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West Wales Health and Social Care Joint Induction Training Pilot

Evaluation report

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- identifying and sharing knowledge about what works and what's new
- supporting people who plan, commission, deliver and use services to put that knowledge into practice
- informing, influencing and inspiring the direction of future practice and policy.

Written by Sam Callanan

Contact **info@scie.co.uk**

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Social Care Institute for Excellence
83 Baker Street, London W1U 6AG

www.scie.org.uk

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1. Foreword

There has never been a more important time to support the development of a flexible social care and health workforce. This pilot has driven and challenged us in West Wales to work in partnership to deliver the skills and knowledge our care support workers need. It is paramount that we develop the skill base and knowledge of the workforce and to support better outcomes for individuals using our health and social care services.

The vocational model of joint delivery provides us in Wales with an exciting opportunity to establish more effective methods of learning delivery across the two major sectors by sharing resources and expertise. This will in turn, provide the foundation for consistent learning and more integrated ways of working. It has been a pleasure to see our learning and development teams working together on this pilot and I think we have demonstrated how this can successfully work in practice, across a large region.

The approach that has been piloted demonstrates that the ambitions of a national workforce strategy for health and social care in Wales can be realised. In doing so, we are committed to seeing better outcomes for the people who need care and support and to realise the fullest potential and positive value of staff working in this sector.

Jonathan Griffiths – Director of Social Services and Housing, Pembrokeshire County Council

This pilot of joint health and social care induction training has been a partnership between Carmarthenshire, Ceredigion and Pembrokeshire local authorities and Hywel Dda University Health Board. It has been a fully collaborative approach to develop the content and deliver the programme.

We have set standards for all new health care support workers who join the sectors and made sure that those workers have the right principles, values, understanding and skills to make sure that the needs of those who use our services are met.

This has been a genuine partnership, and I am so pleased that we can say we have the first integrated health and social care post in Wales to manage the programme and it has worked really well.

I am excited for the next stage in the process and will continue to drive integrated working by sharing our successes and creating a model for Wales.

I want to continue forging new relationships for a seamless approach to continuing with the joint induction, delivering care and support and increasing staff and patient satisfaction.

Mandy Rayani – Director of Nursing, Quality and Patient Experience, Hywel Dda University Health Board

2. Executive summary

2.1. The aims of the pilot and evaluation

The Joint Induction Training Pilot delivered a joint programme of training and support to health and social care workers ('learners') to enable them to complete the All Wales Induction Framework for Health and Social Care (AWIF).

The goal of the pilot was to generate confident workers who could deliver person-centred care, leading to better outcomes for people receiving care and support.

The pilot also tested whether the joint induction of health and social care workers could help support delivery of 'A Healthier Wales', and specifically aim 'to deliver an inclusive, engaged, sustainable, flexible and responsive workforce in health and social care' (Welsh Government, 2018). Accordingly, this evaluation also explored how the programme might impact on recruitment, retention and professionalisation of the health and social care workforce.

The purpose of this evaluation was to determine whether the pilot met these aims and to collate and share learning from the pilot delivery.

2.2. The programme

The pilot programme consisted of six days of face-to-face training on topics aligned to the AWIF. One day was a clinical skills and observations day which was compulsory for learners from health, and optional (though strongly recommended) for learners from social care. Following the training there were three support sessions for learners to reflect on case studies, complete workbooks, and practice multiple choice tests for the formal assessment. Learners were supported to complete the workbooks in their workplace by mentors and managers.

Eighty-three people took part in the pilot programme, 54 (65%) from social care, 19 (23%) from health and 10 (12%) who were pre-employment. The pilot was due to run from July 2019 to May 2020, although the final stages were disrupted by COVID-19.

The programme was delivered within the geographical areas covered by the Hywel Dda University Health Board: Carmarthenshire, Ceredigion and Pembrokeshire.

2.3. The evaluation

The evaluation draws on survey data collected from learners, interviews (22) with learners, managers, mentors, and interviews (12) with other key stakeholders. The key stakeholder group included managers and leaders from regional and national organisations. The evaluation also draws on administrative data collected by the project team during the pilot.

Learners were asked to fill in three separate surveys – at the beginning ('entry') and end of the training ('exit'), and six to eight weeks after the training. Response rates for the final survey were low due to the disruptions caused by the pandemic so this stage is generally not included in this report. However, the responses in the submitted surveys were similar to those in the exit surveys.

2.4. Impact on learners and their practice

The programme increased learners' confidence in the core knowledge and skills needed for delivering good quality care and support. Confidence increased for both learners with limited experience of working in health or social care, and for those with more than a year's experience – the programme could therefore be useful for both experienced and inexperienced workers.

Managers and mentors also observed that learners were more confident in their practice and better placed to mentor or develop other staff than people who had not undergone a similar induction programme.

Managers, mentors and learners felt the programme led to changes in practice in many areas of care and support, including:

- knowledge of specific tasks and practices
- safeguarding
- identifying and balancing risk in decision-making
- treating people with dignity and respect
- identifying poor practice and encouraging good practice
- reporting and recording
- delivering person-centred care.

Managers noted that learners also had better knowledge to underpin their practice. As well as knowing what was correct practice, they understood *why* they were doing something. This better understanding should support ongoing good practice and create flexibility in the workforce, with workers more able to adapt their practice to different contexts.

Managers also observed that the programme better prepared learners for the COVID-19 pandemic. The most tangible benefit was having staff who were able to take basic observations such as temperature and blood pressure readings. But managers also noted that the improved understanding of risk assessment, infection control and taking a person-centred approach helped learners to adapt to the challenges of providing care and support during the pandemic.

2.5. Workforce recruitment and retention

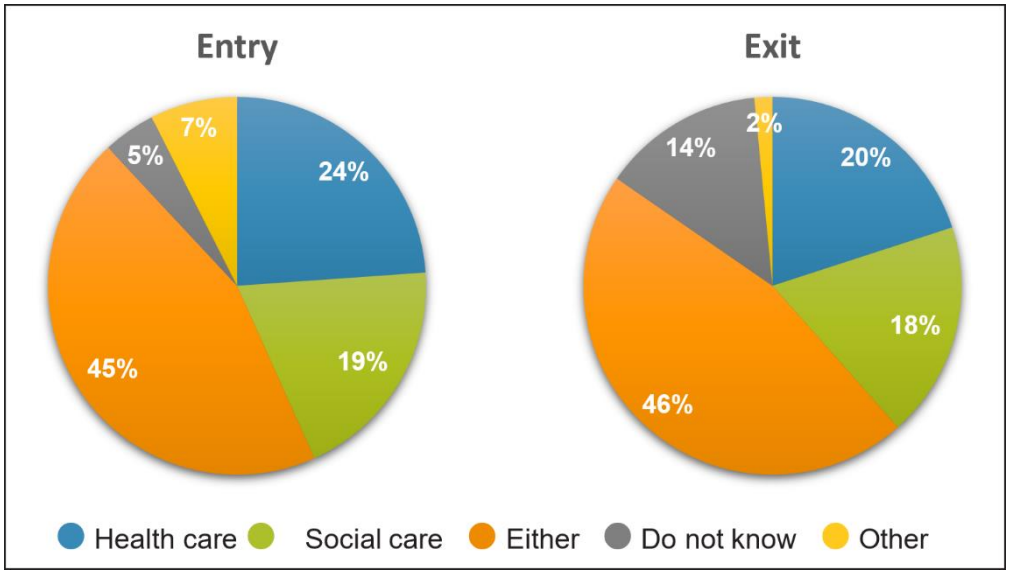
The programme supports a flexible workforce and joint working across health and social care. Through both its content and the joint working in its delivery model, it:

- provides learners with an understanding of how social care and health fit together and roles across health and social care
- gives learners the baseline knowledge and skills that can be applied in both health and social care
- provides both social care and health workers with core clinical skills and knowledge that they can apply in their roles

- reinforces that the care and support which should be given by these workers is of the same quality and importance, regardless of whether that care is delivered in a health setting or a social care setting
- places the emphasis on the person accessing care and support, rather than the setting or situation
- allows learners to learn from one another, and from best practice in both social care and health.

The majority of learners intended to continue working in health and social care. At the end of the training, 84% expected to be working in a health or a social care role in a year's time. Notably, the largest proportion of these (46% at exit) could see themselves working in *either* health or social care. No evidence was found during the programme that learners who had a joint induction would be drawn to work in health at the expense of social care.

Where do you see yourself working in one year's time?



Learners recognised the investment in them and said they felt valued and empowered, which in turn improved their confidence. They reported feeling part of a profession, and that this positively impacted their behaviour.

Many learners saw the programme as a helpful step towards other roles in health or social care, or a step in their progression to more responsibility or seniority. Learners felt that the programme helped them understand other roles in health and social care, and where their role sat in relation to those professions. This can support greater cross-working, and career flexibility.

Managers also observed that the emphasis on learning and theory in the programme and the AWIF supports greater professionalisation. Managers and stakeholders saw the value of a good induction and believed it should help with recruitment and retention of staff.

By demonstrating that joint working is possible, and by training people across health and social care to the same standard, interviewees said the programme should contribute to addressing the disparities they observe across health and social care. However, addressing the issue of disparities in pay between the two sectors is essential.

2.6. Learning from delivery and the core components of the model

The programme combined a high standard of delivery, content, and support for learners, with a joint working approach across all parts of the programme. It is the *combination* of the high quality *with* the joint delivery and joint working that stands out about the model and underpins its success.

The programme took a reflective and iterative approach, learning and adapting from feedback and the experience of delivery, for example, revising the content and structure of the training days after the first cohort, and enhancing the support structures for managers and mentors.

Learning from delivery during COVID-19 is likely to change how the programme is delivered in future, with a move to a model blending face-to-face elements with online and digital learning. The evaluation highlights some core components fundamental to the success of the programme, to be retained in any future spreading or scaling:

Joint delivery and content which prepares people to work in either health or social care	Learners from health were exposed to social care and learners from social care exposed to health. Learners appreciated the breadth of the programme and the content from health and social care. They were very positive about being in mixed groups and learning from the experiences of others – something which should assist in better working relationships across health and social care.
Embedding joint working throughout the programme	Joint working was an important feature of the pilot, with management and delivery shared equally across health and social care. The strong working relationships it developed became particularly important during COVID-19 when resources from the pilot were adapted and used to support urgent training of new and redeployed staff. Vital to the success of the pilot was a dedicated integrated project coordinator who sat across both social care and health teams, bringing people together and acting as the main focal point for the pilot.
Delivery by experienced practitioners and specialist tutors	Tutors were praised for their knowledge and delivery. Having their own experiences of care work helped them bring the training to life, engage learners better, and also increased their credibility with leaners. Tutors were also well placed to recognise and support when learners might be finding things difficult.

Observation and clinical skills training for health *and* social care workers	This was new to social care staff and highly valued by them and their managers. The value was demonstrated during the pandemic when social care workers were able to take observations and report them to GPs and other health professionals. This raises the opportunities for increased flexibility with learners more able to work in either health or social care. In social care, it opens up opportunities for better and more efficient care and early identification of potential health issues.
Providing and facilitating ongoing support for learners	Following the training, learners had three support sessions with the project coordinator. They were also supported to complete the AWIF workbooks by their mentors and managers in their workplace. Although the mentoring system did not work perfectly in all cases, it was generally seen to be very important for supporting learners and encouraging them to complete the programme. Learners praised their mentors and support and said it increased their confidence. The mentor system was seen as particularly important in social care for helping workers feel part of a profession.

2.7. Support for continuing and impact if it were to scale

There was strong support for ongoing joint induction training, and for spreading the model across Wales, particularly in the context of increasing demand for care and support. There was great interest in the pilot from providers, and it wasn't possible to meet all the demand during the pilot period.

The evaluation suggests that scaling the programme up across Wales could have a range of positive impacts:

- Helping to deliver consistent quality of care, with people-centred values at its core, leading to better outcomes for people accessing care and support.
- Creating a more professional workforce, raising the profile of care and supporting moves towards greater parity between health and social care.
- Attracting people to working in care, and social care in particular, by investing in them and demonstrating the range of paths their careers could take.
- Supporting better care for people in their own home or in residential care, and ultimately reducing hospital admissions.
- Supporting more efficient care and better working across health and social care, reducing the 'footfall' in people's homes.

3. Introduction

The joint induction training pilot supports the delivery of the All Wales Induction Framework (AWIF).[1] The AWIF provides a structure for a common induction for social care workers and health care support workers working in community settings. It covers health and social care for adults, children and young people and outlines the knowledge and skills new workers need to gain in the first six months of employment (Social Care Wales, 2017).

The AWIF is complemented by a suite of new health and social care qualifications. The pilot's content mirrors the 'core content' of these new qualifications. The core content also reflects the NHS Wales's mandatory accredited clinical induction and core competencies that NHS Wales workers must complete in their first two weeks and six months of employment (NHS Wales Shared Partnership Services, 2015).

The AWIF and new qualifications aim to support more effective learning delivery across health and social care by sharing resources and expertise, in turn providing the foundation for more integrated ways of working. This joint induction training pilot aimed to explore how this could work in practice by developing and then delivering a package of training and support for new social care workers and health care support workers who will *jointly* undertake the same programme.

The pilot was delivered within the geographical areas covered by the Hywel Dda University Health Board (Carmarthenshire, Pembrokeshire and Ceredigion). The pilot training was delivered in three cohorts, one in each of these areas. The first cohort started in July 2019, and training for the final cohort ended in February 2020. In this pilot period, 83 workers undertook the programme. Support sessions were due to continue until May 2020, however, these, and other elements of the pilot were affected by COVID-19. The impact of COVID-19 on the pilot is discussed in section 10.

The Social Care Institute for Excellence (SCIE) was commissioned by Social Care Wales (SCW) and Health Education and Improvement Wales (HEIW) to carry out an independent evaluation of the pilot. The primary aims of the evaluation were to collate and share learning from the delivery of the pilot, and determine whether, and to what extent, the pilot, and any future joint induction of health and social care workers, could help support delivery of 'A Healthier Wales', specifically the workforce related aim: 'to deliver an inclusive, engaged, sustainable, flexible and responsive workforce in health and social care' (Welsh Government, 2018).

Running parallel to the pilot, SCW and HEIW developed a 'Workforce Strategy for Health and Social Care' (SCW and HEIW, 2020) to support the delivery of A Healthier Wales. The learning from this pilot will inform Action 13 of the workforce strategy, to 'implement a values-based, common induction programme for all of our workforce who deliver health and social care in primary and community settings'.

The SCIE team worked in collaboration with the project working group, formed of experienced trainers, workforce development managers and practitioners from health and social care, as well as representatives from SCW and HEIW.

[1] **https://socialcare.wales/learning-and-development/induction-for-health-and-social-care-awif**

SCIE would like to acknowledge and thank the members of the project working group for their work co-designing the evaluation; interviewing learners, mentors, and managers; and reviewing this evaluation report:

- Ruth Bowman – Carmarthenshire County Council
- Liz Hargest – Health Education and Improvement Wales
- Trish Mathias-Lloyd – Hywel Dda Health Board
- Eunice Moyo – Carmarthenshire County Council
- Lisa Trigg - Social Care Wales
- Rebekah Vincent-Newson – Social Care Wales
- Karen Wakelin – Social Care Wales
- Gethin White – Social Care Wales

4. Method

4.1. Evaluation objectives

At the outset of the pilot there were four objectives for the evaluation:

Objective 1: To gather learning from the West Wales pilot for delivery of joint health and social care induction training across Wales.

Objective 2: To understand the impact of the programme on learners who undertook it.

Objective 3: To understand whether and how the programme leads to changes in practice which deliver truly person-centred care and better outcomes for people receiving care and support, including whether the programme provides a foundation for more integrated ways of working.

Objective 4: To understand the implications for related workforce goals of 'A Healthier Wales' and the potential ramifications of the programme on the employment and development of the health and social care workforce.

Towards the end of the pilot period the COVID-19 pandemic took hold, and it was agreed that it was also important to consider how the pandemic affected delivery of the pilot and what could be learnt from that, and whether the programme had prepared learners to deliver care during the pandemic.

4.2. Evaluation data

The evaluation draws on survey data collected from learners undertaking the programme, and interviews with learners, managers, mentors, and other key stakeholders. The evaluation also draws on administrative data collected by the project team over the course of the pilot.

Learner surveys

Learners were asked to fill in surveys at three points:

- entry (at the outset of training)
- exit (immediately after the training days were completed)
- follow up (six to eight weeks after the final training day)

The survey covered:

- prior experience working in health or social care
- motivations for taking the programme
- any concerns about the programme
- learner confidence in their skills and knowledge

Unfortunately, the follow-up surveys were disrupted by COVID-19, leading to a lower number of follow-up returns than had been anticipated. For this reason, follow-up responses are

generally not reported in the findings below. However, the completed follow-up surveys indicate that the findings at follow up were similar to those at exit.

Interviews

Interview topic guides were designed by SCIE with input from the project working group.

There were 22 interviews with learners, managers and mentors, carried out by members of the project working and steering groups. Recorded interviews were passed to SCIE for transcription and analysis.

There were 12 interviews with key stakeholders including members of the project working group and steering group. These were undertaken by SCIE.

All interviewees took part voluntarily, were aware of their right to withdraw and have been anonymised in this report.

4.3. The relationship between the pilot and the All Wales Induction Framework (AWIF)

As set out in chapter 3 above, the West Wales Health and Social Care Joint Induction Training Pilot (‘The pilot’) delivered a programme of training and support to both health care support workers and social care workers to help them complete the AWIF.

As a model of delivering the AWIF, the pilot necessarily contains many of its key elements, including Social Care Wales’s workbooks and progress logs, the assessment and qualification processes, the role of managers and mentors in supporting learners.

The evaluation’s scope is this programme and its model for supporting learners to complete the AWIF. It is not an evaluation of the AWIF itself.

Nevertheless, it is important to note that learners, managers and mentors often do not make a clear distinction between this specific joint training programme and the AWIF. Some comments and views may also be relevant for the AWIF generally.

5. Introduction to the findings and programme outline

5.1. Introduction to the findings

The findings are linked to the evaluation objectives and organised as follows:

Chapter	Content
6	What worked well and less well during the delivery of the pilot, what needed to be changed or adapted, and how it supported learners to undertake the AWIF (Objective 1)
7	How health and social care organisations worked together on the project (Objective 1)
8	The impact on learners and their practice (Objectives 2 and 3)
9	Workforce recruitment, retention, and development (Objective 4)
10	The impact of COVID-19 on the pilot, and what was learnt from delivery during the pandemic
11	The future of the programme, the potential impact for Wales, and what may facilitate its spread.

5.2. An outline of the programme

The pilot programme consisted of six days of face-to-face training. One of the days was a clinical skills and observations day which was compulsory for learners from health, and optional (but strongly recommended) for learners from social care. Following the training there were three support sessions for learners to reflect on case studies, complete workbooks, and practice multiple choice tests for the formal assessment. Learners were also supported to complete the workbooks in their workplace by mentors and managers.

The topics are aligned to the seven sections of the AWIF and delivered as follows:

Week 1:	Introduction to principles and values (Day 1)
	Health and well-being (Day 2)
	Observation day (optional), including basic observations such as blood pressure and temperature, and signs of deterioration
Week 2:	Safeguarding (Day 3)
Week 3:	Principles and values (part 2) (Day 4)
Week 4:	Health and safety (Day 5)

See Appendix 1: Programme Outline, for a full list of the topics covered.

This evaluation covers three programme cohorts, one each in Carmarthenshire, Pembrokeshire and Ceredigion. Each cohort was made up of two groups of up to 20

learners. The first cohort training sessions took place in July to August 2019, and the final cohorts in January to February 2020.

In total 83 people took part in the pilot cohorts: 54 people (65%) from social care organisations, 19 from health (23%) and 10 (12%) who were ‘pre-employment’ learners recruited from Job Center Plus, Workways, and other Employability schemes. The pilot tried to ensure an even split of health care support workers and social care workers but the need for health care workers to be trained before starting work made this difficult. The mixing of learners is discussed further in section 6.2 below.

6. Learning from delivery

Key points

Feedback on the course content was positive. Learners felt that they learned a lot, and managers emphasised that it prepared people to '*become a carer*', rather than simply provide training which would allow them to do the job.

The programme took a **reflective and iterative approach to improvement**. The content and structure of the training was revised following learner feedback and reflections from tutors on delivery.

Programme cohorts contained a mix of health care, social care and pre-employment learners, with a range of levels of previous care experience. Learners appreciated this diversity. It allowed them to learn from one another, understand a range of roles, settings and practice, and hear examples of good (and sometimes poor) practice.

For tutors, having a range of experiences was positive because it widened learners' exposure to different roles and brought those in pre-employment closer to work.

Managers and mentors supported having a 'refresher' version of the programme for experienced staff based on the feedback from learners with existing experience.

Having experienced practitioners as tutors was key to the pilot's success. The two primary tutors were complemented by specialists in subjects such as dementia, mental health, safeguarding and medication.

Learners and managers praised tutors for their knowledge, delivery, and the support they provided to learners, and particularly their ability to draw from their own personal experiences.

Managers recognised the value of the induction, but there were concerns about how to release multiple learners at the same time. Overall attendance on the programme was very good and managers recognised the value of a good induction and were supportive of releasing their staff to take part. However, some managers expressed concern that releasing multiple staff at the same time would make it challenging to cover their duties.

Some learners didn't feel all parts of the programme, and by implication the AWIF, were directly applicable to their roles. But even when learners felt that the content was not directly relevant for them, they still found it interesting and noted that they gained wider insights into health and social care.

Learners were surprised by the investment of time required. Managers said they were given good advice and guidance on how to support people to complete the programme.

Learners and mentors felt that the workbooks were user-friendly, informative and factual. However, learners were surprised at the amount of work required to complete the programme, particularly the workbooks.

As a result of this, care was taken to clearly explain the requirements and expectations to learners and managers. The workbooks also continue to be revised to address this feedback.

The mentor role was valued by learners, mentors and managers. The mentors provided support and reassurance, and improved learner confidence. Managers felt that the mentor role was particularly important for new staff, and that without it some staff would not have completed the programme.

The mentor role didn't work in every case. Some mentors did not have time to provide the required support. Some mentors were also managers and identified conflicts between the roles. In health, there were specific difficulties setting up mentors for bank staff, who could be in different settings on a day-to-day basis.

Improvements are already in place, including putting in place ongoing support for mentors.

The pilot established the likely costs of conducting similar training in future. Data from the project team indicates that based on 100 learners per year the direct cost of the programme would be £1,458 per learner. Alongside that there would need to be some continued 'in kind' contributions such as management costs, guest tutors, use of venues and equipment.

During the pilot, the programme was free to employers. This made it more attractive, particularly as colleges offer induction training at no cost to employers.

6.1. Developing the programme and content

Developing the programme content

The course content was developed by the project working group. The programme was developed from the current inductions being delivered in the local authorities and Hywel Dda Health Board. Specific elements were mapped to the AWIF and the Hywel Dda Health Board clinical induction for health care support workers.

A key part of the model is the delivery of the training by experienced practitioners and specialist trainers were enlisted both to review and deliver content on subjects such as dementia, mental health, safeguarding, medicines management as well as the nursing specific elements.

Throughout the pilot, the working group reviewed and adapted the programme, looking at what had worked well and what less well. Early feedback was that the content was good, but that the structure needed some adaptation:

> *'[learners] felt it was really, really helpful what they were learning, but they did feel that the structure of it was a bit higgledy-piggledy, that they seemed to go off on one topic then back to another topic…'*
>
> **Manager 4**

The working group revisited the course, reflecting on their experience of delivering it as well as feedback from learners. Both learners and tutors felt there was too much information included in each day, so the content was revised and restructured to ensure that the essential components were covered. This also provided an opportunity to check and revise the content against the Level 2 Health & Social Care Core qualification which was finalised towards the end of 2019.

Tutors felt that course delivery then improved over the first couple of cohorts because tutors were more confident about the course content and how they could adapt it to the needs of the learners.

> *'We knew what we were delivering, we knew how to work around the programme without even looking at the presentation sometimes, because we knew what we were delivering, and the candidates, I think they had a different experience than the ones that had the delivery in July. The feedback had improved then, which meant some things were being done right.'*
>
> **Stakeholder 10**

Manager and learner feedback on the course content was positive. Learners felt that they learned a lot, and managers emphasised that it prepared people to '*become* a carer', rather than simply provide training which would allow them to do the job.

> *'The quality of the course seems more centred on becoming a carer rather than … just providing some care training, if that makes sense. It seems more suited to where they're going. I think they get a better understanding of what care is all about through the course, rather than undertaking the general courses that we've done in the past.'*
>
> **Manager 2**

The observations or clinical training day

In the observation or clinical training day learners are taught several important clinical skills:

- Basic life support and recognition of the deteriorating patient, including consciousness level assessment.
- How to accurately take and record physiological measurements such as blood pressure, pulse, temperature, respiration, and oxygen saturation.

Learners also use and learn about the kinds of equipment that would be used on hospital wards.

These are practical sessions where learners practice on one another and are assessed on these skills by the tutors. Interviewees noted the importance of this hands-on practice:

> *'…when they're practicing physiological measurements on each other and being able to touch the patients and feel their pulse, that is something that needs to be done on a practical basis. Basic life support, chest compressions, being able to resuscitate somebody, you can't actually assess that unless you see them doing [it].'*
>
> **Stakeholder 3**

Initially the observation day was mandatory for health care support workers, but not for social care workers. However, interviewees noted that social care learners from the first cohort were excited about the opportunity to extend their skills and learn how to undertake observations. Individuals felt there was significant benefit to having this training for people working in social care, and while the pilot cannot mandate that social care workers take the observation day it is now strongly recommended.

Workers might support someone who has blood pressure monitoring equipment at home, but not be trained in how to use it, or might be supporting someone who has returned home from hospital, where being able to accurately take and report observations could support their recovery and reduce the number of visitors to their home, making care more efficient. It could also support them to be more aware of a person's condition, reporting changes to managers or health care staff and seeking early intervention to prevent deterioration.

Interviewees noted that the programme improved workers understanding and ability to recognise deterioration in their clients.

> *'… even if staff didn't actually have the technology to record all of the physiological measurements, it gave the support workers a better understanding of - and recognising a deteriorating patient; being able to see that a patient was, perhaps, a little bit more confused today than yesterday.'*
>
> **Stakeholder 3**

Interviewees felt that the training was important for helping social care workers in particular to understand why physical measurements were needed for people after they leave hospital, and to understand the reasons for the care they were giving to patients.

> *'… they all found it really useful because they were looking after patients with multiple needs and multiple comorbidities. They were able to think, well, actually, that's why she has oxygen in the morning. That's why this particular patient has observations and then they have antibiotics to reduce the impact of an infection.'*
>
> **Stakeholder 3**

Managers in social care valued the clinical skills day and health elements of the programme. Managers were particularly positive about the observations training, and felt it was highly relevant for their settings and the people they cared for.

> *'…that health input has been really valued and really appreciated. I think it is so relevant in care homes, or in providing care at home for people. It builds the basis of that shared and that proper integration.'*
>
> **Stakeholder 7**

Training social care workers in clinical skills and observations was seen as important for improving integrated working and creating a flexible health and social care workforce (see section 9.4 below for further discussion).

Interviewees were very positive about combining health and social care into one course and felt that it has worked well. They felt that the benefit for health was that social care has been expert in the legal framework (Stakeholder 8), and stronger on aspects such as safeguarding, judging capacity and supporting best interest decision-making, particularly about putting those into practice.

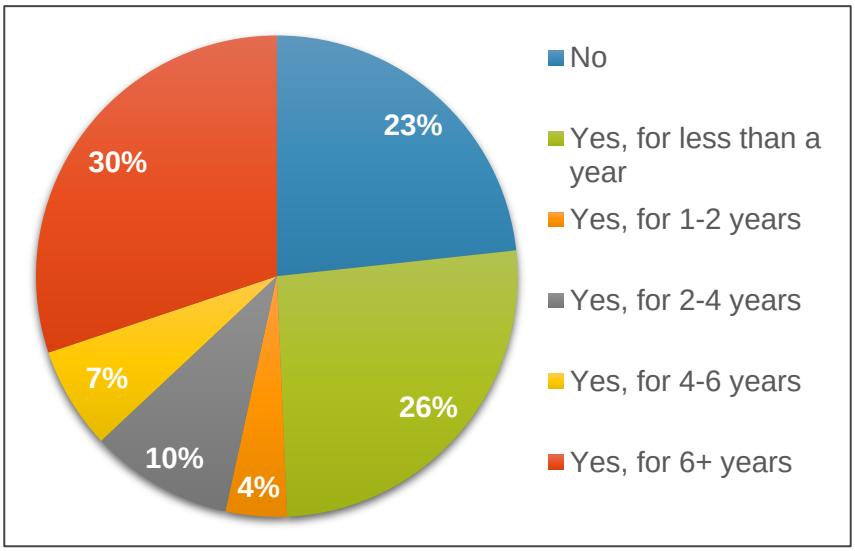
> *'So bringing that in from the social care aspect, and then bringing the clinical skills, … both sides touch on each other's specialities. Together, you've got both outlooks, I suppose. Both views in one package, and I think it works really well.'*
>
> **Stakeholder 8**

Feedback and the experience of early delivery led to changes to the content and delivery of the observation day, making it more accessible to people from a range of backgrounds and settings.

6.2. Bringing together learners with different experiences

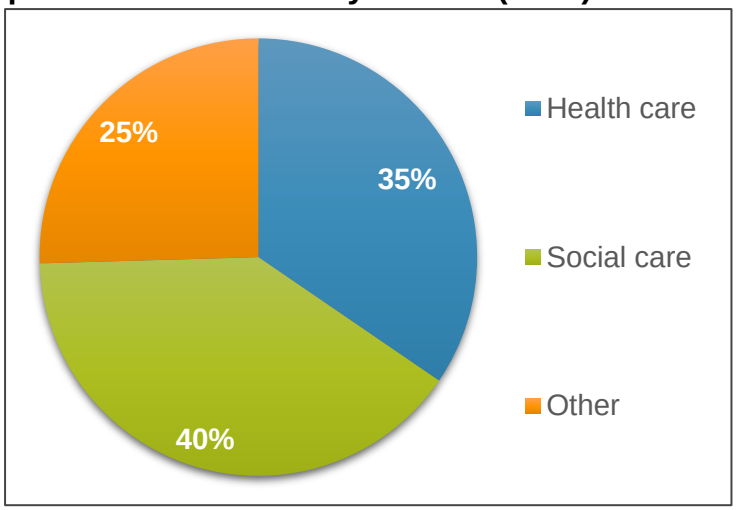
The AWIF is intended to be completed in the first six months of a worker's employment and so the joint induction programme was restricted to people who were within the first four months of their role or had not started their employment. However, a number of learners had previous experience in either health or social care, because they were either returning to work, or had moved to a new role, and so were undertaking the induction as part of that new role. Approximately 50% of learners had either no, or less than a year's, experience working in health or social care.

Figure 6-1. Have you previously worked or taken work experience in the health and social care sector? (n=73)



It proved to be a challenge to schedule inductions with an even split of health and social care workers. Health Board inductions were planned a year in advance, so training dates for the pilot were matched to these as much as possible. But health standards require care support workers to receive induction prior to starting, which meant that many health staff on the programme had not yet gone into practice, whereas social care workers may have been working for a number of weeks or even months before joining the induction. In future it is planned to schedule dates jointly to facilitate a more even split.

Figure 6-2. If you are currently working in the health and social care sector, please indicate where you work (n=55)



When learners were asked whether they worked in health or social care. Many of those who chose 'other' here subsequently indicated that they *were* working in a social care role, but as a support worker, rather than in domiciliary or residential care.

Sharing experiences and mutual support

In interviews, learners stated that they valued being on the course with people working in different settings. It allowed them to learn from one another, share their experiences and hear examples of good (and sometimes poor) practice.

Even when people's experiences were to do with highlighting poor practice, learners valued hearing them.

> *'It was interesting being in with other people as well who were just getting into the care sector and people who were working in there as well, and it was quite scary, some of it, about the practices that they were doing and being told they should be doing by their management. On the course we were saying, "No, you really shouldn't."'*
>
> **Learner 4**

The project working group recognised they needed a way to deal directly with examples of poor practice, address this directly and perhaps provide a platform for people to constructively raise issues with the tutors. This would allow tutors to provide appropriate guidance and raise concerns with the employer if necessary.

Learners also valued hearing about areas or settings that they were not familiar with, which might have different standards or practices.

> *'It was also nice to hear from the children's aspect of things and how what I deemed standard is not when it comes to children.'*
>
> **Learner 9**

Including pre-employment learners in the groups

As well as mixing people from different health and in social care roles and settings, the programme included people who had not yet found a job, or had a job but had not started.

Interviewees felt there were pros and cons to including 'pre-employment' trainees alongside those already in practice. But overall, they felt the benefits of bringing learners closer to work and making them feel valued because they receive the same programme as those in work, outweighed any potential risks of people being put off.

> *'We don't want to hide things from unemployed people. We want them to make an informed decision, but we don't want to put really good people off going to the sector either. I don't know how you do that but I'd say that the positives of training alongside people in work outweighs the negatives. We just have to think about how we do it, how we make that work.'*
>
> **Stakeholder 4**

The same interviewee felt that it would support recruitment if there was a clear training package for people before they went into employment.

> *'It would be amazing if we could put everybody through pre-employment initiatives before they went into a work [setting], so that already when they started [they] had that confidence… 'Well, like I know how to do this', so they don't feel like they're on their own.'*
>
> **Stakeholder 4**

They noted that some groups set up social media / messaging groups for the learners which provided a peer support mechanism, and they felt that this would be particularly beneficial for pre-employment learners.

Support for induction in the first four months – and for 'refresher' training

There was general support for ensuring that learners undertook the programme as early as possible into their role.

> *'Yes definitely, new care assistants should have that as soon as they start. They need a basis. We find what we're lacking is fundamentals of care, going back to basics. I think by having this, it gives them that good, basic start which we can then build on through the experience of working in the home.'*
>
> **Manager 1**

Others thought it would also benefit more experienced staff to undertake the induction, or a 'refresher' version.

> *'I think everybody should have the opportunity, even if they've been in it longer because they do have the understanding and the knowledge required to do well, but the workbooks and the induction itself is, would be very beneficial to all of them, all the current staff, no matter how long they've been in their role.'*
>
> **Manager 5**

Another benefit of a programme for experienced staff was to ensure they were up to date with current practice and regulations. A trial cohort for experienced staff subsequently planned for July 2020 was unfortunately cancelled due to the pandemic.

6.3. Having experienced practitioners as tutors

Delivery of the training by experienced practitioners was a key part of the model. The bulk of the training was delivered by two experienced practitioners, one from health, and one from social care. They were both part of the project working group, and so were involved in all elements of development and delivery of the pilot. In addition, some sessions were delivered by experienced practitioners with specialisms in topics such as dementia, mental health, safeguarding and medicine management.

Feedback on the tutors was very positive. Both learners and managers praised tutors for their knowledge, delivery, and the support they provided to learners.

> *'They were all really good. The hands-on ones where we had the nurse … where she was showing us different equipment for blood pressure, the oxygen, all those sorts of things. That was really, really good and it's good to see hands-on how they actually worked. What to do right, what not to do.'*
>
> **Learner 6**

> *'I mean, [tutors name] she's been, she's a rock, she is, she's fabulous. To be fair, all the tutors, you're going through things and if there's some parts that you don't understand, I mean, you don't feel awkward with asking them the question. […] If you want to know some more stuff at the end of the day, they'll stay behind, they'll help you. … they're really approachable and they're very supportive through the whole of the course. Really, really good.'*
>
> **Learner 6**

Interviewees emphasised the importance of having practitioner tutors from multiple backgrounds with *live* or *recent* experience for both bringing the role to life for learners and being able to give them up-to-date information and examples. Tutors spoke of the advantage they had in being able to draw on real experiences during the training. They gave the example of a new member of staff being asked to give medication by someone more senior or experienced, and how the course gave them the skills and knowledge to question instructions where appropriate:

> *'They could relate to that, because they were saying, that happens to us all the time and I was saying to them, you should be able to say no […], You cannot just take [it] and give [it] to somebody just because your manager has asked you to. You have to have the training; you have to actually know what you're giving to an individual before you can administer it.'*
>
> **Stakeholder 10**

Interviewees also noted that practitioner tutors were better placed to pick up on issues or difficulties that learners might have, which learners themselves might not be aware of and that might affect their ability to practice safely. In this way, having experienced practitioners as tutors is supporting the creation of an appropriate and safe workforce.

'Because if you're going to challenge the Panorama set of horrendous situations, we've got to equip people with the strength to be able to stand up, but also I think to pick out people that might feel vulnerable themselves to situations like that. I guess, what I'm saying is you can pick out people that may struggle, from that direct dialogue, with experience of the topic that you're talking about, whether it be wound care, whatever the case may be.'

Stakeholder 8

6.4. Attendance and release for training

Managers who were interviewed generally saw the value in a good induction and were supportive of releasing their staff to take part. Interviewees noted that managers in health were also very supportive of the programme and happy to put their staff forward for it.

'They were really pleased that we were starting to look at an integrated way of working, because it would give both sectors of staff an appreciation of what happens in each individual [case].'

Stakeholder 3

However, some managers were concerned that the amount of time necessary for the induction would make it hard if they had to recruit and induct multiple staff at the same time.

Learners were also aware that training takes employees out of the workplace and that this can have an impact on the service and on other employees who may need to cover shifts. One learner noted that for some other learners there didn't seem to be much support for them attending the course from their employers.

'… a lot of the people were told that they weren't getting paid or getting paid travel to go to the course and some of them had to go finish and go straight back in on nightshifts. There was no flexibility at all.'

Learner 4

One manager said that despite the potential benefits, many of their staff were resistant to undertaking an induction (either the pilot version or the AWIF more generally). Some even left their service and went to work in a different role where an induction wasn't required at this time.

They said that they had to chase their staff to complete the induction. Even though the staff liked the content and saw it was beneficial to them, there was a lot that they felt was not directly relevant to them as domiciliary care workers, 'We don't take blood pressures or blood sugars or things like that' (Manager 5).

Another manager noted similar difficulties and commented on the difficulties of workers attending multiple sessions, especially with rota considerations. Similarly, a learner commented that training days being in different geographical locations also presented challenges.

Tension between time and quality

The project working group recognised from the outset that it was going to be hard for providers, particularly in the private sector, to release people for a length of time. But they felt it was important to see the induction as an investment:

> *'…this is about getting a gold standard for a care setting, irrespective of where it might be. So we kept that as our central goal and we worked around that as much as we possibly could.'*
>
> **Stakeholder 1**

The best structure for the training was the subject of much discussion. One option was to have a single block of a week or two weeks of classroom training, followed by consolidation in practice, which is more common in health. However, an early exercise to gather information on the existing social care inductions in the region found significant variation between different settings, both in the content and in the standard of the inductions.

This finding reinforced the project team's desire for a more structured and standardised induction model for social care that would give all workers a solid grounding. In order to make the 'gold standard' induction attractive to private employers, the training was designed in chunks of two or three days at a time, or scheduled so that people can do half a day at work as well as some training or learning.

Overall, there was a lot of interest in the programme, with more demand than was able to be met during the pilot period.

While managers initially voiced concerns, there were good attendance levels with very few people dropping out. Interviewees emphasised the importance of setting expectations and good communication with employers and managers to get their support for workers to attend. Those delivering the course said that when people were unable to attend, they had a good reason (and not that managers wouldn't release them). Delivery was flexible, allowing learners to attend a day with another group if they were unable to attend their allotted day.

Interviewees noted that although managers were initially concerned about the number of days, they were more positive when they understood it would be spread over a number of weeks. Good feedback from learners on the programme also helped increase support from managers.

> *'…when they realised they would come in for three straight days and then a week after and a week after and a week after, I think they sort of understood that they needed to come for this training, and the feedback that we were getting from the candidates or staff was that it was really, really good training, and they were looking forward to going back and to learn more things.'*
>
> **Stakeholder 10**

Some stakeholder interviewees expressed frustration with some employers, who ask for support with recruitment and retention, but then don't seem able or willing to release people for the training that is aimed at addressing those issues. They recognised that employers can be in a difficult position given the low margins in social care, but linked the induction to a culture shift and wider moves to professionalise the social care workforce:

'You've got to make a commitment as an organisation to support your staff in time and the ability off rota to invest in their time. That is a culture shift for particularly many of the social care type employers who are operating on, I guess, very low-margin basis, etc., so costs are really watched by those organisations commercially.

Stakeholder 5

Interviewees also noted the concern of private employers in social care that an employee might leave after undertaking the training. This is less of an issue in the NHS where gaps can generally be covered by bank staff.

Chapter 12 explores the tensions between the quality and breadth of the programme (and the AWIF) and the pressures faced by employers and employees, particularly in social care.

6.5. Applicability of the course to all roles and different settings

Some learners didn't feel all parts of the programme (and by implication the AWIF) were directly applicable to their roles. In a programme which aims to provide a broad introduction to health and social care it is highly likely that some aspects may not apply directly to some roles or settings.

For some learners it was only one or two specific parts of the programme (or the AWIF) that they felt were not applicable to them, for others it was more general feedback.

'The course I did felt more that it was for those working within hospital ward environments as opposed to those working within community settings. Now, there are those who work in community settings who aid their patients with bathing, bedding, changing, whereas my role in the community doesn't do that.'

Learner 1

For one manager, the broad coverage of the course was positive, even though a learner from their organisation expressed the opposite opinion.

'I actually think that the All Wales Induction Framework covers everything that I think should be covered for Shared Lives carers, particularly around professional boundaries and some of the other things that are around practice that are in there, which didn't feature in other induction programmes as well, as prominent.'

Manager 3

Interviewees floated the possibility of a more modular approach, with some learners only undertaking certain sections that were relevant to their roles – although they acknowledged making it too modular would lead to a large number of courses.

'Yes, the problem is it's hard to get a catch-all, and if you tailor it for every individual need, you're going to have hundreds of courses running.'

Learner 4

Equally, and perhaps more importantly, a fully modular approach could move away from the goal of having a programme that supports flexibility and more integrated working.

Even when learners felt that not all the content was relevant for them, they still found that content interesting, and there were positives that came from learners being exposed to tasks or knowledge that was not directly relevant to what they expected their role to be.

> *'It gave me an insight, so it made me understand better what they had, then what staff then had to do to make sure that they were recording the right data. Even though I wasn't undertaking it myself, it's given me a better insight to understand what they should be recording and that the data that they're recording is actually correct.'*
>
> **Learner 6**

However, one learner, a family support worker for Team Around the Family in schools, felt that it just wasn't relevant for their role as it was focused too much on the provision of care.

> *'To be honest with you, a lot of it was quite irrelevant to my role. It was heavily weighted in issues around the care sector. …. For us, there's no care, there's no care at all, so a lot of the legislation that we got taught about, the procedures, the policies, the protocols, none of it touched our work at all. So whilst we enjoyed… spending the time with these people, and it was interesting, … but it wasn't really relevant to our role.'*
>
> **Learner 7**

This raises wider questions about whether a single induction should include people from adults and/or children's services who are not in caring roles. We would recommend that attention is paid to checking whether this is the right induction for individuals and their roles.

On a related note, some interviewees raised a question around whether the course should try to accommodate both children's and adult services at the same time.

> *'I think from our perspective in children's services, a lot of it seemed to be geared towards residential care and adults. I think that we would have done better with just a standalone children's induction framework session. I think that's echoed by [the worker] herself who says that a lot of the time she wasn't working on the same sort of material as other inductees.'*
>
> **Mentor 3**

The AWIF covers both children and adults, but the sections on Principles and Values, and Health and Wellbeing, are split to focus on adult services, and children's services separately.

The majority of learners in this pilot were from adult social care, or more likely to be working with adults in health[2]. As noted above those who did work in children's services felt that the course wasn't always as relevant for them, though they praised the tutors' attempts to accommodate them and make it relevant for them. Nevertheless, it this does raise the question of whether in future it might be better to have separate courses for those who will be working with children (in health and social care) and those who will be working with adults.

[2] Two learners were recorded as working in children and young people social care

6.6. The workbooks and the amount of work required

Two important elements of the AWIF are the workbooks, to help learners put the induction into practice, and the progress logs, to record learning outcomes. In the first cohort of this pilot, learners and managers found that completing both the progress logs and the workbooks was repetitive, so the requirement to complete the progress logs was dropped for subsequent cohorts.

Learners were positive about the content and structure of the workbooks

There was positive feedback on the content and structure of the workbooks from learners and mentors. Learners commented that they were 'user-friendly' and 'easy to follow' although one learner said they would have liked more scenarios in the workbooks. A mentor commented:

> *'[The learner] tells me that the workbooks were very informative and factual, and most definitely relevant, so she got something to hang her knowledge-base on…'*
>
> **Mentor 3**

Managers felt they were given good advice and guidance on how to support people to complete them.

The amount of work needed to complete the programme was a surprise to some

However, learners also expressed surprise at the amount of work required in the programme, particularly to complete the workbooks on top of the time spent in the classroom. When asked, many learners said that they would like to have known more about the amount of work required prior to joining the course.

> *'… when I had the interview for the HCA role, they didn't tell me that I needed to do this training. And when we had the training, it was a bit of a shock that we needed to do so much work on top of our shifts. So maybe if you continue the training, you need to just do a sort of breakdown, to say, "This is what you'll be doing. These are the modules that you'll be doing, and this is the work that you need to complete"…'*
>
> **Learner 2**

This issue was recognised early in delivery, and from cohort 2 onwards learners and managers were given more information about the amount of work required. Later feedback indicates that learners felt better informed about the requirements.

> *'…I think it's pretty informative, the information that we had. I mean, I knew I wanted to do something to better my knowledge and understanding so that I could help others more. The info that we had about it was, you know, it was good.'*
>
> **Learner 6**

In section 8.2 we will see that managers recognise that one of the most important impacts on those workers who undertook the joint induction programme is that they have an understanding of the principles and theory underpinning their practice, both of which are reinforced by the workbooks. And in section 9.3 learners cite the workbooks as important for their professionalisation and practice, because they refer to relevant legislation and best practice guidance.

Despite this, some managers raised concerns about the amount of work required both for learners to complete the workbooks, and for managers to support this and mark the workbooks.

> *'They [staff who had undertaken the induction] felt that the timeframe, the six-month timeframe to complete the induction was unrealistic, and I would agree with that because the workbooks are large. There is a lot involved in the induction. When you've got a staff member who works full-time, it is difficult for them to be able to manage their work and home life, balance that and carry out this induction.'*
>
> **Manager 5**

As well as the amount of work, some learners also felt that it was a higher-level qualification than they had expected.

> *'It was far from what I expected. It was a lot more work than I expected. I mean, I've seen the NVQ level of paperwork, and to be truthful, I think the AWIF was a hell of a lot more than the actual level two.'*
>
> **Learner 3**

Those delivering the course also felt that some of the workbook content was at a high level.

> *'I think, initially, when we had the workbooks, we actually realised that there was a lot of work to do, and coming from a college background … I was teaching Level 2s. I found that the workbooks actually had more work than Level 2s would really have.'*
>
> **Stakeholder 10**

Some learners struggled to complete the workbooks because of the level of questions in them. Tutors chose some of the more complex questions to focus on and explain in sessions, but they acknowledged that the workbooks were still a lot of work, and some students were finding it hard to complete them.

There were also difficulties getting managers in health to make sure that learners completed the workbooks. In the Health Board there was already one workbook that health care support workers need to complete during induction, but the AWIF added another five and this was the cause of some issues – despite explanation from the project working group.

> *'… from a Health Board perspective, again, I think there was a lack of understanding in the requirements or the need to have the All Wales Induction Framework workbooks. […] They didn't understand the process and they were only used to having one workbook. […] 'Actually, they've already filled one workbook in; why do they need to fill another one?' I said, 'We have cross-referenced the workbook. We have tried to reduce the amount of work as much as possible.'*
>
> **Stakeholder 3**

Overall, the workbooks and the amount of work required to complete them were the most common concern about the programme for learners, managers and mentors. One manager also commented that the workbooks weren't clearly linked to the assessment for the certificate of induction.

During the pilot steps were taken to address these issues: dropping the requirement to complete progress logs as well as the workbooks, ensuring managers and learners were fully informed about the work required prior to starting the programme, identifying potentially difficult questions and focusing on those in the support sessions. The team also tested different types of training and support:

> *'We did a buddy scheme and a mentor-training system to try and introduce the concept and to explain the importance of filling in the workbooks. I think the workbooks were just way too much and too much to be able to expect them to do in its entirety, then.'*
>
> **Stakeholder 3**

Nevertheless, the pilot working group recognised that the workbooks could benefit from some attention when continuing and scaling up the programme. The workbooks are important as a learning aid and record of progress, but the work involved potentially poses a barrier to learners and managers taking up the induction. Following the pilot, work is being undertaken to streamline the workbooks, and ensure they are at the appropriate level.

Clarity around the assessment and qualification pathway

Some mentors and managers also noted that they were unclear about the pathway from induction (i.e., the AWIF) to the level 2 Core qualification.

> *'I just think a clear pathway so it can, the induction is an induction, and then a clear pathway on to the qualification. It seems to me, even the college that we were using, when they set out and set up the training plan for delivering the AWIF, even they didn't really know how somebody was going to move off that AWIF on to the qualification without repeating the evidence, or having to go back over evidence they'd done just so they pass the test.'*
>
> **Mentor 5**

Interviewees were concerned about learners having to repeat the same evidence (Manager 6), and also the possibility of costs multiplying.

> *Also, like we said, being charged, from the finance point of view we were probably going to end up paying out three times if we did the AWIF, then the core and the practical separately. Just a very clear pathway of how we would like it to be done.*
>
> **Mentor 5**

6.7. The role of mentors and managers

As part of the pilot, each learner should have been assigned a mentor from their organisation to support them through the induction process. This section looks at how this worked in the programme. In some cases, the mentor was also the learner's line manager, particularly in smaller organisations. In other cases, the mentor was another experienced member of staff.

This section also looks at the role of the manager in the pilot and how they supported their workers undertaking the programme.

The programme ran a 'mentor's awareness day' for managers and senior care workers who were going to support learners during and after their AWIF course. The day was open to managers, senior care workers, shared lives officers, domiciliary care supervisors, and any

others nominated by the service. The training was held two to three times per cohort. The day was put in place after the first group of the first cohort and many managers and mentors took it up.

The course supported managers and mentors to:

- develop their own leadership and management skills
- reinforce their own study skills and knowledge of the subject(s) using different learning styles
- go through the programme outline and workbooks
- understand the AWIF course in greater detail so they could be confident supporting new staff to complete their workbooks
- access and identify good answers whilst assessing, and use good practice when giving feedback to candidates
- follow a standardised way of working with support from the programme coordinators
- develop a good mentoring relationship with their candidate.

The impact of mentors on learners

Learners valued having a mentor and the support and reassurance they provided.

> *'I had a couple, actually… And they were brilliant. Literally, I brought my workbooks in, and they talked everything over.'*
>
> **Learner 2**

Mentors felt that they had a positive impact on learners, giving them confidence, reassurance, and more practical support.

> *'I think it makes them feel valued, and they're not on their own.'*
>
> **Manager 7**

Managers also felt that that the mentor role was a good mechanism for supporting new staff.

Not everyone felt they needed a mentor and some learners were happy taking on the work themselves, or alternatively looking to their supervisors for mentoring support. Other learners sought advice and guidance from the course tutors. However, there is a risk that tutors would be overloaded if too many learners turned to them for support and guidance rather than to their mentor or manager.

Overall, there was agreement that mentoring was very important for instilling confidence and encouraging learners to complete the programme, whether it was provided by a manager, or one of the tutors. Managers said the mentor role was critical to some learners completing the programme.

> *'I think without the role of mentor, then I don't think many of our staff would have completed it. […] I had to constantly push for them to complete it. I think without me there*

mentoring them and guiding them through, I don't think they would have done it, they didn't have the motivation - or put in the effort that they did. I think they would have just put whatever down to get through, rather than actually take it on board and listen to it.'

Manager 5

Support for mentors and the impact on them and their role

Mentors found the support that they received, including the mentor training day, very helpful. But also noted that there was a certain amount of learning as they went.

'I attended training… I found that helpful, I found that I got a better idea about what the mentoring role was going to be and what I was expected to do. I think that there were a few things that I found a little bit confusing, but quite often it's a case of, well, getting stuck in and then working out the bits that are a bit confusing.'

Mentor 1

Mentors, particularly those who were also managers, commented on the amount of time being a mentor took, and the challenge of balancing that with their other duties.

'Of course, as registered manager, I've got a lot of things that I need to be doing, so it took a massive chunk of my time, that the induction has done that, me having to sign off and mark the workbooks and constantly chase them, it has taken quite a substantial amount of my time.'

Manager 5

Mentors noted that they had been anxious about the impact on them and being able to fit all the work in. Some had to change their working pattern, and even take on overtime to make sure they could be on shift with their mentee. Other managers had similar concerns that senior staff did not have time to fill in all the logs and double check everything, even though they supported the role of mentor for the day-to-day support it provides for new staff.

One manager commented that there was a limit to the amount of people a member of staff could mentor at one time because of the extent of what was required.

At the same time, not every mentor felt that the extra workload was an issue, and some noted that while being a mentor does change the amount of work they do, they would be doing a lot of it anyway.

'…it's my job to build relationships with the staff members and support them, but as I said, because I've built those relationships, they see me as the person to turn to about everything and anything, which is brilliant, but it does increase the workload at times.'

Mentor 6

Manager involvement

Some managers who were not also mentors felt or wished that they could have been more directly involved.

'I could have had a bigger role in helping the mentor. I know that I have not got that much time to do that role itself, but I do need to play a part in it, so I need to be there for the mentor and the staff member, but in more advisory and guidance.'

Manager 1

This interviewee felt they should perhaps have also done the mentoring training, so that they could guide the mentor.

Tutors noted that it was the manager rather than the mentor who was the main point of contact for them because they had referred learners onto the course. In most instances they would contact the manager if there were any issues. Because of this it was important to maintain a good relationship with the managers.

'If you've got the manager on board and they're having supervision and they're seeing that member of staff, their progress on that qualification, or on that training, should be reviewed and documented as a part of supervision, and it [hangs it] all together.'

Stakeholder 7

Tutors worked with the managers to help make sure learners were ready for the assessment. Interviewees emphasised the importance of keeping learners and their line managers informed and up to date with how the learner is progressing through the course and assessment.

What could have worked better about the mentor system?

In some cases, mentors were unfamiliar with the course or the content / structure of the AWIF (Learner 2). This proved a barrier because mentors had to familiarise themselves before being able to mentor effectively and emphasises the importance of mentors (and managers) attending the mentor's awareness day.

But there were also suggestions that mentors needed greater familiarity with the workbooks and content of the AWIF than they could get from a day of training. As one learner noted, it would be advantageous if mentors have undertaken the AWIF themselves, and this will become easier as more people in roles have undertaken the AWIF.

This was echoed by mentors. Some mentors said they found the level quite challenging and were not sure of the answers in the workbooks. Mentors felt that if they had had to do the programme themselves, they would be in a better position to support their mentees.

'I think it would be really useful if it was mandatory for the mentors to complete it themselves. Even if it's not in a classroom, but if they have to complete the workbooks themselves, just so they can see what the new employees, the new staff members are [learning].'

Mentor 6

Another suggestion was for a follow-up or 'standardisation' meeting for mentors after the training, potentially complemented with some form of troubleshooting forum for mentors. Standardisation meetings have now been implemented, and the coordinator meets with mentors for two hours every month to go over the role, the requirements, share learning and best practice, and offer mutual support.

Not having enough time to mentor as effectively as they would have liked came up in several mentor interviews. One learner also reported that their mentor didn't have any time to support them. They felt there needed to be more support from their manager so the mentor could take time alongside their other duties to support the learner.

> *'… the management needed to set a certain time with us or set a certain amount of hours a week where we could sit down away from everything, rather than the work setting. … because obviously when once you're in the work setting and she was in work, she was called away to do this or she was like, taking phone calls or, it just didn't work as a mentor side of it.'*
>
> **Learner 3**

Sometimes a learner's line manager took on both the mentor and assessor role, i.e. they were signing off on people's workbooks. Mentors felt that ideally these are two distinct roles, but also acknowledged that in some settings or service models it is not easy to provide a separate mentoring role.

In health, the mentoring or buddy system was challenging for bank staff because they wouldn't work in the same place from one day to the next. Interviewees noted that they had tried a number of ways of addressing this issue.

> *'…the bank staff are working everywhere, so they haven't really got one buddy or one mentor they can rely on. We did try a system where they would go to the same place for a fortnight. Then, we tried a system where they would go to the same place for their two shadow shifts, but not even that was working. Sometimes, we would put somebody in one place but then by the second day they'd be moved or they'd be sent where they were actually required more urgently then.'*
>
> **Stakeholder 3**

But none had solved all the difficulties, so it was something they were continuing to work on.

Advice for future mentors

In the interviews we asked mentors for any advice they would give to future mentors. They suggested:

- Make sure you are familiar with the workbooks and other programme material.
- Be engaged and ask questions so that you understand the programme and qualification, and how learners progress through it.
- Meet regularly with the person or people you are mentoring, and set aside time to support them.
- Understand and be prepared for the amount of work required, for both the mentor and the learner.
- Build relationships with mentees so that they feel that they can come to you.
- Be aware of how your practice can influence the people you are mentoring, both positively and negatively.

Importance of the mentor role

Despite some of the difficulties acknowledged above, it was agreed that the mentor role is an important one. Managers felt the mentor role was vital for instilling confidence in learners and encouraging them to complete the induction. Mentors were also best placed to observe and record learners' progress.

Interviewees also felt mentors were important for parity between social care and health, where there is a more established formal mentoring system. Social care settings have tended to have peers or buddies, a less formal system for new staff in their first six weeks.

6.8. Delivery costs

This section shows the estimated costs to deliver the programme to 100 learners over one year. These costs have been provided by the project working group from records kept during the pilot. The planning and development of the pilot and developing the course materials required notable in-kind investment from the working group and steering group, which would not be required in future programmes.

Table 6-1. Estimated direct costs for delivery to 100 learners

Staff	Cost
Learning & development advisor (Social Care) *Full-time, salary + on costs*	£47,000
Learning & development advisor (Health Care) *Full-time, salary + on costs*	£47,000
Business support *Full-time, salary + on costs*	£25,000
Other costs	
Equipment for training (e.g. blood pressure cuffs, temperature probes, PPE)	£5,000
Digital learning resource licences	£1,000
IT (Laptops for students)	£5,000
Communication (flyers, printing workbooks) *£10 per learner*	£1,000
Staff training	£4,000
City & Guilds accreditation *£89 per learner*	£8,900
Agored accreditation* *£19 per learner*	£1,900
Total	**£145,800**
Cost per learner	**£1,458**

* In the pilot region, the Health Board accredits through Agored. They also recognise City & Guilds so dual accreditation might not be necessary in future programmes.

Alongside these direct costs, the pilot was supported by contributions from the project partners. Similar support would be required for future programmes:

- Host manager(s) for the Learning and Development Advisors (approx. 10% FTE).
- IT and finance support in the host organisation.
- Guest training session delivery by social care and health experts (delivered at no cost to the pilot).
- Use of venues, and provision of refreshments for training.
- Use of existing equipment for training demonstrations (beds / chairs etc.).

- Learner travel and release costs were covered by their employers or pre-employment schemes.

During the pilot, the programme was free to employers. Interviewees noted that this helped make it more attractive.

> *'I think for employers, that not having a cost does help. The only thing they've got to do is to plan and to cover and make sure that there is cover… I think anything that's subsidised or free is more attractive to an employer than having to pay for it.'*
>
> **Stakeholder 4**

The same interviewee said that they had a training budget for unemployed people and would consider using that to pay for training like this.

However, some managers felt that the training was already a cost to them because they had to pay staff for their time spent on the training. They noted that this training was five sessions on top of the other training they put their staff through.

Interviewees reported similar views from other employers.

> *'…external providers were not backward in coming forward, in saying, "Well, when you've got this kind of opportunity, and the requirements upon learners and the organisation, you're a big local authority, you can afford to do it. You can let your learners have however many days to go and do this. We're a small independent care home and we can't afford it."'*
>
> **Stakeholder 7**

Interviewees also noted that it was challenging because the pilot was competing with colleges who provide training at no cost to employers. They recommended that, if it continues, the joint induction has to be provided free.

> *'We received funding for the pilot, we've utilised every penny of it and it seems to be expanding, so now we have to seriously look. It's a choice, isn't it now, for the health board and the local authorities to decide: is this something we want to pursue?'*
>
> **Stakeholder 6**

7. Joint working across health and social care to deliver the pilot

Key points

Interviewees felt that **this pilot was a relatively rare example of successful joint working across health and social care**. As such, the learning from the pilot may help inform future joint working, both in this programme and elsewhere.

A number of factors emerged as being important for this successful joint working:

Joint working was embedded in *all* aspects of the project. Both the steering group and working group contained a mix of representation from health and social care organisations. Both groups were co-chaired, each group had one chair from health and one from social care.

Interviewees felt that it was not just the joining of health and social care organisations and staff, but **having the right mix of organisations** involved in the pilot that contributed to the success.

Having a dedicated project coordinator role sitting across social care and health was critical to the project's success. As an integrated post it helped break down barriers and build relationships. As a dedicated role it could drive and manage delivery, and provided learners and managers with a single point of contact.

The programme was co-delivered, with one tutor from health and one from social care, and additional subject matter experts. This **co-delivery meant that learners got both health and social care perspectives, and were better prepared for working in either sector**.

The model of joint working allowed those delivering the project to **build strong relationships crossing health and social care boundaries**. This helped with delivery of the project, reacting to the COVID-19 pandemic, and has led to other opportunities.

Having a shared goal and shared belief that a good quality joint induction would improve outcomes for people receiving care and support was identified early in the project and returned to as a motivating goal.

The **passion and commitment** of the working group to successfully deliver the pilot was identified by many interviewees. This was an example of **leadership at all levels** and was **motivated by belief in that shared goal**.

Having **support and sponsorship from senior leaders** in social care and health legitimised the pilot and meant it could identify and tap into resources.

A full investigation of these factors, and others that contributed to the success of the pilot, is outside the scope of this evaluation, but all these factors echo other work on successful interventions and successful scaling of interventions (Allbury et al., 2015; Collins Ben, 2018; Greenhalgh et al., 2004; Shiell-Davis et al., 2015) and should be borne in mind for the future of this pilot, and for other similar initiatives.

7.1. Health and social care organisations working together

The shared approach to steering, designing and delivering the project was integral from the outset. The steering group was co-chaired by a Director of Hywel Dda University Health Board and a Director of Social Services. The working group was also co-chaired, members were from health and social care, and one of the tutors was from health and the other social care.

Interviewees felt that this pilot was a relatively rare example of true working together across health and social care.

> *'I think it's been talked about, health and social care, health and social care, but it has never really been health and social care. It has always been health that side and social care that side, so the 'and' doesn't really work. I think for this project, it actually says it as it says on the tin, health and social care, because that is exactly what we're doing.'*
>
> **Stakeholder 10**

Although it was outside the scope of this evaluation to fully investigate why this example of working across health and social care was successful, when others have not been, there were certain factors which emerged as important.

Having a shared goal

Interviewees felt that an important part of the success in working together was that the project had a shared goal which they all believed in and could refer back to.

> *'I think that worked incredibly well, because even though we are from a health and social care side of things, I think there was a shared goal immediately in terms of this was about raising the standard and absolutely everyone was on board as far as that was concerned.'*
>
> **Stakeholder 1**

Having the right mix of organisations, people, and support from all levels

Having the right organisations around the table, with clear senior commitment was also important to the success of the project.

> *'So having [name removed] and I both as directors within the two key organisations, taking a lead on this has, I think, been very helpful, because we are able, as I say, to tap into resources and support the people that are actually doing the work on a day-to-day basis. Having HEIW and [Social Care Wales] and others around the table, plus linked into Work and Pensions Department, all the Jobseeker stuff, everybody actually coming around the working group table, has been really helpful. Having training managers from both health and social care has absolutely been critical.'*
>
> **Stakeholder 11**

Interviewees felt that by working together and drawing on the expertise from both health and social care they were able to create and deliver a programme which combined the strengths of both sectors.

Passion and commitment

Another key theme that emerged was the desire and passion from those steering and delivering the project to make it work in the face of numerous difficulties.

> *'There was a real desire from all the parties to make this work to really add value to the learner and to the person receiving care, so it was set up on the right principles and values.'*
>
> **Stakeholder 2**

> *'I'd have to say that [the working group chair], who works for us, and [the working group chair] who works for the local authority, they have been phenomenal and it's, I think, thanks to their real drive, impetus and sheer determination, that we're able to make the steps forward. They have worked in a very integrated way.'*
>
> **Stakeholder 11**

This commitment and passion was said to be rooted in a shared belief that a joint induction with a focus on quality would lead to better outcomes for people accessing care and support.

> *'That was really feeding through the steering group about the positivity around that. In other words, we're not just going to tick an induction framework document where you've got to go through that with your manager as a social care frontline worker or a health frontline worker, that you're going to get a tick exercise around what you've done in your first 30 days of training. No, we're going to have a really joint programme as we walk forward - much more detailed; much more informative; and much more developing in terms of where we see you going in this industry …'*
>
> **Stakeholder 5**

7.2. Building relationships

Interviewees talked about how working on the project had helped to build relationships across health and social care and about the importance of the 'softer' or harder to measure benefits that came from working together. These can be important factors in moving towards greater integration and more efficient working across health and social care. They lead to, and result from, greater understanding of each other's roles, responsibilities and working environments.

> *'I've enjoyed the building of relationships. I think building relationships and working together has been really positive; better understanding of the roles that we've all got and the systems and processes that we've all got to follow. We can't always change the system, but we can change the way we work towards changing a system.'*
>
> **Stakeholder 3**

Interviewees from social care described how health can feel like it is closed to outsiders, 'you feel like if you go to the NHS, you've gone into a territory that is not your territory' (Stakeholder 10). But they felt that the distinction was not so clear in reality, '…we're actually really the same, but just working under different protocols' (Stakeholder 10).

Interviewees described how working with colleagues in health had helped to break down those barriers. They said that at first, when they went into health settings, health staff commented on the fact that they worked in social care, but after some time they were treated like 'a normal member of staff within health' (Stakeholder 10).

They felt that there shouldn't be this distinction between the two, where one is seen as more prestigious.

> *'It shouldn't be like, you work in health, you're not important or you work in social care. It should just be we are working in an environment where we're supporting people with vulnerabilities and we need to just empower them and give them the choices that they deserve, and that's all it should be.'*
>
> **Stakeholder 10**

Interviewees also noted that working jointly had led to opportunities to feed into other projects and initiatives that cut across health and social care (Stakeholder 6). They felt that it was important for all levels to work together because 'no one sector's got the answers to these problems' (Stakeholder 2) and that more joint working will lead to greater opportunities.

> *' I think it's things like that that are happening right now that actually, we're talking to each other. We are dovetailing our work a lot better. I get regular invitations to the Care Home Support Team for the Health Board. … I've presented to them about social care work and this programme…'*
>
> **Stakeholder 6**

7.3. Co-delivery of the programme

As described above, the programme was delivered by one tutor from health and one from social care (with guest tutors for specialist subjects). Tutors felt that this model worked very well because the tutors complemented one another and were able to cover both health and social care (Stakeholder 10). This allowed them to bring real examples and experience to the teaching from both sides, and thereby better prepare learners to work in either sector.

> *'… I think worked really well. We were thinking about both sectors and it was demonstrating that we do work collaboratively.'*
>
> **Stakeholder 3**

They felt the pilot demonstrated that for many topics there was no need to have separate training for health and for social care staff, and there were advantages to delivering the training jointly.

> *'We can work together and there's no reason why we should be delivering the same training in two places about the same thing. With dementia, for example, and infection control, why do we need to deliver them in siloes when we could have a greater understanding and better collaboration?'*
>
> **Stakeholder 3**

The tutor from health noted the impact of having a tutor from social care on health care support workers. They said that they were used to health care support worker trainees being highly engaged and asking lots of questions during health inductions. But they were also pleased to see that in the joint induction pilot the health care workers were highly engaged and interested in the elements of the training from social care, 'they were enjoying the training so much that they were asking even more questions' (Stakeholder 3). 'I was a lot happier because they felt that they got a lot from it' (Stakeholder 3).

7.4. The importance of a dedicated integrated post in the team

A key role in the delivery of the project was that of the project coordinator, a role created specifically for the pilot, with responsibility to coordinate and deliver the Joint Induction and All Wales Induction Framework programme. The coordinator was employed by Carmarthenshire County Council but worked across health and social care to make sure the project was working to its objectives. They were an experienced social care worker, tutor and assessor and were one of the two main tutors who delivered the training.

The coordinator worked with the tutor from health, and other working group members, to take the programme outline and build it into a full training programme with supporting materials. Their coordination activities included scheduling training, recruiting and contacting learners and managing an administrator who provided project administration.

Interviewees felt this role had been critical to the success of the project, and that it was crucial that it sat across both health and social care teams as it helped break down barriers and build relationships.

> *'The role of the learning and development adviser [as project coordinator] has been 50:50 [between health and social care]. It's completely innovative. We've never had a learning and development adviser who sits in both the Health team and the Social Care Workforce team. That starts to build relationships, doesn't it, across teams? You start to realise and recognise and value each other's skills and understand them. Up until now, the barriers are sometimes there because both sides don't see the other side.'*
>
> **Stakeholder 6**

Having one role dedicated to the project was seen to be important because all other members of the working group and steering group were delivering the project alongside their 'day jobs'.

> *'Having the [project coordinator] come in to tie it all together, that was critical because otherwise you've got people doing a day job and trying to do the pilot and everything else. So that was a really good investment. That's where I say, it doesn't need a lot of money to actually make these things happen, but it does need some pump priming. So that was an important point.*
>
> **Stakeholder 11**

Interviewees felt the project would not have worked without this dedicated role.

> *Having [the project coordinator] to be able to manage and steer the pilot was so invaluable. [name removed] and I as co-chairs, I don't think we would have had enough*

time to be able to manage it all. Having [the project coordinator] there to be able to focus it and bring it all together was absolutely the best thing we could have done.'

Stakeholder 3

People taking the programme also felt having a single point of contact, someone who was aware of all aspects of the course, was highly beneficial. It meant that when learners or managers were not sure about an aspect of the course or how it all fitted together, they had a single person they could go to.

'That was useful I think having that continuity and that one person that they can go to who knows what they're doing … and has met them…'

Stakeholder 4

Interviewees felt that having more people in shared roles would help to increase collaboration and sharing of resources and reduce silo working, and that in the context of COVID-19 and post-COVID this collaborative approach was particularly important (Stakeholder 3).

8. The impact of the programme on learners and on their practice

Key points

Evidence from interviews and surveys shows that **the programme increased learners' confidence in a range of knowledge and skills** needed for delivering good quality care and support.

Learner **confidence increased whether they had limited previous experience working in health or social care, or had already been working in health or social care for more than a year**. This suggests that the programme has value for experienced as well as inexperienced workers.

Importantly, **managers and mentors also recognised that those who had been through this induction programme were more confident in their practice than those who had not had an induction like this**. They noted that those who had this induction were better placed to mentor or develop other staff than people who had not had this induction.

Managers, mentors and learners felt the programme led to positive changes in practice. They provided examples of changes in practice relating to many areas of care and support including:

- knowledge of specific tasks and practices
- safeguarding
- risks and balancing risks
- treating people with dignity and respect
- identifying poor practice and encouraging good practice
- reporting and recording
- delivering person-centred care

Managers stated that **learners who had been through this induction programme had a deeper level of background knowledge that underpinned their practice**. Notably, many managers identified that learners in this programme understood *why* they were doing something. Having **that background understanding should support good practice over the longer term and create flexibility in the workforce**. Because workers understand the reasons why they are doing something they can translate their practice to different contexts.

8.1. Learner confidence

Learners reported that the programme had made them more confident. Those who were new to practice felt better able to take on new duties or tasks, and able to ask questions and discuss the care they were providing with colleagues.

> *'It gave me confidence, because I went back to work, and then, obviously, I was brand new, sort of thing, so the people on the ward were saying, "Well, how do you know how to do this?" Or manual blood pressure, for example, they were saying, "How do you know how to do this?" And I said, "Well, we've literally just learnt it," or, "I have the confidence*

to do it," to the nurse. So it sort of helped her out. And I would never have known how to do it if I hadn't have done the course.'

Learner 2

'If you notice anything, you'll bring it up, and discuss it, and tell people. Again, that's all come from the training, I think. Whereas before I might have been a bit - because I was new - not sure I wanted to suggest things. It's certainly given me a lot more confidence to be confident in what I'm doing and why we're doing it really.'

Learner 5

Learners with significant previous experience in either health or social care said that, even they were already confident in their ability to practice, the training impacted on their practice positively.

'No, not necessarily more confident, but just refreshed. It didn't make me more confident, but it also stopped me from becoming more complacent.'

Learner 1

Managers and mentors also observed increased confidence for learners who had undertaken the course, and that they were more confident than workers at a similar stage who had not undertaken the course.

'Confident in some tasks and roles, and they've definitely got an increased knowledge. They don't just know that they're doing something, they know why they're doing it.'

Manager 4

'Yes, they're more confident, the ones who've done the joint, they're more confident, and they tend to mentor a bit more towards other staff coming in. They're more, I think they're better at developing others and helping them with that development.'

Manager 5

Case study 1 below describes the impact of the induction on both worker knowledge and the confidence this knowledge instils in the care worker, both because they know how to deliver good quality care, and that it is okay to ask questions and ask for guidance if they need to.

Case study 1

One learner was relatively new to working in care. They had previously worked in domiciliary care but had left that role because of an incident which had affected their confidence. In that role they had been supporting somebody in the community, including providing personal care. But they needed support for continence products and the learner had not supported anybody with incontinence before. They didn't know what was needed or what to look for. In the absence of advice, they had taken their own personal sanitary products from their car and given those to the client.

The learner said, ‘I didn't know what to use, and this poor lady, I had to get my own pads to put on her.’ They had not seen an incontinence pad previously; they didn’t know how to put one on or how to go through personal care properly. Because of this they questioned their own competence, saying, 'Well, if I don't know how to use a pad, then how can I be helping these people?' They left that role because of those feelings of inadequacy.

Following the training on continence in the pilot, the learner said, 'Oh, there was a box of them in the house. Now I know what they look like.'

The programme gave the learner more awareness and the confidence to ask questions and to look to see if the right supplies or equipment are there to use.

Survey data on confidence in knowledge and skills

Data from the surveys reinforces learner’s statements that the programme improved their confidence. The results suggest that the programme had a positive impact on confidence across all areas of skill and knowledge, regardless of whether learners had significant previous experience delivering care or not.

Learners were asked to rate their confidence in nine areas of knowledge and skills important for delivering good quality care and support:

- Communicating with people I support, or will support
- Applying person-centred care
- Knowledge of relevant legislation, policy and codes of conduct
- Safeguarding people I support, or will support
- Assessing and managing risk in the workplace
- Knowledge of medical conditions and diagnosis relevant to people I support, or will support
- Identifying factors that impact on well-being
- Meeting individual health needs for people I support, or will support
- Developing positive relationships and maintaining professional boundaries

Learners were asked to rate their confidence on a scale of 1 (not at all confident) to 10 (very confident) at three points: the start of the training (entry), the end of the training (exit) and approximately six to eight weeks after their final training day (follow up). However, due to the low number of responses at follow up those results are not reported here[3]. The tables below present the averaged (mean) confidence score for each area of knowledge and skills at entry and exit, and the change from entry to exit.

Table 8-1. Confidence in knowledge and skills

Thinking about your knowledge and skills now, please rate (on a scale of 1-10 - 1 being not at all confident to 10 being very confident) your confidence in the following:

Knowledge or skill	Entry (n=65)	Exit (n=66)	Change
Communicating with people I support, or will support.	7.97	8.67	**+0.70**
Applying person-centred care.	7.73	8.82	**+1.09**
Knowledge of relevant legislation, policy and codes of conduct.	6.01	7.72	**+1.70**
Safeguarding people I support, or will support.	7.67	8.77	**+1.10**
Assessing and managing risk in the workplace.	7.06	8.49	**+1.43**
Knowledge of medical conditions and diagnosis relevant to people I support, or will support.	6.12	7.75	**+1.63**
Identifying factors that impact on well-being.	7.31	8.64	**+1.33**
Meeting individual health needs for people I support, or will support.	7.38	8.63	**+1.26**
Developing positive relationships and maintaining professional boundaries.	8.28	9.12	**+0.84**

Learners increased in confidence in all areas following the training. The areas where learners rated their confidence lowest at entry (knowledge of legislation and policy, assessing and managing risk, and knowledge of medical conditions and diagnosis), were those that saw the greatest increase in confidence. Although they were still the areas of least confidence at the exit point.

Comparing learner confidence between low and high experience groups

We compared the responses to the confidence questions from those learners with little or no experience working in health or social care, with those with moderate to high experience.

[3] The data from the 12 learners that we have at follow up shows a small reduction in confidence between the exit and follow up. But at follow up point, confidence is still higher across all areas of knowledge and skills than it was at entry. While we should not read too much into this because of the small number of responses, it suggests that the training and any subsequent experience delivering care and support, could have had a longer-term impact on confidence.

Table 8-2. Confidence in knowledge and skills (low experience)

Thinking about your knowledge and skills now, please rate (on a scale of 1-10 - 1 being not at all confident to 10 being very confident) your confidence in the following:

Knowledge or skill	Entry (n=65)	Exit (n=66)	Change
Communicating with people I support, or will support.	7.65	8.53	**+0.88**
Applying person-centred care.	7.18	8.47	**+1.29**
Knowledge of relevant legislation, policy and codes of conduct.	5.18	7.44	**+2.26**
Safeguarding people I support, or will support.	7.03	8.39	**+1.36**
Assessing and managing risk in the workplace.	6.15	8.03	**+1.88**
Knowledge of medical conditions and diagnosis relevant to people I support, or will support.	5.15	7.09	**+1.94**
Identifying factors that impact on well-being.	6.62	8.38	**+1.76**
Meeting individual health needs for people I support, or will support.	6.50	8.34	**+1.84**
Developing positive relationships and maintaining professional boundaries.	8.09	8.88	**+0.79**

Table 8-3. Confidence in knowledge and skills (high experience)

Thinking about your knowledge and skills now, please rate (on a scale of 1-10 - 1 being not at all confident to 10 being very confident) your confidence in the following:

Knowledge or skill	Entry (n=65)	Exit (n=66)	Change
Communicating with people I support, or will support.	8.30	8.82	**+0.52**
Applying person-centred care.	8.30	9.18	**+0.88**
Knowledge of relevant legislation, policy and codes of conduct.	6.88	8.00	**+1.12**
Safeguarding people I support, or will support.	8.33	9.15	**+0.82**
Assessing and managing risk in the workplace.	8.00	8.97	**+0.97**
Knowledge of medical conditions and diagnosis relevant to people I support, or will support.	7.16	8.42	**+1.27**
Identifying factors that impact on well-being.	8.03	8.91	**+0.88**
Meeting individual health needs for people I support, or will support.	8.25	8.91	**+0.66**
Developing positive relationships and maintaining professional boundaries.	8.48	9.36	**+0.88**

Unsurprisingly, low experience learners rate their confidence lower than those with more experience at both entry and exit.

The same three areas (knowledge of legislation and policy, assessing and managing risk, and knowledge of medical conditions and diagnosis) are the lowest rated for both experienced and non-experienced learners. Although it is interesting to note that experienced learners rate their confidence in identifying factors related to wellbeing at the same comparatively low level as their confidence in assessing and managing risk. For non-experienced learners, their confidence relating to wellbeing is comparatively higher.

Both groups report an increase in confidence in all nine areas from entry to exit. The increase is highest in non-experienced learners, who had a comparatively lower starting point.

Overall, these results suggest that the programme has had a positive impact on confidence in all these areas of skills and knowledge, regardless of whether learners had significant previous experience delivering care, or no experience.

8.2. Changes to practice, supporting person-centred care and better outcomes

Objective measurement of changes in competence (i.e., ability to practice effectively) was outside the scope of the evaluation because that would have required establishing a baseline for each individual and then some form of observation or measurement after learners had gone into practice. Nevertheless, although learners were not in a position to provide objective evidence that their practice improved following the training, they did identify examples of changes to their practice which they felt were due to the training. Examples of changes to practice covered many areas of care and support including:

- Knowledge of specific tasks and practices
- Safeguarding
- Risks and risk management
- Treating people with dignity and respect
- Identifying bad practice and encouraging good practice
- Reporting and recording
- Delivering person-centred care

This was reinforced by managers who also noted positive differences in knowledge, skills, and approach to providing care between staff who had this induction programme and staff who would have come in without it.

Managers identified that learners who had been through this induction programme had a deeper level of background knowledge that underpinned their practice. Notably, many managers identified that learners understood *why* they were doing something. Having that background of understanding can support good practice over the longer term, and create flexibility because it provides the ability to translate practice to different contexts.

Learners described how the programme had developed their practical skills and understanding.

> *'…when I'm monitoring them, I can be more, I can visualise better what needs to be done and what can't be done. The way somebody is helped out of a chair, the right way, the wrong way.'*
>
> **Learner 6**

Interviewees gave examples of how they were able to apply their learning. One interviewee described how they learnt about 'last offices' on the training, and the following week were asked if they could do them on the palliative care ward.

> *'And literally, I just went through what [the tutor] had taught me, and I was able to sort of put it to the book, sort of thing. Literally, I was calm, collected. And if I didn't know what that was, if somebody had turned around to me and said, "Can you do last offices?" I wouldn't have had a clue. So that was brilliant that they could sort of talk through it. And*

then I wasn't afraid of doing it because they'd spoken about it in a calm and collected way, I knew that I could do it when it came to it.'

Learner 2

Both learners and managers identified the clinical skills and observations as an important part of the programme that led to changes in practice.

'Like if somebody is checking somebody's blood pressure, are they doing that correctly? It's how they're using equipment, so that it's done correctly. Health and safety side of things. That everything is locked away that should be locked away. Storage of equipment, the storage of items and pads even, you know, that they're not left out, that they're put away in a safe place.'

Learner 6

Notably managers identified how this had helped during the pandemic.

'I suppose the classic would be their observations, blood pressure. It couldn't have come at a better time with COVID because obviously, the GPs aren't coming into the building, or weren't initially coming into the building, so we were able to do observations on the residents and the girls were quite confident and competent. They've obviously gone through our own competency checks as well, but it was in AWIF that they were initially shown how to do it. They were taught why they were doing it.'

Manager 4

Another theme in interviews was treating people with dignity and respect. One learner described how, following the training, they were much more aware of the importance of treating people with dignity and respect in both their communications and actions.

'I'm just about to do this to you now, is that all right?' That kind of thing, which I wouldn't have done before. […] I'm more careful to make sure the curtains are closed, make sure the doors closed, or if someone's sat on a commode, stick a towel over their knees. That kind of thing which I probably might not have thought about before. I would have just followed what the other people did. You know a lot more about why, and dignity, and choice, all that kind of thing.'

Learner 5

Notably, this example highlights that following the training, the learner understood the reasons *why* it is important to treat people in this way. Before they might have just followed the cues of other staff, and missed important things, or not been able to extend that approach to care to different contexts.

Interviewees also noted that they were more aware of the risks around litigation and the importance of understanding how their actions might be perceived.

'… because I'm a male in that sort of term or workplace, I have to be aware or more acutely aware of what my actions portray. I can go up to an elderly lady and just ask, 'Can I have a look at the bruise on your back?' and they go, 'My God, this strange guy's

coming up and wants to have a look at me.' So I have to approach it probably slightly differently from the ladies have to.'

Learner 9

Some learners who were new to care said that the programme helped them identify when others were not exhibiting or following good practice.

'And their rules were so different. Like, obviously, when you start work, you slip into bad habits and things like that. So that's what I was noticing, these bad habits were highlighted 10 times bigger…'

Learner 2

They had the confidence to ask questions about those practices and note how they were different from what they were taught in the programme. Managers and senior staff were then able to support or instigate better practice by others.

'…the ward sister told me and the other girl on the course, she said, "You've come in and you've literally wiped the slate clean, and this is how you're supposed to do things." People, obviously, learn from us then. So, yes, it was really good to get that experience.'

Learner 2

Managers were able to make comparisons between staff who have had this induction, and previous/other induction programmes. They noted improvements in knowledge and understanding, as well as confidence.

'…I think the units in it are so good, the content. It might be bite-sized, but it's everything that we need. They're actually learning everything whereas if I look at the ones that haven't had the opportunity to do that when they came in say two years ago because there wasn't induction framework […] I think it took them longer to be able to understand certain things, like the importance of oral health or safeguarding or dementia...'

Manager 1

Managers and mentors also noted positive impacts on reporting and recording practice following the training.

'They're much more aware of reporting and recording. In fact, I think I could safely say that their recording has actually improved, because they've learnt the bigger picture all in one go, they've realised the importance of it.'

Manager 4

Supporting person-centred care

Learner interviews suggest that the programme provides a foundation for delivering person-centred care. Learners knew what person-centred care is and felt more able to practice it.

> *'…it's given me the ability to be a bit more patient-centred, give better patient-centred care and put their needs first, more than anything. Treat everyone accordingly, and whatnot. It's just given me a better understanding…'*
>
> **Learner 8**

Managers also noted that the programme reinforced person-centred approaches.

> *'I think the biggest part of it was the principles and values that gave them a good look at how they should be reinforcing the person-centred approach constantly. I think they realised a lot with the videos of Betsan, how small things can be a much bigger issue. I think it opened their eyes to that and I think it improved that, everybody's awareness of and importance of that person-centred care. They were doing it, but I think they've got more of an understanding of it now, so it's better.'*
>
> **Manager 5**

And learners provided examples of putting this into practice, being responsive to people's desires and treating them and as individuals.

> *'It's not an institution. They can have their dinner a bit later if it's a nice day and they're sitting outside. Occasionally you might say, 'It's going be this for tea,' and it's such a nice hot day, we might say, 'We're not going to do that, we're going to have a barbeque.' That kind of thing. […] I think I understand a lot more now from having done the course about that aspect...'*
>
> **Learner 5**

Managers felt that as part of the person-centred approach, the programme supported positive risk-taking, and that that the programme would lead to better outcomes for people receiving care and support.

> *'I think it's reinforced the importance of the care plans and why we do them in the way that they do. We have that person-centred approach implemented in there and the risk assessments and things that, sometimes, there's things in there that you might think about, unsuitable for somebody, but again, it's about the positive risk taking. The induction reinforced that for people and exactly what that means for them.'*
>
> **Manager 5**

> *'I think for people that receive care I was really happy with the pilot in terms of this is really going to make a difference in terms of the level of care that people have and the standard that they receive.'*

Stakeholder 1

The case study below illustrates how joint training and widening the skills of health and social care workers can lead to both more efficient care (the care support worker was able to do the observations, freeing up time of the hospital staff) and better outcomes for patients

(the observations were accurate because the care support worker knew how to communicate with the patient, and was able to reassure them in what was likely a stressful situation).

Case study 2

One learner worked for a provider of care to people with learning difficulties and/or autism, as well as other disabilities. She enjoyed the training, and her evaluations were very good. On returning to work she found that one of the people that she supported with learning difficulties and communication problems had to go to hospital. She took them to hospital, where they were admitted. Because she knew this person and the support that he needed, she offered to do the blood pressure monitoring and complete the chart. The NHS staff were not used to that, but she was able to convince them by explaining that she'd just had the training and had been signed off, "I know how to do this, and I can communicate with him better than you because I know him and I'm his carer."

She did the observations and recorded them, if she had needed to escalate anything, she knew how to do that because of the training. She said that she'd never done something like that previously and would never have done it if it wasn't for the training. She said that it made her feel important. She said once you got to hospital, you were often seen as just a carer from somewhere.

'I felt like that day, I wasn't just a carer, because I could do what they were doing and I could actually tell him what was recorded, and reassure them that they were not at risk, they were okay. I could still communicate with him and I could still stay with him, because the hospital staff didn't know much about him, but I did.'

As well as showing more efficient care and better outcomes for the person, this example demonstrates the impact that having these skills and the confidence to put them into practice had on the worker and their self-worth. We return to this topic in section 9.3 below.

Another example that illustrates how this induction programme can lead to better outcomes for people comes from a learner's personal life. In one of the training sessions the learner described how they were able to recognise signs of deterioration in their partner, record their temperature and pulse and then contact a GP with that information. The tutor described how that resonated with other learners in the session. They began to see how they could put their learning into practice, and how that would help them to provide better care and support to people by identifying early signs that they might be unwell.

Overall, managers felt that the effect on learner's confidence and competence would have positive impacts across their organisations. Giving managers the confidence that new staff will be able to do more, sooner, and providing more flexibility in their delivery.

> *'I think it is going to change the dynamics. I think people are going to be coming in quite skilled whereas we've always been used to doing our own and sending people on all these different trainings whereas they're going to have an idea of all these different areas within the first few months, which is great.'*
>
> **Manager 1**

Understanding why

A consistent theme across many of these examples is that the programme gives learners the background knowledge and values to underpin their practice. Both learners and managers identified that following the training they were much more aware of the reasons behind their practice.

> *'…the ones that have come in without this [induction] they haven't had any training to back it up in a way, so they're learning as they're going along, whereas the ones that have gone to the induction framework have had the knowledge taught to them.'*
>
> **Manager 1**

Understanding the theory and principles underpinning good care should mean that workers can continue to provide good practice and adapt to new situations and contexts, by reflecting back on the underlying principles and reasons beneath the care and support they deliver.

9. Workforce recruitment, retention, professionalisation and flexibility

Key points

Learners in the programme overwhelmingly intended to continue working in health and social care. In survey data following the training, 84% expected to still be working in a health or a social care role in a year's time. Notably, the largest proportion (46% at exit) could see themselves working in *either* health or social care[4].

Many learners saw the programme as a helpful step towards other roles in health or social care, or a step in their **progression to more responsibility or seniority**.

There was **no evidence during the programme that learners who had a joint induction would be drawn to work in health at the expense of social care**.

Managers and stakeholders saw **a good induction as an investment and believed it should help with recruitment and retention of staff**.

Learners indicated that **being part of the programme had made them feel more part of a profession** and that this positively impacted their behaviour.

Mentors and managers believed that learners recognised the investment in them and felt valued, which in turn improved their self-confidence.

Managers felt that **the emphasis on learning and theory in the programme and the AWIF supports greater professionalisation**.

Interviewees also noted that **there remains a disparity between the status of health and social care and in pay between health and social care**. However, they felt that by demonstrating that joint working can work, and by training people across health and social care to the same standard, **the programme provided an opportunity for moving towards greater parity**.

Learners felt that the programme helped them understand other roles in health and social care, and where their role sat in relation to those professions.

Overall, **the programme helps to support a flexible workforce and better working across health and social care**. It does this through both its content, and through the joint delivery model which embodies joint working. The programme:

- provides learners with an understanding of how social care and health fit together and the roles across health and social care
- gives learners the baseline knowledge and skills that can be applied in both health and social care

[4] It is worth noting that some of the exit data was gathered in the early stages if the Covid-19 pandemic, which could have contributed to the relatively high number of 'Do not know' responses at that point. Though that is speculation.

- provides both social care and health workers with core clinical skills and knowledge that they can apply in their roles
- reinforces that the care and support should be of the same quality and importance, regardless of whether that care is delivered in a health setting or a social care setting
- places the emphasis on the person accessing care and support, rather than the setting or situation
- allows learners to learn from one another, and from best practice in both social care and health

9.1. Introduction to workforce recruitment, retention, professionalisation and flexibility

One of the aims of the evaluation was to understand how this joint induction training programme could help deliver goals related to 'A Healthier Wales', specifically the workforce related aim: 'to deliver an inclusive, engaged, sustainable, flexible and responsive workforce in health and social care' (Welsh Government, 2018). While the pilot has been running, Social Care Wales and HEIW have also been developing a 'Workforce Strategy for Health and Social Care' (SCW and HEIW, 2020) which aims to support delivery of that 'quadruple aim'.

This section summarises evidence relating to how joint induction might support those workforce goals, specifically in relation to the recruitment and retention of staff (which is a greater issue in social care than in health), workforce parity and professionalisation, and in developing a responsive and flexible workforce to deliver 'seamless care' for people.

It addresses the following evaluation questions:

- Are there any observed or potential impacts of the programme on recruitment, retention and development of the health and social care workforce?
- Does the training programme affect workers desire and confidence to consider a wide range of career paths within health and social care?
- Does the programme affect worker's willingness or likelihood to continue working in health and/or social care?
- Does taking part in the training programme affect how valued workers feel as part of the health and/or social care workforce?
- Does the programme support having a more flexible workforce and integrated ways of working?

9.2. Workforce recruitment and retention

There are significant challenges with recruiting and retaining suitable people in social care. This view was supported by managers we interviewed. However, although there may be high

turnover, a significant proportion of that turnover (40 to 60%[5]) is movement between roles in social care, rather than people leaving the sector. One aim of the evaluation was to investigate whether this model of joint induction would support better staff recruitment and retention in health and social care.

Learner career intentions

All learners who were interviewed stated that they intended to continue working in health or social care.

> *'Oh, yes, yes. This is where I'll be staying. I'm happy here. I love my job and I love what I do and love, I'm talking to people, I'm out and about. It's brilliant. I really enjoy it, yes.'*
>
> **Learner 6**

And many noted that the course gave them a better understanding of both health and social care, which would help them in their career.

Some had plans to undertake further training to specialise in certain roles and saw this programme as a useful step.

> *'So yes, it was basically a stepping-stone along a longer road for potentially putting me into something I would like to do, and still would like to do.'*
>
> **Learner 9**

One learner had a place on a critical care paramedic course but had been considering putting it off for a year. The learner noted how the tutor and pilot had been important for giving them that confidence to train as a paramedic.

> *'And I'm so glad that I listened to [the tutor] because I feel I have that confidence to do the course, which is not easy. It's hard. The course is horrible, really hard. But because we'd had that training and, like, the first module is on dignity and respect. Well, I have all the work on my laptop after this course, so I could use it as a reference really. So thank goodness I'd completed the course before going to university.'*
>
> **Learner 2**

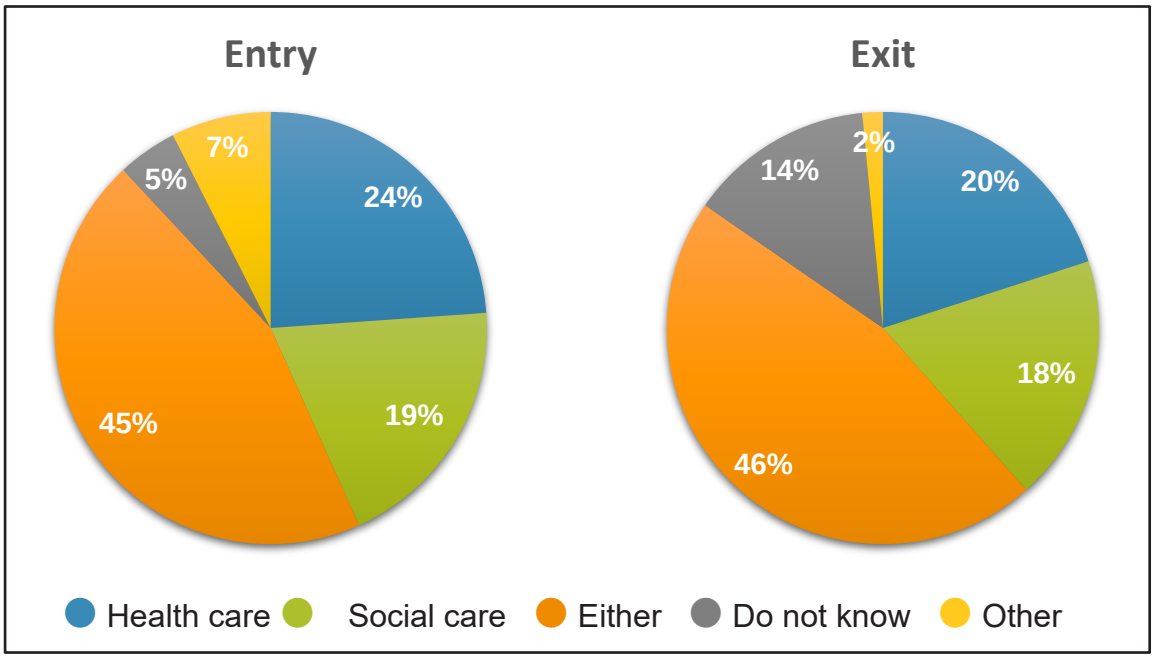
The evidence we hear in interviews is supported by the learner survey where respondents were asked whether they saw themselves working in a health or social care role in 12 months' time.

At entry almost all learners see themselves staying in health or social care (88% in total said 'health', 'social care' or 'either'), and that doesn't change much at exit (84% in total). Notably, the highest proportion of learners seem to be flexible as to whether they will work in health or social care (45% and 46%).

[5] In 2019 data for Commissioned Care Providers in Wales (Social Care Wales, 2021), of the 77% of leavers whose destination was known, 39% went to work for another care provider, 34% left the sector and 3% retired. For England, it is estimated that 66% of people who leave a social care role stay within the sector, and 33% leave (Skills for Care, 2020).

Figure 9-1. Learner career intentions

Do you see yourself working in any of the following roles in one year's time?



The biggest change from entry to exit is in the proportion of learners who do not know where they expect to be working in 12 months' time (+9%), and the reductions in learners who expect to be working outside of health and social care (other, -6%) or do not expect to be working in health care (-4%). We can only speculate as to why this might be, but we should be mindful that many of the exit surveys were taking place near the start of the response to the COVID-19 pandemic, and that may have affected learners' intentions. We should also note that there were 65 people in the exit survey data here, so the % changes reported here represent changes in intentions of 1 to 3 people.

No evidence during the programme that learners would be drawn to health from social care.

There was some concern at the outset of developing this programme that training like this could 'drain' social care because participants would be qualified to work in either, but work in health tends to be better paid and can be seen as more prestigious. This risk was identified early, and all involved were clear that the aim was to ensure that the programme helped deliver the best workforce across a range of health and social care settings.

> *'This was about preparing a workforce that would work with individuals within the community or in an environment, a care setting, that meant that you had individuals who were understanding and complimenting each other, not poaching another workforce.'*
>
> **Stakeholder 11**

Those delivering the course took steps to make it clear to learners that working in health wasn't inherently better, and that social care and supporting people in their homes and community is equally important for people's health and wellbeing.

There was no evidence from the learner survey of an intended move from social care to health, or of a move from health to social care.

There was some evidence that the programme may help people clarify their career intentions. Two people who said they saw themselves working in *either* health or social care in the entry survey said they saw themselves working in health in the exit survey. And 7 people who saw themselves working in either sector at entry, saw themselves working in social care at exit.

Interviewees noted that joint induction may bring more people into the sector overall because it gives learners options of working in either health or social care. Interviewees felt that by providing a wider range of options and giving learners flexibility about their destinations and career paths the overall numbers of people coming into health and social care could increase.

> *'We'd rather that we have as many options to people as possible than we try and funnel people down a smaller pathway.'*
>
> **Stakeholder 4**

This view is supported by the survey data where, at both exit and entry, the largest proportion of learners (~45%, 30 people) could see themselves working in either health or social care in one year's time.

Managers and stakeholders see a good induction as an investment and believed it should help with recruitment and retention of staff.

Interviewees emphasised the importance of a good induction for recruiting and retaining staff.

> *'I think a good induction can do so much to retain staff. You often find … if staff don't get a good induction then they don't choose to stay. I think in terms of attraction, recruitment and retention, this is good. It's a positive. If you set the foundations and you allay those fears and that apprehension of providing certain types of care, and all of that, then it's all positive.'*
>
> **Stakeholder 7**

This view was echoed by managers who felt that the programme would help them to recruit and retain staff because it gives '…them a really good grounding' (Manager 6). This included the recruitment of people who might not otherwise have considered a career in social care. One interviewee had witnessed the surprise of a potential trainee at the amount of investment in the training offered, even before they had a role in social care.

> *'So in essence what she was saying was, 'So I can go and do this pre-employment thing, but even when I've done that, if I then decide to go forwards with this, this is all the training that I'm going to be given before I even go on the job?' It was like, 'Yes, so there's an investment to have to make sure you go through that training.'*
>
> **Stakeholder 1**

This interviewee suggested that a good induction such as this 'raises the game' for social care being an occupation, 'making the role a career choice rather than something you do as a stopgap' (Stakeholder 1). They felt that once someone makes an investment in the career themselves and sees that they are being invested in, it starts them on a journey where they see working in social care as a long-term option.

'So they'll want to learn more. They'll want to be even better at the job they're doing. So with that, understandably the issue of retention falls by the wayside.'

Stakeholder 1

9.3. Professionalisation of the workforce and learners feeling valued

Professionalisation of the workforce and learners feeling valued and invested in relate closely to the goals of A Healthier Wales, and the related Workforce Strategy. These themes, and related issues, emerged strongly in interviews with learners, managers, mentors, and stakeholders.

One of the reasons for the drive to professionalise work in social care is to improve its perception as a desirable career, and to assist the recruitment and retention of staff.

Learners said the course makes them feel more part of a 'profession', that they are invested in, and that there is a body of knowledge and expertise that they are expected to have. At the same time interviews bring up other questions to do with professionalisation, specifically related to pay and social care having equal status with health.

Learners feeling valued and part of a profession

Interviewees felt strongly that professionalisation of the workforce was important, and that a structured induction was an important part of this.

'It's not an occupation for everybody, but we need to make it a professional occupation that people seek out rather than just slide into.'

Stakeholder 1

'It's very much in line with the way that Wales has gone down the route of registering care workers, so bringing a level of professionalism to a role that is always dismissed as being, anyone could do it. So I think having a really well-structured and formal induction helps with some of that perception….'

Learners from health also made a link between registration and professionalisation.

'[Health care support workers] should be registered, maybe that would give us more feeling. Of course I do, I do feel part of a team, I do feel that sometimes I am a part of something. Obviously, I work for a big company. The NHS is a large company and I work for a certain section of it. I think being registered from the course would give us maybe even more hold to the job. We would take more from it perhaps. We would own it more.'

Learner 1

However, stakeholders commented that social care support workers would talk about how they were not seen as being as important or as respected as community care workers from health. Even though they had the same roles, the community care support worker might be doing more advanced tasks such as taking blood pressure and be seen as a more like a nurse.

Learners indicated that being part of the programme had made them feel more part of a profession. One learner explained:

'It's just the confidence and the knowledge and those bits, some of the workbooks as we said, referring to the such-and-such legislation or the guidance or the regs on such-and-such. Before I wouldn't necessarily look at that because I wouldn't need to, or didn't think I needed to. However, because it's mentioned in the workbook on a certain topic, you're actually making the effort and you're reading that through then and you're picking up more and then you're reading further into it.'

Learner 6

Learners noted that the programme had directly affected the way they approached their work. One learner commented that it had encouraged to retain a professional distance with the people for whom they provided care.

'Before starting the course, I was in community care, and I was a little too close to the clients. I gave them too much information about myself. After the course, I knew, in the hospital everything's different. You need to be professional to the letter. … there was no need to tell them stories about me. You need to just listen to the patients. And I'd never have known that if I hadn't have done the course.'

Learner 2

Mentors and managers believed that learners recognised the investment in them and felt valued, which in turn improved their self-confidence. Similarly, stakeholders felt that the investment in training would improve worker engagement and mean they were more likely to see this as a longer-term career.

Managers commented that the emphasis on learning and theory in the programme and the AWIF supports greater professionalisation. They noted that the formal induction process might put some people off, but could encourage others who might be more attracted to a professional role.

'I think it will put a large number off, but then it will also encourage another circle. I know it's a very old-fashioned idea, but a lot of people coming into care don't realise that there's a learning side to it, that there's a theory side to it.'

Manager 4

Managers also emphasised the importance of employees gaining a qualification as an indicator of professionalisation and interviewees stated that learners valued the qualification and certificate which detailed the training they had completed.

Pay

While the evidence suggests that this induction programme supports professionalisation and that learners feel valued and invested in, many interviewees flagged pay as an issue in relation to both professionalisation and parity between health and social care.

Interviewees linked parity of pay to respect for social care and noted that the better pay in health makes it more attractive for some.

'… you can have all the qualifications in the world, but if you're looking over the bed at the person who is working alongside you, doing a doublehanded visit, and they happen to

work for health and be paid more than you, that's always going to stick in somebody's throat, I think.'

Stakeholder 11

Learners also brought up pay and the question of whether undertaking the programme and completing the AWIF would lead to greater pay.

'…all the extra work you have to do at home is unpaid and then at the end of the day you don't get a raise because you've done the course. You just still get your £8 an hour.'

Learner 5

Specifically, they asked questions about the work required to complete the programme and the AWIF, and whether they would be paid more if they would then be expected to take on more responsibilities (Stakeholder 3).

Managers reported similar views from their staff. One noted that staff could see the benefit of the induction in terms of their understanding and professionalisation, but without a reward it was hard to motivate them.

'…it does give them a better understanding, and they can see how it will develop them professionally, but there is no reward for it. That's what they voiced to me. Professional people, they get a wage that reflects on their professionalism, and we don't. Completing all of this makes absolutely no difference to them in the hourly rates and things like that, so they, it was very hard to motivate them to do it because they feel like they're doing it for nothing.'

Manager 5

Managers reported a concern from staff that they could be asked to take on more responsibilities, without that being recognised.

'… I think some of our staff feel that it's just a way to prepare them to take over on some of the health roles. Some of the tasks that the district nurses currently do, … which they weren't happy about because we don't have the time to do that as well as our own role... They just feel that there's something more behind it.'

Manager 5

Interviewees felt that the programme (and associated changes to ways of working) could support arguments for moving towards greater parity of pay, and that the programme had provided opportunities to open up discussion about equal pay.

'I was talking about this workforce strategy with Department for Communities, they were talking about parity of pay, recently. Obviously, we pay less to our care support workers than the hospital care support workers and community care support workers, but I was able to convey recently, that anybody who'd done this programme was trained at the same level. So … there were good arguments if the people did this type of induction, to make sure they were on equal pay terms.'

Stakeholder 6

An opportunity for change

These concerns are linked to the greater integration of health and social care and are not new or specific to this programme. Stakeholder interviewees understood there can be disparities in pay and felt that this programme could provide an opportunity to help address that.

> *'They're doing exactly the same job, hence why they come to this training and they receive the same training because they would be able to execute the same role that they would within a health environment or social care environment. I think respect has to be high priority, just respecting the two sectors really and appreciating what this department does and delivers.'*
>
> **Stakeholder 10**

They also noted that this general issue of professionalisation of social care and parity with health care is something that has been brought to the fore by recent events, providing another potential opportunity to move things forward.

> *'Now goodness knows over the last eight, nine months I think that COVID has done that for us in terms of raising that profile of carers, but we already had that conversation last year around we have to allow people to see that this is a professional role. This is a professional, valued and honourable occupation and we need to get employers engaged with that.'*
>
> **Stakeholder 1**

Interviewees noted that the 'Workforce Strategy for Health and Social Care' (SCW and HEIW, 2020) talks about parity of esteem. They felt that joint induction training was a key part of that because it provides parity of *opportunity*, 'you're getting the same opportunity of training and exposure to a training programme that both health and social care can benefit from' (Stakeholder 5). Interviewees felt that joint induction training can be a cornerstone of professionalisation of the workforce, along with qualification and registration.

Overall, and setting to one side the long-standing question of disparity in pay between health and social care, the evidence from the evaluation is that learners on the programme feel invested in and valued. Similarly, the range of topics covered, depth, focus on theory and regulations, all contribute to raising learner awareness that they are part of a profession.

9.4. Workforce flexibility and supporting integrated working

Another aim of the evaluation was to understand if the programme could support more integrated working across health and social care, as envisaged in 'A Healthier Wales'.

As interviewees noted, training such as this could only be a *part* of a change to integrated working. Full integration, such as the integration of job roles, is something that needs to happen at the system level and be driven by policy. However, there is evidence from both the health and social care sides that there are benefits to being part of training that covers both health and social care, and some changes to practice have resulted from that.

From the social care side, the most commonly identified benefit was the opportunity for clinical skills and observations training. As discussed above (section 8.2), managers noted

that this had been helpful during the pandemic when GPs were not visiting care settings. Staff who had had the training were confident and competent to do observations themselves, with appropriate supervision.

While this was a useful benefit during the pandemic, for that kind of integrated practice to be embedded systematically it would need to be supported at a policy level. Currently undertaking observations is not part of the professional duties of social care workers and they are not paid to undertake that work.

Learners felt that the programme helped them understand other roles in health and social care, and where their role sat in relation to those professions:

> *'Where we fit in in the jigsaw of care really … where our role ends and the other role begins, and I guess that gives you a fuller picture of where professionally you sit in the spectrum.'*
>
> **Learner 7**

From the health care side, learners noted that they gained an understanding of social care.

> *'Yes, it's given me a lot more appreciation for people like social workers and what they go through, and how much strain and stress that they are put under. So yes, it's definitely helped me appreciate what they do a lot more.'*
>
> **Learner 9**

Learners also noted that one of the benefits of having a joint induction was that you learn about ways in which the same issue may be dealt with differently, or manifest differently depending on the context. They gave dementia as an example of this.

> *'If you talk about dementia for instance, the hospital way of dealing with it is not necessarily the same way as the community way of dealing with it. So people who are health carers within the hospital, it does give them an appreciation on how it's handled differently by other carers within different settings. I'm not talking just residential homes there. People in their own homes, it's different again. The amount of times I know I've looked after dementia people who have come in to the hospital and they've been wandering up and down because they simply don't know the area, as in the environment they're in. If they were back home, they would be so much better.'*
>
> **Learner 9**

Other interviewees also identified benefits to having health care staff exposed to how issues such as safeguarding, assessing capacity, and supporting best interests decisions were dealt with in practice in social care settings.

Learners identified other examples of advantages to training alongside people who work in different settings. They gave examples such as infection control and cleaning things like toilets and commodes. For example, in hospitals, toilets are designed to be cleaned regularly, perhaps every time they are used, but when supporting someone in their own home the toilet may be old and need a different cleaning regime. This ability to see issues from the different perspectives of health and social care increases the likelihood of flexible workers who can more easily move between roles, settings, and working with different people.

Interviewees noted that having more flexibility across health and social care could lead to more efficient working. For example, rather than having to ring their manager and arrange for another person to visit, a care worker could take basic observations, report them to the GP, and identify potential health issues early, when they are easier to address. Interviewees felt that this would be much more efficient and cost effective.

> *'… it would be fantastic if they didn't have to call in another layer. I mean, really so much more cost-effective, isn't it, if the people who are there daily giving care have the equipment and the ability to just do something if they notice something's not quite right.'*
>
> **Stakeholder 6**

Interviewees also noted that the joint induction training programme could increase the trust or respect between health and social care. Specifically, they mentioned Health Board staff becoming more trusting of the quality and abilities of care support workers in social care.

> *'So the GPs, the hospital doctors, they're going to know, it's okay. They've done a blood pressure and a temperature and they've conveyed it, and they've trained to do that, so we don't need to send in another care support worker from community care to do that. So it really does start to build that capacity and I think for the Health Board in particular, that is more important than some recognise. As we have a more elderly population, as we have to care for people closer to their own homes, that we have got to find ways of developing the social care and community care workforce to have these more advanced skills, and this is part and parcel [of that].'*
>
> **Stakeholder 6**

They went on to note that the person receiving care doesn't care about the job title of the person taking their blood pressure or temperature, as long as they are confident that they are competent to do it.

Overall, the evidence is that the programme helps to support a flexible workforce and better working across health and social care. As noted above, when asked about where they saw themselves working in one years' time, the largest proportion of learners (45%) saw themselves in *either* health or social care.

In part the programme supports that flexibility through its content, which:

- provides learners with an understanding of how social care and health fit together and the roles across health and social care
- gives learners the baseline knowledge and skills that can be applied in both health and social care
- provides both social care and health workers with core clinical skills and knowledge that they can apply in their roles.

But the model of joint delivery (tutors from health *and* social care and learners from social care *and* health) is equally important because it:

- reinforces that the care and support which should be given by these workers is of the same quality and importance, regardless of whether that care is delivered in a health setting or a social care setting

- places the emphasis on the person accessing care and support, rather than the setting or situation
- allows learners to learn from one another, and from best practice in both social care and health.

10. The impact of Covid-19 and learning during the pandemic

Key points

COVID-19 restrictions, and redeployment of people working on the project in response to COVID-19 meant that **most work on the project was put on hold between March and June 2020**.

There was an **impact on some learner support sessions** and on **the accreditation process which was delayed for some learners**.

Despite these negative impacts **there were positives that came out of the pandemic**.

Strong working relationships that had been built up through the project **meant that people were able to continue collaborating and working together in response to the pandemic**.

This **included developing a range of online resources based on this pilot to support the training of new and redeployed health and social care workers** during the pandemic.

Managers felt that **the programme prepared learners for caring during the pandemic**. They identified having good understanding of **risk assessment, infection control and taking a person-centred approach as of particular importance**, given the vulnerable population and people's understandable fears.

The **clinical skills and observation training meant that staff were able to take observations, such as measure blood pressure**, which was particularly important when GPs were not entering settings.

The **restrictions on face-to-face training led to successful use of new technologies** for training:

- Filming and editing training videos, with bilingual speakers and voice overs.
- Producing animated awareness videos for infection control in the care home.
- Producing a digital brochure containing the course content and additional links to further learning.
- Developing the tools to meet language and accessibility requirements.
- Moving away from traditional e-learning to use digital learning tools that allow people to move backwards and forwards around topics, as they would on a website.

There is **excitement about moving to a 'blended' learning model for the future of this programme**, and potentially other training. This would **combine the best parts of new technologies and digital learning, with face-to-face training** which is important for building relationships, teaching and assessing practical and clinical skills, and assessing and supporting learners with emotional and challenging subjects and themes.

The **advantage of online and digital delivery is that it should allow easier access to training, accommodate different learning styles and paces**, and reduce costs for those delivering training and potentially employer costs as well.

Use of **digital technologies can also allow more flexible ongoing support with learning, and easier more efficient support between mentors and mentees**.

10.1. The impact on delivery of the pilot

COVID-19 had a significant impact on the project. In March 2020, when COVID-19 related restrictions were first imposed, everyone involved in delivering and steering the course were asked to divert their attention to the response to the pandemic.

At that point, the three pilot cohorts had completed the training days of the course, though the Ceredigion cohort had still some scheduled support days to complete. For many learners the assessment process for the Core qualification and health element of the programme was disrupted.

> *'We were expecting to have call-back days. We were expecting to do practice assessments, to undertake the assessments, to try and finalise those that had started in June and July. Unfortunately, that had to stop.'*
>
> **Stakeholder 3**

Essentially all pilot activity was stopped. While in health, there was initially an urgent push to employ more staff, in the local authorities, there was more of a focus on redirecting and redeploying people to work in care settings or wherever there was need. The new focus of the joint induction pilot was redesigning and adapting the induction programme to turn it into a general introduction for new staff.

Health and social care took different approaches to training during the pandemic. The approach taken in health was that training still needed to be face-to-face for the practical and clinical elements. Whereas for social care the local authorities restricted all face-to-face training and in some cases restricted travel between authority areas.

Just prior to going into full lockdown, when it had become clear that lockdown was going to happen, the team realised they need to create resources for online training. In a short period, they made a series of training videos that were then loaded onto Carmarthenshire's website to support learners. The videos were available and used by other geographical areas and by health.

The team had to wait until May or June 2020 to return to the pilot and begin to pick up the assessment process for learners, start to look again at progress made with the workbooks, and think about how to do the controlled assessments. Only in August and September 2020 was it possible to meet candidates or have them come in to do their assessments.

The team had planned to have an extra cohort in July 2020 just for experienced staff, but that had to be cancelled. It was intended as a refresher for people who had been working for a long time (15-20 years) and it was hoped that it would help those more experienced staff to act as mentors to new candidates coming through the induction. The intention is to take this up again when conditions allow to explore the possibilities for more experienced workers.

10.2. Disruption for those taking the programme

There were negative impacts for those learners who hadn't completed the qualification at the point that COVID-19 related restrictions were put in place.

Unemployed learners had work placements cancelled or postponed. Some of those who were due to take up work placements were also put off after the COVID-19 pandemic, 'I know that one of them, [name removed], she was quite shaken up by the whole COVID thing and just wanted to stay away from everything' (Manager 2).

And learners who taking the programme in advance of becoming Shared Lives carers also had their arrangements to have someone live in their home disrupted (Manager 3).

The final cohort were unable to do the planned support days, and learners from that cohort and some from earlier ones had their assessments and accreditation disrupted and delayed.

There were specific issues for learners in Ceredigion because the local authority had strict rules on only allowing staff to work from home, not allowing any face-to-face meetings, or allowing anyone to travel into Ceredigion to train, support or assess learners.

Tutors noted that COVID-19 and the redeployment in reaction to it disrupted many aspects of the assessment and accreditation process for the Core qualification and the health element of the programme.

> *'We were unable to accredit. Because we had to stop what we could, there was reduced support for the candidate to fill their workbooks in. We didn't have time to call them to give them the support they needed to speak to their managers as we'd planned to do. Accrediting the City and Guilds qualification and accrediting the health workbooks still is an ongoing process. We weren't able to have standardisation meetings that we wanted to.'*
>
> **Stakeholder 3**

However, interviewees also noted that they learned from this and the disruption to these processes led them to think about how they could be streamlined in future.

> *'We were doing a lot of things in duplicate and triplicate and I think COVID has definitely brought out a want or a need to be able to streamline a lot of things like workbooks. Face-to-face contact - we can do a lot of support now electronically and on Teams. Whereas, perhaps, we wouldn't have done previously.'*
>
> **Stakeholder 3**

10.3. Different reactions across health and social care during COVID-19

Interviewees noted that during the early reaction to COVID-19, organisations across health and social care pulled together to try to deal with the crisis.

> *'There was a great sense of transparency between all organisations, from the independent sector through to the NHS. There was the barriers, or the politics, as I call it, that seemed to dissolve in many respects. So that left a sense of… a dialogue that could be openly had.'*
>
> **Stakeholder 8**

However, this stakeholder went on to note that this was starting to slow down, with a return to the status quo and concerns about organisational boundaries and where funding would come from.

Interviewees also noted that the two sectors, despite both being directly affected by the pandemic, were treated differently. Interviewees felt that social care seemed to be treated as second best. Interviewees spoke of the NHS being seen as having a 'golden halo' (Stakeholder 8). Whereas frontline care workers, and nurses in the care sector had a sense of being second best.

> *'They said, "We're seen as being second rate nurses usually, because we work in care homes, but now during COVID, we are expected to have the skills to accept people that are very poorly. One person said to me, 'But we have got the skills, that's the point".'*
>
> **Stakeholder 8**

Rightly or wrongly, working within the NHS is seen as more prestigious, even if people have the same skills, qualifications and are delivering the same or similar care. Interviewees felt that the response to COVID-19 amplified that view.

Interviewees noted that the two sectors also reacted differently in response to the pandemic. Health moved to upskill support workers and clinical staff in infection prevention control and treating patients with COVID-19, investing in training and recruiting support workers and opening field hospitals (Stakeholder 2).

> *'It just highlighted the difference between health and social care and the differences that we're structured and organised and funded and viewed and COVID shone the spotlight on health and the need to make sure health was cared for, and we forgot about that care sector.'*
>
> **Stakeholder 2**

Interviewees felt that the different way the two sectors were treated, perceived and reacted during COVID-19, led to tensions within or across the two sectors. However, they also felt that despite these issues, the relationships built through this project meant that individuals were able to continue collaborating and working together. A notable development was the production of online resources based on this pilot to support the training of health and social care workers.

10.4. Did the programme affect practice during the pandemic?

Interviewees praised the way that individuals working on the frontline in social care and health acted during the pandemic. They felt that all staff pulled together and went above what was expected of them in very difficult times.

> *'Well, during the pandemic, all of our staff responded amazingly. We didn't have any go sick or anything like that. They were all very hands-on, very much wanting to be there and do what they can to help. I don't think that the induction played a part in that.'*
>
> **Manager 5**

Interviewees thought that all staff reacted in this positive way, whether they had had the joint induction or not. But they did think there were some practical benefits that came from undertaking the joint induction.

Managers noted that having staff who were able to take observations, such as measure blood pressure, was beneficial during the pandemic. This ability to take clinical observations was particularly important when GPs were not entering settings (Manager 4).

Managers also felt that the subjects covered in the programme prepared learners for caring during the pandemic. They identified having good understanding of risk assessment, infection control and taking a person-centred approach as of particular importance, given the characteristics of the population they were working with and people's understandable fears.

> *'… making sure that the service users are heard and understood, their fears and things like that… Because we had to change the way that we worked with a lot of people because it changed people. When they see on the news, the over-seventies are more vulnerable… a lot of them became extremely frightened. And of course, we're coming in and out of their house, so they felt that could we be bringing it in? The importance of the risk assessments and infection control and things like that was all highlighted in it, and it made the staff more aware of their communication and effectively communicating with the service users, to make them feel more comfortable.'*
>
> **Manager 5**

10.5. Learning from COVID-19

As noted above, COVID-19 disrupted the delivery of the programme, in part because those delivering and steering it were directly involved in responding to the pandemic. Elements of the programme were adapted and reconfigured to provide training to new staff and people redeployed from other roles to support or work in health and social care during the pandemic. This section summarises some of the learning from that period, which can be used in the future of this programme and other programmes or projects.

The use of technology

In many sectors, the pandemic and the restrictions associated with it, has led to a significant shift to working from home, and to doing more online.

Interviewees noted that this forced change led to them experimenting with technologies and digital resources that otherwise they probably wouldn't have previously.

> *'As far as digital resources, I'm not sure that local authorities, health boards, have really invested in the type of digital skills that we really could use within learning and development, and that we're on a huge learning curve.'*
>
> **Stakeholder 6**

They went on to note that they were learning very rapidly and that since March 2020 they had used several new technologies:

- Filming and editing training videos, with bilingual speakers and voice overs.
- Producing animated awareness videos for infection control in care homes.

- Producing a digital brochure containing the course content and additional links to further learning.
- Developing the tools to meet language and accessibility requirements.
- Moving away from traditional e-learning to use digital learning tools that allow people to move backwards and forwards around topics, as they would on a website.

Interviewees noted that using these technologies successfully isn't a simple matter of putting existing content into a new format. It is important to think about how they will be used in practice, make them engaging and to edit them appropriately.

> *'We're really focusing on the quality of the delivery of any digital materials and trying to hone them to be as engaging as they can be. Engaging people's brains, trying not to overwhelm them with information, and giving them control.'*
>
> **Stakeholder 6**

Interviewees noted that the new digital delivery formats allowed them to incorporate things like videos produced during the pandemic to create a more cohesive experience for learners.

> *'We're using some of the things we've produced and putting them into our digital brochures, getting people to do them as pre-learning so that they don't have to spend so much time online doing the induction, they can do a bit of that.'*
>
> **Stakeholder 6**

Interviewees also saw opportunities for further use of technology and new ways of delivering education.

> *'I'd really like to see us using the sort of 360-degree technology that estate agents use when you show people around a home. I think there's huge capacity for us to use that really well within learning and development so people take themselves through at their own pace through a scenario.'*
>
> **Stakeholder 6**

> *'It drove collaboration, it opened up those conversations about how we can work together so with education bodies we're providing rooms, venues, digitalisation of resources, that virtual learning environment. So yes, there's things that we'd wanted to happen for a very long time, COVID was the driver for them happening.'*
>
> **Stakeholder 2**

Interviewees noted that technology could be a way of improving the support for mentors through more regular contact.

> *'Because of the way technology is improving now, it's having these teams and perhaps these regular catch-ups with the mentors and the buddies, more regularly, more frequently; rather than if you've got a problem.'*
>
> **Stakeholder 3**

And that technology provided ways of reducing 'footfall' into people's homes.

'…going back to that footfall, reducing footfall into somebody's home. Again, that's really made us think about that and try to introduce new ways of working, and particularly with technology into patients' homes or peoples' homes, so that rather than them coming out, we're able to monitor from a distance, with SATs monitors, or whatever else.'

Stakeholder 11

Face to face, online and blended learning

The biggest impact to how the programme was delivered was a move to more online training. The forced experiment led to a discussion about how training will work in the future.

'It forced us to think about doing things differently. We stopped being wedded maybe to things that we thought were okay. The conversations were around, so what absolutely needs to be taught face-to-face and what doesn't, and how can we teach that then differently?'

Stakeholder 2

However, as noted above health and social care reacted somewhat differently in the pilot region. Initially at least, local authorities paused everything that was non-essential, redirected efforts towards the pandemic, and moved to working from home wherever possible. This included pausing the support and accreditation stages of some of the cohorts in this pilot. In health there was an immediate push to recruit more staff, but it was felt that induction training for those staff needed to be primarily face-to-face for clinical training and assessments of practical skills, for example, basic life support and resuscitation.

However, it was felt that not all training needed to be face-to-face.

'Things like accountability, delegation, and the role of the health care support worker, for example, can be done virtually. We don't need to have them in a classroom to do that.'

Stakeholder 3

Interviewees acknowledged the continued benefits of face-to-face training. One interviewee noted that learners might be nervous, both because of the pandemic, and because they were moving into a new area of work where they would be unsure of what was expected of them. They felt that having face-to-face training was very important in that situation.

'You're talking about people who've never done this sort of thing before as well or who are those that are being redeployed from other parts, so a lot of them were actually quite scared. We were chucking them into a really quick training programme and then setting them to work. I think you can't beat the classroom. You need that to be able to effectively have those questions.'

Stakeholder 4

Tutors felt that another advantage of face-to-face training, especially for the first day, is that the tutors could get to know the candidates, and the candidates could get to know the tutors, and each other. Candidates could find out where each other worked, and clarify things they were not sure about, and this is easier face-to-face than online.

Interviewees noted that face-to-face training also allowed tutors to pick up on subtle signs from learners and support learners appropriately. Something particularly important for a

profession which can be emotionally challenging, and where those accessing care and support can be vulnerable.

> *'You're teaching, or you're guiding, to pick up on things and issues that they may have, and they might not actually be ready at that time to be going out into the big world to offer that care, and you can pick up on that. You really can, you can pick up on people's belief system, people's attitude, but also any worrying signs that might be a tip over the edge for them. You might be putting somebody in a situation that they're not prepared for, emotionally.'*
>
> **Stakeholder 8**

Interviewees noted that there were significant advantages to doing more online training as well. For example, it should make it easier for trainees to attend, reducing their costs and in turn making it easier for employers to release workers for the programme, and reduce the amount of time they need to find cover for learners undergoing training.

> *'If we get it right, people should be able to get access, they won't have to travel from their places of work if they're in a care home.'*
>
> **Stakeholder 6**

More online training could also allow learners to learn at their own pace, and play to their own learning preferences. It should also provide better options for people who might have to fit learning around caring or childcare.

Interviewees were equally clear that in the future training needed to move on and embrace the learning from the pandemic. They felt strongly that older models of e-learning, which focus on knowledge and have a 'tick box' model of assessment, are not sufficient for properly preparing and assessing learners for work.

> *'I think our training is different in the sense that, we don't just look at the knowledge, we look at the practical skills, we look at the competency of the staff, we look at all of their assessments.'*
>
> **Stakeholder 10**

Interviewees felt that the dialogue between learners and tutors, and demonstration and practice of practical skills is important. Some of that can be done online, but some is best done face-to-face (Stakeholder 5).

Interviewees felt that the future was very much a 'blended' approach and there was a lot of interest and excitement about moving this model of training.

> *'I know that some of the workbooks and things that have been pulled together as part of this induction training, that they're actually really, I would say, quite exciting. You almost want to work through them. So having that, plus the opportunity to tap into people who are more expert in their field, having the 'what about' questions, the scenario questions, that is worth its weight in gold. So that blended learning model is absolutely critical.'*
>
> **Stakeholder 11**

> *'We need to look at how we work a lot more closely and a lot better, more integrated. Again, if we can provide the face-to-face then the local authority can provide the blended*

approach. It's just looking at it from a different perspective. Things are going to change dramatically because of COVID.'

Stakeholder 3

11. Support for continuing the joint induction programme

Key points

There was **strong support for continuing to provide joint induction training**, and to **spread the model across Wales**. There was great interest in the pilot, and it wasn't possible to meet all the demand during the pilot period.

Interviewees felt that **with the current spotlight on health care and social care there was an appetite for induction training like this which 'raises the game'** and sets a high standard.

Interviewees noted that **Wales has an aging population with a high number of people with chronic illness**. They felt that **if joint induction was scaled up across Wales it would make a huge difference**.

Interviewees believed that **if scaled up the programme would have a range of impacts**:

- **Professionalising the workforce** and **raising the profile of care**
- **Attracting people into the sector**, social care in particular
- Helping **set a universal standard of care**
- **Reducing hospital admissions** and leading to **better care at home**
- Supporting **more efficient care**, and **reducing 'footfall' in people's homes**.

There are a number of **factors that have been important for the pilot's success**, and would be important to **continue to focus on when scaling**:

- Engaging with employers and supporting them to release workers for the training
- Using contractual and/or regulatory levers to motivate employees to support their workers through the induction
- Making the most of any opportunities and changes brought about by COVID-19
- Having appropriate funding and resources to support delivery of the programme
- Using evidence and the stories of those taking part to drive things forward
- Publicising the training and engaging the right audiences
- Having support at senior levels and leadership throughout the programme
- Continuing to effectively and genuinely work across health and social care.

11.1. Introduction

Interviewees were asked about the future for joint induction training in health and social care in Wales, the impact it might have on the health and social care system and on people accessing care and support if it was to spread across Wales, and what they felt the main barriers and facilitators are to it spreading and scaling up.

11.2. Support for spreading and scaling joint induction training

Overall, there was strong support for continuing to provide joint induction training and to spread the model across Wales.

> *'…I hope that Social Care Wales do run with it, and I hope that they do fine tune it and … put out a programme because I think it's a really excellent programme of induction.'*
>
> **Manager 3**

> *'… it would benefit a lot of people in the hospital, specifically the older ones. People who have been there a longer time because it gives you the modern approach to certain things. It sounds like I'm putting down the hospital training, no, they also do a very good job too, but it should work hand-in-hand basically.'*

Interviewees noted that there was a lot of interest in the programme, and the pilot hadn't been able to meet the demand.

> *'… what I was really impressed with was the fact that when we were putting the adverts out, the excitement from companies and from individuals were, 'This is going to be a really good thing. This is going to be really good.' We had so much need for it and desire for it. We didn't have the capacity to deliver as much as we wanted…'*
>
> **Stakeholder 3**

Interviewees from health said that they wished to do more training, jointly with social care.

> *'I'd like to be able to set the dates, so that they are suitable, or increase the amount of dates that we do, because our courses are always full, and to be able to welcome social care, and we have a joint induction going forward. For me, having a blended, joint induction is the way we need to go.'*
>
> **Stakeholder 3**

Interviewees believed there was an appetite for induction training like this now, with the current spotlight on health care and social care. They felt that this training 'raises the game' and sets a good standard, and that it is important to make people aware of that, particularly in the context of an aging population who will continue to need care.

Interviewees observed that when the pilot learners went back to work it triggered an interest from other workers and managers in the programme. They want to have it, or a refresher version of it, to promote the right culture and approach in all staff.

'Managers are saying, "I've got a member of staff who has been working for me 15, 20 years, they've gone back to these ways that we don't understand, and I think coming to your induction programme will make them revisit everything anew".'

Stakeholder 10

Interviewees felt that even though not everything had worked perfectly in the pilot, lessons had been learnt, the core of it had worked and they wished to see that expand across Wales.

'I think what we can give is a set of principles, some materials for the rest of Wales to say this is possible, this is doable and this is the learning that we've had. Locally, I would be very disappointed if we didn't continue to provide a degree of joint induction and joint working, in the way that we've developed.'

Stakeholder 11

11.3. Impact if it spread

Interviewees described the impact they thought joint induction would have on people accessing care and support, and on the health and social care system in Wales, if it was to spread across Wales.

Reducing admissions to hospital and providing better care at home.

Interviewees noted that Wales has an aging population with a high number of people with chronic illness. They suggested that the scaling up of the joint induction across Wales would make a significant difference to hospital admissions and raising the standard of care.

'This was about raising the standard from the very outset and getting everybody on a level playing field. So that for someone on the receiving end of that care, it wouldn't matter whether you were in your own home and just needing somebody to come in in the morning to help you to rise and to get dressed and to have a wash or someone needing quite intensive care in more of a hospital type setting. The standard was there and it was about raising that standard…'

Stakeholder 1

Interviewees commented on the positive impacts this would have on people and their families.

'… to actually treat them to prevent them going into hospital in the first place. That would have a massive impact because patients would feel happier. Their families would feel a lot more content, because the stress of going into hospital and picking up a hospital-acquired infection is greater than being at home in their own environment.'

Stakeholder 3

More efficient care and reducing footfall

As noted above, interviewees wished to reduce the 'footfall' into people homes and make care more efficient for them. They saw the induction as a starting point with workers able to deliver the core care, and be able to recognise when specialists need to be brought in.

> *'…if this is the building block from which we begin to ensure that we can streamline footfall … into somebody's home or into somebody's life, then that's got to be a benefit and that's got to improve patient experience or citizen experience…'*
>
> **Stakeholder 11**

Interviewees noted that for people accessing care or support, whether someone is a health care worker or a social care worker, and even what role they have is largely irrelevant.

> *'…they don't give a monkey's who's walking up their pathway, they don't give a monkey's who's coming to their bed in the hospital. They just want a better outcome, they want to be discharged well, or they want to be able to live at home and supported to live at home.'*
>
> **Stakeholder 9**

On the whole, interviewees saw the programme as a positive step towards delivering seamless care for people.

> *'I think the more joined-up that we get, whether it's through just training or whether it's contractual, or whatever arrangement it is, making it feel seamless to the end receiver, that the patient, the citizen, has got to be a positive thing. I get really annoyed if people say, "I had to then wait. There was a referral made." It's joining it up so it's seamless for the recipient, has got to be the way forward.'*
>
> **Stakeholder 11**

Professionalising the workforce and setting a standard of care

Interviewees felt that the induction is part of raising the profile of care, and professionalising it, and that the ultimate impact of this is on people who access care and support.

> *'I think it would make a huge difference for people that receive care because they will be reassured by the fact that people are choosing to go into this line of work because they respect it as an occupation. I think it will make a difference for that.'*
>
> **Stakeholder 1**

Interviewees emphasised the importance and benefit of having a 'universal quality standard' in the workforce, 'you shouldn't go into one care home and see a different style to another one' (Stakeholder 8). Increasing the health care skills of the social care workforce across Wales was seen as crucial for better healthcare in the future.

> *'I think it would improve patient care. It would improve people's confidence. It would bring care in general, I think, to the fore. Again, we have complaints in healthcare. We have complaints in social care. I think it would reduce those.'*
>
> **Stakeholder 3**

Recruitment, retention, flexibility, and development of the workforce

Interviewees felt that a joint induction could attract people into social care and were positive that the programme should be continued and introduced as standard. They noted that some social care settings do invest in their staff, but that not all do, and they hoped that by having a good standard induction, working in social care would be seen as a career choice.

> *'…some of the social care settings I spoke to I was astounded at the level of investment that they gave to their staff in terms of ongoing skills enhancement and mentoring and coaching support. They really, really looked after their staff and had a very robust training programme, but I think there were others that I spoke to where it was a long way away from that. What I hope is that we can raise the standard of investment in people that move into this as a career choice … and allow them to be confident and experienced and skilled to be able to do the job that we would all hope that they are able to do.'*
>
> **Stakeholder 1**

Those involved in helping unemployed people to find work were very positive and supported its spread across Wales.

> *'I think it is brilliant. I think it's really good. It's what we were hoping for really. I was putting together something myself and this came across and I thought this was just obviously much better than me trying to pull together different training courses and patch it all into one. Then this came up and it's perfect and it's done by experts, so for me, I think it's absolutely brilliant. Everybody that's come to us and gone through it have been positive about it and have had great outcomes from it. I think from my point of view, it would be great to do it across Wales.'*
>
> **Stakeholder 4**

The pre-employment day for unemployed people worked well and would like to see that (and work placements) continue in future.

> *'It's another stepping stone into various care roles, other than just advertising and just having those posts as formal posts. It feels risk-free and it's a lot more cost effective to do it that way round than trying to employ somebody and then they find out that they're really not cut out for it.'*
>
> **Stakeholder 6**

The potential for joint induction to complement joint apprenticeships, to provide employment and development opportunities for people, was also highlighted.

Stakeholders also noted that scaling up could also provide greater flexibility within the workforce. During the pandemic, there was a push to recruit care support workers in health in the pilot area due to the projected number of COVID-19 hospitalisations. When the numbers of hospitalisations didn't materialise, discussions were held about diverting workers to employment in social care. In the end that wasn't necessary, but interviewees noted that the *possibility* was created by having a joint induction programme.

> *'We would have both been confident either way that those people could work in either/or settings. So that has the potential and if this programme is continued and rolled out, you*

could see how that could really have potential for that fluidity of the workforce and the flexibility of the workforce, which is so important.'

Stakeholder 6

Interviewees felt that the experience of COVID-19 had emphasised the importance of flexibility and having transferable skills. They felt that this reinforced the important of joint induction training and that it would prepare the workforce for an uncertain future.

'Where we might find ourselves in situations, or being sent out to do something else that we've absolutely never, ever done. So it's preparing as much as we can for a future that is no longer what we expected it to be, and I think that this is the beginning of that opportunity.'

Stakeholder 8

11.4. Barriers and facilitators to scaling and spreading

Interviewees identified a number of potential barriers and facilitators to scaling up the joint induction and spreading it across Wales.

Engaging with employers and supporting them to release workers for the programme

Interviewees felt that gaining the buy-in of employers was important for the future of joint induction. There is a considerable time commitment needed from employers to support the training and, although the programme enrolment is free to employers, managers viewed the induction as a cost. Learners have to be paid while on training, including the support sessions, and employers have to arrange cover while they are not available. Managers recognised the benefits of the induction but said that funding might make them more likely to use the induction in future.

Stakeholder interviewees were aware of the economic difficulties for employers and felt that the sector need to make sure there was a focus on investment in staff to raise the standards of care.

'It's a tricky time in terms of economic impact, care settings are the same as every other business, but they're going to be worried about the impact on their finances. We know that it's a busy time for care settings, but we still need to make sure that they see this as being the right thing to do to invest in their staff now more than ever…'

Stakeholder 1

They noted that challenges were particularly acute for smaller employers who will find it harder to arrange cover.

Interviewees noted that as well as issues to do with funding and releasing staff, employers may be invested in their own inductions, and resistant to a new model.

'There's going to be barriers in terms of probably employers that may feel that they have developed from their part robust induction programmes in line with an induction framework that was already in place that's linked to the qualification frameworks and why are we trying something new. There'll be all those elements to overcome.'

Stakeholder 5

Using contractual and/or regulatory levers

Interviewees noted that providers in social care, 'tend to be running at breakneck speed' (Stakeholder 8) and that things such as completing the AWIF can be undertaken as a 'firefighting exercise', i.e. a hurdle that needs to be jumped through. They suggested that contractual levers could be used to drive employers to take up high quality training. Contracts between the NHS and independent sector might provide opportunities for setting a standard of care.

> *'…maybe put in that you will be expected to provide care, etc., by staff that are, not just the word 'suitably trained', but trained to the standard of the All Wales Induction Framework… I think, sometimes, if you give people too much of an open book, they don't know where to start and where to finish.'*
>
> **Stakeholder 8**

This might also reduce the temptation to take the easiest or cheapest training option to get workers over the line. Interviewees also suggested that the induction might need some form of compensation or bursary to support employers, at least for the first couple of years (Stakeholder 8).

COVID-19 as an opportunity for change

Interviewees noted that with any change there can be resistance, but that the context of the recovery from COVID-19, and what we have learnt from it, provides a lever for change.

> *'We are preparing a workforce for a future that we haven't planned. We can use that now, that lever, because it's real. So it is people. It's people, it's bureaucracy. It's people that influence and put barriers up, not systems.'*
>
> **Stakeholder 8**

Interviewees also noted that timing is important. The sector is still dealing with the pandemic, and as we move towards recovery it will be important to consider when people will have the 'headspace' to think strategically about changes such as this (Stakeholder 11).

Funding to continue delivering the pilot

Interviewees felt that having funding for the pilot to continue and grow was one of the biggest issues, but that there the scaling up of the pilot offers the potential for greater efficiency and streamlining when scaling up. Lessons learned during the pandemic and better use of technology would help with streamlining.

Interviewees were particularly aware of the limited budgets within social care.

> *'… we're in an ever-shrinking budget situation, more and more people to look after. I mean, really if we don't start the integration of our teams, and some of that, a sharing of resources, social care, they would barely touch the budgets of health for education learning and development and research, we have nothing in comparison. We are lightyears behind and we do an amazing job with the resources we have, really.'*
>
> **Stakeholder 6**

Interviewees noted that rolling out at scale will require investment, that providers in social care are probably not set up for that level of investment and would look to government for support.

> *'They will therefore be looking back as a marketplace to the commissioners to how they can invest in that moving forward. It does link to the objectives of a national workforce strategy that really does have to think about … investment in the sector. Whether that's a national investment or local investment, it needs to be a whole new look at … how you can achieve what we really need to achieve.'*
>
> **Stakeholder 5**

Interviewees also identified the importance of the national workforce strategy, and the role of national and local government in driving forward professionalisation and parity between health and social care. They felt that joint training is an important part of this.

> *'Yes, absolutely critical to have an effective joint training programme in place from start to finish. Again, as part of our regional discussions and influencing the future we're moving forward in terms of discussions about joint organisational development teams. I think that's the way forward.'*
>
> **Stakeholder 5**

Using evidence and the stories of those taking part to drive things forward

A number of interviewees mentioned the importance of the evaluation and having the evidence as a driver for taking the pilot to the next stage.

Interviewees felt that 'champions' could be used to advocate and tell the story of the induction and the difference it has made to them or their service.

> *'I think you've got to look at the champions that come through an induction programme: what's their journey; what's their journey outcome been. Let's create those kind of advocates for joint induction, those who've experienced it and learnt it but also from an employer's perspective. Where's the employer champion view about actually this made a real difference to the outcome of the end recipient of services be that health or social care? Find those examples that will really sell this as an approach.'*
>
> **Stakeholder 5**

Interviewees wished to see those who have been involved in the pilot supporting and advising on how to implement it in other regions.

Interviewees felt that there was generally a willingness to share learning within the training and development community across Welsh local authorities and, if the joint induction is seen as a good model of practice, this community will work to adapt it in their local systems.

Publicising the programme and engaging the right audiences

Interviewees observed that publicity for the pilot has been largely via email and direct contact with employers. Interviewees felt there was lots of scope for raising awareness of the project, for example, by targeting or reaching learners/workers directly. An additional opportunity would be to publicise it with practitioners and specialists who provide training, but who are not directly involved in the project.

'There's a bigger picture there that I don't think is being tapped into because of… Nobody knows about it, to a point. I say nobody, but people outside the secret circle. [Laughter] We talk about it to everybody, but if you talk to … the practitioners, the clinicians, the specialists that do provide some training for staff, they're not aware of it.'

Stakeholder 8

It was also seen as important to think more widely than just those with responsibility for the workforce and education and training, and to get the support of professional leads across health and social care.

'…buy-in from the professional leads is going to be critical. So, making sure that the directors of nursing, for example, because these are health care support workers, making sure that the directors of nursing and the directors of therapies, in particular, are bought into it and understand the benefits.'

Stakeholder 11

Efforts to scale and spread should incorporate as wide a group of partners and stakeholders as possible.

Support at a senior level and joint working across health and social care

Interviewees identified that support and leadership from the top of health and social care would be important for spreading the model.

'We need a senior synergy across health boards, local authorities, and commissioners in both of those businesses to genuinely come together and have a joint approach to opportunities like this. If they don't that'll be a barrier because they'll carry on with their same separate HR and OD arrangements and never the twain shall meet. Those are really important in terms of their direct workforce but also their commissioning intentions.'

Stakeholder 5

Interviewees stated that Wales was in a better place than five years ago, and there were opportunities to get support at the highest levels.

'We all now have healthcare organisations within Wales, and certainly Health Boards and Trusts have all been working in a much more collaborative way. Certainly top table, so the regional partnership boards, the … various boards that bring health and social care together. […] we want the minister to actually say, 'Do you know guys, there's a way forward and we want you to be focusing.'

Stakeholder 11

Interviewees noted that HEIW and Social Care Wales have supported the pilot in line with the national workforce strategy and commented how learning from this pilot should help to drive that strategy forward.

'… start to expand these programmes across Wales through regional workforce arrangements, joint workforce arrangements, so that we can take our learning right across this nation.'

Stakeholder 5

12. Conclusion

The evaluation found that the programme met its aim of delivering a high standard joint induction to health and social care workers. Learners were well equipped to take up their roles following the training, with managers noting that they were confident and understood the basis to their practice. The programme led to changes in practice and supported person-centred care. Learners felt valued, invested in, and more professional. Learners were motivated to continue working in health and social care and flexible about their future career options. Managers and stakeholder interviewees felt the programme would aid recruitment and retention of staff.

The programme combined a high standard of delivery, high quality content, and ongoing support, with a genuine joint working approach that was embedded in all parts of the programme. The *combination* of the high standard *with* the joint delivery and joint working stands out about the model and underlies its success.

Joint working and joint delivery to health and social care

The joint working and delivery to social and health care workers at the same time is an important part of the overall quality or standard of the programme. It is integral to the breadth and depth of the programme, leading to exposure of learners from health to social care, and exposing learners from social care to health. This aids mutual understanding and cross-working, which is important for people receiving care and support who will have high levels of interaction with both sectors. All involved felt that both sectors benefited from learning from the other.

Learners appreciated the breadth of the programme and the content from health and social care. They were very positive about being in mixed groups and learning from the experiences of others. It was also clear that having experienced practitioners and specialist tutors deliver the training was critical. By bringing their own experiences to the programme tutors brought the training to life, engaged learners, and were trusted by them. It also meant that tutors were well placed to recognise and support when learners might be finding things difficult.

Observation and clinical skills training

The observation and clinical skills day was highly valued by those in social care, and important for supporting flexibility and integration. It means that the same person could work in either a health or social care setting, and in social care settings it opens up opportunities for better and more efficient care and early identification of potential health issues.

Reflective learning and adaptation

As the pilot ran it took a reflective and iterative approach to its development, learning and adapting from feedback and the experience of delivery. Some examples of key changes made during the pilot period were the early revision of the training days content and structure; removing the requirement to complete the progress logs as well as the workbooks; setting clear expectations for learners and managers about the work required; putting in place training and support for mentors.

Communication and setting expectations

A theme that cut across the evaluation was the importance of good communication, ensuring that learners, managers and mentors were aware of their roles and what is required to complete the programme. Lessons were learned about this during the pilot and changes made to ensure all involved understood what would be required of them and when. But clear communication and setting of expectations is likely to remain important to any future running of the programme. In particular there still seemed to be some uncertainty about the pathway between the Principles and Values Award, the full AWIF, and the level 2 Core qualification in health and social care.

Mentors and support in the workplace

Having a mentor was a core component of the programme and was important for supporting learners and encouraging them to complete. Though the amount of support and encouragement that a learner needed varied between individuals.

For some learners the mentoring system worked well and they got what they needed from it. Others got the support they needed but from a different source such as their manager or the programme co-ordinator. While that worked during the pilot, it might not be practical if the programme scales up. Managers who were also mentors noted the time it needed from them. In some cases, notably for bank workers in health, it proved difficult to get a mentor in place who could effectively support a learner. These issues were recognised during delivery and steps are being taken to address them and provide more support to mentors, but if the programme scales and spreads this is a component where some challenges and opportunities for improvement may remain.

It was acknowledged that although mentors get a certificate for the initial one-day training, there wasn't a clear incentive for them to take part in the programme. Consideration could be given to what else could be put in place to recognise the role of mentors, and motivate them, including linking to their career development.

Balance between quality and the work required

The balance between the quality, depth and breadth of the programme (which underpins the positive outcomes) and the time and effort required to complete it is something that cut across a number of themes.

This was particularly apparent in discussions of the workbooks, the amount of time needed for learners to complete them, and for managers and mentors to support and sign learners off. Learners were initially surprised by the amount and level of work required, and managers noted that supporting multiple learners at once would be hard for one person and in smaller providers.

Similarly, some learners didn't feel that all of the programme was directly applicable to them and their roles. Even though they enjoyed those elements or found them interesting, and managers appreciated the breadth of coverage.

Some steps were taken to address these issues. For example, it was recognised that the workbooks take time to complete and they are being streamlined to help reduce the time needed to work through them, without compromising the breadth and depth of what they cover.

Both of these are examples of a ‘tension’ between having a high quality and broad induction on the one hand, and the time and effort needed to take part in it and complete on the other. It will always take longer and require more work to undertake a high-quality induction which aims to support flexibility and career choice, than it would to do a low-quality induction or one which is highly specific to a single role.

To some extent, to create a flexible workforce you need to expose people to things that they do not need to know immediately, or may not see the relevance of. While some individuals may not need all the knowledge or skills that they gain, for other individuals it opens up opportunities that they might not have realised were there.

As such this might be best thought of as something which has to be managed and balanced, rather than something which can be solved or resolved.

As some interviewees noted, work may need to be done with some providers to encourage them see a high standard induction like this as an investment in staff which pays off in their ability to provide better care and likelihood of continuing to work in health or social care. The challenge in social care in particular is that providers are under pressure to recruit staff quickly, and one provider may make that investment, and then that staff member could go elsewhere.

Parity between health and social care

While this pilot was a successful example of genuine joint working between social care and health, it also brought to the fore some of the disparities between the health care sector and social care. Most notably that equivalent roles are paid higher in health, and that working in the NHS is often seen as of higher status than working in social care.

These issues are long-standing and deeply embedded, a single programme such as this is not going to resolve them. Nevertheless, there was evidence that this programme can contribute to reducing these disparities. For example:

- Learners said that the programme made them feel more professional and part of a profession.
- Managers and others noted that the emphasis on theory and understanding contributed to creating a more professional workforce.
- By training health and social care workers to the same standard it has opened discussions about greater parity of pay.
- The pilot has led directly to health and social care staff working together on other projects and initiatives.

As such, this programme, if rolled out across Wales, could contribute to creating greater parity of esteem between health and care professionals, but that would need to be part of a wider solution.

Core components and the future of the programme

The pilot has been successful in its goal of designing and delivering a joint induction which creates confident workers who can deliver person centred care. The programme supports greater workforce flexibility and the integration of health and social care.

All those involved with the pilot wish to see it continue. Learning from delivery during COVID-19 is likely to change how the programme would be delivered in future, with a move to a model blending face-to-face elements with online and digital learning.

The evidence from the evaluation is that the programme model works, and that there are some core components to the model which are fundamental to its success:

- Joint delivery to health support workers and social care workers, incorporating ways that learners can share experiences and learn from one another.
- Having experienced practitioners as tutors complemented by specialists as required.
- Core content and learning outcomes which prepare people to work in both health and social care.
- Observation and clinical skills training for health *and* social care workers.
- Joint working in all parts of the programme.
- Having a dedicated integrated post that sits in both health and social care.
- Mentors and managers with the time and support to mentor effectively.

These components should be retained in any future spreading or scaling of the programme, alongside any changes to delivery.

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14. Appendix 1: Programme Outline

Background Colour	When
	Week 1
	Week 2
	Week 3
	Week 4

Amlinelliad y rhaglen

Dydd 1: Cyflwyniad i egwyddorion a gwerthoedd

- Cyflwyniad i'r cwrs a disgwyliadau
- Rolau a chyfrifoldebau'r gweithiwr Iechyd a Gofal Cymdeithasol
- Deddfwriaeth, polisïau cenedlaethol a chôdau ymddygiad ac ymarfer
- Dulliau sy'n canolbwyntio ar yr unigolyn/plentyn a dull seiliedig ar hawliau
- Cyfarthrebu

Dydd 2: Iechyd

- Lles
- Ffactorau sy'n effeithio ar les
- Atal a rheoli heintiau
- Gofal personol ac ymataliaeth
- Gofal iechyd geneuol
- Gofal traed
- Gofal ardal bwysedd
- Maeth a hydradiad
- Atal cwympiadau

Dydd 3: Diogelu

- Diogelu
- Eiriolaeth
- Iechyd meddwl
- Camddefnyddio sylweddau
- Cymryd risg gadarnhaol

Dydd 4: Egwyddorion a Gwerthoedd (rhan 2)

- Dementia
- Colled synhwyraidd
- Yr iaith a'r diwylliant Cymraeg
- Cydraddoldeb ac amrywiaeth
- Gweinyddu meddyginiaeth
- Technoleg gynorthwyol
- Gofal diwedd oes
- Perthnasoedd cadarnhaol a ffiniau proffesiynol

Dydd 5: Iechyd a diogelwch a camau nesaf

- Iechyd a diogelwch yn y gweithle
- Asesiadau risg ar gyfer iechyd a diogelwch
- Diogelwch bwyd
- Sylweddau peryglus
- Diogelwch yn y gweithle
- Rheoli straen
- Meddyginiaethau
- Y camau nesaf / paratoi ar gyfer asesiad ffurfiol o'r cymhwyster Craidd

Lliw cefndir	Pryd
	Wythnos 1
	Wythnos 2
	Wythnos 3
	Wythnos 4

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social care
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About this report

This report presents an evaluation of the West Wales Health and Social Care Joint Induction Training Pilot. The Joint Induction Training Pilot delivered a joint programme of training and support to health and social care workers to enable them to complete the All Wales Induction Framework for Health and Social Care.

The pilot aimed to deliver a joint induction programme that would lead to confident workers who could deliver person-centred care, leading to better outcomes for people receiving care and support. It was hoped that the programme would create flexible workers and help provide a foundation for more integrated ways of working across health and social care. The primary aims of the evaluation are to determine whether the pilot met these aims and to collate and share learning from the delivery of the pilot.

The pilot also aimed to determine whether joint induction of health and social care workers could help support delivery of 'A Healthier Wales'. Specifically, the workforce related aim: 'to deliver an inclusive, engaged, sustainable, flexible and responsive workforce in health and social care' (Welsh Government, 2018). Accordingly, this evaluation also explored how the programme might impact on recruitment, retention and professionalisation of the health and social care workforce.

Social Care Institute for Excellence
83 Baker Street, London W1U 6AG

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