



Pre-Nursing Degree Care Experience Pilot

End of Evaluation

Summary Report

PRE-DEGREE CARE EXPERIENCE

The concept of supervised pre-degree care experience, as a pre-requisite for all entering NHS funded pre-registration nursing courses and as a potential tool to promote frontline caring and values was prompted by the findings of the Francis Inquiry¹. Recommendation 187 of the Inquiry suggested that this experience should be *'physical hands-on'*.

In 2013 Health Education England launched a pilot scheme to enable a group of aspiring nurses with little or no previous care experience to be recruited into funded healthcare assistant posts to enable this group to develop insight into the professional commitment for a healthcare professional, to test nursing as a career choice and investigate the costs associated with this model.

'If the staff are caring and compassionate about looking after their patients then it makes the patients feel safe and comfortable and the relatives feel at ease as well'.

Pre-Nursing Degree Care Experience Pilot Healthcare Assistant

ACKNOWLEDGEMENTS

The authors would like to thank Health Education England for commissioning this evaluation and to the Steering Group for their expertise and guidance.

We would also like to express our thanks to the members of the sub-groups of the Steering Group: The Operational Leads Sub-group, the Evaluation Sub-group and the Economic Evaluation Sub-group for their support and close engagement with the work throughout the evaluation.

Particular thanks to all those who completed the online surveys, and those who fully engaged in the focus groups and the semi-structured interviews.

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¹ Francis R (2013) Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry Volumes 1-3 Crown Copyright. Stationery Office: London. Available from: <http://www.midstaffpublicinquiry.com/report>

A PNEP HCA 6Cs journey

'Being a young adult, Care, Compassion, Communication, Competence, Courage, Commitment are not foremost on your mind. When I first started the PNEP scheme, I was not aware what the 6Cs were or the importance of them. I knew that the relationships I built with people I care about are based on respect, empathy and dignity and that I could talk, and these skills came easily.'

Competence, Courage and Commitment DID NOT come naturally. I am currently working on a Neuro-Rehabilitation unit, where I am faced with complex and challenging behaviours every day. When I first stood on the ward, all I kept thinking was how am I ever going to become competent to do this? I was full of self-doubt. Competence requires practice, and when I became more competent the more confident I became. I know now that having courage does not mean you have to carry out a massive gesture, but it is the simplest acts of courage that encourage change, therefore ultimately delivering a better quality of care. Commitment, I find committing hard to do; it doesn't come easily for me. The last few months have been a whirlwind. I've had highs and lows.

So what have I learnt so far? I learnt how to communicate. I have learnt that without effective communication we cannot deliver even the most basics of care properly.

It is the collaboration of the Cs that defines our values and behaviours'.

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CHAIRMAN'S FOREWORD



"I am delighted to introduce this evaluation which is the first stage of gathering and reporting the early evidence about the effectiveness of Pre-Nursing Degree Care Experience pilots.

I make no apologies for reminding readers of the starting point for this work i.e. the tragic failings in care at Mid Staffordshire NHS Foundation Trust. Having spent nearly three years in the midst of the community in Staffordshire, and supporting the staff in their attempts to deliver safe, effective and compassionate care to their patients, I am only too aware of the devastating impact these failings had on many lives.

The evaluation will outline the process by which the recommendations of the Public Inquiry became translated into the pre-nursing care experience pilots across England.

I feel privileged to have led the Steering Group on behalf of Health Education England (HEE), for this important piece of work.

We first met in June 2013 and our final meeting to receive this evaluation was in December 2014.

It was clear from the beginning that there were a wide range of views from all of the stakeholders about the potential effectiveness of this project, and these were aired at the first meeting. I would like to think that this process was helpful in terms of us all recognising that the common ground between us was a very strong commitment to an open mind, a listening ear, a passion for safe, high quality, compassionate patient care and the vital importance of recruiting to nursing, people with the right values and the resilience needed to produce top class practitioners.

HEE is a new organisation and the Steering Group were very aware of the vitally important role that Local Education and Training Boards (LETBs) would play in the pilots.

We were delighted that there was so much enthusiasm from the LETBs and the Steering Group are very clear that the LETBs, together with their partner NHS trusts and Higher Education Institutions have done a fantastic job in translating the recommendation into reality, through several examples of real innovative practice. The Steering Group are very grateful to everyone concerned and recognise very clearly the important role they will play in the future.

Our first steps, as a Steering Group were to develop a set of "Guiding Principles" for the LETBs to use, and these formed the basis for our monitoring of progress. These Guiding Principles were sufficiently broad to ensure flexibility for LETBs to try out different approaches to the pilots but at the same time were framed tightly enough for us to ensure good governance of the overall project.

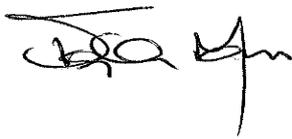
During the course of the pilots HEE hosted a national event that brought together HCAs from the pilot sites along with representatives from the LETBs, NHS trusts, and Higher Education Institutions. It was an uplifting occasion, particularly to hear from the HCAs themselves talking with great passion about how the scheme was helping them to be part of a front line team providing care, and all the associated satisfaction and challenges that this brings.

Of course, we recognised that in order for the pilots to be sustainable in the longer term, the important issue of cost neutrality was vitally important. We commissioned an Economic Evaluation, headed up by Richard Griffin of Buckinghamshire University. The outcome is incorporated into the evaluation report and very clearly there is more work needed in this area as the longitudinal study develops. The Steering Group is very grateful to Richard for the help and support he has given throughout the project.

Finally the acid test will be measuring the longer term impact of this approach in terms of benefits for patients. We are very clear that it is too early to collect the evidence to support any conclusions on this important issue and therefore it has been built into the longer term, longitudinal study being carried out by the University of Nottingham.

I am very grateful to all of the members of the Steering Group for their support, energy and challenge during the period of the pilots. It has been a fantastic experience and the collective wisdom and good humour of everyone has been vitally important to the final product.

Particular thanks must go to the whole team from HEE, especially Simon Young for their untiring commitment and support and of course to Mary Lovegrove for the first class job she has done in producing the Evaluation.”

A handwritten signature in black ink, appearing to read 'S. Moss', with a stylized flourish extending downwards from the end.

Sir Stephen Moss
Chairman
Steering Group

SUMMARY REPORT

The end of evaluation full report is the output of the evaluation of the Pre-Nursing Degree Care Experience (PNEP) pilot scheme designed and developed in response to the Department of Health's (DH) requirement² that '*starting with pilots, every student who seeks NHS funding for nursing degrees should first serve up to a year as a healthcare assistant, to promote frontline caring experience and values, as well as academic strength*'.

The report of the evaluation commissioned by Health Education England (HEE) has been written to be of interest to the Department of Health and other policy makers, NHS employers, service providers, education commissioners and education providers.

This summary report sets out the recommendations, the evaluation question and aims, the approach we have taken to collecting the data, a brief overview of the main findings and the discussions and conclusions.

The purpose of the pilot project was to gain a greater understanding as to whether a fixed period of employment in a care environment would be of benefit to prospective nursing students particularly in relation to career choices; enhance their insight into the professional commitment required to provide compassionate care; and be of benefit to the service they will ultimately deliver. The pilot project also sought to gather evidence about the cost associated with such an approach.

The evaluation was undertaken in two parts: the evaluation of the experience of the stakeholders involved in the pilot scheme and the economic evaluation. This evaluation did not seek to formally capture the patients' views and whilst their opinions are very important, they are recognised as being secondary to the main purpose of this pilot scheme.

Summary recommendations

These 12 recommendations are drawn from the process and impact data that has been collected from the pilot sites. These recommendations relate solely to the pre-nursing degree care experience model that was used in the pilot project and the numbering of the recommendations does not indicate their relative significance.

Aspiring nurses

1. Formalised pre-nursing degree care experience should be one of the routes available to potential pre-registration nursing students.
2. There should be no fixed duration for pre-nursing degree care experience. However, the study has shown that for this model, the optimum period is six months.

² DH (2013) Patients First and Foremost. The Initial Government Response to the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. Available at : https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/170701/Patients_First_and_Foremost.pdf

National policy

3. HEE should continue to work with its partners to make this route available as an opportunity for pre-nursing degree care experience, irrespective of a participant's eventual chosen field or future models of nursing.
4. HEE should work with its partners to make this route available in health and care settings where nursing is practised.

Partnership working between service providers and higher education providers

5. Service providers and higher education institutions must ensure they have strong partnership working to support this model of pre-nursing degree care experience.
6. Although accountability for recruitment into employment lies with the employer, service providers must involve higher education partners in the recruitment and selection process of these employees.
7. The organisations should work together to streamline the university application process for these participants, and the requirements for them to enter nurse training.
8. Service providers and their partner higher education providers should jointly agree the information that is provided to the pre-nursing degree care experience participants.
9. Higher education institutions should explore whether learning undertaken through pre-nursing degree care experience can be accredited.

Service providers

10. Service providers must have clear guidelines for staff and participants, about their role in relation to this model, to ensure that their expectations accord with their experience.
11. Service providers should ensure participants have the essential induction to and support in the clinical settings as part of this pre-nursing degree care experience model.
12. Service providers should enable pre-nursing degree care experience participants to have a depth and breadth of experiences to make an informed career choice.

1.0 Introduction

In February 2013 the second report of the system wide public inquiry into the failings at Mid Staffordshire NHS Trust were published³. A section in this report considered *'caring compassionate and considerate nursing'* and it was suggested that *'physical hands-on training and experience should be a prerequisite to entry into the nursing degree'*

In the subsequent DH report entitled 'Patients First and Foremost' the DH committed to ensuring that staff are trained and motivated. It recommended a period of training as a healthcare assistant before entering a programme of study leading to eligibility to register as a healthcare practitioner.

The pilot scheme was set up to consider this proposal for those aspiring to become nurses. It was launched in June 2013 and the majority of Pre-Nursing Degree Care Experience Pilot Healthcare Assistants (PNEP HCAs) commenced in post during the period September to November 2013 with a view to starting at university in either March 2014 or September 2014.

A steering group, chaired by Sir Stephen Moss was established at the outset of the pilot project. This group oversaw the operation of the scheme and the evaluations. It produced the guiding principles, approved the case study sites, and agreed the experience evaluation question and the economic evaluation aims.

Guiding Principles

The guiding principles were designed to assist the Local Education and Training Boards (LETBs) to develop a standardised best practice approach that would be manageable in the local context and within the time constraints of the pilot.

The principles were clustered under the following headings:

1. Arrangements for the HCA pre-nursing degree care experience pilot
2. Recruitment and selection
3. Induction, supervision and assessment
4. Supporting Pre-Nursing Degree Care Experience HCAs in their university application

Experience evaluation question

The agreed experience evaluation question was as follows:

To what extent does a period of work experience as a healthcare assistant:

- a) Allow this specific cohort of HCAs to develop insight into the professional commitment required to provide competent, kind and compassionate patient care?
- b) Enable potential nursing students to determine whether nursing is the most appropriate career choice for them?
- c) Benefit the individual and their potential contribution to patient services

³ Francis R (2013) Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry Volumes 1-3 Crown Copyright. Stationery Office: London. Available from: <http://www.midstaffpublicinquiry.com/report>

Economic evaluation aims

The Steering Group agreed two aims for the economic evaluation:

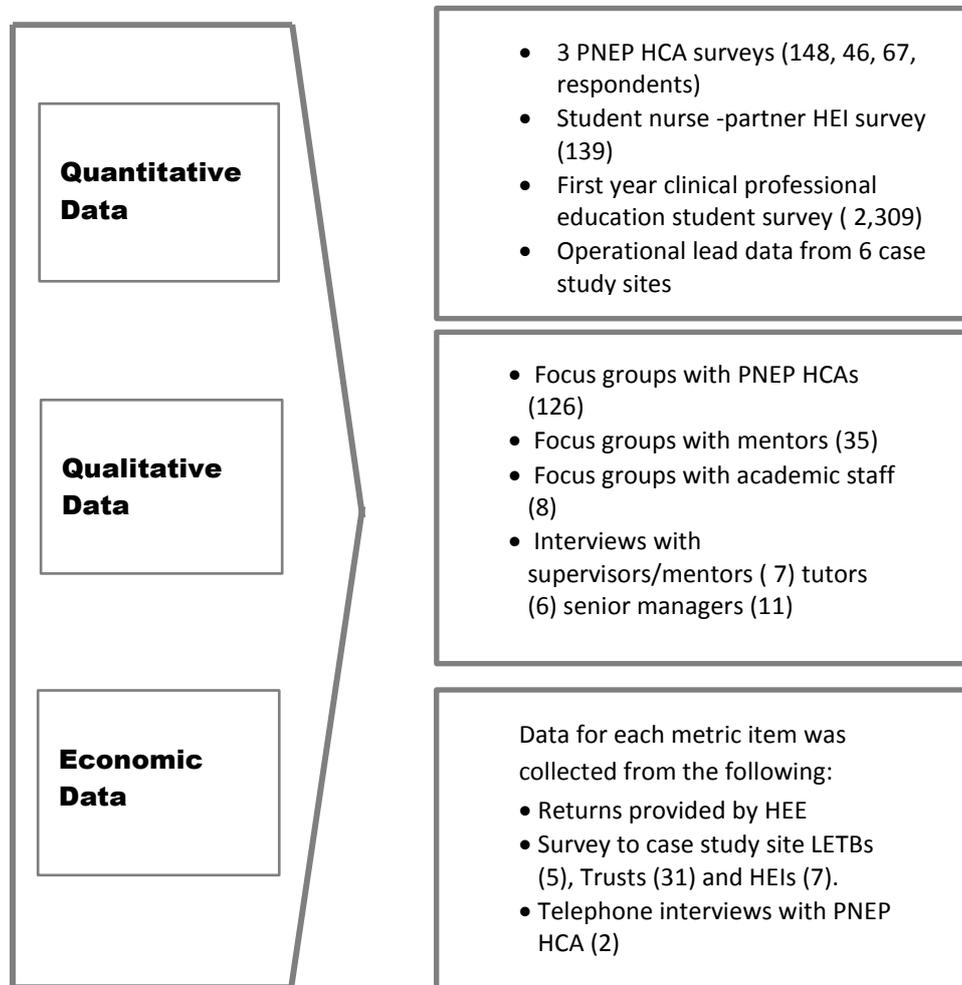
1. To investigate the actual costs of the PNEP pilot project
2. To assess the extent to which the PNEP meets or could meet the objective of cost neutrality.

This one year evaluation did not set out to compare the impact of any work experience gained outside of the pilot scheme or to determine the longer term benefits of the HCAs pre-degree care experience.

2.0 Study design and data collection

The approach to collecting the data for the evaluation recognised that this limited study would add to any existing knowledge rather than provide a detailed understanding of the current situation and any longer term impact of the PNEP HCA model on patient care.

Figure 1 Data collection methods used in the study



The data collection sources were as follows:

1. Online surveys

There were six separate surveys.

Two collected background information from the cohorts of PNEP HCAs about their expectations of undertaking a period of care experience as an employed HCA. These surveys also captured data about their previous paid or unpaid care experience, information about other previous employment, whether they had family members who worked in health care and their demographic profile.

The third survey was modified from the PNEP HCA background survey and sent to student nurses studying at case study site HEIs. The purpose of this survey was to establish to what extent the PNEP HCAs differed from first year nursing students. The fourth survey was a limited version of surveys 1-3 and was designed to capture previous care experience and previous non-health and non-social care employment from students studying a range of clinical professional courses. The purpose of this survey was to enable a comparison between student nurses care experience and the care experience of students from other professional groups. The fifth survey was specifically designed to capture the clinical experience of Cohort 1 PNEP HCAs. The sixth survey was designed to collect metric data from the case study sites.

Table 1 Number of respondents per survey

Survey name	Survey identification	Number of completed responses
Cohort 1 PNEP HCA baseline survey	1	148
Cohort 2 PNEP HCA baseline survey	2	46
First year pre-registration student nurse survey	3	139
First year clinical professional education student survey	4	2,309
PNEP HCA clinical experience survey	5	67
Economic evaluation survey	6	43
Total		2,752

1. Focus groups and interviews

In total 49 focus groups were held with HCAs, mentors and tutors. The 18 interviews with tutors and operations leads were either conducted over the telephone or face to face.

2. Data returns

Data collected by HEE was used to inform the economic evaluation.

Six months into the scheme an event was held in Central London to enable participants to share their experiences of the pilot. This provided an unplanned rich source of data.

3.0 Case study sites and PNEP HCA cohorts

Six LETBs successfully bid to become a case study site for the pilot study evaluations. The number of service providers and education providers engaged in the pilot are listed in table 2.

Table 2 Number of case study site partners

Site	Service Providers	Education Providers
Aqua	7	5 (3 HEI and 2 FEC)
Blue	7	3
Green	4	2
Orange	1	1
Purple	6	2
Red	9	5
Total	34	18



Figure 2 Location of case study service provider organisations

A total of 250 PNEP HCAs (159 Cohort 1 and 92 Cohort 2) were recruited to service providers that were partners of the case study sites. Initially the plan was to have one cohort and as the pilot study progressed it was decided to recruit a second cohort.

The approach to advertising and recruitment varied by site and cohort is shown in Table 3.

Table 3 Approach to recruitment of PNEP HCAs

Approach	Aqua		Blue		Green		Orange		Purple		Red	
	Cohort 1	Cohort 2	Cohort 1	Cohort 2	Cohort 1	Cohort 2	Cohort 1	Cohort 2	Cohort 1	Cohort 2	Cohort 1	Cohort 2
Local media advert	√		√	√			√	√	√	√	√	√
Local radio advert							√	√				√
NHS Jobs	√					√						√
HEI applicants					√							
From existing support staff									√			
From unsuccessful HEI applicants	√			√								
Number of applications	303		199		23		106		342		180	
Number (percentage) interviewed	66 (21.7)		57 (28.6)		23 (100)		32 (30.8)		54 (16.0)		45 (25.0)	
Number (percentage) of interviewees who took up an HCA post	44 (66.6)		40 (70.1)	15	23 (100)	29	23 (71.8)	20	16 (29.6)	22	16 (7.2)	19

The attrition for the two cohorts as of September 2014, the career choice and the progression onto a place at university are set out in tables 4 and 5 below. 74% of Cohort 1 secured a place at university to study a clinical professional healthcare course. 11% of this cohort left the pilot and the healthcare service, 9% stayed in post as permanent HCAs and the remainder have stayed temporarily in HCA posts are still applying for a place at university. The detail for cohort 2 is incomplete as many of them are still on the pilot scheme and are considering applying for university during the 2015/16 academic year. From the data that is available only 4% have left the programme.

Table 4 Summary of Cohort 1 profile

Case study site	Number who took up an HCA post	Number who left the cohort (attrition)	Number who successfully gained a place on a healthcare course	Number whose application *is under consideration	Number who were permanently employed as an HCA
Aqua	44	7	23 Adult Nursing 3-Children's Nursing 1-Midwifery 2-Social Work	1-Paramedic Science 1-Occupational Therapy	6
Blue	40	6	19-Adult Nursing 2-Children's Nursing 2- Mental Health Nursing 1-Social Work 1- Pharmacy 3-Midwifery	1-Ambulance service prior to applying to study Medicine 3-Adult Nursing	2
Green	23	1	20	0	2
Orange	23	3	20	0	0
Purple	16	0	12-Adult Nursing 1-Podiatry	0	3
Red	13	1	6-Adult Nursing 1-Children's nursing	4	1
Total	159	18	117	10	14

* To university to study for a clinical professional course

Table 5 Summary of Cohort 2 profile

Case study site	Number who took up an HCA post	Number who left the cohort (attrition)	Number who successfully gained a place on a healthcare course	Number whose application* is under consideration	Number who were permanently employed as an HCA
Aqua	N/A	N/A	N/A	N/A	N/A
Blue	10	1	-	-	-
Green	29	1	0	28	0
Orange	11	1	10	0	0
Purple	23	0	1	-	-
Red	19**	1	8-Adult Nursing** 1-Medicine	3-nursing	5 (2 may apply to university)
Total	92	4	20	31	5

*To University to study nursing

**9 were offered a place, one unable to start because of health reasons and one not eligible so supported to commence an Access to Health course

- Data not available

4.0 Main findings

Previous care experience

Four of the surveys captured information about previous care experience. This is summarised in table 6 below. The previous care experience for the two PNEP HCA cohorts was very similar, particularly with regards to no previous care experience. Interestingly the student nurse cohort and the clinical professional cohort had almost identical previous care experience reporting 28 and 27 per cent respectively.

Table 6 Cohort comparisons of previous care experience

Cohort of respondents	Previous paid care experience (%)	Previous unpaid care experience (%)	Both paid and unpaid care experience (%)	No previous care experience (%)
PNEP HCAs-Cohort 1	12	22	10	56
PNEP HCAs-Cohort 2	20	17	9	54
First year pre-registration student nurses studying at partner universities (adult field)	33	17	22	28
First year clinical professional students studying in England	34	20	19	27

Student nurses' previous **paid care** experience was primarily gained in health and social care settings. 60% of the responses stated that the respondents had gained care experience immediately prior to starting at the university and 38% sometime in the past. The previous paid care experience for the PNEP HCAs showed a similar trend with the majority of paid care experience gained in a health and social care organisation. 46% of the responses from Cohort 1 and 58% from Cohort 2 stated they gained this experience immediately prior to starting at the university. Similarly 27% of the responses from Cohort 1 and 38% from Cohort 2 reported sometime in the past.

1384 student nurses (1,000 adult nursing, 163 children's nursing, 196 mental health nursing and 25 learning disabilities nursing) who responded to the clinical professional survey provided data about their previous care experience as illustrated in figure 3 below. The data relating specifically to the students studying adult nursing recorded that 96% of the responses stated that paid care experience undertaken immediately prior to entering university was in a health and social care setting and 85% of the paid experience in the past was also in a health and social care setting.

When considering the responses, for the different groups, about how they gained **unpaid care** experience, twice the number of responses from PNEP HCAs Cohort 1 reported having unpaid care experience in the past, when compared to immediately prior to going to university. Although the majority of respondents reported that their care experience was gained in a health and social care setting far more of them gained unpaid care experience looking after family members than those who

reported being paid for caring for family members. For Cohort 2 very few respondents commented that they had provided unpaid care, those who did reported that slightly more of them provided unpaid care for family members than those who provided unpaid care in a health or social care setting. The data provided by the student nurses from the partner HEIs showed a more even distribution between unpaid care provided for family and friends and unpaid care provided in a health and social care setting. As with the PNEP HCAs more of this experience was gained in the past, rather than immediately prior to starting at university.

For the larger subset of adult nursing students who responded to the clinical professional survey, 47% of the responses stated that the unpaid experience prior to going to university was in a health and social care setting and 41% with family members. There were nearly twice as many responses from this sample about unpaid care experience gained in the past but the relative percentages were similar with 49% gained in a health and social care setting and 36% caring for family members.

Figure 3 Percentage of clinical professional education survey respondents to previous care experience for each field of nursing



The evidence from this survey is that percentage of adult nurses who have paid care experience prior to entering their course is comparable to other professions and in many cases higher.

Three quarters of the PNEP HCAs reported that they had previously worked outside of the health and social care sector mostly in public sector facing employment such as retail and hospitality. The

student nurses and the respondents to the clinical professional survey also reported that their previous work experience was in retail and hospitality.

The two PNEP HCA cohorts were asked to identify from a prescribed list what they thought would be the main benefits for them of joining the pilot scheme and undertaking the period of paid care experience as an employee in service provider organisation. Both cohorts agreed that it would be a valuable experience prior to becoming a nurse as more than half of them did not have any care experience when they entered the pilot scheme. Although, approximately 50% of the PNEP HCAs reported that they had family members working in healthcare.

The PNEP HCAs and the student nurses provided demographic profile information: gender, first language, national identity, religion and age range. 90% of Cohort 1 HCAs, 89% of Cohort 2 HCAs and 95% of the student nurse sample are female. The overwhelming majority of the respondents stated that English is their first language (93% of Cohort 1, 100% of Cohort 2 94% of the student nurse sample). Similarly for national identity 93% of Cohort 1 reported they are either English (61%) or British (32%); 98% of Cohort 2 are either English (72%) or British (26%) and 91% of the sample of student nurses reported they are either English (68%) or British (23%). The survey captured religious beliefs as many of these aspiring nurses will support people during the end of their life. For Cohort 1 47% recorded that they are Christian and 43% reported they do not follow a religion. 63% of Cohort 2 respondents described themselves as Christians and 35% that they do not follow a religion. Just fewer than half of the first year pre-registration student nurse sample responded to the question about their religious beliefs. The responses from those who did provide information were very similar to Cohort 1 in that 46% stated they were Christian and 44% that they do not follow any religion.

All the respondents to the three surveys stated their age range. 44% of Cohort 1, 26% of Cohort 2 and 29% of the student nurse sample reported they 20 years or younger on the day they completed the survey. 39% of Cohort 1, 47% of Cohort 2 and 40% of the student nurses were aged between 21 and 30 years. 11% of Cohort 1, 17% of Cohort 2 and 17% of the student nurse sample stated they were between 31 and 40 years of age. The remaining 6% of Cohort 1, 9% of Cohort 2 and 13% of the student nurse sample reported they were between 41 and 60 years old.

The education profiles for the two cohorts of PNEP HCAs and the sample of first year pre-registration student nurses were reported to be similar, particularly Cohort 2 and the sample of student nurses: 65% of the responses from Cohort 1 HCAs, 57% of the responses from Cohort 2 HCAs and 58% of the responses from the first year pre-registration student nurse sample stated that they hold traditional school qualifications. The respondents also provided information about vocational and higher qualifications. 35% of Cohort 1 responses, 45% of Cohort 2 responses and 45% of the first year pre-registration student nurses' responses stated that they hold an NVQ Level 3 or equivalent. When considering a higher qualification 19% of Cohort 1 responses, 26% of Cohort 2 responses and 25% of student nurses' responses reported they already hold a degree. 34% of the responses from Cohort 1 HCAs, 21% of the responses from Cohort 2 HCAs and 16% of the student nurse responses stated they do not hold any vocational or higher qualification.

Economic evaluation

The economic evaluation sought to capture the actual cost of the PNEP HCA scheme and to assess whether this approach meets or could meet the objective of cost neutrality.

When assessing the actual costs of the pilot the following was taken into consideration:

- The input costs of setting up the pilot scheme- pilot management costs, marketing and recruitment
- The activity of delivering the intervention such as recruitment, selection and support for the PNEP HCAs, employment costs, staff turnover.

Actual costs

The actual and estimated costs associated with running the pilot scheme are set out in table 7 below.

Table 7 Actual and estimated costs of running the PNEP HCA pilot

Activity	Cost (£)
HEE central non-recurring	125,000
HEE salary support for trusts (Cohort 1)	1,495,725
HEE salary support for trusts (Cohort 2)	315,700
Estimates of recruitment, selection and support (based on average costs from those who responded and on ten recruitment events)	36,880
Estimated workplace learning support	150,000
Mentor costs based on band 7 salary for one day per week (difficult to estimate as a wide range of grade)	50,000
Estimated total cost of the pilot	2,200,000

These costs do not include the earnings costs incurred by trusts as one of the principles of the pilot scheme was that HCAs would be recruited to vacant posts and contribute to the service. All the trusts who responded to the survey advised they had vacancies in excess of the number of PNEP HCAs they employed.

These costs were modelled for three scenarios based on actual case study site models as shown in table 8.

Table 8 Economic scenarios

Scenario	Cost per PNEP HCA (£)
A/ 20 HCAs recruited into vacant posts for ten months and additional development support is provided by the employer	650
B/ 40 HCAs recruited to vacant posts for eight months. Supported by a dedicated member of staff from a LETB, a mentor and a development programme over and above what would normally be provided to HCAs	847
C/ 14 HCAs recruited to vacant posts for eleven months on an apprenticeship programme (not eligible for SFA funding)	2984

When reviewing the objective of cost neutrality, for the scheme, it is important to take into account the extent to which the PNEP HCAs are filling existing vacancies and contributing to service delivery, as well as any additional recruitment and selection process costs. This model is unlikely to be totally cost neutral although its costs are likely to be minimal.

Future PNEP HCAs should be recruited to funded establishment vacancies to minimise costs and be employed, following completion of the Care Certificate, for a period up to a year delivering support and care. Future PNEP HCA numbers will be affected by overall support worker vacancies. As a result it is reasonable to assume (as at least one of the pilot sites who replied to the survey did), that PNEP HCA productivity will be equivalent to that of a 'normal' HCA role and therefore will not represent an additional cost to the employer. In addition, based on the survey data, it appears that 'quit' rates from the programme are unlikely to be higher than for standard HCA employment. However, if the turnover was substantially higher this would represent a new cost to the employers. Similarly if the Higher Education Institution (HEI) sector is to be involved in recruitment to service provider HCA posts, this will represent an additional cost to the HEIs.

The extent to which any additional costs will be offset by reduced attrition will be fully demonstrated through the longitudinal research study. There are a wide range of factors that influence nursing students' decision to leave their degree course. While it is plausible to argue that pre nursing experience will mitigate against some of these, for example by raising awareness of the reality of caring, its exact impact is not known at this stage.

PNEP HCAs experience of the pilot scheme

The scheme was set up to give a group of aspiring nurses with little or no previous care experience to work for up to a year in paid employment as an HCA. As shown in table 6 44% of Cohort 1 had previous care experience (12% paid, 22% unpaid, 10% both paid and unpaid) and similarly 46% of Cohort 2 had previous care experience (20% paid, 17% unpaid and 9% both paid and unpaid).

Very few of the PNEP HCAs had 12 months paid care experience while part of the scheme. The majority spent between 6 and 10 months in a clinical setting. 69% were employed in a full time HCA vacancy; the remainder were either supernumerary or employed in a part time post.

84% of the respondents advised they gained clinical experience in just one clinical setting and the remainder in two different clinical settings. Cohort 1 PNEP HCAs identified 46 different clinical settings that were used to give them clinical care experience. The most commonly cited clinical areas were: gastro-intestinal wards, mental health rehabilitation and recovery units and trauma and orthopaedic wards. The HCAs reported preferring to work long day shifts as it gave them a chance to get to know the patients better. They reported undertaking tasks that were in line with the routine work of an HCA or nursing assistant such as clinical tasks, domestic and general hygiene tasks, courier activities, administrative tasks including documentation, communication and general emotional and physical support.

The initial induction to healthcare was central to these HCAs perception of what it is like to be employed in the NHS, especially as over half of them reported having no previous care experience. All the PNEP HCAs reported attending an induction programme but their experience of their induction programme was mixed. Some reported it was very good and covered the core skills and others that it was disorganised with too much information.

The experience of the specific introduction to the clinical area was also very mixed. 20% reported they had not received any 'ward' introduction, in contrast to some others who reported that they had been given a bespoke four week introductory period. The support for the PNEP HCAs in the clinical area was also very varied and ranged from having a dedicated mentor or buddy as well as support from everybody on the ward to having no support at all.

The nature of any bespoke development programme varied between the case study sites and was locally determined. For some of the HCAs they had no additional development, for some they had monthly study days and for others they were required to attend a level 2 apprenticeship programme in addition to the trust HCA programme. The extra burden that any intensive development placed on the PNEP HCA was a source of expressed concern. This situation prompted an unexpected development in that some of the HCAs assumed more of a student role than an employee role.

For these cohorts of PNEP HCAs successful application for a place at university to study nursing was extremely important and they were hoping for support from the HEI sector. Just over half reported they had been given support from the local university.

The PNEP HCAs were almost unanimous in the fact that this pilot scheme had helped them to understand the role of a nurse and how demanding the job is. They reported gaining an insight into 'good' nursing and the consequences of less than good nursing. They remarked that they now understand the importance of the nurse in relation to patient care. A recurring theme that emerged throughout the focus group discussions was the importance of a positive attitude towards caring for patients and not making assumptions about patients or their relatives as people are often very different to how they first seem. They explained that they quickly came to realise that no two patients, no two clinical areas and no two shifts are the same.

This evaluation did not set out to capture patients' opinion about the scheme although some of the patients showed an interest in the intervention and commented that they thought it was a really good initiative, primarily as they had observed that nurses who had previously been employed as HCAs make a 'good' nurse.

Most of the HCAs reported that the pilot scheme was a fantastic opportunity and they believed it would help them secure a place on a course to study nursing. Unfortunately not all the HCAs had such a good experience. Those that remarked their experience could have been improved reported problems of poor local organisation of the pilot or lack of support for them in the clinical setting.

Staff views of the pilot scheme

65% of the mentors/ supervisors thought that the scheme was a very good development, as it enables the PNEP HCAs to learn about essential care and importantly what nursing is before embarking on their chosen pre-registration education course.

The staff were very complimentary about the PNEP HCAs' caring skills as they integrated well into the service and very quickly became part of the work family. This scheme works particularly well for those, with very little life experience, who wish to have a career in healthcare. For aspiring healthcare professionals who have never been onto a ward it is really good to have a formal route to give them that experience.

Their expectation is that this scheme, if implemented, should benefit the service as it should help with long term employment and retention challenges. They also noted benefits for healthcare provider organisations such as the prompt to reflect on the experience the traditional HCA workforce has. The mentors really liked this model of learning about care skills as it will give the PNEP HCAs many contexts to reflect on when they start their pre-registration course.

Nobody held a strongly negative view about the scheme, but several of the participants cautioned against making assumptions about the longer term benefits. The unknown is the economic impact and for some of the participants this is the main concern. A significant concern that was strongly expressed was the issue of the PNEP HCAs being seen as 'special', a hybrid between a student and a full time employee. There was some concern that because of this status the pilot participants did not fully embrace their job as a 'regular' HCA.

Concerns were raised by the staff about the lack of guidelines and the paucity of information, available within the employer organisations, about the scheme. The staff acknowledged that the HCAs may learn some of the skills that a new student nurse will be required to develop. However, they pointed out that the PNEP HCAs will learn many skills, that as an HCA, that they will not be able to use as a student nurse. The mentors had a mixed view about the extra workload that this scheme imposed. For some this was not an issue, for others they realised it gave them extra work but it was not a burden, and for the rest they were concerned about their ability to support the PNEP HCAs either because they already had many student nurses to support or simply because they had no previous experience of being a mentor.

Many participants in the wider scheme commented that the existing HCA workforce might be aggrieved by the support that the PNEP HCAs are getting. However the evaluation did not capture evidence to support this assertion.

Management view of the scheme

Initially the managers had some reservations about the scheme particularly as to how sustainable such a model would be and whether the posts that the PNEP HCAs were recruited to would effectively become training posts and consequently lost to the service. They also expressed concern about the pressure on the HR process.

All the staff interviewed (managers and senior clinical nurses) reported an overwhelming level of interest in the scheme and that the recruitment process had been closed early as the numbers expressing an interest in the scheme was far in excess of the very few places available.

The consensus was that the PNEP Scheme was good and that although it couldn't be implemented on a large scale it was very manageable on a smaller scale and the exact numbers should be reviewed annually.

The trusts were very pleased with the calibre of the participants and the fact that this model enabled the HCAs to decide whether nursing was the correct career choice for them. The senior managers hoped that this route into pre-registration nursing might support the organisations to attract prospective nurses into less popular clinical areas such as elderly medicine or mental health.

HEI view of the scheme

The staff from the HEI sector noted that the speed with which the project was introduced was a significant problem for them. Some of the institutions had agreed to take part in the scheme in the hope that they would be able to gain a greater understanding of the scheme and influence the outcome.

Early engagement between the service providers and the HEIs and a joint approach at the outset proved to be essential to the success of the scheme. For HEIs that are committed to widening access

this scheme has the potential to become one of the standard routes into pre-registration nursing without adding significantly to the recruitment and selection process. For those institutions who have For some of the HEIs engaging in the scheme has been of considerable benefit. For example, it has strengthened the partnership between the HEI and the local service providers; highlighted best practice for joint recruitment, and enabled them to develop a sustainable model for phases 3 and 4 of the scheme as it is rolled out.

5.0 Discussion and Conclusion

The context of the evaluation is that it is based on six different case study sites, which by their nature are unlikely to be typical of roll out but allowed us to model impact. The evaluation did not attempt to draw statistical significance so the sample sizes were adequate. Also the evaluation was time limited so it did not capture any evidence about what happens to the PNEP HCAs when they start their formal undergraduate clinical professional education. The probability is that any shortfall in this evaluation, in respect of the time span, will be addressed by the four year longitudinal study into the impact of care experience prior to undertaking NHS funded education and training.

Since the launch of the evaluation of the Pre-Nursing Degree Care Experience Pilot there have been a number of new policy initiatives such as the Care Certificate which should have a bearing on the need for any additional support for HCAs who enter the NHS without any previous care experience.

This pilot scheme has been successful for many of the PNEP HCAs as without this initiative they would not have considered, or possibly been considered suitable to enter, a career in healthcare. This development has also been successful for service providers in two ways: firstly, it has helped them fill some of their HCA vacancies and secondly, it has prompted them to review their induction and support for HCAs. The HEIs have also benefitted from the opportunity to work more closely with the service providers and for both parties to gain a greater understanding of each other's operational systems and challenges.

The evidence collected from this evaluation indicates that the most successful approach is where the service provider and one or more HEI partners work closely together. This approach supports the HCAs in their quest to determine their future career path. Where a case study site closely followed the guiding principles, designed by the Steering Group, the outcome for the PNEP HCAs was very good, the partnership between the service provider organisation and the education provider was strengthened and all the stakeholders were actively engaged in the process.

This evaluation has shown that many of the PNEP HCAs, their mentors and supervisors believe that the optimum period of care experience is six months. This statement should be seen in the context that the HCAs will spend the full six months in full employment as an HCA, that they will not be supernumerary or withdrawn from the service for study purposes, anything less than six months would represent an additional cost to the employer.

The majority of the HCAs were recruited to vacant adult nursing posts. However, some were recruited to HCA posts in mental healthcare settings and some into community support worker posts. These opportunities have been equally successful and this model may attract a greater interest in what are often perceived as Cinderella services that are hard to recruit to.

For some of the HCAs, progression from being a PNEP HCA to a student on a clinical professional course was very straightforward but for others it was one of the most stressful parts of the scheme because the arrangements for them at the end of the pilot were unclear. The different interview stages at the beginning and end of the pilot was very demanding. They repeatedly remarked about the challenges of the multiple interviews and the changes in entry requirements into the university, leaving them very uncertain about their progression from being an HCA to student nurse. Some of the pilot sites realised this was a problem very early on. As a result they changed their approach

recruitment to minimise this demand on the HCAs but still comply with the regulators standards for entry onto a course leading to eligibility to practise as a clinical professional.

The information, or rather the lack of information, disseminated within provider organisations about the scheme and the role of these HCAs was frequently raised by many stakeholders as an area for improvement, as was the diverse approach to PNEP HCA introduction into clinical settings.

Part of the evaluation question of the PNEP HCA experience was to ascertain whether this model enabled potential nursing students to determine whether nursing is the most appropriate career choice for them. The overwhelming view from PNEP HCAs was that this pilot scheme had helped them to understand the role of a nurse and the importance of the nurse in relation to patient care. For many it had helped them decide that they had chosen the correct career, for others that a career as a healthcare professional was correct, but not as a nurse, for others that they would prefer to stay in post as an HCA, and the remainder that a career in healthcare is not the correct choice.

The overall effectiveness of the PNEP is determined by both the “experience” and economic evaluations. The economic evaluation aimed to investigate the actual costs of the PNEP pilot project and to assess the extent to which the PNEP meets or could meet the aspiration of cost neutrality.

The cost of providing pre-nursing degree care experience depends on the following:

- Numbers recruited
- The approaches taken to selection and recruitment
- The support provided including dedicated mentors
- Dedicated administrative support
- Views on the productive contribution of staff

It is important to isolate expenditure that is additional and incurred solely as a result of the scheme from additional costs related to wider implementation of this on a regular basis. If, for example, PNE HCAs were supernumerary this would represent an extra and significant cost.

While employers may choose to provide dedicated mentor time and additional education support, the introduction of the Care Certificate means that this will not be essential in the future. It is reasonable to note that the recruitment and selection of pre-degree HCAs may differ from the standard HCA recruitment processes.

To judge whether the scheme could be cost neutral data were gathered for each of the discreet elements of the pilot: recruitment, selection, employment costs and support such as mentors and account was taken of the disparate approaches adopted in each of these across the various sites. A key issue from an employer perspective is the extent to which PNEP staff may be regarded as ‘normal’ HCAs able to deliver care while employed, whether and to what extent they require additional support in the workplace, particularly taking into account the introduction of the Care Certificate, the duration of their care experience and numbers of staff involved.

In the future it is expected that all pre-nursing degree experience HCAs will be recruited to existing vacancies and be employed a minimum of six months providing care and support. As a result these HCAs will be part of normal funded establishment and as a result will not represent an additional cost to employers and will be accommodated within normal turnover rates.

From the perspective of the NHS as a whole the PNEP HCA model could provide the following potential longer term benefits:

1. Enable the service providers to attract into vacant HCA posts people who previously might not have considered taking this step because of family or personal commitments;
2. Attract into healthcare people who believed that without prior care experience they could not gain a place at university to study for a clinical professional degree;
3. Improve recruitment to degree courses through the strengthened partnership between the service provider and the local higher education provider.

It is too early to be confident that any attrition from the cohort of PNEP HCAs will result in reduced attrition from their chosen pre-registration courses as a result of a more informed understanding of their chosen career path. This benefit may be realised at the end of the longitudinal study.

6.0 Next Steps

This report of the evaluation into the Pre-Nursing Degree Care Experience Pilot will be submitted to Health Education England's Board, for their consideration. Any decision to implement the recommendations will be responsibility of the Board.

7.0 Steering Group Membership

Chair: Sir Stephen Moss, Non-executive Director, Health Education England

Vice Chair: Professor Lisa Bayliss-Pratt, Director of Nursing, Health Education England

Organisations represented on the Steering Group

- Care Quality Commission
- Department of Health
- Council of Deans of Health
- Health Education England
- Local Education and Training Boards
- NHS Employers
- NHS England
- NHS Trust Development Authority
- Nursing and Care Quality Forum
- Nursing and Midwifery Council
- Royal College of Nursing
- UNISON

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