The Recruitment and Retention of Healthcare Assistants at York Teaching Hospital NHS Foundation Trust*

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Executive Summary

Introduction

- This case study report describes a new approach to the recruitment and retention of healthcare assistants introduced by York Teaching Hospital in 2010.
- The initiative centred on the recruitment and retention of HCAs and comprised four main parts:
  - A revised HCA job description/person specification;
  - A new approach to application;
  - A new approach to selection; and
  - An extended induction to be completed before HCAs took up their posts on the ward.
- In examining the initiative, a total of 18 interviews with different staff members were conducted between December 2011 and March 2012.

1. The Emergence of the Initiative

Context

- The organisational culture at York facilitated change. There was a fairly strong consensus amongst interviewees on the nature of this culture, characterised as tight knit and supportive, generating in turn reciprocal commitment to the trust from the staff.
- In recent years York had been seeking to develop this culture, clarifying and sharpening its organisational values. These values were centred on safety and care quality and seeking to contribute to the well-being of the local economy.
- At the same time, this strong and developing York culture was facing pressure.
- This search for efficiency, while at the same time maintaining and improving service quality, had encouraged senior managers at York to devote increasing attention to the nursing workforce and more particularly to its HCAs.
- A concern with the non-registered employees prompted the trust to confront the prevailing character and structure of the HCA workforce. This workforce was tightly compressed into pay band 2 and had developed in a uneven way, assuming very different forms within the trust.
- This had generated a number of challenges and issues for the trust. In particular the disconnect between HCA pay band, training and tasks performed complicated attempts to re-structure the broader nursing workforce and distorted/reduced HCA career opportunities at the trust.
- There was a particular interest in clarifying and strengthening HCA career opportunities. This was associated with the recruitment and retention of HCAs,
the need to offer such opportunities to attract individuals to the role and keep them once acquired.

Direct influences

- York’s introduction of a new model of recruitment was underpinned by two broad considerations: the high turnover of HCAs and the introduction of a values-based element into their recruitment process as a means of aligning the values of new HCA starters with those of the trust.
- Views differed on how retention difficulties were initially picked-up within the trust. Some weight was placed on their identification in an informal, impressionistic manner, particularly by matrons.
- However most obviously such turnover issues were revealed by more formal trust systems designed to monitor and manage the trust’s performance.
- The trust was willing and able to ‘drill down’ and examine this turnover problem in a detailed way, allowing the problem to be diagnosed in a sharper form as one of relatively high HCA turnover in the first six months or so of employment.
- The quick turnover of HCAs encouraged the view that the trust’s recruitment system was not attracting the ‘right’ people to the role. Rightness was viewed in terms of:
  - (the wrong) type of applicants;
  - (lack of) knowledge/understanding of the HCA role; and
  - (questionable) values and disposition.

2. The New Approach to Recruitment and Retention

Processes

- In crude terms, the development of the York initiative rested on three basic processes: identifying the challenging issue; seeking to devise a solution; and implementing changes to the recruitment model.

Identifying the challenging issue

- Retention was picked up by formal trust systems such as ‘health checks’ and performance management metrics, although some concern about this issue had more informally been floating around in the trust particularly amongst the matrons.
- It was acknowledged that these matron concerns about retention were not picked up as quickly as they might have been.
- Formal performance systems, complemented by focus groups, were able to provide a particularly sharp diagnosis which centred on HCA turnover within the first six months.

Seeking to devise a solution

- Devising a solution rested on a close working relationship between different trust functions, particularly the nursing directorate – in the form of the
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assistant chief nurse; the HR directorate – in the guise of the recruitment and resourcing manager; and the Applied Learning and Research Directorate.

- These relations were formalised and extended by the establishment of a small working group comprising matrons and ward sisters, which allowed ideas to be sharpened, and engaged those responsible for working the new systems and dealing with their consequences.

Implementing changes to the recruitment model

- This final process was underpinned by formal sanctioning and senior management buy-in, which lent legitimacy and credibility to the initiative, and more prosaically helped address certain obstacles.
- There was strong on-going support from the chief nurse for the initiative.
- The implementation of the initiative assumed an organic form, in that there was some testing and tweaking of systems and practices.

Substantive change

Job description/person specification

- York’s changes to the (Band2) HCA job description were principally aimed at the values-based dimension of the initiative. The emphasis on applicant disposition rather than formal qualification saw the removal from the person specification of the NVQ 2 qualification as an essential criterion for selection.

A new approach to applications

- This overlapped with emphasis on values: on the new application form candidates were able to present a free flow narrative about their suitability for the HCA role. In the main, however, the application changes sought to address the high turnover of HCAs, which stemmed from the failure of candidates to fully appreciate what the HCA role involved and its associated working conditions. The centrepiece of the change was a mandatory open day: those who wished to apply for an HCA post had to attend such an open day.

A new approach to selection

- Ward sisters were no longer involved, the recruitment function taking sole responsibility for this task. The new sharper person specification and the improved quality of applicants turned short-listing into a less contentious, more ‘straightforward’ process.
- The reformulated interview process for short-listed candidates sought to redress high and quick turnover amongst HCAs by ensuring a better fit between applicant and clinical area. Short-listed candidates had the opportunity to list their order of preference in terms of available clinical areas.
- Changes to the questioning of the short-listed were designed to address the issue of value alignment.

Extended induction

- The previous approach to HCA induction was founded on a couple of corporate days, supplemented by a supernumerary period, usually two weeks, shadowing an HCA on-ward.
• This had been replaced by a more robust induction process in the new recruitment model lasting two weeks, with the new recruit only permitted to take up their post on the ward on its completion. Even on ‘hitting’ the ward, the HCA still remained supernumerary for a further week. During this period they were given a ‘buddy’, typically another HCA with some experience, able to ‘show them the ropes’. They were also allocated a nurse mentor with responsibility for helping them work through and sign-off a competency booklet.

• These developments played to concerns about both retention and values: well prepared HCAs more readily took to and were less intimidated by their new role, and therefore were less inclined to make a quick departure.

3. The Operation and Impact of the New Approach

• Interviewee responses to the new recruitment model were very positive.

• A few organisational concerns were raised, for example, that this model took time and energy to set-up.

• However, interviewees were able to identify a number of benefits associated with different elements of the new model, supported by some ‘hard’ data on positive outcomes. These benefits were most clearly related to York’s interests in improving retention rates amongst HCAs. Attention was drawn to the recruitment of HCAs with values aligned to those of the trust, but gains in this respect were slightly less easy to verify.

• Alongside the achievement of aims related to retention and values, a broader range of positive outcomes was highlighted:
  o Quality HCAs
  o Prepared HCAs
  o Accountable HCAs
  o Supported HCAs
  o Retained HCAs
  o Value aligned HCAs.

4. Overview and Learning Points

• **Organisational structure**: An idiosyncratic organisational design – separate applied learning and development function – contributed to the trust’s capacity to undertake sustained work of developing the trust’s values and, more directly, helped in designing and delivering the extended induction.

• **Partnership working**: Three trust directorates worked in partnership to deliver the initiative: Nursing, Human Resources and Applied Learning.

• **Senior management support**: Support from relevant senior managers lent credibility and legitimacy to the initiative.

• **A real problem**: Significant efforts had been made through various means to establish HCA turnover as a ‘problem-to-be-addressed’.

• **A real solution**: Using ‘before’ and ‘after’ data on attendance at open days and job interviews, and on the appointability of applicants and on turnover, York
was able to convincingly establish its new recruitment model as a ‘real solution’ to the issues it sought to address.

- **An iterative approach:** The new recruitment process was monitored and tested, with modifications being made on an on-going basis.
- **Coalitions of interest:** Senior management in nursing and HR effectively built a coalition of interest involving matrons and sisters, groups with a key stake in HCA recruitment.
- **An inclusive process:** An on-going process of consultation, not least through the regular use of focus groups, helped ensure this extensive involvement.
Introduction

This case study report describes a new approach to the recruitment and retention of healthcare assistants introduced by York Teaching Hospital in 2010. It is one of six innovation case studies being undertaken as part of a project looking at the development of a ‘high performance’ nurse support workforce in acute healthcare. These innovation cases are designed to explore initiatives taken in relation to the management and use of HCAs. One of the primary purposes of the six cases is to track the emergence and development of a new practice to a trust, whether or not that practice has been implemented elsewhere, and in so doing to explore the organisational processes and architecture which might facilitate change as it relates to the HCA workforce. As a means of examining the new practice from different perspectives, each of the six cases is based on interviews with a vertical slice of those involved in and affected by it.

The York Teaching Hospital case study focuses upon an initiative which was in fact fairly novel within the NHS, reflected in its winning of the 2011 Healthcare People Management Association (HPMA) award for innovation in human resources and a similar HSJ award in 2012. The initiative centred on the recruitment and retention of HCAs and comprised four main parts:

- A revised HCA job description/person specification;
- A new approach to application;
- A new approach to selection; and
- An extended induction to be completed before HCAs took up their posts on the ward.

In presenting this initiative for the HPMA Award, York labelled it ‘HCA Retention’, but this belies the pursuit of an ambitious range of goals designed to recruit and retain capable HCAs with ‘appropriate’ values. In examining the initiative, a total of 18 interviews with different staff members were conducted between December 2011 and March 2012. These included interviews with: directors and other senior trust managers (8); matrons, ward sisters and senior nurses (7); and HCAs (3). In presenting the findings from the interviews, the report is divided into the following parts:

1. The emergence of the initiative
2. The new approach to recruitment and retention
3. The operation and impact of the new approach
4. Overview and learning points


1. The Emergence of the Initiative

The emergence of the York initiative can be related to two sets of factors. The first concern context, and connect to the nature of the organisation and its workforce. These factors provide a backdrop to the initiative and some general clues as to how and why it emerged. The second set comprises direct influences; that is factors explicitly linked to the initiative and its development. Each set of factors is considered in turn.

**Context**

There are grounds for suggesting that the organisational culture at York facilitated change. There was a fairly strong consensus amongst interviewees on the nature of this culture, characterised as tight knit and supportive, generating in turn reciprocal commitment to the trust from the staff:

**Service manager**¹: I’ve got a big loyalty to York. I find it a really friendly place to work, the people are really great, the support that you get whatever job you’re in I think is really, really good.

**Service manager**: It is cohesive, it’s very open. I feel it’s a very open trust.

**Trust manager**: It’s an organisation which cares for and is proud of what it does...People are genuinely willing, they’re genuinely proud of saying that they work here and want to make a difference.

**Service manager**: One of the things that people remark upon in York, which is true, that a lot of people have worked here for a lot of years so everybody knows everybody...One thing York really has is a strong sense of community.

Significantly, there was a view amongst some that the trust also backed new ideas:

**Service manager**: If you’ve got an idea they’re quite innovative at York and if you’ve got some ideas about things there’s always somebody there who’s keen to support you, the lead though things that you want to do.

Most tellingly, in recent years York had been seeking to develop this culture, clarifying and sharpening its organisational values:

**Trust manager**: We’ve done a lot of work around [the trust’s] values. We consulted over 400 people in the organisation and governors to get a public perspective, and we’ve been working with those values now for about 18 months.

¹To protect the identity of those we interviewed the quotes use attributions related to three broad job areas: **trust managers**, which include all senior and executive managers and managers within the HR division; **service managers** include matrons, divisional managers and senior nurses not working on wards; **ward staff**, which include sisters and healthcare assistants.
It was a process given added impetus by the presence in the trust of a dedicated ‘applied learning and research’ directorate. In most NHS trusts the learning function falls within the remit of the HR directorate: the presence of a separate function at York might be seen to have supported a sustained focus on organisation development:

**Trust manager:** We’ve got a good strong OD department who did develop the core values for the organisation.

York values were centred on safety and care quality and more distinctively revolved around seeking to contribute to the well-being of the local economy and community:

**Trust manager:** We have a set of values that we espouse which are about safety and quality of care, caring about each other, caring about what we do and the contribution to the wider economy.

Indeed, it was noted that recent attempts had been made by the trust to ensure that these values were given meaning and reflected in behaviour:

**Trust manager:** We recently developed what’s called the personal responsibilities framework in the organisation which sets out behaviours, so rather than it being the value, it would be the behaviour associated with that value that we expect to see.

At the same time, it was apparent that this strong and developing York culture was facing pressure. Most respondents regarded the upcoming merger with Scarborough Hospital, some forty miles away, as the trust’s most immediate ‘strategic challenge’, generating ‘hard’ issues around organisational re-structuring and service rationalisation, as well as ‘softer’ issues, for example, related to the establishment of an integrated culture. There was also some emphasis on the challenges presented by the efficiency agenda, and the financial savings York, along with other NHS trusts, needed to make:

**Service manager:** Certainly in the last [few] years, while I’ve been here things have changed in terms of the expectation of managers and the workforce in general, but particularly the managers. It’s much more driven by performance targets, finance and quality; these are the things that seem to drive it.

This search for efficiency, while at the same time maintaining and improving service quality, had encouraged senior managers at York to devote increasing attention to the nursing workforce and more particularly to its HCA. As a senior manager at the trust noted:

**Trust manager:** The biggest challenge is about balancing quality and safety and the focus on quality and safety of patient care with the broader financial context on not only health but the public service and the economy in general...The nursing and midwifery workforce make up the largest proportion of the workforce [and so] you’d be foolish not to look at how we could minimise the cost of that or make sure we are using it effectively...So we’re looking at alternative models: we’re involved in work that identified how useful the non-registered workforce can be and how we can make it more attractive to the local population.

In general, a concern with the ‘usefulness’ of the non-registered employees prompted the trust to confront the prevailing character and structure of the HCA workforce. This workforce was tightly compressed into pay band 2: around 480 of the trust’s 508 HCAs
were at the band 2 level. Moreover, it was clear that the role at this level had developed in a very uneven way, assuming very different forms within the trusts:

**Service manager:** What is absolutely outstanding is even wards in the same directorate, their healthcare assistants are all working differently...we’ve got this big disparity of what people are doing at a band 2.

The amorphous nature of the band 2 HCA role at York was in part related to a broadly conceived band 2 job description which provided scope for the role to develop in different ways:

**Service manager:** The job description is so generic and so sparse it doesn’t really actually state clearly the tasks of what you do as a band 2.

The scope for uneven development was given full vent by a NVQ system of accreditation which had ceased to effectively and meaningfully regulate and standardise skill development at York. There was an expectation at the trust that new HCAs would either have or acquire within 12 months an NVQ 2, but giving this effect had proved problematic:

**Service manager:** You had a situation where formally there was a training route with an NVQ 2 requirement over a certain amount of time but the truth is it didn’t really function.

This was not least due to a shortage of registered nurse NVQ assessors and the resource intensive nature of the assessment process:

**Service manager:** There were insufficient assessors and that’s where it all fell down basically.

**Trust manager:** In the past we’d have offered them [HCAs] the opportunity to undertake an NVQ qualification, but we were unable as an organisation to support NVQs latterly because of the time it takes to assess somebody on the NVQ framework.

As the efficacy of the NVQ system eroded at York, so HCA training and development at the trust evolved in an ad hoc opportunistic manner, dependent on the aspirations and drive of the individual HCA her (him)self and or the approach of the ward sister. Indeed it was suggested that whether or not the ward sister supported HCA training was crucial in explaining the uneven development of the role within the trust:

**Service manager:** The person who allows the healthcare assistant to expand their skills is very much the ward sister. So if the ward sister has the ethos of “yes I think these are committed staff, they’ve got skills we could utilise better”, their healthcare assistants did far more in their remit. If you have a ward sister who is actually quite negative around the role of the healthcare assistant, who says “well no, I might let some do obs”, but can’t define why some and not others do it, there is no continuity.

In the absence of an HCA band 3 job description at York, the unevenly developed HCA roles were crammed within the single level 2 band. In short, HCAs with very different competences, as a consequence undertaking very different tasks, were all found to be functioning at the same band 2 pay level within York.
This ‘state of play’ generated a number of challenges and issues for the trust. For some there was general ‘uneasiness’ about HCAs undertaking very different tasks within the same pay band:

**Service manager:** On some wards their band 2s are doing the core kind of skills you’d expect and much more being paid band 2, and in other areas, some of their healthcare assistants are literally just washing, bathing, dressing patients and that is it. So they’re getting paid a band 2 for doing that, and you’ve got somebody else in another directorate doing venepuncture and cannulation, catheterising people and doing a lot more enhanced skills on exactly the same pay grade. And to me that didn’t feel very comfortable.

More fundamentally, the disconnect between pay band, training and tasks performed complicated attempts to re-structure the broader nursing workforce. A more ‘rational’ re-distribution of nursing tasks in pursuit of greater cost efficiency and effectiveness appeared predicated on the capacity to distinguish between the roles played at different unregistered pay bands – 2, 3 & 4 – as well as registered nurse band 5 and possibly 6:

**Trust manager:** What we might need is 3s and 4s instead of 5s...we’ve had a gap in terms of 3s and 4s.

Yet York was without clearly developed band 3 and 4 job descriptions, and in taking forward this agenda needed to untangle the different forms assumed by the HCA role at band 2 level.

Closely related, this band-training-task disconnect fed into a concern about (the lack of) career opportunities for HCAs within the trust. An interest in clarifying and strengthening HCA career opportunities was consistently emphasised as central to the trust’s reforming ambitions:

**Trust manager:** It saddens me to think we recruit individuals and then we offer them no career opportunity.

It was an ambition which linked to the trust’s ethos: its desire to engage with the local community and economy:

**Trust manager:** There’s a real opportunity in the non-registered workforce to develop individuals. This links back to our values as well, so one of the things that the Chief Executive talks about is that anyone who comes to work here should leave richer for the experience. And he means that in terms of learning as well. So how we support band 2 HCAs to develop to ensure that when they leave they go on to do bigger things or they feel more able, more equipped to do so. So I think there’s the kind of larger social stuff about developing career pathways for predominantly local people...We are the largest employer in the city, like lots of hospitals, so how do we take our social responsibility seriously in terms of developing the nonregistered workforce?

More pragmatically, this ambition was associated with the recruitment of HCAs, the need to offer career opportunities to attract individuals to the role:

**Trust manager:** Currently here at York we only attract 2s; we have a few 3s but only attract band 2s. If there are other organisations around who advertise band 3s, and they do, aren’t we going to lose some of our good 2s there?
It also explicitly related to the retention of HCAs: the trust risked losing ‘good HCAs’ in the absence of clear career opportunities. It was a concern directly underpinning the trust initiative under consideration in this report.

**Direct Influences**

An increasing interest in the structure and nature of the nursing workforce at York, driven by the search for a balance between efficiency and care quality, and by the challenges faced by the uneven evolution of the band 2 HCA role within the trust, was reflected in a number of developments. Certainly, there was no explicit, detailed written nursing workforce strategy beyond a ‘high level’ nursing strategy which included ‘workforce’ as one of four or five key elements. However, there was an assistant chief nurse with dedicated responsibility for the nursing workforce, supported from February 2011 by a seconded senior nurse with specific focus on the HCA component of that workforce. Alongside a general benchmarking exercise comparing staff levels between York and other trusts according to patient acuity and dependency, two more specific pieces of work centred specifically on HCAs were in evidence. The first revolved around the current allocation, and possible re-distribution of nursing tasks using a model, the Calderdale Framework, adopted by various other trusts for this purpose. This work began in 2011 and is subject to a separate evaluation as part of our broader research project. The second, more discrete piece of work, related to the retention of HCAs, and the introduction of a new form of recruitment. This new model of recruitment was introduced in 2010, and is the focus of the rest of this report.

York’s introduction of a new model of recruitment was underpinned by two broad considerations. The first relates to York’s attempt to modify its recruitment process to deal with a very specific problem, the high turnover of HCAs. The second connects to York’s introduction of a values-based element into their recruitment process as a means of aligning the values of new HCA starters with those of the trust.

The initiative was most explicitly driven by the first of these considerations. The narrative presented by most of the interviewees emphasised that the initial stimulus for the new recruitment model was apparent trust difficulties in retaining HCAs.

**Trust manager:** We said actually our attrition rates are dreadful: what can we do about it? What is it that means we can get people in but can’t keep them?

Views differed slightly on how these difficulties were initially picked-up within the trust. For example, some weight was placed on their identification in an informal, impressionistic manner, particularly by matrons:

**Trust manager:** Some of that need had come from one specific matron who’d said, “why am I having this big turnover [of HCAs]?”

These impressions may or may not (it is unclear from the interviews) have prompted a more formal and thorough consideration of HCA turnover. Certainly such turnover issues were revealed by more formal trust systems designed to monitor and manage the trust’s performance:

**Trust manager:** We developed for each directorate a workforce health check, which basically sets out their [staff] turnover, their sickness, their vacancies, any
workforce issues that we monitor and analyse. One of the indicators that stood out was the turnover for HCAs.

Service manager: We look at all manner of key performance indicators and we will have workforce performance management meetings, and one of the things that we recognised as an organisation was that actually our turnover of healthcare assistants was high.

More striking was the trust's willingness and ability to 'drill down' and examine this turnover problem in a detailed way. Thus the 'health check data' were complemented by a couple of focus groups involving newly appointed HCAs allowing the problem to be diagnosed in a sharper form as one of relatively high HCA turnover in the first six months or so of employment:

Trust manager: When we examined it in more detail, it was the turnover within the first two years of starting in the role. So we did more in-depth analysis asking is it in one area or is it another one, and basically it looked like it was fairly consistent across the board, people coming in and leaving. It actually ended up being more within the first six months, if you were going to leave you tended to leave really early, or you tended to stay.

Framing the problem in this sharper way helped the trust to pinpoint the source of the difficulties. Certainly there was no shortage of applicants for HCA posts, but the quick turnover was manifest in the frequency with which such workers had to be recruited:

Trust manager: We never had a problem recruiting healthcare assistants; we would always fill vacancies, but we were recruiting very frequently. So we were doing monthly rounds of generic recruitments where we'd be recruiting up to 20 healthcare assistants each month.

The quick turnover of HCAs encouraged the view that the trust's recruitment system was not attracting the 'right' people to the role.

Trust manager: The start point was around recruitment, so the start point was let's get the right people in so that we could try and keep them.

This problem of 'rightness' took three different forms: type of applicants; knowledge about/understanding of the HCA role; values and an appropriate disposition. All three will be discussed in turn.

Rightness as type of applicants

In part it was framed as the HCA role tending to attract the 'serial applicant'. The ready availability of HCA job advertisements on the NHS Jobs website was seen to encourage routine and indiscriminate applications from individuals giving little consideration to the appropriateness of the post for them. This interpretation was given weight by data (presented at the HPMA Awards) that a significant proportion (over 20 per cent) of applicants shortlisted failed to attend the interviews, while only a small proportion of applicants, on average only 13 per cent, were appointable.

Trust manager: NHS Jobs is a wonderful tool in terms of actually being able to attract candidates from across the country, but one of the downsides is once people have registered they have an application form at the ready to do and they do literally submit, submit, submit to all the vacancies.
The large volume of applications received under this system ran the risk of driving out ‘suitable’ candidates. There was limited capacity to process more than around 100 applicants during any given recruitment round, with a cap arbitrarily placed at the level. The 100 applications considered would include ‘inappropriate’ and ‘serial candidates’, while those perhaps more suited for the role fell beyond the cut-off.

Rightness as knowledge/understanding of the HCA role

More profoundly perhaps, the ‘rightness problem’ was manifest in applications from, and the appointment of, individuals who were not fully aware of the nature of the HCA job. Indeed those applying and appointed often had a false impression of the role. This was typically labelled the ‘Holby City effect’, and was apparent in a misunderstanding about the range and character of tasks to be undertaken by HCAs as well as about the working arrangements associated with the provision of a 24/7 service. When the ‘realities’ of the HCA role became immediately apparent, newly appointed post holders were quick to leave.

Trust manager: What we discovered was that we had a high turnover of healthcare assistants and we thought well what’s that all about, and part of what came out was that they actually didn’t really understand the job that they were coming to. And so they got here and it was a disappointment to them and they left.

Service manager: The feedback once we got people in post was actually, you know, they lasted three weeks and went, they didn’t know what the job was. Or they’d come in the job – this is another one, another classic as well – is we’d make it really clear at interview that it’s fully flexible, 24/7, nights, every shift going. Yes that’s absolutely fine at the interview and you’ve documents that flexible working was discussed. Turn up on the ward, first day, “I can only work 10 till 4”. “But it was discussed”. “Well, I’m telling you I can’t do it”. So you’re stuck with them then.

Ward staff: So many people just came and didn’t have a clue really what they were going to be doing...They come and think “oh I thought I was only making tea”. Any you think “gosh no, there’s a whole host of things, and tea isn’t one of them.”

Service manager: They [new HCAs] had absolutely no idea what they were coming in to at all. And even things like the business of a 30 [bedded] ward, some thought they had all the time in the world because they were the healthcare assistants and they were there to care and it didn’t matter how busy it was.

Rightness as values and an appropriate disposition

The ‘rightness problem’ assumed a final form, captured by the view that the trust’s recruitment systems were not attracting and identifying those with an ‘appropriate disposition’. In viewing ‘rightness’ in these terms, attention shifted to the values-based dimension of the York initiative. Thus, ‘appropriateness’ was associated with an alignment between the personality or disposition of the HCA applicant and values of the trust. This was reflected in the views of an interviewee who described the initiative as being about:

Trust manager: …prioritising people’s values, people’s work ethic, people’s motivation, over qualification and experience. So it’s about getting somebody that wants to do a role for the right reasons versus somebody that has always done a role.
As another interviewee noted in setting out the initiative that:

**Trust manager:** The biggest thing for me is recruiting individuals with the right core values.

The ‘right’ core values were typically presented in terms of ‘caring’ and ‘compassion’:

**Trust manager:** We wanted to be able create the opportunity for the individual that...could demonstrate their caring disposition.

This emphasis on ‘appropriateness’ linked to the caring values of applicants, encouraged York to rethink the kinds of people it was seeking for the HCA role, and that were being encouraged by their recruitment system to apply. In particular, the weight based on formal qualifications and ‘relevant’ work experience was challenged. Traditionally the trust had sought applicants with a NVQ 2 qualification in healthcare and or had experience of working in health and/or social care. Recruiting to band 2 level, effectively a starter grade, doubts were cast on the necessity of these entry requirements, particularly if they reduced the likelihood of those with ‘appropriate’ values and dispositions from applying. These requirements were increasingly questioned as an effective means of identifying appropriate applicants in these terms:

**Trust manager:** What we started to do was have a process which focused more on the values that people displayed rather than the experience that they had.

**Trust manager:** In the past we would have recruited a healthcare assistant and their essential criteria to be shortlisted would be that they had to have an NVQ 2 in health and social care. But what did that mean for the girl who works in Top Shop, for example, who desperately wants to come and be a healthcare assistant and look after patients or believes that they desperately want to do that? Life hasn’t afforded her the opportunity to do a health and social care NVQ but she’s got that caring, compassionate disposition that we want, compared to an individual that would have got shortlisted with that qualification who might not have those care values and that disposition that we want. So the whole reason we turned our recruitment on its head was because we wanted to be able to create the opportunities for the individual that didn’t have the qualification but could demonstrate their caring disposition.

**Trust manager:** Just because they’d had some experience of being a support worker or a healthcare assistant in a care home, for instance, does that transfer to them being a really effective, really good healthcare assistant within an acute trust? And actually it doesn’t. We’re wanting people to come into the organisation, that their primary focus is delivering first class patient care, that they’ve got that ability to empathise with patients, that they do want to genuinely improve the quality of their stay in hospital, and if somebody’s just come for the pay cheque at the end of the month you’re not going to get that.
2. The New Approach to Recruitment and Retention

Having noted that York was keen to address a particular retention problem amongst HCAs, and more generally to attract those whose values aligned with those of the trust, attention can now turn to how the trust went about taking the steps needed to address these issues.

This section will focus on two features of the change from the old to a new approach to HCA recruitment and retention: first the processes underpinning the shift and second the substantive changes introduced by the shift.

**Processes**

In crude terms, the development of an initiative might be seen to rest on three basic processes:

- identifying the challenging issue;
- devising the means to address it; and
- implementing those means.

Taking forward these apparently simple and clearly defined stages should not, however, detract from the complexities surrounding the way in which they often unfold. The stages might well relate to one another in a ‘messy’ way, not necessarily progressing in a linear fashion. More profoundly, in many organisations different, perhaps competing views inform all three processes, rendering the establishment of the consensus often necessary to progress an initiative problematic. The York case is noteworthy as a case in which these processes did appear to unfold in a fairly efficient and effective manner. This is not to detract from the non-linear nature of some of the developments. For example, the notion of values based recruitment was already being considered before the initiative emerged in a more developed form, while there were elements of the new model which needed to be tweaked over time and in the light of learning from practical experience. However, the relatively ordered and effective implementation of the initiative is striking, and encourages an interest in how these processes unfolded and the form they took.

**Identifying the challenging issue**

Some consideration has already been given to the first of the processes, the identification of HCA recruitment and retention as a trust issue worthy and in need of attention. This was perhaps the ‘messiest’ of the three processes in that while retention was picked up by formal trust systems such as ‘health checks’ and performance management metrics, some concern about this issue had more informally been floating around in the trust particularly amongst the trust’s matrons. As one matron noted:

*Service manager:* It was probably an ad hoc discussion of I’m going to have to go out to advert again. And a few of us were in the same situation and frustrated by it.
Another matron stressed how the close relationship between the trust’s matrons facilitated communication around such matters:

**Service manager:** We were a very sort of tight knit group of matrons and the problem with retention in terms of healthcare assistants was not something strange that had escaped our attention. And so two of the matrons...they were in my opinion instrumental in kind of setting this in motion...I just think it’s important to remember where it started...It was certainly that they had but then Lucy and Cathy have done a fantastic job in pulling that together.

Indeed, it was acknowledged that perhaps these matron concerns about retention were not picked up as quickly as they might have been:

**Trust manager:** Within the organisation we have workforce performance management meetings and I think we were getting kind of softer feedback that there was this issue with healthcare assistants, and that was going on for a number of months. I think we could have acted quicker if there’d have been a more kind of robust process to feed that information to us.

Notwithstanding these concerns, it has been noted that formal performance systems, complemented by focus groups, were able to provide a particularly sharp diagnosis which centred on HCA turnover within the first six months.

At the same time, defining high HCA turnover as an issue worthy of further action needed to be sanctioned by senior trust managers. The assistant chief nurse, recruitment manager and crucially the chief nurse and HR director “had initial meetings to say we’re getting feedback from matrons and ward sisters that the healthcare assistants that are coming through don’t understand what the role’s about.”

**Seeking to devise a solution**

The second process also rested heavily on this close working relationship between different trust functions, particularly the nursing directorate, in the form of the assistant chief nurse, and the HR directorate, in the guise of the recruitment and resourcing manager. The latter was crucial in presenting substantive ideas; thus the notion of values-based recruitment came from HR. However, the former was essential in carrying these forward and ensuring ‘buy-in’ from nurses and sisters to any changes in recruitment procedures, as a member of the HR directorate stressed:

**Trust manager:** It had to be done in conjunction; it couldn’t be HR sat in their ivory tower saying this is what we’re going to do; because I’ve never been a healthcare assistant; I don’t even have a nursing background. I don’t know, if I’m honest, other than what people have told me, what the realities of being a healthcare assistant are. So it’s no good me going away and developing this recruitment process and I think from my HR perspective works, if I then show my nursing colleagues and they say, “well, why are you telling them that, that’s not what they do.” So the four of us sat down and thought “OK, what do we want form our healthcare assistants; what do healthcare assistants do; how can we present that in a manner that is real but also sells the organisation?”

There was a third partner in the design process: the Applied Learning and Research Directorate. It has already been suggested that the presence of a standalone directorate of this kind might well help account for the development and emphasis on
a clearly articulated set of trust values, readily connected to a values-based approach to recruitment. More tangibly this directorate provided a useful resource in quickly designing a credible two week induction programme, an essential element of the new HCA recruitment package:

Trust manager: [The directorate] did a big piece of work, working with HR and nursing to say actually what do they [new appointed HCAs] need to learn. So [the directorate] developed the core content of the programme for induction that is being delivered by nursing now.

Equally significant was the role this department played in supporting the introduction of the new induction programme, and monitoring its quality:

Trust manager: [The department] might have designed the programme and initially delivered it, so a team [from the department] delivered the first three or four cohorts, but then [the department] gradually trained the trainers, transferred it to nursing because it should sit with them...We quality assure the programme content and make sure that it is delivered to standard that fits with the other training.

In the initial stages there was some informal working between these partners, especially the assistant chief nurse and the recruitment manager, testing ideas and establishing a ‘direction of travel’. These relations were, however, formalised and extended by the establishment of a small working group comprising matrons and ward sisters, which allowed ideas to be sharpened and ultimately responsible for working the new systems and dealing with the consequences. There was in addition a further engagement not only from HCAs themselves but from the wider nursing community in the trust: matron meetings were attended and focus groups organised for different staff groups to generate views on how the current recruitment system worked and how it might be improved:

Trust manager: We had focus groups, we went to matrons’ meetings to get their feedback. We tried to pull from a whole kind of range of nursing staff, so we didn’t just talk to the healthcare assistants, we spoke to some of the staff nurses that dealt with them, we spoke to ward sisters, we spoke to matrons...And the feedback we got was really beneficial in terms of how we shaped the process.

Implementing changes to the recruitment model

The final process was also underpinned by formal sanctioning and senior management buy-in, which lent legitimacy and credibility to the initiative, and more prosaically helped address certain obstacles. Thus implementation was approved by the nursing board:

Trust manager: We needed that board level sign up because there was an issue when we needed the freedom to really change things, not just tweak things...I think it was helpful because you know that you did have the ability to change things and actually just to have, if you’re wanting to do it quickly you need that kind of senior sign up.

More importantly, there was strong on-going support from the chief nurse for the initiative:
Trust manager: It is important that you've got the support of your chief nurse and your director of HR who can help overcome some of those obstacles...because there are resource implications.

At the same time, the implementation of the initiative assumed an organic form, in that there was some testing and tweaking of systems and practices. Thus attempts were again made to consult with and receive feedback from the different actors involved in the recruitment, with a view to addressing any difficulties. As a result, the induction programme in particular received some fine-tuning:

Trust manager: So we’ve tweaked and evolved things over time and I certainly know that the two week induction programme bears no resemblance really to what it looked like two years ago when we first introduced it, and that’s based on people’s feedback of what the content of that programme should be. And that feedback’s not just from healthcare assistants, but from ward sisters, from corporate learning and development, from the senior nursing team’s intelligence around complaints and external drivers.

Substantive Change

It has been noted that the new approach to recruitment comprised changes to:

- the HCA job description/person specification;
- the application process;
- the selection process; and
- induction.

These changes were designed to address two related but analytically distinct issues:

- retaining HCAs in the immediate aftermath of their appointment; and
- ensuring that their values were aligned with those of the trust.

Consideration will, in turn, be given to the four different elements of the new approach: how they differed from the old recruitment model and how they sought to address HCA retention and value alignment. As a prelude to this discussion, it is worth noting that the new approach continued to be based on the central recruitment of HCAs. Some years ago HCA recruitment had been pitched at the level of clinical area and ward, with matrons and ward sister driving the process in terms of advertising for HCAs as and when they needed them, interviewing and selecting applicants themselves. It was an approach generally perceived by senior nurses at these levels as sensitive to their needs and circumstances. Before the new approach was implemented, local HCA recruitment had been replaced by central recruitment. The new approach retained central recruitment. This involved organising the recruitment of HCAs on a trust wide and integrated way: wards were trawled to establish their HCAs recruitment needs; application was processed centrally and interviews across all clinical areas and wards held on single designated days.

It was acknowledged that the continuation of central recruitment was a top down decision, not least reflecting the perceived cost efficiencies associated with such an approach. However, this was accompanied by a senior management desire to involve matrons and sisters more fully in the development of recruitment and retention systems:
Trust manager: If you’d asked individuals two years ago, and I’m thinking people at operational level, so in the directorate patches, the matrons and the ward sisters, they’d have said we hate centralised recruitment, we hate generic recruitment; let’s recruit on our own places. You’re imposing this on us and we don’t like it. So actually we’ve done a lot of work in the last two years of saying actually the centralised recruitment is here to stay, and it’s here to stay for these reasons, which are around economies of scale, around cost of recruitment, but trying to get matrons and ward sisters more involved in how that bears out then...so you might not like the fact that it’s central, but if you accept that it’s central, and that it’s here to stay, you can influence how it happens.

This more inclusive approach is reflected in the design of the four elements comprising the new HCA recruitment model.

Job description / person specification

Changes to the (Band2) HCA job description were principally aimed at the values-based dimension of the initiative. The emphasis on applicant disposition rather than formal qualification saw the removal from the person specification of the NVQ 2 qualification as an essential criterion for selection: “so it’s more around can you demonstrate that you want to enter the profession and be caring and compassionate.” The specification was also modified to de-emphasise ‘relevant work experience’, stress being placed on a more general understanding of the role and an ability to demonstrate a caring orientation. As interviewees noted:

Trust manager: Previously if they didn’t have some previous experience, it automatically would have been ‘no’. Even if their application was compelling their person spec. wouldn’t allow them to be short-listed, whereas now the person spec. actually has that that’s one of the things we look for. So if they wrote their form in a way that just didn’t show any desire to want to do any caring, then that might be sufficient not to short-list them.

Trust manager: We actually changed our job description and person specification, because we were hampered by them.

In the past weight had been placed on relevant work experience:

Trust manager: ...but that’s not always what you want; you could have somebody that’s cared for their mother or their family, who have had no kind of formal kind of employment in this sector, but they’re brilliant.

A new approach to applications

The modifications to the application process assumed a number of forms. In part they overlapped with emphasis on values: thus on the revised application form candidates were able to present free flow narrative about their suitability for the HCA role. In the main, however, the application changes sought to address the high turnover of HCAs, which stemmed from the failure of candidates to fully appreciate what the HCA role involved and its associated working conditions. The centrepiece of the change was a mandatory open day: those who wished to apply for an HCA post had to attend an open day. These open days, deliberately held at different times to accommodate the domestic responsibilities of prospective applicants, sought to provide a fully rounded picture of what the HCA role involves:
**Trust manager:** The open day, they come, they talk to other healthcare assistants, and they get a view of what the job actually entails. They can look around at the stands, and yes, it's a really good push into what the role is.

Addressed by the assistant chief nurse and the recruitment officer, a key feature of the day was a presentation by existing HCAs, providing a first-hand description of the HCA role:

**Trust manager:** We do have two or three [HCAs] now that regularly come and talk and share their stories...The only thing we told them initially was you need to be really honest and not shy away from any aspect of the role, the things that you enjoy but please don’t shy away from the other aspects, the areas of work that aren’t glamorous...And they absolutely do strike the right balance.

As one of these presenting HCAs notes:

**Ward staff:** We didn’t pull any punches and I certainly didn’t and gave them an actual scenario of an actual event...It was trying to put across that it’s not just cleaning somebody up; it’s not just giving them a pill to make them better; it’s the psychological side of how you [could] make or break a patient in a split second with one look, one tut, one roll of your eyes.

Another HCA states:

**Ward staff:** I thought about what I would want to know as somebody going into this [HCA] job; what would I want to know? And I thought I can’t say “oh yes its lovely and you have a nice uniform and you go in and say good morning and you give the tea out.” No it’s not like that; I wanted to give them a bit of reality, that the type of patient you get in; that not everybody’s happy to see you; some people are abusive; they swear at you. I’ve been sworn at, spat at, punched, hit, slapped, called every name under the sun, and you have to deal with it.

These open days concluded with an opportunity for prospective candidates to ask questions. Those attending are provided with a unique identification number which allows them access to the application. Signing a register on the open day helps ensure that this number cannot be shared with non-attendees.

As a means of providing more detailed information about the role, the trust also produced a DVD, with the content made publicly available online. Again the intention was to present a fully rounded picture, ‘warts and all’ of the HCA role. The ten minute DVD features six HCAs from different clinical areas – maternity, theatres, outpatients, elderly care and renal – talking in a similarly structured way: they set out the tasks they perform, including the more routine ones; stress that the role has stressful aspects, not least related to the handling of death and bereavement; but they typically conclude with an emphasis on how intrinsically rewarding and enjoyable they find the role.

**A new approach to selection**

The new approach to selection comprised two elements. The first was a change in the short-listing process: ward sister are no longer involved, the recruitment function taking sole responsibility for this task. The rationale for this move in part rested on the time consuming nature of this task for sisters, but also on the view that the new
sharper person specification and the improved quality of applicants turned short-listing into less contentious, more 'straightforward' process. However, the exclusion of ward sisters in short-listing made their involvement in interviewing all the more crucial:

**Trust manager:** Short-listing now, and it was one of the things we were anxious about, was we’ve removed the Ward Sister from the short-listing process, and that was partly because of the logistics of we never, every month was a really arduous task trying to get people to come along and do the short-listing and it was, it was so hard. Whereas now actually what we’ve said is our person spec is quite clear in terms of who we’d short-list and who we wouldn’t, in fact you could even make that an administrative process.

Indeed, the second, more significant element of the new model was a reformulated interview process for short-listed candidates. This new interview model might also be seen as seeking to redress high and quick turnover amongst HCAs by ensuring a better fit between applicant and clinical area. Short-listed candidates had the opportunity to list their order of preference in terms of available clinical areas, and although certain areas are often more popular than others, leading to ‘over subscription’ in those cases, this technique does allow a degree of ordered allocation. This is reinforced by the involvement of sisters and senior nurses in interviewing those who had expressed an interest in working in their areas:

**Trust manager:** The prerequisite is if you’ve got vacancies in your area you have to send someone onto to an interview panel...And one of the things we did in light of sisters’ feedback is we try and direct candidates to a panel that’s got a rep from that area. They’re asked to express their preference in rank order...and whoever is overseeing the interviews looks at that and tries to signpost people to panels where we’d be trying to accommodate them on their first choices.

More fundamentally perhaps changes to the questioning of the short-listed were designed to address the issue of value alignment. The old standard list of interview questions, which had found its way onto the internet, therefore being readily available to interviewees, had been replaced by a more open, scenarios approach. Scored according to their responses, this was seen as better able to assess whether candidates had the appropriate values and in particular a caring disposition.

**Trust manager:** We’ve already got a better calibre [of applicant] coming through to interview, but then when we interview then we use different types of question. So it’s more around “give us an example of when you’ve provided care”, but it doesn’t have to be in terms of a work environments, or things around what motivates them.

**Trust manager:** The questions that we ask are much more focused on them, so less around what they’ve done; it’s about them, why do they want the role; what difference do they think they could make; what would they do in this situation versus tell me what you have been doing previously.

Indeed, more generally the interviews were now much less structured and mechanistic, encouraging the interviews to probe the candidates on their attitudes and values:
**Trust manager:** The interviewers have a set of these values-based questions that they ask as standard but they're encouraged to ask follow-up questions and listen to what the candidates say and really push them. Before they had their list of questions, so they wouldn't follow-up...It's now much more conversational.

A stock of such scenarios was formulated, the shifting selection of the different ones eliminating any opportunity to predict the questioning:

**Trust manager:** All of our interview questions that we asked at interview for healthcare assistants were on Google. So you know as a healthcare assistant if you were coming to York what you were going to get asked before you even came. So what we do now is we make sure that we have a suite of questions that we ask that are around people's values and beliefs, and we rotate and use them differently.

The interview also provided an opportunity for those ward sisters and senior nurses interviewing to ensure that candidates had the ‘appropriate’ expectations on fully flexible working arrangements.

**Extended induction**

The previous approach to HCA induction was founded on a couple of corporate days, supplemented by a supernumerary period, usually two weeks, shadowing an HCA onward. However, this induction might well take place after the HCA had been in post for some time, a practice which caused concern amongst some sisters:

**Ward staff:** In the old way what we did was when they [HCAs] were successful they then came and met you on the ward and they met the ward sister; they were supernumerary for the first couple of weeks and they would work with an experienced HCA. And we would book them on to the induction course that’s run by the trust, but sometimes that might have taken longer, so they would actually be working on the ward as a healthcare before they actually attended the induction, and that was a downside.

This traditional approach had been replaced by a much more robust induction process in the new recruitment model. This now lasted two weeks, with the new recruit only permitted to take up their post on the ward on its completion. These two weeks were mainly to be spent in the ‘classroom’ although a couple of days were spent visiting prospective wards. Even on ‘hitting’ the ward, the HCA still remained supernumerary for a further week. During this period they were given a ‘buddy’, typically another HCA with some experience able to ‘show them the ropes’. They would also be allocated a nurse mentor with responsibility for helping them work through and sign-off a competency booklet.

**Service manager:** [In the past] if they’d just joined the trust, they’d have the two day induction which was hit and miss and that is basically just meet the Chief Executive, what the trust provides; it’s two days very basic but it doesn’t tell you how to be a healthcare assistant...whereas the two week course, they’re given the principles of infection control; they’re given the basics of observation taking and the different parameters, and when to escalate, basic care, assessing the patient’s skin integrity, blood glucose all the basic that they’ll need to work on the ward.

Again these developments play to concerns about both retention and values, but with perhaps a stronger emphasis on the latter. Thus, it was argued that well prepared
HCAs might more readily take to and be less intimidated by their new role, and therefore be less inclined to make a quick departure than those subject to the vagaries and uncertainties of the previous induction process:

**Trust manager:** We’ve started to put in place a more focused induction for non-registered staff because the recruitment and retention issues were quite significant...and that was about failure to prepare appropriately I think.

**Trust manager:** We had a large attrition [amongst HCAs], so actually we sat down and said well what’s going on, and the feedback that we were getting is they didn’t really know what they were letting themselves in for. So what we’ve done is we’ve started to make it more real: we’ve started to have people talking about the job that they actually do, and giving them some intensive basic training so that they go in to a ward environment more confident.

**Trust manager:** What would have happened [under the old induction] is they would have started on day 1 on the ward that they’re going to work on, two weeks supernumerary, straight out they’re on the wards, no induction to the organisation. They should have been supernumerary in that two week period and I can’t, hand on heart, say that everybody would have been supernumerary.

It might also be suggested that the new induction process connected to York’s patient care values; a narrative which implies that better prepared HCAs are better able to deliver quality care. Indeed the shift to a greater reliance on disposition rather than work experience and formal qualification placed increased weight upon the induction process and support to new recruits who were now much less likely to have the capabilities to ’hit the ground running’:

**Trust manager:** You do as an organisation have to take the stance and understand if you’re going down a value-based recruitment line and you don’t have people that are necessary to go on day one, you’ve got to invest in that initial kind of induction and training because they’re not necessarily going to have knowledge around the kind of practical things that somebody would get if they had some experience elsewhere doing a similar role.
3. The Operation and Impact of the New Approach

Interviewee responses to the new recruitment model were very positive. Certainly a few organisational concerns were raised. There was a suggestion that this approach took time and energy to set-up. Asked about the challenges, one interviewee noted:

**Trust manager:** ...probably just the time to set it up. Because there was a lot of work in, you know, producing the DVD, getting people to come and feel confident enough as an HCA to stand up and talk to a room of what can be a hundred people.

In the main, however, interviewees were able to identify a number of benefits associated with different elements of the new model, supported by some 'hard' data on positive outcomes. These benefits were most clearly related to York’s interests in improving retention rates amongst HCAs. Attention was drawn to the recruitment of HCAs with values aligned to those of the trust, but gains in this respect were slightly less easy to verify. It was also noteworthy that alongside the achievement of aims related to retention and values, a broader range of positive outcomes was highlighted. These outcomes were associated with the following: quality; preparation; accountability; support; values and retention. Each will be discussed in turn.

**Quality**

It has been noted that the Open Day in particular was designed to ‘weed out’ ‘serial applicants’ and ensure that those who applied had a fuller appreciation of what the HCA role involved. A number of interviewees stressed that there was a ‘fine line to be walked’ between being honest about the role, so realistically shaping expectations, and at the same time not ‘putting off’ too many potential applicants. In this context, the desired outcome might be formulated as fewer but higher quality applicants, and this proved to be the case. The trust had produced data which revealed the effectiveness of Open Days in attracting those interested in the HCA role: between May 2010 and April 2011, the average attendance was around 100. But the average number submitting a formal application had fallen from some 100 to 67, suggesting some ‘de-selection’ amongst those attending the Open Days. The enthusiasm of those who did apply was reflected in the fact that the numbers of those not attending interviews fell by over two thirds. As noted:

**Trust manager:** What we find is that the really poor applicants don’t even put in an application anymore. So in the past we used to get about a 100 applicants a month and we still get, we might have a 100 plus applicants a month in the past, we still get a 100 plus attendees at the open event. The last one, a 160 attended I think over the two dates. What that results in is about 70 applications now instead of the high number. So we’re being successful, because actually what we want to do is for people to self-deselect, we want people to say we’ve just watched your DVD, heard your talk, actually no, the job’s not for me, I don’t want to do that, so people self-deselect. So what you find is that actually our standard of application has improved in that the people who do go on to apply really, really do write in their supporting information, you know, applications that – what we often find now is everybody’s short-listable.
Ward staff: Whereas with the old system, like we said, you might have five people [invited to interview] and only two turn up, these people have all been to the open day, they really want to do this and so it’s, it’s quite refreshing really to know that you've got so many people that want to come in who would like a job. So I quite enjoy that.

Preparation

The better preparation of individuals for the HCA role, in terms of competence, mainly relates to the extended induction programme. Such preparation might be viewed as an end in its own right: after all it arguably links to the provision of higher quality care. However, it was suggested that better preparation for role might also lower HCA turnover by reducing initial difficulties and stress. The value of the new induction programme was certainly not uncontested. There was, for example, now an inevitable [two week] lag between the appointment of an HCA and their take-up of the role on the ward which caused some concern:

Trust manager: You've got to allow time for the induction, whereas previously they used to come, they'd have a half-day local induction and then they'd go on their corporate induction another day and then they'd be straight in the ward. I don't know the details of what they do on the induction process but my understanding is that they have to go through two weeks of different aspects before they actually start on the wards.

More significantly, it was suggested that the previous approach to induction provided more hands-on, practical experience than the new induction:

Ward staff: We had quite a few [HCA] recruits while we were there before the new induction programme...I think in some respects it’s [the new induction] taken some of the practical experience away from them. For example, in the old way we used to give them two weeks when they came to the ward supernumerary to work with the other healthcare assistants, that’s gone down to one week now. And that to me is the mistake because it is massively, you can't teach practical work in a classroom.

This concern finds a faint echo in concerns about the lack of available facilities for hands-on HCA training:

Trust manager: We talked about something as simple as prepping a bed space, because what we wanted people to know is how do you, how do you properly clean a bed space so that it is clean and meets infection control standards before the next person. And of course what people said again was actually do you know if you showed us physically on a bed how to clean a bed space, and some of that was to do with we haven't got, where would you take somebody to teach them to do that because you need an empty bed or an empty ward or a training ward. And whilst we have got a training ward here, it’s the first dibs on its using it for training purposes. So what we find very difficult in terms of the induction and it's still a problem now, is getting the space to do the practical training, but actually the bit that the candidates love is the practical stuff, and actually there's no better way to learn than to be shown rather than given the theory behind certain things. And it’s a real shame, I really wish we had a teaching ward for nurses and healthcare assistants just like we do for doctors, because actually who spends most of the time with the patients?
In general, however, HCAs were seen as better prepared for their role following the new extended induction:

**Ward staff:** They seem to fit in the team quickly, they pick things up much faster, they have an understanding of what is expected of them, their documentation is pretty quick really, they know what they should be doing and what they shouldn’t be doing. Whereas in the old system it’s, you used to have to sort of show them the documentation and tell them what was expected, very time-consuming, where with this they’re much more switched on, they, you know they’ve had all of, they’ve gone through all of this on their induction and, and they know exactly what to do. And quite often they’ll come and they say to you, you know, I was told I have to do this, is this right, and yes, that’s absolutely right.

**Ward staff:** The induction they’ve got now is fabulous...It is so much better and they learn everything. They can do their blood sugars, they learn how to do the obs, the making of beds, they learn about infection control, they do their manual handling...It’s so much better for them, and then they put it into practice. The only thing is I suppose, actually I think it might be two weeks now, now I think about it.

**Service manager:** I think the girls and boys are coming out much more ready.

**Trust manager:** If you are talking about a positive learning experience, actually if you talk to any of the healthcare support workers that go through the programme, they’ve said that they feel more confident and capable to do the job and they get more satisfaction.

**Accountability**

A less expected outcome, again associated mainly with the new induction group was a greater clarity around HCA accountability. It was suggested that the more open and documented process of skills acquisition provided by the new induction clarified and simplified any concerns about liability for actions:

**Service manager:** I did have a healthcare assistant that had gone through this process, the new recruitment process. She’s had all her training and that’s documented. It’s all there as part of her evidence; she’s had observation training, evidence that she’s had blood sugar training. And she was disciplined because patients said they hadn’t had their observations done that day and that was a separate process, but in support of that I could say that when the individual started work, she went through the new recruitment process, she had the training, she was assessed as competent around that training. In the past she could have just said I’ve never been trained properly so I can’t it’s not my fault.

**Support**

Another less obvious outcome revolved around support, emerging in a couple of guises. The new recruitment model generated an informal network of HCAs within the trust: attending the interview process on the same day, and then undertaking the two week induction together was seen by some to generate a close knit and internally supportive cohorts of HCAs:
Service manager: You’re all in post and there’s almost like a network there’s “well oh yes, I was interviewed with her, she works on ward so and so”, and all those things.

Ward staff: It’s quite nice because they’ve gone through the induction; they have met other healthcares who are on other wards, so they’ve got a support system as well which is really nice because they have got other people to see how it’s going.

This support was also reflected in view that the new recruitment process with its Open Day and extended induction signalled the greater value placed by the trust on the HCA:

Ward staff: It’s nice that they’re actually thinking about us [HCAs] now; that they’re thinking “oh yes well they’re doing this role so we need to put some training in.”

Values and retention

One of the core themes of this report has been the manner in which the new approach to recruitment links to two sets of objectives: one related to the retention of HCAs and the other to values alignment. As implied, there is considerable circumstantial evidence to suggest that HCA retention had improved; thus with the trust recruiting less often for HCAs, there was a feeling that they were more inclined to stay. Figures backed this up: turnover reduced from 17 to 12 per cent in the immediate aftermath of the changes and this lower figure has been sustained for three years. Indeed given the costs invested in HCAs who had previously left, this high HCA retention was seen to render the initiative highly cost efficient:

Trust manager: We’re doing a lot less recruitment because they’re [HCAs] staying and it’s more effective. So instead of every month, I think we do pretty much [recruitment] once a quarter now.

Trust manager: The problem is the time it takes and the intensity of the resource. But the benefit when you look at the difference in terms of attrition, yes, it’s worth it, it pays for itself.

There is similarly anecdotal evidence to suggest that the new interview process was effectively seeking to probe the dispositions of prospective HCA values and dispositions. As an HCA who had been through the process noted:

Ward staff: When I came in [to the interview] they said relax, this is informal and we’re not watching your every move sort of thing. And I think they were definitely trying to find out sort of about your personality as well rather than what you are on paper. Obviously because that’s the first time [name] ever met me from my open day to the interview, and on paper you can be completely different to what you are. And so I think that there was quite a lot of that and there was lots of kind of smiling and laughing and it did feel quite relaxed and I did feel that I could bring my personality across and I wasn’t just kind of reciting the notes in my head and answering sort of regimented questions.

It was further reflected in the examples provided by interviewees of HCA with unusual backgrounds who had become ‘very effective’ HCAs:

Service manager: I remember one lad [name & ward] and when he came he was larger than life and he worked at MacDonald’s, but I knew he’d make a good
healthcare assistant and he's fantastic...The patients absolutely adore him, and there's loads of people like that that have come from factories, that have come from all walks of life. I've got a new girl that's, she's run pubs for 20 years, she's coming to work on ward [name] shortly and I bet she'll be absolutely cracking because she'll, you know, she's bouncy. I've got an ex-nun on, you know, there's people from all walks of life, whereas we always seemed to go for people that had had some care home experience or they'd worked a bit, they'd been carers at home or they always tended to go for the same people. Whereas I do think we give candidates, we take life experience into consideration. I've got a butcher on [ward number], but do you know what I mean?
4. Overview and Learning Points

The interest in the York case lies in both the substance of the initiative and the manner in which it was taken forward. The development of a new approach to HCA recruitment represented a discrete piece of work, which nonetheless connected to broader challenges facing the trusts. It was founded upon a clearly defined set of objectives, and developed a solution, in many respects fulfilled in an efficient and effective way. In presenting the views of those involved in and affected by the initiative, this report has sought to convey the nature of the new recruitment model, how and why it was introduced and with what consequences. In this final section, a summary of the initiative is provided along with some learning points.

Figure 1 below provides an overview of York’s new approach to HCA recruitment drawing upon the findings from the main sections of this report: how this approach emerged, what it sought to achieve; the form it took; and its impact. It can be seen that the initiative was embedded in two closely related but analytically distinct streams of development: a retention steam and a values stream.

The roots of the retention stream can be traced to the trust’s general interest in balancing the search for efficiency and care quality, which in turn generated a concern with the distribution of tasks and responsibilities across the nursing workforce and across its different pay bands. In particular York was faced with specific concerns associated with the somewhat disordered development of the HCA role in the trust. Almost exclusively located within pay band 2, the degradation of NVQ systems within the trust had placed the regulation of HCA training at the discretion of post holders and wards sisters. The result was the uneven and varied development of the HCA role within a single band: HCAs all within band 2 but performing very different tasks within and between clinical areas and wards. Such a scenario was seen to have detrimental consequences for the recruitment and retention of this increasingly important group of workers: career opportunities were opaque and poorly developed; the link between pay and tasks/responsibilities distorted. These concerns were linked to a more immediate and explicit problem associated with the rapid turnover of HCAs, which pointed to features of the trust’s systems of recruiting, selecting and inducting. Slightly less tangible, the values stream was linked to a broader organisational development project within the trust. This project sought to clarify and sharpen the trust’s values and connected to an interest in recruiting and retaining HCAs with ‘appropriate dispositions’.

The retention and values alignment streams can be seen as feeding into the design of the new recruitment model in various ways. The move towards values was particularly strong in relation to the revised job description which marked a move away from a stress on work experience and formal qualifications to an emphasis on displaying enthusiasm and an interest in caring. It was also apparent in a new selection procedure which based interviews upon more open scenarios rather than tightly structured questions. The concentration on retention was especially strong in relation to the new application process based upon the mandatory open day, which sought to provide prospective applicants with a fuller appreciation of the HCA role and the
associated working conditions. This was designed to attract candidates with a genuine interest in the role and to ensure that those who took it up were fully aware of what was involved from the outset. The new and extended induction engaged with both streams: better prepared HCA were less likely to leave and more likely to deliver high quality care.

Figure 1: Tracking the initiative

Figure 2 below sets out the three main processes which implicitly underpinned the York initiative: identifying the issues to be dealt with; designing the means to address them; and implementing those means. The learning points derive from these processes. Some relate to particular processes. For example:

- **Identifying:** It was acknowledged that concerns about quick HCA turnover were common currency with York, but could have been picked up and acted upon more quickly. This suggests that a problem might be well known and articulated informally, but voice systems are needed to ensure senior managers are aware of these problems and sanction the necessary action.

- **Designing:** The HR department was considering the development of values-based recruitment well before it was drawn upon to modify the HCA recruitment model. This implies that the development of an initiative might be non-linear. More specifically, in seeking the means to address a problem, there is scope to draw upon already existing ideas within the trust, and ideas not directly related to the problem in question.

- **Implementation:** York is not unusual amongst trusts in struggling to establish such facilities, but the quality of the extended induction might have been enhanced if they were available. In short, the applied/practical aspects of HCA
induction are more effectively delivered where facilities are available which allow the development of hands-on experience and demonstrations.

**Figure 2: Learning points**

<table>
<thead>
<tr>
<th>Process</th>
<th>Specific Learning Points</th>
<th>Generic Learning Points</th>
<th>New Model:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify</td>
<td>Listen/act on internal voices</td>
<td>- Dedicated specialist function - Partnership working - Senior Mgt. support - A Real problem - A Real solution - Iterative - Inclusive</td>
<td>Job Description: Caring disposition Application: Mandatory open day Selection: Flexible scenarios Induction: 2 weeks, 1 week supernumerary</td>
</tr>
<tr>
<td>Design</td>
<td>Draw upon ideas-in-currency in addressing a new issues</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implement</td>
<td>Ensure resources/facilities available</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Other learning points cut across all three processes, applying with some pertinence to all of them in various ways:

- **Organisational structure**: York was unusual in having an independent and separate applied learning and development function: typically it is part of a trust’s HR department. This idiosyncratic organisational design feature appeared to contribute to the trust’s capacity to undertake sustained work of developing the trust’s values and, more directly, to contribute to the new HCA recruitment model not least in terms of helping design and initially deliver the extended induction.

- **Partnership working**: Three trust directorates worked in partnership at York to deliver the initiative: Nursing, Human Resources and Applied Learning. The three brought complementary capabilities to the process:
  - HR: technical knowledge of recruitment and selection systems;
  - Nursing: sensitivity and knowledge of nursing work and HCA/registered nurse roles;
  - Applied Learning: the skills to design and deliver in-house training programmes.

- **Senior Management Support**: Effective implementation is heavily dependent on the credibility and legitimacy of an initiative. These characteristics are often lent to an initiative by support from relevant senior managers. At York the Chief Nurse and HR Director were involved at key stages in taking forward the initiative and displayed sustained commitment. Such involvement not only had
symbolic significance, but in practice ensured that necessary resources were available and obstacles on the way could be overcome.

- **A Real Problem**: Of course the legitimacy and credibility provided by senior management in turn depends on how senior managers are perceived by those within the organisation. Where senior managers score highly in both respects, their support is clearly likely to benefit the initiative. While necessary, however, such support is unlikely to be sufficient. Credibility and legitimacy are likely to rest on at least two other factors. The first is that the initiative is generally seen by those involved and affected by it as addressing a ‘real’ issue. At York, significant efforts had been made through various means to establish HCA turnover as a ‘problem-to-be-addressed’. Hard data on turnover were important in this respect, but crucially these data confirmed the experience of matrons and sisters.

- **A Real Solution**: The second factor relates to the establishment of a solution which is perceived to be effective in addressing the ‘real’ problem. York was able to convincingly establish using ‘before’ and ‘after’ data on attendance at Open Days and interviews, on appointable applicants and turnover, the positive impact of its intervention.

- **An Iterative Approach**: Never settled, an initiative is always developing. Bob Dylan once said he was ‘always becoming’. Whatever you think of David Bowie (and my views are decidedly mixed) he was also a rock star who might be described in similar terms. The Rolling Stones have long ceased to be an interesting group because they ‘became’ about 40 years ago. An initiative develops organically: it is consequently reviewed and tweaked to ensure the achievement of desired outcomes. At York, the new recruitment process was monitored and tested, with modifications being made on an on-going basis.

- **Coalitions of Interest**: The effective design and implementation of an initiative rests on establishing a coalition of relevant interests. Various parties will be affected by an initiative, producing multiple points of potential resistance. Building support amongst these parties therefore becomes crucial. At York, senior management in nursing and HR effectively built a coalition of interest involving matrons and sisters, groups with a key stake in HCA recruitment. Senior management were able to bargain the continuation of central recruitment, viewed as critical by matrons and sisters, for their on-going influence on and direct engagement in the selection process.

- **An inclusive process**: It is somewhat of a management cliché to suggest that the effective design and implementation of an initiative rests on the involvement of a wide range of parties – again a means of ensuring buy-in and commitment for the range of interests involved and affected by it. At York, an on-going process of consultation, not least through the regular use of focus groups, helped ensure this extensive involvement.