey. The most recent *Skills for Care* data published in 2023 identified an average yearly turnover rate of 28% in the care sector nationally. Given the high turnover nationally, we wanted to know if staff turnover was actually a problem for the managers we surveyed.

As a manager, is staff turnover a problem to you?

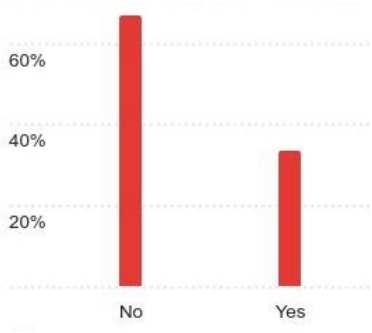


This question provided some interesting results. Whilst the aggregated majority of respondents (71%) indicated that staff turnover was not a problem to them, 26% of the respondents did indicate that staff turnover was a problem for them sometimes. There is some evidence, albeit with small numbers, that this is related to geographical location as much as client group. There was evidence of a variation in turnover within the different areas of CCC. The most obvious variation occurred between the City and Fenland areas. Staff turnover in those care providers covered by Cambridge City Council was much more of an issue for managers than those covered by Fenland District Council. The numbers are small, so it is difficult to draw any firm conclusions on this basis. However, it may be hypothesised that the urban nature of Cambridge CC, the cost of living in the city, and the transient nature of the population, all contribute to this situation.

There are a number of well-documented factors that contribute to staff turnover within the care sector in general. These related to career progression, changes to domestic and/or personal circumstances and disciplinary issues. For example, individuals may use a carer post to gain experience in order to apply for nurse training or other allied health professions. This phenomenon has become more common as the entry requirements for most nurse training courses now include a period of care experience.

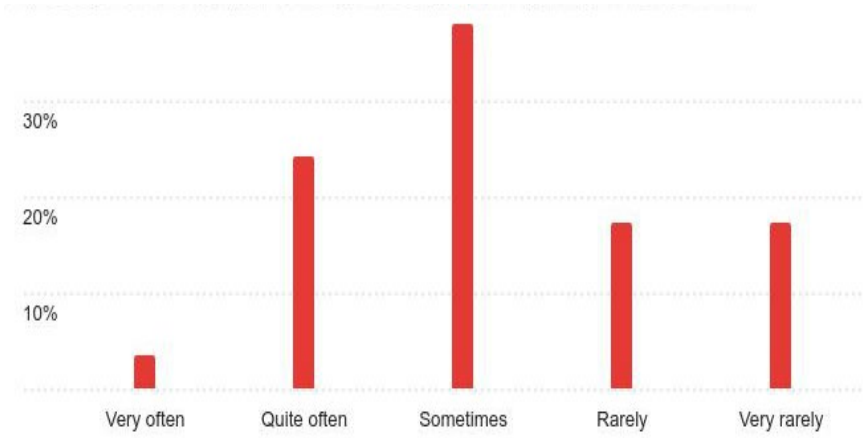
Other key issues that disproportionately affect this sector relate to organising/resourcing childcare, and increasingly, access to reliable public transport. Areas of Fenland for example are very rural in nature, and staff will therefore be reliant upon their own transport to get to and from work.

Have you used agency care staff in the last 12 months?



Despite indicating that staff turnover was not an issue, >30% of the managers surveyed had used care staff agencies within the previous twelve months. The disadvantages of agency staff include increased staff costs and, more importantly, a lack of continuity of care for the residents or clients. This is particularly important for clients with cognitive impairment such as dementia, with a learning disability (LD), or a neurodisability such as autism.

If you need to use agency staff, do you have problems finding appropriately trained agency staff?

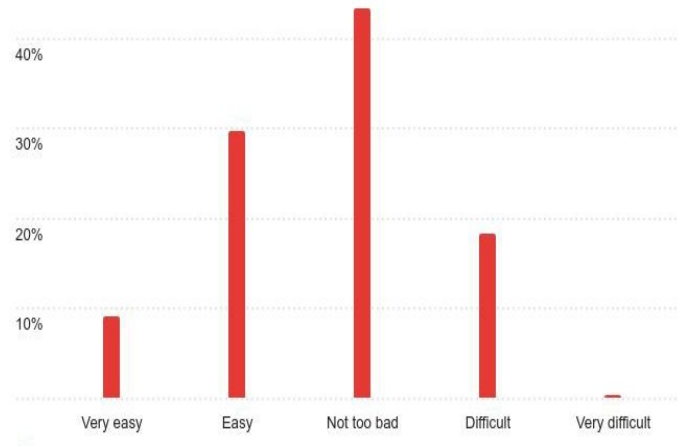


As we can see, the availability of *appropriately trained* agency staff to cover for staff training presents a mixed picture. By aggregating the negative scores, over 50% of the managers identified problems in booking appropriate agency staff to cover shifts. Notwithstanding the need to cover sickness, the ability to 'back fill' staff shifts for education and training is often contingent upon access to agency staff, particularly in smaller facilities. In the absence of agency staff, for whatever reason, the need to release staff for mandatory training may necessitate other staff covering for their colleagues. This situation is far from ideal and presents a potential risk to both client and staff safety if the staff numbers are reduced or colleagues are working overtime to cover shifts.

Approximately 40% of the managers who responded did not have a ringfenced budget for staff training. The financial constraints imposed upon care providers, most of whom are privately run, means that there is a strong disincentive to provide staff training, other than that which is mandated by DHSC or CQC.

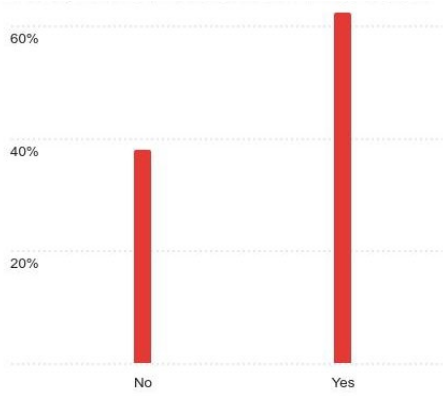
In addition, agency staff may represent particularly poor value for money, not just in terms of the cost to the care provider, but also in terms of the stress involved in dealing with inadequately trained agency staff on a shift. Care providers rely upon the agencies to provide them with staff that are safe and competent in what they do. If not, this raises the prospect of a hidden 'skills gap' in the provision of training for agency staff.

How difficult is it to keep your staff up to date with their training?



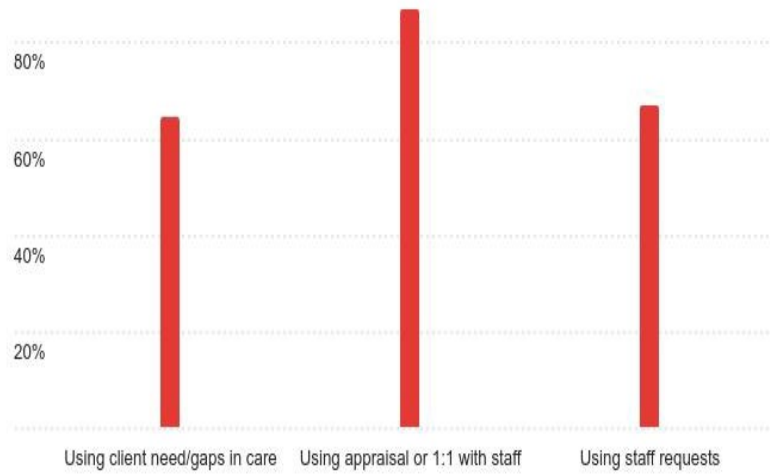
Having said that, the majority of respondents indicated that keeping staff up to date with their training needs was not too onerous a task. Less than 20% of respondents thought that keeping staff up to date was an issue. It would be useful to look at whether there was any link between the size of the facility and the perceived difficulty in keeping staff up to date.

Do you have a 'ringfenced' budget for staff training?



Approximately 40% of the managers who responded did not have a ringfenced budget for training. The financial constraints imposed upon smaller organisations, most of whom are privately run, means that there is a disincentive to provide training, other than that which is mandated. 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. In general, the budget for most types of education and/or training tends to come from the individual home or company. Some of the larger chains do have a ringfenced corporate training budget, however even here there will be constraints upon how and where that budget is spent.

How do you usually identify the training needs for your team?



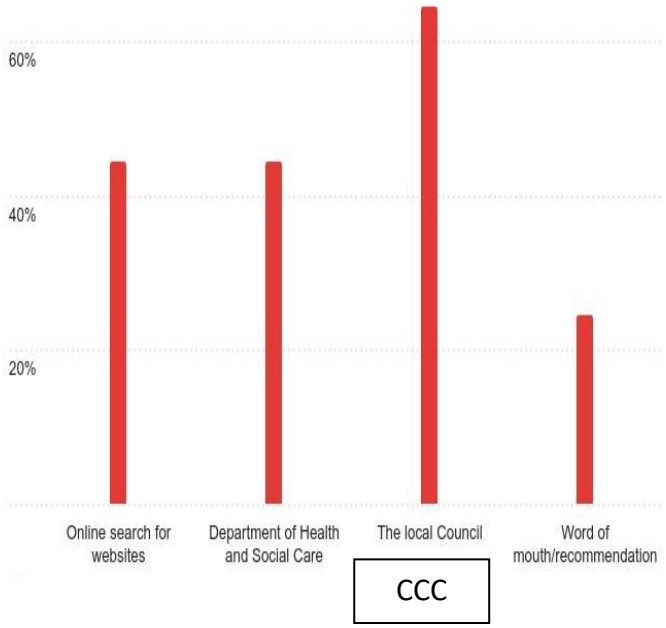
The use of staff appraisals would appear to be the most common way to identify staff training needs. In addition to staff requests, this may be seen as a positive development, as it is important for job satisfaction (and by extension, staff retention) for staff to feel that they have a meaningful say in their own

development. Having identified a need, we asked the managers how they went about finding a suitable course or training programme.

Given how busy the care sector is, the ability to find a training programme quickly and easily is 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.

We asked managers who would be most likely to provide the education or training they were looking for. As would be expected, the majority of the courses accessed by Cambridgeshire care staff were provided by/through CCC (66%). 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, as and when required.

How do you source appropriate training for your team?

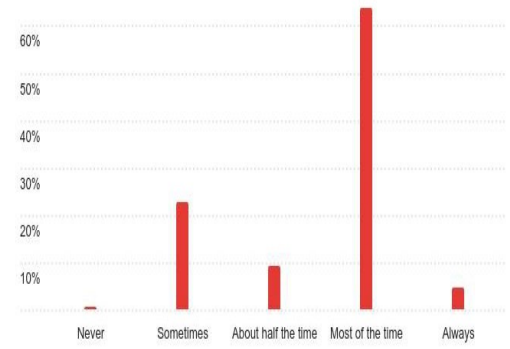


In addition to the fixed costs of purchasing training, there are many other hidden costs which affect the ability of the care homes to provide training for their staff. Therefore, the need to demonstrate value for money and the cost/benefit of any training is vital. There are understandable tensions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

Lone working:

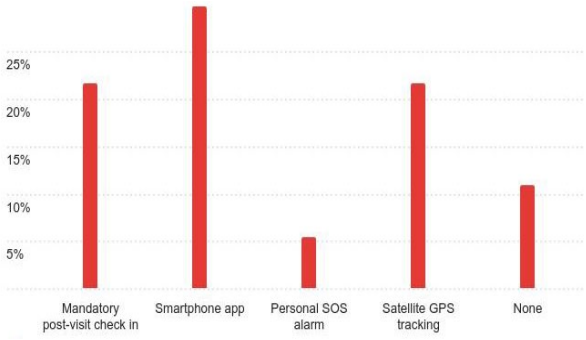
Given the increased emphasis upon health and wellbeing, we were interested in the managers' views on lone working. Over 50% of the managers had staff who regularly worked alone, and there were a variety of views expressed on this subject.

How often do your staff work on their own?



Approximately 15% of the managers were uncomfortable with having staff working on their own, and over 10% acknowledged that there were no specific safeguards in place for lone working. Given the need for appropriate safeguards, we asked the managers what safeguards they had in place for their staff. As expected, safety strategies such as post-visit communication, the use of smartphone apps, GPS trackers and personal alarms were all used.

What safeguards are in place for your lone workers?

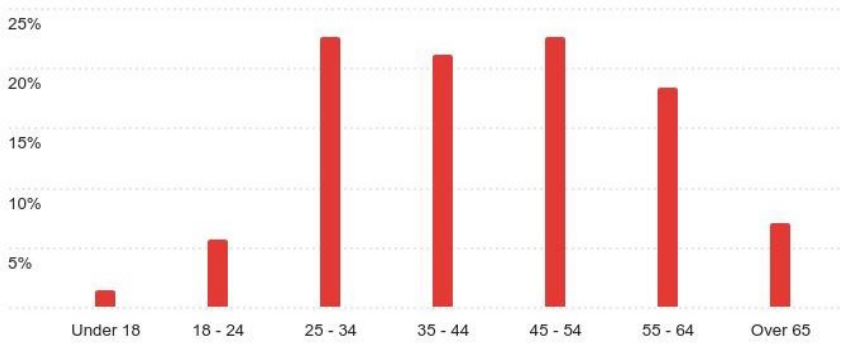


The most worrying aspect of the responses to this question were the ~12% of managers whose staff had no safeguards in place. From a health and safety perspective, the lack of any safeguards presents a significant risk to the workers.

Carer survey:

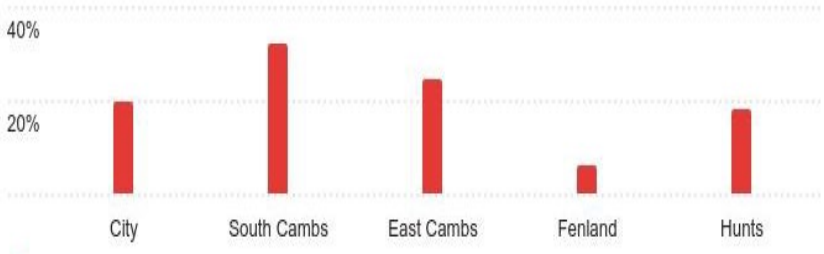
There were 92 completed responses to the carers' survey. The demographic data collected was in line with expectations. The age profile was slightly younger than the manager profile, with an average age of 46 years. In addition, 88% of respondents were female and 58% worked full time.

Age profile



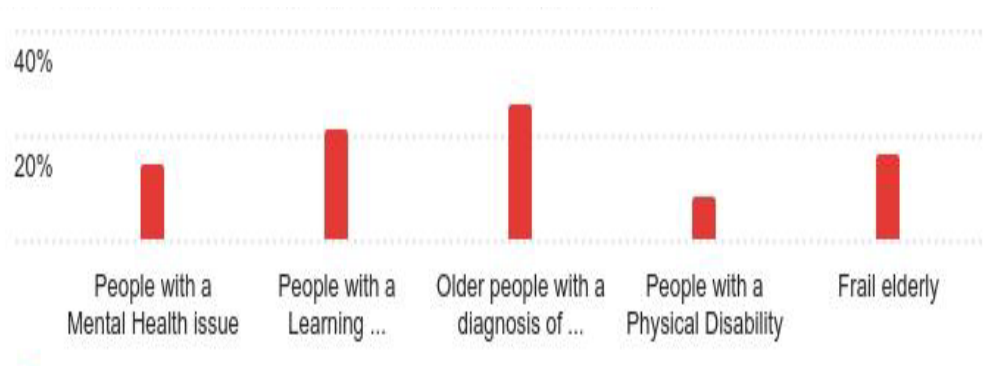
The ethnicity profile for the care staff was similar to that of the managers, with ~70% of respondents identifying as 'White' overall, 14% as 'Asian' overall, and 20% as 'Black' overall.

In which district do you work?



There was a reasonable cross-section of respondents representing each of the five areas covered by CCC, and from each of the different clinical/client group environments.

Which client group do you usually work with?

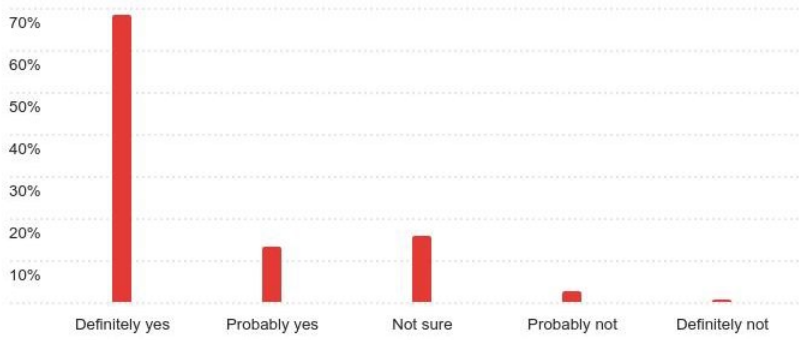


CCC had asked us specifically to look at the views of carers from across the whole spectrum of client groups. There was a reasonable sample from each client group, although there was a predominance of respondents from dementia care, which is in line with expectations.

Section 2

In the next section, we asked the carers about their training experiences. We started by asking them how well-prepared they felt to undertake their role. Over 90% of respondents felt suitably prepared for their roles. In the same vein, we then asked them how beneficial they felt their training had been in preparing them to undertake their role as a manager.

Has your training helped you in your role?

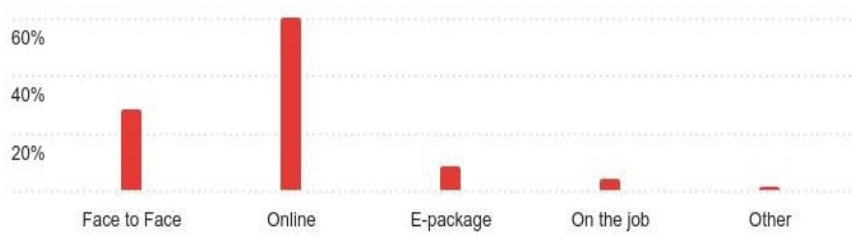


As we can see, when aggregated, an overwhelming majority (81%) of respondents viewed their training as being beneficial to them in undertaking their roles. This is positive and indicates a workforce that is provided with training and sees the intrinsic value of that training.

Preferences for mode of delivery

When asked, the majority of respondents said that, given the choice, they generally preferred training to be delivered 'face to face' either in a classroom setting (43%) or 'on the job' (32%). However, the reality was that most of their training was delivered (a)synchronously online, by e-booklet or e-package. As an example, the delivery used for 'ensuring privacy and dignity' training are shown below:

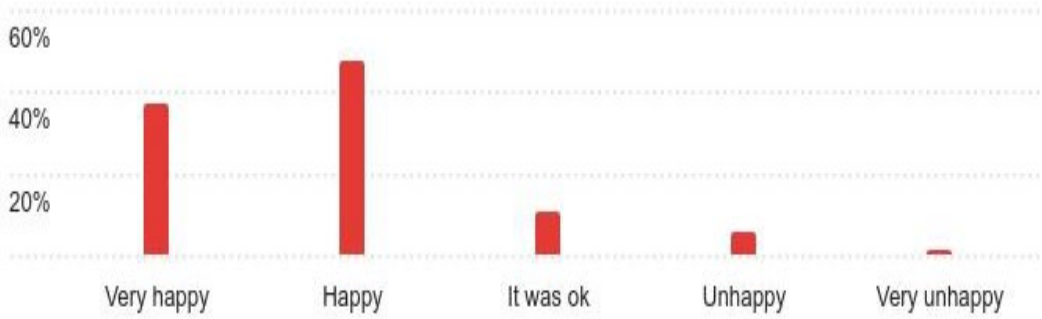
Privacy and Dignity training



However, when the data was interrogated further, it became apparent that, provided the mode of delivery was *appropriate* for the topic, most respondents were happy with the training and the way in which it was delivered. This is nicely illustrated by the responses to two very different Care Certificate topics:

Handling sensitive information: which was delivered **online** in 93% of cases.

Basic life support (BLS): which was delivered **face to face/in the classroom** in 86% of cases.



As we can see, the mode of delivery in each case needs to appropriate for the topic being covered. The aggregated levels of learner satisfaction for each piece of training, and the mode of delivery used, are both generally positive. However, particularly with practical 'hands on' skills, there may be a push for care providers to cut costs by delivering practical training online. In addition to the risks inherent in delivering BLS training online, there may be a temptation to use makeshift manikins rather than those which are specifically designed for BLS.

The inability of commonly used online tutorials to provide 'real time' feedback or correct even basic mistakes as they occur, means that new staff in particular may overestimate their ability to safely and effectively carry out important skills such as BLS or measure vital signs. This may then have serious consequences in real life situations.

Whilst the push for online delivery is understandable, it may actually turn out to be less cost effective than thought. It is suggested that the mode of delivery *per se* is less important than the appropriateness of the delivery to both the topic being taught and the learners. It is important to consider the individual learning styles, where possible.

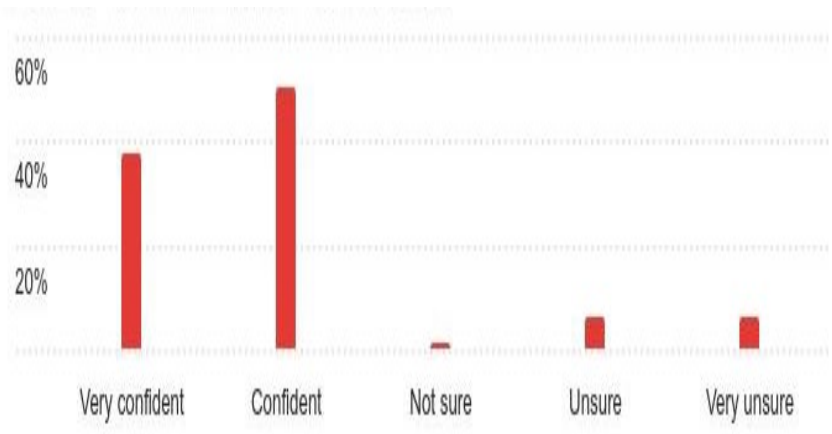
More specialist areas of training:

In addition to the 15 areas of mandated training required for the Care Certificate, we asked the carers for their views on some more specialist areas of training. For example, it was apparent from the managers' survey findings that safeguarding in social care was a significant issue, particularly in domiciliary care and lone working.

Learning disability (LD) training

The longstanding negative publicity surrounding the poor standard of care for adults with LD has resulted in a number of initiatives designed to improve the standard of care. The Oliver McGowan training programme is now mandatory for all Care Quality Commission (CQC) registered providers to ensure their care employees receive learning disability and autism training *appropriate to their role*. This is designed to ensure that the care workforce has the right skills and knowledge to provide safe, compassionate and trauma informed care to autistic people and people with a learning disability.

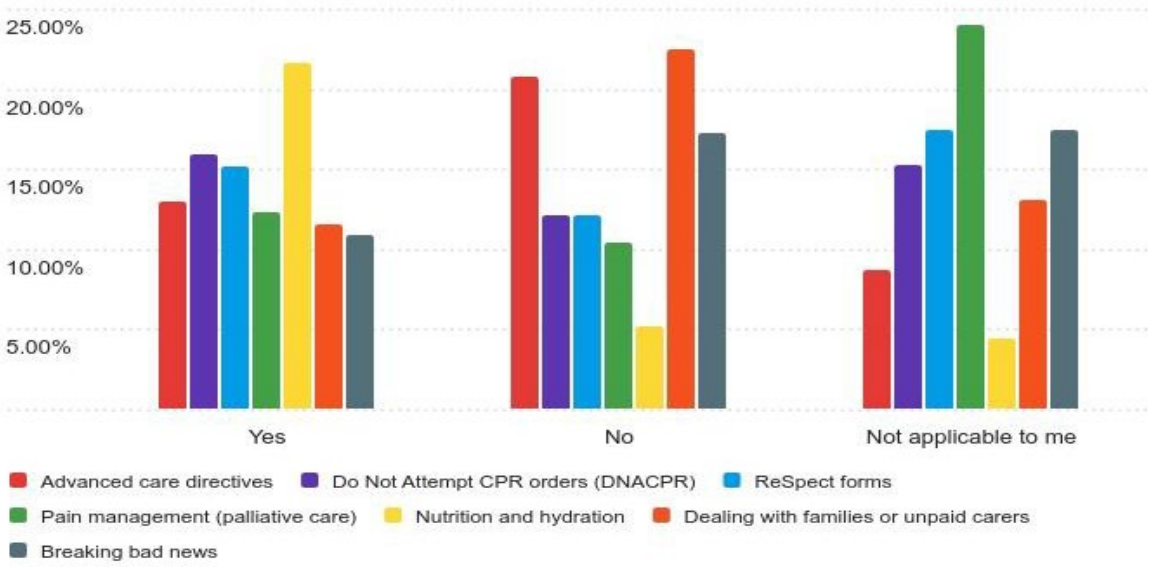
Levels of confidence in safeguarding adults following Oliver McGowan training (tier 1&2)



As we can see, the levels of confidence in caring for individuals with LD and autism arising from the Oliver McGowan training are reassuring. The mixture of online training and classroom delivery seems to work well.

End of life care

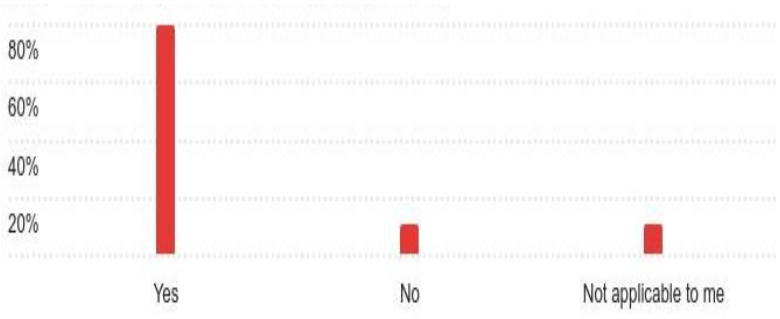
Given that the nature of the carer role will often involve providing 'end of life' care for clients, it seemed appropriate to look at training on the various aspects of the provision of care for people who are dying.



These findings show that relatively low numbers of care staff report receiving any training in end-of-life care. In addition, it is interesting to note that a significant number of respondents indicated that this issue is not applicable to them. Given the nature of the role, it is difficult to conclude that some level of training in end-of-life care would not be of use.

We also asked whether carers had been given any training on the safe administration of medicines or in the measurement of clients' vital signs (such as TPR and BP). The scope of the carer role has expanded in line with increasing demand for home care services, and the need to safely and effectively undertake these wider roles is becoming increasingly apparent.

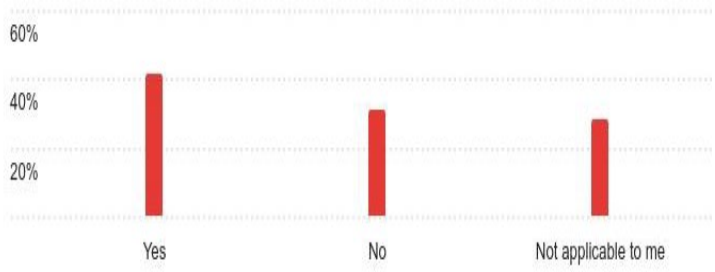
Administration of medicines



Reassuringly, ~80% of respondents had been provided with training on giving clients their medication, although worryingly 11% of respondents had been provided with no training in this regard. The need to

safely administer medicines to vulnerable individuals (with the emphasis on *safely*) is clearly an important aspect of the carer role, particularly when working in the clients' home.

Measuring clients' vital signs



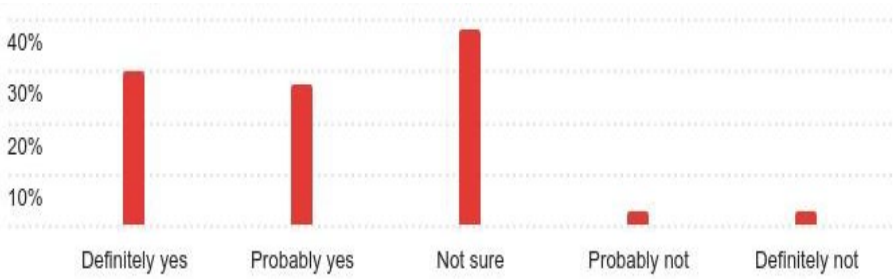
As we can see, 40% of the respondents had been given some level of training on vital signs measurement. What is not clear is the degree to which the training looks at the documentation and *interpretation* of the measurements taken. However, 74% of respondents reported having been given some level of training on escalating their concerns to someone more senior.

Technology enabled care (TEC)

We also asked the respondents about the use of technology enabled care (TEC) and digital telecare. In practical terms this may be as simple as a panic alarm and key safe for an older adult living alone, through to more sophisticated monitoring of long-term conditions such as diabetes or COPD.

In all, 57% of respondents had not had any training in the use of TEC, and 40% did not know what specialist TEC equipment was available to use where they worked. Having said that, when asked whether it would be useful, an aggregated 57% said it (TEC) would be helpful in the care of their clients.

Would a better understanding of TEC be useful to you in your role?

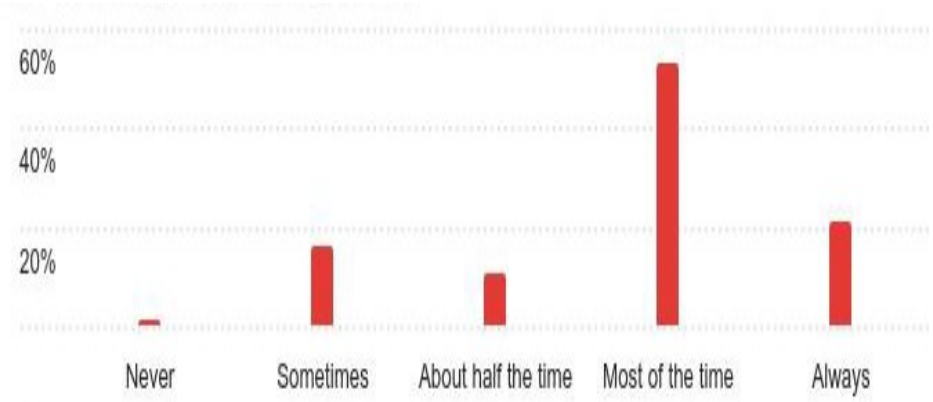


In terms of the increased use of TEC, there is a potential area of synergy between telecare and lone working. The ability to safely and effectively monitor and communicate with vulnerable clients living alone may reduce the need for some domiciliary visits, and by extension, the amount of lone working required.

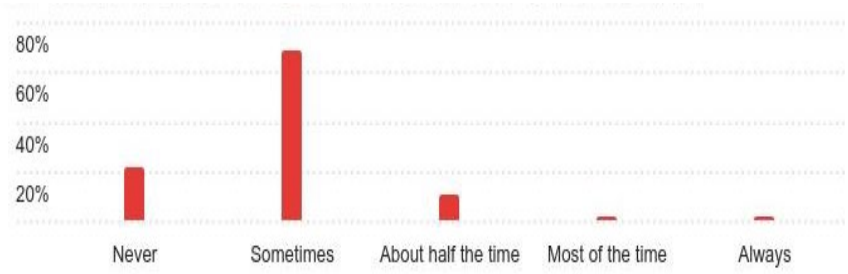
Lone working

An increasing emphasis upon safeguarding in social care is to be welcomed, given the number of care staff (74%) who report working alone most or all of the time. The safety of both client and care staff should be paramount at all times.

How often do you work on your own?



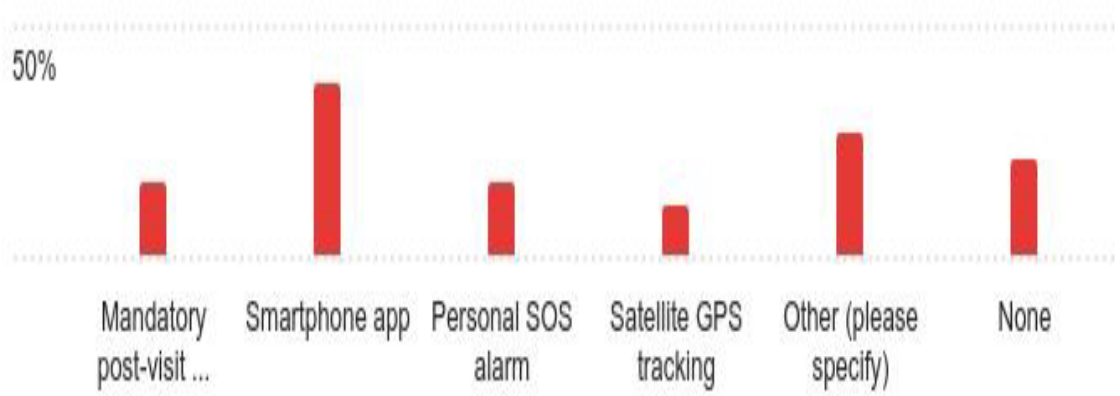
Given the high percentage of respondents who reported working alone on a regular basis, we asked them whether they were ever worried about their personal safety. The results were slightly surprising, in that 21% never worried about their own safety, and 69% of the respondents worried about their safety only 'sometimes'. This lack of awareness over their personal safety is of concern and is something that may need to be addressed in the future.



When working alone, do you ever worry about your own safety?

In terms of personal safety, we asked about the provision of safeguards for lone workers, particularly for those in domiciliary situations. In line with current social trends, there seemed to be a reliance (38%) upon the use of smartphone apps, rather than more routine, mandated pre- and post-visit calls (16%) and GPS tracking (10%). The fact that 20% of the respondents reported the absence of any safeguards is extremely concerning but may be related to the fact that 20% of the respondents did not appear to worry about their own safety.

What safeguards are in place for you when you are working on your own?



Presumably this lack of concern regarding their own safety reflects the carers' experiences in practice; however, there is clearly an urgent need to review the 20% of respondents reporting that there were no safeguards in place for them.

Telephone interviews:

> *"We heavily invest in training our own staff from the start, offering apprenticeships and NVQs so they can progress within the organisation..."*

This final section of the report summarises the key findings from 17 structured follow up interviews with a convenience sample of care managers who had completed the survey. It highlights the challenges inherent in successfully delivering training within the care sector. The structured telephone interviews were designed to provide clarification and enable the managers to add 'colour and detail' to the survey findings.

The follow up data contextualises the findings from the two surveys, and provides valuable insights into the barriers faced by care homes, including staff availability, cost implications, and specific needs for specialised training. It is reassuring to note that the findings from the telephone interviews reinforce the survey findings, but also provide some separate, important insights which help to contextualise and clarify the findings from the survey.

The organisation and delivery of staff training:

Overall, the main challenges that managers face when organising and delivering training are *staff availability, agency costs, training delays,* and *motivating staff to complete online courses*.

Staff Availability:

> *"Finding the right time when carers can actually step away from their duties without leaving us short-staffed is very challenging."*

A number of managers reported difficulties in releasing staff for training without disrupting care home operations. As one manager noted, *"Being able to give staff time off the rota for training is difficult. We have to make do by having team leaders or management cover the floors."* Another explained, *"We often need to get agency staff to cover shifts, which adds a cost that we can't always afford."* One manager summarised the situation: *"Finding the right time when carers can actually step away from their duties without leaving us short-staffed is very challenging."*

Another added, *"I find it hard to juggle staff schedules. We need enough people on shift, but we also need enough to attend the training. That balance is difficult"*. This issue was compounded by the challenge of covering staff shifts during training. One manager said, *"Getting staff off the rota for training is a major challenge, especially when we can't easily find cover."*

Agency Staff Costs:

> *"We try not to use agency staff unless it's a last resort..."*

The use of agency staff to cover shifts was mentioned frequently as a prohibitive cost. One manager said, *"Using agency staff for cover during training increases our costs significantly."* Another remarked, *"We have ended up spending more on agency cover during training than we initially budgeted for. It's just an ongoing expense."* This additional cost is especially burdensome for smaller homes, where budgets are already stretched thin.

Training Delays:

> *"We have had to wait months for certain mandatory training, like medication management, which puts extra pressure on the team..."*

Given the anticipated, but inevitable turnover of care staff, the need for 'work ready' care staff is clear. As a result, any delays to the start date for new staff would be seen by managers as counterproductive. The need for care staff to be 'work ready' means that administrative issues such as DBS (Disclosure and Barring Service) clearance could be a potential source of frustration. In addition, the (un)availability of some mandatory training could mean that new starters were not fully '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.

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.

Several managers mentioned delays in accessing essential training sessions, particularly for onboarding new staff. One manager highlighted, *"We have had to wait months for certain mandatory training, like medication management, which puts extra pressure on the team."* Another added, *"We've had to wait months for certain mandatory training, which puts extra pressure on the team."* The lack of timely access to key training resources can lead to operational setbacks, particularly for new staff members needing rapid upskilling.

Another recurring issue was the limited availability of clinical training sessions. One manager explained, *"It took months for us to secure a spot in medication management training, and the same goes for clinical skills like BP monitoring. The delay impacts the ability of staff to carry out these tasks independently, which increases the burden on others."* Another manager noted, *"We need more frequent sessions for clinical skills like diabetes management and wound care. When training is delayed, it puts more strain on our senior staff who need to cover these responsibilities."* This suggests that more timely access to clinical training would help alleviate pressure on staff and improve care delivery.

Motivating Staff to Complete Training:

> *"It often takes a lot of reminders and nagging to get staff to finish their e-learning..."*

Managers also described the difficulty in getting staff to complete online training courses. A recurring comment was, *"It often takes a lot of reminders and nagging to get staff to finish their e-learning."* Another manager echoed this sentiment, saying, *"We've had situations where staff delay finishing their courses, and it's frustrating"*. This is a pertinent example of the importance of a mixed methods approach for a piece of work such as this. Whilst there is a completely understandable push for online, e-learning there are a number of key issues that need to be addressed: These are (1) the individual's preferred learning style and (2) the purpose for which the training is to be used. Both of these will help to define the pedagogical approach that is used.

How adults learn:

> *"Understanding how adults learn is important**...**"*

It is acknowledged that the incidence of unrecognised dyslexia, dyspraxia and other barriers to 'traditional' learning is significantly higher than average in this particular workforce. Staff may have left school or college without traditional qualifications such as GCSEs or A levels and may have been out of the educational 'system' for a while. An awareness of how to 'deal with' issues such as dyslexia and how to access dyslexia support services needs to be incorporated into any training programme.

At the same time, there is an understandable push to provide much of the mandatory training via an e-learning platform. The perceived advantages of e-learning for the employer are that the training can be undertaken outside of work and be done flexibly at the student's own pace. It removes or reduces the need for managers to provide cover for staff undertaking training, whilst simultaneously ensuring that mandatory regulatory requirements are being met.

As a result, there needs to be recognition that most care staff are paid on or around 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 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.

The use and abuse of e-learning platforms:

> *"Online training just doesn't cut it for* [mental health] *these topics..."*

Online learning remains a common approach, especially for mandatory topics like fire safety and moving and handling. However, some managers expressed significant concerns regarding its limitations. One noted, *"While e-learning is useful, it doesn't compare to face-to-face training, especially for complex topics like mental health and autism care."* Another added, *"It's harder to gauge staff understanding through e-learning compared to in-person sessions."*

One manager shared, *"We use an online platform for mandatory courses like fire safety and moving and handling, which works well for most topics..."* However, they were clear that *"for complex topics like mental health and autism care, face-to-face training is essential. Online training just doesn't cut it for these topics."*

From a CCC 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. The underpinning theory may be provided either in class or online, and it is contextualised and applied 'in situ' by a facilitator. In addition to the inevitable family and social tensions involved in completing e-learning at home and in their own time whilst working, care staff may struggle with e-learning since they find it difficult to contextualise their learning online.

In summary, 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.

Need for Practical Training in Clinical Skills:

> *"Clinical skills like BP monitoring and medication management need hands-on training. Online courses don't provide the level of confidence needed..."*

Some managers expressed the need for more practical, hands-on training when it comes to clinical interventions like baseline observations, BP monitoring, medication administration, wound care, and other vital signs. One manager mentioned, *"For clinical topics like medication administration, BP monitoring, and baseline observations, online training just isn't enough. We need face-to-face training with practical demonstrations to ensure our staff are confident."* Another manager added, *"Practical skills like wound care and diabetes management require in-person instruction to make sure everyone is competent and comfortable performing these tasks independently."* This highlights the gap between theoretical knowledge and practical application, especially for critical clinical tasks.

In-House Training:

> *"We prefer to handle most of our training internally because it gives us more control over the timing and content..."*

Many care homes continue to rely heavily on their own training systems. One manager shared, *"We prefer to handle most of our training internally because it gives us more control over the timing and content."* This preference was echoed by larger providers: *"With over 160 homes, we have our own systems in place and do very little through CCC unless it's something specialised."* Another manager added, *"We've built our own in-house training system, so we don't need to rely heavily on CCC's offerings."*

Bespoke Clinical Training for Specific Clients:

> *"We often take on clients with specific clinical needs, like tracheostomies or stomas. We make sure our trainers provide bespoke training based on the individual client's care plan, including things like BP monitoring and other clinical interventions..."*

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.

Managers dealing with more complex clients require highly specialised training tailored to the clinical needs of their residents. One manager explained, *"We often take on clients with specific clinical needs, like tracheostomies or stomas. We make sure our trainers provide bespoke training based on the individual client's care plan, including things like BP monitoring and other clinical interventions."* Another manager mentioned, *"We also need specialised training for managing conditions like Parkinson's disease, multiple sclerosis, and complex wound care, which requires bespoke approaches depending on each client's needs..."*. This shows that some care homes go beyond general training, developing personalised training based on the medical conditions of the clients they care for.

Reliance on External Trainers for Clinical Skills:

In terms of clinical interventions, managers indicated that they often bring in external trainers for these more specialised skills. One said, *"We bring in nurses or clinical trainers to ensure staff are up to speed with vital signs monitoring like blood pressure and baseline observations, especially for our clients with more complex medical conditions"*.

Another manager added... *"External trainers are also essential for more advanced interventions like tracheostomy care or catheter management, as they provide the expertise and hands-on experience that our staff need..."*. This clearly highlights the importance of getting professional oversight when dealing with these important clinical aspects of care delivery.

Challenges in Delivering Training for Lone Workers

> *"With us, it's quite a specific thing because we're a lone-working service. It's really difficult to have class-based training for everyone at the same time because someone's got to man the place..."*

One of the key issues that emerged from both the survey and interview data related to lone working. The challenges inherent in training and supporting lone workers, particularly those working in domiciliary care, are significant. One manager specifically highlighted the difficulties of training in a lone working environment.

They mentioned, *"With us, it's quite a specific thing because we're a lone-working service. It's really difficult to have class-based training for everyone at the same time because someone's got to man the place."* This reflects the unique challenge of maintaining coverage while ensuring that lone workers receive the necessary training.

Another manager discussed how they adapt to this challenge by splitting the team and training some staff while others continue to work. They explained, *"Sometimes we split the team and train some people while the others man the place. We try not to use agency staff unless it's a last resort."* This is an important strategy for managing the balance between operational needs and staff training, especially in a lone-working context.

To minimise disruption, some managers bring trainers in-house to conduct sessions while lone workers remain close to their responsibilities. One manager said, *"What I started doing is bringing people in to train staff in-house so that we can be around. Residents are independent enough to let us know if they need us."* This approach allows staff to continue their duties without leaving the care home unattended, addressing the concerns of having lone workers.

The findings as a whole emphasise the need for practical, hands-on clinical training, particularly for complex medical interventions, and underline the importance of timely access to such training to avoid operational delays in care provision.

Perceptions of CCC's Training Offer: a summary

General Satisfaction:

Managers who have utilised CCC's training programmes generally had positive feedback. One manager said, *"The safeguarding training from CCC has always been good, and I've never had any complaints."* Another commented, "The CCC training we have accessed has always been beneficial for our staff." Another manager noted, *"Any time we've used CCC's training, it's been beneficial for our staff."*

Limited Awareness of the 'offer':

A lack of awareness about CCC's full range of training was a common theme. As one manager admitted, "I'm not entirely sure what CCC offers; we tend to use private providers." Another added*, "I didn't even know where to find information about CCC's training until this research was mentioned."* This highlights a need for better outreach and visibility of CCC's training resources for all care providers.

Development of Specialised Training Needs:

There is a strong demand for more face-to-face training for specialised areas, such as dysphagia, Speech and Language Therapy (SALT), and autism care. One manager emphasised, "We need more hands-on training for complex cases. Online training just doesn't cut it for topics like challenging behaviour."

Another added, *"It would be great if they could offer face-to-face training for specialist areas like dysphagia and Speech and Language Therapy (SALT). We need more hands-on training for these complex cases."* One manager noted, *"For complex areas like autism and challenging behaviour, face-to-face training is essential. Online training just doesn't cut it for these topics."*

Issues for CCC to consider

Communication with care providers:

> *"A centralised, real-time calendar of all the available courses would make a big difference..."*

Many managers suggested that CCC could improve communication regarding their training offerings. One manager said, *"It would be great if we could get email alerts about upcoming training sessions. I've missed out simply because I wasn't aware..."*

Another added, *"A centralised calendar of available courses would make a big difference."* Another echoed this sentiment, stating, *"Communication from CCC could be better. There's a need for more opportunities for forums where managers can discuss training and share experiences."*

Information from regulatory bodies, commissioners, education providers and other national bodies relating to education and training, staff development and other initiatives could be filtered through a central communications 'hub' and cascaded as appropriate to the individual providers.

This would help to ensure the provision of clear, unambiguous information clarifying the obligations of the care providers 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 could be managed through the hub.

Consistency in Training:

Some managers noted inconsistencies across different trainers, stating, *"Different trainers sometimes teach things slightly differently. There needs to be more consistency so that all carers are being taught the same methods."* Ensuring standardisation in course delivery was seen as crucial to improving care quality. One manager noted, *"There needs to be more consistency across the board so that all carers are being taught the same methods."*

Affordability and Accessibility of training:

> *"It would be great if the training was free or subsidised for homes that predominantly take council-funded residents..."*

The cost of training remains a major concern, particularly for smaller homes. One manager suggested, *"It would be great if the training was free or subsidised for homes that predominantly take council-funded residents. It would make a huge difference."* Another added, *"We simply can't afford to send everyone for*

the training they need because of the pricing." One manager remarked, *"The quality of CCC training is very good, but the pricing can be prohibitive, especially for smaller care homes such as ours..."*

Registered Nurse (RN) development:

Although it has not formed any part of this report, we would argue that there is a pressing, but often overlooked, need to provide post-qualification education and training for Registered Nurses working in care homes. Given that there may be 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 NHS England is restricted.

Future Developments

Skills for Care Workforce Strategy:

While many managers were familiar with the Skills for Care *Workforce Strategy*, they highlighted difficulties in practical implementation. One manager noted, "Implementing the Skills for Care strategy is challenging when working with multiple sectors, like the NHS and private care homes."

Another added, *"We know about the strategy, but implementing it in practice, especially when working with multiple sectors like the NHS and private care homes, is challenging."* There were also comments about the need for more practical guidance on how to integrate these initiatives effectively.

Internal Progression and Apprenticeships:

Some care homes have focused on internal development pathways, utilising apprenticeships and NVQs to support staff progression. One manager explained, *"We heavily invest in training our own staff from the start, offering apprenticeships so they can progress within the organisation"*.

Another added, *"We have developed a strong progression path for carers, which helps us retain talented individuals."* One manager highlighted this focus, stating, *"We heavily invest in training our own staff from the start, offering apprenticeships and NVQs so they can progress within the organisation."*

Conclusions

There were many positives to take away from this TNA. The majority of the care providers *appear to be* doing (or trying to do) a good job under difficult circumstances. This quote demonstrates how some care

homes go ‘over and above’ general training for care staff, trying to develop personalised training based on the medical conditions of the clients they care for.

> *"We need specialised training for managing conditions like Parkinson's disease, multiple sclerosis, and complex wound care, which requires bespoke approaches depending on each client's needs..."*.

Given the demographic changes that will take place over the next decade, the demand for adult social care in Cambridgeshire is going to rise exponentially. It makes sense to anticipate this demand now, and to put into place strategies to ensure that this future demand can be met.

- **Provision of a CCC communications hub:** Information from regulatory bodies, commissioners, education providers and other national bodies relating to education and training, staff development and other initiatives could be filtered through a central communications hub and cascaded as appropriate to the individual care providers.

- **A single point of access (SPA) for CCC training:** The development of a 'single point of access' booking system for all care staff training may be a longer-term aspiration, however a single booking system for all CCC courses would be a shorter term 'quick win'.

- **Locality developments:** The development of a CCC-wide community of practice to provide networking and support for CCC care providers. The first part would involve a local ’network of care’ providing practical and peer support within the locality, and the second part would involve a ‘network of care’ strategic level feed through the communications hub. The development of local ‘networks of care’ will enable providers to support each other in a wide range of areas, including scenarios such as the pooling of staff training and education and the sharing of other resources and best practice

- **Development opportunities for all care staff:** The development of and support for an agreed career pathway for all care staff is vital for the future of the workforce. 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. In addition, the role is often viewed by the media as a menial job with low pay, low status and few prospects. This means that staff turnover is often high, and the quality of applicants may be variable.

- **Being 'seen' to deliver on any change identified by the consultation:** In life, as in politics, the optics are often as important as the actions themselves. It is important therefore that CCC are 'seen' to act upon the findings and any recommendations arising from this report. There may be a need to adopt a clear *'you said, we did'* approach.

- **A training liaison team:** This would contribute to the development of a training network in Cambridgeshire that assists 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. This would be a practical and cost-effective way to ensure both the quality and the availability of the provision.

- **Futureproofing care staff training:** Given the size and scale of the task facing CCC over the next decade, it is vital that any proposed transformation of social care in Cambridgeshire is carried out in a sustainable, cost-effective way. This TNA has provided evidence of the need for change, and the recommendations should be clinically and cost-effective in the long term. The support of CCC is vital in getting to a critical mass of care providers to 'buy into' any changes being proposed.

Specific recommendations for CCC:

1. Review and Update Contact Database:

The report highlighted a significant issue with outdated contact information for care providers, resulting in unanswered emails and wasted resources. A thorough review and update of the contact database is crucial. This could involve:

- Verification: Contacting care providers to confirm the accuracy of existing information.

- Data Cleansing: Removing outdated or redundant entries.

- Centralisation: Implementing a centralised system for managing and updating contact information.

2. Improve Access and Booking Processes:

Feedback from care providers indicated difficulties in accessing course availability, navigating booking systems, and receiving booking confirmations. To address this, CCC could consider the following actions listed below:

- Booking optimisation: Ensure the system is user-friendly with clear information on course availability, dates, and times.

- Booking System Upgrade: Implement a more intuitive and efficient online booking system with automated confirmations.
- Alternative Booking Methods: Offer alternative booking methods such as phone or email for those less comfortable with online systems.

3. Focus on Specialist and Advanced Skills:

The report identified that many care providers obtain training from many different, alternative sources. To maximise impact, the CCC training offer could provide:

- Specialist Subjects: Offer specialised training in areas like complex care, dementia care, palliative care, and learning disabilities.
- Advanced Skills: Provide opportunities for care providers to enhance their non-technical skills beyond mandatory requirements, aligning with the Skills for Care Workforce Strategy for Adult Social Care in England (2024). This could include leadership development, communication skills, and person-centred care approaches.

4. Prioritise Safeguarding Training:

The report revealed a lack of confidence among some care providers regarding safeguarding procedures, and some inconsistencies in their approach to safeguarding. A review of safeguarding training accessed by providers should be considered as a matter of urgency.

5. Enhance Practical Learning Opportunities:

To bridge the gap between theory and practice, CCC could consider offering 'combined' practical learning sessions. These could cover several subjects at one time, and provide a more realistic, holistic learning experience. Examples would include:

- Sample Skills Session: A session combining wound care, BLS, and baseline observations, allowing care providers to practice these skills in a safe, simulated environment.
- Scenario-Based Learning: Create realistic scenarios requiring care providers to apply their knowledge and skills in a safe and controlled setting.
- Confirmation of learning: Care staff work in environments where they are likely to need to use lifesaving skills. CCC could consider the appropriate, targeted use of practice assessments.

6. Investigate Lone Working Practices:

Finally, a number of concerns were raised about the management, contracting, and training related to lone working for care staff (refer to section in survey on lone working). It's clearly difficult for CCC to account for the many ways providers monitor and train for lone working, but given the potential risk and concerns highlighted by the evaluation, a more detailed review/risk assessment of this issue could be considered.

Appendix 1: Education and training for CCC social care staff: considerations

The recent SfC Care Workforce Pathway argues that everyone working in social care should have the chance to develop, learn and grow in their role. All the evidence suggests that learning and development supports good quality social care, together with improved staff recruitment and retention.

The Care Workforce Pathway (DHSC/SfC 2023)

This pathway is designed to provide a career development framework for all social care roles. The long-term plan is to create one career pathway for adult social care, enabling career progression and appropriate pay scale alignment. Pay, terms and conditions are all significant factors in staff recruitment and more importantly, retention.

It is an important part of the infrastructure needed in adult social care and needs to be aligned with the other development frameworks that already exist. The recent proposals on aligning pay scales would enable commissioners to use pay to recognise development. This would help to both recruit and more importantly retain people.

'Supply side' quality concerns

The learning provider market in adult social care appears to be struggling post-COVID, with a significant, and inevitable, growth in the provision of online learning which does not always have the highest level of quality or impact.

The issue is that until 2024, SfC ran the *Endorsed Learning Provider scheme*, with around 130 learning providers having met their quality assurance standards. Lack of funding means that this scheme has finished. There is a clear and present risk to the quality of social care education and training as a result. This is one of the biggest challenges for CCC as a commissioner and provider of online learning.

Care providers, often lacking learning and development specialists, find organising training confusing, time-consuming and costly. Additionally, training recognition and/or portability between providers is limited because providers worry that previous training will not meet regulatory requirements. DHSC is belatedly developing a Skills Passport which should help with this issue of portability.

Until this year, approved and accredited training in the sector was supported with government funding through the Workforce Development Fund, but this is due to be replaced by the Adult Social Care Training and Development Fund. The levels of funding (as with most of the central government funding), will be determined by the new government as it looks at public spending.

In 2023 DfE also introduced local skills improvement plans (LSIPs) and a local skills improvement fund (LSIF). LSIPs were designed to provide an agreed set of actionable priorities that employers, education and training providers and other stakeholders in a local area could use to drive change at that local level. There are opportunities for adult social care which should be considered here because currently the LSIPs awareness of and engagement with social care is clearly variable, and often limited in scope.

The regulated workforce

It is estimated by Skills for Care that in 2023 the adult social care sector employed 33,000 registered nurses and 25,000 registered managers. These roles are crucial for quality, safety, leadership, prevention, and meeting clinical needs, even though they only make up ~6% of the workforce.

Registered Nurses

Regulated professionals in adult social care (such as RNs) carry out professional oversight, for example ensuring that healthcare activities are assessed, planned and overseen as appropriate. The benefits of creating pathways and opportunities for registered nurses working in social care to develop into advanced practitioner roles have been modelled for this the SfC strategy. The results show that creating advanced roles would mean that, for every £1 spent, the sector would generate £2.50 in socio-economic benefits. Moreover, it will produce higher benefits than costs in year one.

Many of the recommendations in the Workforce Strategy relate to the workforce as a whole but need to include the regulated professional workforce. There is a clear need to ensure that adult social care is better reflected in higher education curricula. This may be achieved by working with HEIs that provide health care qualifications to ensure that health care programmes such as nursing better reflect the realities of health and social care with an ageing population.

Registered managers

Belatedly, managers are being acknowledged as a vital part of adult social care but suffer from high turnover (23%) and there are significant numbers of vacancies (10%). Their numbers need to increase to meet growing care needs and staff retirements. However, registered managers are often under-valued compared to other professionals such as nurses and social workers, despite the skill needed in the role

The Messenger Review (2022) provided clear expectations for leaders and managers working in health and social care. This included the development of standards and competencies, consistent training curricula and support for meeting these requirements. Adopted by the NHS, it emphasised proactive and inclusive talent management. Social care needs to develop a similar strategic approach, aligning all the drivers (funding, commissioning, support) to develop and implement a leadership development roadmap for

social care. As we know, Regulation 7 of the Care Act states that Registered Managers must have the necessary *qualifications, competence, skills and experience* to carry out their regulated activities. That is generally accepted to be the **Level 5 Diploma** as recommended by Skills for Care (56% of registered managers have this qualification).

However, as the manager role has become more complex, the CQC 'Fit Person' process needs to reflect this and there should be opportunities for registered managers to do a full degree or master's degree in business administration to support their career development.

Apprenticeships

In this regard, there is a compelling case for the use of DA apprenticeships in adult social care. This would help to attract a younger workforce, but this requires reform as the current model does not work for social care.

Given the changing needs and increasing complexity of care and support work, adult social care needs a system of education and training that delivers both high-quality learner experience and impact. It is noted that there has been a drop in the numbers of people doing apprenticeships in recent years

There is a clear and urgent need to overhaul the apprenticeship system for social care. This would involve looking at funding and working in partnership with, amongst others, the Institute for Apprenticeships and Technical Education, DHSC, the Adult Care Trailblazer Group and Skills for Care. Future discussions would also need to involve HEIs or colleges of FE, together with the various regulatory bodies (Social Work England, the NMC, and the HCPC).

The need for 'joined up' workforce planning in social care

As well as a national workforce strategy for the social care workforce, local-level workforce planning is needed to match the local labour market with changing social care needs. Given that rural areas such as Fenland will have a disproportionately ageing population with associated growing needs, there is a need to either entice working age people to live in these rural areas or entice local people already living in those areas to work in adult social care. The only alternative would be to encourage older people to remain in larger urban centres such as Cambridge City by ensuring age-appropriate housing and financial incentives.

Technology, digital data, and the use of artificial intelligence (AI)

One important aspect of the new Workforce Strategy relates to the use of 'modern' working practices (e.g. digital solutions, assistive technology), innovation in care delivery to improve people's lives and stronger

links with the NHS (i.e. to NHS Digital Academy) for sustainability and integration of services. This would enable a greater degree of 'smart' collaboration with both primary and secondary care providers.

Using financial modelling, SfC have produced indicative returns for each £ of investment on a number of different technological interventions. The results shown below suggest that investing in digital technology for the adult social care sector would yield significant benefits for care providers, the NHS and the people relying upon social care and support. Inevitably this would require investment in training and education to be front-loaded but the benefits in the longer term are clear.

Technology (for each £ invested)	**Care Provider returns (£)**	**NHS returns (£)**	**Quality Adjusted Life Years (QALYs) in £**
Assistive technology	£4.21	£4.10	£4.87
Care management technology	£1.20	£0.36	£2.16
Digital social care records	£6.77	N/A	N/A

Specific recommendations for CCC

- Use the LSIP to offer a robust set of specialist courses to support formal education routes (e.g. regular mandatory requirements and practical topics such as moving & handling, equipment, observation and delegated health care tasks)
- Continue the Care Certificate at level 2 and aim for level 3 competence for all direct care staff
- Use the Care Workforce Pathway to develop a single career pathway for all social care staff with a unified pay scale (c.f. Agenda for Change)
- Revisit the apprenticeship model for training social care staff
- Look into funding the roll out of digital and assistive technology training
- Fully implement the findings from the Messenger Review
- Provide development opportunities for registered managers beyond a level 5 diploma (BSc or MBA)

Appendix 2: Care Providers' Perspectives on External Training Providers in Cambridgeshire

This summarises findings from the Cambridgeshire County Council (CCC) "Training needs analysis" final report that relate to external training providers.

Benefits of External Training Providers

Care providers in Cambridgeshire highlighted several benefits to using external training providers:

- **Wider Range of Courses:** External providers offer a broader selection of specialised courses, including those not covered by the CCC's Care Professional Academy, such as specific conditions (e.g., Parkinson's), advanced care techniques, and management training.
- **Flexibility and Convenience:** External providers offer greater flexibility in scheduling and delivery methods (online, face-to-face, or blended), catering to the varying needs and time constraints of care workers.
- **Expertise and Quality:** External providers have specialised expertise and up-to-date knowledge in specific care areas, ensuring high-quality training. A key finding of the TNA report was difficulty in finding specialised training for topics like - Parkinson's / MS, advanced clinical skills (tracheostomy care, catheter management, observations), and leadership development

Drawbacks of External Training Providers

Despite the benefits, care providers also identified some drawbacks:

- **Quality Variation:** The quality of training can vary significantly between providers. A strong theme in the TNA responses from managers included concerns about the quality of online training for practice skills
- **Relevance to Local Needs:** Some external providers may offer generic training that isn't fully aligned with the specific needs and priorities of the Cambridgeshire care sector.

Degree of Use and Preferences

- **External Provider Usage:** A significant proportion of care providers in Cambridgeshire utilise external training providers, often to supplement the CCC's offerings. The data indicates that roughly 60% of providers use external training to some degree.
- **Online vs. Face-to-Face:** Online training is gaining popularity due to its convenience and accessibility. However, many providers still value face-to-face training for its interactive nature and practical skill development. The survey suggests a near-even split in preference between online and face-to-face, with a slight lean towards online (around 55%).
- **Internal Trainers:** Some larger care providers have internal trainers who deliver training in-house. This allows for greater control over content and scheduling but may limit the range of specialist courses available. Approximately 30% of respondents indicated they use internal trainers.

Provider Map

The map below shows the location of care training provers that offer training to the Cambridgeshire area. It is notable that most providers offer a national or online only presence.

[An interactive and detailed map can be found via this link]

This table highlights further details of the training providers currently offering courses to the Cambridgeshire area:

Provider Name	Website Link	Head Office Postcode	Location	Care Certificate	Dementia	Autism	BLS	Moving & Handling	End of Life Care	Accreditation	Pricing (Lowest £ per user/month)	Provider Description & Feedback
Access Skills	https://www.accessskills.co.uk/	B16 8QG	Online	✅	✅		✅	✅		CPD accredited, IIRSM approved	From £3.50	Offers a variety of health and safety and compliance courses, including those relevant to the care sector.
Cambridge Regional College	https://www.camre.ac.uk/	CB4 2QT	Cambridge	✅	✅	✅	✅	✅	✅	City & Guilds, NCFE, CACHE, AQA	Varies by course; check website	A well-established college with a strong reputation for healthcare training. Offers a good mix of online and in-person learning.
Cambridge Safety	http://www.cambridgesafety.co.uk/	PE16 6JA	Peterborough				✅	✅		Various, including IOSH, Highfield	Contact for pricing	Provides a range of health and safety training, including first aid and manual handling, with a focus on workplace compliance.
Access learning	https://www.theaccessgroup.com/en-gb/digital-learning/elearning-courses/health-social-care-	SG7 6BU	Online	✅	✅	✅	✅	✅	✅	CPD accredited	From £3.95	Specialises in compliance training for the care sector, with a focus on CQC standards.

	courses/											
CBAT	https://cbassociatetraining.co.uk/	PR9 0DH	National	✅	✅	✅	✅	✅	✅	CPD accredited	Contact for pricing	CB Associate Training offers a wide range of health and social care training with a focus on flexibility and tailoring programs to individual needs. They emphasise a learner-centred approach
Caring for Care	https://caringforcare.co.uk/courses-list/care/	SW18 4JQ	Regional/ National (covers Cambridgeshire)	✅	✅	✅	✅	✅	✅	CPD accredited, RoSPA approved	From £85	Offers a comprehensive catalogue of care courses, including specialist areas like medication management and challenging behaviour.
Caredemy	https://caredemy.co.uk/	EC1V 2NX	Online	✅	✅	✅	✅	✅	✅	CPD accredited, RoSPA approved (for some courses)	From £2.75	Focuses specifically on health and social care training with a user-friendly platform. Good value for money.
Curve Learning	https://curvelearning.org.uk/	LN2 2QU	Regional/ National (covers Cambridgeshire)	✅	✅	✅	✅	✅	✅	Not specified on website, but claims to be "accredited"	Contact for pricing	Works with a variety of care providers, offering tailored training solutions and experienced trainers.

Encompass Safety Solutions Ltd	https://www.encompasssafetysolutions.co.uk/	CB6 1AY	St. Ives, Cambridgeshire					✅		IOSH, Highfield Awarding Body for Compliance (HABC)	Contact for pricing	Focuses on workplace safety, including manual handling, with experienced trainers and a practical approach.
First Safety Training (Cambridge)	https://firstsafetytraining.com/safety-training-courses/first-aid/	PE7 3TW	Cambridge				✅	✅		Unknown	Contact for pricing	Offers first aid and health and safety training, but limited information is available.
Flexebee	https://www.flexebee.co.uk/	RG12 1WA	Online	✅	✅	✅		✅	✅	CPD accredited	Contact for pricing	Provides flexible online learning solutions with microlearning modules and personalised learning paths.
Holistic Social Care Training (HOSOCAT) Solution	https://hosocat.co.uk/	PE1 1FT	Ely, Cambridgeshire	✅	✅	✅		✅	✅	Not specified on website	Contact for pricing	Appears to offer a broad range of care-specific training, but limited information is available online. Direct contact is recommended.
iHASCO	https://www.ihasco.co.uk/	CH1 4DS	Online	✅	✅	✅	✅	✅	✅	CPD accredited, RoSPA approved	From £10	Offers a large library of health and safety and compliance training, with some tailored for the care sector.
Interactive Healthcare	https://www.interactivehealthcaretrainin	SO23 8SR	Online	✅	✅		✅	✅	✅	CPD accredited, Skills for Care	From £4.95	Known for its interactive learning approach with engaging content. Might be pricier than some

Training	g.co.uk/									endorsed		competitors.
Prestige Fire Safety	https://www.prestigefiresafety.com/	PE2 6GX	Cambridgeshire	✅	✅				✅	Highfield Awarding Body for Compliance (HABC), IOSH approved	Contact for pricing	Specialises in fire safety but also offers relevant care courses like dementia awareness.
Reed Learning	https://www.reed.co.uk/courses/care-training	WC2R 1LA	Online	✅	✅	✅	✅	✅	✅	CPD accredited	Varies by course; check website	Offers a vast library of courses, including many relevant to health and social care, with a focus on professional development.
Skills for Care	https://www.skillsforcare.org.uk/	LE1 6FP	Online	✅	✅	✅		✅	✅	Skills for Care endorsed	Varies by course; check website	The leading source of workforce intelligence and standards for the UK's social care sector. Offers high-quality, sector-specific training.
The Bridge First Aid Ltd	https://www.thebridgefirstaid.co.uk/	PE27 5UW	Cambridge				✅			Highfield Awarding Body for Compliance Qualsafe Awards	From £60	Specialises in first aid and health and safety, with a focus on practical skills and realistic scenarios.
The Child Protection Company	https://www.childprotectioncompany.com/	PE3 9GZ	Regional/National (covers Cambridgeshire)	✅		✅				CPD accredited	From £95	Specialises in safeguarding and child protection training, with experienced trainers and customizable courses.

The Mandatory Training Group	https://www.mandatorytraining.co.uk/	SK8 1NR	Online	✅	✅	✅	✅	✅	✅	CPD accredited, RoSPA approved, IOSH approved	From £2.25	Offers a large library of mandatory and specialist training courses at competitive prices. A good option for comprehensive training needs.
Virtual College	https://www.virtual-college.co.uk/	LS11 5QH	Online	✅	✅	✅	✅	✅	✅	City & Guilds, Institute of Leadership & Management (ILM), CPD accredited	From £25	A comprehensive online training provider with a wide range of courses and a strong emphasis on compliance. May have higher upfront costs.
W&P Care Training	https://www.wandptraining.co.uk/social-care-training/	DT1 1BE	Online	✅	✅	✅	✅	✅	✅	CPD accredited	Contact for pricing	Offers a comprehensive suite of care courses with a focus on person-centred care.

Appendix 3: Fenland variation report

Fenland Care Providers: Training Needs and Variations

This report analyses responses from care providers in the Fenland district, as documented in the "Training needs analysis" final report and the accompanying interview data spreadsheet. It aims to identify key trends and variations specific to Fenland, considering its rural context, and compares these findings with the overall report.

Challenges in Delivering Training

Staffing and Rurality: Fenland providers face unique challenges due to their rural locations and difficulties in attracting and retaining staff. One manager noted, *"We struggle to recruit staff, and releasing them for training is difficult. It impacts our ability to provide consistent care..."* This challenge is exacerbated by limited access to agency staff for cover, with one respondent stating, *"Finding cover for staff to attend training is difficult, and agency staff are expensive..."*

Travel and Cost: The rural nature of Fenland means longer travel times and increased costs for staff attending external training. One manager stated, *"Sending staff to Cambridge for training is a logistical and financial burden. We need more local options..."* This is further complicated by the need to cover the costs of travel and accommodation for staff attending training outside the district.

Technology and Infrastructure: Some Fenland providers reported challenges with internet connectivity and access to technology, impacting their ability to engage in online training effectively. This digital divide can limit access to online resources and create additional barriers to professional development.

Thoughts on CCC Training Offer

Awareness and Relevance: While generally satisfied with the quality of CCC training, some Fenland providers expressed a lack of awareness regarding the full range of courses available. They also emphasised the need for more tailored training relevant to the specific needs of rural care settings, such as lone working, managing complex conditions with limited resources, and utilising technology to bridge service gaps.

Cost and Accessibility: Cost remains a significant barrier for Fenland providers, who often have limited training budgets. One manager commented, *"We appreciate the quality of CCC training, but the cost is prohibitive. We need more affordable options..."* This concern highlights the need for potential subsidies or alternative funding models to support training in rural areas.

Preference for Face-to-Face: While recognising the convenience of online training, Fenland providers expressed a strong preference for face-to-face training, particularly for practical skills and complex topics. This preference may be linked to the value placed on social interaction and hands-on learning in a region with limited access to urban centres and diverse training environments.

Suggestions for Improvement

- **Localised Training:** Fenland providers emphasised the need for more localised training options to reduce travel time and costs. They suggested utilising community spaces or establishing a dedicated training hub in the district. This would not only improve access to training but also foster a sense of community and shared learning among care professionals in the area.
- **Tailored Content:** Providers requested more tailored training content that addresses the specific challenges and needs of rural care settings. This could include modules on managing isolation, supporting carers' wellbeing in remote locations, and developing skills for working with limited resources.
- **Flexible Delivery:** While valuing face-to-face training, Fenland providers also requested more flexible delivery options, such as blended learning and shorter, more frequent training sessions to minimise disruption to staffing. This flexibility would enable carers to balance their work responsibilities with their professional development needs more effectively.
- **Financial Support:** Providers highlighted the need for financial support to access training, suggesting subsidies or grants to offset costs. This could involve targeted funding initiatives for rural care providers or partnerships with local organisations to provide training at reduced rates.

Variations from Overall Report

Heightened Staffing Challenges: Fenland responses highlight more acute staffing challenges compared to the overall report, likely due to the rural context and competition from urban areas. This underscores the need for targeted recruitment and retention strategies in rural areas, potentially including incentives for carers to work in remote locations.

Emphasis on Localised Training: There's a stronger emphasis on localised and accessible training options in Fenland compared to the overall report, reflecting the challenges of travel and distance. This highlights the importance of considering geographical factors when planning and delivering training programmes.

Technology Access: The report mentions technology access as a potential barrier for some Fenland providers, a factor not prominently featured in the overall analysis. This suggests a need for further investigation into the digital divide in rural care settings and potential solutions to bridge this gap.

Conclusion

Fenland care providers face unique challenges in accessing and delivering training due to their rural locations, staffing constraints, and limited resources.

The small sample size captured as part of the TNA does not provide for much confidence in the information provided above, so this document should be considered an adjunct to the main report that gives some suggestions towards local needs and variations.

Appendix 4 - Cambridge City variation report

Cambridge City Care Providers: Training Needs and Variations

This report analyses responses from care providers in Cambridge City, as documented in the "Training needs analysis" final report and the accompanying interview data spreadsheet. It aims to identify key trends and variations specific to Cambridge City and compares these findings with the overall report.

Challenges in Delivering Training

Competition and Retention: Cambridge City providers face stiff competition for qualified staff from other sectors, including the NHS and the University. Retaining staff is a significant challenge, impacting their ability to release carers for training. One manager noted, *"We have a high turnover rate, and it's difficult to justify investing in training when staff might leave..."*

Cost of Living: The high cost of living in Cambridge City can be a barrier to attracting and retaining staff, further compounding the challenges of releasing carers for training. Providers may need to offer competitive salaries and benefits to remain attractive employers, which can strain their budgets.

Time Constraints: Care providers in Cambridge City often operate at full capacity, with limited flexibility in scheduling. Finding time for staff training without compromising client care can be a significant challenge.

Thoughts on CCC Training Offer

Accessibility and Awareness: Providers in Cambridge City generally have good awareness of the CCC training offer and appreciate its accessibility. However, some expressed a desire for more tailored training options that address the specific needs of urban care settings.

Preference for Blended Learning: There's a growing preference for blended learning approaches in Cambridge City, combining online modules with face-to-face sessions. This allows for flexibility while maintaining the benefits of in-person interaction and practical skill development.

Suggestions for Improvement:

- **Specialised Training:** Providers in Cambridge City specifically requested more training on mental health, learning disabilities, and challenging behaviour. They also expressed a need for training on cultural awareness and diversity, reflecting the city's diverse population.
- **Technology-Enabled Care:** There's a growing interest in technology-enabled care (TEC) in Cambridge City. Providers suggested offering more training on using TEC to enhance client care and improve efficiency.
- **Networking Opportunities:** Providers expressed a desire for more networking opportunities with other care professionals in the city. This could facilitate the sharing of best practices and support collaborative approaches to training and development.

Variations from Overall Report

- **Higher Staff Turnover:** Cambridge City providers report a higher staff turnover rate compared to the overall report, likely due to the competitive job market and the high cost of living in the city.
- **Emphasis on Blended Learning:** There's a stronger preference for blended learning approaches in Cambridge City, reflecting the need for flexibility and the growing acceptance of online training as a valuable component of professional development.
- **Focus on Urban Care Needs:** Providers in Cambridge City highlight specific training needs related to urban care settings, such as mental health, diversity, and the use of technology to manage complex care needs in a densely populated environment.

Conclusions

Cambridge City care providers face unique challenges in delivering training due to high staff turnover, the cost of living, and the specific needs of an urban care environment. To address these challenges, CCC could focus on providing more specialised training options, promoting blended learning approaches, and offering networking opportunities for care professionals in the city.

The small sample size captured as part of the TNA does not provide much confidence in the information provided above, so this document should be considered an adjunct to the main report that gives some suggestions towards local needs and variations