

*Recognition of Prior Learning: Investigating the Skills and
Motivation of NHS Staff*

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Acknowledgements

The researcher would like to dedicate this work to her husband Mark, and sons, Joseph and James. She would like to acknowledge the support of her parents, particularly remembering a conversation with her father – who warned apologetically, *“People like us don’t go to university”*. Well I did...!

As an enthusiast and advocate for lifelong learning, the researcher would also like to acknowledge the hard to reach, non-traditional learners, who are yet to discover the magic elixir of education.

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Chapter 1 – Introduction to the Study

1.0 Introduction and Background:

This research project aims to investigate the introduction of a **Recognition of Prior Learning** policy, developed to support staff employed by the NHS in Wales. The study seeks to establish to what extent staff are motivated to apply for Recognition of Prior Learning policy, and also aims to measure the confidence and skills of individuals considering this route. By discussing their perceptions and insights into the proposed process, any concerns or issues they might have will be ascertained. In doing so, it will be debated whether the policy might encourage greater participation in training and development or will respondents feel it is “easier” to complete a qualification in a “*traditional*” way. It is hoped this study will add to the body of research on the topic of Recognition of Prior Learning, but in a more “local” context, consider how the resulting data may or may not widen participation in learning within the NHS in Wales.

This section aims to “set the scene”, providing context for the study, by outlining the current learning landscape within the NHS, referencing specific NHS strategies which currently support CPD and how these might link to the new Recognition of Prior Learning policy.

In addition, a definition of the NHS and its staffing structures will be presented, highlighting the differences between job roles. Drivers for the RPL policy will also be indicated.

Background:

The world of work is changing, and in the context of this study – this appears to be particularly evident in the National Health Service (NHS) in Wales. In recent years, there has been a shift towards “*professionalisation*” and continuous professional development, in an attempt to address well publicised issues around a service under significant strain. (NHS England, 2017) Nurse Revalidation (a UK-wide cyclic process designed to evidence a “*fitness to practice*”; the advent of Advanced Nurse Practitioners; (specialist “*enhanced*” nursing roles where practitioners are qualified to carry out certain medical procedures without the direct supervision of a doctor); Consultant Pharmacists (another advanced practitioner role who’s responsibilities overlap with those traditionally employed by a clinician); and the recent implementation of the mandatory Health Care Support Worker Framework “*Developing Excellence in Health Care*” (NHS Wales, 2015); coupled with the “*Code of Conduct for Health Care Support Workers in Wales*”, (NHS Wales/Welsh Government, 2011); all of which aim to improve quality of practice, enhance patient care and make way for an efficient and flexible health service by promoting an internal culture of continuous professional development amongst staff.

Cuts to public service spending and resources over the last few years (The Independent, 2017) suggests there is no longer such thing as a “*job for life*”, (The Guardian, 2016) coupled with the fact that many workers have to work longer before they can access their pensions (UNISON, 2016) – pushing up the retirement age – which in turn, making further demands on individuals to be competitive, flexible and up-skilled. (Scottish Credit & Qualifications Framework, 2007:5) The way in which health services are delivered has also changed, with the introduction of private

companies in some instances, facilitating catering and domestic services, (Kings Fund, 2017) which in turn have exposed disparities in terms of access to staff development compared to those employed “centrally” by the NHS.

The literature highlights that qualifications alone are no longer enough in the labour market, validating the need for “*flexible, continuous, adaptive learning*”, (Harris et al, 2014:65), and calling for “*reflexivity*” (Giddens, 1991 & Beck, 1992 cited in Harris et al, 2014:67). Changes in working practices, for example: a rapid evolution of technology, (NHS England, 2017), has influenced the staff recruitment process with job descriptions and personal specifications asking for evidence of *experience* as well as knowledge and qualifications (Liverpool Womens’ NHS Foundation Trust, 2006)

Previous attempts have been made within the NHS, to address the notion of Continuous Professional Development, and also to standardise training and development through schemes such as the Knowledge and Skills Framework (KSF), a complex, universal framework outlining the minimum knowledge, skills and competencies linked to individual job roles in order to deliver services at an appropriate standard. (NHS Employers, 2018) Compliance with KSF was reinforced through the Agenda for Change (A4C), a national system outlining pay scales for all staff (excluding doctors, dentists and the majority of senior managers). Both initiatives were designed to work in tandem, that is, a member of staff would progress through incremental pay points, provided they could evidence the competencies through vocational experience and continuous professional

development. (NHS Employers, 2017) The Personal Annual Development Review (PADR) underpinned the process as a platform to record development discussions and to review evidence of competency and/or progression (NHS Employers, 2011). However in the researcher's experience, compliance with such initiatives are piece meal and depended largely on buy in from supervisors and managers, as well as the employees themselves.

What appears to be common in each of these initiatives is the need to provide **evidence** of CPD through achievement of qualifications, attendance at training courses, and by providing evidence to support the meeting of job-specific competencies. Again this is not uncommon in what are seen as "qualified" or "professional" health service roles, where continuous professional development and skills such as reflective practice, appear to be the norm, with a wealth of resources and advice being offered even before registration and initial training takes place (RCN, 2017). However in the case of the Health Care Support Worker and indeed other jobs placed within the lower wage bands, the notion of continuous professional development appears to be a positive shift, as historically, it has been suggested that those employed in pay bands 1 – 4 have enjoyed little access to training other than that deemed to be "mandatory" from an employer's perspective. This has been reinforced through the trades unions' "widening access" agenda through schemes such as the Welsh Government's Wales Union Learning Fund, (Business Wales, 2017), and initiatives offered by Higher Education Institutes such as the Open University (Open University, 2017).

However the balance has been readdressed through a review of qualifications for both clinical and non-clinical Health Care Support Workers, along with the recent introduction of resources such as the *“All Wales Portfolio Template for NHS Health Care Support Workers”* (NHS Wales, 2015), as well as the Health Care Support Worker Induction Qualification designed to pave the way for the implementation of the new Framework, encouraging some of the skills and behaviours required to meet the criteria outlined within it.

Staffing Structures:

The NHS is a complex organisation in terms of its structures and hierarchy. It is a publicly funded body, part of the Department of Health and overseen by the Minister for Health in Government. Whilst funding is allocated from the central government (via the UK Treasury), its organisation is further complicated by devolved responsibilities in Wales (i.e. managed by a Welsh Government and overseen by its Minister for Health). In 2009, the Welsh Assembly Government’s strategy document *“One Wales”*, outlined a need for change and redesign in order to meet the challenges of an ageing population, an increase in chronic conditions, and the financial challenges associated with being able to deliver *“timely, effective and cohesive services”*. (NHS Wales, 2018) This resulted in services being delivered by seven health boards (organised according to geographical area), and three NHS Trusts (including the Welsh Ambulance Service), with general responsibility taken by the NHS Wales Chief Executive, reporting directly to the Minister. Each Health Board (National Assembly for Wales, 2015) is directed and led by a Board which scrutinises the organisations performance in terms of service delivery, governance

and financial management. It could be perceived that the media presents a picture of the NHS being solely delivered by doctors and nurses. However, the NHS in Wales is thought to be one of the largest employers of (89,000) staff in the principality (Full Fact, 2018) with people employed across nine complicated pay bands as outlined in Agenda for Change (NHS Employers, 2017). Pay bands are expressed from Bands 1 through to 9 and are further sub-classified according to the complexity of the role and/or responsibility undertaken by the individual. For example, a hospital cleaner would be employed at a lower pay band compared to a doctor; a catering assistant would be employed at a lower pay band compared to a physiotherapist, etc.

In the context of this study, it is useful to note the diverse structure of the organisation – since in terms of continuous professional development; it would suggest that “one size does not fit all”. Therefore individual needs, skills and motivation, and level or detail of training required by each job role will differ vastly, and such diversity should be reflected in any initiatives introduced. A more in-depth description and overview of these staff groups are indicated in the table below:

Professional (or Qualified)	Specialist	Unqualified
Examples include: Doctors, Nurses, Registered Nurses, Ward Managers, Charge Nurses, Physiotherapists, Radiographers, Pharmacists, Occupational Therapists	Employed within “niche” roles such as IT Systems Officers, Information Analysts, Laboratory Technicians, Clinical Coding Officers	Examples include: Administration and Clerical staff, Clinical Health Care Support Workers, Non-Clinical Health Care Support Workers
Educated to degree (and/or post graduate level)	Not necessarily degree educated, but Specialist vocational qualifications and training are expected	Entry qualifications vary, i.e. administration and clerical staff are usually expected to have GCSE qualifications. However other staff (e.g. porters, cleaners) may not be required to have qualifications on entry.
CPD presumed as part of the role	Job-specific CPD presumed as part of the role	Varied CPD opportunities. Generally job related
Employed within higher pay bands of 5 and above	Employed within mid range pay bands 4-5	Employed within lower pay bands 1-4

However, since the development of the Recognition of Prior Learning policy was driven by the Health Care Support Worker framework, a more detailed description of the roles is outlined below:

- **Health Care Support Workers (HCSWs)**

First of all the scope is vast – ranging from a hospital porter to a cleaner; from a canteen catering assistant to a grounds person; from someone supporting allied professionals (occupational therapist assistant, physiotherapy assistant) in a ward or out-patient setting. In other words, both clinical and non-clinical staff with varying levels of responsibility.

A former Health Minister at the Welsh Government, Mark Drakeford, AM, previously indicated that HCSWs make up 40% of the NHS workforce in Wales (Welsh Government, 2015). Historically they appear to have had little access to learning opportunities – other than those deemed to be mandatory (Pearson, 2012). However Stonehouse implies the role to be of great significance, stating “*Working as a support worker within a caring role takes a special kind of person.*” (2015), implying the ability to “care” supersedes the need for clinical skills and/or qualifications. The “learner” profile of Health Care Support Worker (as learners) fits with characteristics identified by Wynne (2006, cited in Pearson, 2012) claiming “*many are mature*”, with “*...prior life experience*”. Adding they have a “*...desire and motivation to learn*”, but also cautioning, “*Some learn at a different pace and in a different way*”, alerting us to a possible lack of confidence.

The aforementioned “*Developing Excellence in Healthcare Framework*” (referred to from this point forward as “the Framework”) however relates only to HCSWs employed in a clinical setting. These can be ward based, work in an out-patients clinic, support allied professionals in radiology, physiotherapy, occupational therapy – but would not normally carry out tasks associated with a “qualified” nurse. The Framework became mandatory in 2018. Therefore the notion of continuous professional development and the associated RPL policy emerges as a significant issue for this element of the workforce and could be of major strategic importance.

At this stage, non-clinical health care support workers (porters, catering staff, cleaners, etc) will not be assessed according to the Framework. However there is an expectation in the meantime that this group of staff will complete a mandatory

induction qualification specific to their role. Initial attempts were made by development leads to develop a common induction programme across all areas of Health Care Support Work – but this proved to be problematic given the scope and diversity of the job roles involved.

Responses and Challenges:

The introduction of the Framework has in many respects been regarded as a welcome opportunity – particularly from the perspective of the trades unions, linking to their lifelong learning agenda. Dawn Bowden, former union officer of public service union UNISON, (now Assembly Member for Merthyr Tydfil & Rhumney) stated:

“For too long this group were overlooked in terms of their training and this Framework finally sees these staff given the status they deserve as health and social care professionals. Not only will the Framework develop staff in their existing roles, it will also give them an opportunity for real career progression, including moves into the registered workforce if they wish.”

<http://www.walesonline.co.uk/news/health/healthcare-support-workers-given-mandatory-10393357>

This concurs with the view of the European Federation of Public Services (EPSU, 2002, cited in Harris et al, 2014:154)) who place great value on continuous professional development (and indeed Recognition of Prior Learning) seeing it as a

“cornerstone of quality public services, quality work, trade union rights, gender equality...” (Van Niekerk, 2013, cited in Harris et al, 2014:154)

On the other hand, the sheer diversity of this staff group will no doubt give rise to capacity issues in managing how they progress through the new Framework. Whilst comprehensive in its presentation, the Framework is complex in terms of its detail, with in-depth descriptors of the job roles. This is further sub-classified by a role/level-specific learning pathway, each of which comprises of four elements: Induction, Essential Skills, common Core, and specific skills relevant to each role. In addition to this, HCSWs will be expected to demonstrate 20 hours of CPD per year.

It is likely that staff will have varying experience, length of service, and due to a previous lack of learning opportunities, may not relish the idea of having to meet the extensive criteria stipulated. This would not be dissimilar to other, more “traditional” barriers to learning (*“I’m too old to learn”*; *“I only work part time”*; etc). On one hand, whilst the notion of the Framework recognises a valuable element of the NHS workforce, by offering what is perceived by professionals to be a long overdue opportunity for personal development, it would be interesting to measure the long term impact in terms of staff recruitment and retention. Likewise the inclusion of Essential Skills as a major pillar, may give rise to similar challenges experienced during the delivery of the Welsh Government’s Essential Skills in the Workplace programme. For example: How will essential skills be delivered? Will Health Boards have the funding or capacity to deliver on this? In what ways will staff with Essential Skills needs react? (Union Learn, 2018)

Proposed Solutions:

Taking into account such factors, a Task and Finish Group was formed in October 2016, with a view to developing an All Wales NHS Recognition of Prior Learning Policy to complement the new Framework process. The group was made up of HCSW Development Leads representing the majority of the seven Health Boards in Wales, along with representatives of the Workforce Education and Development Services (WEDS), and the Open University (Employer Engagement). As mentioned the policy is intended to apply to all NHS staff, however in terms of its development, there was no representation of other staff groups (i.e. the group's make up was weighted towards HCSW). The researcher was co-opted as a member of the group, representing trade union led learning, and also as the interface between the trades unions and the working group.

It is important to acknowledge that the scope and recommendations arising from this study should be realistic, given the make-up of the NHS as an organisation. It should be noted that the Policy has only recently been launched in Wales, and a review process has been injected into the document. With this in mind, it is yet to be “fully tested” by staff, and any anticipated issues are yet to proven. However an early case study has been published by the Credit and Qualifications Framework for Wales, (2018) outlining the positive experiences of two staff members utilising the policy to achieve qualifications.

For the purpose of this study, the responses collected from the participants are not intended as a direct criticism of the Task and Finish Group and the practices it

employed in developing the policy. The aim therefore, is to investigate how staff might perceive the notion of Recognition of Prior Learning, with a view to producing valuable data for analysis which is of a consistent quality, and which highlights genuine perceptions of the participants involved, which in turn may be beneficial to the wider professional development community.

The study also forms part of the reflective practice of the researcher, first of all, in respect of her role within the Task and Finish Group developing the RPL Policy, but also in her capacity as Learning & Development Manager on behalf of the Wales Union Learning Fund (WULF). The role involves complex, multi stakeholder management, and it is anticipated the final study may be of benefit in the context of the trades unions lifelong learning agenda.

The researcher acknowledges her position as “*peripheral*” to both stakeholder groups (i.e. the NHS and the trades union). Initial discussions with both the researcher’s trade union and the Task and Finish Group were perceived to be positive. An informal agreement was established with the Task and Finish Group, with individuals suggesting any research into learning and development would be welcomed. All stakeholders were advised that the study had been approved by the University, from an ethical perspective.

Summary:

To summarise, the specific area identified for investigation is the Recognition of Prior Learning policy, aimed at all members of NHS staff in Wales, to encourage easier and wider participation in continuous professional development. The policy aims to reduce duplication of learning, by encouraging staff to apply a number of skills to provide evidence of prior learning and vocational experience, in exchange for academic credit. The researcher aims to explore the “*skills and motivation*” of individuals accessing the policy. The researcher acknowledges the policy was originally developed with HCSWs in mind, but would argue it would be beneficial to capture the perceptions of all staff employed across other areas of the NHS, ideally across wide ranging pay bands, to ascertain how they see the policy working for them.

Now that the aims and scope of the investigation have been established, the next section describes the context of the study.

1.1 Description of the Problem

In the previous section, justification was outlined to investigate the “*skills and motivation*” of individuals accessing a new Recognition of Prior Learning policy to be launched within the NHS.

The policy is deemed to be an enabling initiative, designed to promote staff development and reduce the need for duplication of training. The policy will achieve this aim by recognising prior training and qualifications, as well as vocational skills and experience. Development of the policy was driven by the introduction of the complex Health Care Support Workers Framework introduced to “*professionalise*” the workforce. However the RPL policy will apply to all members of staff irrespective of grade or job role.

For the purpose of this study, NHS staff were invited to share their perceptions and opinions about the policy – and in doing so were asked: *To what extent are staff motivated to participate in RPL – as opposed to completing a qualification in a “traditional” way?* Comparison will be drawn across job roles and pay grades to ascertain whether or not some staff are more motivated than others, and in each case, “*why not?*” In the same way, the policy outlines a raft of skills used in tandem with the process, including portfolio building, presentation of evidence, reflective practice and skill auditing. The professional CPD initiatives (e.g. Nurse Revalidation etc) assume such skills to be the “norm”, therefore: *to what extent are staff employed within the lower pay bands equipped with the same skills?* The policy also references the process itself – as well as acknowledging the role of the RPL Assessor, in which case: *What does this mean to the staff member? What level of*

support would they require from the assessor? How important is this role in terms of achieving RPL? What resources might be introduced to support the individual?

A wealth of literature appears to exist RPL in general, however there is very little published to measure the experiences of individuals. Perceived benefits (e.g. reducing barriers to learning, widening access etc) are widely acknowledged, however there appears to be little available investigating the skills and motivation underpinning RPL. Therefore it may be beneficial to establish a better picture with a view to encouraging CPD in public services.

In short, whilst the Policy was intended as an “enabling” initiative, *how do we know it is?*

Now that the context, scope and aims of this study have been outlined, the following chapter consists of a review of the literature underpinning the debates around Recognition of Prior Learning.

Chapter 2: The Literature Review

Purpose:

The purpose of this literature review is to scrutinise academic studies, policies and toolkits written around the subject of Recognition of Prior Learning, providing the conceptual underpinning to this study. Libraries and online databases at the University of Wales Trinity St David, were used extensively to access appropriate text. Sources primarily consist of text books, online books and academic journals and articles. The researcher has also sourced numerous toolkits, guidance documents, case studies and publications designed to support learning providers, awarding bodies and learners themselves through the Recognition of Prior Learning process.

By and large, the intention of the literature review is to provide an overview of the topic of Recognition of Prior Learning, whilst at the same time identifying common themes and any questions or issues arising from the reading.

Introduction:

“Adults are constantly learning”, (Folinsbee, 2008: 5) and this can be evidenced in a number of ways: through the achievement of formal qualifications awarded by “traditional” educational establishments (Further, Higher Education, Vocational training providers); informal learning achieved through workplace training courses and workshops; and through non-formal learning – learning inadvertently acquired through work or life experiences; or as Fraser (1995:139) indicates, *“adults are what they have done.”* (Andersson & Harris, 2006:5)

History of RPL:

An initial search confirmed that Recognition of Prior Learning (RPL) is a common, widely used practice (Fejes & Anderson, 2015: 154) with worldwide sources published, albeit referenced using different terminology: Recognition of Prior Learning (RPL); Recognition of Experiential Learning (RPEL); Assessment of Prior Experiential Learning (APEL); *“credentialising”* of Learning, etc. For this purposes of this study, it will be referred to as **RPL**. The existence of international publications suggests there are worldwide systems established in Australia, Sweden and USA; and particularly valued procedures in post-apartheid South Africa (Anderson & Harris, 2006 :221) Closer to home there is reference to the European Union’s recommendation that all member states are to have RPL arrangements in place by 2018-2019 (Harris et al, 2014:13), implying RPL is of significant importance.

RPL is not a new phenomenon; the literature reveals there were many post war systems established to acknowledge the wealth of experience acquired by service men re-entering work (Fejes & Andersson, 2015). The process also seemed to complement the Learning Society agenda which evolved throughout the 1960's and 70's when UNESCO and the Council for Europe developed the notion of "*permanent education*" (now more commonly described as lifelong learning or continuous professional development). (Harris et al, 2014: 66). Whilst it was agreed at the time that formal compulsory education would remain at the forefront, it was recognised that we should be encouraged to continue to invest in our educational potential "*...including taking into account ...prior experience and learning as a basis for further continuing learning.*" (Gelpi, 1985; Hobsbawn, 1994 – cited in Harris et al, 2014:67) Currently, RPL policies and procedures are particularly familiar to those working towards the completion of credit based qualifications (e.g. NVQ). (Harris et al, 2014:76). This appears to be standard practice within the social care arena – with assessors appointed to support staff to achieve mandatory QCF diplomas. In the researcher's experience, the role of the assessor varies according to organisation. In the majority of cases, the assessor tends to carry out this function in addition to other duties (e.g. in social care, an assessor may be employed in a care practitioner role, or as in the NHS, for example: a HCSW training lead).

In terms of the process itself, RPL is achieved by presenting evidence of skills, knowledge and experience, and in doing so, candidates can receive "*academic credit*" in exchange for units of study needed to complete a vocational qualification. It would appear that RPL is not intended to replace the achievement of qualifications

and learners would rarely be awarded credit for a qualification in its entirety (i.e. some current learning would be expected to take place).

With this in mind, it could be argued that RPL plays a significant role in the lifelong learning environment. In which case, what is Recognition of Prior Learning?

Definition/Terminology:

A number of definitions exist, but generally it is regarded as a “*method of assessment leading to the award of a qualification.*” (Pearson Education Ltd, 2016:3). A more comprehensive definition stated by NIACE describes it as a process for “*...recognising and valuing what people have learned in their lives, and linking that through personalised lifelong learning to further development steps.*” (Harris et al, 2014: 65). It is commonly applied by the education institutions as part of their entry systems to assess capability and suitability of a student, ensuring they join a learning programme at an “*appropriate stage*” (Open University: 2014:3) and in doing so, discouraging duplication of effort. The researcher was unable to identify any negative descriptors, concluding RPL is generally regarded as an enabling action, embraced as a means of widening access to learning.

RPL as a form of Assessment:

So if it is agreed that RPL is a form of assessment, in what way does this differ from traditional assessment methods? Taking into account our own experiences of compulsory education, we will recall a summative assessment where candidates would sit an examination with a view to achieving a qualification. The examinations would measure to what extent we could demonstrate the appropriate level of knowledge and understanding of a subject mapped against a number of learning outcomes – the end result being the award of a qualification. The process of summative assessment would be repeated (in conjunction with other assessment methods) for those continuing their education – through to A Levels and university courses.

On the other hand, the vocational route of learning – for example, National Vocational Qualifications (NVQ) assess competency based on the production of a portfolio of evidence. Generally, no examinations or tests take place – yet learners might achieve a certificate having satisfied a formative means of assessment to evidence knowledge and understanding

In both instances, qualifications tend to be awarded using a combination of formative and summative assessment (SQA, 2017). However in the case of RPL, assessment appears to be a complex continuum, ranging from multiple assessments resulting in an outcome (*credit exchange*), to a more learning and developmental process with less emphasis on achievement of credits (*developmental approach*), (Follinsbee: 2008:5)

The extent of what is actually recognised depends on the awarding organisation. As mentioned, in colleges and universities, a RPL process generally seeks to assess existing qualifications as an indicator of how “ready” a student might be for learning at the next level. In a vocational sense, RPL tends to be becoming more widespread, particularly in the advent of professional standards being introduced – for example the QCF in Social Care.

Benefits:

It would appear that knowledge and skills are “currency” in an evolving workplace, and as suggested by the literature, there are a number of advantages associated with the RPL process benefiting all of the stakeholders involved. From an employer perspective it avoids duplication of effort, and may be particularly useful in staffing the workplace (i.e. avoiding absenteeism to attend training sessions), therefore also reducing costs (wages, but also the cost of qualifications) (NIACE, 2013: 32). It may also help with skills mapping and the development of future training programmes (Smith, 2004: 4). RPL initiatives, such as “*Steps for Skills*” in Sweden, have resolved issues around staff recruitment in the care sector where applicants did not have the appropriate formal qualifications (Fejes & Anderson, 2015: 146). Therefore it could be argued, in the context of this study, an All Wales policy may give rise to multiple benefits.

In the same way, education providers also appear to benefit from having a RPL process in place – eliminating barriers associated with the cost of qualifications. This

would be equally applicable in the context of this study, where funding for training is incrementally becoming scarce. (Royal College of Midwives, 2016) The advent of student tuition fees is cited as a barrier to learning in some households. However, the Open University for example, claims RPL “*encourages the pursuit of Higher Education.*” (2014:2) Case studies reveal how making an assessment of one’s prior learning and experience helped the learning provider to re-design the remainder of a course. That is, common re-occurring themes identified through the RPL process were subsequently eliminated from the class room, avoiding duplication. (Fejes and Anderson, 2015:149)

In the wider sense of the adult education agenda, the literature claims socio-economic advantages; the possibility of progression in the workplace and society in general; and a move towards active citizenship. (Smith, 2004:5). On the world stage, Shalem and Steinberg (2002: 1) highlight RPL is considered to be politically and socially important (for example: in post-apartheid South Africa), reinforcing the value of all learning, thus fostering a culture of lifelong learning. (Bjornavold, 2000:23)

However it is from the learners’ perspective where the majority of benefits appear to lie. Many sources suggest that RPL is more likely to be accessed by older students (Smith, 2004:118) with the Scottish Credit and Qualification Framework (SCQF) insisting it complements the widening access in encouraging non-traditional learners. It would appear the opportunity is open to everyone provided they can produce the appropriate evidence. From an individual’s view, advantages range from increased

confidence arising from value being placed on their historical experience and knowledge. This in turn, is said to be rewarding and motivating. On a more practical level, barriers concerning cost, time required to study, therefore not compromising family/personal commitments are cited (NIACE, 2013:32). Some learners also report an opportunity for a “second chance” implying the process challenges the idea of formal education being the only option. (Jones & Martin, 1997) There is also evidence to suggest that through accessing RPL, it enhances an individual’s *“employability, labour mobility and career prospects.”* (Harris et al, 2014:132)

Finally it would appear worth acknowledging that from an academic viewpoint links have been made to adult learning pedagogies suggesting that RPL encourages autonomous study (Garrett and Cavaye, 2015:30) and provides an opportunity to learn new skills associated with the process - reflective writing and discussion, portfolio building, self recognition, etc. (Smith, 2004:11; SCQF, 2010:27)

In the same way, it could be argued that the RPL process also appears to align with theories around constructivism – inviting the learner to construct understanding to provide meaning ; thus reinforcing Dewey’s notion that *“qualifications are more than the sum of their parts”* (Smith, 2004:242). It is also implied that there is common agreement between Lewin, Dewey and Piaget’s theories –i.e. *“experience being the basis for education”*, (Smith, 2004:303) as opposed to the behaviourist-orientated theories promoting teacher-learner knowledge transfer. Such thinking may concur with the development of Kolb’s cycle of experiential learning – insisting we learn from our experiences having first reflected on them. (Pearson, 2012)

Criticism:

However the RPL process is not without its flaws or criticism, with organisations emphasising this is “*not a soft option*” (Smith, 2004:211) especially when identifying and presenting evidence in the form of a portfolio. Powys Teaching Local Health Board, adds RPL is not always an “*easier, cheaper or quicker route to a qualification.*” (2014) Smith (2014: 5) reinforces how the process itself can be an issue, stating that a complex procedure can be a major barrier to participation.

Extensive literature searches were unable to reveal anything of significance in the context of the “PDET” environment; (i.e. from a practitioner’s perspective. However, in summary, RPL appears to be a positive, well-intentioned notion aimed at widening access to learning, highlighting and acknowledging individual’s strengths whilst at the same time identifying areas for growth and development (Smith, 2004:4).

Who is accessing RPL?

Having reviewed the literature, there is little evidence to demonstrate “Who” accesses RPL. That is, not one area of society appears to dominate over another. The process is widely applied and had reached as far as post graduate level. In fact, the policies published indicate the process is open to all, provided they meet the appropriate criteria. There is no indication that certain staff groups are more likely to seek RPL more than others, although the majority of health service –orientated literature tends to lean towards doctors and nurses. The documentation concerning the lower pay bands is sparse, with a few published relating to health care support workers, but nothing obvious regarding other occupations (e.g. porters, catering

staff, etc). What does emerge, however, is that RPL is considered to be a “learner-led” initiative, in that they trigger the process by submitting an application (NHS Wales, 2017)

RPL Process:

A number of policies, guidance documents and toolkits were reviewed, published by a variety of education providers ranging from Higher Education establishments (e.g. Swinburne University, Open University); qualification awarding bodies (e.g. Agored Cymru, the Scottish Credit & Qualification Framework); professional bodies (e.g. the Care Council for Wales, Royal College of Nursing); employer policies (e.g. Cardiff & Vale and also Powys Teaching Health Boards). Regardless of level of study, each policy had a number of common elements including a general preamble outlining scope and definition of RPL. Some were more detailed than others; some were simple and easy to understand whereas others appeared particularly complicated. Smith reminds us (2004:4) that associated resources should be “*clear, concise and jargon free*” in order to engage the learner. On the other hand, some of the more comprehensive documents included templates and toolkits designed to aid the learner, including prompts or self assessment questionnaires. (SCQF)

Two common themes occurred in terms of how RPL can be awarded:

- A straightforward “*credit transfer*” system, recognising previously achieved qualifications or units at the same level of study
- Recognition of prior experience and skills (i.e. vocational or life experience)

What is being assessed?

In the main, RPL is offered within a vocational context or by an educational institute. However not all establishments are willing to recognise community or voluntary activities. It is also acknowledged that in many cases there is a “*shelf life*” in respect of prior experience. In other words, learning should be “*current*” or “*recent*”. In the context of this study, this would appear to be a sensible view, since NHS, procedures and working practices have evolved over time. Therefore it could be argued that being able to demonstrate up to date knowledge or experience vital. Of all the policies reviewed, RPL is generally not applied to achieving a “whole” qualification; therefore suggesting there is still a need for some *current* learning – candidates cannot bypass studying a qualification completely by accessing RPL.

Most documents provided a comprehensive overview of the process detailing the roles and responsibilities of all stakeholders, i.e. learners, assessors, learning providers. In the majority of cases, learners must complete a RPL application form, (which of the documents reviewed, were diverse in terms of their complexity), indicating “*all units against which RPL is sought*”. (Swinburne University, 2017).

In submitting an application, learners are then generally met by a designated assessor who triggers the evidence collection process. In cases where credit transfer is sought, this is a relatively straightforward procedure where a candidate’s visible competency is assessed (Harris et al, 2014: 91). This varies between policies – recognising formal qualifications, non-formal learning, workplace un-certificated learning and informal learning. (Harris et al, 2014:128)

Where recognition of prior experience is sought – the process becomes a little more involved. In this instance, learners are obliged to gather evidence in a portfolio to be presented for summative assessment (City & Guilds, 2013: 3). Of the documents reviewed, requirements varied between organisations. Depending on the qualification, there appears to be some consensus on what constitutes as “evidence”. Suggestions include: Reflective accounts, professional discussion, witness statements, oral/written questions, work books, examining products of the learner’s own work (Care Council for Wales, 2015:56). With this in mind, opting for a RPL route is not necessarily a “short cut” to a qualification, given the volume of evidence required in some instances (despite SCQF’s recommendation that evidence should be as “*streamlined as possible*”) (2010:14) It is worth noting that levels of study also determine what sort of evidence is appropriate. In the context of the new NHS policy, it is worth investigating to what extent are staff at all levels equipped or motivated to collect and evidence in this way? Such practices may be second nature to the professional workforce where reflective practice is embedded from the point of initial study and registration. From the health care support workers perspective, this may be more problematic.

Having reviewed a number of policies, there is a common assumption that the evidence presented will be:

Valid	Relevant	Authentic
Current	Sufficient	Reliable

Assuming the evidence presented is acceptable, then the appropriate learning credit is awarded subject to internal and external quality assurance checks. Again from a

practitioner's perspective, it could be disputed that inconsistencies may emerge between different job roles. Therefore in a role as critical as a HCSW, how is "quality" ensured? To what extent is the assessor familiar with the different job roles and responsibilities?

The Role of the Assessor:

The relationship between the learner and assessor features heavily throughout the literature. Shalem and Steinberg (2006:2) reinforce this stating an effective assessor relationship can "*empower*" learners to "*find knowledge in what they already do and to understand it in a new (academic) way*". In other words, there is more to the role than "signing off" evidence. A good assessor will encourage exploration of experience and consider how this can be applied, ideally stimulating "*learning from learning*" or promoting further development and progression. (NSW Department of Education and Communities and the Commonwealth Government, 2015) Smith adds, "*Effective RPL requires experienced, professional assessors to make informed professional judgements*". (2004:4,12) It is fair to say that in the researcher's experience, assessors themselves have raised similar concerns about quality of assessment, and have exercised caution when accepting evidence.

Quality Assurance:

In the main, the literature surround RPL appears positive. However, as is expected with academic debate, it is not without criticism. Of the sources scrutinised, the main concern revolved around "quality", linking this to points already noted in that RPL

should not be seen as a short cut to achieving qualifications. Issues surrounding quality tend to stem from the assessor, who in many instances may have a substantive role in addition to other responsibilities. However it is not uncommon for larger employers like the NHS or Local Government, to have dedicated assessors, usually facilitating the achievement of vocational qualifications (NVQs etc). (Care Council for Wales, 2015)

Whilst there are a number of measures in place in terms of verifying the standard of evidence collected, Harris et al, (2014:219) challenges the interpretation of content – raising concerns about inconsistencies according to who assesses what? The Care Council for Wales are particularly reassuring in that they define expectations of assessors linked to their RPL procedures (2015:7) urging assessors should be “*occupationally competent*” and are required undertake 30 hours of professional development per year. In the same way, they are required to be “professionally qualified” as assessors (recommending the TAQA qualification).

The majority of the documentation examined, provided an element of reassurance in that quality may be ensured through the support of a qualified internal verifier, as well as an external verifier (traditionally linked to a learning provider or awarding body) – cross marking and reviewing decisions to ensure quality. There is also mention of RPL discussion panels where assessors and verifiers meet to share good practice, again ensuring an appropriate standard. However it is important not to overlook the idea that whilst an RPL assessment might confirm the attendance at a training course, to what extent does this confirm whether or not actual learning has

taken place? This is somewhat remedied through the production of witness statements, peer observation and reflective statements which can act as a “*measure*” of learning and subsequent application.

Volume and Capacity:

There is some indication, that despite appeals from RPL practitioners to offer a streamlined process, that the collection and preparation of evidence is as onerous as completing a qualification in full. So why not complete the full qualification in the first place? This might be a natural choice for “new starters” (i.e. starting on a level playing field), but using the Health Care Support Worker Framework as an example, how likely would it be for long serving members of staff to readily and easily meet the criterion? As mentioned previously, is this a barrier to RPL, and would such staff have the skills and confidence to present the appropriate evidence?

Awareness:

Whilst RPL is a widely used process, the literature does reveal a number of issues in a vocational context. Folinsbee (2008:17) highlights a lack of awareness amongst employees in the first place (i.e. employees not knowing such options exist). She also raises concerns about the “*transferability*” between organisations. This would be particularly relevant in the case of the NHS in Wales, since the new RPL policy applies to all staff across all Health Boards. Therefore having a consistent system across the principality is essential to workers who may move between health boards. In the researcher’s experience, there is also an element of disquiet with some staff

asking “*Why do I have to prove I can do a job I am already employed to do?*” This would be pertinent to the new Framework – particularly amongst long serving members of staff.

Summary/Questions Arising:

It could be argued that RPL is an enabling procedure designed to demonstrate value in historical skills and experience. It appears to have beneficial links to societal advancement (i.e. the widening access agenda), allowing a more “*equitable*” cross section to achieve qualifications. (Harris et al, 2014: 178) In recognising historical experience it may boost confidence and capacity in individuals to access further learning opportunities which may have been denied them previously. However it gives rise to the question, “*Who controls the agenda?*” If the initiative is thought to be “learner led”, this appears to contradict the notion that the success of RPL depends largely on the role of the assessor. To be a more learner-led initiative, we would need to ask “*To what extent do individuals have the skills and motivation to apply for RPL?*” (Harris et al, 2014:167), as the literature confirms that skills such as reflective practice, portfolio building may be common practice amongst the professional element of the workforce, but how does this apply to those employed within the lower pay bands? Therefore asking whether the RPL Policy will reach its intended audience (i.e. HCSWs)? To what extent will individuals realise they have appropriate prior knowledge and experience to apply for RPL in the first place? In other words, how do they know what they already know? Will the process appeal to members of staff employed at all levels, rather than professional staff already equipped with the associated skills of reflective practice, portfolio building?

There also appears to be conflict concerning who decides what constitutes valuable evidence. If evidence is rejected, will this be seen as an opportunity rather than a failure? The literature reminds us that RPL can place great value on the individual's prior experience and learning, in turn boosting the confidence and morale of that learner. With this in mind, will NHS staff see this as a motivating opportunity, or are there barriers to participation? What sort of support might individuals need to overcome any barriers identified?

Finally in the context of "PDET", what opportunities does RPL provide in terms of improving the leadership and development skills of education practitioners?

Conclusion:

This literature review serves to inform the design of the research methodology, which is outlined in the following section, along with justification of the methods selected. The literature review has stimulated a number of questions on which to base a design for a methodology – particularly in provoking discussion about how NHS employees perceive the imminent implementation of a new policy will affect their motivation to learn. The methodology will be delineated in the next chapter.

Chapter 3: Methodology

3.0 Introduction

The last section was attributed to a review of literature which gave rise to a number of questions warranting further investigation. However the aim of this section is to present the methodological approaches selected for the research project along with a discussion about their suitability, whilst presenting a philosophical opinion of the approach. Strengths and weaknesses, along with the reliability, validity, risks and limitations of the data collection methods adopted will also be debated.

The research process will be outlined, explaining how the data was collected from semi-structured interviews. Following on from this, the steps followed in respect of data analysis will be presented. The same will be described in respect of the subsequent focus group and how triangulation was achieved through a review of literature.

3.1 Rationale for suitability of research paradigm:

In this instance, the topic for research arises from personal interest. Whilst the researcher also has a professional interest, (i.e. working in an adult education environment), the study seeks to provide a comparison of perspectives of traditional and non-traditional learners, qualified versus unqualified staff, professional as opposed to those employed within the lower pay bands. Since the researcher has a particular interest in the widening access agenda, it is acknowledged that researcher's values and interest around this topic has motivated the study. (Mc'Neill

& Chapman, 2005). However it is also noted that this interest in no way prejudices or affects the outcome of the research.

Prior to confirming a topic of study, the research literature recommends that students establish a position from which Epistemology and Ontology are viewed. Epistemology is regarded as the researchers theory of “*knowing what they know*” comparing this to Ontology, that is, how the researcher views “*phenomena*” (Thomas, 2009). In doing so the researcher is able to confirm a research paradigm appropriate to the project. The appropriate paradigm will subsequently inform the choice of suitable methodology to produce suitable investigation methods. The literature is also explicit in defining methodology and methods as different entities. However it is further suggested that they are inter-dependent with one informing the other. (Cohen et al, 2011) In this instance, it would appear that the research leans towards an Ontological approach, as the aim is to gain an understanding of the motivation, thoughts and perceptions of staff accessing a new policy and associated procedures. In other words, “*How do I feel about this?*”

When selecting a research paradigm, the literature describes two broad themes: “Positivist” and “Interpretivist”. In a general sense, each paradigm demonstrates different ways in which we reach an understanding of knowledge and “*social reality*” (Hughes, 2014). Each paradigm is further sub-classified according to their own defined methodology and research techniques. It was stated that both are “broad” themes and this would appear particularly evident in the case of Interpretivism.

With this in mind, a Positivist paradigm was rejected in favour of an Interpretivist-Phenomenological approach. Since the research project centres on the views, feelings, beliefs, insights and opinions of others, it is unlikely that the responses collected would mirror scientific fact, suggesting that an objectivist line of inquiry would be contradictory. (Denscombe, 2010) In other words, this approach is more “*humanistic*” in nature. The general context of the study was also considered – in that the study arises from social science in an educational leadership environment. Therefore the methodology selected for this research project could be further sub-classified to fall within the *Phenomenological* paradigm

The study aims to examine a new Recognition of Prior Learning policy within the NHS Wales. Whilst there is a wealth of literature on the subject – specifically in terms of policies and processes applied by employers, training providers, educational institutions etc there is little in the way of previous research the NHS. What does exist is piece meal, and tends to focus on the professional element of the workforce, therefore it was not possible to formulate a hypothesis. In the same way, it was recognised that the research topic aims to explore the notion of a policy that is yet to be tested. In other words, how does the workforce see the policy working in practice? The environment in which it will be applied (i.e. the NHS) is a rapidly changing landscape, and it is has already been agreed that the policy in question will be reviewed and adjusted on an annual basis. In other words, the research aims to gather the *initial* perceptions and feelings of those accessing the policy *prior* to its full implementation. This reinforced the rejection of a Positivist methodological approach as quantitative data alone would be insufficient and as such, the need for a

methodology that relied on more exploratory data collection tools appeared more appropriate.

Likewise a Phenomenological approach appears to be favourable in respect of the more practical elements of the study. First of all Denscombe (2010) recommends this for small scale research projects in that the associated techniques do not call for expensive equipment or technology. The focus will be on people and their perceptions of the new policy and associated procedures with a view to encouraging a more rigorous investigation at a later stage. (Collis & Hussey, 2003)

Now that the research methodology has been outlined, the following section seeks to describe the methods and techniques adopted for this study.

3.2 Research Process, Methods/Techniques:

The literature reveals a wide range of research techniques available to researchers in relation to an interpretivist-phenomenological methodology. This includes the assessment of case studies, participant observation, analysis of historical evidence, etc. These are all cited as useful tools in the researcher's kit (Open University, 2001). We are also reminded that organisational documents are a useful source of quantitative and qualitative data. This would be particularly true in this instance, with numerous policies, procedures, toolkits and reports being published on the subject of Recognition of Prior Learning in the wider context of adult education. Apart from an annual review, it is unlikely that development of a Recognition of Learning Policy will

occur again (that is, it is a unique event). Therefore in order to fully explore employees' opinions and perceptions around the policy, (i.e. "How is this going to work for me?") the research methods selected need to be flexible and wide reaching in their application.

Prior to this a draft research plan was developed to act as a guide to the study (Appendix A). The overall purpose of the plan was to aid the researcher to concentrate on specific areas of the study, ensuring the process remained focused. The document outlined a process, including a timetable for the interviews and subsequent focus groups to take place over a twelve week period. The plan addressed potential risk such as resources, lack of participation, respondent withdrawal rates, – and how these might be overcome. A summary of questions (in the instance of interviews) were recorded as an aide memoire, but also as a reference point to help refine the subsequent questions to be included in the focus groups that followed.

It was originally intended that the researcher's trade union would circulate invitation letters to their members within the NHS Wales. Unfortunately, this did not go ahead as originally planned. The rationale behind this approach was to mitigate any bureaucratic delays imposed by contacting each individual Health Boards, identifying the appropriate contact within each Health Board, etc. Having professional links to the trade union, meant any risks associated with data protection were also reduced, that is, the trade union acted as a conduit for the invitation to participate – placing the responsibility on the individual member to contact the researcher to "opt in" to the

study. With this in mind, the research drew on personal contacts within the same arena. Having identified a list of possible participants, an invitation was sent to participants (Appendix B), including a comprehensive overview of the study - explaining the nature of the project, playing close attention to ethical guidelines (both BERA Guidelines (2011) and the University's policies). It also outlined their involvement as respondents, their right to withdraw, and the option whether or not they would join the focus group at a later date. In addition, the invitation gave the opportunity to raise any questions or concerns in advance.

The researcher was in a unique position in that she participated in the Task and Finish Group which developed the original concept of RPL, and as such, had access to the intended RPL process. Having reviewed available documentation, ideas were constructed in respect of possible questions, areas for further investigation. Whilst "on paper", the RPL process appears relatively straight forward, a number of tangents were soon identified, and the scope for investigation was potentially vast. However the researcher refined the topic to focus on the "skills and motivation" of individuals accessing the policy.

Having identified an avenue of enquiry, it was confirmed that the research project would rely on exploratory qualitative methods. In the first instance, a semi structured "open response" interview was considered, thought to be a popular and flexible tool, in that it can be applied almost anywhere. (Drever, 2003) This is of particular benefit to both the researcher and participants given the geographical scope of the NHS. The researcher acknowledged this approach to be more time consuming than

distributing a questionnaire. However this was mitigated by the potential scope and depth of data that could be collected. Risks associated with selecting a questionnaire, as opposed to an interview, were also factored into the final decision – noting the potential costs, and the possibility of a low return rate. A change in strategy in terms of how invitations were circulated, already impacted on the possible number of respondents, therefore, it was thought to be more beneficial to adopt an approach that would capture as much information as possible – from what now was expected to be a smaller number of people. That said, it was also acknowledged that the same risks might be equally applicable in respect of the interview approach – since this means the respondent having to dedicate time to participate. (Drew, 2014)

Apart from the practical benefits, Thomas (2009) reminds us that in a phenomenological sense, an interview is a favourable technique in terms of garnering a combination of facts, opinions and attitudes – aiming for a free flowing, non-directive narrative. The use of interviews would also measure gestures, body language, tone of voice – that is measuring more than just words. This would not have been captured through a paper based questionnaire or by conducting an interview over the telephone. However issues concerning interpretation of data were factored, as the researcher originally intended audio recording the conversations. This was somewhat compensated by the subsequent focus group discussions, which offers the opportunity to overcome any ambiguity. With this in mind, a semi structured interview was developed and conducted according to a subjectivist approach.

As with all methods, there are associated risks, and the researcher was mindful of “*prestige bias*”, that is, the respondents giving what they feel is the “right” answer or what the researcher wants to hear. (Thomas, 2009) A “*probability sample*” of trades members employed within the NHS was sought (the “*known population*”). The absence of trade union involvement, that is, in terms of managing the invitation to participate, somewhat mitigated the risk being the researcher has no control over who responds. (Denscombe, 2010) That said it is “*random*” in that each person contacted has an equal chance of being selected. The positive side of this approach is that there is no bias as to who is included. It could be argued that by relying on personal contacts eliminated the notion of “random” sampling. That said, it was interesting to note that individuals shared the invitation, producing responses from individuals previously unknown to the researcher. However on the other hand, the balance of respondents may have been compromised (that is the balance of professional against non-professional staff). In other words, “*quota sampling*” cannot be guaranteed as the exercise is entirely voluntary.

Having completed the interviews, the data was transcribed and validated by each respondent. A thematic analysis of the data collected was carried out to identify recurrent issues and correlations. Having identified a number of themes, further questions and prompts were prepared ahead of the focus group discussion.

The second phase of the research project took the form of a Focus Group Discussion. A smaller sample taken from the original participants who took part in the interviews were invited to an informal discussion group. The researcher acted as

facilitator and guided the participants through a series of questions generated from the responses from the interviews. This allowed the opportunity to further probe the respondents on their views about impending policy. It was anticipated in advance that the sample size would be smaller than the original group and the risks concerning take up were factored in to the decision making process. In reality, the number of participants was considerably smaller, with two focus groups taking place. Geography and time off work to participate continued to be a factor throughout the study.

Having collected primary data from the interviews and focus groups, a thematic analysis took place in the first instance. This helped to identify common perceptions and feelings, and also discover mutual concerns and issues. Since the majority of data was of a qualitative nature, it is acknowledged that the researcher has the responsibility to interpret topics from the view point of the participant. It could be argued this has both positive and negative connotations (King (1994, cited in Cassell & Symons (2004: 25) -

“...for the qualitative researcher everything is grey, ambiguous and at times “spiritual” the biggest problem is how to make sense of data and how to generalise from a small sample.”

This concludes the description of the research process. The next section will summarise and discuss the strengths and weaknesses associated with the chosen methodology.

3.3 Strengths and Weaknesses

This section seeks to explore the methodology selected, discussing the merits and weaknesses of each.

- **The Process /Identifying Respondents:**

First of all the original intention to circulate invitations to participate via the trade union failed to manifest for reasons unknown. It cannot be proven whether or not this would have produced a greater number of respondents, from a possible population of 33,000. However reflecting on the original notion to adopt this approach, it was initially considered on the assumption this would reach a wider population. As such, the researcher utilised her own contacts, acknowledging the prospect that employees may have been less motivated to respond to a “stranger”, further conceding her role as an “outsider” to both the union and NHS. However a reasonable number of willing participants volunteered to take part, some of whom were originally unknown to the researcher, raising the possibility that if someone has an interest in a subject, they might participate regardless of their relationship with an individual. In fact, those who elected to take part, appeared to do so with great enthusiasm and a genuine willingness to help. However it is important to note that not all respondents were able to commit unlimited time to the interviews and the focus group that followed. Individual job roles appeared to have an impact on the length of time people were able to commit, with those working in patient facing, acute areas being time limited in terms of how long they were able to spend with the researcher, attending during lunch breaks or during their own time. In one instance, a respondent elected to complete an interview by telephone as they were unable to leave their working area for any length of time. Whilst on the surface this did not

appear to have an effect on the data collected – it is possible participants may have felt unable to speak freely.

- **Data Collection Tools: semi structured interviews:**

The selection of an open response/ semi structured interview as a primary research method was justified as first of all as providing the researcher with an opportunity to establish rapport with participants. As mentioned previously, some respondents were previously unknown to the researcher, and as such enabled new working relationships, whilst at the same time gaining useful, nonbiased data based on nothing more than enthusiasm for, or personal interest in the topic.

The original scanning of the population suggested we would be dealing with a high volume of participants, and as such, it was thought the researcher did not have the capacity or resources to manage distribution and collection of questionnaires on such a large scale. However the reality and resulting sample group suggested in some ways, it was helpful to have such a small group of respondents. Prior to this risks were identified around completion and return rates of questionnaires, thus confirming an interview approach may be more effective, allowing for a more interactive means to illicit a response, enabling more qualitative data, capturing insights as opposed to statistics. Although it is noted that some quantitative data will be generated – it is the participants views and the generation of different perspectives presented in part in their “own words,” that are deemed to be of interest in this instance. There was a possibility of this approach generating idiosyncratic responses or that the participants would tell you what they think you want to hear, thus possibly corrupting the data (Open University, 2001). However to re-balance the

argument for the original rationale, it was thought that overall, an interview would provide depth of information and insights – allowing the respondent to express “*what matters to me?*” (Denscome, 2010)

With this in mind, a suite of questions was presented to the participants, with additional “prompts” noted as a contingency action should the respondents express difficulty in responding. The questions were developed according to key themes identified within the literature review, and the analysis of the draft resources prepared to support the new policy. It was reiterated that the toolkit was still only in draft form, therefore what was presented it not “set in stone” and may very well take on a different format by the time it is launched.

The researcher has learned to “expect the unexpected”, and despite preparing a research plan, it is fair to say that the “unexpected” occurred, promoting the researcher to adapt the plan at a moment’s notice. This was particularly evident at the very first interview. Unfortunately the interviewee was unable to access a meeting room, meaning the conversation took place in a busy, open plan office. Bearing in mind, this was a NHS environment, it would be fair to say that the researcher herself was equally exposed to sensitive information – whilst at the same time acknowledging the fact that the participant may not have been able to speak freely in close proximity to their colleagues. This was not an uncommon feature of the study, as the majority of participants working in acute, front facing areas, were unable to facilitate the interview “in private”. Interviews were on occasions, postponed at short notice due to service needs, and in one instance, re-arranged to

finish over the telephone. Taking all of these factors into consideration, the original plan to audio record conversations was soon abandoned, meaning the researcher was forced to take comprehensive notes of all discussions. King's advice is echoed here (1995) reminding us that we have to make sense of qualitative data, and there is a danger that the researcher might interpret the data to steer the outcome in a prejudicial direction. To combat this, the researcher asked each participant to approve a full transcript of the interview.

In summary and despite the challenges described, the selection of semi structured interviews appears to be justified. The data collected was comprehensive, generated by open and willing respondents, each giving a unique insight from their own working environment, into how they see the policy working.

The second stage of the research project took the form of a Focus Group Discussion. This is a widely used method (particularly in areas such as market research), thought to be a particularly useful qualitative method of establishing people's views and opinions. Carey & Asbury (2012: 15) define a focus group as a semi structured opportunity for discussion in an informal setting, which is overseen by a facilitator who guides the topic in hand through a series of questions and prompts. It is further described as a "one off" encounter made up of people sharing a common experience. This would be particularly true in the context of this research project, suggesting it is a particularly suitable qualitative method for examining new topics, where little or no prior research exists - as everyone involved is starting from the same position in that in this instance, a new RPL policy is being introduced – and

none of the participants have advance knowledge of this, therefore it could be described as a “level playing field”.

The literature describes many advantages associated with this approach, specifically the notion that “*people like to be heard*” (Carey & Ashbury, 2012: 16) thus providing a platform for insights and attitudes to be recorded, and in doing so empowering the respondents to be part of the research – rather than them being the topic of research (or research being “done to them”). In other words, proposing their opinions and experiences are of value. This appeared to be a unanimous view of respondents when asked to feed back on their experience. Not one participant ventured they felt under-valued, in fact it was the reverse. All participants universally agreed that by having the opportunity to present their feelings, opinions and perceptions about the topic, they felt enormously valued. It may be fair to suggest that it would be foolish to ignore this when analysing the data that followed, particularly in respect of future recommendations, emphasising that employees could be involved with policy development.

As with all methods, it was recognised that there are many disadvantages of facilitating a focus group, and these include: the capability and skills of the researcher in the role as facilitator, ensuring there are “ground rules” in place that steer the discussion. In this instance, the researcher regularly facilitates discussions, having participated and organised several task and finish groups for the purpose of her job role. That is not to say, these particular encounters were without challenges. From a participants’ perspective, there is a fear that they may divulge

more than they first intended. To combat this, the researcher sought to establish the scope of discussion without inhibiting responses. Another major concern is that whilst every effort is made to ensure anonymity and confidentiality, there is a risk that other participants may share information or statements made by another group member. This again can be addressed by a “group contract” discussed at the beginning of the session – appealing to participants to respect confidentiality. The ground rules were not always effective, as particularly in the case of group one, there was a tendency to drift off topic, discussion work related problems etc. That said, when en point, the conversations were free flowing and generated a wealth of animated discussion.

Apart from this, the idea of a focus group appeared enormously appealing, offering an opportunity to collect a great level of detail, and this is echoed by Carey & Asbury (2012: 11) who summarise the benefits of adopting a focus group approach as being *“more than the sum of its members’ comments”*. Having facilitated both focus groups, there is a temptation to agree with this statement, as some of the opinions and ideas offered by the participants were completely unexpected and revealing.

Again, time to participate appeared to be an issue, with conflicting extremes experienced between the two focus groups taking place. Focus group one comprised of “specialist” staff who did not express any restrictions in terms of time spent with the researcher; whereas the second group, made up of staff working in patient- facing areas, was more challenging. On this occasion, one member of staff participated during a lunch break, with the second group member having to leave

early on in the session due to service needs – subsequently completing the discussion by telephone. Interestingly “time” continued to be a common theme – particularly concerning time spent on personal development. This will be outlined in greater detail when the data is presented.

To summarise, the new RPL policy is yet to be tested, the intended “flow” of the process itself appears uncomplicated, at least on paper. However when each element is scrutinised, it brings forth a number of questions. With this in mind, using a broad phenomenological paradigm and the associated choice of exploratory research techniques, as opposed to quantitative methods, it acknowledges the rapidly changing landscape of the NHS. For example: the trade union movement is yet to give its verdict on the development and application of the policy. On the other hand, the staff themselves were not involved in the development of the policy therefore there is a need to demonstrate flexibility in applying research methods. Finally since the policy is yet to be launched and marketed, this eliminated the possibility of a systematic review (that is recording or measuring “take up”).

3.4 Research Process

Having secured permission from the trades union's Regional Secretary, it was originally intended that an invitation to participate, prepared by the researcher would be circulated to union branches representing each of the eight NHS health boards, representing 33,000 members. The invitation was designed in a way that allayed any fears or concerns they might have as members of staff "lifting the lid" on NHS practices. Unfortunately the invitation was not circulated, for reasons unknown. This prompted a review of how participants would be encouraged to get involved. Eventually, the researcher utilised her own contacts within the movement. This had a significant impact on the number of overall respondents, meaning fewer people opted to take part. However, when the final interview group was secured, a subsequent notification was sent to outline the parameters of the interview with its associated timetable.

The participants were interviewed mainly face-to-face, but where geography was difficult, conversations took place by telephone. Each interview lasted around forty-five minutes to an hour. The interview was semi structured in format, so that a free flowing narrative could take place. However some questions were more closed in nature in order to focus the interviewee on a particular area. (Appendix C) Generally, the semi structured approach allowed an element of flexibility in the conversation, meaning pertinent and important issues could be recorded. It was originally intended that the interviews would be audio recorded, however it became evident at the first interview that this proved to be a barrier. In this instance, the respondent worked in an open plan office, with unintentional distracting background

noise coming from other employees. Access to meeting rooms also proved to be a problem throughout the study, therefore the intention to audio record the conversations was abandoned. Following each interview, a draft copy of the transcript was sent to the participants for approval. Where appropriate, participants indicated areas for amendment. However in the main, respondents gave little feedback on the transcripts.

When transcripts were agreed, a thematic analysis of data took place, with trends and inconsistencies identified. These informed the development of questions to be included in the focus group discussion that followed. The focus group was made up of a smaller sample size of the original group and this was anticipated in advance. In fact, two small focus groups took place. Whilst focus group one were able to access a meeting room equipped with video conferencing; focus group two did not have this equipment at their disposal, therefore a separate discussion took place. At first, the researcher felt a split conversation would compromise the flow of information, however the findings, from what appeared to be two diverse groups, were revealing and contrasting.

The researcher acted as facilitator and guided the discussion accordingly. On this occasion, it was intended that the participants recorded views and opinions on flip chart paper, however it soon became evident at the first group, that the participants were not recording their discussion in this way, and as such, the researcher took notes on her laptop throughout. In retrospect, an audio recording of focus group one would have been beneficial (i.e. the location of the meeting was private with no

interruptions). However this would not have worked in the case of focus group two, which took place in a busy hospital atrium in full view of other staff, patients and members of the public. As with the semi structured interview, quantitative data was collected in addition to a thematic analysis of qualitative information.

3.5 Research Analysis

The results are presented in a narrative form along with supporting tables, diagrams and graphs included to illustrate points where appropriate. A summary of the output of the study is used for analysis and a wider discussion in the next chapter. The semi structured interviews and subsequent focus groups populated mainly qualitative data for analysis and interpretation. The key questions at the forefront of the data analysis were whether the evidence was consistent with common themes identified within the literature review, or did it reveal new phenomena that could support future research.

3.6 Conclusion

This concludes the discussion in respect of the choice of methodology and techniques selected for analysis in this study. The following chapter will present the research results and analysis.

Chapter 4: Research Analysis

4.0 Introduction

The results of the study are presented in this chapter and are analysed using the process of perceiving and summarising as outlined in the Methodology section. A thematic analysis of data is presented and reflected upon in the context of the research topic. The literature review aims to support the analysis by reinforcing the underpinning theories surrounding RPL.

Having confirmed an interpretivist-phenomenological approach, semi structured interviews, followed by a focus group were selected as the primary methods of collecting data. With this in mind, no hypotheses were formulated. The aim of the research was to encourage respondents to share their perceptions, opinions and insights, translating these to measure their skills and motivation as to what extent they might access a soon to be implemented policy on the theme of RPL.

The results of the investigation are presented according to the research “methods” adopted. Data is discussed, by demonstrating what is perceived by reading the data records, and then by presenting a thematic analysis.

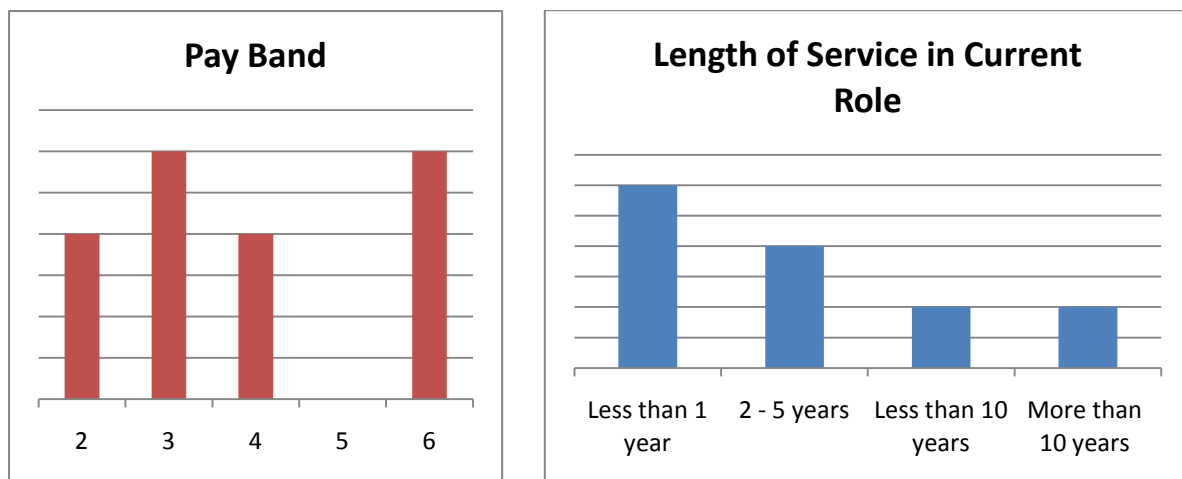
4.1 Presentation of Interview Results:

Semi structured interviews were carried out at various locations over a period of three weeks, and coincided with the availability of staff. Conversations were recorded in short hand by the researcher and to alleviate the threat of misinterpretation, a transcript was presented to each participant for approval.

- **Demographic:**

An analysis of the data revealed a reasonable representation of staff across pay bands – with input from professional, technical and unqualified staff (as defined in Chapter 1), employed by four health boards.

Participants were able to demonstrate varying length of service as generally indicated in the tables below:



- **Achievement of Qualifications**

Participants were asked to reveal the highest level of qualification they had achieved. The original purpose of this question, was establish general background information about the respondents, but also to seek out any common themes. The level of

qualifications between participants varied in line with their role. Two participants employed as HCSWs (clinical and non-clinical) indicated the achievement of qualifications at Levels 4 and 6 respectively. Whereas a Health Informatics Manager employed at Band 4 had a highest qualification at Level 2. With hindsight, it may have been beneficial to ask why this is the case?

- **General Culture of Learning:**

Again, with a view to giving the study some context, participants were asked about their general experiences of personal development within the workplace. With this in mind, the data revealed that attending training courses is common across all pay bands represented, with the majority of respondents stating they had participated in training – both face to face and online during the last two years. In fact, online learning featured frequently in the discussions. However on further probing, many of these encounters were mandatory, (Manual Handling, Fire Safety, etc). Some of the courses described appeared “technical” or specific to individual job roles - ranging from IT software management, use of computerised systems, etc. There was also reference to training implemented in response to changes in legislation (interview 5, female). Only one respondent attended a course based on their own personal development plan (i.e. “Training & Learning in Professional Development” course), which would allow them to support student practitioners in the future.

Motivation to Learn:

When exploring the motivation of individuals to attend training, the response was unanimously positive. Only one participant presented a neutral stance when asked if they liked attending training courses.

Whilst a number of common themes emerged, the majority of respondents linked learning to service improvement – indicating that by attending training, they were able to do their jobs better. One participant further expanded on this explaining the NHS benefited as whole.

“I can always learn something new” (interview 1, female), was also identified as a common theme, further elaborating that it allows the individual to keep up to date with new technology, processes, ways of thinking etc.

Other respondents noted the importance of motivation and interest, with one in particular stating *“It all depends if it’s something I’m interested in”, (interview 5, female)*. This was reinforced by another participant who offered *“It depends what it is... if it’s applicable.”* (interview 7, female).

The importance of continuous professional development was passionately defended by one participant (interview 4, female). Apart from the “personal benefits”, i.e. boosting self esteem, it was suggested all staff needed to be well trained and kept up

to date with learning in order to *“provide the best quality services to NHS beneficiaries.”*

Respondents concluded by highlighting the wider benefits to attending training, indicating it might help them get promotion in the future.

- **Internal Processes: The Personal Annual Development Review (PADR):**

Whilst there is an overall impression of a culture of learning in the workplace, it was interesting to explore the underpinning processes which allowed staff to discuss and explore their development needs. The Personal (Annual) Development Review (PADR) is the platform for such conversations. Despite its title, managers are encouraged to conduct informal (interim) discussions throughout the year – culminating with an annual review.

Despite disparities between frequency and occurrences, the respondents presented an optimistic view of the process– at least “in principle”. Again common themes emerged, recognising PADR as a platform for development discussions, further describing this as a means of documenting actions – meaning there is a record of agreement, etc. Those employed within the higher pay bands presented more of a “big picture” benefit – highlighting how the process helps identify skills gaps within the service. However in comparison, respondents employed within the lower pay bands felt it was a *“tick box exercise”*, (interview 5, female).

- **Personal Development Portfolio:**

Linked to the Personal (Annual) Development Review (PADR), is the personal development portfolio. These vary in format from hard copy files to electronic records. However it was unanimously confirmed that all but one respondent maintained some sort of record. Generally, this was viewed as a record of training and development, with five of the respondents admitting to maintaining copies of qualifications certificates, certificates of attendance at training courses, etc.

All participants were aware of the need to maintain a portfolio – but in some instances, claimed they had not updated it for a while. One respondent indicated they had kept a “*mental note*” (interview 2, male). Commitment to maintaining a portfolio varied between participants, although all respondents were able to describe what was required of them. This information is particularly useful, since portfolio development is a critical element of RPL.

Perceptions of RPL:

When exploring the main purpose of the study, the majority of participants at least had an idea of what Recognition of Prior Learning means. Only two respondents were unable to answer the question. In terms of how this may (or may not) aid their personal development, the consensus was positive. A thematic analysis highlighted the notion of RPL places value on skills, training and experience, with one respondent offering “*Nothing is wasted, it’s all transferrable*”. (interview 1, female). Linked to this idea was the suggestion it might make way for a more flexible

workforce, identifying gaps in training, (interview 2, male), therefore benefiting the NHS as a whole.

Again, links to progression were made – highlighting how the process might aid job applications by demonstrating whether or not a candidate meets the personal specification. Building on this, it was noted that the policy might benefit staff with few or no qualifications (interview 2, male) – but a wealth of work/life experience. The specific example given concerned a colleague who had full time caring responsibilities when much younger (interview 4, female). As such, they missed out on formal education, yet had developed a raft of skills associated with looking after the home, the cared for relative etc. It was noted that the person concerned was a valued member of staff and had potential to develop, yet a lack of qualifications “on paper” meant she had been denied the opportunity to progress in the workplace.

Negative perceptions of RPL related to past experiences within academic institutions and in the workplace. One respondent shared they had been denied RPL in the past, meaning they were required to study the module in its entirety (interview 3, female). In terms of the RPL process, it was described as onerous and time consuming – indicating the volume of effort required in terms of preparing evidence, meant they might as well have studied the module in the first place. Another respondent explained they had attempted to apply for RPL in the past, but having spent time developing a portfolio of evidence, they found their manager did not know what to do with it, (interview 5, female).

As mentioned, many of the respondents were generally familiar with the idea of portfolio building – which is also central to the RPL process. In general, this was viewed as a beneficial activity with a number of opinions offered. In the wider sense of RPL, it was suggested it would be *“Good for people who don’t like exams.”* (interview 2, male). This would appear to link to the widening participation agenda – validated as something that is *“a rewarding reminder of what you can do”* (interview 2, male). Professional respondents confirmed this is common practice for Nurse Revalidation – with others agreeing they already did this to support the PADR process.

Less positive criticism of the activity proposed it was a good idea as long as the individuals efforts would be acknowledged, adding: *“It depends on the process, I suppose... Otherwise, you might as well just do the qualification”* (interview 5, female). This was echoed by another participant who indicated *“It’s a good idea, but I would need some guidance”* (interview 2, male). Reflecting on the literature, none of the respondents raised the notion of *“How do we know what we know?”*, (Fossage, 2011) that is, none of the respondents showed concern about their general awareness of skills and experience in relation to criteria outlined by a qualification or learning module.

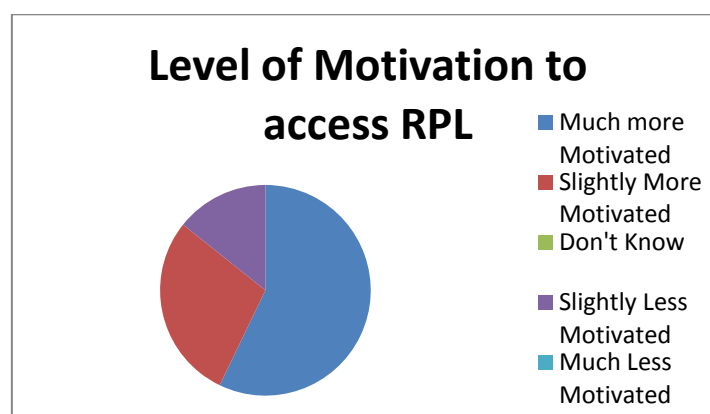
- **RPL Skills - Reflective Practice:**

Another critical element of RPL is revolves around “reflective practice”. When asked how they felt about this, most respondents were first of all able to offer a definition –

although despite this, not all respondents actually carried it out. Only one participant was unable to offer a definition. Those regarded as “professional” staff stated they were conversant with the skills associated with reflective practice –as it “*underpins professional practice*” (interview 3, female), also adding it was part of the “*adult learning process*”. Most agreed it involved an element of “*self criticism*” of past experiences (interview 2, male) – “*Looking back at what you did. How would you do it next time?*” (interview 5, female). Participants employed as HCSWs explained the terminology was becoming more familiar and that new starters were being encouraged to develop their skills of reflective practice to coincide with the Induction Framework. All respondents agreed the notion of reflective practice was a good idea.

- **General Perceptions and Motivation to Access RPL:**

Taking into account the overall discussions, participants were asked to what extent are they motivated to apply for RPL? The table below summarises the findings:



It appeared the majority of respondents (4) felt they were “much more motivated” to access RPL, with 2 respondents volunteering they were “slightly more motivated”

One respondent admitting to a previous negative experience of RPL, remained unchanged in terms of motivation (“slightly less motivated”).

Summary:

It was generally felt that all participants were willing in terms of their contribution to the discussion, with very little need to prompt or add supplementary questions. The overall the data collected was useful and prompted some useful discussion points for the focus group that followed.

4.2 Focus Group:

In this section, data gathered from the subsequent focus group discussions is presented, along with a summary of key themes identified from these conversations.

Identifying willing participants to go on and take part in the focus group continued to be problematic. Whilst a reasonable number of interviewees showed a willingness to contribute, geography (i.e. location of workers), the type of service they were employed in (i.e. acute/front line services) and ability to get time off to attend the discussion were cited as barriers.

However four candidates eventually took part – albeit in two separate groups. This initially caused some concern to the researcher – thinking this might affect the quality and quantity of data. That said, the makeup of both groups appeared to reveal some thought provoking insights.

Group 1 was made up of “*specialist staff*” (Participants A and B). The second group was made up of “*unqualified staff*”, that is, HCSWs (clinical and non-clinical), (Participants C and D). (Questions: Appendix D)

Building on conversations recorded during the semi structured interviews, candidates were sent a draft copy of the toolkit intended to support the RPL policy. It was emphasised that this only exists in draft form and should not be shared with anyone outside the focus groups. The toolkit is currently presented as an interactive pdf

document and contains comprehensive information about the process, as well as offering embedded Word templates (i.e. RPL application forms).

- **Supporting Resources – Access and Format:**

Ahead of each focus group, participants were asked to open the pdf document using a work's computer and a personal device (whether this be a Smartphone, tablet, home computer). They were asked to access any of the "*clickable links*" or menus, and then to attempt to access one of the embedded documents – both at work and at home.

All participants agreed that unless you had access to the internal network, you would only be able to access the information at work. Participant A explained that some staff with remote working rights, had what they described as a "*dongle*" which enabled the member of staff to access the NHS network from home, or from any other location. Permission to access a "*dongle*" in the first place was limited, understandably to restrict the number of employees accessing the secure network, thus protecting patient data etc. This was concurred by Focus Group 2 with both Participants C and D, confirming they would not have access to such a facility.

One group member stated the computers housed within clinical working areas, were for the use of doctors and nurses, to be able to access patients' results etc. To be able to answer the question posed by the researcher, Participant C explained they had stayed behind after work, in order to use the computer. Participant D (non clinical HCSW) stated they would have no access whatsoever to a computer during

the course of their work, and added they did not have access to the internet at home either, stating *“There is absolutely no way I could do this!”* Having established the interactive pdf. toolkit could only be accessed at work, all participants were asked how this made them feel. First of all, Participant B informed that the operating systems and software versions available to staff differed (e.g. some sites working according to different versions of Windows), and this would affect the ability to access the document and certain functions. Generally speaking though, participants of Focus Group 1 experienced very little difficulty in navigating the document, and were able to access the links – the difficulties arose when trying to download the Word templates, which we were told are *“hosted on the HOWIS platform”*, thus establishing the majority of RPL candidates could only access the facility at work. Interestingly Focus Group 1, whilst experiencing very little difficulty themselves, were mindful of the impact it might have on staff employed in different roles. *“What about front line staff?”* as Participant B volunteered, *“My manager would be ok with me doing this in work time, but what about staff working in acute areas?”* Focus Group 2 expressed they were unable to access the *“clickable links”*, with Participant C attributing this to internal “firewalls”, which are apparently common place.

Participant A expressed concern about different levels of digital literacy, asking: *“We both have good IT skills, but what about staff with poor digital literacy skills. Will there be training offered?”*

Participant B continued, *“I was happy to play around with this. But what about the staff who lack confidence, or have poor IT skills? They might not use pdf – so they might be de-motivated?”*

Taking these factors into account, both participants of Focus Group 1 agreed they liked the toolkit in a general sense – it was comprehensive, easy to read, and the inclusion of an extensive glossary eliminated barriers around use of jargon etc.

Focus Group 2 were in agreement, confirming the notion of an interactive toolkit was a good idea, provided all staff could access it, or otherwise have it presented in alternative and inclusive formats – so that people with dyslexia, impaired vision, learning disabilities etc could participate without prejudice.

- **Stakeholders:**

Participants were then asked to look at the draft flowchart outlining the likely process involved in applying for RPL. They were asked to consider who the major stakeholders would be and how each of these might affect their motivation to pursue RPL.

Focus Group 1 appeared to identify all major stakeholders, and added some which were not featured in the flow chart. A summary is presented in the table below.

Assessor	Focus Group 1 believed the role of the assessor to be critical to the process. In their view, they felt that the assessor <i>“needs to know everything”</i> Focus Group 2 was equally aware of the responsibility placed on the assessor, expressing concerns about the capacity of this role, asking if the post would be peripatetic and able to support a diverse workforce with conflicting needs – working across multiple sites.
Learner	Focus Group 1 perceived the role of the learner as one who starts the process, with Group 2 adding the learner was the most important stakeholder of all. However Group 1 elaborated, <i>“the learner could only do it if they know about it.”</i> Therefore raising the question of awareness of the process in the first place. They acknowledged, even though the information is on the <i>intranet</i> – you only pick it up if you’re interested in it in the first place?
Internal Verifier (IV)	Participants felt this role may not be so relevant to the learner. They guessed the IV/EV would have a closer relationship with the assessor and possibly the individual’s line manager.
External Verifier (EV)	
Line Manager	Participant B (Focus Group 1) suggested that all line managers would need to know who the assessor is. They also queried if a line manager might be an assessor as well? Taking into account all other day to day responsibilities, they asked <i>“How are they going to know all this? To what extent are they aware of RPL?”</i> Focus Group Two was equally concerned about how the line manager fits into the process. With Participant C asking, <i>“How will they know what is</i>

	<i>relevant as evidence?</i>” Adding, if the line manager was unaware, it might inhibit an individual’s chances to access RPL in the first place. Focus Group 1 followed with the question, <i>“Will they be trained in this?”</i> They also enquired whether new managers have a “starter pack” when they are first in post. In which case, could information be included in this? Participants went on to suggest, that a line manager might only become aware of the process when a learner approaches them. In which case... <i>“They might go to the HR department and ask “what’s this all about...”</i> (Participant B)
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Focus Group 1 identified a stakeholder which was not featured in the draft flow chart. They suggested the **trades unions** might have a part to play.

Collection and Presentation of RPL Evidence:

Both focus groups were invited to further explore the process of collecting and presenting information to support a RPL application. As identified during the semi structured interviews, confidence and motivation differed, with some respondents feeling this would be a simple process, to others suggesting they would be able to do it with some guidance, whereas at the other end of the spectrum, candidates indicated they had no idea where to start.

On this occasion, participants were asked to review the toolkit, paying particular attention to the suggestions outlined in respect of evidence collection. They were

then asked how this affected their motivation to present evidence, and also to consider how they felt about their own skills to do this. This ended with a discussion about reflective practice and the sort of support they might need to do this.

Focus Group 1 identified that in most instances, learners would receive a certificate of attendance at each workshop. However in some instances, these are being encouraged electronically – giving rise to the same concerns expressed earlier about access to IT equipment and confidence in terms of digital literacy skills. Participant B suggested that on some occasions, you would be relying on your line manager to validate this. It was also noted that “historical” certificates were difficult to retrieve (GCSEs, A Levels etc). Participant A indicated they were mandated to attend training to maintain continuous professional development – and this took place on a cyclic basis. This meant they had lots of certificates and evidence of attendance and as such raised the question “*Where would I keep it all?*”, as there seemed to be a lot of work involved in collecting evidence to support RPL.

When asked the same question, Focus Group 2 was less keen on an electronic learning passport. However they acknowledged issues concerning storage of hard copy documents. Participant C explained that their portfolio was stored in a cupboard in a busy clinical area, but did not express any concerns about this. Participant D added they did not have anywhere to store a portfolio and only had access to a locker for basic, personal belongings. In terms of generating a witness statement, or peer observation, Participant C felt confident that colleagues would support any requests, and gave a comprehensive account of their experience of

writing personal reflective accounts, adding they had stayed on after work to do this in a quiet environment. They confirmed they had been able to upload such documents to a personal drive, but expressed concerns that this facility may not be available to everyone. Participant D again demonstrated an element of anxiety about the lack of resources available to them. Both asked whether the assessor would have the time or capacity to assist people struggling with this.

Focus Group 1 went on to unpick any issues arising concerning reflective practice and the preparation of witness accounts. Generally the participants agreed that if you could easily get a witness account, that would be beneficial. However, they raised concerns about relationships between individuals and line managers: *“What if the line manager is unwilling?” “What if you burned your bridges with your last line manager?” “What if the training and experience was achieved at an external company and they had since closed down?”* (Participant B). They also acknowledged that the NHS is not necessarily the “sole employer” within a hospital – suggesting a member of staff may be employed by an “outsourced company” – therefore would a remote, senior manager even know the individual in the first place?

In terms of reflective accounts, Focus Group 1 agreed this appeared to be a straightforward process, assuming the individual had the skills and confidence to do this in the first place. Group members raised concerns about *authenticity* and *validity*, suggesting the candidate might give it to their spouse or friend to complete (Participant B). Again concerns were raised by Focus Group 2 about literacy skills,

also acknowledging a diverse, multi cultural workplace, where learners may present with English as a second language.

- **Support:**

This prompted a discussion about support. *“Who could help me?”* Interestingly, Focus Group 1 felt it was the responsibility of the assessor to ensure such accounts were completed. They were reassured by the publication of templates, but felt varied formats were important (i.e. both hard copy and electronic, as well as in an accessible format for staff with impaired vision, dyslexia etc). Participants unanimously agreed that RPL workshops would be useful, in order to guide candidates through the process, and promote the skills around reflective practice and professional statement writing.

Focus Group 2 appeared less optimistic about receiving support from the assessor. *“What if there are lots of people applying for RPL, on top of all the other stuff an assessor has to do?”*, (Participant D), thus querying again whether the assessor had appropriate time, expertise and capacity to help individuals.

- **SWOT Analysis:**

Each focus group was invited to present a SWOT Analysis of the RPL Framework. This was to measure their overall perceptions of the process in general. The data is presented according to focus groups in the table below:

Candidates were asked: *RPL seeks to acknowledge prior learning and experience. Generally speaking, what are the Strengths, Weaknesses, Opportunities and Threats of introducing RPL to staff working in the NHS?*

The data is presented in the table below:

Strengths <u>Focus Group 1:</u> It benefits a lot of people It encourages learning It benefits the “right people” (people who missed out) Promotes self worth Helps you move in a job Values your skills and experience Assesses your history	Weaknesses <u>Focus Group 1:</u> Advertising and marketing: How will staff know about it? Raising awareness Managers being aware Managers and workers buy in Time to do it Resources to do it (e.g. A scanner, computers etc)
<u>Focus Group 2:</u> It can only be as good as the learner’s ability to access it in the first place If the assessor is willing to be peripatetic	<u>Focus Group 2:</u> The assessors capacity and time to help learners Lack of buy in from the learner Lack of buy in (or support) from the line manager Awareness and marketing (will it be marketed in a positive manner?) Will staff think: “Not another initiative that does not work!”
Opportunities Possibility of progression, promotion, new jobs Might boost confidence when you go for an interview Will help you re-evaluate your skills and strengths If your portfolio is up to date – you might go for a job earlier (i.e. not put off by a personal spec as you already know what you’ve got going for you)	Threats Time to commit to it (both at home or in the workplace) “Going nowhere” (What if I get nothing from it?) What if it’s a tick box exercise? What if it’s all for nothing? If individuals don’t see the point If managers don’t see the point
Case studies and positive outcomes might boost participation in learning, KSF and A4C	If the process does not work, and evidence is rejected or ignored, it might put people off. It may even inhibit further

Links all of your skills, experience and learning to something current – so values the individual Boost confidence Widen participation in learning Opportunity for the Health Board to promote learning (e.g. Apprenticeship stall)	learning and progression (i.e. What's the point?) Funding (or lack of...) Time to do it
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- **Evaluation of Focus Group Experience:**

Finally all participants were asked to evaluate their experience, having taken part in the focus groups. It was intriguing to note that all candidates felt they had learned something from this approach – ranging from how to use a pdf. document – to learning more about each other's job roles. They were conscious of the need to stay on point – as they recognised there was a tendency to drift off point. All participants were originally offered flip charts to record their discussions, but in both instances, they indicated they preferred it for the researcher to record the discussion using her laptop. It was unanimously agreed that they were pleased to be invited to participate in the first place, suggesting it placed great value on their opinions and perceptions in order to shape policies affecting staff and ultimately the quality of service delivery (in turn affecting patients, their families and the wider community).

In this section, the data gathered through the semi structured interviews and focus group was presented. In the next chapter, the primary information is summarised, along with a discussion of the data, in reference to the secondary research conducted via the literature review.

Chapter 5: Discussion of Findings, Conclusions and Recommendations

Introduction:

In this chapter the findings of the research are discussed aiming to establishing the findings, conclusions and to identify any commonalities and inconsistencies. The discussion will seek to establish links with key text identified in the literature review. Subsequently conclusions will be drawn in relation to the literature and data. The limitations of the research will also be re-visited, with final recommendations presented for future research and also in the context of RPL in practice.

Discussion of the Data:

The findings are discussed with reference to key themes identified in the literature review. It also seeks to examine the findings in the context of the study, that is, exploring the skills and wills of NHS staff applying for RPL.

Pay Bands

Respondents represented the majority of pay bands. There is nothing to suggest that any one pay band were more committed to participate than any other. However the breadth of participation helped present a more varied view of the workforce.

Length of Service

During the development of the RPL policy there was much debate about the level of motivation and commitment expressed by new starters and experienced staff. With this in mind, participants were asked to give a more detailed account of their history

of working for the NHS. Again the data collected varied, and in doing so, no clear picture was established as to whether or not new staff are more committed to their CPD than long serving members of staff.

Levels of Qualifications Achieved:

Those with higher level qualifications generally worked in jobs “appropriate” to the qualifications. In some instances, the qualifications were a mandatory expectation of the role – particularly in the case of the HCSWs who are now working towards the completion of the professional qualification framework – which triggered the study in the first place. However it was interesting to note that a non-clinical HCSW was educated to degree level. In the same way, a clinical HCSW confirmed qualifications at HND level. In both instances, the participants confirmed this arose from personal motivation with a view to progressing in the workplace in the long term.

General Culture of Learning:

It appeared to be the unanimous view that of the staff taking part in this study, the majority of them attended training deemed to be mandatory in nature. Approximately 80% of the respondents confirming they were told to go by their managers, rather than electing to attend out of personal or professional interest.

On the other hand, it would be argued that CPD remains important to staff employed at all levels. It would certainly appear to be more of a priority from an employers’ perspective. However the format of the training suggests that mandatory learning takes priority over education arising from personal interest or to satisfy an

individual's development. Whilst acknowledging that the majority of training attended was mandatory, respondents gave various accounts describing their personal motivation to attend, ranging from "*To maintain my CPD*" (interview 1, female) to thinking the training courses would help them in their job. Only one respondent indicated they attended the course out of personal interest in the topic (interview 6, male). The responses appear to confirm a general interest in professional development, although the motivation to attend appears to be conflicting. Interestingly none of the respondents mentioned "transferrable skills" – suggesting they may not have considered the flexibility or a more wider application of what they had learned.

Therefore whilst a culture of learning appears to exist, it could be argued that this is firmly related to the needs of the job, rather than the interests and needs of the individual. However this was not confirmed during the interviews and would warrant further clarification in order to be established as fact.

Motivation to Learn:

Again the participants appeared united in their view that they wanted to learn. There was a clear link to service improvement, and the notion that they could perform their jobs better as a consequence of attending training courses. The notion of staying up to date and managing changes in work practices, legislation and technology appeared consistent across all participants.

It was interesting to note that some respondents acknowledged the collegiate value of learning together – suggesting “*I can learn from other people’s experiences*” (interview 4, female).

It was clear that all respondents were able to list a raft of benefits associated with learning and development both from a professional and personal perspective, and also in terms of their current situation and what might arise in the future (in terms of progression, more work changes, etc). No one indicated that learning was a “one off” encounter, suggesting a general understanding that they acknowledged (or accepted) the notion of “continuous professional development”.

In the context of “PDET”, it could be argued that there is a leadership role to be played in respect of motivating the learners. Reflecting on some of the comments expressed by Focus Group 2, these would appear to learners in need of support. It could be suggested that effective leadership is essential in terms of supporting reluctant learners through the process.

In the same way, the professional Framework initiating the policy development is viewed in some instances as a significant change. With this in mind, it could be argued that there is a role for education leaders to support learners through this change – particularly acknowledging the associated theories (e.g. *Fisher’s Change Curve*) which outline the various behaviours and emotions experienced by individuals when encountering change. The RPL “leader” plays an important role in encouraging individuals according to their preferences, abilities and behaviour.

PADR:

It was at this stage of the study, that a chasm developed in terms of who is able to access what. The majority of respondents indicated they took part in PADR, however the frequency of interim discussions varied. Those working in a clinical or a more acute environment appeared to have fewer opportunities to discuss their development needs – resulting in just one meeting per year. However respondents working in an office/administrative environment felt they were able to raise issues with their line manager as and when they arose. Two respondents did not have the opportunity to participate in PADR – of these, one person explained this was due to a change in personnel – feeling they were “still in limbo” (interview 2, male). However another respondent could not offer an explanation as to why they had not taken part in a PADR review (interview 6, male). Whilst the process itself is mandatory, it would appear this is not “enforced”.

In terms of the perceived benefits of PADR, this also gave rise to conflicting views, with some respondents (particularly those employed at the higher pay bands) citing service improvement as a positive factor. From an individual’s perspective, participants recognised PADR as the appropriate platform to discuss their development needs, but not all respondents felt their views were taken on board, with one in particular elaborating “*I can’t see how I’ve benefited from this*” (interview 5, female).

Personal Development Portfolio

As previously noted, all but one respondent maintained some sort of record. Again this appeared to be more pertinent to some job roles, with professional staff keeping comprehensive records of training and development – with initiatives such as Nurse Revalidation acknowledged (interview 3, female). The format of the portfolio varied – ranging from a collection of certificates and records of attending courses – to a more comprehensive record, including witness statements, reflective accounts etc. In other words, there appears to be the view that these are presented in hard copy format (i.e. not electronic in format). In retrospect it would have been beneficial to probe further on this subject – asking whether or not they had received any training in terms of “how to” present a portfolio and its contents.

That said, all respondents were able to list benefits associated with this exercise and were also aware that it was an expectation of them as members of staff. One respondent volunteered this was a useful record – especially when applying for a job, aiding them to complete an application, prepare for an interview (interview 1, female). The same respondent added it was a useful exercise, as they could see at a glance what training they had completed, meaning they could avoid duplication. Finally, it was suggested that a portfolio of evidence would be a useful means of assessment, particularly for those who disliked exams, etc (interview 2, male).

In summary, it appeared that the majority of respondents had not thought of portfolio building beyond maintaining records of training, certificates confirming qualifications etc. Only the “professional” respondent (interview 3, female) was aware of some of the additional skills required (i.e. reflective practice, witness statements, peer observation etc)

Perceptions of RPL:

Generally, all respondents were able to give some idea of what RPL means. Only one participant admitted they had never encountered the term previously. This would suggest the numerous discussions led by the Task and Finish Group who developed the policy, may have been correct in arriving at this descriptor. In other words, the title is self explanatory.

The overall perceptions were positive, with a number of different perceived benefits highlighted. It was interesting to note however, that those less positive about the process, were those who had experienced RPL previous. In both cases, the respondents had a negative and unfruitful experience resulting in both candidates completing the qualification via the “traditional” routes, having gone through an onerous and time consuming process of collecting and presenting evidence, only to be told this was rejected. This cannot be linked to any one area of the workforce since this was experienced by both a professional and an unqualified respondent – studying in different circumstances (i.e. one at University and the other through a vocational qualification route).

Reflective Practice:

All respondents, with the exception of one, were at the very least able to offer a definition of what they thought this might mean – compared to those who employed this skill routinely. It was noted this was becoming more of a common language amongst HCSWs in the advent of the Framework, suggesting efforts had been made by development leads to encourage this practice. None of the respondents appeared overly concerned about the activity – but recognised they were not consciously doing it. With this in mind, what could development leads, managers and supervisors do to further encourage this as second nature activity?

In the context of PDET, it could be argued that RPL provides an opportunity to develop future leaders. Refining and developing skills such as reflective practice, critical thinking, which is synonymous with “leadership” may give rise to developing the leaders of the future.

General Perceptions and Motivation to Access RPL:

When asked to explain their reasons why, the respondents offered a range of both positive and negative comments. From a positive view point, participants felt it was beneficial to acknowledge and to place value on an individual’s knowledge and experience. Linked to previous answers, it was also felt it could offer a person a second chance, (interview 4, female). In the wider sense of the workforce, it was felt that it would help eliminate duplication of study, meaning staff would need less time off work. Respondents 1 and 2, added that it would free up an individual’s time,

allowing them to focus on learning what is relevant. From a manager's perspective this solved the problem of having to cover shifts or for an individual not having to catch up with their work at a later date (interview 4, female). It was also observed that it could make way for a more flexible workforce – helping with staff shortages (interview 5, female). One respondent suggested it might help people wishing to change jobs, (interview 6, male).

Some of the negative perceptions revolved around the process itself – concerns were raised about the time needed to prepare a portfolio of evidence – and the volume of work associated with this. One participant asked if staff would be allowed time to do this – as if they were attending any other training course? (interview 1, female). It was interesting to note that one respondent had a very firm view about the achievement of qualifications – stating there should be “*no short cuts*” (interview 3, female). They expressed a “*sense of self worth by working through a qualification in its entirety*”, and that individuals developed a “*deeper understanding*” of a subject by working through a full qualification. Some respondents working in a particularly “specialist” (or technical) occupation suggested “*You can't RPL everything. Certain things have to be studied again and again, because things change...*” (interview 2, male).

Concerns were raised that the process might “fast track” individuals through a qualification resulting quality suffering as a consequence – both in terms of knowledge and professional practice, (interview 3, female), asking “*Is this a tick box*

exercise designed to boost numbers rather than deep learning?” , concluding, “I never got anywhere with it in the past.” (interview 5, female).

- **Supporting Resources – Access and Format:**

Both focus groups confirmed the interactive toolkit designed to complement the policy was generally easy to use. They also recognised the benefits of having such a toolkit was a good idea, provided all staff could access it. In fact, “access” to the toolkit was identified as one of the main concerns (this included format, visual impairment, English language skills, digital literacy skills). The main concern revolved around remote access (i.e. using the tool at home or within a suitable environment within the workplace). It was acknowledged that not all staff had access to the internet – depending on their job roles. Therefore how could the policy apply to all staff? The working environment appears to be a particular concern – especially for those working in acute areas, suggesting an appropriate place be identified to manage CPD.

Stakeholders

Both focus groups identified a comprehensive list of stakeholders – and included some groups which were not factored into the original literature developed by the Task and Finish Group. Both were of the view that the role of the assessor was critical to the process. However concerns were raised about the assessor’s capacity to manage such a diverse workforce with conflicting needs.

In both instances, animated conversations took place about the role of the learner, citing this as the most important stakeholder of all. Questions were raised about the individual's awareness and motivation to apply for RPL in the first place, offering recommendations such as providing information at staff induction, so that new starters are aware of the process at the outset. In doing so it might also promote the importance of the Personal Development Review process.

Internal Verifier/External Verifier:

Both groups appeared less concerned about these roles, suggesting they would be more closely aligned with the assessor. However they acknowledged both roles to be important to the overall approval of a RPL application. No one highlighted the quality element of an IV/EV role.

Line Manager:

Participants expressed concerns about capacity and capability of line managers in what is already a service under strain.

Other stakeholders:

Focus Group 1 identified a stakeholder which was not featured in the draft flow chart. They suggested the **trades unions** might have a part to play. First of all, acknowledging the appeals process outlined in the toolkit, they suggested a disgruntled learner might choose to escalate this as an issue to their trade union

(Participant A, female). However on a more positive note, they recognised the trade unions might have a role in to promoting RPL to their members through their lifelong learning agenda. Participant A in particular, was aware of the role of the Union Learning Representative (ULR). ULRs are enthusiasts and advocates for lifelong learning (UNISON, 2018). Acknowledging their own interest in learning, they encourage others in the workplace to take advantage of the wealth of learning opportunities offered by the employer, trades unions and wider learning community. Participant A explained they had experience of working with ULRs and indicated these would be well placed to support employees through the RPL process, provided appropriate training and guidance was offered to them in the first place. Focus Group one added there may also be scope for the NHS Well Being Groups to provide additional support.

Collection and Presentation of RPL Evidence

Both groups agreed that there appeared to be a lot of work involved in collecting and presenting evidence. Whilst both groups agreed that collecting certificates appeared to be a common format, there was some discussion about varying the format to include electronic certificates, open badges, etc. Interestingly the candidate's solution conflicted with previous concerns raised about digital literacy skills across all levels, suggesting an online/electronic learning passport could be the answer. The notion was validated by the idea that a paper file could be stolen or destroyed by fire. Participant B debated that there was also a significant risk of maintaining electronic records – (i.e. security, reliability). Therefore coming to an agreement that both formats may need to be maintained – but giving preference to an e-portfolio housed

on an independent repository, ensuring the possibility of access outside work – but also to acknowledge learning achieved outside work as well (i.e. someone completing a St. John's Ambulance course). Security issues surrounding both formats were discussed, agreeing that an electronic facility would need to be password protected and ideally hosted via a platform external to the NHS. Consideration was also given to a hard copy folder – highlighting issues surrounding storage and security.

Group 2 however, reiterated their lack of access to computer/electronic equipment, thus ruling out an electronic version. However they were equally concerned about how a portfolio might be stored, particularly where their personal storage was already limited.

Reflective Accounts:

In terms of reflective accounts, Focus Group 1 agreed this appeared to be a straightforward process, assuming the individual had the skills and confidence to do this in the first place. Group members raised concerns about *authenticity* and *validity*, suggesting the candidate might give it to their spouse or friend to complete (Participant B). Again concerns were raised by Focus Group 2 about literacy skills, also acknowledging a diverse, multi cultural workplace, where learners may present with English as a second language.

Support

A number of options were volunteered by both groups in terms of what support could be offered to candidates seeking RPL. The role of the assessor remained at the heart of both discussions, but at conflicting extremes. Group 1 (with no prior experience of RPL) suggested the assessor was responsible to guide the individual through the process. Although this view was presented in a less positive way by group 2 who remained concerned about the time, expertise and capacity of the assessor. Interestingly Group 2 participants had encountered RPL in the past and had negative experiences associated with the role of the assessor.

Again this would appear to have links with “PDET” as it could be argued that those facilitating RPL find themselves in a critical role. It could be argued that the general training for assessors is insufficient – i.e. that being able to follow a process is not enough. Motivation and support of individuals is an important part of the process – therefore this might be factored into future assessors training programmes.

SWOT Analysis

Both groups were able to volunteer a number of strengths (or benefits) associated with the notion of RPL. They were able to make links to continuous professional development – particularly in respect of the non-traditional, hard to reach learner. Opportunities to progress, find a new job, as well as supporting current service delivery were noted as positive factors. The promotion of self worth and value were strongly indicated.

However in terms of “weaknesses”, the need to adequately market the process was highlighted to be of major importance. It was noted that communication across a large scale (as within a Health Board) was generally problematic. Therefore a robust, multi media marketing campaign should be considered. Concerns about the individual’s time and manager’s allowing time to carry out this activity were also listed, linking this to a possible lack of buy in. This was summarised by one participant as *“Not another initiative that does not work!”* Again coming back the idea of promoting a culture of learning – i.e. this can only be successful if staff have the time to do it.

Opportunities

Again the personal benefits were reinforced by both groups, suggesting as originally intended, the policy would be an enabling one. However it was suggested that the Health Boards, develop and promote case studies and positive outcomes in order to continue to encourage staff to engage with this process.

Threats

The main concerns centred around time – that is, would staff be allowed enough time to prepare evidence etc? Leading from this was the worry that evidence might be submitted only to be rejected, in which case, how would you motivate staff – suggesting it might even inhibit further learning?

Sensible solutions were offered by the way of ensuring “quiet spaces” or allowing access to the hospital libraries etc. Links were made to the trades unions

(specifically Union Learning Representatives as workplace champions) and also the possibility of RPL Champions – i.e. someone who has navigated the process and would volunteer to support other candidates.

Interestingly when evaluating the focus group experience itself – it was noted that being invited to participate placed value on their opinions. With this in mind, it may have been appropriate to have had a more wider representation of staff on the Task and Finish Group developing the policy in the first place. However this might be remedied by forming a RPL Committee or User Group made up of former candidates who's experience could be utilised to shape the agenda in the future.

5.2 Limitations of the study

The limitations of this project relate to concerns about subjectivity on the researcher's part, the role of stakeholders, time and resources available to the researcher, and the identification of new areas for research or gaps in the literature published around RPL, following the data analysis.

As described, the researcher is employed as a learning and development manager, and was also a co-opted member of the Task and Finish Group that developed the RPL policy. With this in mind, there was some concern about "unconscious bias" on the researcher's part. However, it remained the researcher's intention to collect and present data beneficial to the professional development, education and training community. Whilst the Task and Finish Group was broadly supportive of the study, they did not formally sponsor the project, and as such a balance was achieved between encouragement and open access, and the freedom of the researcher to investigate and draw conclusions.

Other limitations related to the sample size in relation to the overall number of NHS employees. The sample size was small, however this was somewhat mitigated by the research methods used, which appeared to generate insightful data. In consideration of the sample size, it was disappointing that the original plan (i.e. to distribute invitations via the trade union) had to be adjusted. As a major stakeholder in the lifelong learning agenda, it would have been beneficial for the trade union to

have been more involved, since the overall results of the project would be equally beneficial to them.

Time and appropriate meeting space continued to be a factor throughout the study. A lack of time was particularly pertinent where front facing staff were concerned. Whilst the participants were willing to support the study, it was evident that time was limited. One participant in particular completed an interview via the telephone and similar arrangements were made to complete the focus group that followed. The same applied to meeting space – in the majority of cases, conversations took place in open plan offices, or in communal areas, such as hospital reception areas, staff canteen etc. This may have compromised the information shared.

5.3 Recommendations

Staff Input:

Despite a relatively small sample, there was a reasonable representation of staff across all pay bands, each with conflicting needs in terms of their personal development. It is important that any policy development should reflect the diverse nature of the workforce, emphasising “one size does not fit all”. Evaluation of the focus group activity revealed participants felt their opinions were valued, and as such, it might be useful that any future policy development would include representation from the workforce. This would appear to align to change management theories, that is, to communicate the change – and involving others in developing policies and procedures, they may be less resistant to the change (Kotter, 2012). Also in acknowledging the views and recommendations of staff, this might boost confidence and self esteem – and as such stimulate interest in progression – thus creating leaders of the future.

Support for RPL:

Suggestions of help and support were common throughout the study, indicating that it was not RPL itself that was problem, but rather “how” to achieve it. When discussing the role of the stakeholders involved with RPL, it became apparent there were concerns about the assessor’s capacity to support individuals across the breadth of a busy health board. It might be beneficial to develop a network of “RPL Champions” to be overseen by assessors, but to include candidates who had experienced RPL and could therefore support others to do the same. There would

also be role for the trades unions to play through their Union Learning Representatives networks – by signposting staff to the RPL Champions.

As a network of RPL Champions, members could share information across networks, helping to solve reoccurring problems, to overcome barriers, and to generally share good practice. In the same way, and as recommended in the literature, (Care Council for Wales, 2015) an All Wales panel of RPL assessors would be equally advantageous.

Resources and Workshops:

Leading on from this, whilst the participants were generally complementary of the resources developed so far, they did raise some concerns about the format. Again stemming from equal access – participants suggested all resources be available in electronic and hard copy format. Taking this a step further, it was also recommended that alternative formats be explored to support those with learning disabilities (i.e. coloured paper versions for staff with dyslexia), and large print versions for staff with visual impairment. This would appear to align with the notion of inclusive education, (Petrescu, 2013) and general equalities legislation (UKAAF, 2012)

It was also suggested that staff have access to workshops focusing on the skills associated with RPL. Participants were particularly keen on further exploring skills around reflective practice and portfolio building. Reflecting on the diverse needs of

each staff group, again it could be argued that a “one size fits all” approach would not work. Whilst capacity and availability of appropriate staff might be a factor in terms of facilitating such workshops, consideration should be given for the long term benefits and investment associated with tackling this issue. In boosting confidence and the underpinning skills, it might encourage more staff to opt for the RPL route, hence reducing the need to fund expensive qualifications in full. On the other hand, consideration should be given to how quality is ensured.

By providing additional support and resources, and ensuring a straightforward, uncomplicated process may encourage further learning. This appears to link with the notion of widening access and mature learners, as described by O’Dowd (2005); who suggests that learning in adulthood is *“pleasure driven motivation, which is not associated with the feeling of obligation that often characterises learning in early adulthood.”* (O’Dowd, 2005) In other words, avoiding an onerous process will encourage more learning in the future, creating a cycle of continuous professional development. That said, Field (2012), in Miguel et al, 2016) reminds us that learners expectations of RPL are “predominantly professional” which would appear to align with the aims of the HCSW Framework, it would also concur with the aims of PADR.

Future Research:

It would appear that the participants were at least slightly more motivated to access RPL. Moving forward, it might be beneficial to assess to what extent the policy is utilised, and having experienced the process, to measure how attitudes have

changed towards future learning. Has RPL enabled more learning? Or will candidates still prefer to complete a qualification via traditional routes? This would appear to concur with the views of Anderson and Fejes (2012) who suggest that research on the effects of RPL is still lacking (Miguel et al, 2016). With this in mind, it might also be useful to extend this to investigate quality of learning and service delivery, that is; to compare the depth of learning and understanding between RPL candidates and those completing a qualification in full.

Finally it would be helpful to view RPL from a practitioner's perspective – as an assessor or learning and development lead; asking how is the process managed? How does this impact on the culture of CPD within the workplace? What alternative strategies could be implemented instead?

Conclusion:

Whilst the participants agreed that the notion of RPL is a good one, it is still unclear how this will affect vocational learning. Participants were able to identify a raft of benefits associated with RPL, although again these were mainly work related. Whilst motivation to participate was obvious, several concerns around the process itself were cited. Respondents were able to offer a number of solutions as to how these might be addressed, indicating a need for consultation at “shop floor” level when developing policies and procedures in the future. That said, the policy stimulated interesting debate, suggesting those involved were aware that they now had choices

in terms of how they accessed future development, therefore encouraging more choices and greater opportunities in the workplace.

References/Bibliography

Books:

Anderson. P., Harris. J. (2014) *“Re-Theorising the Recognition of Prior Learning”*,
Leicester, NIACE

Carey. A., Ashbury. J (2012) *“Routledge International Handbook of Qualitative
Nursing Research”*, Oxon, Routledge

Cassell. C., Symon. G. (1994) *“Qualitative Methods in Organisational Research: A
Practical Guide”*, London, SAGE

Cohen. L., Manion. L., Morrison. K., (2011), *“Research Methods in Education”*,
Abingdon, Oxon: Routledge

Collis. J., Hussey. R. (2003) *“Business Research: A Practical Guide for Under
Graduate and Post Graduate Students”*, London: Palgrave Macmillan

Denscombe. M. (2010) *“The Good Study Guide for Small Scale Social Research
Projects”*, London: Open University Press

Drever. E. (2003) *“Using Semi Structured Interviews in Small Scale Research: A
Teacher’s Guide”*, Edinburgh: SCRE

Fejes. A., Andersson. P. (2015) *“Recognition of Prior Learning with Elderly Care
Work”*, cited in *“Working and Learning in Times of Uncertainty: Challenges to Adult,
Professional and Vocational Education”*, pp.145-156

Harris. J., Wihaki. J., Van Kleef. J. (2014) *“Handbook of Recognition of Prior
Learning: Research into Practice”*, Leicester: National Institute for Continuing Adult
Education (NIACE)

Hughes. C., (2014), *"Introduction to Research Methodologies"*, University of Warwick

Available: <https://warwick.ac.uk/fac/soc/ier/glacier/tlrp/> Accessed:06.03.2018

Kotter. J. (2012), *"Leading Change"*, Brighton: Harvard Business Review Press

Mc'Neil. P., Chapman. S. (2005) *"Research Methods"*, 3rd edn, Oxon: Abingdon

Open University (2001) *"Research Methods in Education Handbook"*, Milton Keynes,
Open University

Thomas. G. (2013) *"How to do Your Research Project: A guide for students in education and applied social sciences"*, 2nd edn, London: Sage Publications Ltd

Journals:

Bjornavold. J. (2000) *"Making Learning Visible: Identification of Assessment and Recognition of Non-Formal Learning in Europe"*, European Journal, Vol. 22, pp. 24-32

Drew. H., (2014) *"Overcoming Barriers: Qualitative Interviews with German Elites"*, Electronic Journal of Business Education, Vol. 12, Issue 2, pp.77-86

Follinsbee. S. (2008) *"Prior Learning, Assessment and Recognition: Options for the Workplace and the Workforce – A Literature Review"*, Workplace Prior Learning Assessment and Recognition Committee, London: Tri-En Communications

Fossage. J.L., (2011), *"How Do We Know What We Know? And Change What We Know?"* Psychoanalytic Dialogues: The International Journal of Relational Perspectives, Vol. 21, Issue 1, pp. 55-74

Garrett. J., Cavaye. A. (2015) *"Recognition of Prior Learning: Opportunities and Challenges for Higher Education"*, Journal of Work: Applied Management Vol 7. No.1

Jones. M., Martin. J. (1997) *"A New Paradigm for Recognition of Prior Learning"*, UHWA Research (accessed online: 13.04.2018)

Miguel. M.C., Ornelas. J.H., Maroco. J.P., (2016) *"Recognition of Prior Learning: the participant's perspective"*, Studies in Continuing Education, 2016, Vol.38, No. 2, pp. 179-194

O'Dowd. M. (2005), *"Learning from childhood to mature adulthood: what makes people want to "learn to learn", and keep on learning?"* Compare, 2005, Vol. 35, No. 3, pp 321-338

Pearson. J. (2013) "*Health Care Assistants: Developing Skills in Reflective Writing*", British Journal of Health Care Assistants, published online:

<https://www.magonlinelibrary.com/doi/abs/10.12968/bjha.2015.9.10.479>

Petrescu. C., (2013), "Inclusive Education", Euromentor Journal, Vol. 4(2), pp.140-152

Shalem. Y., Steinberg. C., (2002) "*Portfolio Based Assessment of Prior Learning: A Cat and Mouse Chase After Invisible Criteria*", Pedagogy, Culture and Society, Vol. 10, No.3, pp. 425-448

Stonehouse. D. (2015) "Self Awareness and the Support Worker", British Journal of Health Care Assistants, published online:

<https://www.magonlonelibrary.com/doi/abs/10.12968.bjha.2015.9.10.479>

Internet and Grey Sources:

Full Fact, *"How many NHS employees are there?"*

Available: https://fullfact.org/health/how-many-nhs-employees-are-there/?gclid=Cj0KCQjw1-fVBRC3ARIsAlifYOP2mO_ZEU8CG7Cv_FAVbzU0vVQyAdnIORPDNwugX1rvUxV2ZGcS2QwaAhmmEALw_wcB

Accessed: 27.03.2018

The Guardian, (2016) *"Jobs for life are a thing of the past"*

Available: <https://www.theguardian.com/higher-education-network/2016/may/31/jobs-for-life-are-a-thing-of-the-past-bring-on-lifelong-learning>

Accessed: 27.03.2018

The Independent, *"NHS Funding Cuts will lead to 100 Deaths per Day"*,

Available: <https://www.independent.co.uk/life-style/health-and-families/health-news/nhs-funding-cuts-100-deaths-per-day-public-spending-squeeze-british-medical-journal-a8058101.html> Accessed: 27.03.2018

The Kings Fund, (2017), *"Is the NHS being privatised?"*

Available: <https://www.kingsfund.org.uk/publications/articles/big-election-questions-nhs-privatised> Accessed: 01.05.2018

NHS Employers, *"A Simplified KSF"*

Available: <http://www.nhsemployers.org/SimplifiedKSF>

Accessed: 06.03.2018

NHS Employers, *"Preparing for Appraisal"*

Available: <http://www.nhsemployers.org/your-workforce/retain-and-improve/managing-your-workforce/appraisals/preparing-for-appraisal>

Accessed: 01.05.2018

NHS Wales, *"Health in Wales: Structure"*

Available: <http://www.wales.nhs.uk/nhswalesaboutus/structure> Accessed: 27.03.2018

NHS England, (2017) *"NHS Five Year Forward View"*,

Available: <https://www.england.nhs.uk/five-year-forward-view//next-steps-on-the-nhs-five-year-forward-view/> Accessed: 01.05.2018

Open University, *"Widening Participation"*,

Available: <http://www.open.ac.uk/about/wideningparticipation/> Accessed: 27.11.2017

Royal College of Midwives, (2016) *"Worrying NHS Training and Education Cuts"*

Available: <https://www.rcm.org.uk/news-views-and-analysis/news/%E2%80%98worrying%E2%80%99-nhs-training-and-education-cuts>
Accessed: 08.05.2018

Royal College of Nurses, *"Professional Development"*,

Available: <https://www.rcn.org.uk/professional-development> Accessed: 21.11.2017

Unionlearn, *"Barriers to Learning"*, Available:

<https://www.unionlearn.org.uk/common-barriers-learning> Accessed: 07.03.2018

UNISON, *"Retirement and the State Pension"*,

Available: <https://www.unison.org.uk/get-help/knowledge/pensions/retirement/>

Accessed: 27.03.2018

UK Association for Accessible Formats, (2012), *"The Provision of Accessible Format Materials for Print-Disabled People"*. Available: <https://www.ukaaf.org/.../G002-UKAAF-The-provision-of-accessible-format-materials>

Accessed: 03.05.2018

UNISON, “*Union Learning Reps (ULRs)*”, Available:
<https://learning.unison.org.uk/branch-education-team/ulrs/> Accessed: 26.03.2018

Wales Online, (2015) “*Health Care Support Workers to be given mandatory career frameworks to strengthen their on the job development*”

Available: <https://www.walesonline.co.uk/news/health/healthcare-support-workers-given-mandatory-10393357> Accessed: 06.03.2018

Welsh Government, (2015) “*Written Statement – NHS Wales Skills and Career Development Framework for Health Care Support Workers*”

Available: <https://gov.wales/about/cabinet/cabinetstatements/previous-administration/2015/nhsskillsandcareerdev/?lang=en> Accessed: 28.10.2017

Welsh Government, “*Wales Union Learning Fund*”,

Available: <https://businesswales.gov.wales/skillsgateway/wales-union-learning-fund-wulf> Accessed: 21.11.2017

Other Sources: Reports, Policies, Guidance Documents, Toolkits:

British Educational Research Association (BERA), (2011), *“Ethical Guidelines for Educational Research”*

Care Council for Wales, (2015), *“Best Practice Guidance for Learning and Assessment in Social Care, the Care of Children and Young People and Early Years in Wales”*

City and Guilds, (2013), *“Recognition of Prior Learning: Assessment Policy and Guidance Document”*

Credit and Qualifications Framework for Wales, (2018), *“CQFW Case Study: NHS Wales – Recognition of Prior Learning Framework and Toolkit”*

Liverpool Womens’ Foundation Trust, (2006), *“Recruitment and Selection Policy, Procedure and Guidance”*

National Assembly for Wales, (2015), *“The Organisation of the NHS in the UK: comparing structures in the four countries”*

NHS Digital, (2017), *“Fit for 2020: Report from the NHS Digital Capability Review”*

NHS Employers, (2017), *“Agenda for Change pay bands and spine points from April 1st, 2017”*

NHS Wales (2011), *“Code of Conduct for Health Care Support Workers in Wales”*

NHS Wales, (2015), *“Developing Excellence in Health Care: A NHS Framework for Health Care Support Workers Supporting Nursing and Allied Health Care Professionals”*

NHS Wales, (2017), *“Recognition of Prior Learning Framework”*

National Institute of Continuing Adult Education (NIACE), (2013), *“Using Recognition of Prior Learning within the Qualifications Credit Framework: A Report to the Skills Funding Agency”*

New South Wales Department of Education and Communities and the Commonwealth Government, (2015), *“Assessor Guide to Recognition of Prior Learning”*

Open University, (2014), *“Recognition of Prior Learning Policy”*

Pearson Education Limited, (2015), *“Recognition of Prior Learning Policy and Process”*

Powys Teaching Local Health Board, (2014), *“Recognition of Prior Learning Policy”*

Qualifications Framework UK, (2012), *“Recognition of Prior Learning and How Sectors are using it in the UK and Europe”*

Scottish Credit and Qualifications Framework, (2007), *“Recognition of Prior Informal Learning (RPL) Profiling Tool”*

Scottish Qualifications Authority (SQA), (2017), *“Guide to Assessment”*

Smith. L., (2004) *“Valuing Recognition of Prior Learning: Selected case studies of Australian private providers of training”*, Adelaide: NCVER

University of Technology (2017), *“Swinburne University of Technology: Recognition of Prior Learning Toolkit”*

Research Project Time Table: Karen Fisher (MA PDET) – Appendix A

Task Name	Start	End	Duration (days)	
Submit Research Proposal	16/08/2017	25/08/2017	9	Y
Carry Out Literature Review	16/08/2017	15/09/2017	30	Y
Develop Pilot Questionnaire to support Semi Structured Interviews	22/09/2017	29/09/2017	7	Y
Tutorial	29/09/2017	29/09/2017	0	N
Review Data from Pilot & Make Any adjustments to Interview Questionnaire	13/10/2017	20/10/2017	7	Y
Conduct Semi Structured interviews	20/10/2017	27/10/2017	7	Y
Tutorial	03/11/2017	03/11/2017	0	N 11.12.2017
Complete data collection & analysis	17/11/2017	24/11/2017	7	
Tutorial	24/11/2017	24/11/2017	0	
Formulate Focus Group topics informed by data analysis	01/12/2017	08/12/2017	7	
Organise Focus Group	09/01/2018	20/01/2018	11	
Transcribe data and findings	20/01/2018	02/02/2018	13	
Tutorial	02/02/2018	02/02/2018	0	
Begin 1st Draft	09/02/2018	02/03/2018	21	



Participant Identification Number:

PROJECT TITLE: **The relevance of experience in Accredited Learning: An investigation into the motivation and skills of NHS staff in accessing RPEL**

Dear Participant:

My name is **Karen Fisher**. I will have met many of you in my role as WULF Project Manager on behalf of UNISON's Connecting Learners Project. I am studying in the **School/Faculty of Education at the University of Wales, Trinity St David** and would like to invite you to participate in my research project.

Invitation *You are being invited to take part in a research study. Before you decide whether or not to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully.*

What is the purpose of the study?

A number of continuous professional development initiatives have been implemented (or are due to be implemented) in the NHS Wales over the last few years. For example: Nurse Revalidation, and the Clinical Health Care Support Workers Framework: Developing Excellence in Healthcare. To support such initiatives, NHS Wales has developed a policy designed to recognise and acknowledge previous workplace experience and learning you have taken part in. (*NHS Wales Recognition of Prior Learning RPL Framework*). This aims to help staff achieve the obligations outlined in the professional frameworks – without the need to repeat unnecessary learning.

As a student, I am interested in finding out whether staff will take advantage of the new framework and why (or why not?)

The study will be organised in two parts:

1. A short one to one interview (either face to face or via Skype)
2. Participation in a focus group discussion

Why have I been invited to participate?

You have been chosen as a UNISON member and also as a member of staff employed by the NHS. The aim is to encourage people representing “qualified” and “unqualified” staff groups.

Qualified (examples)	Unqualified (example)
Nurses Occupational Therapists Physiotherapists Pharmacists Pathology	Clinical Health Care Support Workers Porters Cleaning staff Catering assistants Laundry Assistants Transport staff

Do I have to take part?

You may decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason.

What will happen to me if I take part?

The study will be split into two parts. The first part will involve a short interview which can take place in person or via Skype. (Please let the researcher know your preference in advance). The researcher is willing to travel to a location convenient to you.

The interview should take no longer than 45 minutes. The researcher will ask a series of questions which will be audio recorded. There are no right or wrong answers. The researcher is interested in your opinions and perceptions of the RPEL process. Each participant will be assigned a unique code to avoid using their names in the final document. *(For example: Person A stated...)*

The second part of the study will involve short focus group discussion which will involve other participants who have taken part in the same interviews as you. The focus group will be facilitated by the researcher and aims to elaborate on the information collected in the original interview. By signing the consent form, you choose to agree (or not) to an audio recording taking place. The researcher has opted for this approach to ensure your responses are recorded accurately. All data will be completely anonymised. The focus group will take no longer than one hour and thirty minutes.

What are the possible benefits of taking part?

There is an opportunity for participants to share their learning and development experiences and their general views. This resulting data may highlight ideas for improving practices within the NHS and UNISON. This may result in providing better learning and development opportunities for the workforce.

Will what I say in this study be kept confidential?

All information collected about you as the participant will be kept strictly confidential *(subject to legal limitations – i.e. if the participant divulges something illegal, safeguarding breaches etc)*

Confidentiality, privacy and anonymity will be ensured in the collection, storage and publication of research material. Data generated by the study must be retained in accordance with the University's policy on Academic Integrity. The data generated in the course of the research will be kept securely in paper or electronic form for a period of one year after the completion of a research project.

What should I do if I want to take part?

Read through this information sheet. Sign the consent form and return to the researcher.

Please note: You have the right to withdraw at any time before, during or after the study.

What will happen to the results of the research study?

The data collected from the interviews and focus group will be analysed and written up for the researcher's dissertation assessment.

However, UNISON the public service union, may have an interest in the overall findings and may wish to publish the final dissertation (continuing to respect anonymity and confidentiality described. You will not be named or identified as the participant).

Who is organising and funding the research?

The researcher, Karen Fisher is conducting the research as a student of the University of Wales Trinity St David (UWTSD). She has invested in her personal development by funding by Masters degree and the research herself.

Who has reviewed the study?

The research has been approved by the University Research Ethics Committee, University of Wales Trinity St David.

Contact for Further Information

Researcher: - Karen Fisher. Project Manager: UNISON's Connecting Learners in South West & Central Wales

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University Supervisor: - Mark Flagg. Email: - mark.flagg@uwtsd.ac.uk

If you have any concerns about the way in which the study has been conducted, they should contact the Chair of the University Research Ethics Committee.

Thank you for taking time to read the information sheet. Date 09.11.2017

Interview Questions **Participant ID:** **– Date:-**

General Information

1. What is your current job title?
2. How long have you worked your current role?
3. Have you worked anywhere else in the NHS?
If “yes”: What did you do? How long did you work in that post?

Education Experience

4. The researcher will show you a table outlining different levels of qualifications. What is your highest level of qualification?
5. When did you last attend a training course in work?
6. Why did you attend?
7. What was the training course or workshop about?
8. Do you like attending training courses?
9. If “Yes”, Why do you like attending training courses?

The researcher did / did not have to ask supplementary questions and no prompts were needed.

Education and the Personal Development Review

10. Do you have Personal Development Review meetings with your line manager?

10a. Do you find this a useful process?

11. Do you have a Personal Development portfolio?

Recognition of Prior Learning (General)

12. Do you know what Recognition of Prior Learning means?

13. The researcher will give a working definition of what she believes RPL means. How do you think this will help you with your personal development?

RPL Skills

14. To achieve RPL, you will be asked to submit a “portfolio of evidence” to outline your previous experience. Based on previous questions, how do you feel about this?

15. One element of RPL revolves around “reflective practice”. What does this mean to you?

16. Generally speaking, the RPL process seeks to eliminate duplication of study – recognising prior learning and work experience. Taking into account what we have discussed, does this make you feel:

- Much motivated to apply for RPL
- Slightly motivated
- Neutral / Don't Know
- Slightly less motivated
- Much less motivated

17. What makes you feel like this?

This section will be removed from the raw data storage to ensure anonymity in the final report.

Declaration:

I confirm this is an accurate summary of our conversation.

Signed:

Date:

Karen Fisher: MA PDET – Appendix D: Focus Group Questions

1. The new NHS Recognition of Prior Learning Framework will be supported by a comprehensive tool kit. You will have received a copy of the interactive pdf document.

Try to access any of the “clickable links” (menu options) through:

- Your Internal (Work) system
- Using the facilitators laptop
- Using a mobile device of your choice

Try this again, this time aiming to access one of the embedded documents (resources)

What happens? How do you feel about this?

2. The Facilitator will show you the flowchart which outlines the RPL process (page 8)

Looking at the Flowchart, who do you think are the major stakeholders?

How do you think each of these will affect your motivation to apply for RPL?

3. The RPL Toolkit advises how to prepare evidence of prior learning (Pages 14 – 17)

The facilitators research project looks at the “Skills and Motivation” of individuals accessing RPL.

How confident are you of your own skills to prepare the evidence suggested by the Toolkit?

What sort of support (if any) might you need to do this?

How could the support be organised (format)?

4. RPL seeks to acknowledge prior learning and experience. Generally speaking, what are the Strengths, Weaknesses, Opportunities and Threats of introducing RPL to staff working in the NHS?

5. Evaluation of Focus Group

How would you describe your experience today?

What went well?

What could be improved?

Glossary of Terminology, Abbreviations and Acronyms

A4C	Agenda for Change
APEL	Accreditation of Prior Experiential Learning
CPD	Continuous Professional Development
EV	External Verifier
HCSW	Health Care Support Worker
IV	Internal Verifier
KSF	Knowledge and Skills Framework
NVQ	National Vocational Qualification
QCF	Qualifications and Credit Framework
PADR	Personal Annual Development Review
PDET	Professional Development, Education and Training
PDP	Personal Development Portfolio
RPL	Recognition of Prior Learning
RPEL	Recognition of Prior Experiential Learning
ULR	Union Learning Representative
WULF	Wales Union Learning Fund