Learning and Development at Work: Opportunities and Barriers for Non-Registered Clinical Staff in the National Health Service Scotland

**Thesis
by**

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Submitted in partial fulfilment of the requirements for

the Degree of

Doctor of Philosophy

Napier University Business School

School of Management

September 2008

Dedication
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Dedicated to the memory of

My much loved parents, Martha and Rick, and my beautiful sister Audrey
who were all with me when I began this and will always live on in my heart.

> '*No people are uninteresting.*
> *In any man who dies there dies with him, his first snow and*
> *kiss and fight.   It goes with him.*
> *Not people die but worlds die in them'*.
>
> *Yevgeny Yevtushenko (1993)*

And with love to

My husband Alex and my sons Gregory and Samuel

Acknowledgements
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Declaration
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This thesis contains no material that has been submitted previously, in whole or in part, for the award of any other degree or qualification to this or any other university. Except where otherwise indicated, this thesis is my own work.

Signed _____

(Deborah J McCraw)

Abstract

The non-registered assistant workforce in the National Health Service Scotland (NHSS) has recently been afforded increased attention due, in part, to forecast changes in demographics and the NHSS workforce and reorganisation in delivery of healthcare. Government health papers pursue the strategic aims of developing the workforce to meet the changing needs of the Health Service. This thesis reports on research into workplace learning in the NHSS. It examines the NHSS in relation to the concepts of 'The Learning Organisation', 'Expansive/Restrictive Learning Environments' and the learning initiative of the Scottish Vocational Qualification (SVQ) route, adopted by the NHSS for its non-registered clinical employees.

Participants in the research included non-registered clinical assistants to registered nurses and allied health professionals and learning facilitators and managers. A critical realist methodology was adopted and through an embedded case study, data collection methods included one-to-one semi-structured interviews and secondary data from the NHS staff survey. This produced a rich source of data for analysis around the perceptions of the participants. Findings show that the NHSS has introduced the concept of a learning organisation to its strategic plans with no real rigour. Some elements of an expansive learning environment exist but these are evident in only some clinical areas. This means that for the assistant workforce, personal development and learning opportunities are dependent on the place of work and the profession they are employed by. The SVQ is embraced by those who are given the opportunity to undertake this initiative but disparities exist throughout the NHSS. Furthermore, the SVQ is perceived as validation of existing knowledge only that does not provide any new learning. This further curtails development opportunities for the assistant group of staff.

This thesis has provided the NHSS with a basis to reconsider their strategic direction around learning and development opportunities at work for their non-registered clinical staff.

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Glossary

AfC	Agenda for Change
AHPs	Allied Health Professions
APEL	Accreditation of prior experiential learning
CPD	Continuing professional development
CSW	Clinical Support Worker
DOH	Department of Health
HCA	Healthcare Assistant
HNC	Higher National Certificate
HND	Higher National Diploma
HPC	Health Professions Council
HR	Human Resources
HRD	Human Resource Development
ISD	Information Services Division
KSF	Knowledge and Skills Framework
NCVQ	National Council for Vocational Qualifications
NES	NHS Education for Scotland
NHS	National Health Service
NHSL	NHS Lothian
NHSS	National Health Service Scotland
NICHE	National Incremental Competencies in Healthcare Education
NMC	Nursing and Midwifery Council
NVQs	National Vocational Qualifications
ODAs	Operating Department Assistants
OTAs	Occupational Therapy Assistants
PDP	Personal development planning
PDU	Practice Development Unit
PTAs	Physiotherapy Assistants
QIS	NHS Quality Improvement Scotland
RCN	Royal College of Nursing
RDAs	Radiography Assistants
RPL	Recognition of prior learning
SCQF	Scottish Credit Qualifications Framework
SE	Standard Error
SEHD	Scottish Executive Health Department
SGHD	Scottish Government Health Division
SQA	Scottish Qualifications Authority
SVQs	Scottish Vocational Qualifications
TSWs	Therapy Support Workers

Chapter One. Introduction

1.0 Introduction to the thesis

This research is concerned with learning and development at work, specifically for non-registered clinical staff in the NHS Scotland (NHSS).   A certain amount of research has been carried out on this stratum of staff (cf Munro and Rainbird, 2002; Munro *et al.* 1997; Kessler and Heron, 2004) but this has mainly concerned health care assistants to the nursing profession and very little research has touched on other assistants to qualified staff.   This study concentrates on nursing and allied health profession (AHP) non-registered clinical assistants and considers differences between the NHSS Acute and Primary/Community Care Sectors where clinical assistants are employed.   The specific focus is to discover what opportunities and barriers are real and perceived in pursuit of an educated, trained and personally developed assistant workforce in the NHSS, particularly in response to government strategic initiatives.   A variety of titles are used for non-registered assistant staff to health professionals and in this thesis they are collectively described as health care assistants.

1.1   Context of the Study

The NHSS is a vast and unique organisation that is structured in many layers. It is a hierarchical organisation but the power regarding implementation of standards and policy making is not totally centralised.   Decisions are made and policies are set at many autonomous levels within the service.   Change has been a constant within the NHSS and since 2001, the organisational structure has been reviewed three times.   (Figures 1.1 to 1.3 illustrate the various structures). The most recent re-organisation has resulted in previously semi-autonomous Trusts being amalgamated to come under the governing umbrella of Regional Health Boards while still retaining their local decision making powers.   They are now known as Divisions within the Health Boards and a partnership has evolved with local authority social services and community and primary care. The Scottish Government Health Division (formerly known as the

Scottish Executive Health Department) is responsible for national policy while NHS Boards are responsible for local health planning and improvement and the delivery of hospital, community and primary care services. There are now also eight Special Health Boards which provide services on a national basis (NHS Education for Scotland, 2002).

Scottish Parliament

Scottish Executive Health Department

Acute Trusts
Overseeing:

Clinical Directorates:
Units (Departments / Wards)

Professions Allied to Medicine (PAMs)

Ancillary Staff / Departments

Primary Care Trusts

Overseeing:

Mental Health and Learning Disability Services

Community Hospitals

Local Healthcare Cooperatives

Health Boards

Partnership

Local Authority Social Services Departments.

Figure 1.1. Organisation of the National Health Service in Scotland (NHSS) in 2001. Adapted from Morris, C. (2001).

Scottish Parliament

Scottish Executive Health Department

Health Boards

Partnership

Local Authority Social Services Departments

Acute Divisions

Overseeing:
Clinical Directorates who guide:
Clinical Units /departments / wards and
Ancillary staff and
Allied Health Professions (formerly PAMs) who guide:
Local departments

Primary Care Divisions

Overseeing:
Mental Health and Learning Disability Services
Community Hospitals
Local Healthcare Cooperatives

Figure 1.2. Organisation of the NHSS in 2004. Source ISD (2004).
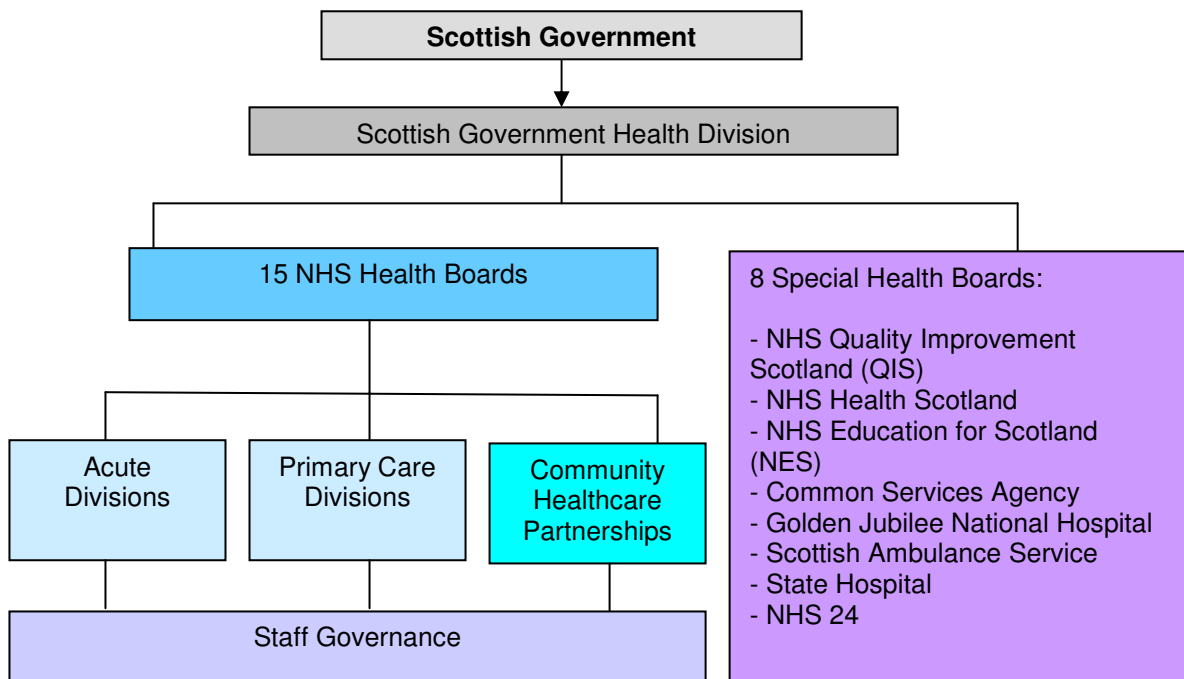
Figure 1.3. Organisation of the NHSS in 2007. Source ISD (2007).

1.2 Research need

In 1999 the Scottish Executive published a paper entitled 'Learning Together: A Strategy for Education, Training and Lifelong Learning for *all* in the National Health Service in Scotland'. The core theme of the paper was that learning should be considered vital for all staff towards delivering modern, high quality and responsive health care. The key aim of the strategy was *'to modernise the NHS in Scotland'* (Scottish Executive, 1999a) and this was to be achieved by promoting a '*fitness for purpose*' which meant that all staff were equipped with the skills, knowledge and attitudes to deliver the services patients and their families expected. Other aims were:

➤ To ensure that all staff were supported and encouraged to develop and maintain their skills

➤ To support a flexible workforce that was capable of responding to changing clinical practice

➤ To help with career progression and job satisfaction to fulfil the needs and aspirations of all staff regardless of their social academic or ethnic backgrounds

- To raise awareness among NHS Boards, managers and service planners concerning the value of education, training and lifelong learning in delivering quality services (Scottish Executive, 1999a).

The strategy also outlined what this would mean for employees of the NHSS. This included:

- Support from their employer in helping them to acquire new skills
- Help to prepare personal development plans to support their career development
- To have their skills and competencies recognised as part of '*the continuous process of lifelong learning*'.

This was all to be contained within an organisational ethos designed around patients' needs and '*not constrained by outmoded professional boundaries*' (Scottish Executive, 1999a). Since the launch of the strategy other papers have followed (cf Scottish Executive, 2000, 2001a, 2001b, 2002b; NHS Education for Scotland, 2003) that have outlined training and development plans for the Scottish healthcare workforce.

To date no research has been undertaken to evaluate the implementation of strategic direction following publication of these papers. This research is therefore timely in order to discover whether the strategic aims have been met in regard to the lifelong learning agenda, career pathways and support from employers for the assistant group of clinical staff. This research is also particularly timely because of the apparent problems around recruitment and retention of trained staff within the NHS (cf Thornley, 1996; Scottish Executive, 1999a), the recent surge in interest towards the assistant group of staff and the workforce planning figures (NHS Scotland, 2007b) which predict a marked decrease in registered staff in all professions by the year 2013 through natural wastage. This places emphasis on recruiting and developing a health care workforce through other means. The government has indicated that the anticipated way forward for the NHSS is to have a total multidisciplinary approach involving all staff at all levels working together. This is to be achieved through promotion of effective teamworking within and across the professions

and encouraging all staff to become multi-skilled in order to promote an integrated approach to patient care (Scottish Executive, 1999a).

1.2.1 Research Aim

The aim of this research is to critically assess the opportunities for workbased learning, personal development and career progression of non-registered clinical staff in the National Health Service in Scotland and to critically evaluate the outcomes against Scottish Government strategic aims for the NHSS clinical assistant workforce. Non-registered clinical assistants are defined as those whose work involves direct patient care.

This research assesses whether the strategies are viable at regional and local levels of the NHSS and whether the intended strategic developments have impacted on the non-registered clinical workforce. In this research, this practical context is examined through the theoretical debates of human resource development with underpinning issues of workbased learning, national frameworks for vocational competency and organisational learning environments.

To realise the aim of the research the following specific objectives were established:

1. To identify key debates within the literature on the concepts of Human Resource Development, Workbased Learning and National/Scottish Vocational Qualifications
2. To establish the nature and extent of training and development opportunities available to a range of staff on assistant grades.
3. To consider the availability and impact of career pathways in relation to assistants in different professional groups.
4. To identify stakeholders' perceptions of opportunities and barriers to workbased learning and personal development.
5. To articulate outcomes with government strategic aims.

1.3 Research Area.

Terminology to describe non-registered employees of the NHSS is difficult. This stratum of employee is most often referred to as 'non-qualified' or 'untrained' but this implies that they are completely inexperienced with no competency which is not the case (Chandler, 1992; Rainbird, 2000).

Since 1990 successive governments have tried to develop and 'modernise' the National Health Service in order to maintain its reputation as one of the most admired institutions in the western world but to limit escalation of costs to achieve this.   As a result of this agenda many changes have taken place within the Health Service (Chiarella, 2002).   The National Health Service has been frontline news over recent years (cf Department of Health, 1999a; Eberhardie, 2002) particularly with regard to the apparent shortage of a skilled workforce and the recruitment and retention of qualified staff.   This apparent problem has been addressed by various strategies outlining plans for modernising and developing a more responsive and professional workforce (Scottish Office, 1997b; Department of Health, 1998a; Scottish Office, 1998a; Department of Health, 1999a; Scottish Executive, 1999a; Scottish Integrated Workforce Planning Group, 2000; NHS Scotland, 2001).

The core theme of many government strategic documents including the Scottish Executive Strategy 'Learning Together' (1999) focus on learning and personal development for *all* staff in order to deliver modern, high quality health care. *Learning Together* (Scottish Executive, 1999a:11) outlines plans for a workforce with flexible and transferable skills who are "*…capable of responding efficiently to changing clinical practice and new models of service delivery*".   In order to achieve this and promote a seamless service between large hospital acute Divisions and community and primary care Divisions, staff are to be actively encouraged to undertake training both in-house and externally.   In-house training includes informal training sessions at shop floor level and short study days provided by Division Practice Development Units and/or Training and Development Units.   External training includes formal courses offered by Further and Higher Education establishments and can on occasion incur personal cost to the employee.

In 1990 a new grading structure was put in place for registered nurses and in this year, other professions working alongside medical and nursing staff were placed under the one generic title of Professions Allied to Medicine (PAMs) (this generic title was changed to Allied Health Professions (AHPs) in 2005). Basic services such as cleaning and maintenance were put out to tender through market testing and were in some cases outsourced to private contractors. Training for nurses was taken away from local hospital affiliated Colleges to Higher Education establishments. In 1992 the enrolled nurse qualification was discontinued (Munro & Rainbird, 2002) and all existing staff at this level were encouraged to undertake further study over an 18 month period to allow them to fully register as staff nurses.

The focus on staff shortages started around 1997 when it was noted with some alarm that there was a definite shortage of skilled, professionally registered people actively working in the service (Department of Health, 1999a; Eberhardie, 2002). For some time work patterns had been changing and skills usually associated with medical staff for example were now being taken over by nursing staff. Nursing tasks were in turn being given to assistants. Added to this, the training for registered nurses had become much more academically orientated than previously and as such a shortage of staff was evident on the shop floor as students no longer contributed to the workforce to the same extent. However, nursing assistants and auxiliary nurses, who developed skills by working alongside professional colleagues and through experience and longevity in the job, took up much of the slack and the Health Service survived (Chiarella, 2002, Thornley, 1996). Meanwhile training for Allied Health Professionals (AHPs) became more intense with all professions requiring a university degree taking three to five years duration to complete. However, assistants specific to these areas were not as numerous as they are now mainly because nursing assistants primarily provided support to AHPs.

In 1997 steps began to rectify the problem of recruitment and particularly retention of staff. One particular strategy was that learning, training and development was to be made available to *all* members of the NHS with the hopes of evolving a seamless service across acute, primary care and community sectors staffed by employees with transferable skills and to enable

career progression routes within the service (Chandler, 1992; Scottish Office, 1997b; Department of Health, 1998b; Thornley, 2000). Since then many more proposed and actual changes have been introduced to the NHS. For example, since 2001 there has been a widespread development of assistants within allied health professions, including Radiography Assistants and Physiotherapy Assistants, who are taught specific skills requirements.

In 2003 a pilot scheme was introduced in England and Wales called 'Agenda for Change' (AfC) (RCN, 2003; UNISON, 2003) which involved a restructuring of the staff grading system. Grades *per se* were to be abolished and a new pay and terms and conditions system was introduced which was to be linked to a Knowledge and Skills Framework (KSF) for staff development (see figure 1.4). The plan was for this to be rolled out in October of 2004 throughout the UK but it has yet to be completed in Scotland. The introduction of a Regulatory Body for all Health Care Assistants (including nursing, midwifery and AHP assistants) was proposed for England and Wales in 2004. Scotland has since taken the lead and is currently piloting a regulation scheme (Scottish Executive, 2004b) and although this was expected to be finalised by 2007 it is still, in 2008, in the pilot phase.

Previous Grades: A to I. Incremental points at annual periods over 5 to 7 years.	**AfC Bands**: 1 to 9. Several annual incremental pay points and 2 'gateways' (one at the lower end of the scale and one at the upper end of the scale) related to KSF	**KSF:** 'Dimensions' to support clear objectives and skill development (linked to appraisal or development review meetings) and career progression at two Gateways. - 6 Core Dimensions. - Choice of 24 Specific Dimensions related to a particular job.

Figure 1.4. Agenda for Change (AfC) and Knowledge and Skills Framework (KSF): (adapted from Scottish Executive, 2004b)

With the stated intention to have a flexible workforce with skills that could be transferred throughout Scotland, it would seem reasonable to assume that national strategic initiatives would dictate levels of education provision throughout the country to ensure this transferability. Currently however, Health Boards within Scotland make their own decisions around educational

provision for their non-registered staff. In some Health Boards there is a requirement for lower levels of staff to undertake specific training such as Scottish Vocational Qualifications whereas in others this is not seen as necessary. There is also a high level of local autonomy where training and development is organised individually by Divisions of the Health Boards. Within the Divisions, training and development is further organised and financed through departmental budgets.

Table 1.1 compares the grading system which was in place in 1990, to the Agenda for Change (AfC) banding system which was introduced from 2004 onwards.

	Whitley Scale (Grades)		Agenda for Change (Bands)
A	Nursing & Midwifery Assistants – Acute Sector	2	Nursing & Midwifery Assistants / AHP Assistants
B	Community/Primary Care Nursing & Midwifery Assistants / AHP assistants	3	Senior Nursing and Midwifery Assistants / Senior AHP Assistants
C	Enrolled Nurse / Technical Instructors	4	(proposed) Assistant Practitioner posts – non-registered
D	Junior Staff Nurse or Midwife / Senior Enrolled Nurse / AHP registrant	5	Junior to Senior Staff Nurse or Midwife / AHP registrant
E	Staff Nurse or Midwife / AHP registrant		
F	Senior Staff Nurse or Midwife / Junior Charge Nurse / Senior AHP registrant	6	Senior Staff Nurse or Midwife / Junior Charge Nurse / Senior AHP registrant
G	Charge Nurse or Midwife / Lead AHP registrant	7	Charge Nurse or Midwife / Lead AHP registrant

Table 1.1: Outline of Grading/Banding Systems within the NHSS for Clinical Staff.

Nursing assistants in the acute sector were always employed at grade A where their colleagues in the community were generally employed at grade B although there was no apparent difference in qualification and experience requirements. Following phasing out of the enrolled nurse post, grade C in nursing was eliminated. AHP assistants were employed at the equivalent of grades B and C – grade C being known as a 'technical instructor'. Following AfC which was promoted as a fairer system of reward (Scottish Executive, 2004a), the banding structure provided more levels within each band which effectively integrated grades B and C of the old Whitley Scale.

1.3.1 Choice of sample and issues investigated through the research questions

The exploratory interviews informed the sample of focus and informed the research questions. Five groups of assistants were studied and included Nursing Assistants, Physiotherapy Assistants, Occupational Therapy Assistants, Radiography Assistants and Operating Department Assistants. Issues arising from exploratory interviews with some employees from these groups further informed the research questions and are identified and explored in subsequent chapters.

The issues included access to training and development opportunities by non-registered clinical staff, the national vocational qualification framework as a training initiative (where some registered staff expressed concern around the effectiveness of these qualifications in measuring competency) and related issues of disparity in employment practices.

As the government continues with its intention to make the NHSS a modern, dependable and economically viable organisation, the effects of government strategic initiatives around workforce development are impacting on the clinical assistant workforce. The government are striving for a seamless service staffed by a workforce with acceptable transferable skills. This research is set in NHS Lothian and investigates how the three Divisions of this one Health Board in one geographical area of Scotland are addressing the strategic goals.

1.4 Structure of the thesis

The following chapters chart the introduction and utilisation of clinical assistant staff from the beginnings of the NHS in Scotland to the present day. Chapter two outlines the underlying drivers for change through the evolving clinical history of the NHSS workforce and chapter three gives an overview of the strategic and policy documents of the NHSS in relation to learning and development in the workplace. Chapter four critically reviews arguments from human resource development, sociology, management and education literature that impact on this research and include the concepts of the learning

organisation, expansive and restrictive learning environments and the national framework for vocational competency. From this literature the following research questions were identified:

1. To what extent can the NHSS be considered a learning organisation?
2. To what extent does the NHSS provide an 'expansive' learning environment for non-registered clinical assistants?
3. How effective are SVQs for supporting the learning and development of non-registered clinical assistants?

The adopted research methodology is outlined and empirical research and outcomes are explained and analysed in chapter five. Chapters six, seven and eight present the three phases of empirical research and discuss the findings. The thesis concludes in chapter nine with a discussion on how the research aim and objectives and research questions have been met, the contribution to knowledge, suggested topics for future study and realistic recommendations from this research.

Chapter Two: The evolution of workforce development in the Health Service
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2.0 Introduction

In order to attempt to understand staff training and development in the NHSS in the present day it is necessary to examine the foundations of the National Health Service (NHS) and the changing training and development requirements for clinical staff.   As an organisation the NHS is one that is constantly evolving and as such the organisational strategic priorities for workforce development regularly change to accommodate this.   This chapter maps the changing structure of the workforce in the NHS by providing an overview of health service origins and traces the foundations of recognised training and development from conception to present day with particular focus on one region in Scotland.

The chapter has five sections.   Section one explores the foundations of the NHS and subsequent evolution of clinical staff roles.   Section two examines key reports that were influential in directing employment practice in the NHS. Section three discusses developments in nursing and supporting education and section four covers developments in relation to allied health professions. Section five outlines the increased awareness and use of healthcare assistants in the NHS.   The chapter concludes with a summary of significant issues that are taken forward for investigation in this research.   Appendix One (page 286) lists historical points of note to assist reading.

2.1 Staffing priorities to support the National Health Service

This section outlines the origins of the NHS.   The organisation of clinical staff and the emergence of professions in the NHS are discussed, and then the delivery of healthcare and changing structures of the NHS are outlined.

2.1.1 Establishing the NHS

In historical terms the NHS is a fairly young institution. It has only existed since 1948 and until relatively recently the majority of staff in the NHS were

considered 'unqualified'. Prior to the introduction of the NHS, public hospitals were staffed by untrained ancillary workers, domestics, portering and administrative staff who assisted the trained and highly skilled physicians, surgeons and nurses. Skills for the untrained staff were acquired through experience and on-the-job learning (Abel-Smith, 1960; Catford, 1984). After the establishment of the NHS, formalised training for clinical staff commenced. Registered nurses, enrolled nurses (who were qualified to a lesser degree) and students (who were trained at hospital affiliated colleges) staffed the clinical areas and were supported by untrained, non-qualified auxiliary nurses (Rivett 1998:18; Chiarella, 2002).

In the latter part of the 19th Century patients were nursed in voluntary hospitals, which were totally funded by voluntary contributions, and generally physician and surgeon time was given willingly and without payment (Catford, 1984). The Royal College of Nursing (RCN) was founded in 1916 as the dominant nursing association and formal registration for nurses followed an Act of Parliament in 1919. The RCN later became a nursing union and attempted to achieve professional closure with formal registration. This was in an effort to have a totally qualified workforce to staff hospitals attending to what was defined by the RCN as 'nursing duties'. The RCN proposed that a very definite line of demarcation was drawn between qualified and non-qualified staff and only specific non-nursing duties were to be assigned to those non-qualified personnel. However, the RCN failed to achieve this closure (Chiarella, 2002) and the subsequent blurring of boundaries between qualified and non-qualified duties persisted. Student nurses were not admitted to the RCN until 1926 and unqualified nurses were excluded by definition (Chiarella, 2002).

The Coalition Government White Paper of 1944 'A National Health Service', recommended that delivery of health care should be centrally controlled by the Secretary of State, advised by a central Health Service Council and five Regional Hospital Advisory Councils (Catford, 1984). There would be local control through Joint Hospitals Boards who would oversee maintenance and delivery of the service, which would be free. At this time there was a definite attempt to highlight the distinction between qualified nurses and assistants at a national level but clarity around the lines of demarcation were not formally

articulated. Where guidance was given, the actual allocation of duties was most probably left to the interpretation of staff in the clinical area. This arrangement persists into the present day NHS where role boundaries are blurred and has been recognised as an area that requires attention (Conrane *et al.* 1996).

The administration proposals of 1944 were criticised by many hospital boards and associations throughout Scotland. However, these proposals and criticisms became academic when in August 1945 the post war Labour Government came into office and their health service plans were prepared. On July 5th 1948 the National Health Service came into being. It was based on the principle that everyone would share the responsibility for the provision of medical care and hospital treatment, as a right and not a charity, for all who needed care and would be financed through taxes and statutory contributions. All professionals (physicians and surgeons) would be paid professional fees for their professional work (Catford 1984; Rivett, 1998). Prior to the formation of the NHS, Scottish health care had consisted of voluntary, municipal, provident, private and government provision in both hospital and community settings (Rivett, 1998). With the advent of the NHS over four hundred hospitals allowing for the accommodation of around sixty thousand patients became Crown property entrusted to the Secretary of State for Scotland and operated through the Department of Health for Scotland (Rivett, 1998).

Since the NHS came into being in 1948 the service has been in continual change. The first administrative change in Scotland was introduced following the publication of the NHS (Scotland) Act of 1972 when fifteen Health Boards acting on behalf of the Secretary of State for Scotland were introduced (Rivett, 1998). The Griffiths Report in 1983 recommended the appointment of general managers who were given overall responsibility for the service in place of the previous consensus management approach where responsibility was shared between doctors, nurses and administrators. In 1989 the White Paper 'Working for Patients' (Department of Health, 1989) led to more changes where responsibility for the service was devolved to a local level and hospitals were given the opportunity to apply for self-governing, independent status to become NHS Hospital Trusts. The Health Authorities ceased running hospitals directly

in 1990 and began to 'purchase' care for the public from 'providers' which were hospitals and other health organisations. The award of Trust status allowed the hospitals to become these 'providers' and to compete against other Trusts and by 1995 all National Health care was provided this way (Rivett, 1998).

However, critics of this change argued that the competition encouraged by the 'providers' resulted in duplication of services. In 1997 a further White Paper 'The New NHS. Modern. Dependable' was published and another way of running the service was proposed built on partnership and driven by performance. Outright competition was to be avoided and a more collaborative approach was to be adopted in an attempt to improve performance by again changing the structure of the NHS (Rivett, 2008). By 2002 all local NHS organisations in Scotland – Primary Care Trusts and Acute Trusts - became part of a single structure under the direction of Strategic Health Authorities. At the end of 2003 Health Care Trusts became Divisions of these Authorities and the most recent change saw the introduction of Community Healthcare Partnerships alongside acute and primary care Divisions (see figures 1.1 – 1.3, pages 2 - 3).

2.1.2 The growth of clinical professions

During the period of 1948 to present day, the clinical staff of the NHS has evolved rapidly in an effort to keep up with changing needs. While nursing and the art of medicine has existed since long before the start of the National Health Service (Weir, 2004), other professions are far younger in origin. A popular image that persists of the NHS is one of acute hospital care provided by doctors and nurses. However, although doctors and nurses are vital to the NHS they are only one small part of its entirety. Along with physicians, surgeons and nurses, those staff known collectively as Allied Health Professionals (AHPs) are a necessary part of the NHS in delivering clinical care and are found in acute, primary care and community settings. There are twelve professions under the generic term of Allied Health Professions and they include amongst others, Physiotherapists, Occupational Therapists, Radiographers and Speech and Language Therapists. Occupational therapy in healthcare has been recognised since the early 1700s, radiography since the mid 1800s and physiotherapy

since the late 1800s but their recognition as professions in their own right came far later.

Many other staff, a good number of whom are considered unqualified, make up the workforce of the NHS and include assistants to nurses and AHPs. Until the 1980s, AHPs worked mostly in isolation and it has only been since the early 1990s that AHPs have secured their own workforce of helpers. Prior to this any help given to them was generally by auxiliary nurses. AHP helpers are also considered to be non-qualified and up until now there has been no particular training made available to this group of employees other than in-house training.

This brief historical overview illustrates that the NHS has never rested since its conception. Forecast figures indicate however that by 2013 the professional workforce will begin to become severely depleted. For example, by that time 25% of nurses in the UK will have reached retirement age and recruitment in present day terms continues at an all time low (NHS Scotland, 2007a). The rate of depletion of the nursing workforce in the UK remains roughly constant at just under four percent per year through death or retirement (Rivett, 2008). The figures for AHPs also indicate that the registered workforce is ageing with fewer recruits to fill the void (NHS Scotland, 2007a). The NHS is committed to its central theme of excellence in patient care. Governments and management see the future depending upon the successful development of all staff within the NHS in order to maintain and exceed current standards. Training and development therefore is considered fundamental to achieving this goal.

2.2 Reports and working groups' influence on emerging developments in workforce employment practices.

This section explores the changes to the boundaries between registered and non-registered staff in the NHSS. Some of these developments have come about as a result of a number of reports and working groups. This section outlines and explores some of more recognised reports and recommendations that have helped to shape the current NHSS structure.

2.2.1 Nursing and nursing assistants

Prior to the establishment of the NHS, The Cathcart Report was published in 1936 and looked at all aspects of health and hygiene in Scotland (Catford, 1984). The report drew attention to the overall shortage of hospital beds and advocated a development of hospital services (Catford, 1984). This report also advised that local authorities should maintain responsibility for improving the deficiencies found in the voluntary hospitals but that they should '*accept a measure of supervision and guidance from the Department of Health*' (Catford, 1984:76). This was possibly the beginnings of a more documented organised training for staff in the health service.

In 1938 the Committee on Nursing, as appointed by the Department of Health for Scotland, reported that hours of duty for nursing staff were between 52 and 60 and up to 70 on night duty (a 48-hour week was achieved in 1948) and they stipulated that '*nurses should be called upon to do only such domestic work as could properly be entrusted only to nurses*' (Catford, 1984:193). However the way the dividing line was to be drawn was not properly explained (Catford, 1984). Because the RCN had failed to achieve professional closure, the components of what was considered to be nursing duties and those considered non-nursing duties, merged over time. The role of experience versus formal training continued to be a point of contention to the RCN and what was considered the 'intellectual' requirements of nursing remained an unresolved issue (Chiarella, 2002).

The Nurses' Act of 1943 introduced the Enrolled Nurse as a new grade of qualified nurse (Weir, 2004). Originally known as nurses' assistants, this grade required a two year training period which was subsequently reduced to one year in 1947, then increased to 18 months at a later date and then further increased to two years again (Rivett, 1998; Chiarella, 2002; www.nmc-uk.org, 2008). It is argued that this enrolment was a new category of qualified nurses with a shorter training period and limited career advancement who were in theory restricted to more limited roles (Rivett, 1998; Thornley, 1999). Most of those recruited to the Enrolled Nurse status were women experienced in healthcare and as those in post retired the number of new enrolled trainees dwindled because of the limited prospects and pay (Thornley, 1999; Chiarella, 2002).

The RCN were given preference in the National Whitley system of collective bargaining for the determination of nurses' pay (Chiarella, 2002). At the same time, following the establishment of the NHS many 'unqualified' people continued to engage in duties that could be defined as nursing and many nurses continued to be engaged in duties that could be defined as ancillary or auxiliary, much to the chagrin of the RCN (Chiarella, 2002). However, the details of the registration process showed that the delineation and ownership of 'skills' was contested terrain in which class-based advantage played a leading role. This was because most nurses were recruited from middle class society. They had access to formal education which allowed them to enter healthcare at a level leading to professional status (Weir, 2004). A training period of three years was required for admission to the register and those nurses without this, which included the 'unqualified' staff, were completely excluded from the future of the profession (Chiarella, 2002).

In 1955 the title of 'Nursing Auxiliary' was formally recognised and by 1958 there were more untrained staff working in hospitals than had been the case before the war (Chiarella, 2002). In the late fifties one major Scottish Hospital found itself in crisis with a shortage of qualified staff and so it began employing nursing assistants from 1960 onwards who, after a brief period of introductory training, helped on the wards. These were generally women who either did not want to embark on a full training course or did not have the necessary basic qualifications to do so (Catford, 1984). This major hospital had been reluctant to accept employment of assistants because many members of the board did not want to '*dilute the high standards of nursing care*' which the hospital was renowned for (Weir, 2004:55). However, the counter argument was that by relieving the student nurses of some simple and time consuming routines, the students would be enabled to become more quickly skilled in the technical aspects of nursing and so help to raise the standards (Catford, 1984).

In 1963, despite the employment of additional staff including State Enrolled Nurses, 106 beds in this major Scottish hospital were 'closed' to admissions and remained closed for five weeks (Catford, 1984). This was due in part to the high demands on the nursing staff with an increased volume of work, long hours (88 hours per fortnight) and the introduction of specialist units such as

renal, thoracic surgery, respiratory, etc.   It was also in part due to the winter influx of elderly patients to medical wards with no extra staff in place there. The five weeks were to allow nursing staff to regroup and '*recover their equilibrium*' (Catford, 1984:197).   Subsequently internal adjustments were put into place which allowed for the working week to be decreased to 42 hours and this coincided with changes to the health service throughout the country.

The significance of this was that it quickly became apparent that the utopian dream by the RCN of having a fully qualified workforce at the clinical face of the hospitals was something that was not going to happen in the immediate future, if ever.   With the reduction in hours, the increased workload and no apparent increase in staffing levels, the registered staff were barely coping.   Someone had to take up the slack and this fell to the assistants (Catford, 1984, Chiarella, 2002).   Thornley (1999) argues that in consequence the State was able to play on the vague definition of 'skill' in nursing and in redefining grades and grade boundaries, cheaper labour was used as a substitute for the more expensive grades.   This process has been described as 'grade dilution' (Thornley, 1999; Chiarella, 2002).   Dilution of skills is an issue which is very relevant to the modern NHS organisation. Frequent reorganisation has resulted in not only nurses' roles being fragmented but also junior doctors' roles.   As doctors develop new treatments and practices, much work traditionally undertaken by them has become part of nurses' duties.   Traditional nursing jobs overspill into the remit of the nursing assistant and inevitable blurring of job boundaries persists.   With the continuing problem of recruitment and retention of qualified staff that is regularly highlighted by governments and media, the issue of skillmix and staff training required to meet the needs of the service is one that has had no apparent resolution judging by the persistent attention that is paid to it (Scottish Executive, 1999a; Department of Health, 2000a; NHS Scotland, 2007a).   This has huge implications on the training and development requirements of *all* staff to meet service needs and to ensure public safety.

2.2.2 Regulation of standards through Statutory Bodies for Healthcare Professions in Scotland

In 1921 General Nursing Councils were set up in England, Wales, Ireland and Scotland and their remit was the responsibility for training, examination and

registration of nurses and approval of training schools. It was not until 1970 that AHPs were regulated by the Council for Professionals Supplementary to Medicine (CPSM). The Health Professions Council (HPC), which was established in 2001, superseded the CPSM.

The General Nursing Council was superseded by the National Board for Nursing, Midwifery and Health Visiting in Scotland which in turn was abolished in March 2002 and some of its functions were taken on by a new unified statutory body, NHS Education for Scotland (NES), who became responsible for ensuring standards of education and training for nurses, midwives, health visitors and AHPs in Scotland and who collaborated with the governing bodies of these professions (www.nes.scot.nhs.uk; www.show.scot.nhs.uk).

The General Nursing Council for Scotland first published a register of nurses in 1922 and this was produced annually and was accessible to the public until the 1940s (www.pcel.info; www.rcn.org.uk). The regulatory body for nurses, midwives and health visitors was the United Kingdom Central Council (UKCC) which was established in 1983 and this body took over the maintenance of the register, set standards for performance, conduct and ethics and provided advice for nurses and midwives (Rivett, 1998). The Nursing and Midwifery Council (NMC) superseded the UKCC in 2001 and continues with the same remit (www.nmc-uk.org).

2.3 Changes in the Role of Nurses and in Nurse Education

The greater use of nursing assistants in healthcare came about, in part, by the changes to the structure of nurse education. This section discusses these changes and focuses on events in the NHSS region under study that influenced the change in work practices. The reorganisation of the nursing hierarchy is also discussed.

2.3.1 Beyond the Bedside

In the same year (1963) that a major hospital in Scotland was forced to 'close' beds to admissions because of staff shortages, the General Nursing Council for

Scotland issued a new syllabus calling for '*wider basic training*' for student nurses (Catford, 1984:197).   From January 1964 the number of weeks student nurses spent in study blocks was increased.   Periods of secondment to other hospitals for experience were also increased.   Each student would be away from their teaching hospital for longer periods and would therefore become a '*less stable element in the ward team*' (Catford, 1984:198).   Consequently, stability would depend on, amongst other things, the '*wiser use of auxiliary personnel*' (Catford, 1984:198).   In 1966 Sir Derrick Dunlop, head of the Nurse Education Advisory Committee stated that assistants had become an indispensable part of the ward team and were likely to become increasingly necessary (Catford, 1984).

Although most nurse training took place in hospital schools of nursing, the University of Edinburgh (noted worldwide for its ability in medical training), had offered certificates, diplomas and degree courses in nursing as an independent field of study since 1962.   1968 saw the first male student nurse, in a combined mental nurse/general nurse scheme, study in Edinburgh.   It was not until 1971 that the first male nurse entered the three year general nursing course and in 1972 the first University Chair of Nursing Studies in Britain was established in the University of Edinburgh (Rivett, 1998 and 2008; Weir, 2004).

In 1966 the Ministry of Health and the Scottish Home and Health Department appointed a committee whose remit was to advise on the senior nursing staff structure from ward sister level and above.   It was chaired by Mr Brian Salmon, CBE, Vice Chairman of the Board of Governors of the Westminster Hospitals Group.   In July of 1966 the Salmon Committee reported on its purpose '*to provide the best possible patient care through effective management of the skills and resources available to nursing*' and recommendations were put into effect (Chiarella, 2002; Weir, 2004).   These included recommendations that a higher provision of support service personnel should be provided to work closely with nurses and doctors.   Also a more robust line of communication was to be developed to demarcate and clarify the levels at which decisions were taken and where responsibilities lay (Catford, 1984).

The Salmon Committee recognised the increased pace and complexity of hospital work and recommended that the line of authority should be more diverse. Previously it was the Lady Superintendent who oversaw the entire hospital and training regime. Her subordinates were ward sisters, followed by registered staff nurses and so on down the line of hierarchy (Catford 1984). The recommended system was to put in place a Chief Nursing Officer (corresponding almost to the former Lady Superintendent role), then Principal Nursing Officers who were to be in charge of a directorate of the hospital such as general nursing, maternity, nurse teaching etc. These people would oversee the Senior Nursing Officers who would be in charge of an area which would consist of a group of units. Under them in the list of superiority would be Nursing Officers who would supervise a unit which would consist of a group of wards. Under them would be the Ward Sisters who would be responsible for one ward (Weir, 2004). Figure 2.1 outlines the organisation of the hierarchy in 1972.
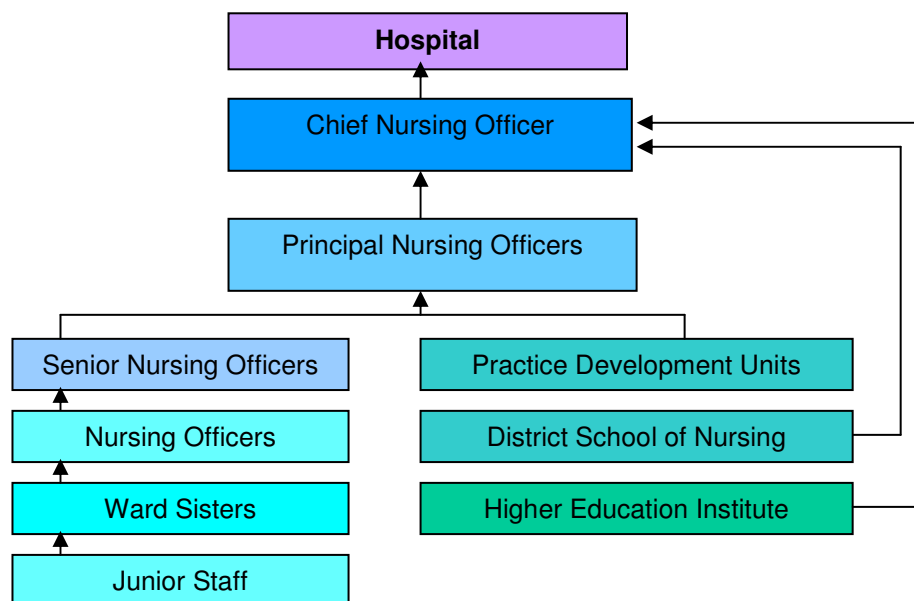
Figure 2.1: Organisational Chart for nursing in 1972. Source: adapted from text in Catford, 1984; Rivett, 1998; Weir, 2004.

Training and development for qualified staff was under the jurisdiction of the newly formed Practice Development Units (PDUs). Annual mandatory study days were introduced for *all* staff incorporating basic life support, moving and handling and fire evacuation. To access other training and development staff, both registered and non-registered, had to be put forward to the PDU by their

ward sisters/charge nurses. AHPs accessed training via their superintendents and the HR department (Weir, 2004).

In response to the Salmon Report (1966) the hospital schools of nursing became district schools of nursing and covered wider areas using more hospitals to provide and meet diverse training needs for student nurses. However, two years after the division of nursing hierarchy the hospitals merged through reorganisation of the NHS. To ensure that effective coordination of nursing and nurse teaching continued, a new senior nurse structure was devised (Catford, 1984). The one Chief Nursing Officer post was superseded by Divisional Nursing Officer general posts (see Figure 2.2). In 1981 working hours for nurses were reduced to 37.5 to bring them in line with other professional occupations in the UK (Rivett, 1998). The effect of this change meant that workforce planning had to be scrutinised to make the best use of human resources and to maintain patient safety. The non-registered workforce expanded even further to accommodate the changes (Rivett, 1998).
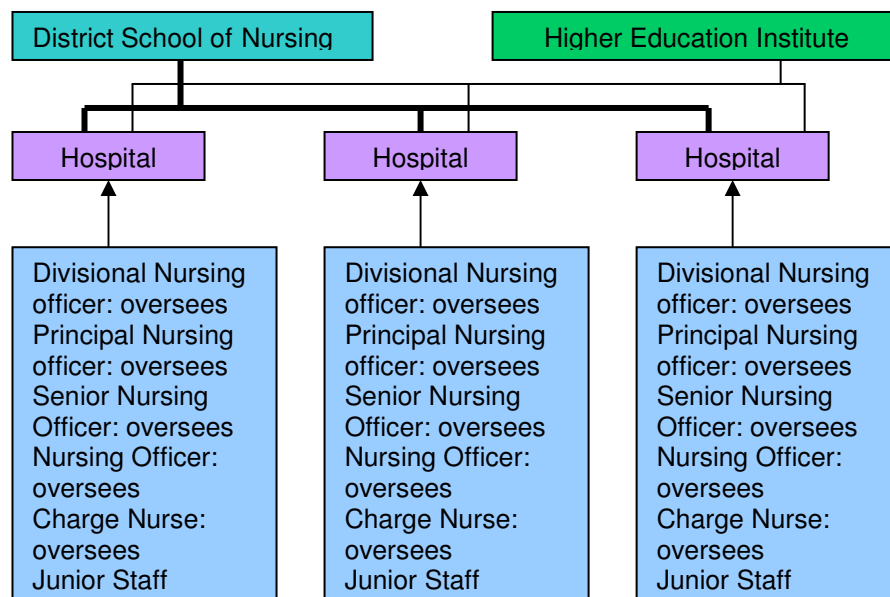
Figure 2.2: Organisational Chart for nursing in 1974. Source: adapted from text in Rivett, 1998.

Since 1981 many changes had occurred in the hierarchy and by 2004 Divisional Nursing Officers became Directors of Nursing and Quality (Principal Nurses) followed by Patient Services Directors then Operations Managers then Assistant Operations Manager and then Charge Nurses. Also included in training and development were Human Resource Departments and Practice

Development Departments. Training for AHPs continued to be in-house or via HR department (see figure 2.3).
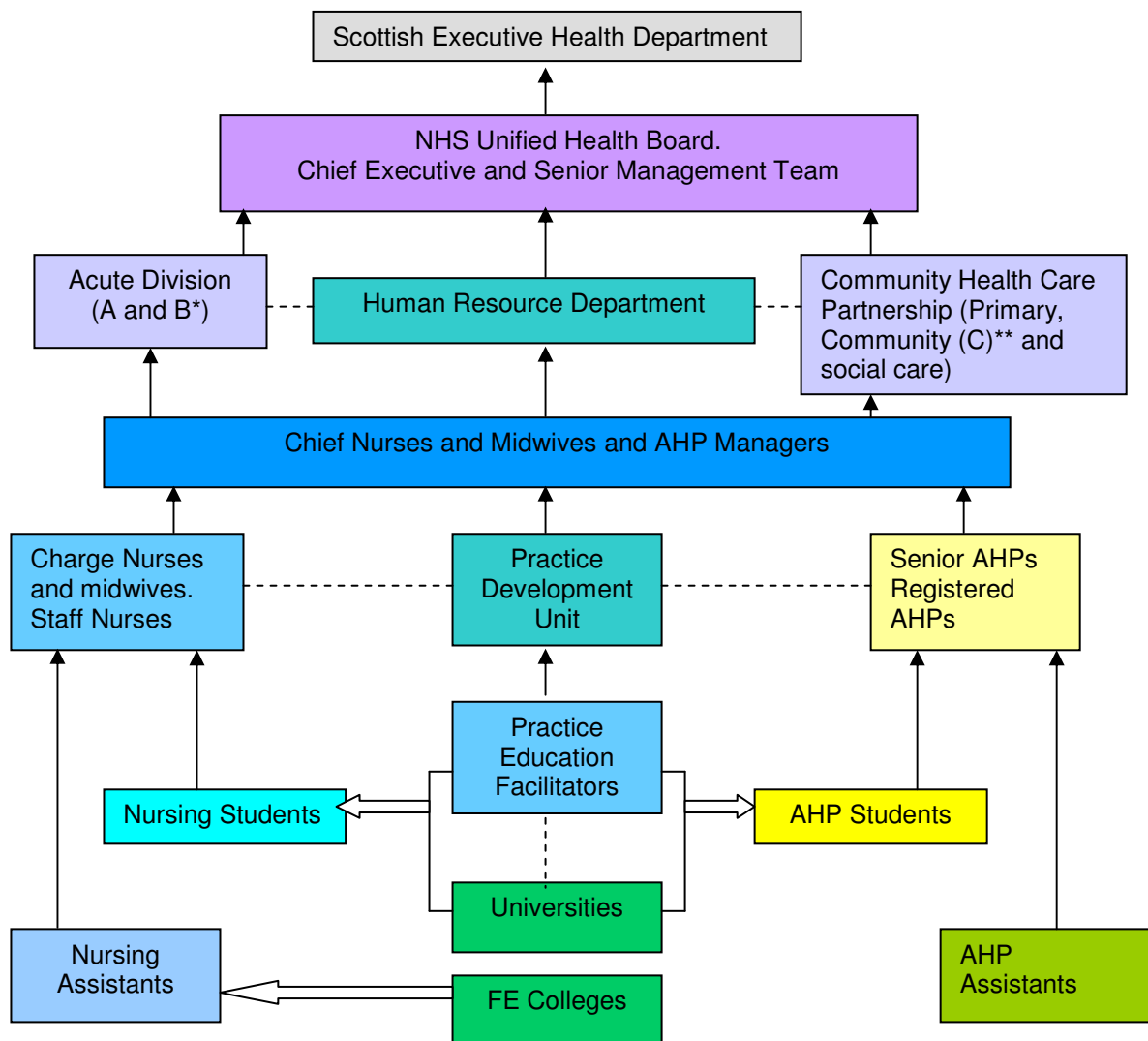
(*A-Large Acute Division, B – Smaller Acute Division, **C – Community Division)
Figure 2.3 Organisational Chart for NHSS and Regional Board in 2005. Source: adapted from text nhslothian.scot.nhs.uk
(⟶ = reporting to, - - - - - - = partnership working, ⟹ = facilitating education)

By 2005, although the NHSS remained unarguably hierarchical, the organisation of management had changed yet again and Health Boards were re-established in some areas with Divisions (formerly Trusts) coming under the one umbrella of the Board. In the area of the NHSS under study three Divisions have been brought together under one Health Board and at this time of writing, facilities are in the process of being amalgamated. The current structure has meant that many senior staff have been displaced with a view to making the organisation more streamlined and specific healthcare services are provided by individual Divisions overseen by the Unified Health Board. Figure

2.3 on the previous page illustrates the current hierarchy and partnership institutions such as Universities who provide formal education for the registered workforce and the college sector who now have some input into non-registered formal education (NHS Scotland, 2003). Regardless of the flow of management, the NHSS remains deeply hierarchical with interpretation and implementation of government directives devolved to regional and local levels which may propagate the apparent inconsistencies of workforce development throughout the NHS in Scotland.

This section has highlighted that despite several attempts to reorganise the Health Service to stabilise the workforce, the problems of poor staffing levels of qualified staff in the clinical area has been a constant. Reorganisation has consisted of focusing on the top levels of the hierarchy ostensibly to make better use of existing staff but in reality has, in past reorganisation, made a top heavy structure with convoluted lines of communication and order. Although the increased use of assistant nursing staff has been evident, there is little mention of their training and development needs to meet the needs of the service.

2.4 Changes in the Role of Allied Health Professions and AHP Education

The history of para-medical professions is not as long as that of physicians, surgeons and nurses as often the particular skills associated with allied health professionals were an integrated part of the medical and nursing professions. The beginning of the 20th century was the time when healthcare workers began to branch off and become specialised in particular skills which in turn became professions in their own right. As indicated, para-medical professions did not begin to appear in Scottish hospitals until the 1920s (Catford, 1984). Dieticians were amongst the first and then in 1924 the first social workers (previously known as almoners) were appointed. The others did not begin to emerge until two years later.

Of the twelve professions under the generic title of AHPs this section focuses on three of them – radiography, physiotherapy and occupational therapy. As mentioned, the history of assistants specific to AHPs is short, (assistance originally being provided by nursing assistants), but none-the-less they have quickly become a recognised part of healthcare. Their separate histories, particularly in the regional Health Board under study, are discussed here.

2.4.1 Radiographers

In 1926 in a major Scottish hospital five radiographers were appointed including one senior and four junior staff (Catford, 1984). At this time there was no official School of Radiography although the Society of Radiographers was founded in 1920. There was a demonstration room attached to the department where some lectures were given to students who worked as dark room technicians while studying independently for examination for the Royal Society of Radiographers (Catford, 1984). It was not until 1936 that the department was recognised for teaching purposes by the Society. Lectures were then given on anatomy, physiology, photography and radiography techniques that resulted in a single diploma. In 1948 two separate diplomas were awarded – one for radio-diagnosis and one for radiotherapy.

After the Health Service reorganisation in 1974 the two divisions of teaching were given distinctive titles – The School of Radiotherapy and The School of Diagnostic Radiography. The volume of radio-diagnostic work undertaken annually increased dramatically from the early days. 13,000 examinations were undertaken in this hospital in 1926 and by 1981 185,000 examinations were being routinely undertaken (Catford, 1984). New skills and new teaching requirements had to be acquired without diminishing the ability to put each patient at ease whilst using the machines (Catford, 1984). Nevertheless this group of professionals were not afforded their own specific assistants until the 1990s, having previously relied on nursing assistants for any help required with patients.

2.4.2 Physiotherapists

The origins of physiotherapy in the region of Scotland in this research traces back to 1922 when a 'massage department' was introduced in a small room in the region's major hospital whose personnel consisted of two part time workers. In 1926 the then 'Massage and Electrical Department' had a variety of equipment including exercise and gymnastic apparatus, a 'schnee' bath, massage couches and rooms to provide treatment by ultra violet rays. In 1943 the name of the professional body for this group of workers changed from 'The Chartered Society of Massage and Medical Gymnastics' to 'The Chartered Society of Physiotherapists' to embrace the variety of treatments practised by their members (Catford, 1984).

A training school for physiotherapists in this region of Scotland was not established until 1941 and the course of two and a half years (later increased to three years and then further increased to four) covered subjects such as anatomy, physiology, medical gymnastics, medical electricity, light and electrotherapy. In 1997 in this region, the responsibility of training physiotherapists was removed from the hospital base and transferred to a University College. The physiotherapist's role has moved from working largely in isolation to becoming a member of the multidisciplinary team jointly aimed to providing a comprehensive rehabilitation programme for each patient. Physiotherapists are now required to assess needs and modify treatment rather than simply carry out prescribed treatments (Catford, 1984). Again, despite their relative autonomy and increased workload, this group of professionals did not acquire their own specific assistants until the 1990s relying as other AHPs did, on nursing assistants to provide help with patients.

2.4.3 Occupational Therapists

Within the studied region of Scotland, this group of professionals is the only branch of the AHPs who has had from the outset, helpers to assist the qualified staff members (Catford, 1984). Occupational Therapists help with the rehabilitation of patients following physical or mental trauma or disability. They promote health and help patients' achieve and maximise independence in their daily lives (www.cot.co.uk). The need for Occupational Therapists in this region of Scotland was recognised in 1970 when the prolonged treatment of

elderly patients became more apparent and so a small unit was established. Occupational therapists now work as part of the multidisciplinary team and their workload is gained through referral from ward staff and doctors or through general practitioners in the community where they have a high profile. Occupational therapists train in higher education institutions to obtain a degree, their course lasting four years. Their assistants have no formal educational requirements on entry to healthcare.

This section has shown that compared to the nursing and midwifery staff employed in the NHSS who make up over 41% of the workforce, the allied health professions are collectively a much smaller number amounting to 6.7% of the total workforce (www.isdscotland.org). It is interesting to note that despite securing their assistant workforce relatively recently, there has been from the beginning, some form of training and development in place for their non-registered staff. The content and outcomes of this training are further investigated in this study.

2.5 The increased utilisation of Health Care Assistants

This section discusses the decline of nurse recruitment, the demise of the enrolled nurse grade and the shortage of registered staff replaced by non-registered assistants.

2.5.1 Quality or quantity?

A recurring critical electoral factor for every potential government has been public pressure to improve wages and conditions and to resolve continuing shortages in healthcare staff, particularly in nursing. The NHS had encouraged recruitment from overseas, particularly India, Spain and the Philippines in an effort to maintain staffing levels (Rivett, 2008). Philippine nurses trained for four years on a degree course but were employed as nursing assistants initially on entrance to the NHS until they were deemed competent to British standards. The recruitment of this 'cheap labour' for Enrolled Nurse grade had been in decline from the 1970s and by the 1980s there was also a deep decline in the number of trainees for nurse registration (Chiarella, 2002). Staff shortages

were noted and acknowledged to be a growing problem and this continues to be so in the 21st Century.

The Enrolled Nurse grade had been in existence since the 1943 Nurses Act and despite theoretically being restricted to more limited roles than their registered colleagues, in practice they often took over the role of registered nurse when required (Rivett, 1998; Weir, 2004). Although their worth was obvious, in an attempt to 'streamline' the service and work towards a totally qualified workforce, a proposal called Project 2000 was tabled in 1986 to introduce nurse training that would result in a single level of registered nurse and to discontinue enrolled nurse training (Rivett, 1998; Weir, 2004). The last intake of pupil nurses for enrolled nurse training was in August 1992 and thereafter the '*EN training was consigned to history*' (Weir, 2004:57).

Project 2000 involved a 'health orientated model' rather than a 'disease orientated medical model' which meant a more academic type of training for student nurses than before. Students had supernumerary status for 80 percent of their training which meant that they were not counted in the ward numbers. This was a key moment in the history of assistant grades as with the phasing out of enrolled nurses and even fewer students working in the clinical area, the reliance on nursing assistants who had even less training was likely to increase (Rivett, 1998). It was acknowledged at this time that vocational training for support staff would need more development (Rivett, 1998; Weir, 2004).

With the introduction of Project 2000 in 1988 the system of nurse education developed by Florence Nightingale ended (Rivett, 1998). Access to nursing was widened by a lowering of entry requirements (Shields and Watson, 2007) and the 'new universities' who were geared to high student numbers, bid for contracts to provide nursing education. This all contributed to government targets to increase the number of people in higher education without too much of an increase in costs (Rivett, 1998). Since student nurses could no longer be considered part of the labour force of the NHS, costs were controlled by substituting less skilled staff for registered nurses where possible (Rivett, 1998). In 2000 the NHSS employed 15,298 nursing and midwifery assistants and by 2006 the number had increased to 15,521 (www.isdscotland.org). The

suggestion was that 'generic' carers with brief training could provide most care in the future in a role that encompassed nursing but did not conform to traditional job descriptions. These assistants would be able to take over a variety of tasks which, although possibly desirable for a skilled nurse to do, might not be a necessity (Rivett, 1998; Shields and Watson, 2007). While it was suggested that the assistant replacements to nurses should have national vocational qualifications (Weir, 2004) there is no evidence to suggest that this became a requirement.

There is little historical writing on AHP assistants' rise in prominence. However anecdotal evidence suggests that their numbers are increasing and their work remit is evolving to the point where they are a necessary part of the multidisciplinary healthcare team. The NHSS employed 1,121 AHP assistants in 2000. By 2006 this figure had risen to 1,903 and the number is predicted to increase dramatically over the next ten years (NHS Education for Scotland, 2007; www.isdscotland.org).

With fluctuating numbers entering the nursing profession it is clear that steps had been taken to rectify this problem through changes in nurse training and recruitment from overseas. Ironically the RCN's desire for a fully registered workforce has influenced the resulting loss of the trained enrolled nurse and a dramatic growth in the assistant workforce. However, it is notable that very little subsequent organised training was suggested, or indeed put in place, for the assistants. Since the assistant workforce continues to increase and to take on roles more traditionally the remit of registered staff, it would be reasonable to assume that education and training provision for them would be of mounting importance.

2.6 Significant issues to take forward

This chapter has demonstrated that while the NHSS continues in its state of flux, strategic priorities change to accommodate the evolving issues and Government proposals and strategies continue to be produced on a regular basis. An array of legislation around training and regulation to improve the

working ethos and professional status of registered clinical staff exists. In comparison, there is little evidence to suggest that their assistant colleagues have been developed in any similar way. Arguments persist around lines of demarcation and the historical situation of difficulty in specifying duties and activities undertaken by assistants continues. Traditional training of registered staff has moved away from the workplace resulting in students becoming supernumerary and coupled to the demise of the enrolled nurse training, a greater use of assistants has evolved. With the predicted workforce shortages and an increasing ageing population to be cared for, there needs to be cognisance of what training and development provisions are being put in place for all clinical assistants to meet service needs, particularly as there is much more recognition of the added tasks being undertaken by them.

To date, the focus on clinical training and staff development has concentrated on the registered workforce and their obvious importance in the NHS. However, as this chapter has demonstrated, the assistant workforce is rapidly increasing in number and is considered a recognised and integral part of the professions that make up the NHSS therefore their importance can no longer be denied. This begs the questions of whether the overall ethos and subsequent distribution of training and development opportunities which has traditionally been a top down approach, has been significantly affected by changes.

The following chapter gives an overview of strategic and policy documents that are being used to inform the education, training and development of staff in NHS Scotland.

Chapter Three. Strategic and Policy Documents on education, training and development in the NHSS: an overview.

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3.0 Introduction.

The strategic and policy documentation reviewed in this chapter relates to education, training and development of the workforce and is from three specific areas of the NHS: UK Central Government Health Department, Scottish Government Health Division and the regional Health Board and local Divisions studied in this research. Documents that reference initiatives for non-registered clinical staff are of particular interest along with those that inform the key themes that have emerged from the reviewed history in chapter two. These are specifically the learning ethos of the NHS organisations, the training and status of non-registered clinical staff, the debates around the acquisition and recognition of skills and the blurring of job boundaries. Documents concerning strategic moves towards creating a workforce that is 'fit for purpose' and has opportunities for career progression are examined. Government strategic and policy documents on the NHS are prolific and so for the purposes of this overview, those published between 1995 and 2007 are assessed in detail. The rationale for this date range is to acknowledge some influential documents in the two years prior to the most recent 'modernisation' strategy for the health service which was introduced in 1997. Often the documents refer to each other and therefore an absolute chronological review is not possible.

For ease of reading throughout this chapter, Appendix Two lists the NHS documents examined and gives the names by which they are most often referred. The table is ordered in four sections covering UK Government documents, Scottish Government documents, special Health Board documents and documents published by the regional Health Board under study. This chapter is structured in six broad sections. Section one covers the emergence of strategic and policy documents relating to the current agenda around workplace learning. Section two discusses the documents relating to the 'modernisation' of the NHSS. Section three focuses on documents covering

specific strategic targets to address staff development and the lifelong learning agenda. Section four reviews policy documents that address the workplace learning environment following a major reorganisation of the NHSS. Section five reviews documents specific to AHPs and section six discusses documents concerning the most recent initiatives around 'modernisation' of the Health Service. Regulation proposals for the assistant workforce are then examined.

3.1 UK and Scottish Government Strategic Documents on Staff Development.

Documentation on workforce development for 'the New NHS' (Department of Health, 1997) is prolific but prior to the victory of Tony Blair and 'New Labour' in 1997 and the subsequent reorganisation of the NHS, the concepts of a learning environment and personal development had been alluded to in government documents. This section critically examines relevant documentation prior to 1997 and subsequent strategic planning and policy development.

3.1.1 The emerging focus on staff development in the workplace

In 1995, Ken Jarrold, Director of Human Resources, NHS Executive, wrote a paper considering policy and change that was underway in the NHS. Jarrold believed the NHS was a divided organisation and in order to advance, he advocated partnership working throughout the NHS (Jarrold, 1995). As will be discussed, Jarrold's recommendations have been adopted and advanced through some current strategies.

In the early 1990s the NHS was going through considerable upheaval. Several reforms had been introduced around a broad set of criteria of quality, efficiency, choice, responsiveness and equity (Robinson and LeGrand, 1993). As a monitoring and evaluation system had not been set up at the same time, the King's Fund Institute commissioned several small research projects to try to evaluate the reforms. However, as the projects were carried out within the first two years of the reforms it was unsurprising that little change was noted (Robinson and LeGrand, 1993).

The reforms encapsulated a national agenda which included strategic efforts to address recruitment and retention problems, create a workforce that was stable, had definite career pathways, was flexible and had the required knowledge and skills to underpin excellence in patient care. Chief Executives for all Health Boards were put in place and their remit was to use their considerable power as decision makers to guide the reforms (Jarrold, 1995). Accepted practice on everything from workforce planning to patient waiting times was challenged, short term contracts were introduced, wards closed and staffing levels questioned. This was not a happy time for the staff of the NHS as the status quo was being challenged and service reviews that were unpopular with the staff were being implemented (Jarrold, 1995).

The remit of 'personnel' or Human Resource (HR) departments was also being scrutinised through the reforms (Buchan and Seccombe, 1993). In 1991, local HR activity was generally concentrated on 'hiring and firing' and there was little input into other activities such as training and development of staff (Buchan and Seccombe, 1993). Up until this point, training and development had been managed at local level through practice development units but this was to gradually change to become the remit of HR departments. Part of this overall strategy involved nurturing collaborative working between the professions who had historically overseen their own staff development.

3.1.2 Cultivating a collective workforce ethos

Since the late 1990s, most government legislative and strategic documents concerning workplace learning in the NHS address knowledge, education and training as a collective variable to be considered (i.e. as one entity) implying that any learning will include all three (cf Conrane *et al.* 1996; Scottish Office, 1997a; Department of Health, 2000a; Scottish Executive, 2001b; NHS Lothian, 2003b; Scottish Executive, 2003d). Many of the documents discuss cultivating a flexible workforce through the acquisition of skills coupled to the design and implementation of robust national occupational standards which would allow for easier transition of staff between Health Boards and UK countries (Scottish Office, 1998a; Conrane *et al.* 1996; Scottish Integrated Workforce Planning Group, 2001; Scottish Executive, 2002e; Scottish Executive, 2003d). Some documents argue that multi-tasking and multi-skilling can be integrated into

workforce planning to allow transferability and flexibility in the workforce (Conrane *et al.* 1996; Audit commission, 1997; Department of Health, 1997; Scottish Office 1998a; Department of Health, 1998b; Scottish Executive, 1999a; Scottish Executive, 2001b; NHS Education for Scotland, 2001; Scottish Executive, 2002e; NHS Lothian, 2003b).

Transferability through multi-skilling may go some way to avoiding duplication of effort on the part of the employee to be allowed to work within their scope of practice. As each Health Board had their own particular educational standard, it was sometimes necessary for an employee to undertake further training in clinical practice to demonstrate their competence rather than be allowed to practice on the basis of a previously acquired and documented skill base (Conrane, *et al.* 1996).

In 1996 a steering group consisting of Conrane Consulting, National Association of Health Authorities and Trusts (NAHAT), The University of Manchester, NHS Trust Federation and the Health Services Management Unit published a report on '*the future healthcare workforce*'. While their report concentrated on the English workforce it included the NHS as a whole (Conrane, *et al.* 1996). The essence of their document highlighted NHS employees' concerns of job insecurity through changing structures which might mean the loss of a 'job for life' (Conrane *et al*. 1996). The lifelong learning agenda addressed continuing employee development, continuing professional development (CPD) and personal development planning (PDP) for all employees (cf Scottish office, 1997a; Scottish Office, 1998a; Department of Health, 1998b; Scottish Executive, 1999a; NHS Education for Scotland, 2001; Scottish Executive, 2002d; Scottish Executive, 2003b). These were reported as being a necessity and a requirement for implementation by all UK NHS Boards (Jarrold, 1995; Conrane *et al*. 1996; Audit commission, 1997; Department of Health, 1997; Scottish Office, 1997a; Scottish Office, 1998a; Scottish Executive, 1999a; Morris, 2001; Scottish Executive, 2001b; NHS Education for Scotland, 2002; Scottish Executive, 2003b; NHS Lothian, 2003b).

The underlying collective message was that the NHS workforce needed to be seen to be constantly developing in line with changing healthcare needs to meet

public expectation. Sub-themes for workforce development included recommendations for the cultivation of a learning environment to facilitate lifelong learning and nurture flexible working and competence (Conrane *et al.* 1996). The need for career pathways, transferable skills, accreditation of prior experiential learning and new learning through vocational qualifications was highlighted in this paper (Conrane *et al.* 1996).

In their report Conrane *et al.* (1996) stated that the workforce figures and employment trends indicated that flexibility in the workforce was already in evidence and was set to continue. Healthcare assistants, for example, were reported as carrying out a variety of clinical tasks on patients, usually the remit of registered staff and at various levels of skill requirement. Conrane *et al.* (1996) argued that there was a need for the redesign of the education and training provisions for the workforce which should be on the basis of patient need rather than being 'constrained by out of date role demarcations':

> *'the current workforce is divided into those with a professional qualifications and support workers. This rigid demarcation reflects neither workload requirements nor current practice'*
> *(Conrane et al. 1996:13).*

A study by UNISON uncovered 85 different titles for healthcare assistants throughout the UK (O'Dowd, 2004) indicating that local need had dictated a growth of specific job roles with varying titles, differing activities and potentially different pay points. Conrane *et al's* recommendations included a common core programme for **all** healthcare workers and multidisciplinary training as far as possible with the 'right to practice' dependent on assessment of competence (Conrane *et al.* 1996). The underlying message was that health educators should concentrate on the current healthcare workforce in particular, to help with predicted recruitment problems in the future. They further recommended that recruitment for trainee therapists (from the Allied Health Professions) should be from existing experienced patient carers which would establish a career pathway for this group and allow for shorter training periods (Conrane *et al.* 1996).

Accreditation of prior learning was briefly discussed in this document with the steering group recommending that access to professions should be broadened to include people with general national vocational qualifications (GNVQs) or with degrees from other disciplines and also healthcare staff who had obtained a National Vocational Qualification (NVQ) (Conrane *et al.* 1996). It was suggested that all staff should maintain a portfolio of achievement that would then form the basis for career transfer or additional training (Conrane *et al*. 1996).

Various strategic documents in Scotland have included the recommendations by Conrane *et al.* (1996). Many of the Scottish documents highlight the need for a flexible workforce at all levels and in all disciplines. The basis for all these strategic plans is around education, training and development of staff to meet the needs of the patients through widening access to professions and in particular, the use of the vocational qualification framework for career development of non-registered staff.

This section has discussed the reforms introduced to address recruitment and retention problems and to challenge historically accepted practice. Where multi-tasking and multi-skilling to aid transferability and flexibility of the workforce has been recommended, this challenges the ability of the workplace to become a learning environment and raises questions around what measures have been adopted to ease a change in culture from didactic to a more inclusive approach. This is particularly relevant where existing staff are required to demonstrate their 'flexibility' through learning and training at work to meet the strategic goals around PDP, CPD and the lifelong learning agenda.

3.2 Modernising the Health Service in Scotland

This section discusses documents addressing modernisation and the establishment of a clinical governance framework for quality improvement.

3.2.1 Changing priorities for staff development

The white paper, Designed to Care (Scottish Office, 1997b) was presented to 'begin the process of modernisation (of the NHS) in Scotland'. The basis of the document recommended evolving partnership in care between acute and primary care sectors and re-organisation of existing NHS Trusts in the move towards more care in the community. For this to be driven forward it required changes in the management of human resources and to '*offer enhanced education and training provision and to address the workforce challenges facing the NHS in Scotland...*' (Scottish Office, 1997b: point 87). This document spoke of the fragmentation of policy and practice in the management of NHS staff which had created inconsistency and had left staff feeling insecure and undermined. The paper pledged to ensure that NHS staff were appropriately trained for both their own personal development in acquiring lifelong skills and in the interest of the NHS. To do this a comprehensive training and development strategy was to be produced to tackle issues including recognition of the value of lifelong learning, equal and easy access to training and development opportunities for *all* staff and promotion of a competency approach underpinned by national occupational standards (Scottish Office, 1997b: point 123).

To meet these needs, the Scottish Office Human Resource Strategy '*Towards a new way of working*' (1998a), addressed continuing professional development (CPD) as a way to ensure fitness to practice. To achieve consistency and fairness across the NHSS an employee relations framework was developed that included The Scottish Partnership Forum which would tackle specific human resource issues, determined Scotland-wide and reported to the Director of Human Resources in the government. Membership of the forum was drawn from NHS Scotland, trade unions and professional bodies. Part of the HR strategy meant that individuals working in the NHSS should expect consistent treatment in employment practice wherever they worked, access to individual training and development plans/portfolios, the opportunity to learn new skills and be involved in a wider range of tasks and to be rewarded fairly. This paper mirrored the points highlighted in *Designed to Care* and further discussed the development of an integrated education, training and lifelong learning strategy

supporting government policies in education and training and including consideration of the following:

- Broader access to education, training and development across the NHSS.
- Development of targets to support government objectives in vocational education.
- Requirement of continuing professional education and development and
- A more proactive approach to learning (Scottish Office, 1998a).

These papers described disappearing traditional boundaries in current employment practice in the NHSS through the acquisition of new skills by staff at all levels in all disciplines. This is significant as although the development of specific education and training plans were notable in Trusts and Health Boards (NHS Lothian, 2005b and 2005c), the issue of a common framework for CPD using occupational standards and Scottish Vocational Qualifications (SVQs) in partnership with the Scottish Qualifications Authority (SQA) was a recurring recommendation that had not yet been actioned. CPD subsequently became a major strand of clinical governance.

3.2.2 Clinical Governance

Clinical Governance was first introduced into the NHS in 1997 and was born out of the need for real accountability for the safe delivery of health services (www.cgsupport.nhs.uk). Clinical governance was defined as '*a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish*' (Department of Health, 1998b:37). Quality improvement activities were to include workforce planning and development and CPD for all employees. At this time The Audit Commission (1997) recommended building on the existing skills of staff and training staff in skills that were in short supply, combined with the re-design of jobs and a commitment to CPD to overcome staff shortages.

In 1998, Alan Milburn, Minister for State of Health launched a wide ranging consultation exercise and reported that a specially earmarked Modernisation

Fund was to be used to, amongst other purposes, provide the training and development staff in the UK NHS needed to renew and enhance their skills for the future (Department of Health, 1998a).   Under clinical governance, each local employer was to have a training and development plan in place, for AHP and nursing and midwifery health professional staff, by April 2000.

This meant a very tight time frame where Health Boards and local employers would have to review their workforce and plan for their future development. However, although the document stated that CPD programmes were needed to meet the learning needs of individuals, they were more importantly needed to meet the wider service development needs of the NHS (Department of Health, 1998a).   Furthermore while the document stated that CPD did not necessarily mean going on courses, which could then lend to opportunities for learning on-the-job, the level of investment to support CPD programmes for all staff was to be left to the local health employer (Department of Health, 1998a).   The implication of this for staff was that the local workforce planning group would prioritise the strategic planning and since there was no specific timeframe for anything other than CPD *plans* for staff, there was no guarantee that anything would develop from this.   However, the implementation of CPD, subsequent planning and lifelong learning was highlighted in *Learning Together* (Scottish Executive, 1999a) and other documents which are now discussed.

3.3 Further recommendations for workforce development

This section critically describes the many UK, national and local documents that focus on the development of staff through specific strategic and policy targets including the development of an N/SVQ framework, staff governance and employee responsibility.   The introduction of a special Health Board in Scotland to concentrate on education solutions for the workforce is discussed.

3.3.1 Lifelong Learning and 'Learning Together'
'Learning Together. A strategy for education, training and lifelong learning for **all** staff in the National Health Service in Scotland' (Scottish Executive, 1999a) may not have been the largest document produced but it provided the foundations

for future documents building on the themes of lifelong learning, careers, access to and opportunity for learning, and the learning organisation with the central aim being quality patient care:

> *'The core theme of this strategy is that learning is vital*
> *to delivering modern, high quality, responsive health care'*
> *(Scottish Executive, 1999a:7).*

This document concerned only NHS staff in Scotland and when Susan Deacon, Scottish Minister for Health and Community Care launched the strategy on 3rd December 1999, she stressed that it was an essential part of modernising the NHS in Scotland to become patient-centred. The messages of *Learning Together* including the notion that integrated learning would go some way to modernising the NHSS, were to be communicated to all staff. The key aims of the strategy were outlined and included:

- ensuring staff were 'fit for purpose' by becoming equipped with the right skills, knowledge and attitude required to deliver the services expected
- properly supporting and encouraging staff to learn through improved access and opportunity
- helping staff to develop a flexible approach to new ways of caring
- building effective teams through working and learning together
- providing career progression and job satisfaction to meet the aspirations of all NHSS staff and
- raising awareness of the value of education, training and lifelong learning (Scottish Executive, 1999a).

This aimed to promote a more cohesive NHSS in that it encouraged multidisciplinary learning to enhance multidisciplinary working across all levels of staff. Prior to this, uni-disciplinary learning and training had been the norm. *Learning Together* proposed that the strategy would encourage staff to develop their learning and that in return they could expect support from the organisation in the form of discussion of learning needs, identification of learning opportunities, PDPs and recognition of skills and qualifications as part of lifelong learning.

Following the publication of *Learning* Together, an NHS Circular was sent out to General Managers and Chief Executives of the NHSS directing them to take action on the strategy and to pursue targets for SVQs, particularly for non-registered clinical staff (targets to be decided at local level), meet take-up levels for the Return to Learn course, provide induction training for all new staff and have personal development plans for all staff by the end of 2000 (Scottish Executive, 1999a). This was significant in that it should then articulate with NHS learning plans and workforce development issues. The Return to Learn course is a partnership provision by the NHSS, The Workers' Educational Association Scotland (WEA) and UNISON Scotland. It is a communication and study skills course, aimed at ancillary and support services in the NHSS in particular and including people with few or no formal qualifications or those who have been away from learning for some time (Scottish Executive Health Department, WEA Scotland and Unison Scotland, 2002).

Learning Together continued on the theme of modernising the health service through staff with flexible skills to 'maximise their potential' (Scottish Executive, 1999a). It did not provide a prescriptive account for the learning needs of individuals or staff groups but provided a '*framework of strategic principles* (applying to all staff) *to underpin education, training and lifelong learning'* (Scottish Executive, 1999a:10). It highlighted responsibilities of employees, employers, professional bodies and education providers. Employees were to be encouraged to take personal responsibility for developing their potential with the support of their employers who would manage staff development. The standards expected of staff were to be defined by professional bodies and wider access to learning was to be the responsibility of education providers (Scottish Executive, 1999a). There was specific reference to career progression, job satisfaction and staff development as being an investment in quality (Scottish Executive, 1999a). The document argued that career development did not however, always mean promotion but could indicate further and different experience within a healthcare setting:

> *'Careers are about not only promotion but also about the personal satisfaction that derives from developing new skills and mastering new techniques (Scottish Executive 1999:39).*

The *Learning Together* strategy (Scottish Executive, 1999a) also advanced the notion of developing the NHSS as a learning organisation (cf Senge, 1990a; Pedler *et al.* 1996; Megginson, 1994; Marsick and Watkins, 1999a). This concept will be reviewed in detail in the following chapter but in the *Learning Together* document, a learning organisation was described as one that promotes and supports learning by all staff as part of a continuous process of development (Scottish Executive, 1999a). Staff were to be placed 'at the heart of organisational development strategy' and would be given the opportunity to develop their potential and have their achievements recognised (Scottish Executive, 1999a). NHS organisations at local level were to meet the indirect costs of providing service while staff undertook CPD activities (Scottish Executive, 1999a). AHPs' education and training was reported as being fragmented and underdeveloped and the intention to consult further on the best way to achieve support for AHP learning was articulated (Scottish Executive, 1999a).

Non-professional staff were considered for the first time in detail in this document. The NHSS intended to place their learning within the SVQ framework to help them to achieve the necessary competencies including the skill, knowledge and attitude required for their job. The SVQ framework was said to '*allow them to work at their own pace towards national, transferable qualifications*' (Scottish Executive, 1999a:26). In this document the SVQ framework was considered to be most beneficial for allowing standardisation of skill acquisition and to help non-registered staff feel valued and motivated to progress within the NHSS. Competency based career progression, recognising and rewarding people for acquiring new skills and taking on additional responsibilities, was intended to give the potential to care assistants (both nursing and AHPs) to pursue entry into these professions (Scottish Executive, 1999a). NHSS organisations were charged with increasing the number of people with recognised qualifications at SVQ levels two and three although no target figures were dictated.

The Executive, through this document, were keen to encourage lifelong learning for all staff in the NHS. New staff were to be provided with a robust induction to allow them to understand their role in the organisation. Learning for all staff

was to be encouraged in whatever form was appropriate including situational learning at work to complement formal training activities. Interestingly the Scottish Executive reported that some disparities existed between staff groups on the issue of funding for education and the strategy stated that local learning plans would provide a vehicle for addressing this and aligning resources more closely with learning needs (Scottish Executive, 1999a).

The *Learning Together* strategy was presented as a framework for working in partnership with health care deliverers and it stated that the way to link staff development with career progression and rewards was to be realised through Agenda for Change (AfC), the modernising of NHS pay and grading system, which was to be based on responsibility, competence and satisfactory performance (Scottish Executive, 1999a). AfC will be discussed later in this chapter but what is interesting to note is that the essence of this document directs Health Boards and local employers to widen access to training and development for all their staff by providing a skeleton framework and no prescriptive direction. At the same time it reinforces the notion of equity of access and multidisciplinary working to promote a flexible, transferable workforce. However, with no specific boundaries, agreed direction or tools for measurement of situational learning the outcomes of local learning plans are likely to vary. Therefore a key aspect for this research is to investigate the interpretation and implementation of targets from this strategy at a regional and local level of the NHSS.

3.3.2 Blurring the boundaries

Central UK government produced a consultation document on developing the NHS workforce in 2000 and in it they stated that traditional demarcation had held services back as the provision of health care should be dependent on the skills of the staff and not their job title (Department of Health, 2000b). The NHS Plan published by the Department of Health (2000b) once again reported that current problems included a lack of national standards and old fashioned demarcation between staff and barriers between services. The NHS Plan confirmed that these would be areas that would be looked at over the subsequent three years, including developing the skills of the workforce. However, as with many of the preceding documents, the focus remained on

educating and developing the registered workforce and little comment was made on supporting staff.

In 2001 the Scottish Executive published *Caring for Scotland: The strategy for nursing and midwifery in Scotland* which continued with the theme of drivers for change being accountability, supervision and leadership, professional and career development and workforce planning. The document stated that all of these drivers required development and implementation to achieve the ideals of the 'Modern NHS'. The education and development of staff was considered central to them all. *Caring for Scotland* reported that support workers should be recognised as valued members of multi-disciplinary clinical teams. Directors of Nursing and education providers were at this time, charged with developing a framework for the training, support and supervision of nursing support workers to agreed occupational standards by 2002 (Scottish Executive, 2001a) and to ensure that support workers had the opportunity to acquire a named award to at least SVQ level two or equivalent by 2005 (Scottish Executive, 2001a). This document articulated the first specific target and reinforced the notion of a career pathway and the opportunity to develop careers within nursing and midwifery for these support workers.

A consultation document was disseminated in 2001 which set out plans for a new 'special Health Board' to be named NHS Education for Scotland (NES). The remit of this organisation was to help staff perform their roles and develop their full potential and to provide a focus for the training and development needs for **all** staff in the NHSS. NES was to combine all the previous national bodies concerned with education including medical, dental and nursing into one umbrella body and to incorporate AHPs who previously did not enjoy similar educational support (NHS Education for Scotland, 2001). The proposals by NES were to build on proposals put forward in *Learning Together* (1999) and *Our National Health* (2002e) requiring staff to be appropriately trained and '*part of a culture that embraces lifelong learning and the flexibility to meet the demands of a modernising NHS'* (NHS Education for Scotland, 2001:4).

In their annual report (2002/2003) NES endorsed an HNC route into year 2 of the pre-registration nursing programme to enable more flexible entry routes into

the nursing profession. They also reported that work was continuing on the production and dissemination of clinical competency frameworks (NHS Education for Scotland, 2003a). Clinical competency frameworks encompass the underpinning knowledge and skills, standards, training and development, accountability and responsibility required for particular areas of clinical practice.

In the workforce development action plan by the Scottish Executive (2002e) core functions for local, regional and national level were proposed and encompassed six strands, one of which focused on training and education of staff. Decisions about training and education were to be taken at *national* level by the national workforce committee on the basis of advice from NES. NES would consult with *regional* workforce groups to ensure that decisions were based on a thorough assessment of needs and constraints at *local* and *regional* levels (Scottish Executive, 2002e). To further strengthen this resolve, The Scottish Executive Health Department strategic document '*Our national health: a plan for action, a plan for change*' (Scottish Executive, 2002e) set out challenges for the NHS in Scotland which included the establishment of a Staff Governance Standard. *Partnership for Care* (NHS Scotland, 2003) further strengthened the NHS in Scotland's commitment to staff governance through partnership working (Scottish Executive, 2002c). The Scottish Executive defined staff governance as '*a system of corporate accountability for the fair and effective management of all staff*' (Scottish Executive, 2002c:8). *Our national health* had recommended that local partnership forums would be directly involved in assessing the performance of NHS Boards employees as part of new accountability arrangements (Scottish Executive, 2002e).

The Staff Governance Standard for NHSScotland was launched in April 2002 and was intended to focus attention on how staff were managed, and how they felt they were managed, by '*the largest employer in Scotland*' (Scottish Executive, 2002c:1). The Governance Standard was to allow NHSS staff across the whole of the country to be asked questions, through a national staff survey, concerning the running of the organisation and the quality of their working lives. Local and national results were published and the intention was to review the results to help improve the way NHSScotland worked. The standard was developed jointly by managers, trade unions and professional

organisations working together.   The evaluation of the results and decisions on future plans for NHSS were also to be decided in a partnership forum.

In evaluating the Standard, a performance assessment framework was to be used which would include the five key standards forming the Staff Governance Standard.   Each would be assessed in relation to policy, targets and organisation effectiveness.   Information would be submitted through audit reports from local partnership forums, human resource and organisation development strategies, statistical information against agreed targets and staff survey results and action plans (Scottish Executive, 2002c).   The five key standards that employers were required to deliver entitled staff to be:

1. **Well informed** (to allow job to be done as effectively as possible). Through this staff would receive information about their organisation at regular intervals and have access to IT and communication systems. Evaluation focused on receipt of information, awareness of long term goals and understanding changes within the organisation.

2. **Appropriately trained** (to do job effectively and progress in accordance with knowledge and skills framework).   Through implementation of the *Learning Together* strategy (Scottish Executive, 1999a) there was to be equity of access to training for all regardless of working arrangements or profession.   Evaluation focussed on induction into the job, personal development planning and training and development opportunities.

3. **Involved in decisions which affect them** (affecting the job).   Staff were to have the opportunity to be involved in planning and development which personally affected them.   Service developments were to be planned alongside workforce issues as standard practice.   Evaluation focussed on staff feeling able to speak up and challenge their NHS Board, the opportunity to contribute personal views before changes were made and satisfaction about personal influence in the work area.

4. **Treated fairly and consistently** (policies, procedures and behaviours practised in the workplace).   The NHSS was to have best practice HR policies and procedures in use.   Fair and consistent treatment was to be given to all employees regardless of where they worked within the service and staff were to be able to expect security of employment

throughout the modernisation agenda and organisational change. The evaluation focussed on the good use of skills and abilities, recognition for good work, quality of opportunity and satisfactory dealings to resolve bullying, harassment and discrimination.

5. ***Provided with an improved and safe working environment*** (health and safety). Evaluation focussed on balance between work and home life, levels of pressure in job, physical working environment and sickness absence (Scottish Executive, 2002c).

Further questions in the evaluation were around the perception of the job and the organisation and included questions and statements concerning support from colleagues, morale, job security and benefits packages. Demographic information included questions regarding age, gender, working pattern, disability, pay range and staff group.

The Scottish Executive published a document in 2003 entitled *Ongoing learning and development in NHSS: Planning Manual* which set out broad principles that were to govern learning and development in the NHSS and which highlighted equal access for all staff to learning and development opportunities, PDP and ongoing support (Scottish Executive, 2003c). In the same year NHS Lothian published their *Trust Learning Plan* which articulated a commitment to providing a range of learning opportunities for staff and to developing the organisation into a 'learning organisation'. Their strategic priorities included staff 'fitness for purpose' through CPD and PDP (NHS Lothian, 2003b). They also promised improved access and opportunities and reported that access varied considerably depending on the individual's occupation grouping. The document indicated that NHS Lothian had successfully supported the principles and practice of encouraging flexible working through the provision of SVQs integrated in support worker programmes and stated its commitment to these programmes that acknowledged individual competence through the award of SVQs at level two and three in clinical and non-clinical professions (NHS Lothian, 2003b). NHS Lothian's intention was that all staff appointed into nursing clinical support worker posts were to progress through development programmes to ensure they were able to demonstrate the knowledge, attitudes and skills to a necessary standard.

Also in 2003 the Scottish Executive published their five year lifelong learning strategy for Scotland – *Life through learning through life*. The document reported on the results of a Scottish Employers skills survey collated in November 2002 which showed that there were skills gaps where people already in jobs were not fully proficient and this was more extensive than skills shortages. Where skills gaps existed they were mostly in a lack of 'soft skills' such as communication, team working and customer-handling and those skill deficiencies were most common in lower skilled jobs (Scottish Executive, 2003b). In response to this the Scottish Executive once more committed to becoming a learning organisation and cited Keep (1999):

> '*[in a learning organisation] instead of training and skills being a bolt-on extra, learning moves to central stage and becomes the chief organisational principle around which business strategy and competitive advantage can be developed*'. (Scottish Executive, 2003b:49).

What is important about these documents is that they place a particular emphasis on the training and development of the non-registered clinical staff of the NHSS where previous documents had largely referred to this group of staff in a less focused way. The issues of skills gaps were given more focus where previously they had not been afforded the same considerations. However, there is no clear indication why the NHSS decided to go down the SVQ route to address these issues and to standardise learning and development for their support staff. The documents also place the issue of developing a learning organisation as central to the NHSS agenda.

This section has raised several key issues that will be addressed in this research. While employees are to be encouraged to take responsibility for their learning, the support offered to them by colleagues, managers and the organisational as a whole will be investigated. The documents stated the intention of the SVQ agenda was to help staff feel valued and motivated to progress. Considering that there was also the acknowledgement that access to and funding for education and training could be dependent on staff group it is necessary to investigate disparities in opportunities between assistant staff and whether undertaking an SVQ has had the intended outcomes.

3.4 Effects on policy through reorganisation of the NHSS

This section discusses policy documents that revisit initiatives around skill mix and teamworking, underpinned by training and development. The emergence of a career structure for nursing assistants through a corporate rather than a clinical route is discussed.

3.4.1 Emphasis on skill mix and teamworking.

Through re-organisation, unified NHS Boards came into being in Scotland on 1st April 2004. This involved the previously existing 43 NHS Trusts and Health Boards being replaced by 15 single NHS Boards covering individual geographical areas. The new unified Health Boards became responsible for all health services with overarching responsibility for acute and community care Divisions within their geographical area. In the Scottish health workforce plan of 2004 the Scottish Executive outlined measures to relieve the pressures on the health service which re-visited previously discussed initiatives such as flexible work patterns; skill mix and team working; new education and training routes and new ways of delivering services to make the best use of scarce resources (Scottish Executive, 2004c). Through the 'New Deal' (Scottish Executive, 2004c) junior doctors' hours had been reduced dramatically and other healthcare professionals then had the potential to develop their roles to encompass responsibilities traditionally considered the role of doctors. This in turn meant that clinical support staff might be required to take on responsibilities that would release the other healthcare professionals to take on the new duties.

The Scottish Executive determined that these shifts of responsibilities and duties must be reinforced and supported through suitable training and development and ongoing clinical governance (Scottish Executive, 2004c). Evidence from the Information Services Division (ISD) figures at this time suggested that the skill mix shift was already taking place with clinical support staff taking on some responsibilities previously assumed by registered nursing staff (Scottish Executive, 2004c). National occupation standards for all groups of staff were still to be finalised and would provide a further focus on skills and roles and movement away from traditional professional boundaries. Standard setting was the remit of the NHS Board Quality Improvement Scotland (QIS)

which was set up by the Scottish Parliament in 2003 to take the lead in improving the quality of care and treatment delivered by the NHSS. However, QIS had to start somewhere and their focus was with the registered contingent of the Health Service, using a top down approach to standard setting (NHS Quality Improvement Scotland, 2005).

Reference to AHP assistants came through the NES strategic work plan for 2005-2008. This addressed the issue of professional development for AHPs and outlined its strategy concerning improved access to professional roles, investment in CPD and the intention to '*pump prime assistant staff to undertake a newly developed HNC whilst facilitating AHP leads in developing assistant roles*' (NHS Education for Scotland, 2005:15). To support this, the Scottish Executive deemed that regional workforce plans needed to be produced by January 2006 and each September thereafter (Scottish Executive, 2005c). NHS Lothian's Clinical Governance Strategy (2005b) also referred to local and regional workforce planning and development of a comprehensive training and development strategy for all staff.

The Scottish Executive Health Committee published its second report in 2005 concerning its inquiry into workforce planning in the NHSS and stated that it was the '*committee's contention that until recently there has been little effective strategic workforce planning within the NHSS*' (Scottish Executive, 2005b:2). The report speculated that the previous Trust structure may have resulted in less planning as there was more competition between Trusts and less motivation for workforce planning. This report highlighted the relatively slight progress made in workforce development despite all the previous strategic recommendations and documentation.

As a unified Health Board, NHS Lothian published its learning plan for 2005-2007 and announced its strategy called 'The Lothian Way'. In this, NHS Lothian pledged to provide a working environment that was progressive and '*rich in developmental opportunities*' (NHS Lothian, 2005a:3). It stated its aim to become a learning organisation and outlined an integrated approach to workforce development through a multiprofessional framework which incorporated single system working, single operating Division and community

health partnership. Two strands were developed from this which were learning and development and CPD.

The learning and development strand was to encompass, amongst other things, vocational qualifications for non-registered staff, PDP and appraisal systems for all staff. The CPD strand would encompass professional induction, competencies, practice development and other initiatives around specialist practice (NHS Lothian, 2005a). Education, training and development for clinical assistants was to be overseen by the corporate strand of the framework rather than the clinical strand, moving away from the traditional clinically led development framework to a corporate model. The investment in creating a career structure for nursing support workers was highlighted. In this career structure assistants could commence at SVQ level two and feasibly terminate at MSc level with appraisal and PDP a constant support (NHS Lothian, 2005a). The document also noted that AHP assistant development was required but a similar career structure for these assistants was not mentioned (NHS Lothian, 2005a).

The plan to oversee clinical assistant development via the corporate route is an interesting choice. The corporate strand oversees the whole of the organisation, where the clinical strand is more focused on needs at the clinical interface between staff and patients. The 'Learning Plan' implies that the educational and developmental aspects of clinical career development for this group of staff will be overseen by *business* expertise rather than *clinical* expertise. This raises questions concerning the drivers for education, training and development of this group of staff and for whose benefit it will be weighted. If the drivers are centred on excellence in patient care, it is debatable which strand would be more effective in realising the goal of clinical assistant development.

In 2006 the Scottish Executive published *Delivering Care, Enabling Health* which had a subtitle of *harnessing the nursing, midwifery and allied health professions' contribution to implement 'Delivering for Health'* (a national framework for service change in the NHSS). This document discussed the move away from acute services to community based services and the need for

staff whose clinical skills and knowledge were up to date and fit for purpose (Scottish Executive, 2006a). This could mean a whole new way of looking at staff training and development as it would now be required to work across boundaries and meet the needs of both acute and primary care sectors collectively. *Delivering* Care also discussed the issue of regulation of health care support workers, following the final report of the Shipman Inquiry (Cabinet Office, 2005). The Shipman Inquiry had challenged the concept of self-regulation by the various professions and had concluded that healthcare support workers required to be regulated (something that had not happened up until this point) but no consensus could be reached on how this was to happen. Following major work undertaken by the Scottish Executive on this subject, Scotland was to take the lead on regulation by conducting pilot studies commencing in January 2007. Regulation requires a minimum of standards to be attained by the workforce and, once the standards had been decided, this again would have significance on the training and development opportunities afforded to the non-registered group of staff to meet the minimum requirements.

Delivering Care commented on the national workforce planning framework (Scottish Executive, 2006a) and announced that the framework would be complemented by a *model careers framework for NHSS* which would be competency based and linked to the Scottish Credit and Qualifications Framework (SCQF) to allow a 'building block' approach to learning and development. This would then be linked to the Knowledge and Skills Framework (KSF). The KSF was part of the AfC strategy where each job within the health service was to be afforded specific skills and knowledge requirements that employees would have to attain. This would be discussed at the employee's appraisal where their CPD and PDP would be examined and where any development needs to meet the requirements would be identified.

Delivering Care discussed health care support workers' roles and registered nurses, midwives and AHPs were challenged to have the confidence to allow support workers to take on tasks under experienced supervision and once deemed competent, to do so under less direct supervision. This raises questions surrounding the notions of competence and transferability of skills particularly as regulation for support workers, as will be discussed later, is not

intended to be linked to professional statute through a governing body but rather to be employer led.   This model of regulation would mean that assistant staff would not be on a central register and therefore potentially be recognised only locally as a competent employee.

Delivering Care reported that a national education and training framework for support workers was being developed and work was under way to ensure the *model careers framework for Scotland* would be relevant to support workers (Scottish Executive, 2006a).   It was intended to promote the HNC in healthcare for nursing assistants as a non-traditional route into pre-registration/undergraduate nursing but that a framework of awards and qualifications for the work of AHPs and their staff was yet to be developed. However, the document stressed that once this framework was developed the competencies would be nationally recognised and therefore transferable (Scottish Executive, 2006a).   It was left up to the Scottish pilot study on employer-led regulation to decide whether a register of support personnel would be established or whether to omit this.   So while the strategic documents highlight the need for transferability and flexibility, the regulation pilot process could have the effect of minimising the transferability to local healthcare venues only if the adopted framework curtails information sharing throughout the country.

This section has highlighted several key issues.   Reorganisation has emphasised the need for teamworking and evaluation of skill mix at the clinical face which includes a career structure for nursing assistants.   How this may be put into practice requires investigation, particularly as it is to be overseen by the corporate strand of the organisation in the Health Board under study.   AHP assistants remain without any specified career structure to inform their PDP and CPD which in view of impending regulation requires clarity around future proposals.

3.5 Specific AHP Strategic Documents

Nursing and midwifery strategic documents are prolific, and there are several specific documents concerning Allied Health Professionals (AHPs), but few documents that discuss all professions together. It is worthwhile now examining specific documents relating to AHPs to investigate the strategies particular to AHP assistants' education, training, development and career progression.

3.5.1 Designing AHP assistant development

Several policy documents have described the key role that AHPs play in delivering high quality patient care and many of them consider the importance of continuing professional development (CPD) in supporting the development of skills. In 2002 the Scottish Executive published *'Allied health professions in NHSScotland: key players in the healthcare team',* a document concerning careers for AHPs. In this document, assistant posts are mentioned as being varied and interesting work with plenty of patient contact but currently not a route to a qualification as an allied health professional, although with in-service training the assistants are given the chance to specialise in a particular therapy.

This document highlights that training for AHP assistants is mainly on-the-job and there *may* be a chance to obtain a formal qualification such as an SVQ level two or three in a relevant subject (Scottish Executive, 2002a). This notion does not support the equity of access to opportunities to develop skills that the Scottish Government strategic documents have outlined (Scottish Office, 1998a; Scottish Office, 1998b; Scottish Executive, 1999a). As of 2007, the only AHP discipline so far to offer a route to a registration is occupational therapy. This involves in-service courses to suitably qualified assistants which, on completion, enables these staff to apply for access to undergraduate programmes at second year. Other AHP assistants *may* be able to undertake an SVQ at generally level three but thereafter there is no career pathway unless they study in their own time to gain the required Scottish Highers (or equivalent) for acceptance onto an undergraduate AHP associated course. They would then have to resign their jobs and study full time with no guarantee of a post on completion of their studies. *AHP/Key Players* described this as a barrier for

existing assistants and for mature applicants with previous qualifications and experience as an AHP assistant, as there was no guarantee that they would be accepted via this route (Scottish Executive, 2002a).

The Scottish Executive reported that there was a need to develop alternatives to the traditional path of full-time study leading to registration and to action this they suggested a national working group should be established by the Scottish Executive Health Department in partnership with the Health Professionals Council, Universities, NES, Scottish Qualifications Authority (SQA) and professional bodies (Scottish Executive, 2002a) to examine the way forward for this group of staff.   This supported the recommendations from their document '*building on success: future directions for the allied health professions in Scotland'* (Scottish Executive, 2002b)*.*   This document was the report of a consultation exercise discussing career development for AHPs within clinical areas.   At this time there were nearly 9000 allied health professionals and support staff working throughout NHSS.   A key priority outlined in the document was better overall management of recruitment and retention across the NHSS of AHPs and assistants and meaningful career development including flexibility and transferability into new roles.

Building on success stated that although many AHPs had already developed specialist practitioner roles or extended the scope of practice of existing qualified and support staff to improve services, it was recommended that a reconfiguration of skill mix should be considered.   This was to allow practitioners to make the best use of clinical time and to enable support workers to enhance their role appropriately through additional training and support (Scottish Executive. 2002b).   *Building on success* stated that those assistants who did not wish to pursue state registration in the professions should not be forgotten and that employers should make appropriate arrangements to ensure these staff were offered opportunities to develop their skills and knowledge base to improve practice (Scottish Executive, 2002b).   However, no actions were suggested to allow this to happen.

When *Building on success* was published in 2002, NHS Education for Scotland (NES) had still to address the issues surrounding support in education, training

and lifelong learning for AHPs. Regulation and attainment of competencies was discussed in detail in relation to registered AHPs but there was no direct reference made to assistants on these subjects despite the government documents indicating that assistants were to be afforded more input. As far as developing learning plans, *Building on success* advocated protected time for learning and development for all AHP staff of a minimum of a half day per month pro-rata for dedicated CPD activity (Scottish Executive. 2002b). It is notable that it is only AHP documents which refer to dedicated and protected CPD and learning time for staff whereas the nursing contingent are not awarded the same consideration. This would indicate continuing disparities around access and opportunity to training and development for assistant staff dependent on the profession they are affiliated to.

Overall the assistants who participated in the consultation exercise for *Building on success* were enthusiastic and committed to their work (Scottish Executive, 2002b). However, many stated that they faced challenges through the inconsistent expectations of their professional colleagues. Their roles varied considerably depending on the restrictions or flexibility of their responsibilities as determined by individual registered practitioners. To this end, guidance on competencies (i.e. specific requirements for knowledge and associated skills) for assistants had been developed by the professional bodies to help clarify the variety of roles held by assistants. Core competencies around 'soft skills' such as communication, diversity and teamworking for all healthcare assistants in Scotland had also been established through a project undertaken by the Strategic Change Unit at the Scottish Executive Health Department (SEHD) and new recommendations from the Pay Review Body allowed assistants to be given incremental recognition of training through SVQ modules. This meant that on completion of an SVQ they would be entitled to a small pay rise but without promotion. To action this, SEHD directed Trusts and AHP leaders to review opportunities to develop the role of AHP support workers to enable them to train at SVQ levels two and three to support continued learning and career progression (Scottish Executive, 2002b).

In 2005 the Scottish Executive published *'Allied Health Professions: Flexible Working'*. This document was concerned with ideas for change to allow the

workforce of AHPs to be more flexible in approach to their working patterns which included flexible shifts and job sharing. In order to fully utilise the expertise of AHPs, SEHD outlined its support of initiatives to retain existing experienced staff including the provision of development opportunities for support staff, junior and experienced practitioners (Scottish Executive, 2005a). Also in 2005, SEHD published their *'Framework for Role Development in the Allied Health* Professions (Scottish Executive, 2005d). This document discussed the need for role clarity and associated preparation to meet role responsibilities for all levels of AHP staff including assistants (Scottish Executive, 2005d). This theme was further expanded upon in the NHS Education for Scotland document (2006): *CPD and the allied health professions in Scotland*. A learning needs analysis was carried out throughout Scotland by the various Boards to determine what was required for AHPs. Responses to the questionnaires sent out to every Health Board suggested that the concept of role development for AHPs throughout all grades of posts from assistant practitioners and support workers to staff at specialist and consultant levels was to be embraced (NHS Education for Scotland, 2006). Education and learning opportunities were considered essential if AHPs were to develop and extend their roles and to respond to changing needs in the health service and were equally important in addressing recruitment and retention of AHP staff (NHS Education for Scotland, 2006).

All the responding Health Boards had stated that the education and training budgets they received were inadequate to meet the CPD needs of staff. It was reported that as a consequence, many AHPs at times contributed financially towards their own professional development. In general it was felt that support for training was seen as inequitable compared to other health care professions and this was felt to extend to provision by higher education institutions as well (NHS Education for Scotland, 2006).

In the document *AHP Flexible* working (Scottish Executive, 2005a) it was noted that there was variable use of departmental learning plans and these were often perceived as more applicable to the strategic objectives of the organisations rather than the individual aspirations of AHPs. The AHPs were asked to identify their priority development areas and amongst them was role

development. The AHPs believed that consistent validated competency based learning and training for developed roles and advanced practice for both qualified and unqualified staff was a requirement for a clinically effective workforce that is fit for purpose (NHS Education for Scotland, 2006). This was something that was to be addressed alongside the new pay system, Agenda for Change (AfC) being introduced into the NHSS and, if properly addressed, would allow for equity in access to training and development, learning portfolios, recognition of learning and career pathways for all staff.

The above proposals indicate that a workbased learning model is a preferred option for the development of AHP assistants rather than learning being facilitated by a primarily academically led model although the two models are not mutually exclusive. The key issues include access to SVQ attainment for career progression and dedicated study time for CPD activities. This research will investigate whether these proposals have been actioned and what impact this has had on personal development for clinical assistants.

3.6 The proposed way forward by the NHSS

This section critically discusses the most recent initiatives for modernisation of the health service and development of the workforce. The strategies emphasise the need for multi-disciplinary working and the introduction of specific initiatives such as Agenda for Change (AfC) and the Knowledge and Skills Framework (KSF) to support strategic goals is discussed.

3.6.1 The (re)introduction of 'new' initiatives
Benton (2003) highlighted a common feature of many health policy documents as being the recognition of a pressing need to redesign the NHS workforce and that until recently this was advanced *by* and *for* single professional disciplines. Benton argued an integrated redesign across all disciplines was essential (Benton, 2003). Agenda for Change, the review of NHS pay and grading system, was first mentioned in the central Government's response to the report on future staffing requirements (Department of Health, 1999b). *Future staffing requirements* (Department of Health, 1999a) stated that current trends showed

the number of clinical staff would fall well short of requirements to deal with current shortages and future developments. As a solution the government recommended that healthcare assistants should be *registered* appropriately which, they argued, would provide professional motivation for the individuals concerned and act as a necessary safeguard for the public as competence would be known and recognised (Department of Health, 1999a). Registration would require acknowledgement of a professional status for this group of staff and the setting up of a register under a governing body who would be responsible for maintaining it. It would involve a cost to the registrant and the development of national standards for practice that would require to be adhered to by the registrant in order to remain on the register. Registration of assistants is not re-visited in any other documents to date but *regulation* of healthcare assistants is a topic that has recently been brought into the public forum (see page 53) and will be discussed more fully later in this chapter.

3.6.2 Agenda for Change

In 1999 the government stated that it was determined to improve the working lives of NHS staff and that the current pay system inhibited service modernisation, was widely regarded as being unfair and had not kept up with change in NHS practice (Department of Health, 1999b). AfC was the 'new' pay system that was first introduced in June 2003 in England and was then introduced to the rest of the UK. AfC had been discussed in Scotland's Health White Paper *partnership for care* (2003) which stated '…*for the first time lifelong learning will be embedded in pay arrangement for these staff [all healthcare staff] rewarding them for the development of knowledge and skills, allowing them the flexibility and freedom to design jobs that are more rewarding and providing them with the opportunity to develop new roles that can respond more effectively to patients' needs'* (Scottish Executive, 2003d:53). Following on from the pilot that was carried out in Scotland, the consensus was that AfC improved partnership working and after a review in March 2004, it was formally introduced in December 2004. The new pay system was to apply to all NHS staff, except for doctors and dentists and the most senior managers at or just below board level (Scottish Executive, 2004a).

The system was rolled out in stages, the final date for completion originally intended to be October 2005. However, that date is long past and the roll out continues. The system included a job evaluation scheme, knowledge and skills framework (KSF), on call arrangements, NHS minimum wage, new pay banding and unsocial hours (Scottish Executive, 2004a; RCN, 2005). Through assimilation, the post, and not the person undertaking the post, was to be placed on one of nine pay bands by using the job evaluation scheme which would match the post to an appropriate national profile or local job evaluation (Scottish Executive, 2004a; RCN, 2005).

The outcome of the new job evaluation scheme was to be a means of fairly rewarding people by measuring their job-related skills, knowledge and responsibilities and to reward staff for the actual responsibilities they take on rather than the job title they work under (Department of Health, 1999b). AfC replaced the Whitley Councils who made national decisions on pay and terms and conditions of service (Scottish Executive, 2004a). The DOH paper stated that alongside the discussion surrounding pay, the government wanted to pursue parallel but *'equally important issues'* such as investment in lifelong learning and continuing personal development for **all** staff (Department of Health, 1999a:8). These strategies once again reinforced the notion that CPD and education for all staff were to be considered important but again the documents were strategic recommendations only and were non-prescriptive.

AfC would be a huge undertaking with timescales that were ultimately unrealistic. Before CPD could be given the proper attention that the preceding documents said it merited, all staff needed to be assimilated.   The priorities had to be AfC and once the banding system had been agreed in all Health Boards, CPD would be addressed through KSF.   The government did not recommend any system for prioritising which staff groups would be assimilated first.

3.6.3 Knowledge and Skills Framework

The Knowledge and Skills Framework (KSF) makes up a large part of the AfC policy and was intended to be *'...a tool which provides a means of recognising the skills and knowledge a person needs to apply to be effective in a particular*

NHS post' (Scottish Executive, 2004a:14).   It was also said to be designed as a link between education and development and career pay and progression (Scottish Executive, 2004a) and was about investing in the development of all NHS staff in the future (AfC Newsletter, 2005).   KSF was said to be based on good human resource management and was concerned with treating individuals fairly and equitably (AfC Newsletter, 2005).   KSF is made up of 'dimensions' which are the main components of the framework.   Six dimensions have been defined as core to any job in the NHS and these are communication, personal and people development, health, safety and security, service development, quality and equality, diversity and rights (Scottish Executive, 2003a; Scottish Executive, 2004a).   A further 24 dimensions have been defined as specific and relating to some jobs but not others.   It is anticipated that most jobs will be made up of the core dimensions and probably three to six specific dimensions. Although it is essentially a development tool it is expected that it will contribute to decisions about pay progression for individual staff members (Scottish Executive, 2003a).   KSF is said to be capable of linking with current and emerging competence frameworks including regulatory requirements/competencies, and national occupational standards (Scottish Executive, 2004a).

It was also intended that KSF would allow qualified nurses to support vocationally qualified staff who may, under the new approach to lifelong learning, progressively develop skills to allow them to complete professional training.   For AHPs, the intention of the proposals of AfC and KSF was that they would support better career development but nothing is mentioned about career development or accountability of AHP support staff (Department of Health, 1999b).

KSF is a whole new concept that staff will have to become familiar with, particularly as it is inextricably linked to PDP.   KSF is designed to form the basis of a development review process which will link organisational and individual development needs and will be used to inform an individual's point on the new pay band introduced with AfC (Scottish Executive, 2004a).   Within KSF there are two gateways to each pay band. The first gateway is to ensure that staff can meet the basic demands of their post and is generally reached after

the first year in post. The second gateway is to confirm that staff are applying their knowledge and skills to consistently meet the full demands of the post and is located near the top end of the pay scale for each post (Scottish Executive, 2004a). Current employees of one year or more service will be expected to have already passed through the first gateway. This has implications around previous learning and development for assistant staff as meeting the demands of the first gateway is expected but not guaranteed for them.

3.6.4 Personal Development Planning

The Personal Development Planning and Review policy in the NHSS is designed to promote a system of learning and development that meets the current and future service needs of the NHSS (www.workinginhealth.com, 2006) and is informed by KSF (Scottish Executive, 2004a). The general argument was that in order to benefit all concerned, there must be clear links between individual PDPs and the needs of the NHSS (www.workinginhealth.com, 2006). PDP was to involve annual review meetings between staff and their line manager to develop clear and consistent objectives to develop knowledge and skills required for their jobs to support the expectations of the SEHD (Scottish Executive, 2004a).

By linking PDP to KSF it was the intention that organisations would then be able to audit existing knowledge and skills, identify skill and knowledge gaps in the workforce and organise training and development across staff groups (Scottish Executive, 2003a). The development review was to be an ongoing cycle of review, planning, development and evaluation for staff linked to organisational and individual development needs (Scottish Executive, 2003a; RCN *et al.* 2006) and when measured against KSF, it (in theory) would enable the employee to access appropriate training and development to allow them to work towards meeting and maintaining their second gateway in their pay scale. Benton (2003) argued that AfC, KSF and PDP had the potential to retain staff through better assessment of individual staff needs thereby supporting role fulfilment and ongoing development (Scottish Executive, 2004a). This however, would be dependent upon resources being made available to all staff and equity in allocating time and resources to them. Interestingly, the strategic and policy documents concerning PDP and KSF up until 2005 did not mention in any great

detail, the recognition of prior experiential learning that longer serving employees may have, which could influence their PDP and KSF outline. Furthermore, there is no evidence to indicate whether PDP actually works in the form that it has been adopted by the health service as no studies have been carried out to investigate this.

3.6.5 Recognition of Prior Learning

In 2005 NHS Education for Scotland hosted a conference on '*Realising the potential of Scottish Credit Qualifications Framework (SCQF) and KSF for careers in NHS Scotland'* and subsequently published a report outlining the strong links between KSF and existing SCQF. The document stated that if a partnership was worked on by both, this would allow for recognition of prior learning and accreditation through SCQF for NHS staff. The conference included a talk from an independent consultant to the UK KSF Development Group who described how national occupational standards and existing national competences were utilised in the development of the KSF and it was emphasised that NHS Boards were being encouraged to move from local competences to quality assured, benchmarked, best practice competences.

A spokesperson from SCQF talked about recognition of prior learning (RPL) and workbased learning and concluded that RPL can cover all prior informal learning – that which has not been accredited or previously assessed and is achieved through life and work experiences (Whittaker & Mills, 2005). RPL would involve a learner reflecting on experiences and providing evidence of the learning. In this way 'recognition' has a broader scope than 'accreditation'. There is little else in the policy documents concerning RPL and is an area that could have great importance on the opportunities for NHSS staff to pursue career development as learning that is mapped to a competency framework may lend to the notion of transferable skills. For non-registered staff with experience this may mean that learning would not require to be repeated in order to gain recognition of their skills and those staff with other qualifications may have the opportunity to have these qualifications articulated with the required competencies. It is possible that this would widen the entrance to pre-registration courses if RPL was embraced by both the service side and the

Universities and Further Education Colleges. RPL, in this way, could support the national standards required for regulation of support staff.

The key issues from this section that will be taken forward in this research include the awareness by assistant staff of the specific initiatives of AfC and KSF. KSF is an integral part of AfC and is linked to PDP and CPD which could have a huge impact on career pathways and role development for clinical assistant staff in the NHSS. One further initiative that could have a huge impact on staff development is regulation which is now discussed.

3.7 Regulation and accountability of NHSS support staff

Regulating an occupational or professional group can take several forms including statutory, professional self-regulation, service-led regulation (or employer-led and linked to employment contracts), voluntary regulation and individual self-regulation. Regulation fundamentally sets out to ensure that members of the occupational group or professional group maintain minimum agreed standards expected of the group and practitioners' performance can be measured against these nationally-agreed standards. An occupational standard is an agreed level of working that acts as a benchmark for people employed within a staff group (www.workinginhealth.com, 2006). The title of competency is given to specific tasks as well as generic 'skills' such as the soft skills of communication, equality and diversity, teamworking, numeracy and literacy skills. The standards are said to inform employers on how to recruit, train, support and develop staff. In health professions, the main purpose of regulation is to protect the public (www.workinginhealth.com, 2006; Scottish Executive, 2006b).

The standards being devised for healthcare support workers in Scotland are defined as '*the consistent integration of skill, knowledge, attitudes, values and abilities that underpin safe and effective performance in a professional/occupational role*' and will be for all healthcare staff whose work has a direct impact on patient care (NHS Scotland 2007c:Section 3). The core competencies for this group of staff were negotiated on a national basis in 2001

and this work has been used to inform the latest development work on standards relating to these staff.

The negotiated core competencies were categorised into five identified domains and agreed by the National Stakeholders Group. These were, service delivery and practice support, communication, organisational services/facilities, health and safety and managing self (Cowie, 2002). The categories were intended to be used for the generation of specific support workers competencies that would be relevant to the profession-specific requirements. While it was reported that healthcare support workers were not accountable to a professional statutory body, the competencies were intended to reflect the level of accountability that support workers have to their patients, the professional team and their employer (Cowie, 2002). National occupational standards could be used for those who do not have access to SVQs as they are designed to be stand alone competencies (RCN *et al.* 2006).

Occupational standards are developed by Sector Skills Councils and other bodies with a responsibility for occupational groups in negotiation with stakeholders, and they focus on the needs of employers to deliver NHS services (www.workinginhealth.com, 2006; Scottish Executive, 2006b). The rationale for developing and adopting occupational standards is that they are intended to aid flexibility and transferability of the workforce across, not only Health Boards but sectors within. They are also intended to ensure that workers within a particular occupation are 'fit for purpose' (that is, fit to do the job they are employed to do) by having their performance measured against these standards. Standards outlined in the Scottish Executive consultation document '*National Standards relating to healthcare support workers in Scotland. A consultation document*' (Scottish Executive, 2006b) related specifically to a code of conduct and practice for employees (including accountability); a code of practice for employers and induction standards which would be compatible with existing staff governance and clinical governance arrangements (Scottish Executive, 2006b). This document indicated that no arrangements had yet been decided on the monitoring of compliance to the standards by healthcare support staff (Scottish Executive, 2006b).

The document stated that the standards are required to be achieved through induction and can be used to support ongoing achievement within the knowledge and skills framework and will form an important part of the PDP and review process for healthcare support workers (Scottish Executive, 2006b). The consultation document on regulation (Scottish Executive and Social Services Inspectorate, 2004) advocated early introduction of regulation at the induction stage as '*introducing regulation at an early stage in the career pathway will make it easier for support staff to move on to professional roles later if they wish*' (Scottish Executive and Social Work Services Inspectorate, 2004:10). However, currently the length of induction period is not explicit and is decided locally which could mean a period of time from one week to three months. This is often referred to as a probationary period in many Health Boards and while induction and probation are very different things, they are not always recognised as such by some local employers (Cowie, 2002). The documents do not specify what measures would be put in place to regulate existing employees who are past their induction or probationary period.

The question of who would regulate healthcare support workers has been contested since it was first brought to the public forum (www.nmc-uk.org, 2004; Health Professions Council, 2004b; Scottish Executive, 2004b; Scottish Executive and Social Work Services Inspectorate, 2004). The Nursing and Midwifery Council (NMC) had been calling for regulation of healthcare assistants (HCAs) since around the year 2000. The main reasons given were that registered nurses remained accountable for delegating duties to HCAs and also to close an existing loophole where registered nurses who had been removed from the register could return to work as an HCA without detection (www.nmc-uk.org, 2004; Scottish Executive and Social Work Services Inspectorate, 2004). It was postulated that by using nationally agreed occupational standards through regulation, professional staff would have more confidence in delegating more skilled work to assistants (Scottish Executive and Social Work Services Inspectorate, 2004).

An intercollegiate information paper was developed by the Chartered Society of Physiotherapists (CSP), the Royal College of Speech and Language Therapists (RCSLT), the British Dietetic Association (BDA) and the Royal College of Nursing (RCN) in January 2006 that looked at the drivers behind the growing

scope of work activities undertaken by support and assistant staff (RCN *et al.* 2006). It also concentrated on clarifying the delegation process and the associated issues of accountability and supervision in response to the growing numbers of enquiries concerning the management and support of assistants by registered staff (RCN *et al.* 2006).

This paper looked at the terms delegation, accountability and responsibility and concluded that *delegation* is where a registered practitioner allocates work to a support worker whom they deem *competent* to undertake the task and then the worker becomes *responsible* for that task but the registered practitioner remains *accountable*. The registered practitioner maintains the assessment; planning, implementation and evaluation of the delegation and the support worker must have the appropriate level of experience and *competence* to carry out the task (RCN *et al.* 2006). However, *accountability* relates to both registered staff and non-registered staff insofar as all are accountable to both criminal and civil courts and to their employers through their contract of employment but currently only the registered employee is accountable, within statute, to their regulatory and professional body in terms of standards of practice and patient care (RCN *et al.* 2006).

This is an important finding which has the potential to impact on opportunities for development of assistant staff. Guidelines need to be explicit and need to be linked to national occupational standards and assessment protocols. Without this there is a very real chance that registered staff will remain reluctant to delegate progressive work and tasks to non-registered staff which will impede progression for this group.

The intercollegiate paper also discussed competence and defined being competent as *'apply(ing) knowledge, understanding, skills and values within a designated scope of practice… and involv(ing) critical reflection on their practice'* (RCN *et al.* 2006:8). The paper is explicit in advising that '*any support worker to whom a task has been delegated should be appropriately trained and supported to ensure that the activity can be undertaken competently'* (RCN *et al.* 2006:10). What is missing from all of these documents is a robust definition of competence. In general, registered staff declare themselves as competent

following assessment, by their peers or superiors, in any task or skill as it is a requirement of their professional accountability and code of conduct to recognise their competence and limitations. Non-registered staff do not have that professional accountability and there is currently no definitive explanation on how their competence in attaining and maintaining national occupational standards will be measured other than through KSF and PDP review with their line managers. This raises questions about how subjective this exercise may be on the part of the line manager who may have their own personal definition of professional standards and whether regulation is able to regiment this remains to be seen.

The Health Professions Council (HPC) were originally recommended by the Department of Health in England as being the most appropriate body to regulate the assistant group of staff and this was a task they were keen to take on, believing that statutory regulation was necessary to protect the public (Health Professions Council, 2004b). The intention was to set up a Statutory Committee within the HPC which would be called the Health Occupations Committee and would cost approximately £20 - £25 for each support worker, which the HPC acknowledged, was an important issue for this workforce (Health Professions Council, 2004; O'Dowd, 2004). The Nursing and Midwifery Council (NMC) contested the inclusion of nursing assistants in regulation by the HPC, stating that the NMC would be the best body to regulate this group of staff by maintaining what they referred to as 'the nursing family' (Harrison, 2004, Gray, 2004). In 2006 it was decided to pilot employer-led regulation in Scotland, which if successful, would be rolled out across the UK after 2007.

The pilot study involves the voluntary participation of support workers employed in the pilot sites. The significance of this is that if the pilot study is deemed successful, each Health Board and local health provider will be required to ensure that their support staff have a PDP, undertake regular appraisal, are working to the recognised standard and are able to evidence this. The healthcare support worker can then be called to account as a semi-professional, working to regulation standards.

The HPC indicated their support of the proposed Scottish project (Health Professions Council, 2006) and commented that consistent regulation across

the four countries of the UK would allow transferability of qualification and skills for all healthcare workers. This was also in agreement with responses to the Scottish Executive consultation document on national standards (Scottish Executive, 2006b; Health Professions Council, 2006).

The Scottish framework for employer-led regulation does not currently recommend the inclusion of a register or list of regulated healthcare assistants. Concerns were raised on this issue by the HPC in 2004 who believed information that would be available through a register was needed for public protection. The Scottish Executive have reported that if a national register was to be considered in the future for this workforce then it would have to be set in statute (Scottish Executive, 2006b).

It is considered that regulation on a Scotland-wide basis should allow arrangements with existing UK-wide frameworks such as the Knowledge and Skills Framework, national occupational standards and national workforce competences to be dovetailed (Scottish Executive, 2006b). A summary of findings from the national standards consultation document (Scottish Executive, 2006c) reported that 93% of respondents who included medical staff, nursing staff, AHPs, social service staff, dentists, representatives from professional bodies and others, thought regulation should be extended to cover health and social services assistants and support staff. Of the respondents to the consultation document, 81% felt that assistant staff should be accountable for their own practice dependent on the level of training and/or scope of their practice and 70% felt that setting standards should be the responsibility of employers or managers in consultation with support staff. There was a consensus that support staff should be regulated as a single group within a single framework but that it would make sense for the four UK countries to have core/common standards with discipline specific standards to facilitate transferability of staff and while most believed that *statutory* regulation was the preferred way to protect the public, many believed that employer-led regulation was the way to go (Scottish Executive, 2006c).

A report published by the SEHD on the review of medical and non-medical regulation Scottish stakeholder events (Scottish Executive, 2006c) indicated

that because of the growing diversity of the healthcare workforce there was a need to clearly articulate scopes of practice, competence and proficiency standards for *all* staff and a need to define what 'fitness to practice' means and how it can be measured. This definition would require to be robust enough to *'stand up in court'* (Scottish Executive, 2006c:9). Other points that were considered at these events raised questions and anomalies by the stakeholders including the option of guiding support staff through the clinical governance framework rather than regulating them. Concerns were raised that one single regulatory body would result in a generic health support worker rather than profession specific. Also there was concern that once support workers fully understood regulation and accountability issues they would begin to practice 'defensively' or be reluctant to enlarge their role. An RCN public health policy advisor argued that employer-led regulation would result in a 'sliding scale of standard' and would be inadequate as many organisations are 'too small' to take on a regulatory role (Scottish Executive, 2006c).

3.8 Chapter summary

This chapter has looked at relevant recent documents surrounding the issues of education, training and development of NHSS staff and the strategic moves towards creating a workforce that is 'fit for purpose' and has opportunities for career progression. The underlying message of all of these documents is that patient care and services have to be updated to meet the needs of the population and to make the NHSS a more patient-centred organisation, proactively promoting health rather than just reacting to poor health. With this coupled to skills shortages and gaps being the main determinants to restructuring the health service and most aspects of healthcare being taken out of the acute sector into primary care and community through a variety of measures, staff development is considered vital. All of these strategic plans require staff training and development to meet the changes.

There are three key areas within this overview of strategic and policy documents that have raised issues and questions to be carried forward and investigated in this research. While the documents advocate access to

education, training and development for *all* staff, this critical review has indicated that the notion of a hierarchy of importance concerning these issues is none-the-less reinforced. The research will address these issues by investigating the perceptions of both non-registered and registered staff.

The NHSS has declared its intention to develop into a learning organisation and a change in culture has been recommended to nurture multi-professional integration. The first key area is the concept of the NHSS as a learning organisation which will be further investigated in this research. The investigation will include perceptions by non-registered staff concerning their registered colleagues' attitudes towards delegation of duties, support and guidance offered, consistent treatment in employment practice regardless of employing department or profession and the opportunity to learn new skills and be rewarded fairly and consistently. This will inform access to learning and training and will investigate the balance between individual and organisational needs. It will also inform the establishment of PDPs and CPD for assistant staff and these are concepts which have been afforded immense importance in the strategic and policy documents.

The second key area concerns vocational qualifications. Some of the documents discuss the use of SVQs and national occupational standards as providing a competency based framework to allow career progression and skill transferability. All healthcare assistants were to be encouraged by being given the opportunity to undertake competency based vocational qualifications and this research will investigate whether this strategy has advanced for healthcare assistants. SVQs as a learning initiative will be examined and mapped with any recognition of prior learning. Perceptions of career and role development for all assistant staff related to the SVQ initiative and to workbased learning in general will studied particularly as there is very little specific documentation outlining career or development pathways for the assistant group of staff.

The third key area focuses on awareness and implementation of strategic and policy plans and developments including regulation, agenda for change and the knowledge and skills framework. In reality this area dovetails with the SVQ initiative and the learning organisation concept but will be considered as an

area to further inform the outcomes of workplace learning in the NHSS for assistant staff.   Regulation, AfC and KSF all include national occupational standards and requirements to meet these standards.   They have the potential to impact hugely on job roles and future development of assistant staff.   It is necessary to investigate any developments in addressing these strategies including assessment of workbased learning and issues of progression.

Chapter Four. Literature Review

'What we have to learn to do, we learn by doing'
- Aristotle

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4.0 Introduction

This chapter critically reviews literature from the body of work on Human Resource Development (HRD) and concentrates on issues pertinent to this study. The previous chapter highlighted specific concepts of relevance from the policy literature, particularly the learning organisation, the learning environment and the learning initiative of vocational qualifications and a theoretical framework centred on these concepts is used here. The research framework used is one of an underpinning theme of education, training and development at work.   Figure 4.1 illustrates the steps taken to identify specific literature to address the research questions from the large body of work that is HRD.
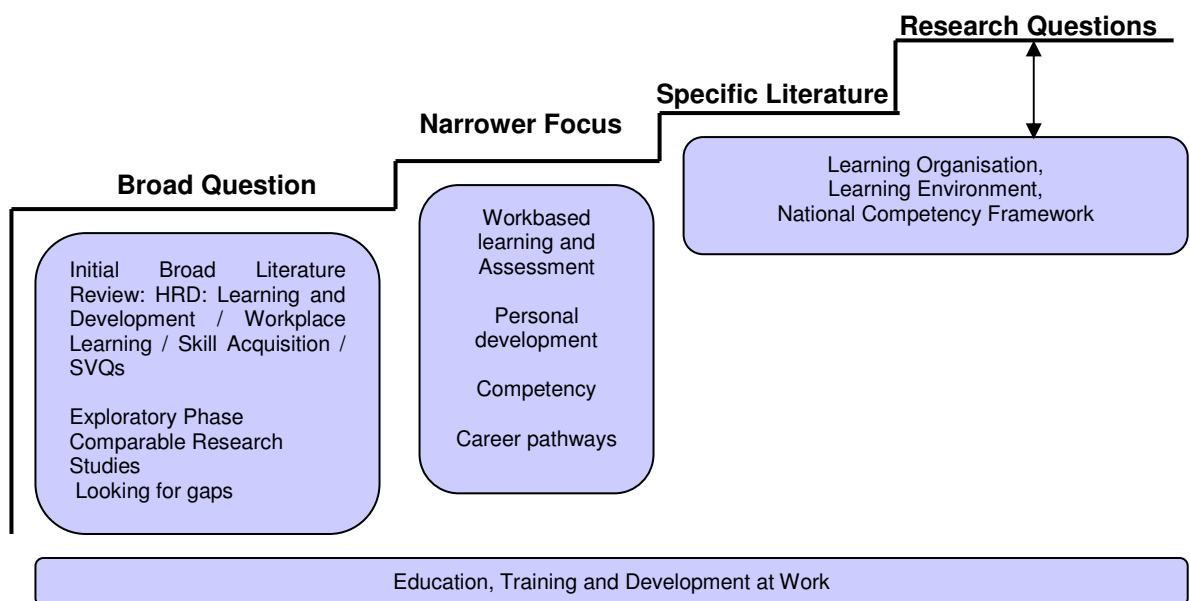
Figure 4.1 Steps to identify specific literature

The theoretical framework includes a broad overview of some HRD literature relevant to workplace learning and is then narrowed down to specifics focusing on identified elements of workplace learning that are associated with the relevant concepts identified above.

The chapter is organised into three sections in which HRD literature on relevant debates is critically analysed. The first section discusses workplace learning, the concepts of education, training, development and learning and the meaning of competence. Section two critically analyses the debates around the concepts of the learning organisation and the learning environment, examining the notions of expansive and restrictive environments. Section three critically reviews the debates surrounding the learning initiative of N/SVQs, national competency standards and frameworks. The notion of transferable skills and nurturing a flexible workforce along with mapping of tacit and explicit dimensions of skill is discussed. This links into recognition of prior learning and career progression which has impact on specific government policies such as the knowledge and skills framework and the regulation of non-registered employees within the NHSS which was discussed in the previous chapter.

This review of the HRD literature focuses on the three main themes of the research, highlighting specific arguments which are of particular relevance to the non-registered workforce in the NHSS. With the recent increased attention given to this staff group due to the changes in workforce planning to meet the needs of the organisation, the notion of a learning organisation, the learning environment and the national framework for competency assessment through SVQs are critically examined. The chapter concludes with a summary of the key debates and an illustration of the theoretical framework adopted for this research.

4.1 Workplace Learning

The term workplace learning can encapsulate learning that forms part of everyday activities in organisations whether organised or ad hoc, formal or informal, explicit or implicit. The term also may cover learning *at* work which could be considered formal learning (cf Lovell, 1980; Swiatczak and Benson, 1995), learning *through* work which could be considered experiential or informal (cf Rainbird, 1998; Lave and Wenger, 1991; Marsick and Watkins, 1990) and learning *for* work which could be considered requirements for the job at hand (cf Reid and Barrington, 1999; Megginson *et al.* 1993). This section discusses the

concepts concerned with learning – education, training and development – and looks at the various methods of learning such as on-the-job, off-the-job, formal, experiential and skills acquisition.   The meaning of competence is explored to inform the discourse around personal development planning and continuing personal development.

4.1.1 Education, training and development

The terms training, development, education and learning are used interchangeably in the NHSS strategic documentation.   Within the HRD literature the consensus is that these concepts are used synonymously in some organisations as they are only contextually appropriate and so meaning cannot be set (cf Harrison, 2000; Reid and Barrington, 1999; Garavan, 1997).   Others view them as distinct in nature (cf Jarvis, 1995).   Garavan (1997:39) argues that in terms of workplace learning, '*it is perhaps more appropriate to view the first three concepts, i.e. training, development and education as an integrated whole with the concept of learning as the glue which holds them together*'. There is a large volume of literature on these concepts (cf Cockburn and Ormrod, 1993; Scottish Executive, 1999a; Thornley, 1999; Bradley *et al.* 2000; Munro and Rainbird, 2002) and an overview is given here.

Some authors argue that learning is at the heart of training and development and is multifaceted (Megginson *et al.* 1993; Reid and Barrington, 1999).   The outcome of learning is said to be a change an individual's behaviour, knowledge, skills and attitudes through either the addition of new and different capabilities or by the extension and enhancement of those already possessed (Lovell, 1980; Megginson *et al.* 1993; Reid and Barrington, 1999).   People learn in a variety of ways including being taught; being instructed; experience; trial and error; observation; perception and reflection (Megginson *et al.* 1993; Reid and Barrington, 1999) and Stewart (1996:159) states that '*individuals learn all the time and not only when they are being educated or trained*'.

Fuller *et al.* (2004) argue that **education** is considered to be a formalised method of teaching and learning and in organisations is sometimes provided in-house or outsourced and can be in both on-the-job and off-the-job venues (Fuller *et al.* 2004 cited in Keep 2004; Keep, 2004).   It is argued that education

forms habits, manners, intellectual and physical aptitudes, skills and moral values and is therefore not just a knowledge and skill base relating to a limited field of activity (Harrison, 2000; Nadler and Nadler, 1992; Reid and Barrington, 1999). This definition implies that education as a formalised method of learning is fundamental and possibly superior to any other form of learning. In a formal situation, education is assessed and awarded by certification of qualifications. Some lower grade clinical employees in the NHSS have had only minimal formal education input. Whether this has had a negative effect on their career progression is of interest, particularly around the notion of opportunities within workplace learning where there may be other methods of teaching and learning available. Currently, the NHSS provides education for its employees through pedagogic teaching methods, both in-house and externally and the perception of the importance of formalised education and qualifications as a way of learning in the workplace is of interest here.

Training on the other hand is described in the literature as a planned process which modifies attitudes and knowledge of skill behaviours through learning experience so that effective performance in an activity can be achieved (Harrison, 2000; Reid and Barrington, 1999). Other contributors to this debate (cf Nadler and Nadler, 1992; Pearn, Roderick & Mulrooney, 1995) describe training as vocational or practical teaching that leads to skilled behaviour and can be considered to include working towards a specific goal or objective by practising in a uniform way. This implies sustainable knowledge whereas Walton (1999) defines training as the *short-term* acquisition of knowledge, skills and attitudes which individuals need to learn in order to be able to effectively undertake their job role. While Walton's definition may constitute theoretical underpinning, a *long-term* sustainability of knowledge, skills and attitude is important to enhance employee development. The NHSS provides training for its staff, particularly following national directives and in terms of career progression and recognition of learning, the perception of content and outcomes of training is of importance here. For the purposes of this study, training refers to skill acquisition, from in-house on-the-job and off-the-job teaching and learning.

Literature on **development** of employees describe an overall consensus that development is focused more on the learner rather than learning *per se* (Garavan, 1997; Harrison, 2000; Nadler and Nadler, 1992; Megginson *et al.* 1993) and learning is considered to be an outcome of development (Garavan, 1997; Harrison, 2000; Megginson *et al.* 1993; Beard, 1993; Rainbird, 2000). Development is described as a diverse process that has no uniformity, unlike training, and occurs both consciously and unconsciously (Garavan, 1997; Megginson *et al.* 1993).   Harrison (2000) argues that the purpose of development is to enhance jobs by enhancing employees which in turn allows for both organisational and individual growth.   Megginson *et al.* (1993) describe employee development as the notion of creating a portfolio of learning activities which are learner-orientated, jointly managed and have a longer time span than training.

This image of employee development could be considered as attractive to both employees and employers as it describes development as a win/win process. However, some authors (Beard, 1993; Holt, Love & Heng, 2000; Rainbird, 2000) argue that in reality it is one which has not been attained by most organisations or individuals.   This raises questions about whether non-registered employees in the NHSS are cognisant with the focus of employee development and in this study development is considered in tandem with personal development planning (PDP) and opportunities for career progression for the non-registered clinical workforce in the NHSS.

4.1.2 Learning

Learning is the intended outcome of any training, education or development initiative in the NHSS and, as a concept, is now discussed further.   The literature on learning is vast and is generally separated into *formal* learning (cf Lovell, 1980; Swiatczak and Benson, 1995) and *informal* learning (cf Bentley, 1998; Coffield, 2000; Marsick and Watkins, 1990; Dale and Bell, 1999).   In general *formal* learning is said to occur in a specific context (such as a classroom or workshop) with a teacher in charge of directing the learner's progress (Lovell, 1980).

Informal learning has been variously described as *experiential* (Lovell, 1980; Usher, 1993; Rainbird, 1998), *situational* (Lave and Wenger, 1991) and *incidental* (Bentley, 1998; Coffield, 2000: Marsick and Watkins, 1990; Dale and Bell, 1999).   In general, both experiential and situational learning focus on the social context of learning and learning from peers and other colleagues within an organisation (Lovell, 1980; Usher, 1993; Rainbird, 1998).

The third description of informal learning - incidental learning – will be considered as a separate entity.   Incidental learning is argued as being fundamental, necessary and valuable whether it is directly relevant to employment or not (Coffield, 2000).   It is generally considered to happen, often unconsciously, as part of everyday activities and in this context, learning is interpreted and integrated into a person's experiential world (Knowles, 1980 and 1990; Tough, 1991; Candy, 1991).   In order to organise and interpret any new knowledge gained through incidental learning, it would involve a period of reflection on the part of the learner.   This type of learning therefore could be argued to have emerged from Gestalt theorists' view of *cognitive* learning (Craik and Lockhart, 1972; Wilson and Hayes, 2001).   In this concept, successful learning is a result of integration and organisation by the learner of perceptions of new knowledge through reflection and cognitive relation to past experiences (Craik and Lockhart, 1972**;** Conner *et al.*, 2003).

Incidental and other informal learning is increasingly being recognised as possibly the most important type of learning within organisations (Clark, 2004; Jones and Hendry, 1994; Coffield, 2000). Learning through training, education and development in the workplace is seen as a means by which reflection on practice can generate experiential and contextual knowledge (Megginson, 1994; Rigano and Edwards, 1998).   These commentators discuss distinguishing between the notions of explicit and tacit knowledge from learning where the former is that which is codified and formally transmitted within organisations and the latter is that which is deeply ingrained within the actions and practices of particular social and cultural contexts within an organisation. It is this tacit form of knowledge in particular that more recent attention has been given within the literature where efforts have been directed at seeking to understand how tacit knowledge might be converted into explicit knowledge. By its very nature

however, measuring or assessing informal learning outcomes can pose significant problems (Marsick and Watkins, 1997; Clark, 2004; Keep, 2004). The literature reveals that there is no specific framework to quantify informal learning activities at work (Marsick and Watkins, 1990 & 1997; Bryans and Smith, 2000; Clark 2004; Eraut 2004) and this is an area that requires some attention as it could arguably have implications for career pathways and recognition of prior learning (RPL) – a concept that is described later.

Informal learning is often unplanned and *ad hoc*, and as learning outcomes are therefore not generally specified prior to learning taking place, informal learning cannot be measured using traditional tools. Most informal learning therefore may not be directly testable. A number of authors have argued that if organisations wish to encourage informal learning then support mechanisms need to be available for reflection and translation of learning into practice (Marsick and Watkins, 1997; Bryans and Smith, 2000). The standards of support however, are an additional area that has no specific testing methods, particularly for *ad hoc* learning. As Clark (2004) argues, writings on measuring informal learning generally lack significant empirical evidence to justify any claims made regarding the mechanisms of support. Clark (2004) suggests that there are difficulties in trying to measure or properly evaluate learning *per se* and that any evaluation undertaken is generally to improve instruction rather than demonstrate individual outcomes. This raises questions about whether reflection, organisation and integration of incidental knowledge are naturally occurring skills or whether they are learned. This again could have important implications for personal development of non-registered clinical staff in the NHSS who may require explicit support to learn how to reflect.

Megginson *et al.* (1993) argue that learning at work is often seen as learning *for* work and therefore this may be the fundamental objective of any organisation's training and development policy. If this is a common perception amongst employees it may also have an effect on the attitude and motivation in the uptake of training opportunities if employees do not perceive any personal benefit. Reid and Barrington (1999) argue that attitudes to learning are both positive and negative. Where confidence and a sense of achievement in

attaining competence (a concept that is discussed later) may act as a motivator to further learning, apprehension and fear of change could act as a demotivator.

Off-the-job training has some value although it cannot always be transferred to a work environment (Marsick and Watkins, 1990). Marsick and Watkins argue that learning at work through experience has the potential to reinforce inaccurate ways of doing things. They advocate finding a way to link training activities with informal and incidental learning in the workplace (Marsick and Watkins, 1990). Furthermore this incidental learning by observation may modify the attitudes and values of the learner (Lovell, 1980) that, if not of the accepted standard, may exacerbate other associated poor practice. This raises questions around standards of assessment and supervision aspects of workplace learning and skill acquisition for non-registered employees of the NHSS. As a concept, it is argued that learning evolves from skill and competency acquisition. This is reinforced by work experience and a greater focus on the cognitive processes of learning in conjunction with skill acquisition (Sambrook and Stewart, 2000; Garavan et al. 2002). It is to this latter concept that we now look.

4.1.3 Skill acquisition

There have been many attempts in the literature to define exactly what skill is. While there is no one overarching definition, most writers agree that skill requires ability (Cockburn, 1983; National Skills Task Force, 2000; Scottish Government, 2007). Cockburn (1983) sees skills as both ability within the worker and abilities required by the job. Abercrombie *et al.* (1984:71) argue that '*skill is a social construct as well as a reference to real attributes of knowledge and/or manual dexterity and is thus an ambiguous concept*'. Skills are further subdivided into *manual* skills which includes the notions of competence, capability and proficiency and *soft* skills which refer to personal attributes such as problem solving, communication, team work and leadership (National Skills Task Force, 2000; Keep, 2004; Scottish Government, 2007). Hall (1997) (cited in McKenna, 2002) further argues that skill must also take into account experience, intuition and instinct, all of which are difficult to quantify. The Scottish Government (2007:55) when discussing soft skills state that '*in the broader sense [soft skills] are not readily assessed*'. It is not the purpose here

to develop theory relating to skill as such and therefore for this purpose, skill shall be considered as encompassing both manual and soft skills, acquired through experience and/or formal or informal instruction that demonstrate ability or competence in a job.

Much of workplace learning in the NHSS is concerned with the acquisition of skills or the further development of existing skills. Some writers (cf Thornley, 1999; Munro and Rainbird, 2002) argue that skill acquisition has relevance to motivation for learning. In some cases, staff can perceive skill acquisition as a positive thing, giving them a sense of achievement, positively impacting on their self-esteem, empowering them and enlarging their job experience where others view it as more responsibility perhaps with no tangible rewards and therefore a demotivating experience (Munro and Rainbird, 2002).

Skill acquisition is arguably linked with personal development planning, employee appraisal and recognition of prior learning (RPL). An existing framework in the NHSS links PDP with mapping of existing skills and potential career development. However, little is made of the concepts of tacit and explicit dimensions of skills which could arguably have some impact on PDP and career progression (cf Evans, Kersh and Sakamoto, 2004; Rainbird, 2004). Evans *et al.* (2004) argue that although there is very little research on the codification of tacit skills and knowledge in work performance, it is well recognised that this happens because adults draw on life experiences to good effect in learning programmes. Previous life experiences such as time management, negotiation skills, budget planning, etc., could be considered basic, tacit and important skills for work performance. By facilitating communication of some of these tacit dimensions, the skills and knowledge could become explicit and therefore codifiable which would then allow transfer of these skills and knowledge (Evans *et al.* 2004). However, the authors go on to argue that it is naïve to try to map 'key skills' that are transferable to any job because in reality in another work environment they must be '*underpinned by domain specific knowledge*' (Evans *et al.* 2004:223). This raises important issues as the mapping of tacit and explicit dimensions of skill is of potential importance for RPL and overall career opportunities for non-registered clinical staff in the NHSS.

As discussed in the previous chapter, in light of NHSS reforms (cf Scottish Executive, 1999a), the acquisition of skills or the further development of existing skills relevant to the job at hand is considered important for all employees. Strategic documents have looked at skillmix and reprofiling as a way of addressing these issues (cf Scottish Office, 1998a; Scottish Executive, 2001b). Skillmix considers grades and levels of staff working together in one area towards an organisational objective – in this case excellence in patient care in the NHSS. Reprofiling considers job roles. There are arguments to suggest that skillmix and reprofiling should be interpreted as deskilling (cf Thornley, 1996). When jobs are reprofiled this can mean that the job is compartmentalised which allows for fewer skill requirements by both the job itself and of the operator or employee assigned to do the job (cf NHS Scotland, 2004; Thornley, 1996; Bradley *et al*. 2000; McKenna and Hanson, 2002). Thornley (1996) has also argued that skillmix and reprofiling is another way to get lower paid staff to carry out more complex tasks which will save money for the organisation. In this research, deskilling is not an issue. Rather the issue is the grade mix and upskilling of the non-registered workforce to take on tasks previously performed by the registered workforce.

Grugulis (2002) argues that individuals can benefit from skill development because they gain knowledge that is 'intrinsically valuable as well as portable credentials to facilitate their progress in the labour market'. However she goes on to argue that that despite a consensus that *'skills are good things'* most jobs in Britain still demand few skills and that skills are influenced by the needs of the organisation more than the needs of the employee (Grugulis, 2003a:7-8). Therefore if the work is organised, reorganised or compartmentalised then it is arguable that this has an effect on what skills are utilised and encouraged within the employee or conversely left to wither (Grugulis, 2003a). Reorganisation of the workforce is a current major undertaking within the NHSS and may have some impact on skill acquisition or indeed non-utilisation of existing skills for non-registered employees.

Most commentators agree that skills in the workplace are acquired through many forms including either informal learning and/or formal training (cf Lovell, 1980; Crompton *et al.* 1997; Marsick and Watkins, 1999b; Coffield, 2000).

However, as discussed earlier, the literature reveals that there is not one agreed definition of what a skill is and subsequently the values placed on skill are diverse and reflected in the variance of rewards given to employees in different workplaces (cf Thornley, 1996; Keep, 2004). It is argued that skills are socially constructed and become recognised and valued only by the complex interplay between employer strategy and other stakeholders (Thornley, 1996; Abercrombie *et al.* 1984). Furthermore, as some writers point out, the boundaries between skilled and unskilled are becoming blurred as more organisations develop generic job descriptions (Munro and Rainbird, 2002). If skill is an ambiguous concept as argued by Abercrombie *et al.* (1984) then it is arguable that the acquisition of skills can only be relative to the area of work that an employee practices in. Thornley (1996) and McKenna and Hanson (2002) argue that where workplace learning focuses on the job at hand, it does not allow for diversification by the employee to allow for skill development. Where the notion of transferability of skills – that is the ability to apply a set of skills from one area of work to another (cf Thornley, 1996; Marsick and Watkins, 1999a) is said to be a desired outcome of learning, it could be argued that with the subdivision of jobs with specific job outlines, transferability is more likely to be only possible with basic generic attributes such as communication and team working. Other skills learned on-the-job are less likely to be completely transferable because they are job specific.

This has implications for assistant grade staff in the NHSS as occupational standards are not employed across the entire workforce and the ambiguity of skill would likely make only soft skills transferable across the workplace. As outlined in the previous chapter, the NHSS is aiming to form a flexible workforce with transferable skills and so it is of interest to discover whether the area of employment will have any impact on skill acquisition for this group of staff.

Interestingly, the provision of training for employees to assist in developing their skill level is not always considered as a positive (Gallie, 1996). Gallie argues that on the positive side workers can both personally develop and develop transferable skills but on the negative side, specific skill acquisition for a job may result in fewer opportunities for personal development. This can be through work intensification where becoming skilled in a particular area results

in more intense work focused in that field only (Gallie, 1996). Another negative is that skill acquisition can act as a demotivator where there is a perception that more responsibility is being given without any notable financial rewards (Gallie, 1996; Munro and Rainbird, 2002). Rainbird (2000) argues that where training and development of staff can be seen as a reward or recognition, equally it can be perceived as a threat or punishment, *'indicating poor performance or the forerunner of work intensification'* (Rainbird 2000:2). Assistant clinical staff in the NHSS are lower paid workers and it is important to discover perceptions around the acquisition of skills and whether this is considered by them as a positive or negative experience as this may have an impact on their uptake of any learning provision and their competence in a job role.

4.1.4 Competence

Competence is a concept that remains open to debate in the literature. Through their study of the literature around competencies and competence, Garavan and McGuire (2001) argue that there is a lack of a precise and widely accepted definition. Some commentators argue that the terms competence and competencies are given multiple meanings dependent on the context and perspective they are used in (Garavan and McGuire, 2001; Eraut, 2001; Berge *et al.* 2002). In the UK the approach to competencies is argued by some to relate to the attributes of job holders and also refers to standards for job functions and professions where the purpose is assessment and certification of employees through performance standards (Garavan and McGuire 2001). Berge *et al.* (2002) and Dalton (1997) argue that some definitions of a competency include personality traits such as motives, beliefs and values which imply a selection strategy rather than a training and development strategy. This has implications on the perception of non-registered employees in the NHSS towards attainment of competency. It will therefore be necessary to first clarify if there is a common understanding of the concept of competence with both the employer and the employees in this study.

Competencies are often considered as 'clusters' or 'bundles' within a competency framework that address skills, knowledge, attitudes and abilities that are demonstrated in a job context (Garavan and McGuire, 2001;

McLagan,1996; Berge *et al.* 2002). Berge *et al.* (2002) argue that these clusters or bundles of competencies can be measured and evaluated so that they can be improved through training and development of employees. Some commentators postulate that competency models promote a conformist culture and give recognition to insular learning activities with the focus on what has to be learned rather than the learning process (Eraut, 2001; Garavan and McGuire, 2001). Greenhaus and Callanan, (1994), (cited in Garavan and McGuire, 2001) argue that in order to be marketable and meet skills requirements of other employers, an employee needs to ensure that the bundle of competencies they acquire facilitates transferability. This raises questions around whether non-registered employees are able to negotiate competency bundles for their own personal development in the workplace.

McLagan (1996) had identified six approaches to defining workplace competencies and Berge *et al.* (2002) state that competency frameworks developed since 1996 have corresponded at least partially to, or with a combination of, McLagan's identified approaches. Garavan and McGuire (2001) tabled some definitions that were mapped under three approaches: worker-oriented (focusing on the *behavioural* characteristics of an individual related to their job performance), work-oriented (focusing on the *ability* to perform related tasks and activities) and multidimensional (focusing on the ability to *apply* knowledge, understanding, practical and thinking skills in a given context. How competency bundles are facilitated for non-registered clinical staff could have some influence on the competency approaches outlined above and are significant to this research.

The main criticisms of competency frameworks and the value of competencies in a workplace learning context are that they are a recipe for under-achievement and that competence is difficult to define, classify, measure and assess (Garavan and McGuire, 2001). Furthermore, they are considered problematic when linked to promotional opportunities and organisation career development pathways as often management maintains tight control and close prescription of required competencies for the fit between strategic objectives and competencies possessed by employees (Garavan and McGuire, 2001). Holms (1995), (cited in Garavan and McGuire, 2001) argues that competency

frameworks force people to reconfigure their experience to match specific demands of competency discourse and that that assessors lack autonomy because they need to make judgements within specifications. Personal performance requirements are difficult to define when an organisation is dynamic and Stewart (1996) argues that this is becoming true of more jobs and organisations. This has implications for the non-registered workforce in the NHSS who may consider competency to be more personally attributed rather than job related.

Some writers argue that within a competency framework, many organisations place great emphasis on recognised qualifications and other formal learning experiences such as courses and off-the-job training (Keep, 2004) and fail to formally recognise experiential learning on the job and any other informal training that exists (Keep, 2004; Eraut, 2001; Grugulis, 2002). Keep (2004) argues that it is within this informal training that competence can be demonstrated and assessed. However, whether it is competence in a task or the understanding and ability to relate knowledge to a job is not clearly articulated in the literature.

While organisations may develop and implement competencies to enable employees to respond to business needs more quickly and flexibly, Garavan and McGuire (2001) argue that the drive for mobility, flexibility and employability has resulted in employees expecting that their enhanced competencies are recognised through certification processes. They further argue that, as such, competencies should be embedded within the supporting HR systems and employees must understand how competency enhancement fits into their career development (Garavan and McGuire, 2001). On this latter point the authors say that this 'perhaps requires a shift in the way competencies are defined and places a greater focus on their context dependent nature' (Garavan and McGuire, 2001). In the NHSS the term 'competencies' generally refers to *performance* in single functions or contexts underpinned by the necessary knowledge and understanding required to perform to an appropriate standard. The definition of competencies and employees' understanding in relation to their personal development plans (PDP) and continuing personal development

(CPD) requires investigation in this study and are concepts that are now discussed.

4.1.5 Continuing personal development and personal development planning.

It is argued that as part of a lifelong learning strategy and employee development, continuing personal development has been embraced and promoted by many organisations as an effective tool to aid learning by employees (Jessup, 1991; Pearn, Roderick & Mulrooney, 1995; Holt *et al.* 2000; Walton, 1999). Some writers on the subject of CPD state that it is taken to mean learning activities which update existing skills and is identified on the basis of the needs of the individual within the context of the needs of the organisation (Department of Health, 1998b; NHS Education for Scotland, 2003b; csp.org.uk). The CPD model often follows assessment of needs, planning to meet the needs, implementation of training and development required and evaluation of the outcomes (Department of Health, 1998b). The Department of Health (1998b) stressed that CPD did not mean going on courses.

CPD needs are often decided at appraisal meetings between the employee and their line manager where training and development requirements are discussed to meet these needs and documented in a personal development plan. Clark (2004) states that organisation-wide staff appraisal, and the use of personal development plans, is acknowledged within the training and development literature as important practices to identify learning needs and facilitate learning. A PDP is a profile of the employee's competence and can include formally recorded qualifications and uncertified competencies acquired through experience at work. Some writers argue that PDPs are worthwhile as a record of achievement and evidence for promotion or a change of employment (Jessup, 1991; Walton, 1999; Holt *et al.* 2000). Clark (2004) states that within the UK healthcare system, informal learning such as that gained on the job and the importance of reflection on learning gained through practice is widely extolled within formal government policy and by the healthcare professions as a central facet of continuing professional development. Jessup (1991) argues that managers and supervisors will need to have the development of their staff

written into job descriptions to meet PDP goals.   The previous chapter outlined the plans of the NHSS for every employee to have a PDP.   It will be necessary to discover if this has happened and whether this has had any impact on the education, training and development opportunities for non-registered clinical staff.

Rainbird and Munro (2003) however, argue that training relevant to employers does not necessarily enrich the working lives of their employees and that there is a limitation to tools such as appraisal.   The authors argue that managers have an integral part in facilitating or blocking access to learning for employees and the adoption of tools such as appraisal, do not mean a guarantee that employees' needs will be met (Rainbird and Munro, 2003).   It is further argued that management objectives dictate the training strategies (Munro and Rainbird, 2004) and in general workbased training tends to be prescriptive (Rainbird and Munro, 2003).   This is significant in that it is arguable that the perception of personal development by employees will be heavily influenced by the approach taken by employers and managers and will have a huge impact on the uptake of development opportunities.

The implementation of PDPs and the CPD model as outlined above could have significant impact on the education, training and development opportunities for non-registered clinical staff in the NHSS and is of relevance to this study.   This also raises questions around how CPD is actioned in terms of learning opportunities, whether current job descriptions include staff development and whether workbased learning is a major part of PDP.

This section has shown that defining workplace learning is not without its difficulties.   There is no one definition that can be stated in a single sentence, rather workplace learning involves a mix of concepts related often by context and defined by providers and recipients of learning, often in a variety of ways. Where learning is said to result from education, training and development these are concepts that can be considered individually or collectively with further sub-concepts of formal and informal learning.   The purpose of learning in the workplace can be a job requirement and/or a personal achievement with or without the motivation of career advancement and can be linked to skill

acquisition. Skill acquisition is often measured by competence although competence is a concept that remains debateable as being difficult to define, classify, measure and assess. Competence often forms the basis of PDP to inform CPD which in turn determines learning needs. With so many variables involved in workplace learning it is necessary to investigate and attempt to define the workplace learning model adopted by the NHSS and non-registered employees within the NHSS.

4.2 The learning organisation

The site of learning is of interest in this study, particularly around the impact on opportunities and barriers to workplace learning for non-registered clinical staff. The NHSS, as described in the previous chapter, has iterated its commitment to becoming a 'learning organisation', striving to provide a better, patient-centred service through workplace learning for all staff (Scottish Executive, 1999a). This section considers the concepts of a learning organisation and the learning environment.

4.2.1 What is a learning organisation?

The term 'learning organisation' is now common in management practice (Stewart, 1996) and there are several definitions of what a learning organisation is (as will be discussed). However, Stewart (1996) states that while some definitions provide an indication of what a learning organisation *might* be in practice, the definitions are often generalised which would make the application of them alone, very difficult.

When demands from the organisational environment change, Sambrook and Stewart (2000) argue that continuous learning in the workplace is necessary to cope and as a consequence organisations are continually striving to create more opportunities for continuous employee learning. What is not clear is that although opportunities may be created, the equity of provision may not be taken into account and this could be an important aspect for many employees. Nor is the type of learning required to cope specified and as Stewart (1996) notes, in any change the 'human factor' is of paramount importance. In the NHSS it is

possible that the majority of change taking place is centred on the registered workforce and, at best, the assistant staff may be considered in a secondary way. Table 4.1 outlines some features of a learning organisation that are debated in the literature and discussed further in this section.

Features of a Learning Organisation	Authors
Employees encouraged to learn through improvement of job related skills, abilities and competence	Senge, 1990 Dodgson, 1993 Nutley and Davies, 2001
Collaborative working to bridge between organisational and individual needs encouraged	Senge, 1990 Dodgson, 1993 Nutley and Davies, 2001
Learning is facilitated *by* the organisation *for* its employees and the organisation continuously transforms itself.	Pedler *et al.,* 1996 Watkins and Marsick, 1993
Processes of learning are double loop and meta- learning models.(adapted from Argyris and Schon, 1978)	Nutley and Davies, 2001 Stewart, 1996 Davies and Nutley, 2000
Encouraging and supporting mutual learning with processes to facilitate dissemination and sharing of learning	Stewart, 1996 Senge, 1990 Pedler *et al.,* 1996 Pearn *et al.,* 1995
Learning and development is placed as a core characteristic of the organisation	Davies and Nutley, 2000 Marsick and Watkins, 1999
Structures and human resources developed to be flexible, adaptable and responsive.	Davies and Nutley, 2000
Cultivate open systems thinking to cross over and interconnect departmental boundaries	Senge, 1990 Stewart ,1996
Update mental models challenging deeply held assumptions and generalisations	Senge, 1990
Cultivate a cohesive vision with clear strategic direction	Senge, 1990
Policy to specify general purpose and plan of organisation	Pedler *et al.,* 1996
Leaders are responsible for learning and specific leadership qualities are nurtured and developed	Senge, 1990
A culture and management style which supports experimentation, risk taking and involvement and independence on the part of employees at all levels.	Senge, 1990 Stewart, 1996

Table 4.1 Some features of a learning organisation. Adapted from various authors

Literature in support of the 'learning organisation' describe it as a place where employees are encouraged to learn through improving job related skills, abilities and competence and thereby learn to function more effectively in the workplace (Senge, 1990b; Dodgson, 1993; Nutley and Davies, 2001, Dierkes *et al.* 2001). In this type of organisation collaborative working is encouraged to bridge between individual and organisational needs. This in turn is said to result in optimum work output (Senge, 1990b; Dodgson, 1993; Nutley and Davies, 2001, Dierkes *et al.* 2001). In this definition of a learning organisation the implication is that the needs of the organisation will match the needs of the individual and vice versa.

Most authors on the subject do share common beliefs of what a learning organisation should and should not be (cf Marsick and Watkins, 1999a; Dodgson, 1993; Longworth, 1999; Spencer, 2002).   Some argue that learning organisations are developed through matching the skills already existing in employees with the collective organisational knowledge and routines (Dodgson, 1993; Nutley and Davies, 2001).   Dodgson further argues that in a learning organisation there is a win/win ethos where the employee develops as the organisation grows as a result of the collective learning of employees.   In this way everyone benefits.   He sees the learning organisation as giving the employee empowerment, autonomy, satisfaction and fulfilment.

The supporting literature on learning organisations argues that learning is *by* the organisation *for* its employees (Pedler *et al.* 1996; Watkins and Marsick, 1993). Pedler *et al.* (1996) argue that this means a top down directive from management to employees where Watkins and Marsick (1993) argue that it is more a bottom-up or democratic approach to learning.   Critics say that learning organisations are just as likely to develop into places of managerial control Forrester (1999) (cited in Spencer, 2002), where in reality policy makers can decide on what training they believe is necessary based on the demands of the employers rather than the wishes of the employees (Grugulis, 2003b).

Furthermore, some commentators argue that becoming a learning organisation is a complex procedure, not least because an agreed definition of exactly what it is does not exist (cf Marsick and Watkins, 1999b; Dodgson, 1993; Longworth, 1999; Spencer, 2002).   Spencer (2002) argues that the ideology of the learning organisation is one where everyone shares exactly the same goals. Spencer (2002) insists that there must be an acknowledgement that not all organisations are 'unitary' but rather they are often 'pluralist'.   By this he means that management and employees have differing interests, some of which coincide but some of which conflict.   An idea supported by Reid and Barrington (1999) who argue that this is particularly true if the general perception is one of employee skills being channelled towards organisational needs and so personal employee needs being compromised for the organisation's benefit.   This has implications around lines of communication, particularly in regard to lower paid employees in the NHSS.   In a flatter management structure, collaborative

working would be more easily facilitated whereas in a hierarchical structure, such as the NHSS where there are one way paths of communication, it may be that different agendas will exist between the organisation and the employees without the benefit of negotiation.

The advocates of a learning organisation appear to assume that all organisations are similar but as Spencer (2002) argues the concept does not take into account public service organisations like the NHS. Furthermore a learning organisation is often said to be one that invests in training its managers and focusing on their personal development which in turn assists the organisation to meet its strategic needs (Senge, 1990a; Beard, 1993). In this definition it is assumed that the outcomes of managers' development will cascade down to the other employees but this is an area that has little discussion in the literature and in a hierarchical structure such as the NHSS may be less likely to occur. While it is possible that a change in behaviour by managers from their learning will have an affect on employees, specific learning outcomes by managers may not necessarily be articulated to junior staff and therefore will have little impact.

Nutley and Davies (2001) argue that in order to truly become a learning organisation, organisations must change their processes of learning. Some authors discuss Argyris and Schon's (1978) single loop, double loop and meta learning model as the preferred process (Stewart, 1996; Nutley and Davies, 2001). Single loop learning (also known as adaptive learning) involves generating a negative feedback route so that organisations can maintain a pre-set pathway. Clinical audit could be considered a single loop learning route where poor practice is flagged up and measures taken to correct it. Double loop learning (generative learning) redefines organisational goals through feedback and meta learning is 'learning about learning'. In meta learning, an organisation is able to identify when and how they learn and when and how they do not and then adapt accordingly (Nutley and Davies 2001).

Some definitions of a learning organisation concentrate on the idea of continual learning and change. As Garavan (1997) notes this indicates that the organisation is in a constant state of flux. In general the definitions of a

learning organisation are rather prescriptive in that they state what a learning organisation ought to be and ignore the realities of organisational structures. A more useful way to view learning within organisations would be to consider the organisational values and processes which adopt a learning based approach as at this stage the learning organisation is more of an ideal than a reality (Garavan, 1997). As Dale (1994) states, there is no diagram of a learning organisation and therefore no model to replicate this concept. It is possible that a more informative way of looking at learning within organisations, and in particular the NHSS, is to consider the environment that learning takes place in rather than the organisation as a learning entity.

4.2.2 The learning environment

Workplace learning can be highly contextualized and significantly influenced by the setting in which it occurs (Rainbird, Fuller and Munro, 2004; Eraut, 2004). It is also arguable that along with both negative and positive effects, the learning environment can motivate or demotivate individuals to take up any learning opportunities available. This section considers the learning environment and in particular the notion of expansive and restrictive environments having an influence over workplace learning.

Rainbird (1998) discusses the concept of intrinsic and extrinsic factors related to employees' motivation for workplace learning and influencing learning within an organisation. In her model Rainbird describes *intrinsic* factors as being relative to the individual such as skills and educational qualifications which may encourage them to be proactive in their quest to learn, to access learning opportunities and to build on their existing attainments. On the flip side, employees may be reluctant to seek learning opportunities for a variety of reasons including fear of failure, lack of confidence or unwillingness to take responsibility. This point is supported by Marsick and Watkins (1999b) who argue that organisations send out mixed messages saying on the one hand it is okay to experiment but on the other hand it is definitely not okay to fail. In this case employees may avoid opportunities to learn or train through a fear of failure and destruction of their self esteem (Lovell, 1980; Marsick and Watkins, 1999b). Furthermore it is suggested that often lower paid workers are those who perceive certain forms of workplace learning as an indication of failure on

their part or as a punishment for imperfect work (Rainbird, Fuller and Munro, 2004). Rainbird (1998) views *extrinsic* factors as the employee's structural position in the organisation and requirements of the job that they hold which could be both positive and negative in terms of employee perception.

Rainbird's model is a parallel to Pearn, Roderick and Mulrooney's (1995) enhancers and inhibitors model. According to Pearn *et al.* (1995) organisational enhancers include cross-functional teams, quality reflection time, open learning, learning laboratories, action learning and managers as facilitators. Personal enhancers mirror Rainbird's intrinsic factors. Organisational inhibitors include too many management levels; workers confined to narrowly defined tasks; too hierarchical; centralised decision-making; preoccupation with getting it done; only doing what is permitted. Personal inhibitors mirror Rainbird's negative intrinsic factors.

Using Rainbird and Pearn *et al's* comments in relation to the NHSS, the influence of extrinsic factors and organisational enhancers and inhibitors is of relevance to questions around the provision of an enhancing learning environment by this organisation. Employee motivation towards learning in the workplace through personal enhancers and intrinsic factors is also of relevance. Rainbird (1998) argues that it is important to recognise that in the workplace, the possession of qualifications may serve as a recruitment mechanism rather than as an indicator of the potential of employees. The question in relation to the NHSS is whether management decisions to offer learning opportunities are driven by extrinsic factors such as specific employee roles and requirements for strategic goals to meet the needs of the organisation. If extrinsic factors are the drivers, the types of learning opportunities are likely to be tailored to meet these needs. This may dictate which employees are given access to learning opportunities, regardless of individual employee's intrinsic factors.

If the learning environment influences access to learning, it is worth also considering Fuller and Unwin's (2004) discussion around expansive and restrictive learning environments. The authors argue that overall an expansive environment fosters learning at work and the integration of personal and organisational development (Fuller and Unwin, 2004). Fuller and Unwin

postulate that workplace learning is shaped by the organisation rather than existing as a separate activity and that, through an understanding of this, training sessions for specific purposes and everyday workplace learning is better accommodated. Reid & Barrington (1999) define a learning environment as being part of an organisation where employees are privy to a continuous learning experience from the reactions of others within the organisation and from day to day experiences and that a thriving organisation is, by its very nature, a learning environment. However this definition does not consider the underlying culture of the organisation in the way that Fuller and Unwin's (2004) expansive/restrictive theorising does.

As outlined in table 4.2 on the following page, an *expansive* learning environment allows employees to access learning with planned time off the job for knowledge based courses and reflection. It allows for career progression for employees and supports the employees as learners. Managers act as facilitators to workforce and individual development and employee development is aligned to the goals of both the individual and the organisation (Fuller and Unwin, 2004). A *restrictive* learning environment allows for learning only particular to the tasks and knowledge required for the job. Virtually all training is on-the-job and there are limited opportunities for reflection. Career progression is limited and little support is evident for learners. Only key workers or groups are given access to development opportunities and managers control other workers development (Fuller and Unwin, 2004). This model further supports Pearn *et al.*'s notion of organisational enhancers and inhibitors. Fuller and Unwin agree however, that there is a distinction between the extent that individuals decide for themselves to engage in learning opportunities and also the extent to which the organisation gives access to diverse forms of participation (Fuller and Unwin, 2004). This supports Rainbird's notion around intrinsic and extrinsic factors and their influence on workplace learning. Nutley and Davies (2001) argue that a lack of access to formal training and development can demotivate staff regardless of whether the organisation's ethos is one of learning.

Expansive learning environment	Restrictive learning environment
Breadth: access to learning fostered by cross-organisational experiences	Narrow: access to learning restricted in terms of tasks/knowledge/location
Access to range of qualifications including knowledge-based VQ	Little or no access to qualifications
Planned time off-the-job including for knowledge based courses and for reflection	Virtually all on–the-job: limited opportunities for reflection
Vision of workplace learning: progression for career	Vision of workplace learning: static for job
Organisational recognition of, and support for, employees as learners	Lack of organisational recognition of, and support for, employees as learners
Workforce development is used as a vehicle for aligning the goals of developing the individual and organisational capacity	Workforce development is used to tailor individual capability to organisational need
Widely distributed skills	Polarised distribution of skills
Knowledge and skills of whole workforce developed and valued	Knowledge and skills of key workers/groups developed and valued
Managers as facilitators of workforce and individual development	Managers as controllers of workforce and individual development
Chances to learn new skills / jobs	Barriers to learning new skills/jobs

Table 4.2 Expansive – Restrictive Continuum: Adapted from Fuller & Unwin (2004)

Fuller and Unwin's continuum categorises approaches to workforce development according to their expansive and restrictive features and the list is not exhaustive. In devising this framework, their purpose was to identify features of the environment or work situation influencing the extent to which the workplace creates opportunities or barriers for and to learning (Fuller and Unwin, 2004). Fuller and Unwin (2003) developed their expansive/restrictive continuum for analysing workplace learning through their study on situated learning. Their research took place in the UK's Modern Apprenticeship programme and their aim was to further develop Lave and Wenger's framework for communities of practice (Lave and Wenger, 1991). This was advanced through the identification of features of expansive and restrictive participation and the learning opportunities experienced by the apprentices under study.

Their research sample was small in number – eight apprentices in total were studied from three companies of varying size, all associated with the steel industry in England. The rigour in their research came from the methods used. Fuller and Unwin (2003) applied a case study approach with mixed methods of interviews, observations and weekly learning logs to investigate opportunities and barriers to learning in the three contrasting organisational and cultural contexts.

In their analysis, Fuller and Unwin (2003) categorised the evidence in three broad overlapping themes that captured the range of expansive and restrictive features. They were able to conclude that reforms of the modern apprenticeship programme should be built on the theory of situated learning and consideration of the features of expansive/restrictive learning environments.

Subsequently, Fuller and Unwin (2004) argue that by identifying a restrictive approach, it cannot be assumed that organisations will immediately reform along expansive lines because there may be many reasons why they cannot or will not do so. The authors also argue that creating more expansive learning environments will not automatically produce new forms of work activity but evidence from their empirical research suggests that an expansive approach is likely to increase the quantity and range of opportunities for participation and therefore employee learning and to promote synergies between personal and organisational development.

Studies concerned with lower paid employees' perceptions around opportunities and barriers to workplace learning and personal motivations to take up any learning opportunities have not had a great deal of attention afforded to them. While there is some literature investigating lower paid employees' perceptions around this subject (cf Rainbird, Munro, Holly and Leisten, 1999; Fearfull, 1997; Kessler and Heron, 2004), much of the other literature examples are focused on management rather than lower paid workers. There are other factors that need to be considered when debating the influence of a learning environment on workplace learning including variables such as peer support, access, place of work and organisational needs. Several authors have argued that the concept of an expansive learning environment needs to be in evidence for effective workplace learning to happen (cf Marsick and Watkins, 1990; Senge, 1990a; Pedler *et al.* 1996; Longworth, 1999; Coffield, 2000; Lave and Wenger, 1991; Fuller and Unwin, 2004).

Using Pearn *et al's* enhancers and inhibitors model (1995), Rainbird's intrinsic and extrinsic factors model (1998) and Fuller and Unwin's expansive/restrictive continuum (2004), the NHSS can be investigated to establish whether it has an expansive learning environment based on the variables mentioned above.

Employee motivation for workplace learning can also be investigated using these models. The expansive/restrictive continuum will also allow for investigation into whether localised environments within the NHSS organisation, such as clinical wards or areas, have conflicting learning environments which in turn could have impact on learning opportunities.

This section has outlined what could be expected of the NHSS if it is to be considered a learning organisation. The environment can motivate or demotivate staff and can have a negative or positive effect on the uptake of learning opportunities. Extrinsic factors and organisational inhibitors can dictate where opportunities for learning and development are offered and this is of particular importance in this research where lower paid assistant staff are the focus of study.

4.3 National/Scottish Vocational Qualifications

Specific learning initiatives can be adopted for workplace learning and the NHSS has gone down the route of Scottish Vocational Qualifications as a recognised learning initiative for some of its non-registered clinical staff. Other NHSS initiatives include continuing professional development aligned with the knowledge and skills framework (KSF) which is in the process of being introduced. Debates surrounding N/SVQs (cf Jessup 1991; Gallie and White 1993; Keep and Rainbird 1995; Pearn, Roderick and Mulrooney 1995; Eraut, 1998 and 2001; Nutley and Davies 2001; Grugulis 2002; Keep 2004; Keeney *et al.* 2004) are explored below. In particular, the use of National/Scottish vocational qualifications (N/SVQs) as a national framework for competency is discussed.

4.3.1 N/SVQ as a learning initiative
The main debates around National/Scottish Vocational Qualifications are centred on whether undertaking an N/SVQ results in the acquisition of new knowledge (cf Jessup, 1991; Unwin *et al.* 2004) or whether an N/SVQ results in validation of existing skills and knowledge (cf Keep and Rainbird 1995; Pearn,

Roderick and Mulrooney, 1995; Eraut, 1998; Nutley and Davies, 2001; Grugulis, 2003b; Keep, 2004).

Vocational education and training has been offered in a variety of forms over the last twenty years for managing work organisation and great emphasis has been placed on qualifications and other formalised learning experiences which have been primarily courses and off-the-job training (Keep, 2004; Eraut, 2001; Grugulis, 2002).   The emphasis has now shifted from manual skills being the important factor in employability to 'softer' skills which include personal attributes and social skills (Keep, 2004; Keeney *et al.* 2004).   It is argued that social skills are fast becoming a prerequisite for many jobs and form a mandatory core of units for any vocational qualification (www.sqa.org.uk, 2006; Gallie and White, 1993; National Skills Task Force, 2000; Keep, 2004). These 'skills' such as effective communication and team working are argued to be amongst the most desired by any employer of a potential employee (Keep, 2004; Keeney *et al.* 2004).   However, there is no evidence to suggest that 'soft skills' can be quantified and it is arguable whether they are actual skills *per se* or simply compliance.

The N/SVQ system was established in 1986 in response to the apparent limitations of the existing system of vocational training.   An employer led National Council for Vocational Qualifications (NCVQ) was set up to tackle associated problems such as limited access to training, accreditation of prior learning and too much testing knowledge rather than skills and competences. As N/SVQs were to be national qualifications, competence specification was decided by a committee who developed the national occupational standards (Eraut 2001).

While the literature reveals obvious arguments around the value of N/SVQs, most contributors to the debate have voiced some reservations, regardless of whether they consider N/SVQs to be a worthwhile undertaking or not. Supporting arguments include that N/SVQs encourage investment in training and provide *'glue to bind devolved training systems'* (Keep and Rainbird, 1995:522).   National standards underpinning the VQs means increased coherence and by focusing on outcomes rather than learning processes the

possibility of workers obtaining recognition of their skills acquired through experience in employment has been raised (Keep and Rainbird, 1995).

Jessup (1991) believes that N/SVQs are efficient and substantial, enabling new knowledge and offering a non-prescriptive way of learning. VQs are said to be 'efficient and motivating' (Jessup, 1991) and Unwin *et al.* (2004) argue that vocational qualifications can certify a person's competence, can provide entry to professions and progression to further and higher education and are of benefit to an individual's self confidence. Unwin *et al.* further argue that N/SVQs promote flexibility, transparency and credit accumulation and therefore match features of the new global economy. Some studies have shown that in some cases those undertaking a VQ have reported the effect of perceived empowerment, work enhancement, increased levels of motivation and more understanding and knowledge (cf Fearfull, 1997) where other studies have shown that employee attitudes to training and development, including undertaking VQs need to be interpreted in the context of changes taking place in the workplace (Rainbird and Munro, 2003).

Fearfull (1997) conducted a case study in a community based residential healthcare home where NVQs were being introduced with the aim of enhancing employee performance and contribution to the quality of care. Fearfull's research question addressed this aim. Fearfull (1997) used a convenience sample and participants were those workers on duty during the period of study. Her sample was a total of 56 contacts including 20 professional members of staff and 36 non-professional and the contact time varied from 30 minutes to full day shifts (Fearfull, 1997).

Fearfull (1997) adopted an underlying philosophy of phenomenology and used mixed methods for data collection including semi-structured interviews, work shadowing, participation, observation and casual chats giving methodological rigour through multiple sources of evidence.

In her conclusions Fearfull (1997) reported perceived benefit by those undertaking an NVQ demonstrated by increased confidence, motivation, knowledge and understanding and a more professional attitude. Fearfull

(1997) acknowledged difficulty in extrapolating on the evidence of one case study but reported confidence in suggesting that the NVQ framework can have positive impact dependent on its implementation in the workplace.

Rainbird and Munro (2003) conducted a large scale research project in the public sector, using a case study approach in three local authorities and three NHS hospital trusts. Methodological rigour was achieved using mixed methods including a pilot survey of employees' learning experiences in one local authority and one trust and over 330 interviews (mostly one-to-one and some group interviews) with participants from various workgroups within the organisations.   Their findings indicated that management and structures influenced employee attitudes to training opportunities.

The key elements from the above contribution to the debate are the notions around recognition of previous experience in the workplace, the flexibility and transferability of knowledge and career progression.   These are issues that, in the current reorganisation of the NHSS workforce, could have huge implications for the assistant staff and are further investigated in this study.

4.3.2 Content of Vocational Qualifications

N/SVQs offer core skills such as communication, numeracy and problem solving and it is argued that the essential feature of core skills is that they are common to many activities and can therefore be generalised or transferred to other areas and contexts which employ the same skill (Jessup 1991; Grugulis 2002; Keeney *et al.* 2004; Keep 2004).   Jessup (1991) believes that N/SVQs have the potential of creating a common framework of core skills (particularly the 'soft skills' as highlighted above). However the N/SVQ model, being employer led, does not prescribe the form of learning to take place (Jessup 1991) which on one level would hinder the creation of a common framework. N/SVQs focus on outcomes of learning by concentrating on specific objectives and targets (Jessup 1991). Through this type of learning, some authors argue that competencies can be updated easily in the workplace without returning to external training (Jessup, 1991; Fearfull, 1997).

The other side of the debate however, argues that N/SVQs simply validate already held knowledge and add nothing new (Eraut, 2001; Munro and Rainbird, 2002; Grugulis, 2003b). VQs are said to be achievable by trivial tasks rather than knowledge and skills activities (Munro and Rainbird, 2002; Grugulis, 2002). Young (2004) argues that occupational standards in relation to N/SVQs are variable across organisations which would have some impact on the transferability of the qualification. Other criticisms of VQs include that they are narrowly defined competencies, are task specific and require a minimum level of skills to perform a job rather than broader based learning in transferable skills (Keep and Rainbird, 1995). The current UK approach is argued to be closer to a narrowly defined skill certificate for a specific job rather than transferable career training (Keep and Rainbird, 1995). Eraut (2001) has further argued that the VQ experience has shown that national specifications do not match the diversity of workplace learning needs and a more flexible approach is required.

N/SVQs are employer led – that is the content is developed in partnership with the providing bodies, employers and trade unions – and Young (2004) believes that this is the correct method as the skills and knowledge needed by employees at work should dictate any off-the-job provision of learning provided by colleges, where some VQ provision is based. However, while VQs accredit workbased learning, the actual knowledge required is only to underpin the performance of the skills and tasks being carried out effectively in the workplace (Young, 2004). Furthermore there is a huge diversity between sectors on what underpinning knowledge is required to attain an N/SVQ and at what depth (Young, 2004). VQs simply describe behaviour that is required by competent workers but do not explore the academic content or practical content of each skill or task or behaviour. Keep and Rainbird (1995) argue that N/SVQs are grounded on specific learning outcomes rather than learning processes which would indicate a lack of underpinning knowledge associated with them. This raises important issues around the content of the SVQ for assistant staff in the NHSS as if the content is already decided it is probable that it is more for the benefit of the organisation as a whole rather than the employee and their individual workplace. It raises questions around whether assistant staff perceive they have acquired new knowledge that underpins their skill level at work or whether the VQ simply validates their existing knowledge and skills.

Some authors comment that obtaining a vocational qualification is seen as a springboard to accessing higher education rather than a strand of higher education itself (Fearfull, 1997; Keep, 2004). However there is an argument that suggests VQs do not aid upward progression within the labour market for people on the lower end of the scale but act as evidence of existing skills that only allow sideways movement in an organisation (Rainbird, 1998; Munro and Rainbird, 2002). Keep (2004) further argues that this lends to the explanation of why there is little or no monetary reward gained by achieving a Vocational Qualification at levels one to three and that many organisations fail to formally recognise experiential learning on the job and any other informal training that exists (Keep, 2004; Eraut, 2001; Grugulis, 2002). It is necessary to discover assistant staff's reasons for undertaking an SVQ and their perceptions around rewards and recognition of prior learning – a concept which is discussed shortly.

4.3.3 N/SVQs and competence standards

The term 'competence' was selected in relation to N/SVQs because it declared the purpose of accrediting effective performance at work (Eraut 2001). The occupational standards had to be a comprehensive description of occupational performance rather than just a benchmark to allow them to be valid in any workplace (Eraut 2001). Eraut argued this was also to allow for assessment of which there were no explicit training requirements. This meant that the standards were homogenous to allow them to be valid but Eraut (2001) states that there are few occupations where such homogeneity can be found and so a national set of standards cannot meet the diversity of working practices found in the workplace. The solution was to break down the VQs into functions which described what *had* to be done but not *how* to do it. This was to allow formal comparisons for equivalent jobs in different contexts but this could still not guarantee transferability between jobs (Eraut 2001; Grugulis 2003).

Eraut (2001) believes that qualifications should be judged by their fitness for purpose, not on some notion of standards which cannot be applied in all workplace settings. In the case of VQs, it is argued that fitness for purpose includes the ability to perform aspects of the required role and possess the underpinning knowledge to support it (Warr, 1998). However, this simply underlines the arguments around whether obtaining a VQ is actual learning. If

the underpinning knowledge aspects are not tested then there can be no guarantee that the person is not just performing a learned *task* rather than a *skill* and this is something that requires investigation.

It is further argued that not all workplace learning needs to be incorporated into qualifications, particularly since VQs do not guarantee transferability throughout the labour market (Eraut, 2001; Grugulis, 2003b). While N/SVQs are considered to be accreditation for workbased learning (Grugulis, 2002; Young, 2004), as discussed, the criterion is based on national occupational standards and Young (2004) argues that herein lies a fundamental problem. He states that knowledge is of secondary importance to the actual skills being carried out effectively and there is a huge variance between sectors as to what constitutes acceptable occupational standards (Young 2004). Furthermore, if someone is assessed as performing competently it is assumed that they must have the adequate underpinning knowledge which is not necessarily the case particularly since VQ outcomes were identified as to what employees would be expected to *do* and not what they needed to *know* (Young, 2004). A national specification cannot reflect the diversity of learning needs in the workplace, particularly in the NHSS where even localities within a Health Board are diverse, and a more flexible approach is needed (Eraut, 2001). It will be necessary to discover if this applies to the Health Board under study where the diverse nature of employment practice is huge and whether assistant staff perceive the national specification to be relevant or not.

In previous studies conducted in the NHS, some workers felt they already possessed the 'skills' required by an N/SVQ and felt annoyed or patronised by the tasks they had to complete to gain their qualification and believed that they had gained nothing towards skills and knowledge (Munro and Rainbird, 2002; Grugulis, 2002). This goes some way to support the arguments that VQs look at behaviour and not underlying skills and knowledge required for the job, are simply certification rather than a qualification and cannot be said to have succeeded in raising the skills levels of people at work (Grugulis, 2002)

Grugulis (2002) argues VQs have effectively put a ceiling on progress rather than acting as a springboard to further attainment by missing the opportunity to

increase the skills of those most disadvantaged in the labour market (2002). In light of this it is necessary to discover if assistant staff undertaking an SVQ perceive it to be a gateway to career progression in the NHSS or not. Eraut (2001) argues that VQs are a fragmented process of learning that leads to a fragmented assessment process and there are too many awarding bodies in any one sector which devalues the national competence standard. Eraut (2001) believes that VQs are frustrating and non-developmental for candidates and that they lack workplace validity compared to the older models of vocational qualifications that offered academic syllabus, academic testing, technical syllabus, technical testing and practical syllabus as well as practical testing and social skills. It could be argued that the current vocational qualifications offer only the latter two (Grugulis, 2003b). This could have significant influence on career progression and transferability of the outcomes of qualifications such as the SVQ for assistant staff as any underpinning knowledge for transferability may not be evident and therefore context specific only.

Since N/SVQs describe the level of competence needed in the workplace, this assumes that skill and competence level is at its premium (Grugulis, 2002). It is arguable then that, where there are no prescriptive guidelines, any existing problems with skill and competence level will continue undetected and will be imitated by learners. VQs detail competences and standards in the form of behaviours which can be observed in the workplace. Grugulis (2002) argues that the NCVQ hoped to ensure that workers who were already skilled through experience on the job could gain the qualifications readily. She further argues that from the point of view of extending individual's skills levels there is little evidence to suggest that this happens. Furthermore N/SVQs describe the actions which should be performed in any given occupation but Grugulis (2002) argues that jobs are designed in a different way from company to company and person to person which means that, although it could be deemed useful to consider the function of work, specific competences cannot be mirrored.

Eraut *et al.* (1998b) (discussed in Eraut, 2001) conducted research into the mid-career learning of nurses, engineers and business people undertaking vocational based qualifications and found they were more successful in making the link between theory and practice. This was because they were able to

reflect on their previous practical experience and could make sense of new learning by associating it with past experience. Eraut argues that this raises questions about the timing of qualifications based learning and suggests that relevant practical experience should be acquired prior to this. This is not without its problems however. People learn at different rates and in different ways and it may be difficult to judge when the required amount of practical experience is attained. This is particularly relevant in the NHSS where some people have come back to learning after a period of years. While they may be able to reflect on their previous practical experience it could have instilled habits and practices that they may resist reconsidering regardless of any new theoretical underpinning knowledge.

This raises issues around the timing of undertaking an SVQ for assistant staff in the NHSS. Many will have been in post for several years while others will be relatively new to the job and it is necessary for the purpose of this study to discover their perceptions of the content of the SVQ and what difference it may have made to their job. Undertaking an SVQ requires input from an assessor and this is an area we look to now.

4.3.4 Assessors and the assessment process

Literature on the assessment of vocational qualifications mainly focuses on the processes and there is little debate around the actual robustness of the assessments themselves. Discussion of the processes is largely of the opinion that consistency and objectivity in assessment are in question. Grugulis (2003b:465) argues that as the VQs set out exemplars to aid in assessment, listing behaviours in this way provides '*a multiplicity of criteria for assessors to gauge competence against*'. Safeguards for objectivity and reliability require to be adequate (Prais, 1995) otherwise assessment could become a subjective process on behalf of the assessor, particularly when assessment is measuring the outcomes of actions and behaviours (McMullan *et al.* 2003). Grugulis (2002) further argues that the lack of consistency in the assessment procedure makes the N/SVQ an expensive and pointless qualification.

Workplace learning includes incidental learning, a concept discussed earlier, which can often be facilitated by workers' peers and involves acquiring

knowledge and skills by observing and following example (Munro *et al.* 2000). Since VQs are assessed on workplace performance, this could have implications for assistant staff in the NHSS as some commentators argue that in this situation the facilitator's own work ethic will influence learning for the learner and this could be both positive and negative (Newell, 1992; Grugulis, 2003a). This is a valid point as learning in this way could exacerbate poor practice by example if no formal recognised standards were agreed or adhered to which in turn could effect the outcome of assessment of the SVQ.

To ensure standardised underpinning theory to support workplace learning based on national occupational standards, a robust system of assessment would be a fundamental requirement.   This supports the arguments of Keep, (2004) and Keeney *et al.,* (2004) who say that there is a definite need for a standardised national assessment tool.   However, as there are no explicit or prescriptive *training* requirements for an SVQ, the process of assessment could be problematic as there is a risk of false positive decisions (Eraut, 2001). Further there is the risk that trainers or assessors in an organisation will base their assessment on their own needs rather than the reality of the business (Pearn *et al.* 1995).   What constitutes acceptable occupational standards is not consistent across the sectors (Young, 2004) particularly as assessment is dependent on the specific work area.

McMullan *et al.* (2003) argued that the purpose of assessment was to contribute to the maintenance of standards and facilitate judgements about qualities, abilities and knowledge against predetermined criteria. The assessments of VQs are on reflective accounts of learning at work based on a multitude of scenarios to cover a unit within the qualification. The NHSS strategic documents discussed in the previous chapter emphasised the need for reflection in learning.   However, McMullan *et al.* (2003) stated that the purpose of assessment raised questions about the methods used and the role of the assessor as competence cannot be observed directly and can only be inferred from performance.   While attempts can be made to make the exercise of assessment as objective as possible, no assessment schedule can ever be 'assessor proof' as each assessor has their own interpretation of competence (McMullan *et al.* 2003).   Eraut (2001:97) comments that the perfect

assessment is unattainable as performance is often context specific. Therefore seeking the perfect assessment leads to '*endless assessment as people try to cover every activity as well as several contextual variations*'. This supports arguments that much of the assessment time for VQs is taken up with assessors instructing their students how to complete their portfolio of evidence (Grugulis, 2002).

Some authors believe that observation of performance alone will not be sufficient to infer competent performance and a breadth of evidence relating to a variety of situations is needed to take into account more than one perspective (Gonzi, 1994 cited in McMullan *et al.* 2003; Eraut, 2004). This supports the findings from McKenna *et al.'s* study (2003) on training requirements for midwifery assistants. Their study showed that registered staff expected and accepted without question, their role in supervising and teaching assistants. However, significantly, the respondents felt ill-prepared for their role as assessor and felt that training and assessment of assistant staff should be an ongoing process and not one confined to the achievement of a qualification (McKenna *et al.* 2003)*.*

The Scottish Qualifications Authority (SQA), state that assessors need to be occupationally competent and be working towards their SVQ assessor's award (www.sqa.org.uk). Assessors are required to produce evidence of their assessment methods which is reviewed and validated by a recognised qualification training centre (www.sqa.org.uk). The SQA has quality assurance measures in place in the form of internal verifiers (in the workplace) and external verifiers (from the SQA) to ensure compliance to standards for assessment. However, in reality only a random selection of samples can be chosen to quality assure at any one time and it is necessary to discover whether all assessors of assistants in the NHSS undertaking an SVQ possess, or are working towards, an assessor's qualification to gauge whether assessment standards are on an equal footing across the organisation.

There are arguments to suggest that tacit theoretical knowledge in the workplace should be an important facet of vocational assessment but support for this type of learning is actually minimal and there is little time set aside for it

(Eraut, 2004).   This is an important point and relates closely again to occupational standards and standards of assessment in the workplace, particularly in the NHSS.   Where training and skill acquisition does take place, the practice and assessment of competency is often overseen on the shop floor. Investigation is needed into whether understanding of underpinning theoretical knowledge is clarified at the point of practice and competency assessment as this could have implications on the transferability of knowledge and skills by assistant staff.

This section has raised several questions for this study.   Whether assistants undertaking an SVQ have a qualified assessor, what the assessor's input is, whether assessment is perceived as equal across the professions and what methods are used including assessment of underpinning knowledge to observed behaviours?

One further concept is now discussed briefly in relation to workplace learning and assessment of vocational qualifications. This is the notion of recognition of prior informal learning (RPL).

4.3.5 Recognition of prior learning

The measurement of experience was introduced in the UK in the 1970s, originally capturing the skills of coal miners who had been made redundant (Adams, 2001). Their accumulated skills in using various pieces of engineering equipment were assessed and given credit which counted towards a formal qualification. This enabled those who wanted to progress to go on to add further qualifications which could lead them into new careers and professions. This proved to be a cost effective route to formal qualifications for some (Adams, 2001).

From this Accreditation of Prior Experiential Learning (APEL) evolved. APEL is a system that allows for skills and knowledge acquired through life experiences, uncertified study, workplace training, CPD and independent learning to be given academic credit (Howard, 1993; Whittaker and Mills, 2005).   The main emphasis of APEL is that learning resulting from experience and uncertified knowledge can be demonstrated (Howard, 1993).   The process requires a

learner to reflect on experiences and provide evidence of learning. Adams (2001) argues that the majority of UK universities and colleges have an APEL policy in place but there are few students actually gaining credit.

APEL assessment methods generally include production of a portfolio of reflective accounts of experience, an interview, witness testimonials and on occasion an exam or test (Hamill and Sutherland, 1994b; Adams, 2001; Lester, 2007). Organisations are able to assess the abilities of their employees and successful assessment of APEL can reduce time required to obtain qualifications (Adams, 2001). APEL is said to motivate existing employees (Adams, 2001) and the processes associated with documenting and assessing APEL are said to be recognised as having a wider potential, particularly in CPD (Hamill and Sutherland, 1994b).

While there is a volume of literature on the concept of APEL, there is very little literature on the concept of Recognition of Prior Learning (RPL) as it is a subject that has only recently been afforded interest, particularly in relation to assistant staff in the NHSS. RPL is distinguished from accreditation by the argument that 'recognition' has a broader scope (Whittaker and Mills (2005). It is the intention that RPL will be aligned with the Scottish Credit and Qualifications Framework (SCQF) (Whittaker and Mills, 2005). The SCQF is a framework based on a twelve level scale that reflects the current Scottish system of education and training. In a conference presentation Whittaker and Mills (2005) described RPL as a process involving reflection on experiences to provide evidence of learning which could form part of CPD. RPL could be used to help plan a career pathway and identify core and other skills. RPL could also help to prepare people for further learning and development and allow them to gain credit for knowledge and skills learned through experience. It would allow them access to programmes and qualifications and shorten periods of study (Whittaker and Mills, 2005). A possible further advantage of formalised RPL is that it may go some way to avoiding duplication of effort and help with transferability of skills.

What was not made explicit was whether credit for experiential learning to allow shorter periods of study would extend to the SVQ. It is necessary to this

research to discover if SVQ participants have previous knowledge and skills that they perceive to be worthy of recognition.   Also whether any previous learning, training, education or development has been taken into account and recognised by any means and whether this has had any impact on the provision of a career pathway for this group of staff.

This section has critically reviewed the SVQ learning initiative which has been adopted by the NHSS for some non-registered clinical staff.   The main debates are whether the N/SVQs offer new knowledge or are merely a validation of existing knowledge and skills and whether only the core 'soft skills' can be considered transferable in the workplace.   Other debates that focus on the worth of N/SVQs in career progression and the consistency and objectivity of the assessment process for N/SVQs have also been discussed.   The concept of recognition of prior learning, as a method differing from accreditation of prior learning has been introduced.

4.4 Chapter summary and research questions.

This chapter has raised significant questions and issues that will be further investigated in this research.   In particular the way the NHSS is attempting to realise the concept of a learning organisation and using Fuller and Unwin's expansive/restrictive continuum (2004), the research will investigate whether an expansive learning environment is evident in micro and macro levels of the NHSS.   These concepts will also aid investigation of the existence of learning opportunities, negotiation of competency bundles, the uptake of any learning opportunities and initiatives such as the SVQ, the motivation of assistant staff and whether the environment has created a synergy between personal and organisation development in the NHSS.

The research will look into perceptions of assistant staff on issues such as attainment of formal qualifications and whether recognition of prior learning is seen as an important enabler in continuing personal development and workplace learning.   Of particular significance will be whether any education, learning, training or development has an impact on any career pathway that

may be available to this group of staff.   Figure 4.2 illustrates the theoretical framework used in this research to inform the research questions.

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                        │   Broad Question    │
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Broad Question

Initial Broad Literature Review:

HRD: Learning and Development / Workplace Learning / Skill Acquisition / SVQs

Exploratory Phase.

Comparable Research Studies

Looking for gaps

Narrower Focus: education, training and development at work: Workbased learning and assessment/personal development/competency/career pathways

Specific Literature: Learning Organisation, Learning Environment, National Competency Framework

Research Questions:

1. To what extent can the NHSS be considered a learning organisation?
2. To what extent does the NHSS provide an 'expansive' learning environment for non-registered clinical assistants?
3. How effective are SVQs for supporting the learning and development of non-registered clinical assistants?

Figure 4.2 Theoretical Framework

Chapter Five. Research Approach
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5.0 Introduction

This chapter reveals the research approach adopted for this study and discusses, in part, the researcher's 'journey' from a primarily inductive grounded approach to a more pragmatic realist position.   Two main sections make up this chapter.   The first addresses the methodological approach while the second outlines the methods of data collection.   Sections on the participants of the study and on data analysis techniques follow.   The chapter is completed by a summary of key points.

5.1 Adopted methodology

This section describes the paradigm and adopted methodology for this research which was initially influenced by an interpretivist epistemology that places importance on the subjective realities of participants but as the research progressed, the researcher moved towards a realist position in which it is accepted that there is an identifiable external social reality.   Therefore, a pragmatic approach embedded in a realist ontological stance is the preferred methodology.   Both qualitative and quantitative data collection methods are used through interviews and secondary data analysis.

5.1.1 Discussing paradigms and epistemologies

While a **paradigm** is a basic worldview or set of beliefs, some writers (cf Guba and Lincoln, 1994, Denzin and Lincoln, 1998) state that there are three fundamental questions to any paradigm which are interconnected and must be considered.   These are the epistemological question, the ontological question and the methodological question.   The epistemological question asks how we know the world and what the nature of the relationship between the inquirer is and what can be known (Gummesson, 2000; Holloway and Wheeler, 2002; Saunders *et al.*2007).   The ontological question asks what the nature of reality

is (Tashakorri and Teddlie, 1998; Saunders *et al.* 2007) and the methodological question asks how the inquirer can gain knowledge of the world through adopted methods (Saunders *et al. 2007).* Guba and Lincoln (1994) argue that not all methodologies will be appropriate to a specific research question and methods adopted should fit to a predetermined methodology. Saunders *et al.* (2007) state that the axiological question should also be considered. The axiological question relates to the role the researcher's own values play in all stages of the research process.

Epistemology concerns what constitutes acceptable knowledge in a field of study and encompasses the *positivist* position and the *interpretivist* position. In positivism the researcher studies observable social reality similar to the position adopted by the physical and natural scientists (Saunders *et al.* 2007, Lincoln and Guba 1985, Punch, 1998). Interpretivists advocate that it is necessary for the researcher to understand the differences between humans and the social roles of others are interpreted in accordance with the researchers own set of meanings (Morgan, 1997). Saunders *et al.* (2007) note that in interpretivists' epistemology, researchers adopt an empathetic stance to enter the social world of research participants to be able to understand the world from their point of view. Saunders *et al.* (2007) further note that some argue that this perspective is highly appropriate in business and management research, particularly in fields such as organisational behaviour, marketing and HRM. However, this raises questions about the generalisability of research that 'aims to capture the rich complexity of social situations'. The interpretivist argues that this is not crucially important as the world of business organisations is constantly changing (Saunders *et al.* 2007). In this research the epistemological position was one of pragmatism informed by critical realism. The researcher accepted the view that the subjective reality of participants was important but at the same time an external reality existed through the procedures and policies used by the NHSS.

Saunders *et al.* (2007) describe the term **paradigm** as 'a way of examining social phenomena from which particular understanding of these phenomena can be gained and explanations attempted'. In this research a **realist** paradigm is adopted using a mainly inductive approach from a **pragmatic**

philosophy (Saunders *et al* 2007, Tashakkori and Teddlie, 1998, Streubert and Carpenter, 1995).

An inductive approach allows the researcher to understand *why* something is happening rather than *what* is happening (Saunders *et al.* 2007, Gummesson, 2000, Hussey and Hussey, 1997, Streubert and Carpenter, 1995) and in this study the researcher leaned towards, although did not wholly adopt, the inductive approach. 'Thick description' of a phenomenon is achieved through interpretivism and it is linked to Weber's *verstehen* approach where something is understood in context (Neuman, 1991, Holloway and Wheeler, 2002, Miles and Huberman, 1994) and this was important to the researcher. However, where the *emic* perspective addressing the views, perceptions, meanings and interpretations of those being researched is considered through interpretivism (Hussey and Hussey, 1997; Holloway and Wheeler, 2002; Saunders *et al.* 2007), positivism also has a place in a pragmatic realist's epistemology where structures and observable social reality can also be researched (Gummesson, 2000; Holloway and Wheeler, 2002; Saunders *et al.* 2007).

A realist epistemology argues that what our senses show us is reality. Direct realists would say that our senses portray the world accurately and therefore '*what you see is what you get*' (Saunders *et al.* 2007:105). A critical realist's position is an awareness of non-observable structures such as power and hierarchy and a need to understand the social structures giving rise to a phenomenon in order to understand the social world of the participants.

In this study, the researcher took the view that the choice between a positivistic and an interpretivist epistemological position was unrealistic as the research questions required investigation into both the subjective realities of the participants but also the awareness of the 'external facts' within the organisation such as strategic aims, policies and protocols (Sanders *et al.* 2007). By adopting a pragmatic approach informed by critical realism, the researcher was able to study both objective and subjective views and by recognising the value of different types of data was able to use mixed methods and use theory to help interpret and make sense of the data.

Gummesson (2000) argues that paradigms are often discussed in terms of an antithesis between the two schools of philosophy – the *positivistic* traditional natural science school and the *humanistic* school (Gummesson, 2000). While both have many facets and names, Gummesson refers to the humanistic school as *hermeneutics* (from the Greek hermeneuien which means to interpret). He argues that researchers must be aware that their paradigm is not static and can shift (Gummesson, 2000). Generally, these two paradigms are considered the extremes of a continuum of paradigms (Morgan, 1997, Hussey and Hussey, 1997, Gummesson, 2000). As discussed, in this study a paradigm shift occurred. It is argued that once a paradigm is adopted it is not unusual to mix approaches in collecting and analysing data (Hussey and Hussey, 1997) which is the case in this research.

Adopting a realist epistemology allowed the researcher to gain an understanding of the meanings attached to events by the population taking part in the research. It further allowed for a closer understanding of the research context and a more flexible structure to allow for changes in the emphasis as the research progressed (Saunders *et al.* 2007).

To address the research questions both qualitative and quantitative methods were used. A qualitative research methodology uncovers meaning and interpretation that attaches significance to numbers and classifications (Saunders *et al.* 2007). A quantitative research methodology helps a researcher to explore, describe and examine relationships and trends within data (Saunders *et al.* 2007). In this study, both were appropriate.

5.1.2 Ontology, axiology and pragmatism

Ontology is concerned with the nature of reality and is divided into two aspects – objectivism and subjectivism. Saunders *et al.* (2007) argue that objectivism 'portrays the position that social entities exist in reality external to social actors concerned with their existence' whereas subjectivism 'holds that social phenomena are created from the perceptions and consequent actions of those social actors concerned with their existence'.

Ontological subjectivism considers a phenomenon as being created from the perceptions and consequent actions of people. Subjectivism is associated with the term *social constructionism* where it is necessary to explore the subjective meanings motivating the actions of people in order to be able to understand these actions (Morgan, 1997). In this case reality is regarded as socially constructed. Research participants may have different interpretations on situations in which they find themselves as a consequence of their own view of the world. Their interpretations affect their actions and their social interaction with others. A researcher therefore has a duty to seek to understand the subjective reality of the people taking part in the study in order to make sense of and understand their motives, actions and intentions in a way that is meaningful. In this way reality is constantly changing (Saunders *et al.* 2007).

In this study the researcher's ontological position rested between the two extremes of objectivism and subjectivism. While the subjective meaning may motivate the actions of the NHSS workforce in a given situation, it is also the case that systems within the NHSS work to specific procedures, protocols and policy and therefore exist externally to the assistant workforce's perception of their social world.

An ontological objectivist would view the NHSS culture as something that the organisation 'has' where subjectivists would argue that the culture is something that the organisation 'is' as a result of a process of continuing social enactment (Saunders *et al.* 2007). Subjectivists go further and argue that culture is created and re-created through a complex array of phenomena including social interactions and individuals attach certain meanings, rituals and myths to these phenomena (Saunders *et al.* 2007).

The ontological approach adopted here was critical realism where the researcher was cognisant of the multiple 'realities' associated with the culture of the NHSS by individuals but at the same time the researcher was aware of non-observable structures, such as the hierarchy within the NHSS and the strategic policy initiatives, which have an impact on the culture. In this way, the overarching culture of the NHSS is something that the organisation 'has' which

can be manipulated and changed to produce the desired state but at departmental level the culture 'is'.

Axiology is concerned with judgements about value and is a branch of philosophy that could be adopted when studying something that is emotive (Saunders *et al.* 2007). Heron (1996) (cited in Saunders *et al.* 2007) argued that researchers demonstrate axiological skills when they can articulate their values as a basis for making judgements concerning the research they are conducting and the methods they use. In justifying the methods for data collection for example, researchers are illustrating their axiological standpoint. In this research, the preferred method of data collection was a use of mixed methods through one-to-one interviews with participants but also analysis of secondary data gathered from a large scale anonymised questionnaire conducted on behalf of the NHS. The one-to-one interviews articulated the value placed on personal interaction with those being studied and the analysis of the data from the questionnaire articulated the researcher's pragmatic realist stance. Also, from a practical aspect secondary data from a large scale anonymised questionnaire enabled comparison with results from the interviews on a larger scale.

Gummesson (2000) discusses the concept of *preunderstanding* whereby the researcher has insights into a specific problem and social environment before starting a research study. He argues that if a researcher has preunderstanding they are enabled to interpret events without having to spend considerable time gathering basic information about an industry or organisation. The researcher will then be able to sense impressions and understand and interpret the language of the organisation (Gummesson, 2000). As with any 'speciality', language is specific and understandable to those who have underlying knowledge of the organisation or department within an organisation which could be incomprehensible to anyone without the underlying knowledge. From this point of view, a researcher with an amount of understanding of the organisation and specialised 'language' affords them *'knowledge behind the words'* (Gummesson, 2000:59). However, a counter argument is that it is not always possible to have preunderstanding about everything that is under investigation and in this case, preunderstanding implies a certain attitude and commitment on

the part of the researcher to demonstrate theoretical sensitivity and be able to change their paradigm, or basic worldview, if reality requires them to do so (Gummesson, 2000).   In this study the researcher had, through several years as a practicing nurse, specific knowledge of institutional conditions and social patterns within the workplace that is the NHSS.   This allowed the researcher to add weight to a number of factors and relationships and allowed the best method for access to data to be adopted.   However it was necessary to acknowledge that, through experience in the environment under study, assumptions could be made by the researcher and this was consciously addressed to avoid corrupting any data collection or analysis.

As the researcher came from an NHSS practitioner background and having worked and 'lived' the culture of the NHSS, total detachment from the research context was not possible.   However, as the researcher had experience as a practitioner in a variety of contexts and areas within the NHSS, the researcher was able to use past experience to advantage, being cognisant that there are many perceptions of reality and multiple urban myths.   By being aware of these prior views, the researcher was able to set them aside when conducting this research.

Pragmatism is an ontological position that argues that the research question is the most import determinant of the research philosophy adopted and that it is possible to draw on both philosophies of positivism and interpretivism.   By applying a practical approach this then allows the researcher to work with mixed methods and use both qualitative and quantitative methods to collect and interpret data (Saunders *et al.* 2007, Tashakkori and Teddlie, 1998).

The researcher took a pragmatic realist position in order to understand how the participants in this research interpreted their world and what their motives and actions were in relation to strategic changes taking place that had the potential to have some influence over their working lives.   As a pragmatist informed by critical realism the researcher accepted that NHSS world external to the participants and was keen to include the perspectives of the participants and to recognise the value of differing sets of data.   The researcher was also keen to use theory and the researcher's own value system to study what was important

and to help interpret and make sense of the data in an attempt to get as clear a picture as possible of the social world of NHSS clinical assistants (Tashakkori and Teddlie, 1998). Critical realism is now discussed.

5.1.3 Critical realism

A *critical realist* epistemological position was adopted to conduct the data collection for this research. As a philosophy, realism recognises the importance of multi-level study where researchers can only understand the social world by understanding the social situations giving rise to the phenomenon (Saunders *et al.* 2007, Bhaskar, 1994). Realism reaches for clarity and simplicity (Lopez and Potter, 2001) while assuming a scientific approach to the development of knowledge (Saunders *et al.* 2007). Critical realists base their arguments on a more complex understanding of reality in order to give a richer and fuller description of the nature of the phenomenon (Lopez and Potter, 2001). The critical realist position argues that social reality is concept and people dependent (Bhaskar, 2001 cited in Harre, 2001). Miles and Huberman (1994) argue that critical realism has come to mean many things to researchers. The authors describe themselves as 'transcendental realists' by which they mean that they believe social phenomena exists in both the minds of research participants and the objective world around them. This belief allows Miles and Huberman, (1994) to argue that while most social constructs are invisible to the human eye, they are not invalid because of this. They further argue that social phenomena (such as language, decisions, conflicts and hierarchies) exist objectively in the social world and 'exert strong influences over human activities because people construe them in common ways. Things that are believed become real and can be inquired into' (Miles and Huberman, 1994).

This research lends itself to a critical realist philosophy, drawing on both elements of positivism and social constructionism, as the perceptions of the participants are highly regarded. How participants of the research are affected by specific strategies, policies and structures that are in place in the NHSS is fundamental to understanding the outcomes of the study.

5.1.4 Theory development

When the social situations are understood through a critical realist philosophy, a theory can be devised. A theory is the cause and effect relationship between two or more entities which is used to predict, explain and understand the social world (Saunders *et al.* 2007, Neuman, 1991, Lobiondo-Woods and Haber, 1998). Saunders *et al.* (2007) argue that by recognising the importance of implicit theory in our everyday lives, this then makes it explicit.

Saunders *et al.* (2007) describe various reasons for undertaking research, one of which is to place an in-depth investigation of an organisation within the context of a wider understanding of the processes that are operating. As the NHSS is constantly evolving, this research sought to capture and understand the impact of processes in place around learning, training and development specific to lower paid clinical workers within the organisation.

Basic, fundamental or pure research is generally undertaken as a result of an academic agenda and little attention is given to practical applications. This research is applied research in that it seeks to be of direct and immediate relevance to the NHSS with findings that can be acted upon (Saunders *et al.* 2007). Saunders *et al.* (2007) suggest starting research with a general focus which leads on to more detailed questions and the definition of research objectives. In looking at the NHSS learning and development strategies, the general focus in this study began with the question:

> '*Why does the education, training and development provision for healthcare assistants at local operational level not seem to reflect the NHSS corporate strategic plans for this group of staff?*'

This question arose from the personal experience of the researcher who was at that time working in a clinical role which in part involved mentoring junior staff members, including non-registered clinical staff. The researcher had knowledge of corporate strategic documentation concerning staff development and was interested in investigating how the aims were articulated, processed and implemented at operational level. From this general focus question more detailed questions emerged that looked specifically at the non-registered clinical

staff of the NHSS. Objectives then followed, designed to help answer the research questions.

Phillips and Pugh (2005:47) describe *intelligence gathering* as the 'what' and 'why' questions and this is often called 'descriptive research'. This may form part of a research project but Saunders *et al.* (2007) say that by building on intelligence gathering, the researcher should seek to explain phenomena and analyse relationships.   This is achieved by comparing what is going on in different setting and by then predicting outcomes and generalising.   At this stage a researcher is working at the theoretical level (Saunders *et al.* 2007).

Layder (1993) discusses theory as 'a network' or 'integrated clustering' of concepts, propositions and worldviews.   In this sense a theory is more than a simple specification of the way in which two or more entities relate to each other in the empirical world.   Layder (1993) argues that theoretical ideas often act as 'background assumptions' to empirical research and where they are implicit they should be made explicit and the relevant connections detailed.   Through analysis of the data gathered informed by a review of strategic NHSS documentation and a critical literature review, the theoretical connections within this research are made explicit.

5.1.5 Reliability and validity

It is argued that in qualitative research, reliability is linked with replicability (Holloway and Wheeler 2002, Hussey and Hussey, 1997) and validity is linked with generalisability (Gummesson 2000).   Reliability is concerned with whether an alternative researcher would reveal similar information (Saunders *et al.* 2007, Gummesson, 2000, Hussey and Hussey, 1997, Punch, 1998).   This research could be replicated anywhere within the UK NHS as nursing and AHP assistants are employed in all clinical areas throughout the UK.   Furthermore, policies and strategies relating to this group of staff are similar throughout the UK. Also the research findings accurately represent what is really happening (Hussey and Hussey, 1997).

Validity has several sub-sections which include *content* validity*, internal* validity and *external* validity*.   Content validity relates to the conclusions and

inferences arrived at by the researcher regarding the 'causal' relationship between variables and events (Tashakkori and Teddlie, 1998, Hussey and Hussey, 1997, Punch 1998). Internal validity refers to the confidence that the relationships between variables and events are conclusive at that time and in that context and not due to alternative explanations (Tashakkori and Teddlie, 1998). Gummesson (2000) argues that in research, new knowledge is constantly sought and therefore if it can be agreed that a research project will provide the best available truth for the moment rather than the ultimate truth, the traditional demand for generalisation is less urgent. External validity is also known as *generalisability* where findings and conclusions can be applied to other similar settings and populations (Holloway and Wheeler, 2002).

In this research achievement of reliability is sought through examination of contemporary strategic and policy documentation relating to the assistant workforce of the NHSS. The assistant workforce incorporated a level of employee throughout the NHS in the UK and therefore the methodology in this particular study would be relevant and replicable elsewhere in the NHS. Since all national strategic and policy processes relating to clinical assistant staff encompass the entire assistant workforce, in this research, the best available 'truth' is presented for the present situation in the NHSS and therefore internal validity is assured.

5.1.6 Rigour

Rigour in qualitative research is required to accurately represent what those who have been studied experience (Streubert and Carpenter, 1995). The methodological rigour should be transparent to demonstrate the clarity, appropriateness and intellectual soundness of the overall methodology and conduct of the study (Hussey and Hussey, 1997). By this means, integrity and competence are shown (Holloway and Wheeler, 2002). This research has been conducted rigorously in both methods used and analysis conducted. This has been achieved, as will be discussed, through the use of semi-structured interviews where the initial structure of topics covered was identical and inclusive to ensure accurate representation. Analysis of the data, as will also be discussed, identified distinct categories of participants' experiences.

5.1.7 Reflexivity, bracketing and audit trail

Researchers need to be aware of and explore their assumptions and experiences that may influence the construction of knowledge. The ways in which a researcher endeavors not to allow their assumptions to shape the data collection process and their efforts not to impose their own understanding and constructions on the data are known as 'bracketing' (Crotty, 1996). The concept of bracketing is most often associated with phenomenological research (Holloway and Wheeler, 2002). Bracketing can be supported by the practice of reflexivity (Ahern, 1999; Cutliffe & McKenna, 1999; Hellawell, 2006).

Ahern (1999) argues that the ability to put aside personal feelings and preconceptions when conducting research is more a function of being reflexive rather than objective because it is not possible for researchers to set aside things that they are not aware of. Reflexivity involves the researcher being aware that they are part of the social world they study (Ahern, 1999) and that the process of bracketing is an iterative, reflexive journey entailing preparation, action, evaluation and systematic feedback on the effectiveness of the process (Ahern, 1999). In this way a researcher can understand the *effects* of their own experiences rather than attempt to eliminate them. Insight into areas of bias that might affect the researcher's data collection or analysis allows them to become a reflexive researcher (Ahern, 1999).

The concept of the insider-outsider when conducting research is discussed by Hellawell (2006) who refers to this debate in its relation to reflexivity in qualitative research. The debates around the insider-outsider concept focus on the merits of either having intimate knowledge of an organisation or culture that the researcher is studying or coming from an outsider's perspective. Hellawell (2006) argues that ideally researchers should approach their research from both inside and outside perspectives and that both empathy and distance are useful qualities for researchers. In this way a researcher is aware of both ends of a continuum from complete participant to complete observer and through reflexivity is able to place themself somewhere along this line.

Arber (2006) argues that documenting the feelings and emotions about the identities and roles assumed by the researcher during the research process can

be a useful part of the audit trail of the research process which can include, for example, a research journal, identification of daily activities and sampling techniques (Lincoln and Guba, 1985).   An audit trail is argued to enhance the credibility and rigour of research and should be attended to throughout the research process (Bradbury-Jones, 2007).   Bradbury-Jones (2007) advocates continued reflexivity through the use of the research journal as an integral part of any research being carried out.   An audit trail can support the ethical approach adopted by the researcher.

5.1.8 Ethics

In research, ethics refers to appropriate behaviour by the researcher in relation to the rights of participants (Saunders *et al.* 2007).   Ethics relates to formulation and clarification of the research topic, research design and research questions. Ethics also relates to how the researcher gains access to participants, collects data, processes, stores and analyses the data and writes up findings in a moral and responsible way (Saunders *et al.* 2007).   In order to achieve this, the researcher must ensure that the research design is both methodologically sound and morally defensible to all who are involved in it (Saunders *et al.* 2007).   Specific points must be taken into account when considering the ethics of a research project and the data collection methods.   The researcher should be sensitive to how gaining access to participants is achieved. Saunders *et al.* (2007) argue that conducting face to face interviews places the researcher in a position of some power as the researcher is in charge of the questioning, including some with the potential to be discomforting or even stressful.

General ethical issues include maintaining the privacy of participants, ensuring participation is totally voluntary, giving full information to afford participants informed consent, maintaining confidentiality and anonymity of data provided by participants and behaviour and objectivity of the researcher towards participants (Saunders *et al.* 2007, Miles & Huberman 1994, Punch, 1998, Holloway & Wheeler, 2002).   All the aforementioned have the capacity to harm participants and the 'cornerstone' of ethical issues concerns avoidance of harm (non-maleficence) (Saunders *et al.* 2007).

When data collection commences, ethical principles continue. The participants continue to have the right to withdraw from the study at any time. The researcher must maintain objectivity so that data is recorded accurately and fully (Saunders *et al.* 2007). Saunders *et al.* (2007) advocate recognising and considering potential ethical issues from the outset of the research and being aware that ethical concerns are likely to occur at all stages of the research project.

Research in the Health Service requires particular processes of ethical approval. Ethical approval was sought from the appropriate bodies of the Local and National Ethics Research Committees. Ethical clearance was approved (see appendix six). Further approval was sought from the Chief Executive of the Health Board under study to allow reference to be made to strategic papers which made the organisation identifiable. This was granted (see appendix seven). All participants were assured of anonymity and confidentiality. Participants were given information on the study and the option of withdrawing at any time. Permission was asked to audio tape the conversations with the knowledge that, while the interviews would be transcribed verbatim, the participants would remain anonymised and the recordings would be destroyed after transcription so that no-one else would have access to them. It was important to secure the managers' agreement so that the participants would feel at ease, knowing that the time away from work to take part in the interview process was sanctioned by their line manager.

The interviews took place in the workplace during work time but away from the clinical setting so that there were no interruptions. Each interview lasted approximately one hour. The researcher's field notes were recorded post-interview and used to support analysis of the interviews. Generally, all participants managed the appointment time except for two occasions with two different participants where the interview had to be rescheduled because of excessive workload on the part of the participant or because of staffing problems which would not allow them to take time away from their clinical area.

At the start of the interview, the purpose of the study and the interview schedule was again explained and permission was once more requested to audio tape

the interview. All participants agreed to this. No leading questions were asked (Crano and Brewer, 2002) and where clarification of an answer was required, this was asked for.

This section has explained the methodological pragmatic approach embedded in a realist ontological stance adopted for this study and discussed the requirements of reliability and validity, rigour and ethics. The following section discusses the empirical phase of this research.

5.2 Data collection

While the research looked at the opportunities and barriers to training, development and career progression for non-registered staff within the NHSS as a whole, the focus was on an embedded case study where the sub-unit of one Health Board was studied (Saunders *et al.* 2007, Gummesson, 2000, Holloway and Wheeler, 2002). The empirical data was gathered through data triangulation where a variety of data sources were sought (Tashakkori and Teddlie, 1998, Hussey and Hussey, 1997, Layder, 1993, Holloway and Wheeler, 2002, Denzin, 1978) and these included semi-structured one-to-one interviews with participants, a group interview and secondary data through the analysis of a staff survey undertaken by the NHSS.

5.2.1 Research design
The research design is the overall plan for the research as opposed to tactics which are the finer details of data collection and analysis (Saunders *et al.* 2007). The three identified research questions were addressed through the phases of the research and the link to methods adopted will be outlined and discussed in each individual phase below. Research questions are:

1. To what extent can the NHSS be considered a learning organisation?
2. To what extent does the NHSS provide an 'expansive' learning environment for non-registered clinical assistants?
3. How effective are SVQs for supporting the learning and development of non-registered clinical assistants?

As stated previously, the NHSS is in a constant state of flux and it was noted that, through reorganisation, greater emphasis was being placed on strategies to develop the workforce. In particular, the non-registered clinical workforce was being afforded more attention than previously. The research was therefore timely to discover what impact changes of this nature may have had for this group of staff.

The NHSS is a massive organisation and therefore it was important to be as representative as possible while working within the more focused philosophy of critical realism. The research centred on an embedded case study of the NHSS. A case study is usually used for a contemporary phenomenon to be studied in its own context and can generate answers to the why, what and how questions (Saunders *et al.* 2007). If the case study concerns the organisation as a whole then it is a holistic case study. However, if sub-units are being studied within an organisation, even although the concern is with the organisation as a whole, then this is known as an embedded case study (Saunders *et al.* 2007).

One Health Board was chosen as an embedded case study as it had all variables necessary to allow for replication and generalisability. At the start of the study, this Health Board had three specific Divisions (originally Trusts) which included a large acute Division, a smaller acute Division (with a primary care affiliation) and a primary care Division. As the study progressed, reorganisation meant that the Divisions within this Health Board came together under single system working. However, while the names of the Divisions changed to the acute Division and the community health care partnerships, no radical changes had taken place concerning staff at the clinical level.

Assistant staff in this Health Board and in the NHSS in general are prolific and therefore one criterion for choosing one staff group over another was that they must have direct patient contact and so must work within a clinical area. The main reason for this was that all of the strategic documents examined concerning staff development had the stated outcome of being improved patient care. There are three main groups of clinical employees in the NHSS: medical staff, nursing staff and allied health professions (AHPs) staff. Of these, nursing

and AHPs employ assistants in clinical settings and therefore these were the professions looked at.

There are currently twelve registered allied health professions, some of which work in both acute and community/primary care settings, others which are exclusive to one healthcare setting only. For the purposes of this research, professions found in both acute and community settings were used to assist again with replication and generalisability.

5.2.2 Phases of the research

Preliminary, exploratory/investigative work to inform the research questions took place prior to the investigative fieldwork and in tandem with an initial literature review and review of Government policy documentation. Following this, the empirical research was conducted in three specific phases. The results of the data collection are detailed in the following chapters but a summary of the reason for each phase is outlined here.

Exploratory work

The exploratory work involved investigative information gathering from 12 registered staff managing non-registered assistants, representative of all three Divisions of the Health Board under study. This incorporated nursing, AHP and the wider organisation at clinical level and above and this allowed the researcher to get a feel for what was going on and what the perceived issues around training and development for non-registered clinical staff were. This work informed topics for discussion in phase one questions around perceived and real opportunities and barriers to education, training, development and learning.

Phase One

Phase One involved semi-structured interviews being conducted with both assistant staff and managers involved in training and development of staff. In total five managers with an education provision remit and 15 assistants from across nursing and allied health professions were interviewed. The interviews focused on specific points raised from the exploratory/investigative work and following on from a review of strategic and policy documents on learning and

development in the NHSS and from a review of literature on pertinent topics. Questions concerning transferability of learned skills, vocational qualifications, the workplace as a learning environment and perceived opportunities and barriers to workplace learning were asked of both groups of staff.   Analysis of phase one revealed themes which were further developed in the following two phases.   The managers were also able to act as gatekeepers giving contact names of others who could help the researcher gain access to assistant participants.

This phase addressed all three research questions with particular focus on what training and development opportunities were available, induction into participants' current role and perceptions around workbased experiential learning (learning organisation), support from colleagues, sharing of skills and experience, personal development planning and appraisal and perceptions of being a team member (expansive learning environment) and perceptions around undertaking an SVQ, learning outcomes and impact on current role (SVQs).

Phase Two
In phase two, secondary data from the NHS staff satisfaction surveys (2002, 2003 and 2006) was used to enrich data associated with themes previously identified from phase one.   Several questions asked in the NHS staff satisfaction survey related closely to the questions asked in phase one of the data collection and the survey yielded quantitative data analysis which further supported phase one data analysis (see chapter seven, page 179 for detailed discussion).   It also further informed data collection in phase three.

The first two research questions were addressed through this phase by the further analysis of data extracted from staff survey results.   Particular questions asked in the staff survey around perceptions of the job and the organisation related to research question one on the learning organisation.   The staff survey questions contained in the section 'appropriately training' (see appendix four, page 291) related to research question two on the expansive learning environment.

Phase Three

Following analysis of the staff survey results and a further review of NHSS policy and strategic documents, phase three included a small group interview which was conducted with a group of twelve non-registered staff who had recently completed an SVQ in care.   As opposed to a focus group which often involves follow up meetings, a one-off group interview allows a variety of points of view to be explored.   It also allows members to consider points raised by others in the group and to challenge each others view.   A group interview helps to identify key themes to be used for further interviews (Saunders *et al.* 2007).

One-to-one semi-structured interviews then took place with nine assistants representative of three professions which were nursing, occupational therapy and physiotherapy.   One-to-one interviews were also conducted with six experts who included two line managers who were involved in education and development and the assessment of SVQs, a senior HR manager, a Scottish Executive Health Department (now known as Scottish Government Health Division) manager overseeing the proposed regulation of healthcare assistants and two senior managers in NHS Education for Scotland (NES) whose remit involved the education and development of healthcare assistants.   One NES manager was concerned with AHP assistants and the other with nursing assistants.   This phase was more focused following on from phases one and two and allowed for richer data collection around specific identified themes.

Phase three addressed all three research questions in more depth than the previous two phases.   In-depth accounts around induction into the organisation, training and development opportunities and knowledge of organisational strategies and policies addressed the first research question around the learning organisation concept.   Further probing around the perceptions of support from managers, colleagues and peers, recognition of previous learning and access to appraisal and personal development planning linked to the second research question on the learning environment and the content and perceived learning outcomes of the SVQ experience mapped to future aspirations and career pathways addressed the third research question on the effectiveness of SVQs in supporting learning and development of non-registered clinical staff.

Table 5.1 illustrates the phases of data collection and the number and position of participants.

Stage	Method	Number
Exploratory	Investigative Interviews: Policy analysis	12 Managers
Phase One	Interviews:	14 Assistants 5 Managers
Phase Two	Secondary Data Analysis:	2002 – 2006 NHSS Staff Satisfaction Survey
Phase Three	Group Interview: Interviews:	1 with 12 assistants 9 Assistants 6 Experts

Table 5.1 Data collection participants

5.2.3 Semi-structured interviews

A research interview is a purposeful discussion between two or more people and a semi-structured interview generally consists of a list of themes and questions to be covered (Saunders *et al.* 2007).   The order of the questions can vary depending on the flow of the conversation and additional questions may be required to explore emerging themes from the conversation.   Semi-structured interviews are often used to understand and infer causal relationship between variables (Saunders *et al.* 2007).

Interviews can allow participants to reflect on events and have the advantage of allowing them to explore their feelings (Marshall, 1997).   Saunders *et al.* (2007) argue that the exploration of feelings by participants is not always possible where a questionnaire is used as they may feel reluctant to provide sensitive and confidential information to someone they have never met.   Also participants may be reluctant to spend time providing written explanatory answers, particularly if the meaning of the question is ambiguous.   The use of interviews therefore ensures the interviewer has more control over who answers the questions, as a questionnaire has the potential to be passed from one person to another to answer (Saunders *et al.* 2007).   Interviews are also advantageous when trying to obtain answers to a large amount of questions or where the order of questions may need to be varied (Saunders *et al.* 2007).

An interviewer must be aware of interviewer bias where the comments, tone of voice or non-verbal behaviour can create bias in the way that interviewees respond to the questions being asked. Therefore an interviewer must be careful not to impose their own beliefs and frame of reference through questions asked and to interpret responses in an unbiased way (Saunders *et al.* 2007).

The researcher was very aware and addressed the issue of interviewer bias through the concepts of reflexivity and bracketing (see page 125). Field notes were recorded as soon as possible after the interviews but the researcher consciously waited for a period of days before transcribing the interviews and beginning analysis in order to re-bracket the focus of the research and set personal feeling aside. While conducting the interviews the researcher considered that the process was from both an insider and outsider perspective (Hellawell, 2006). An insider can acknowledge certain realities that are considered to be common knowledge by participants and can phrase questions accordingly. As the researcher had, throughout the research process, changed employment from clinical practitioner/mentor to teacher/facilitator to strategic/operational developer, this could have had some effect on conducting the research as the perspectives of both the non-registered participants and the managers could be understood. The researcher consciously avoided becoming too close to the perspectives of those being interviewed.

It was interesting to note that the researcher could be considered an 'insider' by some participants through working knowledge of the organisation and an 'outsider' by other participants as the research was being conducted through a university. The researcher consciously aimed to strike the right balance between being too involved with the participants and being too estranged from them.

To aid analysis (which is discussed later) and address interview bias the researcher maintained a reflective diary throughout the research process. When listening to accounts from participants during the interviews, the researcher was aware of personal feelings. For example where a participant might give an account of a particular barrier they had faced the researcher sometimes had personal experience that could be shared or advice to give

around the topic.   As this could not be voiced in the interview, recording personal feelings in the reflective diary allowed the researcher to acknowledge the feelings, set them aside and re-bracket the focus of the research.   In this way there was an understanding of the potential that the researcher's own values could influence the data collection and analysis and by addressing these personal issues in this way, a true reflective account of participants' views could be given, adding to the rigour of the research.

It was decided that by interviewing a smaller number of participants rather than sending out an anonymised questionnaire with specific questions to answer would yield more in-depth responses which would result in richer data.   Some of the questions could be interpreted as sensitive in that perceptions and feelings from the respondents were being asked for.   Other questions included eliciting personal information such as their career plans and perceptions around support from colleagues.   Some responses were anticipated to require further probing to elicit more detail and this could not have been achieved through the use of a questionnaire.

As suggested by Crano and Brewer (2002), the interview design was decided by the question content.   The exploratory/investigative interviews had allowed analysis and coding of particular themes that were specific for more in-depth investigation.   The questions in the subsequent interviews were grouped under four specific themes, known only to the interviewer, that allowed the same questions to be asked of each participant but not necessarily in the same order (Saunders *et al.* 2007, Holloway and Wheeler, 2002).   This had the added benefit of allowing further probing of any novel comments that arose throughout the interviews.   The four themes were:

> ➤ Current educational status
>> o   Including access to education and training
>> o   Recognition and/or accreditation of previous learning
>> o   Current undertaking of a recognised qualification (e.g. SVQ)
> ➤ Support from managers, assessors, mentors, colleagues
>> o   Considering expansive and restrictive environments

- ➢ knowledge of organisational strategies and policies
  - ○ including proposals for regulation
  - ○ understanding of agenda for change and knowledge and skills framework
- ➢ future aspirations
  - ○ opportunities and barriers to learning and development
  - ○ career pathways

5.2.4 Secondary data from NHSS staff survey

As discussed, the exploratory interviews informed the initial literature review and the following phase one semi-structured interviews which formed one data source. Analysis of a quantitative survey carried out by the NHSS was then used as secondary data which further informed the phase three data collection. The statistical methodology used for this phase is explained in chapter seven.

There are several advantages to using secondary data. They often yield a far larger data set than a single researcher could obtain. This was particularly the case here where the data was gathered on behalf of the entire NHSS. Furthermore, the data is open to public scrutiny as the sources are permanent and available (Saunders *et al.* 2007). However, one disadvantage of using secondary data such as compiled reports is that the further away the researcher is from the original data, the more difficult it is to judge the quality (Saunders *et al.* 2007).

The NHSS staff survey results contained more general information needed to help answer the research questions and meet the objectives of the research on a wider scale. The survey results also helped to inform phase three of the data collection where identified themes could be further explored with the respondents. The survey covered the population included in the research. There were certain limitations in the secondary data in that the studied population could only be separated from unwanted data to a degree. However, the data was collected in the right time period and was sufficiently up to date. Collected data were reliable and credible as they were from an independent scrutiniser. The source of the data was clear. The method was clearly described, the anticipated sample was the total workforce of the NHSS and the

response rate was documented although in this case it was not as high as the researcher may have wished. The data could be downloaded into a spreadsheet for analysis by the researcher. The researcher saved valuable financial and time costs by obtaining data this way (Saunders *et al.* 2007).

5.2.5 Reflections on the data collection

The one-to-one interviews worked well as the researcher had credibility as a healthcare professional and was able to reassure participants and put them at ease. In this way, rich data was gathered using the four themes as outlined above. The group interview, while yielding rich data, proved more difficult to manage as the researcher had little experience in this method of data collection. In retrospect it would have been more manageable to either have a smaller group or an assistant to help note body language and non-verbal cues that can be evident in potentially emotive discussions. None-the-less the wealth of data gathered added greatly to the findings.

As will be discussed in chapter seven, there were limitations to the secondary data obtained through the staff survey. Access to the data was given freely however, the raw statistics were not available and it is possible that analysis would have yielded even richer data had the researcher been able to access this. None-the-less the available data was able to be sufficiently scrutinised and analysed to compare with findings from phase one and to inform phase three.

At the outset the researcher had decided to use a wholly inductive approach with a grounded theory strategy. However, it quickly became apparent that, as discussed previously, the researcher moved towards a pragmatic approach informed by a critical realist epistemology and used both qualitative and quantitative methods.

5.3 Study participants

The sample was chosen purposively through the use of gatekeepers who were the managers of particular areas being studied (Neuman, 1991, Streubert and

Carpenter, 1995). The heterogeneous groups of staff were chosen because they were all assistants involved in clinical work (i.e. working with patients) and because recent strategic documents concerned the development of assistants as part of 'the way forward' for the NHSS. Heterogeneous groups differ from each other in one major aspect (in this case professions they were affiliated to) but are involved in the same thing (in this case patient care) (Holloway and Wheeler, 2002, Punch 1998). The Managers were approached to ask their staff if they wanted to take part in the research. The researcher acknowledged the possibility that managers could be selective in those assistants they approached for inclusion in the research. However, in this case the researcher was confident that there was no coercion or subjective selection involved on the part of the managers and potential participants were informed of the request for participation and then left to decide whether or not to take part. Names were given to the researcher who personally contacted the potential participants to arrange a suitable time and place for the interview to proceed.

LeCompte and Preissle (1997) (cited in Holloway and Wheeler 2002) argue that rather than refer to this type of sample as purposive, a better term is 'criterion based'. The criteria for this sample included that they be:

      a. a healthcare assistant
      b. employed in a clinical area
      c. employed in the Health Board under study
      d. employed for at least three months in their particular post

The rationale for these criteria is that they matched the research questions and aims of the research. As the Health Board under study has a three month probationary period for all employees, it was felt necessary to stipulate that the employee had passed this time and would therefore be in a substantive post and have access to any training and development opportunities being offered.

The exact participants, sample size and selection process have been outlined above. The benefits, as stated previously, of a smaller sample size in a realist philosophy where the focus is on the *emic* perspective (Holloway and Wheeler, 2002) is that more in-depth data can be gathered which will yield a 'thicker

description' of the phenomenon under study. It allows the research to be approached in context and emerging themes can be further probed if necessary. The disadvantage of having a smaller sample size is in relation to the generalisability of the results. However, as argued previously, in this type of study where the organisation is constantly changing, the importance is in capturing reality as it is now and offering a depth of understanding rather than breadth of coverage.

5.4 Qualitative Data Analysis

Throughout data analysis a critical realist will work to identify distinct categories of participants' experiences (Saunders *et al.* 2007). Conducting analysis from this position allows theory building to be adequately grounded in the data (Saunders *et al.* 2007, Holloway and Wheeler, 2002). According to Miles and Huberman (1994), data analysis includes data reduction. In data reduction, the researcher will select, focus, simplify, abstract and transform the data from the original transcriptions. From this data is coded, clusters are formed and themes are recognised. Miles and Huberman (1994) argue that data reduction is a necessary part of analysis to discard and organise data, to sharpen and focus it, so that final conclusions can be drawn and verified. Much of qualitative data analysis is done with words which can be assembled, clustered and broken into semiotic segments which allow the researcher to contrast, compare, analyse and award patterns to (Miles and Huberman, 1994).

Gummesson (2000) favourably discusses *historical analysis* where the history of the organisation and the processes that have led up to its present condition are investigated. Arguments for the use of historical analysis include that an organisation's history helps to put a problem in its context and environment and helps to place facts and events within a shared memory (Gummesson, 2000). An historical account of the NHSS from conception to present day was carried out prior to data collection to help explain the present situation surrounding the strategic objectives on training and development of assistant staff.

The empirical data analysis was carried out in three stages corresponding to the three phases of data collection. All audio taped interviews were transcribed verbatim and where required, participants were contacted again for clarification of particular points. This was to reduce bias and to elevate the validity of the study. Notes were added to the transcribed documents to indicate where the respondent had used a particular tone of voice or had given non-verbal cues to add emphasis to their responses. Transcription took approximately three hours for every hour of interview. This was time consuming but beneficial as it allowed the researcher to reflect on the interview and to add any useful comments to aid analysis. Figure 5.1 illustrates the process of qualitative data analysis used in this research.
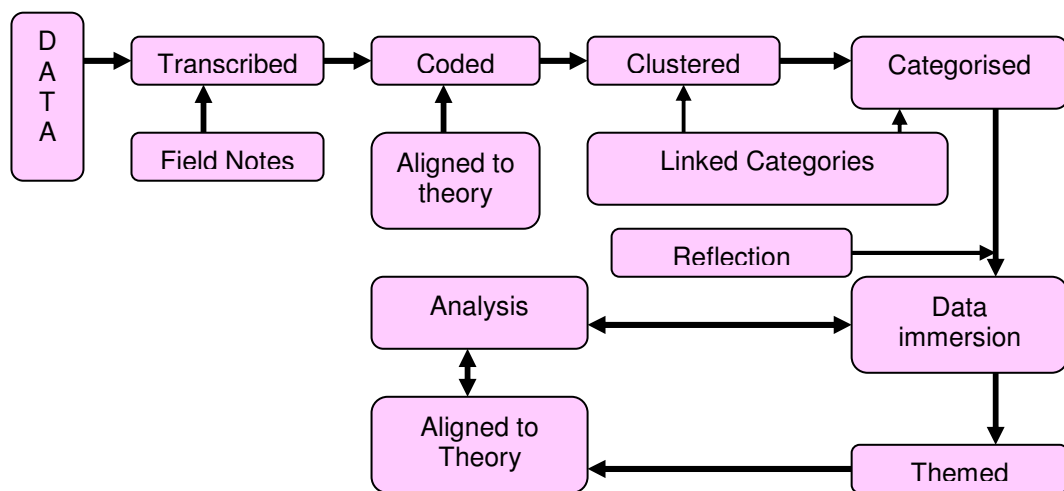
Figure 5.1 Process of qualitative data analysis

In phase one analysis was carried out on the transcribed interviews with the aid of the NVivo computer software package. Using a framework devised from the four identified themes used for the interviews, (as previously discussed), the data was arranged into meaningful and related *categories* (Saunders *et al.* 2007). The initial categories were descriptive and from this an emergent structure was revealed which aided order and organisation of the data. The data was then *unitised* (Saunders *et al.* 2007) where relevant chunks of data were attached to the relevant categories. This had the effect of reducing and rearranging the data into more manageable and comprehensible forms guided by the purpose of the research (Saunders *et al.* 2007, Neuman, 1991). In reorganising the data, the researcher is 'engaging' with the data (Miles and Huberman, 1994, Saunders *et al.* 2007) or becoming 'immersed' in the data

(Streubert and Carpenter, 1995:24). Initially the categories were descriptive and, as suggested by Saunders *et al.* (2007), Strauss and Corbin, (1994) and Streubert and Carpenter, (1995), as the analysis developed a more hierarchical approach took place where some categories were developed to indicate linkages and interpretation of the emerging data and to summarise key points. This also allowed the researcher to contextualise the responses from participants and look for meaningful patterns in this way (Streubert and Carpenter, 1995, Miles and Huberman, 1994). Analysis of the data allowed a conceptual model and a theoretical framework to be devised which showed how the interrelated concepts fit together through their relevance to a common theme (LoBiondo-Woods and Haber, 1998, Marshall, 1997, Punch, 1998).

A theoretical framework provides a rationale for predictions about the relationships among variables of a research study and so specifies the relationship between the concepts of the study (LoBiondo-Woods and Haber, 1998). This is considered necessary so that the theoretical framework acts as a guide or map to systematically identify a logical, precisely defined relationship between the variables. This in turn informed analysis of the secondary data for phase two of the data collection. Phase two data was analysed using specific mathematical formulae which is described in detail in chapter seven. Analysis of phase three was carried out both manually and with the use of NVivo software package in the same way as described above.

5.5 Chapter summary

This chapter has outlined and described the adopted methodology and methods used in this study. Because of the continuing change in the NHSS, the phenomenon under study had the potential to grow and change throughout the life of the project. For this reason, the researcher adopted a critical realist philosophy using a pragmatic approach and mixed methods to study the reality of opportunities and barriers to workplace learning for non-registered clinical staff.

The researcher started out on one end of the research methodology continuum with an interpretivist / inductive approach and moved further along the continuum as the study progressed to a pragmatic realist position. The gathering of data allowed the researcher to gain valuable experience and knowledge of methodologies, methods and data analysis. Using a critical realist approach yielded a large amount of rich data that is up-to-date and relevant to the current community that is the NHSS. A mixed method approach also elevated the assurance of representativeness, generalisability and validity to the study.

While data collection was challenging and time consuming, it proved a worthwhile exercise as the researcher was able to secure a large amount of data from a meaningful sample size over a wide geographical area that encompassed all variables under study. Through pre-working knowledge of the NHSS, the researcher was aware of processes of working in the Health Service and knew who to approach to act as gatekeepers, saving valuable time. Furthermore, through face-to-face interviewing, the researcher was able to develop trusting relationships with gatekeepers and participants. This had the benefit of enabling participants to answer questions honestly and reflectively which enriched the data collected.

Analysing the data both manually and with the use of computer software had both advantages and disadvantages. The researcher had to first become familiar with the computer software which was then upgraded to a newer version by the time the analysis for phase three was taking place. Both manual and technical analysis is time consuming as the data still needs to be themed and categorised. Technical analysis allows for quicker retrieval of units of data to be categorised but manual analysis can allow for a deeper immersion in the data. The researcher gained valuable experience carrying out both types of analysis. One of the biggest challenges facing the researcher was conducting the study on a part-time basis and therefore moving from one role to another, at times on the same day, with the added challenge of maintaining the pace of data collection to keep the study current.

Overall the methodology adopted worked well. The use of both qualitative and quantitative methods added to and supported findings from the analysis. If the researcher were to conduct this study again, a set period of time concentrating wholly on the research study would be preferable rather than conducting the study on a part-time basis. However, the researcher maintained interest and enthusiasm throughout as the research remained topical and fascinating. Analysis of phase two quantitative data required a steep learning curve by the researcher and on reflection, a more in-depth knowledge of statistical analysis methods prior to analysis of the data would be preferable. However, the researcher maintains the opinion that both the quantitative and qualitative data collected and analysed in this study enriched the findings and, should the researcher repeat the process, for this study both methods would still be included. While acknowledging that the computer software for data analysis was helpful to a point, the researcher preferred conducting some manual analysis to allow for a deeper immersion in the data.

The following chapters present and discuss the findings of the three phases of data collection.

Chapter Six. Phase One Interviews

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6.0 Introduction

This chapter reports on the first main phase of the fieldwork and is arranged in five sections. Section one reports on the exploratory scoping work prior to the main empirical study, where interviews were conducted with managers in the participating Health Board. These interviews raised a range of questions and issues to be investigated in phase one of the data collection. The issues that arose were grouped into three broad headings that covered questions around the NHSS as a learning organisation, the learning environment, the strengths and weaknesses of the SVQ as a learning initiative and the notable barriers to workplace learning.   Each of these is discussed below in sections two, three four and five.

6.1 The exploratory scoping work

This section pulls together the questions and issues taken forward in this research from the exploratory interviews with managers whose work remit included education and training of staff in the Health Board under study.   These were used to inform phase one of the main study. The titles and location of those participating in the following phase one interviews are then outlined.

6.1.1 Identifying the issues

As a preliminary to the investigative fieldwork, exploratory interviews were conducted with registered staff in the Divisions being studied who managed non-registered staff.   This was to gather their perceptions of what training and personal development was offered to non-registered assistants at that time. The twelve managers interviewed were recruited from both community/primary care and acute sectors of one geographical area of the Health Service across professions and included Occupational Therapy, Physiotherapy, Radiography, Operating Department Services and Nursing.

From the exploratory interviews the managers from most disciplines reported that the majority of assistants were female apart from Operating Department Orderlies (ODOs) who were exclusively male. The workforce figures from 2005 showed a total of 113 allied health professions assistants from both acute and primary care and 2,880 nursing and midwifery assistants from both acute and primary care were employed in the Health Board under study (www.isdscotland.org, 2005). All managers reported and agreed that very few males ever applied for assistant positions other than in the operating department services.

The ratio of assistants to registered staff in all of the departments was on average one to twelve. The managers reported that in their view the assistants all undertook patient care but to varying degrees. Nursing assistants tended to spend the majority of their working day in patient care and occupational therapy assistants (OTAs) were given structured tasks to complete with the patients and left to carry out this work unsupervised once they were deemed competent by a registered staff member. Work for the other allied health professions' assistants was reported by the managers to usually involve 'housekeeping tasks' such as tidying areas and ordering stock but where patient contact was involved it tended to be assisting the patient to get ready for their treatment rather than being involved with the treatment itself. From this, most of the managers felt that the training the assistants were given was adequate to cope with what they were expected to do but all agreed that more training and personal development opportunities could be offered which would in turn, they perceived, enhance the work experience for non-registered staff.

It was perceived by the managers that all of the assistants received corporate or organisational induction on commencement of post but thereafter the majority were mentored and instructed by their experienced assistant peers. All managers said that the assistant staff were expected to receive mandatory updates but most admitted that this tended to be irregular and not annually as directed by the organisation. The mandatory training provided for all assistants included update on basic life support, moving and handling, fire safety and evacuation, infection control and, dependent upon the associated profession, would also include job specific subjects such as food hygiene and handling, etc.

Lack of time and low staffing numbers were cited as being the reasons for the irregularity of this training.

Three out of the twelve managers interviewed said that their non-registered staff were offered in-house training and this was generally in the form of weekly to fortnightly 'in-services'. These sessions involved a registered staff member giving a talk on patient care or new equipment being introduced or recent developments within their speciality. The assistants that were offered regular in-house training were AHP assistants.

Any initial on-the-job training that the assistants did receive was solely to instruct them on the tasks they would have to perform and no underpinning knowledge to the tasks and procedures was taught at all. All of the managers said that non-registered staff could access other training offered in the Division but only if it was relevant to their post and of value to the department. Some managers said that they perceived there was an obvious reluctance by the non-registered staff in their departments to put themselves forward for any training at all. While no reasons were articulated for this at this time it was the intention to discover if reasons could relate to Rainbird's (1998) negative intrinsic factors where employees may be reluctant to seek learning opportunities through fear of failure or lack of confidence. Alternatively it could have been due in part to extrinsic factors such as the employee's position in the organisation (Rainbird, 1998) and this was taken forward for investigation.

In relation to transferability of skills, all of the managers reported that of the skills learned by the assistants on-the-job only the basic 'skills' such as communication and team working would be transferable to other areas of the Health Service but that the other skills learned were too job specific. Only two of the managers, one from physiotherapy and one from occupational therapy, ensured that their assistants received annual appraisals where their career aspirations and learning and personal development needs could be discussed. The other managers, including one other physiotherapy manager and one other occupational therapy manager cited lack of time again as the reason for not complying with this.

At this time only three of the departments offered recognised qualifications in the form of Scottish Vocational Qualifications (SVQs) to their assistants. These were nursing, physiotherapy and a special initiative that had been set up within the large acute Division to develop a generic role for existing physiotherapy assistants (PTAs) and OTAs to be called Therapy Support Workers (TSWs). Eight candidates in total were recruited to this initiative which had funding from the Scottish Executive for only one year and then it would require to be reviewed before further funding would be secured. The manager of this initiative reported only a small number of PTAs and OTAs had indicated an interest in pursuing an SVQ.

The radiography manager commented on one radiography department assistant (RDA) who was interested in pursuing a career in nursing and had been given the opportunity to apply to undertake a Higher National Certificate (HNC) in Care which would guarantee a place in second year of a nursing diploma. However in order to qualify for study towards an HNC, a requirement was that she had specific nursing assistant experience. She therefore had to work extra shifts as a nursing assistant on the 'nurse bank' of her Division in her spare time and she had to secure a mentor for herself from a nursing area which was proving difficult to do.

The managers admitted to varying input from registered staff towards facilitating training and personal development of assistants. One radiography manager spoke of her frustration at there being no accredited learning for the assistants in her department. She had independently set up lunchtime tutorials for anyone who was interested to come along and take part in talks around specific investigative procedures and treatments but it meant that staff had to give up their lunchtime to take part and there was no recognition or accreditation in place for this type of learning. As there was no recognised organisational requirement for assistant staff to record any learning, other than through their appraisals which were sporadic at best, then it was unlikely any accreditation or recognition of prior learning would be possible (Howard, 1993; Whittaker and Mills, 2005).

A physiotherapy manager stated that her perception was that registered staff would be reluctant to accept assistants as being totally competent even following completion of an SVQ. She stated that this was probably because registered staff believed they would remain accountable for the actions of the PTAs and therefore would be unwilling to help them increase their skill base:

> *There are issues about competence and accountability that*
> *should be addressed….. where they employ generic workers*
> *… these peoples have 'skills' in physio, OT, etc… I am a bit*
> *suspicious of this type of worker being totally competent and*
> *as the trained staff are accountable then I would be reluctant*
> *to accept that responsibility. (Physiotherapy manager).*

The operating department manager and the therapy support manager also perceived that registered staff would resist any skill development of assistants as it would involve change which was something, in their opinion, registered staff did not like.

As indicated in the introduction, the initial interviews with managers indicated a range of questions and issues to be investigated in the first main phase of fieldwork. The main issues included the type and amount of training and development provided for assistant staff to support their current work requirements and the access to other training opportunities for personal development to enhance the work experience. Other issues were around task training as opposed to learning with underpinning knowledge, transferability of learning, variable support from registered staff, teamworking and limited career pathways. Each of these is discussed below, related to specific concepts, after the next section which outlines the interviews conducted as part of the first main phase of fieldwork.

6.1.2 Phase One Interviews with assistants and managers

Interviews were conducted with a total of fourteen assistants and five managers from three Divisions of one Health Board. The assistants interviewed were recruited via their managers and the breakdown of numbers and professions are shown in Table 6.1. Training and development is overseen by several pockets of personnel throughout the Divisions and the managers interviewed were approached because of their direct relation to non-registered staff working

in a clinical area.   All of the managers had input into training and development provision but in varying degrees.   While all were employed at a senior level within the health service, only two had training and development as their specific job role and had a large remit covering several disciplines while for the others, training and development was only part of their job remit and specific to their own discipline.

	Assistants		Managers
Large Acute Division	**Smaller Acute Division**	**Primary Care and Community Division**	**All Divisions**
Trainee Clinical Support Worker - nursing (CSW)	Nursing Auxiliary (NA)	Trainee Clinical Support Worker - nursing (CSW)	Senior Nurse, Support Worker Development.
Physiotherapy Assistant (PTA)	Physiotherapy Assistant (PTA)	Occupational Therapy Assistant (OTA)	Therapy Support Worker Coordinator.
Radiography Department Assistant (RDA)	Radiography Department Assistant (RDA)	Physiotherapy Assistant (PTA)	Operating Department Education Facilitator.
Operating Department Assistant (ODA)	Occupational Therapy Assistant (OTA)	Physiotherapy Assistant (PTA)	Radiography Services Manager.
Therapy Support Worker- AHPs (TSW)	Therapy Support Worker - AHPs (TSW)		Practice Education Facilitator for assistants.

Table 6.1. Title, affiliated professions and locations of participants

The nursing assistants were known by different titles depending on what Division they were employed in.   In the large acute Division they were known as Trainee Clinical Support Workers and as part of their contract of employment they were required to undertake an SVQ at level two after their probationary period of three months. Once they had completed their SVQ they were known as Clinical Support Workers (CSWs).   In the smaller acute Division, where there was no requirement to undertake an SVQ, nursing assistants were generally known as nursing auxiliaries.   In the primary care and community Division the nursing assistants could be known as nursing auxiliaries (no SVQ), trainee clinical support workers (undertaking an SVQ) or clinical support workers (completed an SVQ). In this Division of the Health Board again there

was no requirement for assistants to undertake an SVQ. The given title did not depend on the level of SVQ being undertaken and could therefore relate to SVQ at levels two and three. The AHP assistants in all Divisions were known by the profession they were employed with. The analysis of these first phase interviews is now discussed in the three broad sections already outlined. These are the NHSS as a learning organisation, the learning environment and the strengths and weaknesses of the SVQ as a learning initiative.

6.2 The NHSS as a learning organisation

Some of the arguments around the learning organisation, which the NHSS has stated it is striving to become, involve the cultivation of its members existing skills to allow them to become empowered, satisfied and fulfilled in their work (Dodgson, 1993; Marsick and Watkins, 1999a). The interviews probed the concept of a learning organisation and the NHSS learning environment in general through questions around access to learning, learning on-the-job and personal development planning and support (see appendix three). As this section shows, several disparities were highlighted between, not only the Divisions of the Health Board but within the departments of each separate Division.

6.2.1 Learning at work

As discussed in the literature, learning at work can take many forms and can include formal, informal, explicit or implicit (Harrison, 2000; Reid and Barrington, 1999; Garavan, 1997). The work remit of assistant staff is important in investigating the types of learning experienced or considered necessary. The care of patients is likely to involve specific learning and training and the reported range of patient contact amongst the interviewed assistants varied greatly. One CSW and a PTA reported the most patient contact with ninety percent of their workload involving direct patient care. The remaining assistants reported between ten percent and forty percent patient contact and the rest of their time was taken up with administrative tasks or housekeeping tasks. This contrasted with the accounts given by their relevant managers in the exploratory interviews. The OTA manager had reported significantly more patient contact

time for assistants in that department and the PTA manager had reported significantly less patient contact time for PTAs in his department. The reality of a job remit may indicate the importance placed on learning and training for various staff groups and could have some bearing on access to learning opportunities. It could also have some bearing on whether workplace learning in this situation is *through* work (experiential or informal) (Rainbird, 1998, Lave and Wenger, 1991; Marsick and Watkins, 1990) or *for* work which is learning required for the job (Reid and Barrington, 1999; Megginson *et al.* 1993).

The majority of the managers interviewed expressed concern that there was a very real deficit of registered staff in most disciplines and that the skillmix was not always appropriate. Often the level and complexity of patient care required meant that only a registered staff member or someone with extra, more in-depth training would be able to deliver the necessary care. The managers believed that this contributed to the lack of guidance, encouragement and imparting of knowledge from the registered staff to the non-registered which would have some impact on informal learning opportunities for assistants (Usher, 1993; Rainbird, 1998). One manager expressed the concern that there was inequity in definition of roles for assistants and the level of work often depended on the area the assistant was employed in:

> *Dependent on the area… how much skillmix you can get away with. The future looks like it will be more dependence on support workers and that's probably not altogether a good thing. (TSW coordinator).*

Skill acquisition has relevance to motivation for learning (Thornley, 1999; Munro and Rainbird, 2002) and there are, according to one manager, plans for developing all support workers in the future but this is something that appeared to have a low priority because of a lack of finance and resources:

> *I think we are not meeting the needs of the organisation because we don't have the resources at the moment. (Senior nurse).*

In some cases assistant participants reported that their registered colleagues were not fully aware of what the assistant role actually entailed which would

then make it difficult for these registered staff to quantify what training and development issues there were for the assistants:

> *I think they have their own perceptions…. there have been a*
> *lot of discussions… there was a lot of inter-professional problems.*
> *(TSW large acute Division).*

> *Again it's down to the… interpretation of what an assistant's role*
> *is I think and obviously… thinking about the legal aspects…*
> *because ultimately the [registered person] is responsible*
> *(RDA large acute Division).*

This argues that the strategic plans to address skillmix and reprofiling (Scottish Office, 1998a; Scottish Executive, 1999a) have not yet impacted on clinical staff on the shop floor as job profiles and scope of practice for assistants remains uncertain and debatable for many staff.

All of the assistants reported that they enjoyed learning and the majority believed that what they had learned so far had resulted in transferable skills to some degree. In certain circumstances the assistants acknowledged that their skills were specialised and therefore could only be marginally applied to elsewhere in the Health Service. This was considered the case for example by the OTA and PTA in primary care and the RDA and TSW in acute care. This supports the arguments that workplace learning can be highly contextualized (Rainbird, Fuller and Munro, 2004; Eraut, 2004).

The ratio of assistant to registered staff ranged from one assistant to five registered staff to one assistant to many registered staff. Interestingly, the assistants did not consider the implications of skillmix which would have an impact on any care that they were expected to carry out and all reported that the registered staffs' workload was often such that there was no spare time to spend on study or ad hoc teaching sessions. There was also, in some circumstances, no time for the registered staff to take on the role of inductors to new staff and this fell to the assistant and became a tacit understanding that this was part of their job:

We've got to show them [the new starts] what to do.. first you're training care assistants and then new staff nurses come in and you're showing them as well…[the registered staff don't do this] …because they've not got the staff to do it.. they're too busy or whatever.. (ODA large acute Division).

This indicates that in some cases assistant staff were taking on the role of educators. It could be considered then that by default some aspects of the learning organisation concept have been realised in this Health Board through empowerment and collaborative working (Senge, 1990b; Dodgson, 1993; Nutley and Davies, 2001).   However, the counter argument is that lower paid staff are carrying out tasks beyond their remit which will save money and time for the organisation (Thornley, 1996).

On commencing their current posts the majority of assistants said that they had been given initial 'competencies' to be completed within the first few weeks. These generally involved a tick list of tasks that were to be completed under observation and then the assistant would be deemed competent by a registered member of staff.   Assistants from the small acute Division reported that this was ongoing but in a less formal way and if some new way of working developed in their area they were given instruction or teaching on how to deal with the new development and this was then followed by supervised practice. Two of the participants, an ODA and an RDA, reported that they were supervised and deemed competent by their assistant peers rather than registered staff.   Five assistants however stated that they had not received any specific training for the job and had come in with no real idea of what the job would entail.   They learned by asking and by being told what was required on a task to task basis.   This is at odds with the concept of a learning organisation as employee skill development is channelled towards organisational needs rather than employee needs and is unplanned and ad hoc (Reid and Barrington, 1999; Spencer, 2002).

Just over half the assistants interviewed reported occasional to regular in-house teaching taking place in their work area.   The remaining assistants reported either irregular or no teaching taking place in-house.   Ten assistants stated that they believed management were committed to training and development of staff however the remaining four assistants perceived that this was only for trained

staff and that non-registered staff were overlooked. Table 6.2 illustrates access at this time to SVQs and other training in the three Divisions of the Health Board.

	SVQ L2	SVQ L3	HNC	In-House	External
CSW Large	X	X	X		
CSW Small	X	X	X		
CSW PC	X	X	X	X	
PTA Large		X			
PTA small		X		X	X
PTA PC		X		X	X
OTA Large		X			
OTA Small		X		X	X
OTA PC		X		X	X

Table 6.2. Access to SVQs and other training

What is interesting about this information is that it highlights the disparity between the Divisions regarding training and development opportunities for non-registered clinical staff, despite being under the same Board level management.   At this point AHP assistants have a ceiling on their progression as they can only develop to SVQ level three where their non-registered nursing colleagues have the opportunity to progress to HNC level. Ironically the nursing assistants, who have no apparent ceiling to their progress, receive far fewer opportunities for in-house and external workbased learning compared to their AHP assistant colleagues.

Within the Divisions there are various media used to inform staff of training and development opportunities including the intranet, email, flyers, booklets and notice boards.   Anecdotal evidence suggests that not all staff within the Divisions have access to all of the information, often because they do not have passwords to use the intranet or time to access it. However, the majority of assistants interviewed stated that they had access to information technology facilities including the intranet, internet and email through their employment and they also had access to all other information outlets.

Part of the SVQ (which will be discussed later) and a recognised method of work based learning is reflection, and while half of those interviewed stated that they were encouraged to reflect on their work, most reported it being in a very informal manner with no real substance. One assistant did not see it as a positive thing at all, rather as a punishment tool:

> *I actually find it quite threatening – this reflective thing –*
> *because it's generally something has gone wrong*
> *(PTA large Acute Division).*

As discussed in the literature chapter, informal and incidental learning is increasingly being recognised as important within organisations (Coffield, 2000; Clark, 2004) to allow reflection on practice to generate experiential and contextual knowledge (Megginson, 1994; Rigano and Edwards, 1998). Tacit knowledge which is ingrained within the actions and practices of employees could be converted into explicit knowledge through facilitated reflection Marsick and Watkins, 1990; Clark, 2004; Eraut, 2004). Since the perceptions of the assistants indicate that reflection on their work is a negative undertaking, and in some cases threatening, it is an opportunity lost in harnessing already held skills and knowledge which could be further developed through the cognitive processes of reflection (Sambrook and Stewart, 2000; Garavan *et al.* 2002). This is likely to have a negative impact on recognition of prior learning and the uptake of new learning by assistants.

Overall the perceptions of job roles differ between managers and the staff undertaking the roles which will impact on education and training provision offered. Assistant staff work to differing levels dependent on their area of work and there is no consistency in initial preparation for their job roles. Indeed there is no evidence of consistency in what an assistant role is meant to include across the professions and Divisions of this Health Board.

6.3 The learning environment

This section discusses the support for learning given to the assistant staff, personal development planning and opportunities for continuing personal development.

6.3.1 Support from colleagues, seniors and managers

While all the managers who were interviewed were enthusiastic regarding future training and development for non-registered staff many agreed that there were barriers that caused obvious obstruction to taking plans forward for this group of staff. One such barrier could be the attitude of registered staff.

Although many of the assistants stated that their registered colleagues were supportive, many felt that this support was not shown in any obvious way and that often the assistants' enthusiasm was dampened by the frustration of not knowing where to go or who to turn to for practical assistance:

> There is this course that's meant to be getting up and running….
> I've been trying to find out about it for about two years now…
> I just can't get to the bottom of it… but I notice all the
> auxiliaries – they're all doing things and we're doing nothing
> (OTA primary care Division).

Less than half of the assistants believed that the registered staff in their area were willing to pass on their own knowledge and skills to non-registered staff which would possibly help assistants have a fuller understanding of their discipline or help to make their job more interesting and enlightening. Six assistants reported resistance from registered staff to allow the assistants to increase their skill base or to give them increasing responsibility or any autonomy. Two reported the older more established staff hindering them from learning by refusing to share their knowledge and skills and others not sharing unless specifically asked:

> There are certain [staff] I would ask first on the ward because
> I know that they would [answer any questions I had]
> (CSW acute Division).

> I've seen them putting up an x-ray before and I've asked do you
> mind if I sit in and I've had varying answers from – 'this isn't
> relevant to you' to talking it through with me – depends on who
> it is. (PTA large acute Division).

Update meetings, or handover reports, generally occur in clinical areas so that staff coming on shift are updated on patients' and clients' progress. Four assistants stated that they had either irregular update meetings or no update

meetings at all at work and therefore were again unable to update their knowledge, even on daily activities:

> *You come in and do your job and then you go home again*
> *and you never get to know anything….. I find it very frustrating*
> *(TSW large acute Division).*

Only half reported that they felt they were a valued member of the multidisciplinary team:

> *I just think they're [qualified staff] the ones with the qualifications*
> *and they think they know best and I suppose I'm not qualified and*
> *I don't think they would listen [to me]. I just get that impression.*
> *(CSW large acute Division).*

The managers cited lack of time and finance as being major problems to providing training and development opportunities. A further problem reported by some managers was staff shortages. This occurred in most of the disciplines apart from physiotherapy and occupational therapy in the acute sector. Because of low staff levels, even if finance for training was available, some non-registered staff found that they were working overtime and this left no free time for study of any sort. This was reported as being particularly relevant in the operating theatres.

All of the above points to the NHSS as having a restricted learning environment (Fuller and Unwin, 2004). Assistant staff have reported little planned time, and in some cases no time, off the job for knowledge based courses or reflection. Access to learning is most often to master tasks required of the job. Access to qualifications is limited and there is little evidence of career progression opportunities. There is also little evidence of support from registered colleagues in facilitating any learning in the workplace.

6.3.2 Personal development planning and continuing personal development

Many of the assistants interviewed already had qualifications or several years of experience in healthcare behind them. One OTA had previously completed the first year of a nursing diploma, a TSW had previously completed year one of an

Occupational Therapy degree and a PTA had achieved a degree in Sports Science. Other assistants had some years of experience, not necessarily in their current discipline but mostly in some aspect of care. None reported having their previous learning taken into account when planning their personal development with their seniors. Since a personal development plan is intended to be a profile of an employee's competence and a record of achievement (Jessup, 1991; Walton, 1999) it would seem anomalous that this was the case. Only three assistants reported discussing their PDP which, at the time, was a newly introduced mandatory procedure to complement the appraisal system and is now intended to become an integral part of the Knowledge and Skills Framework which is to be introduced following finalisation of Agenda for Change.

Staff appraisal was meant to occur annually but both the managers and the assistants reported that appraisal was sporadic at best. A variety of reasons were cited but as this was a strategic goal by the Scottish Executive (1999), it was significant that it did not happen regularly. A main purpose of appraisal meetings was to discuss training and development requirements based on PDPs. Since previous learning was not included in PDPs, it is likely that should appraisal occur it would be of little value to the personal development of the assistant. This supports the arguments around the limitations of the appraisal system as a development tool (Rainbird and Munro, 2003). Only five assistants reported receiving an annual appraisal where their objectives, including training and personal development, were discussed with their manager or mentor. These same five assistants received mandatory updates which are the previously mentioned stipulated specific updates on health and safety issues and basic life support.

Analysis of data from the assistants interviewed in phase one has shown that a key feature in access to learning is dependent on the area they are employed. Positive examples include a PTA in the smaller acute Division of the Health Board who had been offered funding to undergo further training in a specific competency to allow her to help set up and run a particular therapy class for patients recovering from cardiac problems. This PTA already had a degree but in a different discipline from the area she was working in. Another example is a

TSW in the smaller acute Division who has no evidence of prior learning and has limited years experience in health care and has been given the opportunity to undertake further study with a view to being upgraded and receiving higher pay.

On the flip side a PTA in the larger acute Division of the Health Board also had evidence of prior learning to a higher standard but could not secure funding to go on any other courses that she believed would enhance her job. A further example is a TSW in the larger acute Division who had evidence of university study in a relevant healthcare related discipline but felt she could not ask to further her study through work because it would not be granted.

Ways to address CPD without going on courses were discussed in various documents (cf Scottish Executive, 1999b; NHS Education for Scotland, 2003). Any CPD model adopted by the NHS would require to assess needs, plan to meet those needs and implement training and development required (cf NHS Education for Scotland, 2003). Analysis of phase one interviews indicates that this has not happened uniformly across the Health Board under study.

This section has shown that workplace learning in this Health Board, at this time, is centred on learning *for* work (Megginson *et al.* 1993) with little attention paid to recognising any learning *through* work (Rainbird, 1998; Lave and Wenger, 1991). An expansive learning environment (Fuller and Unwin, 2004) is evident in only certain clinical areas and is very much dependent on the perception of registered staff towards learning needs of assistant employees and the willingness to recognise and facilitate any learning opportunities that arise.

The key issues that have emerged from this initial phase include the uneven opportunities afforded to assistants regarding access to learning, the lack of personal development planning, the negative attitude of some registered staff towards developing the assistant workforce and the failure by the organisation to recognise any previous accredited and workbased learning by assistant staff. All of these impact on the future development and career opportunities for assistants.

6.4 Strengths and weaknesses of vocational qualifications

This section describes the introduction of the SVQ to the Health Board under study and the perceptions of assistants and managers of the SVQ's strengths and weaknesses. The disparities around other learning opportunities related to the SVQ are discussed along with the assessment process and the transferability of the qualification.

6.4.1 Training or travesty?

The original SVQ training was introduced for the CSWs in the large acute hospital as a response to a directive from the Scottish Executive in 1996 which aimed to reduce junior doctors' hours. The Human Resources Director decided that nurses should undertake more clinical skills previously the remit of doctors to help reduce their hours and it was recognised that the nurses would need more assistance and so the role of the CSW evolved and training for vocational qualifications commenced for them. Thereafter it became a mandatory part of recruitment into this post that an SVQ at level two was undertaken.

In the large acute Division the SVQ was supplied by the workplace as it is a recognised assessment centre for SVQs in Care but in the community/primary care Division the SVQ was outsourced to a local further education college which had implications for funding of staff to undertake an SVQ. The managers in general were enthusiastic about the SVQs offered to assistants but also recognised that there was often a reluctance by assistants to commit to an SVQ as they saw no tangible benefits from it:

> *…you are talking about a group of people who are not highly paid and they have to have quite a bit of motivation to make themselves do it. The financial difference will not be great. I see that as a barrier. (TSW coordinator).*

> *The SVQ is global… you need specific competencies to make a difference… the Division should follow through making this mandatory for all [assistants] as with the CSWs otherwise it would be very wrong. (TSW coordinator).*

> *SVQs make no difference to the job title or to the role… although I see it as a huge opportunity… personally and professionally. (Operating department education facilitator)*

Eight out of the fourteen assistants interviewed said that they had been given the opportunity or were currently undertaking a Scottish Vocational Qualification at level two or level three. An SVQ relating to health care has four mandatory units that must be completed and a further two units specific to the person's place of work. Within the Divisions being studied only one group of employees, the clinical support workers in the large acute Division, were given further clinical competencies to complete and to compliment their SVQ units and these had to be achieved before the employee could be said to have achieved their SVQ.

The extra competencies were classed as clinical skills and were task specific such as recording of patients' blood pressure, temperature and pulse and venepuncture (taking blood samples from a vein) etc. Those undertaking clinical competencies were given instruction on the procedures and supervised practice until they were deemed competent, by a registered staff member, to carry out the clinical skill on their own. The clinical skills were generally relevant to work historically carried out by registered staff and in this way, new learning to the assistant staff. This initiative was a local requirement and an expansion of the SVQ and while considered a positive and progressive thing by the senior nurse, it was recognised that there were limitations to these competencies as they were not always transferable because they were often considered specific to the department or clinical area where they were practiced. In other departments and professions within the large acute Division and in the other two Divisions, extra competencies were not a requirement and generally not facilitated. The AHP candidates undertaking an SVQ for example, had only the designated units to complete which consisted of the four core units and two extra and no clinical competencies were facilitated for them.

Most of the assistants undertaking an SVQ believed that it gave them no new knowledge but only reinforced knowledge and skills that they already possessed. These perceptions support the arguments that SVQs simply validate already held knowledge (Eraut, 2001; Munro and Rainbird, 2002; Grugulis, 2003b). The RDAs reported that no appropriate SVQ was available to them at present and no likelihood of one being made available in the near future. One PTA from the primary care Division and a TSW from the larger

acute Division both stated that they had undertaken an SVQ and found it of little relevance to the job and that they had learned little from it:

> *I wouldn't say I've actually learned anything new doing the SVQ.*
> *It's just a paper exercise and there's a lot of work to it and I don't*
> *get any time here at all to do that. (TSW large acute Division).*

> *To be honest I did expect a bit more from the SVQ… a bit more*
> *competency based… but I don't think it really does work that way.*
> *(PTA large acute Division).*

However, one assistant perceived that achieving the SVQ would improve her chances of securing a post elsewhere in the health service:

> *If you were looking for jobs outside the hospital it benefits to have*
> *an SVQ but at the moment there are no advantages [to doing it].*
> *(OTA small acute Division).*

Another assistant originally perceived that undertaking an SVQ would improve her status within the clinical team but concluded that it had made little difference:

> *I thought it would improve my skill base and effect how*
> *valuable [I am] to the physios but it doesn't really do much.*
> *(PTA large acute Division).*

The general consensus was that the extra competencies, which as described were the specific clinical skills added on to the SVQ by the large acute Division, were the site of learning where the SVQ itself only validated existing knowledge. Yet only the CSWs from the large Acute Division were given access to these and there were no plans for clinical competencies to be designed or made accessible to other assistants.

For the CSWs who were undertaking an SVQ, the extra competencies that they were required to complete meant that they were taught some underpinning knowledge to the skill which they then practiced under supervision and were then deemed competent and so allowed to practice the skill independently. However, although these skills were recognised within their own departments they were not always required in other departments within the Division and therefore if an assistant moved to another job they were often unable to practice

their skills because their competencies were not needed. Also one manager reported that an employee who had achieved several skills within the large acute Division moved his employment to another Health Board in Scotland where, although he was employed at the same grade, he was not covered to practice his skills as this Health Board did not recognise the CSW job remit. These accounts support the debates around the transferability of the SVQ where it is argued that only the soft 'skills' such as communication and team working are transferable (Eraut, 2001; Grugulis, 2003b; Young, 2004).

6.4.2 The SVQ assessment and rewards

At the time of the interviews there were major structural changes taking place within all three Divisions and for many staff in the smaller acute Division, the opportunity to commence an SVQ had been put on hold until there was a clearer picture of who would be controlling this area within the Division. The operating department manager related that the opportunity to undertake an SVQ had been introduced only three years previously as a voluntary option and then, in the theatres, only three non-registered staff took the opportunity. Two of the three dropped out citing lack of incentive due to there being no tangible rewards for a large effort in completing the SVQ and the remaining staff member had yet to complete their SVQ. There had also been tentative plans to combine operating department support workers and operating department orderlies' jobs within the smaller acute Division but the manager reported that the assistants were reluctant to consider a change like this. This was an interesting finding in that it supports the arguments that SVQs are sometimes not perceived as a springboard to upward progression particularly where no evident rewards are given (Rainbird, 1998; Munro and Rainbird, 2002; Keep, 2004).

Some of the managers questioned the robustness of the training to meet standards set by the Scottish Executive, particularly the SVQ. They inferred that the standard achieved was often dependent on the assessor assigned to the assistant undertaking an SVQ:

…[the SVQ] is workbased so it's highly dependent on how good your assessor is. If you have a very good assessor who has excellent standards and is current with their knowledge then I think you'd get a pretty good training…. But that's not always the case… I think that's where the downfall is. (Practice Education Facilitator).

This is a very interesting perception and relates significantly to the debates around the objectivity and therefore consistency in assessment of SVQs (Grugulis, 2002, 2003b). Keep (2004) and Keeney *et al.* (2004) have argued that a standardised national assessment tool is a definite need and where occupational standards are not consistent across the sectors (Young, 2004), there is the risk that assessors will base the outcomes on their own needs (Pearn *et al.* 1995). This latter argument has been supported by the managers in this study.

This section has shown that SVQs were introduced into this Health Board to increase the skill base of assistants. However, analysis of the interviews has found that the perceptions of the assistants are that they have acquired no new knowledge through this initiative. It is the extra clinical competencies that are considered the site of learning by assistants and yet only one group were afforded this opportunity, reinforcing the notion of a restrictive learning environment (Fuller and Unwin, 2004). The transferability of the SVQ as a qualification was considered limited by both assistants and managers indicating that without the extra clinical competencies it could be considered a huge but ultimately restrictive undertaking on its own (Grugulis, 2002). This highlights a real paradox in that the most valuable elements in terms of learning are not formally part of the SVQ and are site specific, limiting transferability. The assessment process was alluded to as a subjective exercise which further questions the value of the SVQ as a learning initiative.

6.5 Opportunities and barriers to the uptake of learning and training

This section discusses the findings from investigation into motivation of assistant employees around workplace learning. The availability of education

and training opportunities is outlined along with recognition of existing knowledge and skills of assistants and support from colleagues and the organisation. Disparities in career and development pathways are outlined.

6.5.1 Motivating the workforce

Skill development is not always considered a positive (Gallie, 1996) and can influence motivation for undertaking any learning. Assistants' perceptions around motivation for undertaking training and development opportunities was analysed and the main motivators were identified as including higher status, self gratification, enjoyment, interest, benefit from increased knowledge base, career progression, increase in salary, change in routine, chance to gain qualifications and recognition for work already taking place. Within the workplace both formal and informal learning can support and realise these motivations.

In the analysis of the interviews only one assistant stated that she had learned more from studying an SVQ than from experience on the shop floor. All other assistants interviewed believed that most of their learning, relevant to their current post, had occurred through experience on-the-job. As mentioned, incidental and informal learning within organisations is gaining increasing attention (Coffield, 2000; Clark, 2004) and support mechanisms for translating this learning (Marsick and Watkins, 1997; Bryans and Smith, 2000) could be considered an urgent requirement to maintain the motivation of employees as described above. This is particularly the case in this study where the overwhelming perception of assistants is that the current SVQ initiative offers no rewards.

Many stated that the fact there was no upgrade and little or no pay reward was a definite barrier. Motivation to progress or to personally develop in relation to their job was hindered because, in many cases, it was perceived as a lot of effort for no tangible purpose. A further factor that could influence motivation was that a large number of the assistants interviewed believed that their workload had increased over the time they had been in post. The majority of the AHP assistants reported an increase in responsibility and/or autonomy

within their post both in primary care and acute care settings with no obvious rewards such as pay increase or elevated status:

> *[my role] has expanded but I was taken on at exactly the same rate of pay and the same grade… I wouldn't have accepted that now. (TSW large Acute Division).*

The majority of assistants communicated that they would enjoy not only more training on practical skills but would like a more in-depth theoretical background to training which in turn would improve their input and subsequent patient care:

> *I think it [theory] makes it more interesting. Makes more sense why we are doing things.   I think then I would feel more confident…. (PTA primary care Division).*

The above lends to the debate that skill and knowledge acquisition can act as a demotivator where the perception is that more responsibility is being given without any rewards, particularly financial (Gallie, 1996; Munro and Rainbird, 2002).

6.5.2. Recognising existing skills and previous learning

Another factor influencing the uptake of learning opportunities was the apparent non-recognition or non-utilisation of existing skills.   Many of the assistants described themselves as being unable to practice learned skills through a variety of circumstances.   One had moved to another post within the Division and found that her practical clinical skills were not required in her new post.   She therefore was unable to practice these skills and felt demoralised as a result.   Another assistant had been used to working to a certain level and when new management took over her unit she found she was not permitted to work in the same way:

> *The competencies I had…. have been thrown out the window and they are not taken on board by my senior… I do feel I have been deskilled and I feel frustrated by this.*
> *(PTA large acute Division)*

Another assistant with previous experience and qualifications in a different Division stated:

> *I think sometimes that my skills aren't used… as much as*
> *they could be… maybe it's because it's not in the protocols*
> *or [its not] the way they work…. (PTA small acute Division)..*

Recognition of prior experiential learning is not an acknowledged procedure or policy in this Health Board and a perceived barrier to role development or career progression by some assistants involved prerequisite qualifications over experience:

> *…has been doing this job for about 16 years and is competent*
> *and should have the status of [higher level] because of her*
> *wealth of experience but she hasn't got the qualifications so it*
> *needs to be almost documented or evidenced… sometimes to*
> *have a certain qualification opens certain doors for you.*
> *(TSW small acute Division)*

> *[applying for a new post]… I think they would go for the person*
> *with the SVQ. (CSW primary care Division).*

In general the managers had little comment on recognising previous learning although one manager felt that there were certain assistants with previous experience and qualifications who should be recognised by the organisation through a robust system for accrediting prior learning:

> *Some people who have done first year of nursing for example*
> *and given up for whatever reasons get a poor deal because*
> *their skills are not acknowledged… (Practice Education Facilitator).*

As discussed in the literature chapter, systems are in place to recognise and accredit previous learning (Hamill and Sutherland, 1994; Adams, 2001). It is significant that in considering workbased education and training for assistant employees, this Health Board has apparently not investigated the RPL/APEL route which could prove to be cost effective in both time and finances and would likely further motivate employees in the uptake of learning and training opportunities (Hamill and Sutherland, 1994; Adams, 2001).

6.5.3 Training, funding and study time

The overall consensus by the assistants was that there were very few relevant courses or further training opportunities offered to them.   Most frustratingly, in their opinion, there was no recognised structure to any training that might be

available to them. As a majority they believed that this was something that would be beneficial for all concerned:

> *[our induction]… I think it would have been good to go*
> *out with other [disciplines] in the community to get a real feel*
> *for what goes on out there… [it] could have been followed*
> *up with structured training… building on something that we've*
> *come up against. (PTA primary care Division).*

> *I have learned from experience definitely. The courses have*
> *acted as a reinforcer. (TSW large acute Division).*

> *You just learn it [your job] yourself. You just get on with it.*
> *(ODA large acute Division).*

Unless an assistant was undertaking an SVQ there was no dedicated study time offered to them and in areas where this was offered it was often sporadic and very dependent on the staffing levels whether dedicated study time was honoured or not. Disparities existed in the provision of in-house training between Divisions and also between departments within the Divisions. For example, the TSW coordinator stated that the assistants generally had regular in-house meetings and training sessions attended by all staff within the department but the radiography services manager said this rarely happened because of the nature of the department. He argued that other AHP departments worked on an appointment basis and therefore they were able to set aside time for in-house training whereas the nature of work within the radiography department meant that patients were always coming through the doors and therefore there could be no protected study time within the department:

> *[we are] an acute area so it is difficult to organise in-house*
> *training or to give time off for study days… quite a lot of*
> *things are cancelled. (Radiography Services Manager).*

All training requires to be funded and money for training is budgeted on an annual basis which means that managers spend time pulling together projected plans or 'manpower' analysis of areas to bid for a slice of the budget. The money comes from a variety of sources including the Scottish Government and the higher management of the Divisions. For this reason, it is not always possible to secure substantive training and development posts in the workplace

as the needs of the organisation are considered first. Therefore if money is required to increase staffing levels in the clinical areas or work has to be carried out in response to a directive from the Scottish Government then money to provide extra personnel for training and development of existing staff will be considered last.

6.5.4 The hierarchy of training opportunities

In general the managers believed that there were opportunities within the organisation for assistants to learn and to develop their current roles. However, they considered the main problems were lack of funding and often insufficient numbers of registered staff as the skillmix in some clinical areas could not support any real development of assistants. The managers spoke of the registered staff being threatened or disinterested in the career progression of their non-registered colleagues which could also be a barrier to workbased learning:

> *Not all of the qualified staff are really able to appreciate the*
> *assistant role and I think sometimes the qualified staff can*
> *actually be quite obstructive in the whole process.*
> *(TSW coordinator).*

Most training and development opportunities are perceived by the assistants as being offered from a top down perspective so that the registered staff in general are given priority in any training and learning opportunities and there is more choice available to them rather than the non-registered staff. Some believed this was because the content of training offered was considered to be more applicable to those with a recognised form of education:

> *They [management] should bring in more for assistants.. let*
> *assistants do some of the courses. Why do trained members*
> *always have to get and untrained don't? (ODA large acute Division).*

> *I think to be honest, the care assistants don't get a lot of opportunity*
> *to do [extra training]. You maybe hear things through the grapevine*
> *and think – why didn't we get asked to do that?*
> *(ODA large acute Division).*

The above can be related to Pearn *et al's.* (1995) organisational inhibitor model where workplace learning is negatively influenced by too many management

levels and where decision making is centralised as it is in this case around opportunities for training and development of assistant employees.

Despite the perception by the assistants that commitment to training and development by the organisation and management was directed at the registered staff some felt that their registered colleagues encouraged them to progress as much as they were able:

> *Anything [courses] that came up and were relevant to me I was encouraged to do and went on. We are encouraged to develop ourselves as we go along… to take a subject and research it and give a talk on it [to our peers and managers]. (OTA small acute Division).*

> *Everybody's input is important, not that 'oh well you're just an assistant or you've just come here so we won't ask you'… it encourages you and makes you bolder. (CSW primary care Division).*

> *I think my role is quite unique and I think that maybe we are being given better opportunities to develop and become better qualified and to train than maybe other assistants. (TSW small acute Division).*

The negative perceptions of the assistants were somewhat mirrored by the managers who were interviewed. As part of her job remit, one manager assists in designing programmes of learning for CSWs within the acute sector. Some of this training is in response to directives from the Scottish Government which must be followed and made to happen as must legislation from Government but this manager also responds to preferred options which are decisions that come down from senior management. Recently the geographical area that she oversees has expanded to include other Health Boards of the NHSS to assist them in launching SVQ orientated training for their non-registered clinical staff. However, she has had no further resources or personnel made available to her.

> *I feel I'm just treading water… I'm just troubleshooting because I can't really drive anything [as] I don't have time to drive anything.. (Senior Nurse).*

The practice education manager assessed training needs in the community/primary care Division according to the needs of the service rather than the individuals themselves and set up training accordingly. The other

managers related to staff shortages and a general lack of resources including time and funding for the apparent deficit of opportunities for training for assistant staff:

> *Some of the training is not appropriate.. and so you can't justify taking away from clinical time… [you have to ask] is it really developing staff? (TSW coordinator).*

The lack of funding for training and education however was only focused on by a minority of the assistants. While most assistants reported a lack of relevant courses or teaching opportunities others believed that there were sufficient courses available and that it was a lack of personal motivation that stopped many from progressing:

> *I think the opportunities are there but you have to take them and you have to want to do them. (PTA Primary Care Division).*

The majority of the assistants however were enthusiastic regarding learning and increasing their knowledge base apart from one assistant who stated that she was happy doing what she was doing and was simply working her way towards retirement which she hoped would be in the near future and therefore did not feel the need to undertake anything 'official'. Some others were quite discerning regarding the need for training and development:

> *I think knowledge is a good thing if it is used properly. (PTA large acute Division).*

> *If the opportunity was there to learn more skills I would. I wouldn't want a reward. I'd consider it just part of the job. (OTA primary care Division).*

> *I've always been motivated to learn… [I would] get enormous personal satisfaction because I had gained competencies… I don't need to have the status or pay increase that goes with it. (TSW small acute Division).*

> *Learning for learning's sake is not ideal because if you are not using it you lose it basically. (PTA large acute Division).*

Analysis of the interviews with the assistants highlighted more perceived barriers to training and personal development than opportunities. Many talked

about time being one of the biggest barriers, both from a personal and a professional angle. If there were opportunities for attending teaching sessions or courses, often the assistant would feel too busy to take time away from their work and they reported having feelings of guilt if they did attend a course as it left more work for their colleagues. Occasionally a booked course was cancelled at the last minute due to staffing shortages and so they were unable to get away from their work area to attend:

> *You're lucky to get away for anything really. It's just so*
> *hard to get away just now. (ODA large acute Division).*

> *Things that hinder or prevent me from learning at work are*
> *lack of qualifications, lack of there being anything for our*
> *level, basically lack of anything for us. (RDA large acute Division).*

Others referred to family commitments, working part-time and missing any opportunities available, setting personal standards too high and outside interests preventing them from pursuing job related training and development:

> *If they simply increased my hours by one hour I would be able*
> *to attend the [teaching] sessions. (PTA large acute Division).*

> *The barriers are just basic stuff like staffing levels and timing.*
> *Commitment of where you're meant to be and its not people*
> *saying well you can't do that. (PTA primary care Division).*

One TSW reported that she had, along with a registered staff member, taken the initiative and set up a combined physio/OT therapy group for patients within her unit. It was held once a week for two hours and was well attended and verbally supported by both the patients and the nursing staff in that area. Without warning a directive came down from higher management in her discipline instructing them to discontinue. The reason given was that it was considered a waste of health professionals' time and money. No evaluation of the project was requested, it was simply stopped. The assistant felt that, apart from benefiting the patients, this had been a development of her role which was stopped abruptly. She was left feeling very frustrated and believing that management at a senior level were not interested in training and development for workers at her level:

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There is no autonomy in these posts. There is no opportunity to
think for yourself or progress really…. You'll always be just
'the assistant'. (TSW large acute Division).

The above is another example of a restrictive learning environment (Fuller and Unwin, 2004) where support of the employee as a learner was not in evidence and where management controlled the individual development of the employee.

6.5.5 Career pathways

Currently there is only one recognised career pathway in place for this group of staff and only for the CSWs from the large acute Division. The CSWs can undertake an SVQ at level 2 as a starting point, progress to HNC level and go on to join the second year of a nursing diploma course and ultimately register as a nurse. All other clinical assistants have no such career pathway mapped out for them although the organisation pays lip service to this situation by stating that this career pathway is open to all clinical assistants but only if they meet certain criteria, the main one being that they have the support of their manager. It is a general perception that they will not receive the support of their manager from any discipline other than nursing.   The consensus by the assistants was that if there was a recognised career pathway and more opportunity then there would be more people interested in learning more skills. This was particularly true as the assistants without a career pathway did not believe any current training offered would help their career progression:

…..say you were starting at a wage and they [management]
said well after you've done your competencies or whatever then
you get onto your next increment…but if you're not getting
anything out of it.. its much easier just to do the practical things.
(PTA primary care Division).

I think it would be fantastic if they said if you could achieve this
then… a structured training course and career pathway.
*(PTA large acute Division).*

No there is nowhere to go. (PTA primary care Division).

Once you get to a certain stage there's nothing else to look
forward to.   There's no other way.   It's only how you can do
your job better. (TSW small acute Division).

Although there is a definite career pathway for CSWs in the Acute sector it leads only to nursing which restricts other assistants who may want to progress in a different route.   For example some have expressed an interest in paramedic training, operating department practitioner training or pharmacy amongst other careers. These professions however have specific prerequisite qualifications which are not always attainable by certain assistants who, the managers believed, are therefore being marginalised by there being nothing else offered:

> *I think it is very good to have structure with career pathways and*
> *be very clear as to what the options are but I do think we should*
> *have more options so that it [suits] more people. (Nurse manager).*

Figure 6.1 illustrates the current career pathway available to assistants in this Health Board.
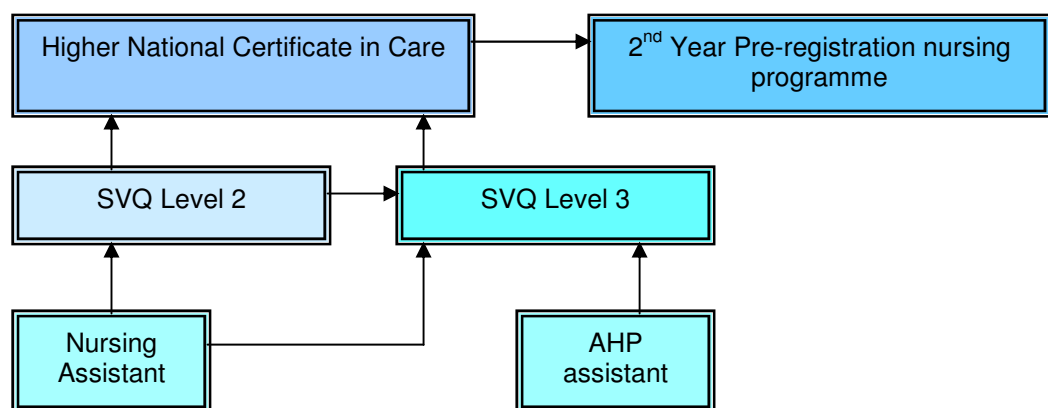
Figure 6.1 Current career pathway for assistant staff

As stated, in order to undertake an HNC the assistants must secure the support of their line manager as it involves day release study at a local further education college and the assistant must also have a mentor assigned to them in the clinical area.   The nurse manager believed that very few clinical managers would be willing to support their assistants in the pursuit of an HNC if the assistant then intended to move into a different profession:

> *..getting them [the assistants] released from the clinical areas…*
> *what's the value… if someone is in a CSW role but they*
> *are going away to do something totally different like pharmacy…*
> *what's the value in that ward supporting them when they*
> *are losing them? (Nurse manager).*

This is at total odds against the learning organisation concept and further represents a restrictive learning environment. However, as Fuller and Unwin (2004) argue, there may be many reasons why an organisation cannot reform their learning environment along expansive lines. This is an issue that is further investigated in this research and reported in the continuing chapters.

6.5.6 Supporting workplace learning

Paradoxically, although the most organised career pathway for assistants was offered in the large acute Division for the nursing assistants it was this area where staff felt least supported. In comparison, assistants in the smaller acute Division and in the community/primary care Division perceived much more support by managers and colleagues. Learning opportunities were more in evidence, both in-house and externally, and yet there was no defined career pathway in place for this group of staff. However not all of them believed that registered staff actively encouraged or supported them:

> *I think they're [registered staff] quite absorbed in themselves and their own jobs and getting the job done and they would probably say they don't have the time to encourage me.*
> *(OTA primary care Division).*

> *I'd say 80% [registered staff] are good and try and encourage you …then you get the 20% who…think well you are there to serve.*
> *(OTA small acute Division).*

Aspects of human resource management is devolved to line managers in the Health Board and it is a tacit norm for junior staff members to be assigned a mentor and when they are undertaking any formal training such as an SVQ, then they are also assigned an assessor to evaluate their performance. Only six out of the fourteen assistants interviewed reported having a mentor or assessor and two of these said that they had difficulty in meeting with them. The other two assistants, one from the smaller acute Division and one from the primary care Division, met with their mentors/assessors on a regular basis which was generally once per week to once every two weeks. These assistants felt supported by this arrangement, knowing that it was a regular occurrence.

One assistant inferred that the problem of resistance from staff was not particularly from her superiors but from her peers who made her feel she was

too enthusiastic and where they were content to come in and do their jobs she was making them feel inadequate because they were not asking for further training:

> *I'm continually pushing to go on courses and do other things and they're [registered staff and peers] not really supportive of that. I think they think you're trying to get above what you should be… it's not anybody new… it's the well established ones [peers] I have problems with. (TSW large acute Division).*

Some assistants believed that they would not receive any support from their senior colleagues to help them progress or gain more knowledge and skills and that their input was not valued by some registered colleagues:

> *…there's quite a division. I mean we work with them [registered staff] every day but I suppose there's a lot of things they wouldn't discuss with us… they go on courses and things but they never let us know about them. (OTA primary care Division).*

> *If you're untrained you're dispensable. (CSW large Acute Division).*

The above accounts have highlighted issues that are further investigated in the following chapters. These involve a more in-depth look at the NHSS as a learning organisation and its learning environment. Key issues continue to be access to training and development, access to accredited qualifications such as the SVQ, personal development planning, support from registered staff and colleagues and recognised development and career pathways.

6.6 Chapter Summary

This chapter has discussed findings from initial questions and issues covered in three broad sections that investigated the concept of the NHSS as a learning organisation, the learning environment within the NHSS and the strengths and weaknesses of the SVQ learning initiative all underpinned by discussion around opportunities and barriers to workplace learning. A main driver for training and developing staff was the apparent shortage of, and difficulty in, recruiting and retaining registered staff (Scottish Office, 1997b; Scottish Office, 1998a; Scottish Executive, 1999a). However the analysis of the interviews indicates

that existing training does not act as a springboard to career development or progression for assistant staff and therefore the current training and development provision is inadequate to address the problems of staffing levels and skillmix. The apparent narrow access to learning for this group of staff does not appear to lend to an expansive learning environment (Fuller and Unwin, 2004).

The SVQ as a learning initiative was largely considered to validate existing knowledge and skills rather than provide new learning. In this way the SVQ did not address learning needs (Munro and Rainbird, 2002; Grugulis, 2003) nor did it facilitate transferability of skills (Grugulis, 2003). The analysis of the phase one interviews has highlighted that there appears to be a general lack of insight regarding what the SVQs and other training, is meant to achieve. In some cases this can result in registered staff become territorial and reluctant to share experiences and knowledge with non-registered colleagues. However, the scenario differs across the Divisions and through departments within the Divisions and the hierarchy of access to training implies negative extrinsic factors (Rainbird, 1998) (see page 94). Access to training and personal development can depend entirely on the department that the assistant is employed in as there is no centralised budget for training nor is there a centralised policy relating to training and personal development of staff suggesting organisational inhibitors (Pearn *et al.* 1995) (see page 95).

Reorganisation of the NHSS has meant that the centres originally offering education and training to non-registered staff have in some cases disbanded and the work has been passed to other departments whose priorities are towards the registered staff. Despite the directives for training and development for all staff to be developed properly (Scottish Executive, 1999a) there is still no actual policy for this within the Divisions and as such it is often a very low priority in the clinical areas.

This chapter has identified issues that are further explored in phases two and three of this research. The findings from phase one have indicated that for the NHSS to become a learning organisation (Senge, 1990b; Dodgson, 1993; Nutley and Davies, 2001) it has some way to go to achieve this objective. A

more in-depth investigation into the outcomes of undertaking vocational qualifications is addressed, particularly regarding new learning and development of transferable skills and the impact on development and career pathways. Issues around access to learning opportunities for assistants and support from registered staff are further investigated. As the NHSS continues with reorganisation and restructuring, new proposals and strategic plans impacting on the assistant workforce and the perception of the existence of a learning environment in this organisation are examined.

Chapter Seven.   Phase Two: NHSS Staff Satisfaction Survey

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7.0 Introduction

This chapter examines data particular to the Health Board under study, gathered from reports on the staff satisfaction surveys that were conducted in the NHSS on three occasions from 2002 onwards.   There were limitations in analysing the data from 2002 and 2003 as these were published reports of the earlier studies and the raw data was unavailable.   However, access to the data from the most recent survey conducted in 2006 was available for analysis. Data particular to non-registered clinical staff are extracted from the survey results and answers by the groups under study to questions relevant to this research are examined and compared to that for other staff.

The chapter begins by describing the survey background and content and then discusses where this data came from.   Data made available (to the researcher) are described and explanation of the statistical approach adopted to analyse the secondary data is given.   The limitations of the survey data are discussed and the published reports and results are examined.   A discussion follows on the latest staff survey (2006) findings and their relationship to phase one of this study.   The chapter concludes by identifying questions raised from this phase to be taken forward to phase three.

7.1 Survey background and content

As discussed in chapter three, the staff satisfaction survey was undertaken to measure staff perceptions on the effect of policy in response to the key standards identified in the Staff Governance Standard (Scottish Executive, 2000:6).   The first staff survey was carried out in 2002, with another the following year in 2003 and a third in 2006.   The target groups for all surveys were **all** staff working in the NHSS.   Within NHS Lothian, 26,500 questionnaire packs were sent out to staff in 2002, 27,000 in 2003 and 21,722 in 2006. Response rates within Lothian were 25%, 17% and 33% respectively which is

low and could indicate response bias either way as there is no way of determining why respondents chose to answer. All of the questionnaires in all three surveys consisted of grouped questions within seven main headings as taken from the reports (see staff questionnaire as Appendix Four):

1. *Well informed* (to allow job to be done as effectively as possible).
2. *Appropriately trained* (to do job effectively and progress in accordance with knowledge and skills framework).
3. *Involvement in decisions* (that affect job).
4. *Treated fairly and consistently* (policies, procedures and behaviours practised in workplace).
5. *Provided with improved and safe working environment* (health and safety).
6. *Perceptions of the job and the organisation.* (support, morale, job security and benefits).
7. *Demographics.* Including age, gender, working pattern, disability, pay range and staff group.

The questionnaire asked for answers within a five point Likert scale of 'strongly agree' to 'strongly disagree' with the exception of the section on effective communication which was a six point scale of 'very effective' to 'not aware of it'. In this way, employees were asked to respond to their level of agreement with the statement. This type of questioning results in data that shows the sum of ratings for all of the categories and therefore deeper meaning from individuals cannot be gauged. For example, the statement *'I am satisfied with the recognition I receive for doing a good job'* – this statement is very broad and does not take account of variables such as pay, conditions or status and therefore the meaning is indistinct. Other statements are more direct such as *'I am able to access the training and development opportunities available to me'*. The design of the questionnaire is discussed later in this chapter.

Table 7.1 shows nursing, midwifery and AHP staff headcount in NHS Scotland and NHS Lothian for years 2002, 2003 and 2006. Interestingly over Scotland, the numbers of non-registered staff steadily increase in the community sector and remain relatively static in the acute. It is a similar picture in NHS Lothian.

Table 7.1: Nursing, Midwifery and AHP staff by headcount.

Scotland	Nursing and Midwifery						Allied Health Professions					
	2002		2003		2006		2002		2003		2006	
	Reg	NReg	Reg	NReg	Reg	NReg	Reg	NReg	Reg	NReg	Reg	NReg
ALL *	63,335		64,293		67,099		9,368		9,894		10,996	
Acute	34,861	18,283	35,541	17,938	37,862	17,199	7,731	1,637	8,094,	1,800	9,090	1,903
Community	7,766	1,202	8,075	1,276	8,843	1,654						
Physio **							2,321	255	2,395	242	2656	188
OT							1,446	311	1,537	289	1,794	185
Radiography							1,498	225	1,557	264	1,637	306
NHS Lothian												
ALL *	9,442		9,552		10,309		1,500		1,574		1,718	
Acute	5,509	2,682	5,571	2,680	6,128	2,552	1,268	232	1,327	247	1,482	246
Community	993	206	1,030	223	1,200	358						
Physio **							389	57	408	56	459	42
OT							268	55	279	62	308	42
Radiography							256	25	260	31	268	22

(Source ISD Scotland).

* Figure includes Senior Management, Occupational Health, Blood Transfusion Service, NHS24 and others for Nursing and Midwifery. AHP acute and community figures are combined.
** Breakdown of specialities within AHPs of interest in this study are shown

7.1.1 NHS Scotland's interpretation of the survey

In 2004 NHS Scotland published their 2003-2004 report on National Staff Governance. The report was produced by the Staff Governance Working Group and it described national findings following implementation of the Staff Governance Standard (NHSScotland, 2004:1). The report stated that overall the action plans by the Health Boards had been completed or were carried forward as a priority for 2004/05 (NHSScotland, 2004:1). The working group had gathered information on the response rate for the staff survey from 83% of NHSS organisations. The average response rate throughout Scotland was 39% and the group recognised that this figure was low.

It is impossible to say for sure why the response rate was so low but there may have been some response bias. There is the possibility that respondents were staff who overall were content in their job and were happy to engage with the survey but alternatively respondents could have been staff who were generally discontent in their job and looked at the survey as a way to make their feelings known.

The report summarised findings from the five key standards which are discussed below. The group reported that 'system-wide approaches to training and development interventions [were] at different stages of development throughout NHSScotland' (NHSScotland, 2004:4). Overall, throughout Scotland, the staff survey had demonstrated significant progress with an increase of 8% on the national average in the number of staff reporting that good training and development opportunities were provided by their organisation.

While there was a 12% increase in the number of staff reporting that they had a personal development plan, the group acknowledged that this figure was disappointingly low at 52% despite Chief Executives of NHS Boards being instructed to ensure that all staff had a personal development plan by the end of 2000 (NHSScotland, 2004:4). Formal partnership mechanisms had been in most organisations since 1999 but the report showed that only 17% of staff who responded were aware of these partnerships and the role they played in enabling staff involvement in decision making. In their recommendations, the group reported that NHSScotland had only completed its second year of the staff governance process and the move to single-system working had made progress slower than anticipated.

7.2 Survey data (made available)

The staff satisfaction survey was carried out in the NHSS to find out about the overall staff population's perceptions around the personal effects of HR policies. When an article was published in the organisation's monthly bulletin reporting on the outcome of the latest staff survey (2006), it was anticipated that the results could be used as secondary data, and therefore enhance the findings of phase one of this study. The intention was to examine the findings of the surveys and articulate them with findings from phase one of this study. It was also likely that the results would generate further questions for phase three. Access to the collated data from the survey results was requested. This was granted and organisational reports from the 2002 and 2003 studies were

supplied along with access to a resource described below that allowed the researcher to generate limited tables from the 2006 survey data.

The reports from 2002 and 2003 conducted by MORI Scotland (www.nhslothian.scot.nhs.uk/news/mediaroom) gave an overview of findings with statistical analysis in the form of percentages and brief discussion of the findings. The results from the 2006 survey were not yet published, and at the time of writing are still not published, but Excel spreadsheets covering answers to all questions in the survey were also made available to all Health Boards and access was granted by NHS Lothian to these spreadsheets. The results from the spreadsheets were particular to NHS Lothian although overall scores from NHS Scotland were also included. Six broad categories were available for analysis from the 2006 spreadsheets and were grouped as follows:

1. Health Board figures were broken down into corporate, acute and primary care sectors.
2. A further breakdown of the acute sector
3. A further breakdown of the primary care sector.
4. A breakdown of the acute sector into generic staff groups including administration, ancillary, dental, GPs, scientific and technical, senior management, nursing and midwifery and allied health professions.
5. A breakdown of the primary care sector into the same generic staff groups.

7.2.1 Statistical approach adopted

The 2006 spreadsheet did not supply a complete set of survey data but did cover the selection of the staff survey questions of interest to this research to complement data collected in phase one of this study. Although access to raw data was blocked, the spreadsheet allowed tables to be generated. The total number of responses and those showing the percentage positive scores for the questions of interest were extracted from the resource supplied by NHS Lothian (NHSL) and entered into the researcher's own Excel spreadsheet. Comparisons of interest were between:

➢ NHS Scotland as a whole and NHS Lothian (NHSL)
➢ Acute and community care sectors

- NHSL nursing staff and AHP staff
- NHSL registered and non-registered nursing staff
- NHSL registered and non-registered AHP staff
- NHSL non-registered nursing and AHP staff.

The survey results from NHSL had a high non-response rate and, as discussed on the previous page, there is no way to account for the employees who did not respond. Due to the random variation the percentages were subject to statistical random error compared to what might have been found in a larger sample. Where $P\%$ is the percentage calculated from the number of respondents (N) then the standard error due to random variation is $\sqrt{P(100-P) \div N}$. Where the P_1-P_2 is the difference between two percentages where P_1 is based on a sample of size N1 and P_2 is based on a sample of size N_2 then the standard error of the difference due to random variation is $\sqrt{P_1(100-P_1) \div N_1 + P_2(100-P_2) \div N_2}$ (Gardner & Altman, 1989:29). This error will be smaller in bigger samples. As the sample sizes varied the difference was calculated between groups and the standard error (SE) of the difference was calculated for each comparison.

The SE is an estimate of the standard deviation of the sampling distribution based on the data from a random sample. Using inferential statistics a researcher can make statistical inferences or draw conclusions about the data (Camilli, 1996). A confidence interval (CI) gives an estimated range of values which is likely to include an unknown population parameter, the estimated range being calculated from a given set of sample data. Therefore it is an interval with an associated probability generated from a random sample of a population. Confidence intervals only relate to the effects of the sampling variation on the percentages and their differences but do not control for errors such as biases in the study design, conduct or analysis or to non-response bias.

SEs quoted are those relating to the accuracy of the estimated effects where the measurements are obtained from a random sample. These can be used to assess if there is any evidence of difference that is likely to be more than chance. This is known as statistical significance. This involves calculating a p-

value which is the probability of observing a difference as large as found in the data by chance if there is really no difference between the two groups being compared. A small p-value indicates evidence that something more than chance is being observed. To calculate the p-value one first divides the difference found by its standard error and refers the value found to tables of the normal distribution. These tables show that if the absolute value of this ratio exceeds 1.64, 1.96 or 2.57 then the p-value is less than 10%, 5% and 1% respectively. This is an approximate result but it provides good guidance provided the sample numbers are large, which is the case for the survey data analysed here. This means that this difference is unlikely (less than 5% chance) to be due purely to random sampling variation. Therefore a small SE indicates a high degree of confirmation of results where a high SE would indicate a lot of uncertainty (Camilli, 1996). In the following tables * for $p<10\%$ is used, ** for $p<5\%$ and *** for $p<1\%$

Table 7.2 shows the response numbers from registered versus non-registered nursing and AHP staff in the 2006 survey. It should be noted that the AHP numbers in NHS Lothian will be particularly prone to random error as response numbers were low and so may not enable precise conclusions to be drawn.

Table 7.2. N = responses registered v non-registered nursing and AHP staff in Scotland as a whole and NHS Lothian - 2006.

Staff group:	Registered Nursing	Non-registered Nursing	Registered AHP	Non-registered AHP	Total
		Number of Responses			
All Scotland	14875	3811	4950	704	24340
NHS Lothian	2246	654	889	115	3904

(Source NHS Lothian)

7.2.2 Limitations of the survey data

The 2006 results were broken down into particular staff groups and generic professions only. This meant that there was no way to distinguish particular grades of staff or particular professions within the generic groupings. Registered and non-registered AHPs were therefore examined as single entities rather than specific professions within the generic title of AHP. Similarly the non-registered grouping for nursing and midwifery staff included nursing assistants and student nurses. This meant that the figures did not comment on

demographics and yielded only overarching data.   There was no opportunity to determine which specialities staff members were affiliated to and therefore no indication of whether one staff groups' perceptions differed from another's within the same organisation.   The response rates may have had a bias in the overall percentages and comparisons from similar respondents in the different staff groups may have therefore proved better had the raw data been available.

The following provides an overview of the results from the answers gathered from the Health Board in this study to statements and questions particularly concerned with training and personal development opportunities for staff.   The 2002 and 2003 data was gathered when the Health Board was still organised as separate Trusts.   Reorganisation to single system working and unification did not occur until 2004 when NHS Lothian was organised into an acute Division and five community health and care partnerships (CHPs) and therefore subsequent data is organised in a different format.   The 2006 survey was conducted by ORC International and the results disseminated as before to all Health Boards within NHSS.   Results from the three surveys relevant to questions of particular interest to this study are now discussed.

7.3 Staff survey results – all staff groups

The total headcount of staff in the NHS Lothian Health Board was 25,100 in 2002,   26,632 in 2003 and 21,722 in 2006.   With each staff survey carried out questionnaires were sent to **all** staff.   The total response in 2002 was 6,156 which equalled a 25% response rate; in 2003 4,415 responded equalling a 17% response rate and in 2006 7,144 responded which equated to a 33% response rate and was the largest response rate so far since the launch of the Staff Governance Standard.

Table 7.3 shows the response rates from the individual Trusts within the Health Board for the years 2002 and 2003.   The breakdown of figures for 2006 was not available in great detail and table 7.3 shows the figures for the entire Unified Division.   Interestingly, the total headcount in this Health Board has decreased substantially by 3,128 employees since 2002 and 4,616 employees since 2003.

Unfortunately, individual figures for staff groups and professions from 2002 and 2003 are not available for comparisons and no data is available to explain the overall decrease in numbers.

Table 7.3. Headcount and response rates 2002, 2003 and 2006.

	2002		2003		2006	
Totals:	Headcount	Responses	Headcount	Responses	Headcount	Responses
Scotland	u/k	u/k	u/k	u/k	u/k	49,206
Lothian:					21,722	7,154 (32%)
WLT	3,800	1,090 (28%)	4,083	517 (12%)		
PCT	8,700	2,270 (26%)	9,485	1,587 (16%)		
LUHT	12,350	2,374 (19%)	12,770	1,495 (11%)		

(2002/2003 source MORI Scotland on behalf of NHS Lothian). (2006 source NHS Lothian).

The primary care Trust (PCT) gave one of the highest response rates in 2002 and the highest in 2003. However, as staff groups were not identified in relation to the number of responses received, it is difficult to speculate on the reasons for this. Specific responses from the 2002 and 2003 reports concerning training and personal development planning are further compared in table 7.4.

Table 7.4. Percentage comparisons between Trusts in Health Board on training and personal development 2002 and 2003.

	2002				2003			
	All	**LUHT**	**PCT**	**WLT**	**All**	**LUHT**	**PCT**	**WLT**
Number of respondents	5,934	2,374	2,270	1,090	4,226	1,495	1,587	517
Statement	% agree				% agree			
Satisfied with current level of personal Training and development	46	41	51	49	50	41	57	53
Has a Personal development plan	43	42	47	40	49	44	54	49
Training needs regularly reviewed	42	37	47	39	48	38	55	45
Training and development helps (responder) do job more effectively.	63	61	66	66	66	59	74	70
Organisation provides good Training and development opportunities	50	44	57	55	57	45	65	62

(source MORI Scotland on behalf of NHS Lothian)

While the majority of responses indicated that good training and development opportunities were provided to some extent by the organisation, overall personal levels of training and development were presented in the reports as being insufficient. Responses from the larger acute trust (LUHT) demonstrate a

lower level of agreement to the statements. The data as presented indicates that overall, all respondents believed that training and development helped them to do their job more effectively (Nadler and Nadler, 1992; Pearn, Roderick and Mulrooney, 1995) but that they were less than satisfied with the provision of training and development.

Despite the strategic directive to have personal development plans in place for every employee by 2000 (Scottish Executive, 1999a), the figures indicate that this had not happened. As outlined, the NHSS had documented its commitment to becoming a learning organisation (Scottish Executive, 1999a). The responses from staff in the 2002 and 2003 surveys indicate that this Health Board within the parent organisation still had some way to go.

Table 7.5 shows a breakdown of responses by all employees in NHSL concerning the good provision of training and development for all three surveys. The reports from 2002 and 2003 provided identical tables for comparison. Responses from 2006 were extracted from the figures provided. The 2006 results did not have an exact match as some of the questions/statements were slightly ambiguous and therefore could be interpreted in different ways. For example the statement 'I am satisfied with the support I get from my work colleagues' could be referring to peer group members only or to the multi-disciplinary team. The statement 'My last performance review reflected by performance' could be either negatively or positively and therefore the responses are less meaningful. Only those that were exact have been illustrated here.

Those who responded were generally in agreement that training and development opportunities were in evidence in their organisation and that any training or development they had received was beneficial to their work. However, although the results were slightly more positive overall in 2003, the response rate was lower than 2002 and this could indicate bias either way. Similarly the response rate for 2006 was much larger than 2003 and again could indicate bias either way. In 2006, from the answers available, it appears that fewer respondents believed that they were able to access training and

development opportunities to improve both professional skills and personal development than reported previously.

Table 7.5. NHS Lothian - percentage agrees to statements around perceptions on the provision of training and development 2002, 2003 and 2006

	2002	2003	2006
Number of Respondents	6156	4415	7154
Statement		**% Agree**	
I know who has responsibility for my training and development	69	74	
Overall training and development has helped me do my job more effectively	64	66	
I am able to access training and development opportunities that further improve my practice/technical skills	61	63	
I feel that I am given the same opportunities to develop as other staff	60	64	
I believe the organisation provides good information about the training and development available to me	57	60	
I am able to access training and development opportunities that further improve my professional skills	57	62	54
I am able to use these new skills	56	60	
My line manager encourages me to continuously develop new skills	54	59	
If feel the organisation provides good training and development opportunities	51	57	
I am able to access training and development opportunities that further improve my personal development	51	57	53
I am satisfied with my current level of training and development	46	50	
I am able to access training and development opportunities that further improve my career	46	50	
I have a personal training and development plan	44	49	59
Training is provided to suit my working pattern (e.g. part-time, evenings, weekends if appropriate)	43	48	46
My training needs are regularly reviewed	42	48	
After training I review with my line manager what has been achieved	34	37	45

(2002/2003 source MORI Scotland on behalf of NHS Lothian) (2006 source NHS Lothian).

The net results from 2002 and 2003 show that in response to the statements: *'my training needs are regularly reviewed'* and *'after training I review with my line manager what has been achieved',* less than 50% agreed and this response continued in 2006 with only 45% agreeing. Having a personal development plan increased from less than 50% to 59% in 2006, a 10% increase from the previous year. However, this still means that 41% of respondents do not have a PDP and therefore although there is an improvement, there remains a serious gap.

Debates in the literature around personal development planning and employee satisfaction are ongoing where some writers argue that the use of staff appraisal and PDPs are important practices to identify learning needs and facilitate learning (Jessup, 1991; Walton, 1999; Clark, 2004). Other writers argue that there are limits to the appraisal tool (Rainbird and Munro, 2003) particularly where management dictate training strategies (Munro and Rainbird, 2004). The above results have indicated that where staff agree training and development helps them to do their job better, the provision of training and development opportunities identified through PDP is insufficient to meet the demand. This could result in staff becoming disillusioned with the intended purpose of PDPs if no tangible outcomes in the form of training are evident (Rainbird and Munro, 2003). The changes between 2002 and 2003 show that generally staff are more aware of the learning organisation ethos articulated by NHSL, regardless of whether or not they are fully cognisant of the concept of a learning organisation. By 2006 however, access to training and development opportunities was perceived as being less and any training that was provided was not always at a convenient time.

7.4 Further discussion of the staff survey 2006

The data from the 2006 staff survey was analysed to compare the findings with themes uncovered in phase one of this study. Phase one had highlighted particular recurring themes around perceptions of training and development opportunities, support and induction into roles. Comparison tables have been produced from the 2006 data to show differences between Trusts (as they were

prior to reorganisation) and Divisions and between nursing and midwifery and AHP staff groups within the Health Board under study. The following tables compare responses to ten questions from the staff survey covering training and development opportunities from the 'appropriately trained' section and an example from the 'well informed' and 'perceptions of the job and organisation' sections of the questionnaire to examine and articulate with the results from phase one. The tables show these staff groups from NHS Scotland as a whole and review results from NHS Lothian. Discussion of the findings follows presentation of the tables.

Table 7.6. NHSScotland - statistically significant differences in comparisons of ten specific questions extracted from survey response 2006.

NHS Scotland		Nursing & Midwifery				Allied Health Professions			
	All	Registered	Non-registered			Registered	Non-registered		
Number of Respondents	49206	14875	3811			4950	704		
Statement		% Positive Score		Diff	SE of Diff	% Positive Score		Diff	SE of Diff
I understand why the following changes are taking place within my NHS Board:-Agenda for Change	65	72	51	-21***	0.9	80	70	-10***	1.8
I received an effective induction into my job	64	65	73	8***	0.8	69	78	9***	1.7
Have you been involved in the Knowledge and Skills Framework Awareness training?	35	37	33	-4***	0.9	52	49	-3*	2.0
Do you have a Personal Development Plan (PDP)?	61	71	61	-11***	0.9	72	72	0	1.8
Have you had a performance review within the past 12 months?	47	48	42	-6***	0.9	56	54	-2	2.0
There are sufficient opportunities for me to receive training to improve my skills in my current job	49	52	49	-4***	0.9	50	49	-1	2.0
My performance has improved as a result of skills I have developed over the past year	56	63	54	-9***	0.9	68	62	-6***	1.9
My job makes good use of my skills and abilities	72	76	66	-10***	0.8	82	72	-10***	1.8
I believe this NHS Board offers me equality of opportunity	45	41	39	-3***	0.9	53	44	-9***	2.0
I am satisfied with the support I get from my work colleagues	74	75	71	-5***	0.8	81	82	0	1.6

(Source NHS Lothian).

*(p-value = *for p<10%, ** for p<5%, *** for p<1%)*

Table 7.6 shows results to these ten questions from NHS Scotland as a whole. The results indicate that differences between the registered and non-registered nursing staff for answers to all questions show statistically significant differences, meaning that the differences between groups are unlikely to be just due to random sampling errors. Nursing assistants throughout Scotland reported more positive responses to receiving an effective induction into their job than their registered colleagues. Far fewer understood why changes in the form of AfC were taking place in their Health Board. Only 33% (n=1,257) of nursing assistant responders had been involved in the KSF awareness training and this appears to have been evenly spread across all staff groups with the overall figure being low at 35% (n=17,222). This result was despite the drive to introduce this framework as an integral part of AfC.

61% (n=2,325) of nursing assistants reported having a personal development plan which matched the national score of 61% (n=30,016) from all employees in NHSScotland. This was an interesting result as only 42% (n=1,601) of nursing assistant responders agreed that they had received a performance review with the past 12 months and yet the PDP is intended to be an integral part of the performance review. Less than 50% (n=,867) believed that they had sufficient opportunities to receive training to improve their skills and only 54% (n=2,058) believed their performance had improved as a result of skill development. Interestingly while only 39% (n=1,486) of nursing assistant responders believed that their Health Board offered equality of opportunity, 71% (n=2,706) were satisfied with the support they received from their work colleagues. This statement is rather ambiguous and could relate to either recognised assessment and/or mentorship at work or to general camaraderie in the clinical area. Comparing it to the equality of opportunity statement it is likely to be the latter.

The results also showed some statistically significant differences for AHP assistants in relation to their registered colleagues. While 78% (n=549) of AHP assistants answered positively to receiving an effective induction into their jobs compared to 69% (n=3,416) of qualified AHP responders, this was a difference of 9 with a standard error of 1.7 indicating precision in the results from the random sample. AHP assistants answered less positively than their registered

colleagues to the statement around understanding why changes with AfC were taking place in their Health Board. Similarly they answered less positively to the statements around improved performance as a result of skill development, good use of skills and abilities in their job and equality of opportunity within their Health Board.

More than half the workforce who responded to the questionnaire had a personal development plan in place at an overall score of 61% (n=30,016). This figure still falls far short of the projected figure of 100% expected to be achieved by all Health Boards by the year 2000. However, only 47% (n=23,127) had received a performance review within the past 12 months and only 49% (n=24,111) overall believed there were sufficient opportunities to receive training to improve skills. Equality of opportunity in general for the majority did not score positively with 55% (n=27,063) of the Scottish workforce reporting there was no evidence to support this statement.

Table 7.7 on the following page compares answer to the same questions by NHS Lothian registered and non-registered nursing staff and registered and non-registered AHP staff. The results indicate that differences between the registered and non-registered nursing staff for answers to all questions show statistically significant differences as above. The responses from the AHPs however, are statistically significant in only the question on satisfaction with support from work colleagues. This may not be due to inherent differences but to the fact that smaller numbers in AHP groups in NHS Lothian are more affected by random noise. In this way there is no predictable relationship between the question and response and results may be less reliable which could indicate response bias either way. The AHP assistants indicated positively that they were satisfied with support received, more so than their registered colleagues. However, it is impossible to determine whether they meant specifically their peers or their registered colleagues or both. AHP assistants had less understanding than their registered colleagues on why changes were taking place within their Health Board around AfC.

Nursing assistants gave less positive responses to most of the 10 questions. They responded more positively to having received an effective induction into their job and there was no difference in their response to believing that their

Health Board offered equality of opportunity. In this statement the positive percentage score was low overall at 48% (n=3,433). Far fewer nursing assistants had been involved in KSF awareness training, had a PDP or a performance review within the past 12 months. Only 56% (n=366) of nursing assistant responders believed there were sufficient opportunities to receive training to improve their skills and this result supported their response to the statement that their performance had improved as a result of skill development (58%: n=379).

Table 7.7. NHS Lothian – statistical differences in comparisons of ten specific questions extracted from survey response 2006.

NHS Lothian		Nursing & Midwifery				Allied Health Professions			
	All	Registered	Non-registered			Registered	Non-registered		
Number of Respondents	7154	2246	654			889	115		
Statement		% Positive Score		Diff	SE of Diff	% Positive Score		Diff	SE of Diff
I understand why the following changes are taking place within my NHS Board:-Agenda for Change	64	71	49	-22	2.2	82	73	-9**	4.3
I received an effective induction into my job	68	70	76	6***	1.9	73	80	7*	4.0
Have you been involved in the Knowledge and Skills Framework Awareness training?	47	52	43	-9***	2.2	72	73	1	4.4
Do you have a Personal Development Plan (PDP)?	59	70	56	-14***	2.2	70	75	5	4.3
Have you had a performance review within the past 12 months?	51	51	42	-9***	2.2	61	62	2	4.8
There are sufficient opportunities for me to receive training to improve my skills in my current job	54	60	56	-4**	2.2	51	59	8*	4.9
My performance has improved as a result of skills I have developed over the past year	59	66	58	-7***	2.2	70	61	-9*	4.8
My job makes good use of my skills and abilities	74	78	70	-8***	2.0	83	79	-4	4.0
I believe this NHS Board offers me equality of opportunity	48	45	46	0	2.2	56	58	2	4.9
I am satisfied with the support I get from my work colleagues	77	79	73	-6***	1.9	86	93	7***	2.7

(Source NHS Lothian).

(p-value = *for p<10%, ** for p<5%, *** for p<1%)

The standard error shows no statistically significant difference between registered and non-registered nursing and midwifery staff in relation to opportunities for skills development and equality of opportunities. Once again responses to several of the questions, at face value, indicate that registered and non-registered AHPs overall feel more positive towards training and development opportunities than their nursing colleagues. The statement concerning sufficient opportunities to receive training to improve skills has a less positive response at 51% (n=453) of registered AHPs.

Overall in NHSL involvement in the Knowledge and Skills Framework (KSF) awareness training was reported as being low at 47% (n=3,362) of all responders. The figures indicate that while 64% (n=4,579) of staff surveyed understood why changes were taking place within their Health Board around AfC, far fewer nursing and midwifery staff had been involved in KSF awareness training despite the drive to introduce this framework as an integral part of AfC.

Several strategic documents (Scottish Executive, 2003b, 2003d) have reinforced the expected positive outcomes of effective induction for staff into their posts. In NHS Lothian, this survey indicates that a high percentage of both nursing and AHP staff (registered and non-registered) report receiving an effective induction into their job although the figures are higher for the assistant staff. At 68% (n=4,864) this figure is on a par with the national average which was 64% (n=31,492) of responders.

More than half the workforce who responded to the questionnaire had a personal development plan in place at an overall score of 59% (n=4,221). Again this figure still falls far short of the projected figure of 100% expected to be achieved by all Health Boards by the year 2000. Furthermore only 51% (n=3,649) overall reported receiving a performance review within the previous 12 months.

In general the NHS Lothian figures indicate that over half the responders (54%: n=3,863) believed there were sufficient opportunities to receive training to improve skills in their current job. Similarly, overall there were more positive responses concerning skills development, support from colleagues and

performance reviews than the national average. However, perception of equality of opportunity in their Health Board remains low for the majority of responders at 48% (n=3,434).

*Table 7.8. NHS Lothian: **statistical differences in comparisons of five specific questions between same group staff in acute and community Divisions. Extracted from survey response 2006.***

NHS Lothian	Registered Staff							
	Nursing & Midwifery				Allied Health Professions			
	Acute	Community			Acute	Community		
Number of Respondents	923	1091			354	462		
Statement	% Positive Score		Diff	SE of Diff	% Positive Score		Diff	SE of Diff
I received an effective induction into my job	67	71	4**	2	71	74	3	3
Do you have a Personal Development Plan (PDP)?	72	67	-5***	2	74	67	-6**	3
There are sufficient opportunities for me to receive training to improve my skills in my current job	53	66	13***	2	46	56	9**	4
I believe this NHS Board offers me equality of opportunity	44	47	4**	2	53	60	7***	3
I am satisfied with the support I get from my work colleagues	76	82	7***	2	81	91	9***	2

	Non-registered Staff							
	Nursing				Allied Health Professions			
	Acute	Community			Acute	Community		
Number of Respondents	176	379			25	80		
Statement	% Positive Score		Diff	SE of Diff	% Positive Score		Diff	SE of Diff
I received an effective induction into my job	73	79	6*	4	38	85	48***	10
Do you have a Personal Development Plan (PDP)?	66	53	-12***	4	76	76	0	10
There are sufficient opportunities for me to receive training to improve my skills in my current job	51	59	8*	5	26	65	39***	10
I believe this NHS Board offers me equality of opportunity	46	47	1	5	48	58	11	11
I am satisfied with the support I get from my work colleagues	67	77	10***	4	90	94	3	6

(Source NHS Lothian).

*(p-value = *for p<10%, ** for p<5%, *** for p<1%)*

Table 7.8 on the previous page is a further breakdown of responses to the five specific questions that will form the basis for further investigation in phase three, although all 10 questions will be investigated in more depth. The table shows comparisons of staff in NHS Lothian, and compares both registered and non-registered staff in the acute Division to their colleagues in the community Division.

It is interesting to note that the number of responses to the staff survey was higher in all staff groups from the community Division despite there being far more clinical staff employed in the acute sector. Answers by community registered nursing staff were all statistically significantly different by a higher percentage positive score apart from the statement on PDPs. The community AHP registered staff answers showed statistically significant differences in all but the statement on induction. Again fewer AHP registered staff reported having a PDP.

Numbers of respondents from the non-registered staff are low which makes analysis more difficult as the standard errors are becoming high and therefore the percentage positive score is unreliable, particularly in the AHP non-registered staff group. Within the non-registered nursing group variations are in evidence particularly in two statements. Only 53% (n=201) reported having a PDP compared to 66% (n=116) of their colleagues in the acute sector. The difference was -12 with a standard error of 4. However, 77% (n=292) stated they were satisfied with the support received from work colleagues which was a higher percentage than their colleagues in the acute sector.

Comparisons of the results from the staff survey data of 2006 were also separately conducted on the acute Division, the community Division and on nursing assistants versus AHP assistants in the acute and the community. The acute Division showed statistically significant differences in some responses between the AHP assistants and their registered colleagues particularly around receiving an effective induction and receiving training to improve skills. All of the staff groups in the acute Division gave a higher than 50% agreement response to having a PDP. Satisfaction with support from colleagues was in evidence although there was a statistically significant

difference between nursing assistants who reported less support than their registered colleagues with a difference of -9 and a standard error of 3.8.

Statistically significant differences were most in evidence in the community Division, particularly between nursing assistants and registered nursing staff. In all categories the standard error was less than 3 indicating confidence in the percentage scores. Nursing assistants in this Division scored less than 50% in questions on AfC, KSF, performance review and equality of opportunity. While there were some differences between AHPs and AHP assistants' answers, the number of responses rate from these assistants was small and therefore more difficult to compare confidently.

Interestingly AHP staff in the community Division answered more positively in response to the question of equality of opportunity than their nursing colleagues, (AHP 60%, AHP assistants 58% / nursing 47%, nursing assistants 47%). While all groups in the community Division reported positively on satisfaction with support from colleagues, the AHP assistants scored highest at 94%.

In comparisons between the nursing assistants and the AHP assistants in both Divisions the results rendered similarities. However, the number of responses was extremely small, particularly from the acute AHP assistants and therefore statistical analysis was not as effective. At face value the AHP assistants in the community Division answered more positively than the community nursing assistants in all questions. A similar picture emerged in the acute Division where the AHP assistants answered more positively in 6 out of the 10 questions.

While nursing assistants in both the acute and community Divisions and AHP assistants in the community Division answered positively to receiving an effective induction, only 38% of the AHP assistants in the acute Division responded positively to this. The nursing assistants in both the acute and community Divisions scored less than 50% positive to being involved in the KSF awareness training whereas AHP assistants from both Divisions scored above 50%. While all scored over 50% concerning having a PDP, the nursing

assistants in both the acute and community scored less than 50% on receiving a performance review in the last twelve months. Interestingly only the AHP assistants in the acute Division scored less than 50% positively (at 26%) on there being sufficient opportunities to receive training to improve skills. However, all but the AHP assistants in the community scored less positively than 50% in the equality of opportunity question. While all scored over 50% positively on satisfaction with support from work colleagues, the AHP assistants in both acute and community scored very high at 90% and 94% respectively.

7.5 Chapter conclusions and questions for phase three

This chapter has given a brief background to the purpose of survey, explained the survey content and commented on reports from the survey provided by the Health Board. Particular attention was paid to the findings from the grouped questions under the headings of 'well informed', 'appropriately trained', 'treated fairly and consistently' and 'perceptions of the job and the organisation' which allowed for comparisons between staff groups and professions under study.

Many of the results from the staff survey data support findings from phase one of this study although there are some differences. One of the five key standards from the staff governance report included keeping staff well informed. The results from the staff survey indicated that this was one area that had not improved. Awareness of changes to pay and conditions under the AfC strategy was less by assistants than registered staff. Similarly few assistants had received KSF awareness training which will impact on PDPs.

While phase one of this study showed assistants perceived they had fewer opportunities to receive training and that equality of opportunities was biased towards registered staff, as a point of interest the staff survey results indicated that the registered staff feel equally disadvantaged in these areas.

Responses to several of the questions, at face value, indicate that registered and non-registered AHPs overall feel more positive towards training and development opportunities than their nursing colleagues. This is interesting

considering that, compared to their nursing colleagues, to date fewer strategies and policies have been introduced by special Health Boards (such as NHS Education for Scotland) in educational support for this group of staff. Also this is at odds with opportunity for skills improvement and career pathways.

Overall these figures suggest that within each Division there are marked differences in the opportunities offered to assistants dependent on which profession they are affiliated to although the survey results available did not define this accurately. It is necessary therefore, to investigate this further in phase three by studying employees from both nursing and AHP professions in both acute and community settings. The survey results suggest that AHP assistants in particular responded positively to receiving support from their work colleagues. As this is an important element of workplace learning (cf Pedler *et al.* 1996; Rainbird, Munro, Holly and Leisten, 1999; Nutley and Davies, 2001; Fuller and Unwin, 2004), phase three further investigates this and ascertains which group of colleagues in particular give the most support.

The concept of induction to the job is further investigated in phase three. Both nursing and AHP assistants reported receiving a more effective induction than registered staff and this is a phenomenon that deserves more attention as staff survey results could not examine this in depth. Questions on communication of information, staff awareness of opportunities for training and development and perceptions on career pathways are also further examined in phase three.

The survey questionnaire only allowed for ratings answers so that deeper meaning or variations to answers could not be gauged. Phase three therefore includes gathering rich in-depth data from answers to the questions outlined above. This addresses three of the five key standards in the performance assessment framework of the staff governance standard: 'well informed', 'appropriately trained' and 'treated fairly and consistently' and expands on results from both this phase and phase one of the study. Phase three is discussed in the following chapter.

Chapter Eight. Phase Three Interviews
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8.0 Introduction

This chapter discusses the concept of the NHSS as a learning organisation through a report on phase three of the data collection and discussion of themes identified previously.   In this phase, in-depth interviews were conducted in order to probe more deeply into the themes that had emerged from the first round of interviews (chapter six) and analysis of the secondary data from the staff survey (chapter seven).

This chapter is organised in four main of sections.   The first section outlines the context in which the empirical data was collected.   The following sections expand on the themes of learning in the workplace and address the key debates around the concept of a learning organisation (Senge, 1990; Pedler *et al.* 1996) and the concept of expansive/restrictive learning environments (Fuller & Unwin, 2004).   The previous chapters discussed the SVQ as a learning initiative and this theme is further developed in partnership with the concepts of competence, support for learning and career pathways for the assistant group of staff in the NHSS.

8.1 Context of phase three data collection

For this phase, one group interview was conducted with twelve assistant participants and nine other assistants were individually interviewed, representing all three Divisions of the Health Board under study and consisting of three from nursing, three from occupational therapy and three from physiotherapy.   In addition, six identified experts were interviewed for their specific knowledge of issues identified.   Table 8.1 on the following page gives an illustrative breakdown of participants in this phase.

Assistants			Experts
Large Acute	**Small Acute**	**Primary Care & Community**	**All**
Nursing Assistant	Nursing Assistant	Nursing Assistant	HR Manager – Health Board
Physiotherapy Assistant	Physiotherapy Assistant	Physiotherapy Assistant	NES Education and Training Manager (Nursing & Midwifery)
Occupational Therapy Assistant	Occupational Therapy Assistant	Occupational Therapy Assistant	NES Education and Training Manager (AHPs)
	Group Interview		Regulation Manager - SGHD
			SVQ Facilitator / Assessor (AHP)
			SVQ Facilitator / Assessor (Nursing & Midwifery)

Table 8.1 Illustrative breakdown of participants in Phase Three.

This final phase took place as the NHSS was embarking on a pilot initiative to regulate healthcare support workers in NHSScotland. This section provides the context and discusses the significant strategic plans for the clinical assistant workforce. Regulation will influence the future education, training and development of clinical assistants in NHSScotland as regulation is to be based on minimum 'induction standards' for public protection which requires a minimum level of education and training.

8.1.1 Significance of regulation on clinical assistants' learning and development

Healthcare assistants have been brought to the forefront of proposed strategic changes in the workforce in recent years. Regulation for non-registered healthcare support staff, including clinical assistants, is currently being piloted in Scotland. The evaluation of the pilot will inform the way forward for all four countries in the UK.

The proposed regulation is likely to have a huge impact on non-registered clinical staff and their education and development. As part of this research the views of managers and assistant staff were sought regarding the effects of current and proposed strategies and policies on assistants' personal

development.   The drivers for regulation were described by an education and training manager from NHS Education for Scotland (NES) as being open career structures and the lifelong learning agenda:

> *Everything you'll read at the moment will say that there's*
> *a need for national clarity, transferability and flexibility…*
> *related to open career structure and part of lifelong learning…*
> *(NES Education and Training Manager).*

These drivers are complemented by others from the service side of the NHSS, particularly in remote areas such as the Highlands and Islands of Scotland, where a shortage of qualified staff has spurred on developments in an attempt to meet the needs of the service.

Regulation is not at present intended to include *registration* for this group of staff.   That would involve a centralised registration process through a governing body which would incur costs for NHS organisations and for individual assistant employees.   It would also intimate that the non-registered staff group would hold a 'professional' status which the UK regulation steering group did not feel was appropriate.

The current plan is that regulation will be employer led.   This means that the required standards will be articulated at a national level and then the processes of meeting the standards will be devolved to the individual Health Boards to put programmes of development in place.   Responsibility for this will likely be with the training and development or practice development units of each Health Board.   Each individual Health Board will be responsible for maintaining a record of their own employees and regulating their participation towards meeting the standards.   There does however remain the possibility that a centralised 'list' will be held through the new Scottish Workforce Information Standard System (SWISS) repository.   This model of regulation was decided by the national steering group who had considered the various options.   It is intended that the regulation of healthcare support workers will be articulated to specific occupational standards but there is unlikely to be any requirement for formal qualifications for this group.   A Scottish Government Health Division (SGHD) regulation manager stated that regulation is not about facilitating

attainment of qualifications for support workers, rather it provides a foundation for future learning based on threshold standards of competence underpinned by national occupation standards.

One HR manager of the Health Board under study hoped that the development of the standards for regulation of this group of staff would allow local organisations to accredit individuals against the standards which would go some way towards recognition of previous learning. He believed this was appropriate through clinical governance and the model of employer led regulation. The regulation manager reported that some non-registered staff were aware of the plans around the regulation pilot as she had received correspondence from a few. Most often their queries focused on the possibility of registration, suggesting that regulation and registration are often considered synonymous. This indicates that while information around regulation may be filtering down to non-registered staff it is not necessarily the correct information.

In view of the changing roles for non-registered staff, all participants in this research were in agreement that regulation was necessary. An education and training manager presumed that part of regulation would be evidence of continuing learning by the non-registered workforce but so far, this has not been an apparent part of the pilot. The absence of a centralised register of regulated assistants could have impact on the relevance of any training, education or development of staff. Registration requires maintaining an evidence based portfolio of achievement which demonstrates a level of knowledge and experience and can be used as transportable accreditation (Grugulis, 2002). This particular group of staff have not been encouraged to maintain a portfolio of achievement and without this evidence the transportability of credentials could be problematic (Grugulis, 2002) and may result in duplication of effort on moving to a different Health Board.

8.1.2 Significance of other strategic and policy developments for assistants

The other major strategic and policy developments taking place within the time frame of this research included agenda for change and the knowledge and skills framework which formed a major part of AfC. The non-registered participants

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perceived that AfC had made no difference to their current roles. However, there continued to be some confusion around job titles which vary considerably, both countrywide and specifically within the Health Board under study. In the large acute Division nursing assistants are known as trainee clinical support workers until they have completed an SVQ when they are then called clinical support workers. In the smaller acute and primary care Divisions they continue to be known as nursing assistants, auxiliary nurses or clinical support workers. AHP assistants have a variety of titles, dependent on the profession they are employed by and their specific job role.

Job assimilation which involved being moved from a Whitley Scale grade to an AfC band had been completed during 2006/7 for the assistants in this study and all of them had been placed at band two as they had expected. No one was able to say for sure what this meant for example in terms of monetary reward for undertaking an SVQ. Historically, following successful completion of an SVQ an assistant would, in the large acute Division, be awarded a minor elevation in salary, although their actual grade would not change. AfC has levelled out the pay band and there was no answer regarding whether or not the practice of a small pay increase would continue. Furthermore, it was never the intention for the nursing assistants in the small acute Division who were undertaking an SVQ to receive a pay rise. This was due to the fact that they did not have the opportunity to learn extra clinical competencies (see chapter six, page 161), which will be discussed later in this chapter, and therefore their learning was not considered to come under the title of a 'clinical skills programme' as offered in the other Divisions. A clinical skills programme is a 'learning package' consisting of an SVQ and extra clinical competencies.

This disparity meant that should the assistants in the smaller acute Division wish to move elsewhere within the Health Board they would be required to undertake further training in clinical skills. Furthermore, with no consistency in titles, confusion is probable as it is likely to be an expectation that any nursing assistant at band two of AfC with an SVQ would have undertaken a 'clinical skills programme' and this would not be the case.

While KSF was promoted as a tool to address the inconsistencies in workforce development not all assistant staff were fully cognisant of the concept. Although there were 'awareness days' made available to all the staff in this Health Board on KSF, the majority of non-registered staff participants knew very little about it other than vague notions of it having 'something to do with PDP'. From the meagre understanding that the assistants had around KSF, most believed it to be a way of being upgraded or given more money for working harder to meet the standards. These perceptions indicate that the assistants' understanding of KSF is mis-directed. KSF will work as a development tool in so far as knowledge and skills for the job at hand will be addressed through the identification of levels of required standards. What it will not do is add to the personal development of an employee outwith the boundaries of their existing role. If information around KSF is misunderstood as this research has shown, then there may be a tendency by non-registered employees to rely on KSF to provide a transparent career pathway for them which is not the case.

Several initiatives have either commenced or been proposed during the time frame of phase three which could enable some assistant staff to advance but generally there are limitations to these. For example, in this Health Board one SVQ facilitator/assessor reported that additional clinical competencies (which will be discussed later) were being added to the clinical skills portfolio every month as specific skills required for some assistant posts. In 2007, a pilot scheme commenced in the Health Board where chemotherapy and oncology nursing assistants are now being trained to a level that equates to a higher level senior assistant and given their own workload to manage. Their job includes procedures and tasks that were usually the remit of the registered nurse. In theatres, some assistants are being trained to scrub and assist in minor operations. On a national level, radiography assistants in some places already have the opportunity to train to a higher level and to undertake non-complex radiographic images of adults or in a radiotherapy department assist in delivering radiation treatment of cancers. However, none of the assistant participants in this study were fully cognisant of these development opportunities which in reality are few. This training is only available to staff already in post in these particular areas and therefore these initiatives, while

providing development opportunities for some non-registered staff, are of little use to the majority of others.

8.2 Learning in the workplace

In the previous two phases of data analysis, recurring themes around workplace learning focused on the introduction to the place of work, informal and formal learning opportunities and recognition of previous learning and access to learning. The perceptions of non-registered clinical staff on these themes are now discussed.

8.2.1 Induction for assistant staff in study Health Board
The analysis of phase three data suggests that the range of education and training opportunities for the non-registered clinical workforce differs greatly across the Divisions of the Health Board under study. This Health Board has begun to re-organise the local Divisional education and training departments to merge them into one centralised department. The intention is that the apparent disparities in education and training provision between the Divisions will be negated as all staff will have access to the same training and education opportunities.   Regardless of this, at local departmental level between professions and between units within those professions, the analysis of the interviews shows that the differences are still marked which is in keeping with the results from the staff survey (chapter seven).   The HR manager was determined to address the disparities and intended to gain consensus on what was mandatory so that all staff would receive that training.   What was considered developmental would then be made available across the Divisions:

> *What I really want to do is to move on to identification by each*
> *group of staff of what's mandatory and what's developmental*
> *so… [some]… could be deemed as … straightforward mandatory*
> *types of programmes (HR manager).*

One of the most significant mandatory programmes delivered by the Health Board for new employees is induction to the workplace.   Historically, this has varied across Health Boards and disciplines and has often been conducted at a

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local level.   The national strategic plans instructed that a robust induction was to be provided by all Health Boards (Scottish Executive, 1999a) and both the HR manager and the regulation manager alluded to an initiative whereby the induction period would become uniform across the Health Service for new employees.   As induction involves education and training, non-registered participants were asked to recount their experiences and perceptions of their own induction to their posts.   The answers were variable and analysis of the responses showed that while all employees had some sort of induction, the length and depth depended on the discipline that the employee was affiliated to and the clinical area that they were employed in.

Nursing assistants in general received a longer, more organised initial induction which included both corporate and clinical elements.   The AHP assistants in general received corporate induction only and clinical induction was carried out at local level.   However, as the following quotes illustrate this was not uniform policy and could vary across disciplines, departments and sites:

> *[I had] just a two day thing and [then] in the door (nursing assistant - medical ward, large acute).*

> *It was two half days, not even a full day and that was you – you would get on with it (nursing assistant – medical, small acute).*

> *I got a full week.. it was everything.. a tour of the hospital, each ward, introduced to staff…(OTA – community hospital).*

> *I… shadow[ed] everyone on the ward.. all different grades from assistants up to seniors and the clinical specialist….they did a lot of teaching with me…it went on for a good couple of months … so it was really good (PTA – large acute).*

Personal values and attitudes can be modified by immediate peers and line managers (Lovell, 1980; Reid and Barrington, 1999) and the literature discussed tacit knowledge, which is non-codified and ingrained in actions and practices of particular contexts in an organisation (Megginson, 1994; Rigano and Edwards, 1998).   Where no formal introduction into healthcare is given through a robust induction, it will then result in learning by experience through using existing staff as role models.   As discussed in the literature, this is not always a good thing.   Outcomes of tacit knowledge and informal learning are

not able to be measured (Marsick and Watkins, 1997; Clark, 2004; Keep, 2004). If sub-standard attitudes and values are introduced and reinforced through tacit knowledge and informal learning this is unlikely to reflect the standards expected by the organisation as a whole.

As discussed, the current induction in this Health Board has a uniform element where all new employees are given information on the structure and expectations of the employer and fundamental skills such as moving and handling and basic life support. Thereafter only nursing staff, both registered and assistants, are given a further short period of induction on policies, procedures and, in the case of the assistants, basic clinical skills. AHP assistants do not receive any further centralised induction and it is left to their clinical area of employment to decide whether anything further is required locally. It is significant therefore that the phase three data analysis suggests, in general, AHP assistants receive a more in-depth induction regardless of this. Localised induction for AHP assistants can include awareness of relevant local strategies and policies, introduction to the team and to working procedures, knowledge of other agencies and sectors involved in patients' care requirements and in some cases, underpinning knowledge to specific therapies for patient treatments.

There is no recorded rationale for this decision to exclude AHP assistants from the lengthened centralised induction but it appears to be a tradition within this Health Board. While it appears however that their localised induction is more enhanced than a lengthened centralised induction, the issue is in the parity of this provision which varies between departments and professions. The assistant staff are being compartmentalised from the outset which does not lend to creating a flexible workforce with transferable skills (Scottish Executive, 1999a) nor does it equate to a expansive learning environment (Fuller and Unwin, 2004) within a learning organisation (Senge, 1990; Pedler *et al.* 1996). Furthermore a haphazard induction period could have some influence on the uptake of further training and education if it is originally seen as holding little importance to the initial development of employees. This phase of reorganisation in the NHSS and the imminent introduction of regulation policy is an ideal time to ensure that all assistant staff are given the same fundamental

introduction to healthcare and to their workplace. By providing an agreed organisational standard at induction, further learning in the workplace can be benchmarked by the learner against the induction standards and could go some way to recognising the outcomes of tacit knowledge gained in the workplace thereafter (Marsick and Watkins, 1997; Clark, 2004; Keep, 2004).

8.2.2 Other learning in the workplace

As discussed in chapter four, learning in context (cf Eraut, 2004; Clark, 2004; Coffield, 2000) is argued to be an effective method of increasing personal knowledge as the learner can relate the new knowledge immediately. This was obliquely referred to by some participants when they discussed learning in their workplace and the intention was to discover if, in addition, they perceived formal learning was of benefit in their job role. Most participants believed formalised, certificated learning was of benefit and increased their personal confidence. However, they reported that experiential learning and specific training in skills and competencies required for their immediate roles was of more benefit than any formal qualification in allowing them to carry out their jobs effectively. This perception was followed by the assertion that some sort of validation of competence was still required:

> I think it is [important] in a way.. we need to know stuff… not
> [a formal qualification] itself but the competencies that come
> with it I think, but apart from that.. no [formal qualifications
> are] not required (nursing assistant – large acute).

> … showing that piece of paper says that you have studied or
> you are capable to that level… but I think experience counts for
> much more (PTA – small acute).

One PTA from primary care who had previous qualifications in another discipline up to masters level said that she believed a more formalised programme of *training* was preferable rather than attaining specific qualifications as that would allow people to develop in a more structured way.

> I think if you have formal training… [this] would make you more
> comfortable with your own role and your own knowledge …
> otherwise you can get yourself into situations where actually
> you think you are helping but your are hindering and I think
> that's important to know (PTA, primary care)

Some assistants described learning by observation in the workplace as being more meaningful because they were learning in context. This was particularly true where specific skills were involved such as measuring a patient for a walking frame or learning the procedure for follow up treatment after discharge of a patient.

The HR manager was in favour of workbased experiential learning rather than off-the-job learning as he believed that this had a greater benefit for a variety of reasons. These included the cost and time involved in taking someone away from the workplace to study and having to 'backfill' their post for the duration of the study. Also, as many staff now worked twelve hour shifts this did not fit in with 'normal' study days which were generally between the hours of nine to five. Staff attending a study day had to make time up, either by returning to their workplace following the study day or at a later date. This posed enormous problems for those people who came off night duty to attend study days. The HR manger believed that the current way of delivering education and training would have to be re-visited:

> I think what we should be doing is actually working out a training
> plan for the department and an awful lot of study time for …
> non-qualified clinical staff should be on-the-job as an experiential
> thing (HR manager).

The HR manager believed that experiential learning was a more meaningful way to learn and had the added benefit of being easier to manage.

One SVQ facilitator/assessor also commented on making any training and development 'fit' with the needs of the individual as well as the organisation, while ensuring a robustness to any programme. In an organisation such as the NHSS, workbased learning and assessment is immediately beneficial on many levels. From a management point of view, workbased learning can omit inflated costs which are necessary when taking people away from their workplace to study for lengthy periods. The need for replacement staff to cover and difficulties around staff off duty times is greatly reduced. From the employees' point of view, workbased learning is of immediate relevance and can be applied instantly (Eraut, 2004; Clark, 2004; Coffield, 2000). Workbased learning in this

way would go some way to supporting the concept of a learning organisation (Senge, 1990; Dodgson, 1993; Nutley and Davies, 2001) as employees would recognise learning through improving job related skills, abilities and competence.

However, the negative aspect to workbased learning is that it does not allow the employee paid time away from the workplace for learning and reflection and if it is not accredited learning then it will not result in 'portable credentials' (Grugulis, 2002). Formal education on the other hand gives recognition of learning that can be taken elsewhere and has been shown to elevate confidence on the part of the learner. A model of workplace learning combining both on and off-the-job learning may therefore be better and lend to a more expansive learning environment (Rainbird and Munro, 2003; Fuller and Unwin, 2004) which would allow time for reflection and knowledge of underlying theory.

8.2.3 Recognition / accreditation of previous learning

Overall the perception by the assistant staff was that there was little or no recognition of previous learning, whether formal qualifications or experiential learning. The picture given in the NHSS is often one of a 'skills shortage' whereas this research has shown that a number of staff have skills and qualifications that they themselves consider of benefit to their current roles. However, it is overwhelmingly the case that the skills and qualifications the assistant staff bring to the job are not often recognised in the assistant role, particularly in any official way. The issue therefore may not be about skills shortage *per se* but may be about the procedures for recognition of existing skills which, this research has shown, is an area that has been afforded no particular relevance to date. Eraut (2001) and Grugulis (2003) argued that not all learning needs to be incorporated into qualifications and it has been noted that many organisations fail to recognise experiential and informal learning on the job (Eraut, 2001; Grugulis, 2002; Keep, 2004). Formalised recognition of existing skills in assistant staff would foster the notion of the NHSS as a learning organisation.

As an example of non-recognition, one assistant working in physiotherapy had a higher degree in project management and although she acknowledged that it

was not directly involved with healthcare, she argued that it had given her experience in managing workloads and prioritising which she believed she was not given credit for. Another assistant, working in occupational therapy, had studied and achieved a vocational qualification and a Higher National Certificate (HNC) in health and social care and a counselling VQ at level two. She was currently undertaking an SVQ level three having been told that there was no way to accredit any learning from her HNC or previous VQs:

> *I've had to learn [through undertaking qualifications] how to work with stakeholders… develop partnerships.. teamworking.. listen to people and really hear what's being said… I've learned all those skills and actually I apply them here and it works very well (PTA – community hospital).*

Another assistant had life experience through travel, had studied politics, reflexology and massage and then had undertaken a sports therapy HND programme prior to commencing work as a physiotherapy assistant. She explained that her line manager had looked into accrediting or recognising her previous learning but that it was considered nothing overlapped:

> *I found [that] quite surprising…the modules for the HND are similar to the SVQ…. [I was] absolutely [disappointed]… not that I thought I was overqualified for the job here… because I had never worked in a clinical environment before… but I certainly thought…all the IT stuff and.. the communication skills… the anatomy and physiology… health and safety and hygiene… I thought they would be overlapping…I felt.. well I've done all this already (PTA – acute).*

The HR manager recognised that this was happening and described it as a 'ludicrous' situation. His vision included a 'skills lab' where employees would be able to be accredited by senior colleagues in specific skills so that if an employee came to the job with previous experience and / or qualifications they would be tested on them and accredited accordingly:

> *If we decide this is the training for the job you go through the training. If you can prove you don't need the training and your manager is happy with that then that's fine… they may test you but they will not put you through the whole programme again… I would like to see some form of [portable] accreditation (HR manager).*

One nursing assistant was working in a busy clinical area and concurrently studying towards both an SVQ at level three and a pre-HNC qualification to allow her to progress to the HNC and then nurse training. This assistant already had an SVQ at level three in customer care, coupled with experience of dealing with the public in her previous job. She was given no credit from this towards her current position and although she admitted to learning new knowledge from the pre-HNC relevant to her current post, she was disappointed that no credit was given for her previous studies towards the SVQ:

> The communication [part of the SVQ] I did was with elderly
> [people] that had learning disabilities and I thought maybe
> that would tie in with it [SVQ in care] but when they looked
> through it they said it wasn't in enough detail or something like
> that…I was [quite annoyed] because I thought…well that was
> an SVQ three and the one I'm doing now… so surely…well I
> don't know how I managed to pass that if its not got enough in
> it (nursing assistant – large acute).

One of the NES education and training managers also commented that certain individuals should be able to have previous learning recognised but that it was up to the individual and the local systems in place to do the accreditation. There is a process for accrediting prior learning through this Health Board but it is reported to be a long process. For articulation with the SVQ, previous learning may result in exemption from one or two units but not the entire SVQ and this is a process that rarely happens:

> …because its vocational they have to show that they can put that
> [knowledge] into practice rather than [it being] an academic award.
> … I think they have to do a workbased assessment… the clinical
> support worker lead [for the Division] makes the decision and
> then its sent on [to the SQA].. (SVQ facilitator/assessor).

This process seems reasonable because there will be aspects of the SVQ that will cover new experiences and new learning. However, for the decision to be made by one person could be flawed where there is a chance that bias will be evident. Furthermore, if the process takes such a long time, it is little wonder that some assistants go ahead and complete the entire SVQ rather than wait to see if they are going to be accredited for any previous learning. One reason for the apparent lethargy in accrediting previous learning could be the cost

implications. In reality it is significantly less expensive to put an assistant through an entire SVQ rather than formally accredit any previous learning.

Although the majority of assistants believed that any previous qualifications they held should be recognised and accredited towards current learning, there was a marked difference of view regarding learning by experience. Interestingly none of the assistants considered that any experiential learning should be formally accredited. They were all focused on officially recognised qualifications such as the SVQ as evidence of their knowledge and skills.

At the moment, staff shortages are not a real issue in this Health Board. However the HR manager stated that forecast figures indicated that labour would become scarce again in the not too distant future and for that reason alone, recognition of prior learning should be encouraged:

> *People going through gateways under the KSF [knowledge and skills framework].. they are going to be very reluctant to give up what they've got and also if… labour becomes a scarce resource.. we've got to have proper accreditation for them in the first place and opportunity to test rather than just an interview (HR manager).*

From a management perspective, looking at developing the workforce to a level that is officially recognised through accredited learning would meet the strategic goals for a flexible workforce with transferable skills. However, this research has shown that assistant staff tend to view the accreditation of learning as a personal achievement rather than any particular benefit for the organisation.

This section has shown that in this Health Board, prior learning is not given any official recognition. Despite the fact that there will be skills shortages in the very near future, the emphasis is on processes adopted by the Health Board to recognise learning through the vocational qualification route. This has tremendous implications on career progression for this group of staff, particularly where, as will be discussed, disparities exist in accessing learning opportunities. This also does not lend to the concept of a learning organisation (Pedler *et al.* 1996; Watkins and Marsick, 1993), rather it supports Spencer's (2002) view that organisations are pluralist and goals may not always coincide but may sometimes conflict.

Further, Fuller and Unwin's (2004) expansive/restrictive learning environment model does not include the features of recognition of prior experiential learning and accreditation of prior qualifications.   This research suggests that to adopt this model for the NHSS, these are two features that should be included.   Also these features would complement previously identified features of a learning organisation model.   Not all learning requires to be accredited through official systems and if the NHSS adopted and promoted this view, experiential learning could be recognised in a variety of forms.   Recognition could then mean a myriad of ways to acknowledge learning from encouraging non-registered staff to compile a portfolio of learning and achievement to use as portable credentials to being told 'well done and thank you' and appreciated as a trusted and valued member of the healthcare team.

8.2.4 Access to learning

All participants reported that there were other types of learning and training offered, apart from the SVQ, but generally this was sporadic and involved mostly in-house short tutorials. Often this was when a new piece of equipment or a new initiative was introduced to the workplace. Only a few non-registered staff felt that the opportunities to be updated in this way were similar for them as for the registered staff in their area, particularly when it was the registered staff who decided if the assistant should be included in the tutorials.   The participants who responded most positively to being included in tutorials and other in-house training were nursing assistants from community and some of the AHP assistants:

> *Anything new that comes along… we'll find out about it…we are always included… because it's a good place.. you're part of the team (nursing assistant – community hospital).*

> *..it's about the same… the [training directory] is there for personal development… and if you think its appropriate you go for it and you always get to go on it (nursing assistant – community hospital).*

The nursing assistants in the acute sector were all very negative about their inclusion in on-the-job training and education.   The general feeling was that, as assistants, they were expected to do the assigned work and it was the registered staff who received the most training and education in the workplace.

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The nursing assistants also reported that the information from the sessions and tutorials they were not included in was rarely passed on to them. In an expansive learning environment (Fuller and Unwin, 2004), workforce development is nurtured through learning opportunities that cross boundaries such as inclusion in colleagues' learning outcomes. Some of the nursing assistants in this study described a restrictive learning environment where their learning was restricted to tasks required for the job and skills were focused on the delegated tasks to hand with no account given to other existing skills.

It was generally agreed by participants of all levels that education, training and development was a good thing and something that everyone should have access to:

> …I think all sections of the workforce are entitled to good quality education that has theoretical underpinnings (NES education and training manager)

However, when questioned none of the participants (both registered and non-registered) were able to give an exact list of what was available in the way of training and development. Variations were noted amongst the professions and the disciplines within the professions. This was because much of the training and development opportunities were provided locally in the separate Divisions. Centralisation of the overseeing department was taking a long time to happen and communication around the availability of training and development opportunities was not reaching the employees it was intended for.

Another reason for variations was that spending on training and development came out of localised departmental budgets which meant that the decisions concerning training opportunities was, in part, left to the line manager to finalise. This meant that in some departments, managers were facilitators of development while in other departments managers were controllers (Fuller and Unwin, 2004). This was also the case concerning access to the SVQ in the small acute Division and the primary care Division. This is a very important issue because it may convey a negative message to non-registered employees. Where parity in opportunities to attain qualifications would be more likely through centralising the process, the delay in this centralisation could intimate

that the learning and development of assistant employees is of little importance to the organisation. Furthermore where there is no synergy between the goals of the employees and the employing departments within the Health Service, a division in the workforce community is created, hampering the quest of the NHSS to become a learning organisation (Pedler *et al*. 1996; Watkins and Marsick, 1993; Spencer, 2002).

This section has shown that there are major differences across the Health Board and the key is finance. The policy at Board level is that training and development is provided for all employees. How this policy is actioned is determined at local level by the budget each department is assigned. The only exception to this is the mandatory training which comes out of a centralised budget because it is an expectation that all employees will attend this. In order to synergise employee expectations and clinical area needs, thereby lending to a wholly expansive learning environment (Fuller and Unwin, 2004) and encouraging the ethos of learning and development as a core characteristic of NHSScotland (Davies and Nutley, 2000; Marsick and Watkins, 1999a), centralisation of a learning budget may be the key. However, this may not be the complete answer as the attitude of the local manager may still dictate who is put forward for any training and development opportunities.

8.3 Barriers to becoming a learning organisation and developing an expansive learning environment

As discussed in chapter three, the strategic and policy documents frequently refer to the NHSS as striving to become a 'learning organisation'. This section reports on perceptions of assistant staff on their working areas as learning environments and maps their responses to Fuller and Unwin's (2004) views of expansive and restrictive learning environments. This section builds on the argument that this Health Board has adopted the notion of a learning organisation at a corporate level but at departmental level this concept is not always interpreted in the same way. Fuller and Unwin's continuum is addressed through the perceptions of assistant staff to specific elements and how they translate to either expansive or restrictive learning environments.

Overall the assistants perceived there to be more barriers for access to training and development, particularly when compared to their registered colleagues who they believed would always be considered first for any funding required for development or time away from the workplace.

8.3.1 Lack of access to knowledge based courses and reflection time

One of the features of a learning environment (Fuller and Unwin, 2004) as discussed earlier is planned time off-the-job for courses and for reflection of work. Analysis of the data indicates that the AHP non-registered staff appear to receive more time and opportunity for learning and reflection than their non-registered nursing counterparts. The SVQ facilitator/assessor employed in the smaller acute Division had recently, through single system working, been involved in facilitation across the three Divisions of the Health Board. She was enthusiastic in her description of what was available to the AHP assistants from all disciplines, specifically in the small acute Division, but to an extent in the other Divisions also. She described 'in-service' activities which included talks from representatives of other relevant organisations (such as the MS Society), information on changes to procedures or policies, the introduction of new equipment to the area, mandatory training, journal clubs and joint workshops between community and acute OTAs for example, all of which foster cross-organisational experiences (another feature of an expansive learning environment). In her opinion, the introduction of the SVQ was a good opportunity for the non-registered workforce to progress:

> *There is a lot of in-house stuff… they're able to access… and ..*
> *getting a lot of mandatory training that they have to do but in terms*
> *of their own …development and learning… I think they kind*
> *of looked on this [the SVQ] as an opportunity to actually get a*
> *qualification and so that they could progress onto other things*
> *(SVQ facilitator/assessor).*

Many AHP assistants reported being involved in these 'in-service' staff meetings at regular time intervals, ranging from weekly to monthly. Several of the assistants also reported having 'supervision' time with their senior or mentor which consisted of a one-to-one meeting, again at regular time intervals. The supervision meeting would be used to discuss and reflect on their work, air any worries or grievances and to discuss what support the assistant needed to help

them in their job. In stark contrast, none of the nursing assistants reported attending staff meetings or receiving supervision sessions.

8.3.2 Lack of personal development planning and continuing personal development

Personal development plans were meant to be in place for all healthcare workers by the year 2000. Evidence from phase three data indicates that this has not happened. As PDPs were intended to be a cornerstone of other strategic developments such as KSF and regulation, this has implications on the organisational initiatives to educate and develop the workforce. While very few assistants had a PDP in place, all were aware that this was something that 'was going to happen'. The HR manager voiced his concern over the length of time and apparent lethargy around PDPs:

> *AfC and KSF and PDP are all about [progressing people]…but there is a great deal of work to be done… for that level of staff [non-registered] to be taken with the same seriousness as PDPs for professional staff…we are not as far along… as we hoped we would be by this stage (HR manager).*

Those who had received an appraisal and personal development planning viewed it as an exercise to set objectives for the coming year and a reinforcement of areas in their work that required improvement. Most respondents indicated that they had discussed their impending PDPs with senior colleagues but in some cases, registered staff had not had an appraisal or PDP for several years and they felt it unlikely that theirs would be addressed in the near future.

One assistant reported that when she first started in the health service she received an appraisal annually but that it was a tick box exercise. However, she believed that with the advent of AfC, appraisal and PDPs were 'coming back'. The intended purpose of PDPs for all staff (as discussed in chapter three) was to ensure that KSF and national occupational standards would be firmly embedded in future CPD for staff. At present it is probable that PDPs and appraisal would have little impact on enhancing workplace learning as the organisation uses a prescriptive model for education and training provision. In any case this research indicates that the concepts of PDP and CPD have not

been afforded the anticipated attention up to this time. In relation to Fuller and Unwin's (2004) continuum, this indicates a restrictive learning environment through the features of managers controlling workforce and individual development and barriers to learning new skills or jobs. A lack of personal development planning would mean that continuing personal development within a job role is likely to reach a plateau.

The biggest restriction that the majority of respondents reported was that, whether they had been given the opportunity to undertake formalised study, or regardless of what they learned on the shop floor, their job roles remained relatively unchanged. For many this was a source of frustration.

8.3.3 Lack of career and development pathways

Having undertaken the formalised qualification of an SVQ, most assistants stated that they felt inspired to continue with further study and possibly career progression. Others felt it had empowered them within their current position as their understanding and confidence had increased. This perception supports findings from the staff survey (chapter seven). Some had already voiced ambition to move up the career ladder and felt that the SVQ had acted as at least a motivator, and in some cases a springboard, in that direction:

> *I had [thought about] doing some kind of course because I had been told I would have to wait about five years before I would [get promotion] and I thought.. oh no I need to get a new job because I can't keep going on like this…(PTA – large acute).*

The NHSS strategic documents all indicated that one of the main intended outcomes from development of non-registered staff was transferability of the workforce. The majority of the non-registered participants believed that the skills they had developed through experiential learning and through the more formalised SVQ route, had given them basic skills that could be easily transferred to any clinical area. All of them felt that it would be the basic skills such as communication and teamworking (referred to as soft skills in the literature) (McKenna, 1995; Evans *et al.* 2004; Keep, 2004) that could be transferable.

> *I think everything that you learn through the SVQ [is transferable]*
> *things.. are applicable to whatever discipline you worked in (nursing*
> *assistant – mental health, small acute).*

> *It's more than a foundation its an actual career…it'll open doors..*
> *[for other jobs] its more and more desirable… you've got a better*
> *chance (nursing assistant – community hospital).*

The AHP assistants, however, were less convinced that current learning and development initiatives would help develop a career pathway for them:

> *There is a career pathway.. it goes up to TI1 [technical instructor*
> *level 1- senior AHP assistant – highest level] but its very slow*
> *…some have been working for ten years and they are now TI3*
> *… and there is a ceiling.. that's fine if you don't have qualifications*
> *and don't particularly want to gain them but it's different if you*
> *do and you want to (PTA – community hospital).*

> *What I find quite a pity is that even though you're working along,*
> *you've got to apply for these jobs that come up and it doesn't*
> *matter how much work you've put in you're just not progressing*
> *…it would have been [good] to move up from assistant to*
> *technical instructor (OTA – small acute).*

Some assistants, while keen to progress, were frightened of leaving a paid post to take the registration route. With no pathway through a workbased direction, AHP assistants reached a definite ceiling. The only way to access a registration course was to resign from their post and attend university on a full time basis. This was reported by many AHP assistants as being particularly intimidating as there were no guarantees for them:

> *To walk away from a job to go to university to come*
> *out qualified and maybe not have a job is quite daunting…*
> *do I carry on and do something and maybe not have a job*
> *at the end of it or do I just stay where I am and work*
> *away and see where it takes me.. so that's the problem*
> *(OTA – small acute).*

This particular occupational therapy assistant had several qualifications already. She had previously worked as a nursing assistant before moving into an AHP assistant role. She had come into her nursing assistant post with an NVQ in care which was not recognised at all by her current Health Board. She then personally financed an HNC in social care. She was told that prior to AfC, this

would have made a difference to her grading. However, when her job was assimilated under AfC, she was told that her HNC had no impact since the banding had levelled out the pay scale:

> *.. that was a year and a half for nothing.. still just an A grade,*
> *…..I never made it to my top increment sitting with all*
> *those qualifications. It was really disheartening. The attitude*
> *of older assistants who had been there a long time [was*
> *difficult too] they couldn't understand why you were going to*
> *college.. what were you trying to achieve, you're not going*
> *to get anywhere and they were right to a point.. it didn't*
> *get you anywhere (OTA – small acute).*

This research has highlighted something of a paradox in that AHP assistants in particular are given the most opportunities for workbased formal, incidental and experiential learning and yet they have no formal career pathway. This is particularly significant as no framework or process for recognising experiential and previous learning has so far been adopted in the NHSS and therefore the ability to transfer this learning is unlikely to happen (Eraut, 2001; Grugulis, 2002).

The current career pathways are restrictive. While a nursing assistant can advance professionally it is only in the direction of entering the nursing profession. There is no opportunity to use their learning as currency for any other profession in the Health Board through workbased learning. The AHP assistants can progress to a very limited level unless they chose to resign from their jobs to study independently with no guarantee of employment once their studies are complete. To enable an AHP assistant to progress to a senior post through the current process often takes years to achieve, particularly as the senior posts are scarce in number. The idea behind the SVQ in this Health Board was that people would be prepared to a level that would allow them to *apply* for jobs should they come up but not be automatically upgraded. This was particularly true of the SVQ level 3 for nursing assistants, where few posts existed:

> *It's.. a stepping stone if people then want to go on.. it's about*
> *confidence building actually… but there isn't any pressure [to*
> *go on] (SVQ facilitator/assessor).*

The extra competency clusters were available only to the nursing assistants and even then there was no choice or negotiation. The area of work determined the competencies undertaken by the nursing assistants.

Future national developments for AHP assistants are intended to include design of specific HNC awards that will articulate with existing degree programmes. However, at this time plans include only three of the twelve AHP professions and are highly specific to staff employed in these disciplines. One of the education and training managers pondered on whether this was the right way to go but the drivers behind the developments dictated the route. The drivers include predicted shortfall of registered staff due to large numbers reaching retirement age, fewer candidates entering the professions and an increased elderly population requiring care. Interestingly the intention is to have no particular pre-requisites such as an SVQ for entry into the AHP HNC. The NES education and training manager explained that it was felt significant experience in an assistant role was perceived to be more important than a recognised qualification - which is in direct contrast to the situation for nursing assistants.

8.3.4 Lack of rewards

One of the main barriers was perceived to be a lack of communication around development opportunities other than the SVQ. The SVQ had been given a lot of promotion throughout the Divisions and for the nursing assistants, the HNC was also promoted. Otherwise there was a distinct lack of knowledge about any other learning opportunities which also supports findings from the staff survey (see chapter seven) and on-the-job experiential learning was rarely discussed or reflected on to allow it to become explicit. This meant that assistants felt undervalued by being overlooked.

Other barriers reported by participants were more fundamental and were generally around a lack of team working, having no support from colleagues and peers and feeling underpaid. One assistant described how she had gathered information for a catering employee who was interested in applying for a vacant post as a physiotherapy assistant. However, once the PTA disclosed her salary the catering assistant declined to take the application further because she would have had to take a drop in salary. While insisting that she was not

deriding catering assistants, the PTA was angered that her pay would be less when her job involved a large amount of patient care and the responsibilities that go with the clinical job. Prior to AfC the financial reward for undertaking an SVQ was minimal. Since AfC it appears that this meagre financial increase has been stopped. What could be considered an indirect consequence of AfC where the grading is based on the content of the job is that there are now fewer incentives to undertake formal qualifications for assistant staff, particularly as the career pathway is limited for nursing assistants and non-existent for AHP assistants. However, it also appears that in the future, assistants will have little choice in the matter.

8.3.5 Lack of recognition of prior learning

Recognition of previous experiential or informal learning (RPL) did not exist in this Health Board although both the managers and the assistant staff felt that it should be recognised 'in some way'. Furthermore there was no robust system in place to accredit any previous qualifications to map them to future qualifications. This meant that those assistant staff in possession of qualifications often perceived that they were required to duplicate their efforts in order to gain an SVQ.

8.3.6 Disparities in support

Analysis of phase three interviews showed that of the three Divisions within this Health Board, the assistants working in the small acute Division perceived they were given much more support and encouragement to develop within their roles. One assistant reported that her clinical area was very supportive and she felt very much part of a team:

> I think they expect quite a high amount from their assistants…
> they are really fair…they recognise peoples' [abilities] and when
> they identify [a problem] they'll try and help and offer development
> (OTA – small acute).

However, an assistant working in the primary care environment reported that she often felt undervalued through lack of communication between the registered staff:

I'm working for as much as ten therapists at times and it's horrendous… one is telling your one thing and another is telling you something else. You're just bamboozled with it (OTA – community hospital).

Many of the assistants voiced the perception that some registered colleagues and some of their peers did not support them in their efforts to personally develop. Some registered staff were openly dismissive of initiatives such as the SVQ and some of the assistants reported that their peers derided their efforts as pointless, particularly when there were no apparent change to their working conditions or responsibilities and no financial rewards were in evidence. For people who may be coming back into studying after a long period away, or for people who perhaps struggle with learning then a perceived lack of support in the workplace would have a hugely negative impact on the discussed intrinsic factors (Rainbird, 1998) (see page 94) for personal development.

However, those who perceived that there were sufficient opportunities accredited this to their line managers' willingness and enthusiasm in helping them to develop, particularly with off-the-job courses. This perception aligns to the feature of a learning environment that managers will act as facilitators of workforce and individual development (Fuller and Unwin, 2004). The AHP assistants, who had less opportunity for off-the-job courses were, in general, enthusiastic with the support and guidance received in their clinical areas. This also highlights the importance of line managers in enabling *and* encouraging staff.

Another barrier to workplace learning and support was cited as time. Off-the-job courses that were organised could be vetoed at the last moment due to staff shortages. Some managers appeared to encourage their assistants to attend study days but were unwilling to allow them to attend during working hours. Where no reward is given for personal development it is unlikely that many assistants would be willing to study during their time off duty. One SVQ facilitator/assessor commented that it was not always practical to give dedicated study time, particularly to staff whose hours at work were part-time to start with. She reported that despite the initial grumblings around these perceived barriers, staff remained very enthusiastic and determined and she reasoned that

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although it was an expectation of the Health Board that staff would undertake an SVQ, assistant staff had ownership of the award on completion.

Barrier:	Nature of problem: individual / department / Health Board	Importance / significance
Access to knowledge based courses and reflection time	Dependent on profession affiliated to, clinical area of work, Divisional site of work, categories available	Impacts on role development, staff morale, career pathways and patient safety
Personal development planning and continuing personal development	Very few non-registered staff have PDPs. Appraisal system inconsistent. No time for reflection. No forum to raise awareness of local, regional and national initiatives	Impacts on possible career pathways, personal development and workbased learning.
Career and Development Pathways	Limited: for nursing assistants a pathway available but only to a nursing registration through workbased learning and further education. For AHP assistants nothing available at present beyond application for promotion to higher band following several years experience – few posts available.	Impacts on skill development, attitude, motivation, personal aspirations, multidisciplinary working and projected skills shortage. Could influence attrition rate if perceived that there is 'nowhere to go'. Limited career or development opportunities impacts on rewards, both financial and self confidence as a valued member of staff
Rewards	No upgrade for qualification attainment. No increase in pay. Very little encouragement or praise for work well done	With no tangible financial rewards and limited career choices, staff need encouragement and praise to boost self confidence and feelings of being a valued team member
RPL	No current system in place to recognise previous formal or informal learning	Can result in duplication of effort for staff with several years experience or with accredited formal learning. Cost implications for organisation and employees
Support	Variable from peers, seniors, assessors, mentors and organisation and dependent on profession affiliated to, clinical area of work, Divisional site of work	Learning can be perceived as a threat. Can cause discontentment and reluctance if disparities noted. Can result in feelings of being undervalued and excluded
SVQ	Does not suit all, is not considered 'fit for purpose' without 'extra' clinical competencies. Competency bundles pre-determined and limited in transferability	High costs in time and finance with very little perceived learning. Disparities between groups for competency and skill acquisition. Possible non-utilisation of competencies and skills in other areas
Time	Protected study time afforded to only a few dependent on profession affiliated to, clinical area of work and Divisional site of work. Very little reflection on experiential and incidental informal work	Work / life balance affected. Support perceived as minimal if learning mainly at home. No way of experiential and incidental informal work becoming explicit, codified and ultimately transferable

Table 8.2 Barriers to workplace learning

Table 8.2 on the previous page illustrates the particular barriers and their significance within the Health Board under study towards learning and development at work by assistant staff.

The small acute Division at this time most closely resembles an expansive learning environment (Fuller and Unwin, 2004). The general feeling is that non-registered staff from all disciplines are more valued and their development is considered along with the rest of the workforce. In this way the staff feel more supported and, in general, more content at their work with the knowledge that they are considered a valuable member of the team.

This section has discussed the findings from phase three of the empirical research related to access to knowledge based courses and reflection time, personal development planning and continuing personal development, career and development pathways, rewards, recognition of previous learning, support and time. The following section discusses the processes of undertaking an SVQ in more detail.

8.4 Experiences of undertaking an SVQ or an HNC

In this Health Board, the route towards a recognised qualification was through Scottish Vocational Qualifications (SVQs). This section reports on the experiences of staff undertaking an SVQ or an HNC and the initiative of extra clinical competencies offered to some as part of the SVQ. The assessment process and support for learning in the workplace is further discussed in relation to expansive and restrictive learning environments and the learning organisation.

8.4.1 The SVQ and HNC initiatives
For nursing assistants in the large acute Division, the SVQ at level two was a mandatory undertaking after three months in post. In the smaller acute Division, the SVQ level two was just being introduced to nursing assistants. This followed the introduction of single system working where the three Divisions were coming under one single newly re-organised Health Board.

Previously for assistants in the smaller acute Division, all their education, training and development had been in-house, workbased and with no formal recognition or a qualification at the end of it. This is a significant development that could have either positive or negative effects. Learning at work can be considered as learning *for* work (Megginson *et al.* 1993) and in some cases can be interpreted as a punishment for poor work or an indication of failure (Rainbird, Fuller and Munro, 2004). Staff in the smaller acute Division may now consider themselves to be playing catch up to their colleagues in the large acute Division or they could feel under pressure to comply with the drive to obtain qualifications where they may have felt no pressing urgency prior to reorganisation.

In the primary care Division, nursing assistants were not required through mandate to undertake an SVQ at level two or three but were given the opportunity. Prior to reorganisation this was facilitated by a further education college, thereafter it was to be facilitated by the Health Board. AHP assistants had not been afforded the same opportunities until relatively recently. The SVQ that the AHP assistants were offered was always at level three simply because there was no available VQ at level two of relevance to this group of staff. As an SVQ at level three requires more evidence of workbased learning and has more methods of assessment, to undertake this could be significantly more daunting, particularly to someone who had little or no previous educational attainment (Lovell, 1980; Marsick and Watkins, 1999a) and could have significant effects on the uptake of an SVQ at this level. Regardless of this, most of the AHP assistants indicated that when the SVQ *was* offered, they were all very keen to take part. The initiative had been presented to them as a development opportunity and they were all assured of support from their clinical areas, including protected study time and time with their assessors and mentors:

> *There are quite a lot of the assistants doing [the SVQ]…*
> *every one in the department is doing it. I think the department*
> *as a whole is quite keen for the assistants to go and develop*
> *themselves (OTA – small acute).*

One occupational therapy assistant in the large acute Division who did not want to pursue an SVQ stated that for personal reasons, the time was not right but that she had been given the opportunity and would return to it later.   It is interesting to note that she was given the choice where the nursing assistants in the large acute Division were expected to undertake an SVQ level two as a mandatory element of their job.

Level three SVQ for nursing assistants was a rarer opportunity, mainly for the reason that there were very few level three posts available to this group of staff. Interestingly, the pre-requisite for nursing assistants to undertake an HNC was only an SVQ at level two, negating the need to undertake a higher level SVQ. An agreement was in place between a local Further Education College, a local University and the Health Board to allow non-registered nursing staff undertaking an HNC to go directly into second year of a pre-registration nursing programme.   As will be discussed more fully later, this greatly enhanced the career pathway for the nursing assistants.

One SVQ facilitator/assessor discussed the possibility of every new employee being expected to undertake an SVQ.   While this may be perceived as restrictive by some, the SVQ facilitator/assessor felt that it was a growing expectation and this would lead to a 'certain quality of staff coming in'.   One nursing assistant described a colleague who was 'a really good support worker' but who was struggling to complete her SVQ.   This assistant felt that undertaking an SVQ should not be an expectation as it was creating a division between some of the workforce.

In the HR manager's opinion, the SVQ route had been chosen as the large Division had become an accredited centre.   This meant that they could provide some education for their workforce, tailored to organisational needs with local control. Had the Division decided to go down the route of, for example, National Incremental Competencies in Healthcare Education (NICHE programme), which is one option in other Health Boards in Scotland then the qualification would be less work based and would be overseen by a university. The comparison of the two approaches is outwith the aim of this research but is a topic that could be further investigated.   The implications of the SVQ route in this Health Board

would seem to be that training and development of non-registered staff is based only on the requirements of the organisation to bring employees up to a uniform standard.

While the HR manager was enthusiastic about any education, training or development opportunity for non-registered staff he felt that a uniform approach was not always the answer. He was against a concept of every clinical employee working towards an SVQ and felt that there was room for other types of learning:

> *… we try to treat everybody the same and what we need to do is treat everybody as an individual… people are learning at their own speed… so there has to be an agreement… appropriate training (HR manager).*

As discussed, along with the SVQ and dependent upon the level or grade of the staff member, an HNC in healthcare was also available to nursing assistants. In the case of some nursing assistants, a pre-HNC course was a requirement before a definite offer of an HNC place was made.   A pre-HNC course took eight weeks of continual assessment in the workplace and involved literacy and numeracy skills.   No satisfactory answer was given as to why this was a pre-requisite for some assistants and not others and it appeared to be at the discretion of the line manager proposing the candidate for HNC. This presents a double problem where on the one hand centralised policy on education and training does not allow for individual needs but localised decision making appears to be a subjective exercise on the part of the person in charge of the clinical area.   It remains unclear whether education and training decisions taken at local level are to meet organisational, departmental or individual needs.

Much of the literature on learning organisations (cf Senge, 1990b; Dodgson, 1993; Nutley and Davies, 2001) and learning environments (cf Rainbird *et al.* 1999; Fuller and Unwin, 2004; Kessler and Heron, 2004) talks about individual versus organisational need.   A key element of this research has shown that, in practice, departmental need relates to immediate service delivery issues and ultimately patient safety.   In this respect the departmental needs will take precedence over individual desires.   With the practical focus on service

delivery, should individual desire match departmental needs then this could be considered a bonus. The power to address individual desires and attempt to align them with departmental needs is in the hands of key managers.

When the SVQ was first introduced to this Health Board, nursing assistants were offered an SVQ in healthcare. This has since been changed to an SVQ in health and social care. The reasons for this were not articulated by anyone in the organisation but recent strategic developments in the NHSS (including regulation) indicate that this is to address issues of transferability of the workforce as there is a national initiative to move as much healthcare as possible into the community and to develop a generic healthcare assistant role that crosses professional, and possibly sector, boundaries. The SVQ has sufficient units other than the core units to allow choices to be made tailored to the corporate needs of the organisation and as they are based on national occupational standards, have a uniform composition (Eraut, 2001). The reasons for changing the SVQ were not articulated to the assistant staff and in any case the format of the 'new' SVQ meant that fewer units were required to be completed which was seen as a positive thing by both assistants and assessors. AHP assistants, regardless of the discipline they were affiliated to, were originally offered an SVQ in therapeutic and diagnostic support. This has also been revised and SVQs are now more tailored towards the specific profession such as occupational therapy or physiotherapy.

All of the assistants who were undertaking an SVQ believed it to be a good and worthwhile thing. Most saw it as a catalyst to further training, education and development. However, the majority felt that although gaining an SVQ would increase their confidence, it would make no actual difference to the job they were currently doing. As previously outlined there is a huge debate in the literature around whether current vocational qualifications can be considered robust, standalone qualifications that impart new knowledge or whether they amount to nothing more than a validation of existing knowledge and skills (cf Eraut, 2001; Munro and Rainbird, 2002; Grugulis 2002). Analysis of the data showed that the majority of participants felt that the SVQ validated what they already knew through experiential learning in the workplace and although it did make them more aware of what they were doing in their work it was generally

not completely new knowledge.   However, none of them had a problem with this and believed it was probably the only way to progress in their workplace:

> *I'm thinking more of a career thing…… I think if you want*
> *to progress and enjoy the job and want to do something then*
> *this [the SVQ] is the way to go…(nursing assistant -*
> *mental health, small acute).*

> *Well a bit of both [new knowledge and validation of existing]…*
> *I now want to do something else definitely (PTA – large acute).*

> *I think a lot of the stuff… I'd learned or knew about before .. it*
> *makes you more aware of policies… it [just] makes you more*
> *aware.. so it was a good thing (nursing assistant – mental*
> *health, small acute).*

Some looked on the attainment of recognised qualifications as a reward for their experience, a ratification of their effort and an acknowledgement of their ability:

> *There is a lot of responsibility for us. You do have a lot of*
> *responsibility on a ward level and I think that with that responsibility*
> *there should be some kind of qualification for us (nursing assistant -*
> *Mother and Baby unit, Acute).*

> *I think it's good to have something at the end of it because if*
> *you're putting in all this work … well…[if] I haven't got a qualification*
> *or better pay.. what was the point of putting in all that work and*
> *putting yourself under all that stress to complete (PTA – large acute).*

> *..going through it [the SVQ] has… well not empowered me.. but*
> *it makes me think, well I've got the right to do the job now because*
> *I've proved myself (PTA – large acute).*

Two nursing assistants believed that the SVQ did give underpinning knowledge in as much as it explained why the work involved what it did:

> *I knew I was good at my job.. but I wanted to know why I was*
> *doing what I'm doing.. why do you need infection control.. things*
> *like that… [it's] fantastic.. everybody should do it [the SVQ]…*
> *it's justifying what you do… if there is a question [from a patient*
> *or a relative] you can answer .. (nursing assistant – community*
> *hospital).*

[I was] unqualified in my area and [I was] not confident.. I really
expected a lot more training in the job before I got started…
I think this [the SVQ] would have helped if I'd had this before
I was actually in the ward (nursing assistant – Burns Unit, Acute)

One of the SVQ facilitators/assessors thought that the SVQ contained some new knowledge along with being a validation of existing knowledge. She described previous candidates having told her that they themselves had not realised how much they knew until they put in down on paper as part of the SVQ. The other SVQ facilitator/assessor described the SVQ as being an assessment tool where an obvious knowledge gap in the reflective statements would allow further input from facilitators and that the SVQ was a 'base to build on'.

In discussion of the HNC one of the NES education and training managers stated that it would be difficult for anyone to actually fail an SVQ or an HNC because that was not the point to them:

…I think we'll end up with, potentially, workbased units that you
can't actually fail which.. you query what's the value of something
that everybody is going to pass anyway from the outset… it never
says fail, it just says not enough evidence produced… whether
we go for that approach… I don't know (NES education and
training manager).

The terminology had previously been a contentious issue and one of the SVQ facilitator/assessors believed that it had improved somewhat although there were still problems being reported to her:

If you are covering everything from intensive care to community
to mental health.. it has to be a bit ambiguous… they may not
have understood that standard but when you actually go through
it with them and you can highlight – well actually you are
demonstrating that… it happens a fair bit (SVQ facilitator/assessor).

The information gathered from analysis of the data around the SVQ indicates that, contrary to Eraut's (2001) argument, the national occupational standards relevant to the SVQ are sufficiently homogenous to allow them to be valid in the diversity of occupations and clinical areas within this Health Board. From that perspective, the SVQ has transferability within the confines of this particular

workplace. However, as it is a reflective exercise that requires context specific accounts of 'learning' then transferability to other healthcare settings of any actual knowledge gained as a result remains in doubt. As will now be discussed the extra clinical competencies achieved had more currency around transferability issues.

8.4.2 Competencies and competence

In this Health Board, the term 'competence' relates to the ability of an employee to work to the standards required of them. 'Competencies' relate to specific learned tasks and clinical skills that are assessed in clinical practice and once performed to the satisfaction of the senior staff member assessing the competency, the employee is 'signed off' as being competent and is able to practice the skill independently. These clinical competencies are described as 'extra' because they do not form part of the SVQ.

One SVQ facilitator/assessor reported that a competency board meet every three months to discuss new competencies being put forward for non-registered staff to undertake. The board consists of the lead practitioner in clinical support worker development as well as the team employed to facilitate the SVQ route of development. A registered member of staff from a clinical area in the Health Board presents the competency they want their assistants to undertake in their specific clinical area and the final approval is made by the competency board. Certain restrictions are put on these competencies where, because of their specialised nature, they may be applicable to assistants working in that particular area only. This means then in effect that many of the competencies are highly specialised and therefore not transferable to any other part of the organisation. This also means that, despite being deemed competent in a skill, if it is not a requirement in another clinical area the assistant will not be able to practice that skill elsewhere in the Division.

At the time of the study, only the nursing assistants working in the large acute Division were given the opportunity to undertake extra clinical competencies such as recording blood pressure, taking blood from a vein, etc. Nursing assistants in the small acute Division and all AHP assistants did not practice any extra competencies, regardless of whether they were undertaking an SVQ

or not. Some of the nursing assistants in the small acute Division did not realise that the extra competencies would not be facilitated and all expressed disappointment in this:

> *…sometimes it's so busy in [my department] and there's*
> *nobody taking obs [blood pressure, pulse, etc] and to me I*
> *think it would be a benefit for the department (nursing assistant -*
> *accident and emergency, small acute).*
>
> *I think just getting everyone to level two and stopping is rather*
> *strange. We're supposed to be the one [Health Board] now so*
> *why are we not getting the opportunity (nursing assistant – medical,*
> *small acute).*

The overall perception was that it would only enhance their clinical practice and it was something that their clinical areas were all keen for them to do.   A few reported that their clinical managers were also unaware that they would not have the opportunity to undertake further clinical competencies and were unhappy with this:

> *[my charge nurse] said that there's no point to putting us through*
> *it [the SVQ] [if there was no clinical competencies] and yet when*
> *we applied [for the SVQ] they did say that it would be part of [it]*
> *and now they've backed out and said no, not just now (nursing*
> *assistant – Burns Unit, small acute).*

This lends to the notion that at departmental level the extra competencies are of high value to address workplace needs. Strategic initiatives at corporate level advocate the SVQ to address organisational needs. However the two do not dovetail sufficiently as there is no mechanism for wider recognition of skills acquired at departmental level and therefore no transferability.

The analysis of the data showed that interest in extra clinical competencies was dependent on the area of work.   Some AHP assistants for example did not feel that it was a necessary part of their role, although others felt that specific tasks they undertook (such as measuring a patient for a walking aid) would translate into a clinical competency. Tasks such as this were generally taught at clinical level with no underpinning theoretical knowledge.   One nursing assistant was unsure:

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> *I enjoyed the SVQ as it was.. it's hard to comment on something that you haven't experienced but it probably would be a good thing…you're doing the practical and theoretical… maybe it would make more sense…(nursing assistant - Mental Health, small acute).*

Generally becoming competent in a clinical skill requires a certain amount of underpinning context specific knowledge. The clinical skill dictated the amount of underpinning knowledge being taught. Learning outcomes were based on successful completion of the task, for example fitting splints and giving advice on the care of the splint, rather than understanding the reasons behind the treatment:

> *For the very first one [splint fitting] there was someone with me but subsequently I was allowed to do it on my own… I think a minimal level of awareness where you could demonstrate an awareness of symptoms would be sufficient….maybe if you had … set criteria for these conditions…you would be alert to [things] very quickly (PTA – community hospital).*

Grugulis (2002) argued that skills are influenced by the needs of the organisation rather than the employee and in this Health Board that seems to be the case. The issue here is whether without sufficient underpinning knowledge these clinical competencies can be considered as actual skills and therefore learning or are simply performing a repetitive procedure or task. Further, Gallie (1996) and Munro and Rainbird (2002) argued that skill acquisition and increased responsibility without notable financial reward can act as a demotivator. In this Health Board there is no financial reward for skill acquisition and a limit to their transferability, yet all of the assistants were highly motivated to gain clinical competencies as they were viewed as portable credentials (Grugulis, 2002).

8.4.3 Assessment and support

The standard of mentoring and assessing is debated in the literature (Eraut, 2001; Grugulis, 2002; McMullan *et al.* 2003). A few of those interviewed who expressed an opinion believed that in workbased learning, assessment could be a subjective exercise. One of the education and training managers however believed that this was not an issue as within the SVQ there were internal and external verifiers so that there was a robust quality assurance measure in place:

> *[this] should stop the worst excesses.. of an individual*
> *favouritism … or the reverse if someone is being unduly*
> *heavy on one participant compared to others (NES education*
> *and training manager).*

One SVQ facilitator/assessor agreed with this. She stated that although different people tackled assessment in different ways, the standards were always the same. Randomised checks took place to ensure this was the case and this was measured against verification criteria.

The majority of the non-registered staff reported their assessors had not had any training to validate them being as assessor at all and felt this impacted on their understanding of the role:

> *I think they went to a chat… like one of those 'come along*
> *for the morning and we'll go through it…' (PTA – large acute).*

Several other assistants also identified this as a problem:

> *I think a lot of the assessors wanted to put that on their CV …*
> *but they didn't want to put anything into it [the role] (nursing*
> *assistant, community hospital).*

> *Sometimes they didn't fully understand what was being asked*
> *of them as well… I've not really had any input from my*
> *assessor. She doesn't grasp what was to happen and*
> *what she was to do (nursing assistant – community hospital).*

One SVQ facilitator/assessor was confident that as a registered practitioner and mentor to students she was sufficiently qualified to assess an SVQ candidate. She also believed that as the SVQ had changed to become more tailored to each profession, the assessment methods were more appropriate:

> *…now we've been through the whole process… the award has*
> *changed slightly…we were able to select enough units to get*
> *the candidates through… there was a far greater selection and*
> *they are all more appropriate (SVQ facilitator/assessor)*

Support from assessors was perceived as variable and again it was the AHP assistants who were most satisfied by the support given which is in keeping with results from the staff survey (see chapter seven). However day to day feedback

on performance at work was lacking in almost all cases and the assistants felt undervalued by this:

> *I think it's a shame… not that I crave for it [praise].. but even if*
> *they said 'oh that was well done.'…kind of boost your confidence*
> *(nursing assistant – outpatient department, small acute).*

Time was quoted as a barrier to support, particularly when undertaking an SVQ. Some participants described 'stolen time' where they would have perhaps a few minutes with their assessor every few weeks:

> *They couldn't find time. I don't think it was because she couldn't*
> *or wouldn't.. it was just finding time to come off the ward or to sit*
> *with somebody on the ward just wasn't practical (nursing assistant -*
> *Mother and Baby unit, acute).*

However according to the HR manager, protected time for this was unlikely to be introduced routinely and it was to be left to the individual clinical area to decide what protected time, if any, would be afforded to the SVQ candidate and their assessor.

Some of the nursing assistants felt that their registered colleagues gave little or no support because they were resentful of the drive on SVQ uptake. While the assistants saw it as an opportunity, some of their registered colleagues were less enthusiastic and the assistants reported that some of the registered staff saw it as a 'way in the back door' towards registration:

> *..depends how they qualified… if they're old school and they took*
> *their highers and went to university… it's a bitterness because*
> *they did it their way and they see that you've gone in probably*
> *through the back door (nursing assistant – mother and baby unit,*
> *small acute).*

In these cases, the assistants reported that registered colleagues gave them no encouragement to continue with their learning in any form. One physiotherapy assistant felt that the organisation in general did not support learning because the roles dictated parameters of practice.   She was highly motivated to learn and expressed the desire to train as a physiotherapist but because of financial constraints she did not believe this was possible.   She said that she could

accept that the NHSS did not have the money or resources to satisfy every employee's ambitions but she had hoped that she would be given more support in her own clinical area:

> ..[the registered staff] rely heavily on the assistants... but even
> when I feel there is time... to work on something.. they say no,
> you just go and do some photocopying or .... some menial
> task... and I think ... at times they can be really supportive
> but with regards to my objectives... no I really don't get the
> chance to meet them (physiotherapy assistant - community hospital).

Assessors do not get any recognition or reward for their role. It is considered part of their job if they agree to act as an assessor or mentor. One SVQ facilitator/assessor reported that some assessors felt the role had an impact on the time they were able to spend with their patients but there were also other issues impacting on the type of support given:

> ... [there are] still ongoing problems with assessors like lack of
> time and their expectation of what's required. I think a bit about
> remuneration or identification is probably another issue with the
> assessors not getting as involved as you would hope but on the
> whole they have been very good here [in the small acute Division]
> (SVQ facilitator/assessor).

One assistant reported that his assessor was less than enthusiastic in the role and described it as 'just something else to do in this job'. This had the effect of demotivating the assistant. Education, training and development that is time consuming and costly in terms of staff hours but is viewed as of little importance in the workplace must be questioned. Furthermore, those assistants who were currently not undertaking an SVQ did not have access to a mentor or assessor. This is an interesting point as it indicates that this Health Board is currently focused on facilitation of measurable learning outcomes and experiential or informal learning outcomes are not supported, deeming them less significant. Support for learning is disparate across the Health Board which is another factor at odds with the learning organisation concept (Senge, 1990b; Pedler *et al.* 1996; Nutley and Davies, 2001).

The above data highlights the inconsistencies around training, education and development of assistant staff dependent on their area of work. Any

competence they do acquire through the SVQ is context specific and therefore not easily transferable and not always recognised. The extra clinical skills (see chapter six, page 161) that could be considered transferable to other areas of the Health Board are not facilitated for all non-registered staff which means that many of them feel undervalued in their job role. Where learning and development is concerned, the assistant staff view the organisation as already a working amalgamation of the three Divisions and in their opinion the learning and working environment should be consistent throughout.

8.5 Two models of organisational development

The finding from this research can be related to two models of organisational development. The first being the Learning Organisation (cf Senge, 1990b; Pedler *et al.* 1996; Watkins and Marsick, 1993; Dodgson, 1993; Stewart, 1996; Nutley and Davies, 2001; Spencer, 2002). The second being Fuller and Unwin's (2004) expansive restrictive continuum. This section pulls together the findings of this research and illustrates them in relation to the two models.

8.5.1 The Learning Organisation Model
As will be discussed, while some aspects of an expansive learning environment (Fuller and Unwin, 2004) were in evidence in this Health Board, the opportunity to learn and develop very much depended on where the assistant was employed. While the disparities were recognised at corporate level, addressing these issues has not been a priority which is at total odds with the concept of a learning organisation (Pedler *et al.* 1996; Watkins and Marsick, 1993; Stewart, 1996; Spencer, 2002).

It appears almost a certainty that for the foreseeable future the SVQ will be the choice of accredited qualification for the assistant groups of staff. However, it is very apparent that the SVQ alone is not 'fit for purpose' as a qualification (Keep and Rainbird, 1995; Pearn *et al.* 1995; Eraut *et al.* 1998a; Nutley and Davies, 2001; Munro and Rainbird, 2002; Grugulis, 2003; Keep, 2004) and 'extra' clinical competencies are almost always required to develop the assistant workforce to meet the needs of the service. (Table 8.3 on the following page

illustrates the current position of this NHSS Health Board as a Learning Organisation based on the findings of this research).

Features of a Learning Organisation	This NHSS Health Board: Current Position
Employees encouraged to learn through improvement of job related skills, abilities and competence (Senge, 1990; Dodgson, 1993; Nutley & Davies, 2001)	**Has not** fully achieved this feature as adoption of this ethos throughout the organisation has not yet happened
Collaborative working to bridge between organisational and individual needs encouraged (Senge, 1990; Dodgson, 1993; Nutley & Davies, 2001).	**Working towards** this feature with the intended implementation of a robust PDP facility
Learning is facilitated *by* the organisation *for* its employees and the organisation continuously transforms itself (Pedler *et al.* 1996; Watkins & Marsick, 1993).	**Has not** achieved this feature which is secondary to attempts at transformation to meet the needs of the service
Processes of learning are double loop and meta- learning models. (adapted from Argyris and Schon, 1978) (Nutley & Davies, 2001; Stewart, 1996; Davies & Nutley, 2000).	**Working towards** this but often directed by national requirements which do not always facilitate this feature
Encouraging and supporting mutual learning with processes to facilitate dissemination and sharing of learning (Stewart, 1996; Senge, 1990; Pedler *et al.* 1996; Pearn *et al.* 1995).	**Has not** achieved this feature. Learning continues to occur in professional and discipline dictated silos
Learning and development is placed as a core characteristic of the organisation (Davies & Nutley, 2000; Marsick & Watkins, 1999).	**Working towards** this feature but with no recognition of all types of learning, this has not yet been achieved
Structures and human resources developed to be flexible, adaptable and responsive (Davies & Nutley, 2000).	**Conflict within** this feature with policies to address work/life balance but needs of service dictating momentum and education provision
Cultivate open systems thinking to cross over and interconnect departmental boundaries (Senge, 1990; Stewart, 1996).	**Has not** achieved this feature. Illustrated by lack of transferability of some employee skills and knowledge
Update mental models challenging deeply held assumptions and generalisations (Senge, 1990).	**Has not** achieved this feature. Requires a shift in organisational culture to acknowledge diverse ways of learning to achieve goals
Cultivate a cohesive vision with clear strategic direction (Senge, 1990).	**Working towards** this feature. Vision is agreed. Strategic direction – development of entire workforce – remains variable
Policy to specify general purpose and plan of organisation (Pedler *et al.* 1996).	**Working towards** this feature. Purpose and plan outline. Policy interpreted at local level resulting in variable implementation
Leaders are responsible for learning and specific leadership qualities are nurtured and developed (Senge, 1990).	This feature not properly explored in this research but worthy of future investigation in this context
A culture and management style which supports experimentation, risk taking and involvement and independence on the part of employees at all levels (Senge, 1990; Stewart, 1996).	**Working towards** this feature. Variable dependent on profession / department / line management

Table 8.3. NHSS Health Board current status as a learning organisation

The competency clusters related to the SVQ (McLagan, 1996; Garavan and McGuire, 2001; Berge *et al.* 2002) are prescriptive and non-negotiable. This

supports the argument that competency models such as this promote a conformist culture where the focus is on what is learned rather than the learning process (Eraut, 2001; Garavan and McGuire, 2001) and further illustrates that this Health Board has not achieved the feature of a learning organisation which develops structures and human resources to be flexible, adaptable and responsive (Davies and Nutley, 2000).

While national strategic plans exist for the clinical assistant workforce including regulation, development to meet national occupational standards and KSF, the data analysis showed that at local level, these plans were either unknown to, or not understood by, the workforce they were intended for.   Analysis of the data also showed that for some of the assistant workforce a career pathway towards registration is attractive. For many others however, the opportunity to develop within their current role is more attractive but the perception is that the opportunities are few.   Regardless of whether learning in the workplace is formal or informal, all the assistants indicated that some form of recognition for their efforts would be welcomed but there are no formal systems to facilitate this. This results in duplication of effort by some assistants when formal learning is embarked upon and does not cultivate open systems thinking within the organisation (Senge, 1990b; Stewart, 1996).

PDP and CPD were given no urgent attention in this Health Board for non-registered staff, further curtailing opportunities for personal development. Support for assistant staff from colleagues, managers and mentors or assessors was variable.   The lack of consistency around the SVQ devalued the initiative and therefore despite being a costly exercise in terms of employee hours it was viewed as insignificant by some registered staff and some assistants.   Other than the SVQ, assistant staff were not supported in developing a portfolio of achievement which would have significant impact on the issue of transferability in the NHSS and does not support the processes of double-loop and meta-learning required within a learning organisation (Nutley and Davies, 2001; Stewart, 1996).

8.5.2 Fuller and Unwin's expansive / restrictive learning environment Model

Drawing on Fuller and Unwin's (2004) expansive/restrictive learning environment continuum, the recurring themes outlined above are related to this model. An adapted illustration is provided in table 8.4 incorporating the specific features of Fuller and Unwin's model used in this research.

Features of an expansive learning environment	Large Acute Division		Small Acute Division		Primary Care/Community Division	
	N & MW	AHP	N & MW	AHP	N & MW	AHP
Breadth: access to learning fostered by cross-organisational experiences	X	X	X	√	X	√
Access to range of qualifications including knowledge-based VQ	√	√	√	√	√	√
Planned time off-the-job including for knowledge based courses and for reflection	X	√	X	√	X	√
Vision of workplace learning: progression for career	√	X	√	X	√	X
Organisational recognition of, and support for, employees as learners	√	√	X	√	X	√
Workforce development is used as a vehicle for aligning the goals of developing the individual and organisational capacity	X	X	X	X	X	X
Widely distributed skills	X	X	X	X	X	X
Knowledge and skills of whole workforce developed and valued.	√	X	X	X	X	X
Managers as facilitators of workforce and individual development	√	√	√	√	√	√
Chances to learn new skills / jobs	√	√	√	√	√	√
Recognition and articulation of previous experiential learning	X	X	X	X	X	X
Accreditation of previous qualifications related to PDP & CPD	X	X	X	X	X	X

Table 8.4 The learning environment in studied Health Board. Expansive continuum adapted from Fuller & Unwin, 2004. (N & MW = nursing and midwifery assistants; AHP = allied health professions assistants). Note: last two elements added through this research.

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It must also be appreciated that positive features of an expansive learning environment (indicated by a tick in table 8.4) are locally implemented in each Division and therefore methods of implementation, as previously discussed, are variable.

While this table shows similarities between all Divisions in the elements of access to qualifications, managers as facilitators and chances to learn new skills and jobs, this was true of the Divisions at macro level only. At departmental level this was variable and therefore while these elements seem to indicate an expansive environment overall, this was not always perceived as the case by every employee. Another similarity between the Divisions concerns the elements of alignment between individual goals and organisational capacity. These indicate a restrictive environment overall which this research has shown is the perception by non-registered staff.

This table shows key differences around planned time for off-the-job for courses and reflection and support for employees as learners. In both cases the AHP assistants fared more positively than their nursing and midwifery colleagues. The elements of progression for careers showed a major disparity between nursing and midwifery and AHP assistants, with an obvious ceiling to career progression for AHP assistants.

The Health Board under study has addressed the lifelong learning agenda through workforce plans (NHS Lothian, 2005c). However, it is evident that the implementation of the plans is by a top down approach, emphasising the notion of a hierarchy of importance concerning learning needs and provision of training and development. The model of employee education and development used by the organisation is prescriptive and therefore although some opportunities are available for non-registered staff, the choices are limited and defined to meet organisational needs. The needs of the organisation are being addressed but often employees' aspirations, and ambitions are not. Furthermore there are specific strategic plans on a national level that could have some impact on career pathways for assistant staff, particularly some from the allied health professions. However, the outlines of these plans are not widely disseminated which means that many non-registered staff continue to

feel undervalued with little or no development opportunities to look forward to. Table 8.5 summarises the position of this Health Board in relation to adopting an expansive learning environment.

Expansive learning Environment	This NHSS Health Board: place on the continuum	Restrictive learning Environment
Breadth: access to learning fostered by cross-organisational experiences	**Middle:** Pockets of learning across the organisation. Some areas more proactive than others.	Narrow: access to learning restricted in terms of tasks/knowledge/location
Access to range of qualifications including knowledge-based VQ	**Towards Expansive:** Slowly developing opportunities for non-registered staff. Aware of disparities and attempting to address this.	Little or no access to qualifications
Planned time off-the-job including for knowledge based courses and for reflection	**Middle:** No centralised organisation of learning opportunities. Budgets held at local level. Dependent on area / site of work.	Virtually all on-the-job: limited opportunities for reflection
Vision of workplace learning: progression for career	**Middle:** Dependent on employing profession. Opportunities disparate across the Divisions and the departments within.	Vision of workplace learning: static for job
Organisational recognition of, and support for, employees as learners	**Towards Restrictive:** Overall recognises potential of non-registered staff as learners. Support variable dependent on site of work and in some cases, staff on duty.	Lack of organisational recognition of, and support for employees as learners
Workforce development is used as a vehicle for aligning the goals to developing the individual and organisational capacity	**Towards Restrictive:** Opportunities exist to meet the needs of the service and if synergy achieved then this is a bonus.	Workforce development is used to tailor individual capability to organisational needs
Widely distributed skills	**Towards Restrictive:** Skill development dependent on site of work and transferability not assured.	Polarised distribution of skills
Knowledge and skills of whole workforce developed and valued	**Restrictive heading towards middle:** Hierarchy of importance for staff development. Top down approach. However, strategic plans state more attention to be afforded to non-registered staff	Knowledge and skills of key workers/groups developed and valued
Managers as facilitators of workforce and individual development	**Middle:** Localised budget, some managers more facilitating than others, dependent on site of work.	Managers as controllers of workforce and individual development
Chances to learn new skills / jobs	**Towards Restrictive:** Some reluctance to extend assistant roles by both registered and non-registered staff	Barriers to learning new skills / jobs
Recognition and articulation of previous experiential learning	**Restrictive:** No structures in place to recognise any previous learning and allow implicit knowledge and skills to become explicit	Non-recognition and non-articulation of previous experiential learning
Accreditation of previous qualifications related to PDP and CPD	**Restrictive:** No use of processes to accredit previous qualifications often resulting in duplication of effort on part of employee	Non-accreditation of previous qualifications related to PDP and CPD

Table 8.5. NHSS place on expansive/restrictive continuum. Adapted from Fuller & Unwin (2004). Note: last two elements added through this research.

8.6 Chapter summary

This chapter has discussed the findings from phase three of the empirical data collection and has highlighted that to achieve an expansive learning environment within a learning organisation, the NHSS still has some way to go. Overall, learning and development at work in the NHSS for non-registered clinical staff is non-uniform and disparate depending on the profession and department within the profession that the assistant is employed in. The government strategic aims as outlined in chapter three (page 32) have not as yet been met in full. However, this research has provided evidence to indicate that there is a definite move at regional level within the Health Board under study to meet these strategic aims. An absolute consensual actioning of the government strategic plans throughout Scotland has shown to be unlikely as each Health Board has interpreted the strategies in their own way, reducing the likelihood of a totally flexible workforce with transferable skills. This therefore does not meet the strategic aims outlined in *'Learning Together'* (Scottish Executive, 1999a) nor in the following strategic documents discussed in chapter three.

The NHSS documents had stressed that all staff were to be encouraged to undertake training, both in-house and external and through informal sessions on the shop floor (Scottish Executive, 1999a). The interpretation and implementation of this is left to direct line managers and in some cases, where there is an effort to provide an expansive learning environment within a department, shift work means that incidental and informal learning opportunities are dictated by the person in charge of a unit or department at any given time.

Thornley (1999) and Munro and Rainbird (2002) argued that skill acquisition has relevance to motivation for learning. In the context of this research, skill acquisition concerned both manual and soft skills to demonstrate ability or competence in a job role. Findings from this research have shown that assistants are motivated when they perceive that they are gaining extra skills but the extra skills are almost always perceived as manual skills (competence, capability and proficiency) rather than soft skills (personal attributes such as teamworking, problem solving, communication and leadership). The common

understanding between assistant employees and the organisation is that competence refers to manual skills and the attainment of soft skills is not widely recognised by non-registered staff whereas it is considered an important element of skill acquisition by the organisation.

Where clusters or bundles of competencies addressing skills, knowledge, attitudes and abilities demonstrated in a job context (Garavan and McGuire, 2001; McLagan, 1996; Berge *et al.* 2002) are used in competency and capability frameworks within the NHSS, this research has shown that competency is not recognised in bundles by the non-registered workforce. Further, negotiation around acquisition of competency bundles is not facilitated in this Health Board but remains a prescriptive requirement to meet the needs of the service.

Findings have further shown that while financial rewards for education and skill acquisition hold some importance to assistant staff (Gallie, 1996; Munro and Rainbird, 2002) the lack of such rewards has not had any impact on the uptake of learning provision. Rather, the assistant staff all indicated that they felt empowered by any learning opportunities they were given and motivated to further develop within their own job roles with or without career progression.

Workbased learning models are the preferred option by this Health Board for development of assistants rather than academic models and include the SVQ attainment and, in the case of AHP assistants, protected study time for CPD activities. Findings indicate that the SVQ is perceived as being an academic achievement by some assistant staff as it is viewed as a transferable 'qualification' in much the same way as any academic 'qualification'. However, despite the overall consensus that the SVQ did not supply new knowledge but worked as a validation of existing knowledge, the perception was that in order to progress in healthcare, a qualification such as the SVQ was the only way to achieve this other than gaining academic qualifications outwith work and progressing through the traditional channel of full time study at a university. As this can entail leaving a job and personally financing studies, it is not an option open to many non-registered staff who are some of the lower paid workers in the NHSS.

Delivering Care (Scottish Executive, 2006a) emphasised that reorganisation in the Health Service increased the need for teamworking and evaluation of skill mix to include a career structure for nursing assistants, supported by the SVQ learning initiative. To date the career structure involves further study through an HNC as access to 2nd year of a nursing diploma. While facilitating a career pathway for some assistants, this career structure is in itself restrictive. As the HNC is profession specific there is no room to negotiate access to other professions in the health service. Furthermore a career pathway to registration for AHP assistants has not been articulated, despite there being plans at a national level for this. However, AHP assistants have been given the opportunity to develop to SVQ level with support and workbased learning much more in evidence compared to nursing assistants and therefore development objectives outlined in *Building on Success* (Scottish Executive, 2002b) have been addressed.

There has been no research within this organisation on the impact of the SVQ experience and as the SVQ has been available to nursing assistants for over ten years it is arguable that this is long overdue. However, this research has gone some way to addressing this pragmatic issue. Where findings have shown that the site of learning is considered to be through 'extra' clinical competencies, there remains disparities across the professions and therefore the 'right to practice' (Conrane *et al.* 1996:14) dependent on the assessment of competence remains an unresolved issue where registered staff are often reluctant to allow non-registered staff to undertake an extended scope of practice.

Support is necessary, both as part of an expansive learning environment but also as a fundamental to achievement of an SVQ. This research has shown that support is variable, again dependent on the site of work. One of the intended outcomes of the SVQ initiative was to make staff feel valued and motivated to progress (Scottish Executive, 2002). However, unless it was perceived that support was available, the assistant staff did not feel valued and in some cases, perceived that their registered colleagues saw the assessment of the SVQ as a chore that was going to make little difference to the assistants' actual job role and therefore was a pointless exercise. None-the-less, the

assistants were motivated to continue with some form of learning following completion of an SVQ.

This research has shown that most assistants do not consider the SVQ, on its own, to be a gateway to career progression. However the consensus is that the SVQ is almost a pre-requisite to any further training and development opportunities which could in turn be a gateway to career progression. That is to say, the SVQ acts as an access to further learning opportunities, not least because the completion of an SVQ motivated the assistants to look for other learning opportunities to either progress in their career or to enrich their current job role. The timing of undertaking an SVQ did not have any impact on the understanding or completion of the qualification as suggested by Eraut (2001). Some of the assistants had been working for many years prior to commencing an SVQ where others were relatively new to the job but perceptions on the content and outcomes of the SVQ were similar by all assistants. Grugulis (2002) had argued that vocational qualifications had put a ceiling on progress but this research has shown that the perception of those undertaking SVQs argues against this.

Chapter Nine. Discussion, Conclusions and Recommendations.

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9.0 Introduction

This research began at a time when the NHSS was going through change by reorganisation and although this research has concluded, reorganisation in the NHSS continues. The findings from this research are relevant and useful throughout the NHSS as an organisation at corporate, regional, departmental and localised levels. This final chapter concludes and discusses the main findings in relation to the original aim and research questions. The contribution to knowledge provides a different way of considering certain concepts from Human Resource Development and Management literature, particularly those around the learning organisation, the learning environment and the national framework for vocational competency. There is a gap between strategic policy making in the NHSS and the implementation of policy at board level. The nature of this gap is demonstrated through the three areas mentioned. Limitations to the study are discussed, along with suggested topics for future research and finally, recommendations for action from this research are given.

9.1 The overall research aim, specific objectives and research questions.

This research aimed to critically assess the opportunities for workbased learning, personal development and career progression of non-registered clinical staff in the NHSS. The aim also included critical evaluation of the outcomes against Scottish Government strategic plans for the NHSS clinical assistant workforce. The attainment of the specific objectives (see page 5) and research questions (see page 11) are discussed in this section.

9.1.1 Meeting the objectives

The **first** objective was to identify key debates within the literature on the concepts of human resource development, workbased learning and

National/Scottish vocational qualifications. This was achieved through a critical examination of literature on training, development, education and learning, skill acquisition (see Chapter Four, page 76), and competence and competencies, CPD and PDP (see Chapter Four, page 85).

The overarching concepts of the learning organisation (page 90) where learning and development as a core characteristic of an organisation is considered and the learning environment (page 94) including access to learning, support and wide use of skills were also critically reviewed. These two concepts were identified as key models against which the NHSS was assessed (refer to Tables 8.3 page 242, 8.4 page 244 and 8.5 page 246 for specific findings in relation to these models).

The **second** objective involved establishing the nature and extent of training and development opportunities available to non-registered clinical staff. This was achieved through in-depth semi-structured interviews with assistants and with providers and facilitators of education and training in one Health Board covering a large geographical area and incorporating acute and primary care/community sectors. The interviews were conducted following an overview of policy and strategic documents from the Scottish Government Health Division (formerly the Scottish Executive Health Department), local strategic and policy documents pertaining to nursing and midwifery and allied health professions and analysis of results from the NHSS Staff Satisfaction Survey (see chapter seven, page 179).

The **third** objective was to consider the availability and impact of career pathways in relation to assistants in different professional groups. Again this was addressed and achieved through the use of in-depth semi-structured interviews following a review of relevant national, regional and local strategic and policy documents and analysis of the staff survey.

The **final** objective was to articulate the outcomes from the empirical research with government strategic aims (See chapter eight, page 247). As the strategic aims related to the learning and development of all staff and the realisation of becoming a learning organisation, this objective was achieved through analysis

of the data and comparison of the assistant staff groups. The results were then aligned in detail with the specific government aims.

9.1.2 Addressing the research questions

Following the literature review, this study had three specific research questions (see chapter one, page 11). This section synthesises the findings. The adopted methodology of a pragmatic approach informed by critical realism and the quantitative and qualitative methods used allowed for an in-depth study of the perceptions of non-registered clinical staff and of in-house education providers and managers relating to these questions.

Question One: To what extent can the NHSS be considered a Learning Organisation?

This research has shown that at a national level, the NHSS can be seen to be working towards becoming a learning organisation and this is evidenced by the plethora of documentation relating to this concept (see chapter three, page 32). However, because there is no specific guidance from the government, the interpretations of strategies are carried out at regional level and there continues to be a lack of collective ethos. Furthermore, actioning of strategies at local level further dilutes the common aim and propagates disparity between the workforce.

Despite the fact that since 2005 there has been a marked increase in the use of assistants at the clinical face of healthcare there has been no corresponding increase in training and development opportunities for this group of staff. The majority of training has been ad hoc or concentrated in pockets of clinical practice demonstrating 'good practice' throughout the Health Board under study. The NHSS documents suggest that a culture change has to occur to allow multi-skilling with multi-professional integration. However, the disparities in education provision between nursing and AHP assistants highlight that this had not happened. In reality, the NHSS consists of multiple cultures such as management hierarchy, professional groups, individual departments and staff peer groups. This makes the cultivation of a collective ethos particularly challenging when there is no prescriptive direction or cooperative dialogue concerning the implementation of strategic aims.

The staff governance standard (Scottish Executive, 2002c) supported *Learning Together* (Scottish Executive,1999) by recommending that staff be well informed, appropriately trained, involved in decisions which affect them, treated fairly and consistently and provided with an improved and safe working environment.   Findings from this research suggest that the staff governance standard has not been achieved.   Analysis of the staff survey intimated that this was the case and phase three data collection supported this.   In response to the first standard, non-registered staff have increasing access to communication systems within the organisation. However, the information gleaned is often mis-directed, particularly around important evolving issues such as KSF which will have an impact on the future development and career opportunities for non-registered staff.   Findings from this research indicate that in regard to the other four standards there is still some way to go to achieve them.

Access to learning and training and establishment of PDPs and CPD for assistants were given immense importance in the strategic and policy documents but have yet to be realised.   This research has shown that the opportunity to learn new skills and be rewarded fairly and consistently is variable across the professions.   The findings from this research indicates that many assistant staff are unaware or confused around specific policy plans and national developments, including regulation, AfC and KSF, all which will have a huge impact on their future in the health service.

To date, recognition and/or accreditation of previous learning has not been given any notice and therefore, highly skilled and experienced individuals have hit a ceiling in their development because there is nothing for them to work towards or attain that is within their financial and personal constraints. Evidence from this study suggests that the development of PDPs is regarded by assistants as the key to opening up access to training and development opportunities.   However, as PDPs have yet to be embedded in the organisation culture and structure, it is unlikely that any intended impact will happen in the near future.

The study has shown that management decisions to offer learning opportunities are driven by extrinsic factors (Rainbird, 1998) where the structural position of

the employee in the organisation and the requirements of the job they hold dictate the learning opportunities which are intended to address the strategic goals of the organisation. At this time the drivers for employee development include further populating the assistant workforce to meet the needs of the service rather than provide workbased opportunities to progress into professional status through registration.

Conrane *et al.* (1996) had suggested that there was a need for career pathways, transferable skills and APEL and new learning through VQs. However, twelve years have passed since the publication of Conrane *et al's* document and the situation remains relatively unchanged. Another recommendation from Conrane *et al.* (1996) was that recruitment to AHP registration should come from existing AHP assistants to establish career pathways and shorter training periods. Attempts have been made to address this at a national level, through strategic plans to develop the AHP assistant workforce. However, as discussed, this is limited to only three professions and there remains the issue that AHP courses in higher education are well populated and the attrition rate is small and therefore the need for AHP registered staff at this point in time is perceived by AHP assistants as less urgent than nursing needs.

Question Two: To what extent does the NHSS provide an 'expansive' learning environment?

Learning together (Scottish Executive, 1999a) had recommended that staff be 'fit for purpose' to be supported and encouraged through access and opportunities to learn, to develop flexible approach to caring and to become aware of the value of education training and lifelong learning. The implementation of *Learning Together* at regional corporate level involved recommendations through the government workforce plan (NHSScotland, 2007c). At local level, these recommendations have not been actioned in all areas, perpetrating the disparities experienced.

Grugulis (2003) argued that reorganisation can impact on skill acquisition or non-utilisation of existing skills for non-registered staff. This research has shown that utilisation of skills by assistant staff can be dependent on the

registered person in charge of a clinical area at any given time. *Delivering Care, Enabling Health* (Scottish Executive, 2006a) challenged registered staff to have confidence to allow assistant staff to undertake additional tasks under supervision and once deemed competent, practice with less direct supervision. This research has shown that this rarely happens with any consistency. Again it very much depends on the area of work and also, in many cases it depends on the staff member in charge of the clinical unit.

Question Three: How effective are SVQs for supporting the learning and development of non-registered clinical assistants?

This research has shown that the interpretation and implementation of government targets at Health Board corporate level has mainly focused on the registered staff groups and although the implementation of the national framework for vocational competency through the SVQs has happened rapidly in the large acute Division of this Health Board, it is taking much longer in the smaller acute and primary care/community Divisions.

The SVQ is seen to only underpin the performance of the skills and tasks required to function effectively in a job role (Young, 2004) and therefore, without the added clinical competency bundles, cannot be considered as a personal learning and development tool. As a standalone qualification, the SVQ validates previous learning and development of non-registered clinical assistants but does not support any new learning and development.

9.2 Contribution to knowledge and policy making

This research has highlighted limitations to the application of the concepts of the learning organisation, expansive/restrictive learning environments and the national framework for vocational qualifications within the NHSS. It has particularly demonstrated the way the concept of a learning organisation is being applied in NHSS policy documents without rigour. The NHSS introduces strategic policies for implementation at board level but does not always give sufficient time for implementation of strategies to be properly embedded before strategic direction is reconsidered. This demonstrates a process of single loop

learning which is at odds with recommended processes of double loop and meta-learning features within the learning organisation model (Stewart, 1996; Davies and Nutley, 2000).

9.2.1 The concept of a learning organisation and the NHSS

To achieve the goal of being considered a learning organisation, the NHSS has some way to go before it can be considered in this way other than being an example of Garavan's (1997) argument that defining a learning organisation as one of constant learning and change indicates a constant state of flux. The NHSS can identify with some of the ideals of a learning organisation such as encouraging employee learning through job related skills, abilities and competence (Senge, 1990b; Dodgson, 1993; Nutley and Davies, 2001). However, this research has shown that this is only happening in silos throughout the organisation, and often in a top-down hierarchical way. Findings support Forrester's (1999) argument (cited in Spencer, 2002) that learning organisations can easily be a place of managerial control. Learning here is *by* the organisation but not intentionally *for* its employees (Pedler *et al.* 1996; Watkins and Marsick, 1993). Rather learning by the organisation is in response to the needs of the population through prescriptive training of employees for public protection purposes.

The NHSS is such a large organisation, made up of many sub-organisations which in turn are diluted into Divisions, departments and clinical units, and strategic plans around employee learning and development are devolved from government. For the NHSS to cultivate expansive learning environments within the autonomous organisations that make up the NHSS as a whole, the cultural ethos has to be focused on proper workforce planning which will allow meta learning to occur (Stewart, 1996; Nutley and Davies, 2001). This study has shown that most often, single loop learning takes place where attitudes to learning and development are reactive rather than proactive. This is because decisions around workplace learning are addressed at local level where the budget is held and where the needs of the department are considered rather than the organisation as a whole or indeed the needs of the individual employees. As the Government does not prescribe the implementation of organisational strategic directions in response to an identified need or gap in

delivery of patient care, a cohesive approach to required learning and development opportunities is unlikely to be achieved which in turn will have an effect on the transferability of the workforce. Therefore meta learning could be considered difficult to achieve by the NHSS as the parameters of need are constantly changing. In reality, the NHSS does not adapt according to cognisance of when and how it should learn which argues against the supporters of the learning organisation concept.

The NHSS has only relatively recently been reorganised from separate Trusts who competed against each other to an organisation encouraging flexibility and transferability across the sectors. This research has pulled together and reviewed in depth, all relevant government strategic and policy documents relating to the future healthcare workforce and all suggest achieving learning organisation status is desirable. However, as interpretation of strategies are devised in the separate Health Boards that make up the NHSS, it is unlikely the NHSS will achieve a learning organisation status unless the culture changes to become an inclusive one rather than continuing as separate entities.

9.2.2 The NHSS workplace as an 'expansive' learning environment

This research has shown that assistant employees often perceive that they learn through experience which in turn enhances their jobs. Garavan (1997) and Megginson *et al.* (1993) argued that development is diverse and occurs both consciously and unconsciously. Harrison (2000) added that development enhances jobs by enhancing employees which allows for both organisational and individual growth. However, the assistants in this study do not believe that their knowledge and skills are always valued. This is because there remains no process to recognise their knowledge and skills in an explicit way unless they undertake a recognised qualification that accredits their learning. There is a reluctance to step out of their defined role, even on the occasions that this is made possible, to actually work in an enhanced way. An expansive learning environment would promote development within safe parameters underpinned by robust training and learning opportunities. As findings from this research have shown, many assistants expressed the opinion that they would be content to have their skills and knowledge recognised and utilised without the requirement for any other type of reward.

These particular findings can be linked to Herzberg's theories on motivation in the workplace (1959) and his subsequent work on his motivation-hygiene theory (1966, 1982 and 1983). Herzberg's (1959) main interest was with peoples' well-being at work and findings from his research indicated that people are truly motivated at work by being enabled to realise personal achievement, advancement, development, recognition and responsibility. These factors were more motivating than, what Herzerg (1959) termed, 'hygiene factors' (or maintenance factors) such as policies, salaries and status which people considered as a temporary satisfaction.

Since 1972, access to any training and development opportunities, including mandatory training sessions, has been via the line manager and this has not changed since then (Weir, 2004). Management objectives dictate the training strategies and, as has been noted, training in this Health Board is prescriptive in general. Local areas hold the budget and as long as this continues, opportunities for training and development are likely to remain disparate throughout the Health Board.

To cultivate this expansive learning environment, appraisal and subsequent PDP for CPD needs to be conducted properly to an agreed organisational standard. This research has shown that to date, particularly in the nursing profession, any PDP that does take place lacks substance and is a tick box exercise to devise a number of objectives to be addressed through specific learning opportunities. This does not have the effect of promoting synergy between employee needs and organisational needs. Rather it promotes the idea of appraisal being another task that is required to be completed but that has no substance to it and is likely to be meaningless (Rainbird and Munro, 2003; Munro and Rainbird, 2004).

Incidental learning is cognitive (Coffield, 2000; Clark, 2004) and tacit knowledge gained from incidental learning needs to be harnessed and made explicit. There are currently no processes used in this Health Board that allow for articulation of tacit knowledge (Marsick and Watkins, 1997; Clark, 2004; Keep, 2004). While periods of reflection would help with this and could be aligned to appraisal and PDP, it may be that staff would need support to enable them to

learn how to reflect and to record their reflections. Further study on appraisal systems and their place in an expansive learning environment would be worth considering.

There is evidence of expansive learning environments in isolated areas of the NHSS but collectively as a large organisation, a cultural ethos as a learning environment has not been achieved. In order to progress further with this model, the additional elements of recognition and articulation of previous experiential learning and accreditation of previously achieved formal qualifications require to be added to Fuller and Unwin's expansive/restrictive learning environment model (2004) (see tables 8.4 page 244 and 8.5 page 246) to encourage proper utilisation of PDP and CPD.

9.2.3 The national framework for vocational qualifications

This research has provided an in-depth and thorough assessment of the SVQ in relation to a key and growing occupational group in the NHSS. The vocational qualification route as a way of validating learning in the NHSS has been shown, in this Health Board, to be inadequate in terms of delivering new knowledge and skills. While results support the theories that the SVQ is merely validating existing skills and knowledge (Keep and Rainbird, 1995; Pearn *et al.* 1995; Eraut *et al.* 1998a; Nutley and Davies, 2001; Grugulis, 2003; Keep, 2004), it is perceived by the organisation as a robust qualification to allow for or to enhance career progression. However, it cannot do this alone and in this way it can only be considered as a platform for competence building supplemented by more in-depth workplace learning.

The national specification related to vocational qualifications reflects the diversity of learning needs in this organisation in so far as there are a multitude of units to choose to make up an SVQ which is in contrast to Eraut's (2001) view that a national specification could not reflect the diversity of learning needs. However, the outcomes of SVQs remain reflective accounts of work situations and very little underpinning knowledge is given or required to complete them. More workbased experiential learning associated with the units in the SVQ would elevate their usefulness as actual vocational, practical qualifications and give them more credibility by enabling real learning to take

place.   Findings from this research indicate that at present the emphasis on completing an SVQ is not on any learning but on the writing of evidence to complete the units in a context specific way (McMullan *et al.* 2003; Eraut, 2001; Grugulis, 2002).   Actual organised workbased experiential learning could articulate *what* knowledge was needed, *why* it was needed and *how* to translate that knowledge into workbased practice.   While it is recognised that accreditation of this type of learning is likely to be at a higher SCQF level than the SVQ, this type of learning could be achieved through effective teamworking, periods of organised workbased reflective teaching sessions and effective and robust mentorship.

Despite the quality assurance measures in place from the SQA and the organisation, this research has shown that assessment methods are less than robust.   Many of the SVQ assessors have not completed or are not working towards their assessment award (www.sqa.org, 2007).   In many cases, time spent with assessors by assistants undertaking an SVQ involved instruction on completing their portfolio of evidence rather than being observed in workbased activities (Eraut, 2001; Grugulis, 2002).   Despite all the negatives surrounding the SVQ initiative, the assistants in most cases found it a useful undertaking in so far as it motivated them to actively pursue further learning opportunities.

9.2.4 Discussion around the models of organisational development

The findings from this research were related to the two models of organisational development as discussed above.   While there were some problems with the two models, in general they were very useful tools.   Ten features from Fuller and Unwin's (2004) expansive / restrictive learning environment model were relevant to the NHSS and allowed the researcher to relate findings thematically and contextually.   However, in this study the model lacked two further features – recognition of prior experiential learning and accreditation of prior qualifications – as explained in chapter eight (page 212).   Recognition of prior learning would allow tacit knowledge to become explicit and allow non-registered employees to build portfolios of achievement for personal development planning or be rewarded by an acknowledgement of their value as a team member.

The learning organisation model again allowed the researcher to relate findings thematically and contextually but as the learning organisation model is itself still in development many of the features could be considered open to interpretation. The sense that this model may not easily translate to a large organisation such as the NHSS is evident. However, if used as a 'toolkit' where the various features can be developed, as has been demonstrated in this research, the model can be considered to have some value. By further developing some of the features such as collaborative working, processes of learning and cultivation of a cohesive vision, the gap between policy making and policy implementation could be narrowed considerably.

9.3 Limitations and suggestions for further study

While this research was able to gather the perceptions of a representative sample of the assistant workforce in this Health Board there were certain limitations in the population studied. Night duty staff for example, were not approached as there are particular issues around their access to education and training opportunities that require specific attention. The majority of assistant staff employed on night duty are aligned to the nursing profession and therefore would not have represented the assistant workforce as a whole. Another group of non-registered staff employed in this Health Board are those who work in the 'staff bank'. These are people who do not have a substantive position within the organisation but none-the-less have education, training and development requirements. These two particular groups warrant further research within this subject area.

Some comments from this research suggest that there may be a perception by some registered staff that assistants are being developed to fill previously held registered vacancies as they arise. Reprofiling of jobs through AfC and the KSF have not been fully investigated in this study and particularly in light of recent developments such as proposed regulation and emerging new roles for assistant staff, it is an area that deserves attention. This would investigate the arguments in the literature that skillmix and reprofiling means lower paid staff

carry out more complex tasks previously performed by registered staff which saves the organisation money (Thornley, 1996).

While this study did not focus on the demographics of the workforce, gender may have the potential to influence what training is offered to clinical assistants and what career pathways are available to them. Healthcare continues to be predominantly female orientated and although there are some males employed in clinical healthcare as assistants, the majority are employed in the nursing profession rather than midwifery or any AHP profession. Male nursing assistants tend to be employed in mental health, dementia care or acute trauma such as accident and emergency. Fewer are employed in general clinical areas or community and primary care posts. It would be interesting to discover whether this has any bearing on what development opportunities there are for assistants and why the male assistant workforce is distributed in this way.

Although the assistant workforce were the focus of this research, the staff survey results (Chapter Seven) showed that disparity is perceived within and between other groups, including the registered staff. Bearing in mind that the Health Service is likely to be placed high in a list of training provision by employers, it would be worthwhile conducting similar research focusing on registered clinical staff members, particularly as the strategic documentation (see Chapter Three, page 32) has to date paid more attention to the development of these staff groups.

As mentioned in chapter eight, although SVQs were recommended for development of the assistant workforce (Scottish Executive, 1999a) some Health Boards in Scotland are using the NICHE programme rather than the SVQ to educate their assistant workforce. NICHE is not currently accredited or levelled in line with the SCQF and the outcomes have not been measured in comparison to the SVQ. This would make an interesting study to consider differences and outcomes and consider a place for both in the education and development of assistants.

Senge (1990b) and Beard (1993) described an element of a learning organisation as one that invests in training its managers and focuses on

nurturing and developing specific leadership qualities to meet the organisational strategic needs.   While this research did not consider this in any depth, results show that the perception by assistants is that learning by managers is not always articulated to junior staff.   The paths of communication in a hierarchical organisation such as the NHSS would be worth considering further as an enabler of multi-disciplinary, cross professional learning.   Further, while the assessment process in relation to SVQs was considered in the study, mentorship has not been examined but is an area, particularly aligned to workbased learning and the national framework for vocational qualifications that requires further investigation.

9.4 Recommendations

There are specific recommendations that have emerged from this study concerning the future for the assistant workforce in the NHSS. This final section discusses these in relation to existing and future strategic plans for the larger organisation.   Table 9.1 outlines the main recommendations.   A short discussion of each follows.

	National	
	Immediate	**Longer Term**
Essential	Scottish Government Health Division (SGHD) should provide clarity on roles and parameters of working for assistant staff throughout the NHSS. SGHD should recommend a formal process of RPL for use throughout the NHSS SGHD should commission the construction of explicit development and career pathways for assistant staff throughout the NHSS	SGHD should work to promote the importance and status of workbased learning and assessment throughout the NHSS
	National	
	Immediate	**Longer Term**
Desirable	SGHD on behalf of the NHSS should revisit the concept of competence in relation to learning, training and development of assistant staff. SGHD should revisit the strategic aims of the NHSS becoming a Learning Organisation and apply with more rigour	SGHD should further develop partnership models between service and education providers

Table 9.1 Recommendations for action

9.4.1. Essential recommendations

Immediate:

Scottish Government Health Division (SGHD) should provide clarity on roles and parameters of working for assistant staff throughout the NHSS. The use of non-registered clinical staff in the NHSS is increasing and will continue to do so to meet the changing needs of the Scottish Society. Through national agreement and 'official' recognition of the assistant status several issues highlighted in this research would be addressed:

- Transparent articulation of accountability, responsibility and supervision requirements would address attitudes of registered staff towards delegation of duties to non-registered staff, giving them more confidence to do so.
- Requirements for support and guidance for learning and consistent treatment in employment practice for assistants would be articulated meeting one aim of the staff governance standard.
- Clarity would negate the possibility of subjective decision by separate Health Boards on the education and development of assistant staff
- Clarity would enable flexibility and transferability and therefore meet the government aims outlined in the strategic and policy documents.

SGHD should recommend a formal process of RPL for use throughout the NHSS. Following achievement of role clarity, a formal process of RPL will acknowledge the importance and enable transferability of knowledge and skills for non-registered staff. This links into the suggested additions to the expansive/restrictive learning environment model (Fuller and Unwin, 2004) (see page 246):

- Knowledge and skills would be made explicit and able to be added to portable credentials for assistant staff (Grugulis, 2002).
- Staff would feel valued
- Where accredited qualifications were a requirement, some units of the SVQ or HNC could be omitted saving time, money and duplication of effort

> Embedded in processes, RPL would be of benefit to recruitment, appraisal, PDP and CPD.

SGHD should commission the construction of explicit development and career pathways for assistant staff throughout the NHSS. To address the predicted shortfall of registered professionals in the NHSS it would seem logical to properly develop the existing workforce as well as considering ways to attract a future workforce. The construction of explicit nationally agreed development and career pathways for assistant staff would go some way to addressing current and future needs. It would also address other issues highlighted in this research:

> For those assistants with no interest in climbing the career ladder it would give the opportunity to develop in a recognised way within their current role.
> The work experience of assistant staff would be enhanced
> The inconsistent incidental and informal learning opportunities currently evident throughout the NHSS for assistant staff would be addressed
> Workbased learning and assessment routes would be promoted.

Longer Term:

SGHD should work to promote the importance and status of workbased learning and assessment throughout the NHSS. If the NHSS were prepared to adopt the ethos that not all workplace learning requires accreditation (Eraut, 2001; Grugulis, 2003b) this would enhance the drive by the NHSS to become a learning organisation in several ways as has previously been discussed in this research (refer to table 8.3 page 242):

> Would meet staff governance standards
> Would complement the SVQ which has limited use without 'extra' clinical competencies
> Development of workbased learning programmes with core competency bundles would be aligned to SCQF levels (continuing previous work – see page 64) allowing for transferability and possible accreditation in the future

- ➢ Sustainability of long-term knowledge, skills and attitudes promoting synergy between employee and employer would be enhanced
- ➢ Would promote the notion of identified mentors for all employees
- ➢ Negate the need for absence from the workplace for lengthy periods complemented by robustly developed workplace learning material
- ➢ Would help to keep staff motivated

9.4.2. Desirable recommendations
Immediate:

SGHD on behalf of the NHSS should revisit the concept of competence in relation to learning, training and development of assistant staff. As this research has shown, the concept of competence in the NHSS focuses on observed clinical skills. An assessment tool to measure experiential and informal learning at work needs to be developed for the NHSS. This would further enhance the notion of the NHSS as a learning organisation, would result in a measurable aspect of informal learning and would address issues such as:

- ➢ Allowing tacit skills and knowledge to be recognised, articulated and made explicit
- ➢ Further enhance RPL, transferability and role and career development
- ➢ Avoid duplication of effort on the part of the workforce
- ➢ Enhance the learning experience for employees

SGHD should revisit the strategic aims of the NHSS becoming a learning organisation and apply with more rigour. Table 8.2 (page 227) outlined barriers to workplace learning. To properly realise its intention in becoming a learning organisation the NHSS needs to address these issues. Working on the previous recommendations some of the features of a learning organisation that have not been achieved (see table 8.3 page 242) would be addressed:

- ➢ Access across professional boundaries would be widened (Senge, 1990; Stewart, 1996) enabling flexibility and transferability through interdisciplinary working, education, training and learning
- ➢ Deeply held assumptions and generalisations (Senge, 1990) about the way the NHSS 'should' operate would be safely challenged

> ➢ Robust communication channels would be developed giving staff awareness of strategies and policies effecting future workplace learning and development and facilitate dissemination and sharing of learning (Senge, 1990; Stewart, 1996; Pedler *et al.* 1995).

Longer Term:

SGHD should further develop partnership models between service and education providers. Although partnership models exist, these should be further developed to embrace the developing assistant workforce:

> ➢ This would help inform the provision of workbased learning and assessment programmes with the option of being formally accredited
> ➢ It would enhance recognition of assistant job roles through clarity of requirements, standards and abilities achieved through formal education thereby promoting an expansive learning environment (Fuller and Unwin, 2004)
> ➢ Impact on attrition rates from universities, particularly around nursing programmes, where students unable to complete undergraduate programmes could apply for entry into assistant workforce through RPL/APEL and possibly only workbased competency bundles to bring them to the required level.

9.5 Summary

To summarise, workplace learning in the NHSS is largely prescriptive where the organisation decides learning requirements and methods of learning for their non-registered staff to meet organisational needs. This means that for clinical assistant staff this can result in more barriers than opportunities. Not all learning requires to be accredited and not all non-registered employees wish to climb the career ladder to registration.

The findings of this research indicate that while the strategies are considered viable at corporate levels of the NHSS, interpretation and actioning of the strategic plans is variable across the professions at both regional and local

level. The intended strategic developments have therefore had variable impact on the non-registered clinical workforce, very much dependent on the site of work.

To promote an expansive learning environment and afford more rigour to attaining a learning organisation status, the NHSS needs openness and transparency around development opportunities. This research has shown that some assistants perceive there is no way to progress within the organisation and therefore, other than personal satisfaction, there is little reason to take up learning opportunities particularly as any learning does not change their job in any noticeable way.   Therefore if transparency was evident then education, training and development could be understood as an opportunity to develop within their roles with the potential to advance in their career when a vacancy became available and would facilitate transferability throughout the NHSS and beyond.   Transparency would have the added benefit of attracting a future assistant workforce.   With the projected depletion of a registered workforce in the near future, development of existing staff must become a priority. Therefore, to accommodate both employee needs and the needs of the service and thereby promote synergy through an expansive learning environment, the strategic plans of the NHSS need to acknowledge that one prescriptive route to employee development is not sufficient.

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Appendix One:

Historical Points of Note in the evolution of the NHSS and staff development

Date	Notable historical events
1916	Royal College of Nursing (RCN) founded
1920s	Paramedical professions emerge in Scottish hospitals
1921	General Nursing Councils (GNCs)established in all four UK countries
1922	GNC for Scotland publishes register of nurses
1943	Enrolled Nurse grade introduced
1948	National Health Service (NHS) Established
1955	Formal recognition of Nursing Auxiliary grade
1970	Regulation for Allied Health Professionals (AHPs) by Council for Professional Supplementary to Medicine (CPSM)
1972	Reorganisation of the NHS in Scotland – 15 Health Boards established
1972	Salmon Report - reorganisation of hierarch at management level of regional organisations - Hospital schools of nursing become district schools
1981	Working week reduced to 37.5 hours
1983	United Kingdom Central Council (UKCC) established
1988	'Project 2000' launched
1990	NHS Trusts established
1992	Last intake of pupil nurses for Enrolled Nurse training
2001	Health Professions Council (HPC) supercedes CPSM
2001	Nursing and Midwifery Council (NMC) supercedes UKCC
2002	Strategic Health Authorities established
2002	NHS Education for Scotland (NES) supercedes National Board for Scotland (which had superseded GNC)
2003	Trusts disbanded to become Division of Health Authorities
2004	Further reorganisation of hierarchy at management level of regional organisations
2005	- Reorganisation of management hierarchy in regional organisations once again - Health Boards re-established - Trusts abolished – Divisions formed under umbrella of Health Boards - Marked and noted increase in use of assistants within nursing, midwifery and allied health professions

Appendix Two:

Critically examined strategic and policy documents on education, training and development in the NHSS

Date Published	Title	Author / NHS Body	Referred to as
UK Government Documents			
1997	The New NHS. Modern. Dependable	Department of Health (DOH)	The new NHS
1999a	Future staffing requirements. The Government's response to the Health Committee's Report on future staffing requirements.	Department of Health	Future staffing requirements
1998a	Working together. Securing a quality workforce for the NHS.	Department of Health	Working together
1999b	Agenda for change. Modernising the NHS pay system.	Department of Health	Agenda for Change
2000a	A health service of all the talents: developing the NHS workforce. Consultation document on the review of workforce planning.	Department of Health	Developing the NHS workforce
2000b	The NHS plan. A plan for investment. A plan for reform.	Department of Health	The NHS plan
Scottish Government Documents			
1997	Lifelong Learning. The way forward	Scottish Office	Lifelong Learning
1997	Designed to care. Renewing the National Health Service in Scotland	Scottish Office Department of Health	Designed to Care
1998a	Towards a new way of working. The plan for managing people in the NHS in Scotland	Scottish Office Department of Health	The HR Strategy
1998b	Working together for a healthier Scotland. A consultation document	Scottish Office Department of Health	Working Together
1999	Learning together. A strategy for education, training and lifelong learning for all staff in the National Health Service in Scotland	Scottish Executive Health Department	Learning Together
2000	Our National Health. A plan for action, a plan for change	Scottish Executive Health Department	Our National Health
2001a	Caring for Scotland. The strategy for nursing and midwifery in Scotland	Scottish Executive Health Department	Caring for Scotland

2002a	Allied Health Professions in NHSScotland: Key players in the healthcare team	Scottish Executive Health Department	AHP/Key Players
2002b	Building on success. Future directions for the Allied Health Professions in Scotland	Scottish Executive Health Department	Building on Success
2002c	Staff governance standard. For NHSScotland employees	Scottish Executive Health Department	Staff Governance Standard
2002d	Working for health. The workforce development action plan for NHSScotland	Scottish Executive Health Department	Working for Health
2003a	The NHS knowledge and skills framework and related development review	Scottish Executive Health Department	KSF Framework
2003b	Life through learning through life. The lifelong learning strategy for Scotland	Scottish Executive Health Department	Lifelong Learning Strategy
2003c	Ongoing learning and development in the NHSS. Planning manual	Scottish Executive Health Department	Ongoing Learning
2003d	Partnership for care. Scotland's health White Paper	Scottish Executive Health Department	Partnership for Care
2004a	Agenda for change: what will it mean for you? A guide for staff	Scottish Executive Health Department	A guide to AfC
2004b	Regulation of health care support staff and social care support staff in Scotland. A consultation document	Scottish Executive Health Department	HCSW Regulation Consultation
2004c	Scottish health workforce plan 2004 baseline	Scottish Executive Health Department	Workforce Plan
2005a	Allied Health Professions. Flexible working	Scottish Executive Health Department	AHP flexible working
2005b	Building a health service fit for the future. A national framework for service change in the NHS in Scotland	Scottish Executive Health Department	The Kerr Report
2005c	Delivering for health	Scottish Executive Health Department	Delivering for Health
2005d	Partnership: delivering the future. Taking stock of partnership working. Report by the project steering group	Scottish Executive Health Department	Partnership Working Report
2005d	Framework for role development in the Allied Health Professions	Scottish Executive Health Department	AHP Framework for role development

2006a	Delivering care, enabling health. Harnessing the nursing, midwifery and allied health professions' contribution to implementing 'delivering for health' in Scotland	Scottish Executive Health Department	Delivering Care
2006b	National standards relating to healthcare support workers in Scotland. A consultation document	Scottish Executive Health Department	National Standards for HCSWs
2006c	Summary report prepared by the Scottish Council foundation on the DOH (England) post-shipman reviews of medical and non-medical regulation. Scottish stakeholder events	Scottish Executive Health Department	Regulation Summary Report

Special Health Boards and other Documents

2001	Planning Together. Report June 2001	Scottish Integrated Workforce Planning Group	Planning Together
2001	a new special Health Board for education in NHSScotland. Consultation	NHS Education for Scotland	NES consultation
2002a	Introduction to NES	NHS Education for Scotland	NES introduction
2003	Annual Report	NHS Education for Scotland	NES annual report
2005	Educational solutions for workforce development. The NES strategic work plan 2005-2008	NHS Education for Scotland	NES strategy
2005	Clinical governance and risk management: achieving safe, effective, patient-focused care and services. National standards – October 2005	NHS Quality Improvement Scotland	QIS National Standards
2006	Continuing professional development and the Allied Health Professions in Scotland – a national learning needs analysis. Final project report	NHS Education for Scotland	NES CPD for AHPs

Regional Health Board Documents

2003	Trust Learning Plan	NHS Lothian	Trust Learning Plan
2005	NHS Lothian learning plan 2005-2007	NHS Lothian	NHS Lothian Learning Plan

Appendix Three:

Interview Schedule (Phase One)

The questions posed to the assistants in phase one covered the following:

Personal:

- Job title
- Length of service
- Job role
- Motivation to learn and develop

Training and development opportunities:

- Training provided for current role
- Access to training and development opportunities
- Theoretical and practical elements to any training
- Informal learning opportunities
- Perceptions around workbased experiential learning versus organised courses

Undertaking an SVQ:

- Requirement or opportunity to undertake SVQ
- Level of SVQ
- Time limit for completion
- Extra competencies
- Protected study time

The workplace learning environment:

- Type and amount of support from registered staff
- Type and amount of support from management
- Mentor and / or assessor input
- Supported reflection time for work
- Sharing of skills and experience by registered staff
- Personal development planning and appraisal
- Informal teaching sessions in the workplace
- Perceptions of being a team member
- Transferable learning and skills

The workplace as a learning organisation:

- Recognition / accreditation of previous learning
- Rewards for training / learning
- Perceptions of career and development pathways
- Perceptions of opportunities for learning and development in the workplace
- Perceptions of barriers to learning and development in the workplace

Appendix Four: NHS Staff Survey Questionnaire (2006)

Completion Instructions

- Please work through this questionnaire by reading each question and ticking the most appropriate response option from those listed.

- Please try and answer every question. However, if you come across a question that is not relevant to you, please leave it blank rather than selecting a response that doesn't meet your needs.

Where do you work?

The questions in this section are being asked to provide information that will be used to analyse and understand how different groups of employees feel about various subjects. This will allow ORC International to provide us with reports specific to your area and enable us to understand if there are differences in opinion amongst different groups of staff to any of the questions asked in this questionnaire. We are not interested in identifying how individuals have responded and **no results will be available that will allow an individual's response to be identified**.

1 In which Division/Directorate/Department/Sector do you work?

University Hospitals Division:	Medical & Associated Services □1	Surgical & Associated Services □2
	Performance Management Team □3	Chief Operating Officer's Team □4
Primary Care and Community:	North Edinburgh CHP □5	South Edinburgh CHP □6
	East Lothian CHP □7	Midlothian CHP □8
	West Lothian CHCP □9	Royal Edinburgh Hospital & Associated Services □10
	Astley Ainslie Hospital & Associated Services □11	Other Primary Care Organisation Directorates □12
Corporate and Support Services (including HQ/Deaconess House): □13		

2 To which staff group do you belong?

Admin and Clerical □1		Qualified AHP (Registered OT, Physio, Dietician, Radiographers, etc) □9	
Ancillary (Hotel Services, Facilities etc) □2		Other AHP (Helpers, Instructors) □10	
Salaried General Dental Practitioner □3		Private Contractors □11	
Salaried General Practitioner □4		Scientific and Technical (MTO, Chaplains, etc) □12	
Maintenance/Estates □5		Scientific and Technical Support (MTAs, etc) □13	
Medical/Dental □6		Senior Manager □14	
Nursing/Midwife (NMC Registered) □7		Other □15	
Nursing/Midwife (N/As HCA, SHCA, Student Nurse, Nursery Nurse, etc) □8			

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Section A: Well Informed – All staff should be provided with appropriate and timeous information to allow them to do their job as effectively as possible

Please tick one box only for each question	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
1 I have the information I need to do my job well	☐	☐	☐	☐	☐
2 I am clear about what I am expected to achieve in my job	☐	☐	☐	☐	☐
3 I am kept well informed about what is happening in my NHS Board	☐	☐	☐	☐	☐
4 The information I receive is generally in a format I can access easily	☐	☐	☐	☐	☐
5 I am aware of the long term goals of my NHS Board	☐	☐	☐	☐	☐
6 I feel my line manager is open and honest with me	☐	☐	☐	☐	☐
7 I believe senior management in my NHS Board are open and honest in their communication with staff	☐	☐	☐	☐	☐
8 My line manager communicates effectively	☐	☐	☐	☐	☐
9 I believe communication between management and staff in my NHS Board is effective	☐	☐	☐	☐	☐
10 I am satisfied with the information I receive about changes taking place within my NHS Board	☐	☐	☐	☐	☐
11 I am aware of what the Area Partnership Forum does	☐	☐	☐	☐	☐
12 It is usually easy to find out who to talk to if I need to talk to someone about an issue/task/project	☐	☐	☐	☐	☐

I understand why the following changes are taking place within my NHS Board:

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
13 Agenda for Change	☐	☐	☐	☐	☐
14 Major service change	☐	☐	☐	☐	☐

How effective are the following in communicating what is happening in your NHS Board and enabling communication between staff?	Very effective	Effective	Partially effective	Not at all effective	Not applicable/ Don't have access	Not aware of it
15 The NHS Board's newsletter/magazine/bulletin	☐	☐	☐	☐	☐	☐
16 E-mail	☐	☐	☐	☐	☐	☐
17 Notice boards	☐	☐	☐	☐	☐	☐
18 Team briefings/Department meetings	☐	☐	☐	☐	☐	☐
19 Briefings by the Chief Executive/Directors	☐	☐	☐	☐	☐	☐
20 Intranet	☐	☐	☐	☐	☐	☐
21 SHOW (Scotland's Health On the Web)/Scottish Executive Health Department Communications	☐	☐	☐	☐	☐	☐
22 Attachments to payslip	☐	☐	☐	☐	☐	☐
23 Area Partnership Forum (or equivalent)	☐	☐	☐	☐	☐	☐
24 Letters/Memos/Facsimiles (Fax)	☐	☐	☐	☐	☐	☐
25 Meetings with immediate line manager	☐	☐	☐	☐	☐	☐
26 My staff side/union representative	☐	☐	☐	☐	☐	☐

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How effective are the following in communicating what is happening in your NHS Board and enabling communication between staff?	Very effective	Effective	Partially effective	Not at all effective	Not applicable/ Don't have access	Not aware of it
27 The NHS Board's Annual Report	☐	☐	☐	☐	☐	☐
28 E-Library	☐	☐	☐	☐	☐	☐
29 Newspapers	☐	☐	☐	☐	☐	☐
30 The 'grapevine'/word of mouth	☐	☐	☐	☐	☐	☐

Section B: Appropriately Trained – All staff should be provided with the appropriate skills and knowledge to allow them to do their job as effectively as possible and to progress in accordance with the Knowledge and Skills Framework

Only answer question 31 if you have joined the organisation or changed job within the last 2 years:	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	I did not receive an induction
31 I received an effective induction into my job	☐	☐	☐	☐	☐	☐

	Yes	No	Don't know
32 Have you been involved in the Knowledge and Skills Framework Awareness training?	☐	☐	☐
33 Do you have a Personal Development Plan (PDP)?	☐	☐	☐
34 Have you had a performance review within the past 12 months?	☐	☐	☐

If you have not had a performance review within the past 12 months please go to question 37

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
35 My last performance review accurately reflected my performance	☐	☐	☐	☐	☐
36 During my last performance review my line manager helped me to focus on improving my performance	☐	☐	☐	☐	☐
37 My line manager reviews with me the effectiveness of any learning and development I have undertaken	☐	☐	☐	☐	☐
38 There are sufficient opportunities for me to receive training to improve my skills in my current job	☐	☐	☐	☐	☐
39 I believe I have the opportunity for personal development and growth in NHS Scotland	☐	☐	☐	☐	☐
40 I am satisfied with the opportunities I have to get a better job in my NHS Board	☐	☐	☐	☐	☐
41 My performance has improved as a result of skills I have developed over the past year	☐	☐	☐	☐	☐
42 My working patterns are taken into account adequately when training and development is made available to me	☐	☐	☐	☐	☐
43 I am able to access the training and development opportunities available to me	☐	☐	☐	☐	☐
44 Sufficient funding is available for the provision of training and development activities	☐	☐	☐	☐	☐

Section C: Involvement in Decisions - Staff should have the opportunity to be involved in the decisions that affect their job

Please tick one box only for each question	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
45 I believe it is safe to speak up and challenge the way things are done in my NHS Board	☐	☐	☐	☐	☐
46 I am satisfied with the opportunities I have to put forward new ideas or suggestions for improvement	☐	☐	☐	☐	☐
47 I am confident my ideas or suggestions would be listened to	☐	☐	☐	☐	☐
48 I have the opportunity to contribute my views before changes are made that affect my job	☐	☐	☐	☐	☐
49 I understand the reasons why my views are not always acted on	☐	☐	☐	☐	☐
50 I am satisfied with the extent to which I can participate in decision making where I work	☐	☐	☐	☐	☐
51 I am satisfied with the influence I can have on what goes on in my work area	☐	☐	☐	☐	☐
52 I am satisfied with the amount of freedom I have to choose my own method of working within the protocols of my job role	☐	☐	☐	☐	☐

Section D: Treated Fairly and Consistently – Policies, procedures and behaviours practised within the workplace should ensure the fair and consistent treatment of staff

Please tick one box only for each question	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
53 My job makes good use of my skills and abilities	☐	☐	☐	☐	☐
54 I am satisfied with the recognition I receive for doing a good job	☐	☐	☐	☐	☐
55 My line manager recognises and acknowledges when I do a good job	☐	☐	☐	☐	☐
56 I believe poor performance is dealt with effectively where I work	☐	☐	☐	☐	☐
57 I believe my manager values my work	☐	☐	☐	☐	☐
58 I believe this NHS Board offers me equality of opportunity	☐	☐	☐	☐	☐
59 I am treated with dignity and respect in this organisation	☐	☐	☐	☐	☐
60 I believe this organisation respects individual differences (e.g. cultures, working styles, backgrounds, ideas)	☐	☐	☐	☐	☐

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Bullying, harassment and discrimination may mean different things to different people. Guidance around the types of behaviours commonly experienced under these categories are given below. However what we are really interested in is what you perceive it to be.

Bullying is used to describe a threatening or intimidating work environment in which a group of people or an individual may become fearful or intimidated because of hostile or negative behaviour which can include verbal abuse, belittling, displays of temper against an individual, invalid criticism or excessive supervision.

Harassment is behaviour by one individual, whether intentional or not, that creates feelings of anxiety, humiliation, awkwardness or distress in another which can include verbal or physical threats, offensive jokes, unnecessary bodily contact, offensive language or personal comments about a person's physical appearance or character.

Discrimination occurs when someone is treated differently to other people or groups in identical circumstances, especially without justification. Discrimination can also be indirect where a requirement or condition is applied which, whether intentional or not, adversely affects a large proportion of a particular group and which cannot be shown to be justifiable.

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
61 I would feel able to report bullying/harassment/discrimination without worrying that it would have a negative impact on me	☐	☐	☐	☐	☐

In the last year, whilst working for this organisation, have you been treated in a way you would describe as any of the following types of behaviour?

	Yes	No
62 Bullying	☐	☐
63 Harassment	☐	☐
64 Discrimination	☐	☐

If you have not personally experienced bullying, harassment or discrimination in the last year go to question 70

65 Who was the source of this behaviour?

Senior manager ☐	Line manager/supervisor ☐	Public (patients/relatives) ☐
Senior clinician ☐	Colleagues/other staff ☐	Other ☐

66 What form did the bullying, harassment or discrimination take?

Sexual (innuendos, leering, rude jokes/remarks) ☐	Racial (name calling, racist jokes) ☐
Verbal (shouting, threatening, humiliating) ☐	Physical (inappropriate touching) ☐
Excessive criticism ☐	Victimisation (keeping you out of things, singled out for unfair treatment) ☐
Non-verbal (mimicking, ignoring, staring, disregarding) ☐	Other ☐

	Yes	No	
67 Did you report the incident(s)?	☐	☐	- If "No" go to question 69
68 Were you satisfied with the outcome?	☐	☐	

69 If you did not report the incident(s), why was this? (please tick all that apply):

Nothing would happen ☐	Possible victimisation ☐
Unaware of how to report it ☐	Time it would take to report it ☐
Fear of what would happen if I did report it ☐	It would take too long for anything to be done about it ☐
Concerns about confidentiality ☐	Other ☐

Section E: Provided with an Improved and Safe Working Environment – Staff should feel safe in their workplace and confident that their employer meets health and safety requirements

Please tick one box only for each question	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
70 I am able to strike the right balance between my work and home life	☐	☐	☐	☐	☐
71 I am comfortable with the level of pressure placed on me in my job	☐	☐	☐	☐	☐
72 I am given realistic deadlines to work to	☐	☐	☐	☐	☐
73 I have enough time to do my job effectively	☐	☐	☐	☐	☐
74 I can meet the requirements of my job without regularly working excessive hours	☐	☐	☐	☐	☐
75 I am satisfied with my physical working environment	☐	☐	☐	☐	☐
76 Where I work there are enough staff to get the job done	☐	☐	☐	☐	☐
77 Where I work the technology available to us enables us to complete our work effectively	☐	☐	☐	☐	☐
78 I feel that my working environment is safe	☐	☐	☐	☐	☐
79 Health & Safety is taken seriously by this organisation	☐	☐	☐	☐	☐
80 I feel my safety during my journey to work is taken seriously by my NHS Board	☐	☐	☐	☐	☐
81 People in my Department only take sickness absence if they are genuinely ill	☐	☐	☐	☐	☐
82 In my Department taking sickness absence is the only way of getting time off for emergencies	☐	☐	☐	☐	☐

In the last 2 years, whilst working for this organisation, have you…	Yes	No	
83 …had an accident during your 'working day' that resulted in you needing to seek medical advice or treatment?	☐	☐	
84 …personally experienced a violent/aggressive incident?	☐	☐	If "No" go to question 89

85 Who was the source of this incident?

Senior manager ☐   Immediate line manager/supervisor ☐   Senior clinician ☐   Patients ☐

Colleagues/other staff ☐   Relatives of patients ☐   Other ☐

	Yes	No	
86 Did you report the incident?	☐	☐	- If "No" go to question 88
87 Were you satisfied with the outcome?	☐	☐	

88 If you did not report the incident(s), why was this? (please tick all that apply):

Nothing would happen ☐   Possible victimisation ☐

Unaware of how to report it ☐   Time it would take to report it ☐

Fear of what would happen if I did report it ☐   It would take too long for anything to be done about it ☐

Concerns about confidentiality ☐   Other ☐

6

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Section F: Perceptions of the job and the organisation

Please tick one box only for each question	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
89 I am satisfied with the support I get from my work colleagues	☐	☐	☐	☐	☐
90 Morale is good where I work	☐	☐	☐	☐	☐
91 Senior managers in my NHS Board are focused on meeting patients'/clients' needs	☐	☐	☐	☐	☐
92 My NHS Board manages change effectively	☐	☐	☐	☐	☐
93 I feel secure in my job	☐	☐	☐	☐	☐
94 Considering my duties and responsibilities, I feel my pay is reasonable	☐	☐	☐	☐	☐
95 I am satisfied with the total benefits package (i.e. pension, leave entitlement)	☐	☐	☐	☐	☐
96 I feel proud to work for my Board	☐	☐	☐	☐	☐
97 I would recommend NHSScotland as a good place to work	☐	☐	☐	☐	☐
98 I feel a strong sense of belonging to NHSScotland	☐	☐	☐	☐	☐
99 I intend to still be working within NHSScotland in 12 months time	☐	☐	☐	☐	☐
100 I intend to still be working within this NHS Board in 12 months time	☐	☐	☐	☐	☐
101 Considering everything I am satisfied with this organisation as a place to work	☐	☐	☐	☐	☐

Comments

102 What do you enjoy most about your job?

103 If you could suggest one change to make your working life within your Board better what would it be?

About you

The questions in this section are being asked to provide information that will be used to analyse and understand how different groups of employees feel about various subjects. This will allow ORC International to provide us with reports specific to your area and enable us to understand if there are differences in opinion amongst different groups of staff to any of the questions asked in this questionnaire. We are not interested in identifying how individuals have responded and **no results will be available that will allow an individuals response to be identified**.

104 Are you:

Male ☐1   Female ☐2

105 How old are you?

20 years or under ☐1	21-30 years ☐2	31-40 years ☐3
41 - 50 years ☐4	51 - 60 years ☐5	Over 60 years ☐6

106 Are you:

Full-time ☐1   Part-time ☐2   Bank Staff ☐3

107 Which, if any, of the following working patterns applies to you? (tick all that apply)

Conditioned hours ☐1	Casual ☐2	Compressed week ☐3	Flexi-hours ☐4	Home working basis ☐5
Job share ☐6	Shift working ☐7	Term time ☐8	Other ☐9	

108 Do you consider yourself to have a disability as defined under the DDA?

(The Disability Discrimination Act defines a disability as "A physical or mental impairment which has a substantial and long term adverse effect on a person's ability to carry out normal day to day activities", e.g. asthma, dyslexia)

Yes and I have declared my disability ☐1

Yes, but I have not declared my disability ☐2

No ☐3

109 What is your employment contract type?

Permanent ☐1   Temporary/Fixed Term ☐2   Secondment into the Service ☐3   Secondment out with the Service ☐4

110 How long have you worked for the NHS in Scotland (this includes previous Trusts and Boards)?

Less than 1 year ☐1	Between 1 & 2 years ☐2	Between 2 & 5 years ☐3
Between 5 & 10 years ☐4	Between 10 & 20 years ☐5	Over 20 years ☐6

111 Do you have direct line management responsibility for staff?

Yes ☐1   No ☐2

112 Do you have day-to-day caring responsibilities for dependant children or disabled/sick/elderly people outside of work?

Yes ☐1   No ☐2

113 What is your pay range?

Up to £16,000 ☐1	Between £16,001 & £24,000 ☐2	Between £24,001 & £35,000 ☐3
Between £35,001 & £45,000 ☐4	Between £45,001 & £55,000 ☐5	Over £55,000 ☐6

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114 What is your religion?

No religion ☐1	Buddhist ☐2	Christian (inc. Church of Scotland, Catholic, Protestant and any other Christian denomination) ☐3	Hindu ☐4
Jewish ☐5	Muslim ☐6	Sikh ☐7	Other ☐8

115 What is your ethnic origin?

Asian, Asian Scottish or Asian British:

Indian ☐1   Pakistani ☐2   Bangladeshi ☐3   Other Asian background ☐4

Black, Black Scottish or Black British:

Caribbean ☐5   African ☐6   Other Black background ☐7

Chinese: ☐8

Mixed:

White & Black Caribbean ☐9   White & Black African ☐10   White & Asian ☐11   Other Mixed background ☐12

White:

Scottish ☐13   Other British ☐14   Irish ☐15   Other White background ☐16

Any other background: ☐17

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Appendix five:

Interview Schedule (Phase Three)

The questions posed to the assistants in phase three covered the following:

Personal (including current educational status):

- Job title
- Length of service
- Job role
- Motivation to learn and develop
- Training and development opportunities
    - Formal / incidental
    - Induction
    - Perceptions around importance of formal qualifications versus experience
- Recognition of previous learning
- Undertaking an SVQ
    - Perceptions around new knowledge or validation
    - Perceptions around the SVQ as currency for progression
    - Extra clinical competencies
    - Perceptions around the SVQ enhancing practice
    - Perceptions around the SVQ impacting on current job role

Support:

- From managers, other colleagues, peers
- Assigned mentor or assessor
- Assessor training
- Perception of assessment standards
- Protected study time
- Access to appraisal and personal development planning

Knowledge of organisational strategies and policies:

- Perception of regulation
- Perception of Knowledge and Skills Framework
- Perception of Agenda for Change
- Perception of personal accountability

Future aspirations:

- Opportunities for learning and development at work
    - Rewards
    - Transferable learning and skills
- Barriers against learning and development at work
- Perceptions around development and career pathways
- Perceptions of being a team member

Appendix Six:

Ethics Approval

Peter Reith [Peter.Reith@xxx.xxxx.xxx.uk]
04 August 200316:15 D.McCraw@napier.ac.uk
Re: possible ethics review

I have confirmed with our LREC Chair that this study does not require ethical approval from an NHS Research Ethics Committee.

Peter Reith
Secretariat
Manager

0131XXXXXX

Appendix Seven:

Approval from Chief Executive of Health Board

"McCraw, Deborah" <deborah.mccraw@xxx.xxxx.xxx.uk> 05/06/2007
15:29
>>>

Dear Professor Barbour

I am currently working towards my PhD and my research is within NHS
Lothian, looking at workplace learning for non-registered clinical staff.   As
part of my studies I have looked at strategic and policy documents related
to this subject from NHS Scotland nationally and locally with NHS Lothian
papers.

Because I intend to cite these papers it will make anonymising them
extremely difficult and therefore I am asking your permission to allow
me to discuss, and so identify, NHS Lothian in my thesis.

I look forward to hearing from you soon.

Yours

Debbie McCraw

From: XxXXX XxXXXX
Sent: 19 June 2007 12:06
To: McCraw, Deborah
Subject: RE: your approval is sought

Professor Barbour is happy for you to do this.