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Susan Elizabeth Parker

BSc (Open)

MA (Ed) Lifelong Learning

Thesis Title:

***Golden Goose or White Elephant?
Exploring Lifelong Learning through the Professional Group of
Operating Department Practitioners***

Degree of Doctorate in Education

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CONTENTS

	<i>Abstract</i>	3
	<i>Acknowledgments</i>	5
Chapter One	Introduction	6
Chapter Two	The Operating Department Practitioner	18
Chapter Three	Operating Department Practitioners as a Community of Practice	41
Chapter Four	Lifelong Learning and Continuous Professional Development	56
Chapter Five	Learning and Organisations	78
Chapter Six	Continuous Professional Development and the Operating Department Practitioner	92
Chapter Seven	Research Design	104
Chapter Eight	Ethical Considerations	115
Chapter Nine	Data Presentation and Findings	139
Chapter Ten	Discussion of Findings	189
Chapter Eleven	Conclusion, Research Critique and Recommendations for Practice	209
	References	221
<i>Appendices</i>		
<i>Appendix One</i>	<i>Questions for online survey</i>	237
<i>Appendix Two</i>	<i>Covering email letter for survey participants</i>	240
<i>Appendix Three</i>	<i>Training Supervisor interview questions</i>	241

1 Student details

Your full name: Miss Susan Elizabeth Parker

Personal identifier (PI): R8685585

Affiliated Research Centre (ARC) (if applicable):

Department:

Thesis title: Golden Goose or White Elephant? Exploring Lifelong Learning through the professional group of Operating Department Practitioners.

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General findings indicated practitioners were engaging in a variety of learning as advocated by their regulatory body, and thus meeting their professional and organisational responsibilities. Further investigation presents a tale of contrasts: from the positive experiences of learning which are driven by a commitment to delivering high standards of patient care, to the negative experiences with regards to participation and provision. Participation was hampered by a range of structural and organisational barriers, some of which were identified as being unique to this group. Providing a 'snap-shot' of learning within the NHS at a time of challenge and financial constraints the research questions the underpinning philosophy of lifelong learning policy in promoting inclusivity and prosperity and exposes deficiencies within organisational policy.

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CHAPTER ONE

INTRODUCTION

Operating Department Practitioners (ODPs) are a small, but increasingly emergent, group of healthcare professionals whose specialised knowledge and clinical skills are considered essential to the NHS workforce modernisation (DH 2003). In comparison to the more recognised healthcare roles of Nursing and Medicine, little research has been undertaken with respect to this professional group. The significance of this research is such that it offers a unique and valuable insight into this professional group and thus provides, in the first instance, opportunity to generate profession-specific knowledge with particular emphasis around their experiences within the lifelong learning field.

The foundations for the research originated through observation of the impact of a series of rapid and successive changes to this healthcare group. The outcome of the changes was a move to an academic-level qualification which pre-empted the attainment of professional regulation with the Health and Care Professions Council (HCPC). A requirement of professional registration and regulation is the necessity to engage in mandatory continuous professional development to ensure competency to practice. Operating Department Practitioners are currently one of the few remaining professional healthcare groups not to have attained graduate status which places them at odds with the commonly held view of a professional occupation (Ellis 1998; Jarvis 2004). Yet they are still expected to engage fully in the culture of responsibility, accountability and continuous professional development as deemed necessary by their regulatory body. Prior to the introduction of CPD as a pre-

requisite of professional responsibility many ODPs may not have been actively engaged in learning activities beyond the requirements of their immediate roles and responsibilities.

As a Senior Practitioner working within clinical practice, as well as being responsible for training and development, I experienced first-hand the changes to the profession as well as the impact of the changes within my own clinical area. Of particular interest was the first re-registration process where a randomly selected number of ODP registrants were required to submit a personal profile outlining their engagement in a range of learning activities. Observation of the renewal process from within my own practice area, where three colleagues were selected for profile submission, indicated wide variations in attitude and understanding of the professional requirements for CPD as well as diversity in quality and quantity of learning activities undertaken. Reflection on this initial registration process and experience of similar issues which arose during subsequent registration renewal periods provided the catalyst for the research which explores the relationship of the Operating Department Practitioner to their responsibility to engage in continuous professional development.

The multi-dimensional nature of continuous professional development leads the research to take a three-fold approach. Firstly, it focuses on determining the range of learning activities Operating Department Practitioners are engaging in and importantly explores the reasons or motivation for the particular learning being selected and undertaken. Secondly, the relationship of professional to continuous professional development is inherent, thus the research provides opportunity to examine the nature of this relationship and how the ODP is endeavouring to meet

their professional responsibilities. And thirdly, as Ellis and Nolan (2005) point out the nature of training and development, particularly within such a widely diverse organisation as the NHS, is extremely complex and its multi-dimensional character are rarely acknowledged.

Research context

It has long been recognised that initial training and qualification is insufficient to meet the needs and expectations of a changing society (Roscoe 2002). Rapid global and social changes have altered the once comfortable frameworks within which individuals worked, measured and understood the world. A changing society and changing business conditions means that there is no longer the security of a job for life; individuals are expected to take on added responsibility; become multi-skilled; plan their own careers and engage in lifelong learning opportunities. As Barnett (1999) succinctly pointed out ‘the world is changing’ and ‘we now live in world of *supercomplexity*’ where knowledge has a limited shelf-life and initial qualifications are considered inadequate to meet the demands of changing workplace practices (Barnett 1999 p.7). Watkins’ et al (1992) furthermore estimates that the lifespan of the knowledge obtained through vocational degrees is approximately four years. Knowledge, once held as accurate and constant, may now no longer be considered as such having been modified, transformed or replaced in response to rapid external development. As Longworth succinctly pointed out:

New knowledge, new procedures, new processes and new environments will enforce new thinking, new actions and new ideas. A professional person who does not understand and implement the need for continuous improvement in a lifelong learning world is not just standing still. He / she is falling behind (Longworth 2003 p.130).

The relevance of lifelong learning and its consort, continuous professional development, cannot be underestimated. Both are multi-faceted concepts which fulfil a number of obligations for the individual, organisation and wider society. Not least in keeping knowledge and skills current and helping meet the challenges which are becoming more apparent both within the immediate workplace as well wider social and environmental contexts. They are especially pertinent within a dynamically changing healthcare environment and one which has recently undergone major re-organisation as well as being subject to increased public scrutiny.

Tight (1998) viewed lifelong learning as a *trinity*: recognising that individual learning, the learning organisation and learning society are essential conditions for each other's survival. The relationship of these central characters is portrayed as synergistic, where each part contributes and mutually benefits from the association and one which reflects the ideal or utopian model of a lifelong learning framework. But in reality this relationship is far from balanced: displaying hierarchical and frequently unyielding tendencies. Within a healthcare context an additional element can be included – that of the professional regulatory body which not only adds another dimension but contributes to further disruption of the balance alluded to by Tight. As important stakeholders in the lifelong learning framework the organisation, professional body and practitioner each holds their own perceptions and expectations of the benefits and value and of learning. The organisation and professional body are, however, key stakeholders being both influential and instrumental in mapping the direction of learning, with the practitioner having to respect their guidance.

Within the literature the benefits and motivation of engaging in learning opportunities are widely acknowledged and serve to fulfil multiple purposes. As well as contributing to personal and professional development (Murphy et al 2006; Davey and Robinson 2002), learning is deemed 'essential to the future quality of the health service' (DH 2008 p.7). The regulatory bodies for registered healthcare practitioners emphasise the importance of maintaining knowledge and skills in order to deliver safe practice for clients and service users (HCPC 2008). From a wider perspective lifelong learning has alleged associated individual benefits such as increased employment opportunities and promotion which contributes to increased social mobility, stimulate economic growth and develop personal well-being (Longworth 2003).

For the healthcare practitioner, continuous professional development is a well-established principle, whose framework guides their on-going education and development (DH 2008), and one which enables practitioners to meet the challenges brought about by changes to their working environment. The relationship between professional and continuous professional development is innate according to extensive and on-going research undertaken by Friedman et al (2008 p.7) who state that 'doing CPD is part of what defines [us] as professionals'. CPD thus forms an integral part of the practitioner's identity being widely recognised as one of the defining characteristics of a professional. It further serves to demonstrate practitioner's ongoing competence and fitness to practice amidst an increasingly litigious society.

Operating Department Practitioners attained professional status in 2004, being regulated by the Health and Care Professions Council (HCPC). The subsequent introduction of a sanctions model of continuous professional development (Madden

and Mitchell 1993) on behalf of the regulatory body in July 2006 has brought the concepts and practices of lifelong learning to the forefront of their practice. The HCPC employs a sanctions model (Madden and Mitchell 1993) for monitoring practitioners' learning activities, which are measured against set standards (HCPC 2008). Evidence of practitioners' CPD is required from practitioners on a two-yearly cycle of re-registration. Failure to submit sufficient evidence of continuous professional development activities can result in suspension or removal from the register. The rationale for the introduction of mandatory CPD was founded on the basis that it formed an essential dimension of professional self-regulation, and one which linked with the primary function in protecting the health and wellbeing of the public (HCPC 2005). The importance and responsibility of engaging in career-long, self-directed learning as a mechanism of maintaining competence and fitness to practice is clearly stated within their Standards of Proficiency (HCPC 2008).

Although the onus is on the individual to meet their professional responsibilities, it is also important for the organisation to have a workforce whose knowledge and skills are current in order to deliver an effective and efficient service. As the largest employing organisation in the United Kingdom (UK), with approximately 1.3million employees, the National Health Service requires a highly-skilled, well trained and increasingly flexible workforce to meet the challenges of a changing health service (DH 2012). Lifelong learning is considered pivotal to attaining sustainability, efficiency and adaptability for the organisation which reflects in part the intentions portrayed by Longworth above. Although education is not its primary function, a profusion of policies serves to promote the value and importance of learning in all its forms makes in delivering its quality agenda, enhancing patient care and helping achieve local and national organisational strategic objectives. The NHS Constitution

(DH 2010) highlights its commitment in providing staff with personal development opportunities in order to undertake their roles.

The majority of organisations have learning strategies and policies in place to support their employees in achieving both their professional obligations as well as meeting wider organisational and corporate educational targets. However, as Draper and Clarke (2007) indicate there are a number of structural, organisational and cultural barriers to learning which can obstruct the individual in achieving their goals. Their research, which examined the experiences of CPD within nursing, further raised questions regarding the effectiveness of these organisational policies and learning strategies.

As a healthcare profession, ODPs are in direct competition with the more dominant groups of Nursing and Midwifery in terms of funding, support and access to learning opportunities. In addition they could be further disadvantaged due their small number in comparison to the aforementioned groups. Data supplied by the HCPC indicates the number of registered ODPs stood at 11,786 in November 2013 (HCPC 2013) when compared to nursing numbers which were 369,868 in 2012 (NHS Confederation 2012). With reference to their specialist skills ODPs are acknowledged as being on the shortage occupation list (Home Office 2011).

One particular barrier to effective engagement in learning which could be seen as detrimental specifically to ODPs is their lack of identity in relation to the wider healthcare community. A review (O'Dowd 2012) highlighted the growing confusion as to whether ODPs should be classified as Allied Health Professionals and represented by the Allied Health Professions Federation. According to the Department of Health they do not include ODPs under the AHP umbrella but NHS

Careers lists them as AHPs. Some Trusts see them as AHPs, as do some ODPs themselves, but the Allied Health Professions Federation does not include them under their remit. Some Trusts place them under the Nursing and Midwifery umbrella in terms of management which includes support for training and development. The NHS records Operating Department Practitioners under the general remit of operating theatre staff, alongside Nurses and other related technical staff (Home Office 2011). This lack of identity could be seen as a major disadvantage with regards to accessing learning within their own organisations as well as for the organisations in terms of future workforce commissioning, a problem which O'Dowd presented in his review stating; 'A lack of clarity over ODPs' position in the workforce also makes it difficult to commission continuing professional development' (O'Dowd 2012 p.3). In clarifying this potential problem he further states that:

If funding comes into a trust for an AHP training and development budget... and ODPs try to access this, the fact that a person is not officially classified as an AHP may possibly lead to [them] not being allocated funding for training (O'Dowd 2012 p.3).

As a learning organisation the NHS recognises the inter-relationship of Tight's *trinity* through displaying commitment in supporting lifelong learning and recognising investment in human capital as essential to 'delivering the government's vision of patient-centred care in the NHS' (DH 1998 p.42). Yet their education and learning policies are determined by organisational objectives, local service level requirements and wider health service initiatives which dictate the parameters and expectations of individual learning.

More recently the NHS and its policies and practices have been subject to increased scrutiny which has highlighted a series of fundamental failings in delivery of patient

care with organisational strategies and training issues implicated (Francis Report 2013). These failings have raised concerns relating to its ability to deliver its quality agenda and maintain a competitive and current workforce. In a bid to reform a tired, overstretched and increasingly costly NHS, the Government's Health and Social Care Act (DH 2012) saw the devolvement of the Strategic Health Authorities, and subsequent emphasis on a service-provider approach to commissioning led by GP consortia (DH 2010 section 4.13). The Act set out the Government's continuing commitment to supporting education and training, the driving principle of which focuses on having a high quality workforce comprising the right professional with the right clinical skills (DH 2012). It further proposed increased involvement of organisations in planning education and training recognising the various levels of patient contact of different groups as well as varying local service needs. As a method of ensuring accountability an Education Outcomes Framework monitored the new national body - Health Education England - which has the responsibility for supporting Local Education and Training Boards in promoting high quality education and training (DH 2012).

The proposed partnership between employers and professional groups aimed towards 'greater autonomy and accountability for planning and developing the workforce ... [and] ownership of the quality of education and training' (DH 2010 section 4.32) has the potential to create tension. Employers, in planning a responsive workforce may hold differing perceptions, expectations and requirements in terms of both initial qualification and continuing learning needs to those of the professional groups. Funding streams for supporting continuing professional development activities may experience significant reduction and re-direction according to service requirements deemed more 'deserving' by the proposed local commissioning

consortia. This re-organisation serves to compound the already existing issues being experienced within the NHS where workforce restructuring has resulted in a reduction of frontline staff but an increase in service workload.

It is amidst this climate of change for both the profession, the professional and the NHS that this research takes place and which raises a number of key issues central to the study. With the advent of professional regulation and the necessity to engage in continuous professional development, how have ODPs endeavoured to fulfil their professional responsibilities? What are their views on continuous professional development? What is the relationship of their learning to professional responsibility? From an organisational perspective what provision and support for learning is available as service needs are increasing and financial support is decreasing.

In order to investigate the phenomenon of lifelong learning within this professional group a mixed-methods research approach was deemed appropriate. This particular methodology, which aligns itself with a pragmatic paradigm, has as its core principle a practical *what works* approach in addressing everyday human problems and experiences (Taskakori and Teddlie 2010). As an integration of traditional philosophical assumptions, pragmatism draws on many ideas and diverse approaches, valuing both objective and subjective knowledge thus offering multiple viewpoints, perspectives and standpoints of knowledge, truth and reality according to Johnson et al (2007). Acknowledging that different Operating Department Practitioners have differing expectations and experiences of continuous professional development was an important consideration and one which prompted the adoption of this particular research design. A sequential explanatory design (Creswell 2009) was used to explore the phenomenon. This particular research methodology

employed the collection of quantitative data in the first phase in order to obtain a breadth of practitioner experiences of continuous professional development.

Questions for the second phase of data collection - a series of semi-structured interviews – were derived from analysis of the quantitative data of areas which warranted further depth of explanation.

Due to the complex nature of continuous professional development and its relationship to professional practice and identity two sets of research questions have been devised. Both sets of questions respect mixed methods traditions of combining quantitative and qualitative perspectives in order to address the overall intent of the investigation:

Question 1

What are the experiences of continuous professional development within this group of Operating Department Practitioners?

- a. What forms of continuous professional development is this professional group undertaking?*
- b. What factors motivate the practitioner to engage in their particular learning activities?*
- c. How are intentional learning activities identified and provided for? And what factors influence provision and participation?*
- d. What factors affect provision and participation of learning activities for this group?*
- e. What are the benefits of continuous professional development, and who are the beneficiaries of learning?*

Question 2

What is the nature of the relationship of continuous professional development to the professional? And how does the learning undertaken meet professional responsibilities?

The conceptual framework for this research study is fairly broad and comprises a six key dimensions including the theory and practice of lifelong learning; professionalism and continuous professional development; organisational learning as pertaining to the NHS and Lave and Wenger's seminal theory of 'communities of practice' as applied to Operating Department Practitioners. Due to the lack of ODP-specific literature these themes will therefore be drawn upon from across other healthcare professions and in particular nursing. Lifelong learning strategies from across a wide range of disciplines including healthcare and education provide means of comparing and contrasting the rhetoric and reality of policy. Due to the uniqueness of this healthcare group the thesis commences with a presentation of the historical, educational and professional development of the Operating Department Practitioner. This serves to provide background and context to the research study, and from which the research issues and questions are derived.

CHAPTER TWO

THE OPERATING DEPARTMENT PRACTITIONER

From *beadles* to *box carriers* and technicians to assistants, a historical review of the origins of the Operating Department Practitioner indicates a long and established association with operating theatres and surgical practice (Kilvington 1998). These early ‘surgical assistants’ whose main duties included carrying the surgeon’s instruments and restraining patients during their operative procedures, received very little formal training until 1947 with the inception of Theatre Technicians. Further examination of the emergence of this relatively new group of healthcare practitioners furthermore saw a succession of changes in titles, qualifications, roles and responsibilities culminating in the recent and more familiar title of Operating Department Practitioners. Analysis of these successive changes within the profession indicates a mirroring of governments’ own political and educational strategies.

Prior to the inception and organisation of Theatre Technicians no evidence of any formal training structure appeared to have existed for this group of staff. Instead they had to rely on training delivered in-house and which was dependent on the requirements of the local hospital. Under the governance of The Institute of Theatre Technicians, training became more formalised although it continued to differ between hospitals. The roles and responsibilities of these technicians also differed, although they were predominantly associated with the technical aspects of theatre practice in preparing equipment rather than administering patient care. In response to a report into the Staffing and Organisation of Operating Theatres (Lewin 1970), which highlighted a shortage in recruitment and retention of Theatre Nurses, the government ‘created’ a new grade of healthcare practitioner – Operating Department

Assistant (ODA). Recognising and drawing upon the existing training of Theatre Technicians a national training scheme for this new group was introduced - the Hospital Operating Department Assistant Certificate 752, accredited by City and Guilds of London Institute.

Training for this new group of healthcare workers was clinically-based, loosely following an apprenticeship model of training. Trainees, as they were then known, were hospital employees on training contracts and considered part of the theatre team and this promoted ownership and commitment to their training and development. Knowledge, skills and understanding of their role were developed through direct involvement in the practical dimensions of the work environment.

Trainees were taught and assessed by Senior ODAs through a process described by Lave and Wenger as 'observation and imitation' (Lave and Wenger 1999 p.21). This master / apprentice relationship and method of teaching and learning was later criticised by Lave and Wenger who concluded that this model was 'too literal a coupling of work processes and learning processes' (Lave and Wenger 1999 p.22).

In developing their theory of legitimate peripheral participation through research into how apprentices were trained, Lave and Wenger argued that learning is more than 'replicating the performance of others or by acquiring knowledge transmitted in instruction' (Lave and Wenger 1999 p.25). Furthermore the apprenticeship model has been traditionally associated with informal learning predominantly undertaken within the work-place. In relation to ODAs, the 1980s signalled a departure from a practice-oriented, localised and unstructured training, with small, regional, hospital-based training schools providing additional theoretical in-put with trainees attending on a day-release basis. This formalised training curriculum indicated a move away from the traditional views of learning associated with apprenticeships. However,

variances in roles undertaken by ODAs between hospitals were still apparent. Practitioners who trained under the City and Guilds model traditionally took up positions within the anaesthetic remit, echoing the traditional associations with the early Theatre Technician role of assisting the Anaesthetist in preparing equipment. Later incarnations of this training model saw ODAs undertaking the role of a scrub practitioner which had been traditionally the domain of Theatre Nurses. This role expansion or crossing of occupational boundaries (Timmons and Tanner 2004) was attributed to on-going difficulties in recruiting nurses into the highly-specialised area of theatres. Theatre Managers further acknowledged the potential value this staff group could bring in being specifically trained within theatres and deemed them capable of providing a level of service to meet changes in healthcare delivery.

The early 1990s saw a further change to the training with the introduction of a National Vocational Qualification (NVQ) in Operating Department Practice, accredited at level three which, according to the National Qualifications Framework, was labelled as 'technician, advanced craft and supervisory occupations' (Gray et al 2000 p.51). The principle of the NVQ was preparation of individuals for employment. This reflected the government's stance of creating a 'more highly skilled and flexible workforce' (Wolf 2002 p.68) and an attempt to 'tighten the bond between education and the immediate needs of industry' (Lea et al 2003 p.6) in response to a changing economic climate and increasingly competitive global market. Alongside the change in training and education came a subtle change in title from *assistant* to *practitioner*. This arguably reflected the widening roles and responsibilities becoming apparent at both professional and organisational level in response to imminent health service changes. Difficulties in recruitment and retention of theatre staff, particularly nurses, and increasing waiting lists saw more

ODPs being trained and employed to meet increased service needs with many hospitals recognising their potential and flexibility. Subsequently their roles and responsibilities were expanding with practitioners employed across all three areas of peri-operative practice and increasingly outside of the traditional theatre environment to include areas such as sterile services, emergency departments and critical care areas. These changes equally served to reiterate the impending galvanisation towards professionalisation.

The NVQ system worked well producing skilled and competent practitioners who filled the gaps in the workforce. The apprenticeship model of on the job training again proved invaluable, although the focus shifted from hands-on clinical-based training to an award 'based solely on the outcome of assessment' (Jessup 1991 p.18). This outcome-based model with its mechanistic, atomised approach to assessment focussing on product rather than process was heavily criticised (Hyland 1994, Wolf 2002). Vocational qualifications were seen, and still are, regarded as narrowly-focused, both limited and limiting the individual to the 'present and particular' (Bailey 1984 in Lea et al 2003 p.11).

The Government White Paper *A New NHS: Modern and Dependable* (DH 1997) pre-empted further change through acknowledgement of the increasing complexity required in delivering a high quality health service. As the healthcare relationship shifted from a once medically-dominant and profession-centred '*doctor knows best*' approach to a client-centred and patient-focussed service, the government further recognised the imperative for professional self-regulation and closer control over all healthcare professionals.

The professional body for ODP (College of Operating Department Practitioners) also recognised the necessity for statutory regulation ensuring practitioners assumed parity with other Professions Allied to Medicine (PAMs) who possess a minimal qualification of a Diploma in Higher Education for entry into the workforce. The NVQ award did not ensure this same level of equality for a number of reasons: complexity of the role and the level of learning involved did not compare with other NVQ level three awards and newly qualified ODPs are expected to work alongside and swap roles with qualified nurses who hold similar if not higher qualifications (WDC 2001). Furthermore the NVQ award was not recognised within higher educational institutions, being considered of dubious value due to its lack of theoretical and academic rigour and preference towards competence and skills (Wolf 2002). In order to meet professional aspirations and Government stipulation for professional self-regulation the education and training changed in 2002 to a Diploma (HE) in Operating Department Practice and then statutory professional regulation with the Health Professions Council (HPC) followed in 2004.

The Professionalisation of Operating Department Practitioners

The root of the term profession originates from the Latin *professare* which means a declaration of one's beliefs based on knowledge, experience and values. The term *professional* according to Watkins (1999) describes a special group of occupations exhibiting a wide range of activities which should be open to scrutiny, analysis and evaluation to determine their validity (Farrugia 1996). *Professionalism* can be defined as 'commitment to professional ideas... expressed in attitudes, ideas and beliefs' (Freidson 1970 in Matheson and Matheson 2000 p.65).

Whereas each is definable in relative terms they are not as simple to define in absolute terms according to Wilkinson et al (2009). From the literature and multiple definitions the terms professional and professionalism appear to be interchangeable. For an individual to be a professional they are expected to meet certain criteria as determined by their professional body and demonstrate professionalism through internalising certain behaviours, values and attitudes expected by both the profession and the public. Further review of the literature indicates that the terms themselves have evolved. Whilst Eraut identifies professionalism as being traditionally associated with specialist expertise and knowledge, autonomy and service (Eraut 2006 p.223), more recent examinations of the term indicate a move away from technical attributes to focus on values, attitudes and behaviours. These 'newer' characteristics are 'culturally determined' according to Matheson (2000 p.77) and arguably result from a changing culture which exhibits shifting perceptions and expectations of professionals. Therefore in today's society and particularly within healthcare which is under increased scrutiny being a professional comprises both technical and non-technical dimensions.

The Health and Care Professions Council recognise the difficulties being experienced by the newer professions resulting through the changing nature of professionalism:

Professions which are newly 'professionalised' may find it harder to gain this support and recognition that more established ones. The context specific nature of professionalism means that further in this area should address the development of professionalism as a dynamic judgement rather than a discrete set of skills (HCPC 2011 p.4).

Reviewing the Standards of Proficiency for Operating Department Practitioners (HCPC 2014) indicates a focus on the technical and clinical knowledge and skills required as well as encompassing expected behaviours, values and attitudes of the individual.

Investigating the core elements of professionalism from within the medical profession Wilkinson et al (2009) conclude that it is by nature multi-faceted and complex, hampered by varying definitions. Their intention was to define and quantify the key dimensions which constitute professionalism in order to implement them into a measurable assessment tool for doctors. From their literature review they identified five clusters of professionalism which echo both the technical and non-technical components: adherence to ethical practice, effective interactions with patients and their relatives or carers, effective interactions with colleagues and other healthcare individuals, reliability and commitment to improvement of competence in oneself, others and systems (Wilkinson et al 2009 p.551).

A recent study undertaken by the Health and Care Professions Council exploring professionalism across a range of healthcare professions they regulate serves to highlight the change in professional characteristics discussed earlier:

Professionalism is under increasing scrutiny across the health and social care professions, with many of the issues that emerge later in people's careers being linked to a broad range of behaviours distinct from their technical ability (HCPC 2011 p.5).

Their study identified both similar and differing key dimensions of professionalism from those previously cited. The first dimension identifies professionalism as a holistic concept which encompasses a whole rather than a set of discrete characteristics, where respondents referred to '... an overall way of being that comprises a range of attitudes and behaviour' (HCPC 2011 p. 40). The second

category echoes the traditional ideology of technical skills which they termed 'good clinical care', where the ability to demonstrate competence in carrying out their job were important aspects. Associated with this theme was the importance of establishing trust and confidence with their patients and clients. Complementary to this category of good clinical care practitioners highlighted the importance of reflective practice and keeping their knowledge and skills up to date through continuous professional development. 'Expression of self' and a deeply held core belief which defines the individual practitioner's thoughts and actions was the third dimension. Other attributes include enthusiasm towards the job, positive attitude to study, politeness, trustworthiness, honesty and appearance (HCPC 2011).

Despite these definitions and identified characteristics, debate surrounds the actual nature of a profession with Eraut (2006) stating that 'professions are a group of occupations, the boundary of which is ill-defined' (Eraut 2006 p.1). Jarvis (2007) supports this, arguing the term is a 'contested concept' with no agreed typology due to the constantly changing nature of a profession, as well as the apparent differences between traditional professionals and those deemed 'semi-professions'. This is further exacerbated by the rapidly increasing numbers of professions, the shifting nature of their roles and responsibilities (Watkins 1999) and the changing social and cultural perceptions and expectations.

Health-related professions are often referred to as semi-professions, a term first coined by Etzioni (1969) to differentiate them from the elite, traditional and more powerful professions of Medicine and Law (Eraut 2006 p.1). Ellis uses the all-encompassing phrase 'caring' profession as a method of singling out these occupational groups from others. In clarifying this term, Ellis defines *caring* as

'intending to identify a group of professions that have characteristics in common and are distinguishable from others' (Ellis 1998 p.43). Both of the terms *caring* and *semi-professional* allude, perhaps unjustifiably, to the idea that healthcare-related professionals are lesser-professions. The main argument for this division relates primarily to the shortness of training and non-graduate status of healthcare occupational groups (Ellis 1998). In developing his earlier statement regarding training and education of professions, Ellis makes an important observation related to the acquisition and application of knowledge which reaffirms traditional ideological viewpoints attributed to the value of a recognised qualification, incorporating specialist expertise, which still pervades within professions:

The mastery of this material... must be achieved in such a way as to enable the professional to select from and indeed extend knowledge. This will require not just a training but an education. (Ellis1998: p.45).

Although training and education appears to be the dominant differential characteristic separating traditional professions from those designated semi-professions, further reviews indicate that the apparent differences run deeper than this. Jarvis (2007), for example, in defining a semi-profession identifies the following dimensions: a distinct lack of theoretical knowledge base; the non-exclusive possession of skills or special area of competence; less specialisation than traditional professions and a tendency for their control to be governed by non-professionals (Jarvis 2007 p.294).

The observations put forward above are perhaps less than convincing when applied within the context of the Operating Department Practitioner and indicate that the boundaries between the '*true*' professions and those deemed semi-professions are becoming increasingly less well-defined. In addressing the main concern of non-

graduate status, the majority of healthcare professions (Nursing, Radiography, and Physiotherapy) have attained full graduate status, the current exception being Operating Department Practitioners. Yet the credentialism afforded these groups through the move to a higher education qualification, whether diploma or degree, makes a credible argument that healthcare professions including ODP meet the conditions previously laid out by the traditional elite professions (Witz 1992). However, a statement issued from the professional body The College of Operating Department Practitioners has indicated that the Diploma (HE) ODP will be withdrawn from September 2015 and the BSc Operating Department Practice will become the recognised pre-registration award (CODP 2012). The College, in making this statement, have recognised the changing roles and responsibilities become more apparent within the ODP community which reflects wider healthcare change and expectation. To ensure that practitioners remain clinically effective and fit for purpose, as well as acknowledging the constant reviews and re-validation of healthcare programmes CODP made the case for a degree-level curriculum.

Possession of a distinct body of knowledge or theoretical knowledge base through profession-specific education and training are undoubtedly recognised as important aspects of being a professional with knowledge and responsibility being considered synonymous with traditionally held definitions of professionalism (Hoyle and John in Tight 2002). For Larson (1977), the profession's technical knowledge is cited as being the most important persuasive factor in facilitating professionalisation for any group. With regards to Operating Department Practice the possession of a distinct body of knowledge could be questioned. The ODP curriculum comprises 'borrowed' knowledge components from other professions to derive their own uniquely distinguishable and hybridised professional body of knowledge. In terms of

specialist knowledge and skills, ODPs are the only healthcare group to hold a recognised operating theatre qualification, trained within three areas of perioperative practice and more specifically within the anaesthetic remit which is acknowledged as being a significant area of specialist practice requiring a recognised qualification (AAGBI 2010). Education and training, including curricula development, are driven by the College of Operating Department Practitioners whose members are registered ODPs with extensive experience within their field. The professional regulatory body, the HCPC, comprises a panel of profession-specific individuals who provide specialist input and advice.

Additional and equally significant common characteristics are identified by Whittington and Boore (1993), and ones which the *caring* professions also endeavour to aspire to, achieve and maintain: selective recruitment and self-regulation via the establishment, monitoring and validation of education and training; codes of ethics, and participation in a professional subculture sustained by formal professional associations. Three further inter-related and associated characteristics define professionalism: a register of members, robust systems to maintain standards, and continuing professional development. Membership is controlled; admission is established through completion of a recognised and validated programme of education and training. Standards are maintained through the power to discipline and potentially debar members whose standards of practice are deemed unacceptable. Engagement in continuous professional development is a mechanism for maintaining membership and demonstrating fitness to practise.

Professionalisation identifies the social process through which an occupation or trade becomes a profession, and by association the individual becomes a professional:

a process by which an organised occupation... obtains the exclusive right to perform a particular kind of work, control of training for and access to it, and controls the right of determining and evaluating the way the work is performed (Friedman 1973 in Goodlad 1984 p.7).

The process involves establishing acceptable entry qualifications and association with a regulatory or professional body which oversees the conduct of the members. This entails a level of demarcation: a divide between members and non-members, referred to as 'occupational closure' where the profession becomes closed to entry from individuals from the outside. Part of the process entails establishing the standards of conduct and performance of the group to which members are expected to conform and be regulated by. These include exhibiting and adhering to the multiple key dimensions which constitute professionalism which were presented earlier.

Operating Department Practitioners attained professional status in 2004 after meeting one of the pre-requisite conditions of professionalisation, which was the move to an academic qualification albeit a Diploma in Higher Education. In realising professionalisation, the literature examined assumes that becoming a profession, and indeed a professional, is both desirable and beneficial (Scales et al 2011). Yet the process of professionalisation for Operating Department Practitioners was a long, arduous and contested journey. Investigation of this journey both examines and questions the fundamental values and benefits of being a professional.

The boundaries which professions seek to nurture and protect tend to be founded on a hierarchy where each group seeks to establish a privileged position for themselves and in doing so exclude those groups deemed below them through a phenomenon which Weber (in Timmons and Tanner 2004 p.646) refers to as 'social closure'. Simultaneously some professional groups have attempted to expand and crossover those boundaries in order to gain access to the privileges associated with the higher group. This phenomenon is particularly apparent when examining the two dominant groups within the healthcare sector: Nursing and Medicine. Whilst Medicine strives to maintain its privileged status, restructuring and changes within both medical and non-medical professions have created new and overlapping roles which have served to blur the boundaries between these two previously well-defined and closed-off professional groups (DH 2003).

In contrast to the usual professional boundary disputes between Medicine and Nursing which are often investigated, Timmons and Tanner (2004) explored the occupational boundaries between two semi-professional healthcare groups considered of equal standing and undertaking very similar roles within the same environment - Theatre Nurses and Operating Department Practitioners. Their exploration identified three important themes which serve to mark the boundaries between these two professions. Nurses were especially critical of the perceived lack of patient-care delivered by ODPs which appears to elicit through their long-established association with the technical aspects of their role. Associated with this theme was the *doctor-support* role which serves to reiterate the non-care related dimensions of the role particularly their purely technical role in preparing equipment within the anaesthetic remit. The third theme related directly to ODPs who were not considered a 'proper-profession' (Timmons and Tanner 2004 p.654) although

professionalisation had been attained. No mention of the differences in professional qualification was made, however. Of particular interest was one positive comment regarding the new diploma Student ODPs who were viewed as being very knowledgeable, caring and not unlike nurses (Timmons and Tanner 2004 p.660), which could directly be attributable to the professional dimensions underpinning the new academic curriculum.

In his critical examination of the professionalisation of healthcare occupational groups, Timmons (2011) identified a number of reasons or drivers for seeking professional status. Firstly, and importantly, he stated that 'an occupation seeks to become a profession in order to protect its interests, though with a rhetoric of protecting the public' (Timmons 2011 p.339). With this statement it would appear that the profession considers itself to be of greater importance than those it was designed to serve, and one which echoes the closed, elitist, nature of professions identified in the above definition where autonomy, self-regulation and exclusivity are deemed paramount. Timmons further cements this self-interested prospect by adding that the group becomes a profession in order 'to achieve a monopoly in the delivery of its service' (Timmons 2011 p.339). Friedman's (1973) earlier argument that the role of professions is service provision retains a degree of accuracy although the privilege of status once held by elite professions in dictating the terms and conditions of that provision have altered. Similarly the security with which professions controlled access to information to the public is no longer valid (Goodlad 1984). This is particularly evident within healthcare where the relationship between professional and client has changed in favour of a client-centred approach (Eraut 2006) resulting from a growing mistrust in scientific and technical knowledge, and a rejection of the adage 'doctor knows best'. These arguments

appear to be in direct contrast to how the State perceives professionalisation, in that they focus on protecting the public first and foremost, and secondly aim towards reducing the 'exclusive power' held by the professions themselves.

For the professional, the process and product of professionalisation are usually accompanied by benefits or privileges such as increased standing within the healthcare community as well as economic gains such as pay awards. Timmons (2011), taking a sceptical approach to the professionalisation of smaller healthcare groups, explored the process Operating Department Practitioners undertook, and examined the drivers for their application and attainment of professional status. From his evidence professionalisation was initiated and driven by the then professional body – The Association of Operating Department Practitioners. The weakness of this professional group in terms of membership numbers and the increasing need for the government to regulate healthcare workers meant that the process of professionalisation was completed by the State.

Professionalisation was promoted and driven by the Association as having a number of perceived advantages for its members: for example enhancing patient care; assuring comparability with other Allied Health Professionals and particularly nurses with whom they worked alongside undertaking similar roles; increased social and economic status through greater access to lifelong learning; improved career and promotional opportunities and increased pay awards. Timmons' research, however, concluded that 'professionalisation did not live up to... expectations' (Timmons 2011 p.348). Some of the advantages did not achieve fruition due to wider government changes occurring at the same time. The introduction of Agenda for Change (DH 2004a) assimilated and equalised pay bandings and progression across

the majority of healthcare professionals and therefore removed the potential for increased economic reward.

Of further interest, Timmons raised a particularly valid point which questions the meaning of professionalisation itself. Once principally concerned with achieving professional autonomy and independence, the nature of professionalisation appears to be more concerned with regulation from both within the profession as well as increasingly by the state:

For many groups, the state is now so comprehensively dominant in the process of professionalisation that it can effectively dictate professional status on its own terms. Many of the advantages that accrued to professions that developed historically will not be available that professionalise under the new regime (Timmons 2011 p.348).

Timmons further argues that the newer professions, ODP included, are a profession in name only and that regulation is the only defining characteristic. Furlong (1998 in Scales et al 2011 p.28) also displayed concern that the themes which underpin professionalism were being eroded by bureaucracy and an increasing agenda based on meeting targets, control and accountability.

In reviewing the concept of professionalism, Scales et al (2011) focused on the following aspects which reflect the traditional dimensions presented earlier: knowledge, autonomy and responsibility; rights and responsibilities; professional identity. It is these inter-related dimensions which define the role of the professional, guide their practice and shape who the professional becomes. Yet these are questioned and challenged in everyday practice, by organisational policies and procedures and also from within the profession itself. This ultimately leads to conflict between individual practitioner, organisation and profession particularly with respect to continuous professional development and challenges the idea of

Tight's *trinity*. These sentiments are to some extent reflective of Coffield's (2000) argument whereby, in his opinion, lifelong learning is deemed a form of social control and one which is becoming increasingly apparent within the healthcare sector. Attainment of professional regulation confers responsibility and accountability on practitioners to maintain knowledge, skills and competence ensuring *fitness to practise* under the terms and conditions determined by the professional regulatory body. This is realised through participation in a sanctions model of continuous professional development which facilitates the re-registration process. Failure to comply with the regulatory framework for re-registration can result in the practitioner being held accountable for their actions and non-actions with subsequent suspension or removal from the register (HPC 2008).

The Academicisation of ODP

The current description of an Operating Department Practitioner indicates a move from the purely technical dimensions to a holist practitioner who 'fulfils a highly-skilled, specialist role as a member of the multi-disciplinary team... where they are involved in the delivery and evaluation of perioperative care' (CODP 2010 p.2).

Undertaking this specific level of clinical practice requires acquisition and application of knowledge across a range of healthcare, academic and speciality-specific disciplines, combined with the development of a complex range of clinical skills within the three phases of peri-operative practice: anaesthetics, surgery and recovery (CODP 2010). The introduction of the Diploma (HE) Operating Department Practice, which encompassed these elements, presented further major change for the profession. The small, regional training schools were absorbed into Higher Education Institutions, where the focus and delivery shifted from a practice-

dominant to an academic-centred programme. Ownership of the teaching and training of Students also transferred from the clinical area to the HEI. Professional practice emerged as the central driving theme of the curriculum with emphasis on evidence-based practice, critical analysis and a more diverse patient-centred programme.

Within the ethos of lifelong learning it could be argued that ODPs were the archetypal New Labour profession whereby academic qualification provides a stepping-stone for economic growth and increased social status through attainment of professional registration. As the government green paper *The Learning Age* stated:

Learning is the key to prosperity – for each of us as individuals, as well as for the nation as a whole. Investment in human capital will be the foundation of success in the knowledge-based economy of the twenty first century (DfEE 1998a p.7).

Whilst these changes in education and status have undoubtedly presented opportunities and created possibilities for Operating Department Practitioners, the extent to which their attainment or participation in lifelong learning actually brings prosperity could be brought into question. Professionalisation brings increased standing and parity within the healthcare community for all practitioners, yet the move to an academic qualification has to all intents and purposes created the undercurrent of a class system within the professional group. This class system, created by the introduction of an academic-level qualification, imbues practitioners with differing levels of *capital* which may directly or indirectly affect their opportunities for personal or professional prosperity.

Furthermore the changes and developments in pre-registration ODP education and training were not without criticism. From within the profession elements of

discontent became apparent particularly in relation to the move to higher education. Similar concerns were voiced from within the nursing profession when Project 2000 (UKCC 1986) was introduced, where resistance, scepticism and negative perceptions of university-based courses were evident during the transition period (Fitzpatrick et al 1993). These negative perceptions manifested in practitioners raising concerns regarding the apparent disregard of the highly practical nature of the role as the course became more theoretical in execution, leading to the increasing creation of a theory / practice divide, an observable fact also occurring within nursing (Maben et al 2006). Of interest was a series of anonymous letters published in the profession journal - *'Technic'* from practitioners who viewed the changes negatively. One in particular felt that attainment of professional status would disadvantage older practitioners, perhaps recognising that their qualification was becoming increasingly inadequate (Anonymous 2000).

Although there has been a significant shift in culture and attitude towards the *'academicisation'* of ODP since the introduction of the diploma-level qualification, the full impact of the changes have yet to be fully realised. On the surface it is just another change in education, training and qualification but its scope extends beyond this having the potential to introduce inequality, exclusion and resentment which is the complete opposite to policy intent. Associated with Project 2000 came the streamlining of nursing grades, reduction in duties with subsequent dissolution of the State Enrolled Nurse (SEN) and conversion to Registered General Nurse (RGN). Although no directive indicates this upgrading could occur within ODP the most recent development which has the capacity to both challenge and compound the current tenuous situation is the proposed introduction of an all-graduate profession from 2015 (CODP 2013).

The rationale for the introduction of an all-graduate profession emanated through acknowledgement of the challenges and changes becoming increasingly apparent within the NHS particularly the changing social dynamic of an ageing population, rapid advancements in medical and surgical treatments and a changing workplace (CODP 2010). Coupled with these changes was the introduction of Modernising Medical Careers (DH 2003) alongside the European Working Time Directive (DH 2009) which potentially creates fewer doctors with less experience, leaving gaps in responsibilities and clinical skills to be filled by suitably qualified and advanced practitioners (CODP 2010). In order to attain the required level of knowledge and skills which ensures that the provision of high quality patient care is achievable, high quality education and training is essential in ensuring practitioners 'respond more effectively and flexibly' (DH 2008 p.72) a consideration paramount particularly within the peri-operative environment. In response to changes in service demand and provision many ODPs are specialising whether in one of the three phases of peri-operative practice such as anaesthetics, surgery or post anaesthetic care, or sub-specialism such as paediatrics, neurosurgery and trauma. Management, education and research roles for ODPs are increasingly more common. The incorporation of advanced clinical skills as well as introducing research and leadership elements within the degree curriculum ensures future practitioners will meet these changing demands and continue to meet their professional Standards of Proficiency (HCPC 2014) and CODP Scope of Practice.

The one over-riding element apparent within the rationale, however, was the focus on practitioners developing and maintaining their competence to practice through recognising and adapting to imminent change and utilising their expanding knowledge and skills effectively in responding to new and creative situations. This,

according to CODP, emanates through a robust pre-registration award incorporating the necessary learning to learn skills which prepare practitioners for future practice (CODP 2010). Although focusing on maintaining and developing competence to practise, CODP appear to advocate formal learning with little consideration afforded the less formal, practical and accessible dimensions of continuous professional development. This raises the question of how the less-academically inclined (and qualified) practitioners will adapt to the impending changes in maintaining their own competence to practise and thus meeting professional obligations. Morgan et al (2008) question the insufficiency of initial qualification level or 'minimum threshold of CPD' (Morgan et al 2008 p.3) which they argue only ensures practitioner competence over a period of time, an argument which echoes both Roscoe's and Barnett's observations regarding the potential inadequacy of initial qualifications. Although they discussed this within the context of individual practitioner's ability to maintain a base level of currency and competence to practice appropriate to their initial qualification, this could equally extend to individual's initial ability to engage in a variety of CPD activities in order to meet constantly changing professional and organisational learning requirements. This is especially pertinent with the profession having three very different entry-level professional qualifications.

The creation of three levels of qualification, each with their own *capital*, has the potential to significantly affect individual's perceptions, participation and access of lifelong learning activities. Capital, according to Bourdieu (1997), represents the structure of the social world which in turn determines an individual's chance of success in that world. Institutionalised cultural capital, in the form of academic qualifications, confers 'a certificate of cultural competence' (Bourdieu 1997 p.50) on the bearer, thus serving to raise their social status. Matheson and Matheson (2000)

use the term 'cultural distance' defined as 'the space which exists between one set of cultural capital and another' (Matheson and Matheson 2000 p. 10). Individuals, who are not aligned to a particular discourse, in this case engagement in formal learning activities, will be unable to close the distance between cultural capitals. Thus the older practitioner with non-academic qualifications, possessing less cultural capital which facilitates ease of access to higher educational programmes, and not disposed towards formal learning is disadvantaged. Future professional proposals, current employer expectations, and educational directives citing the importance and value attributed to degree-level education locates diploma practitioners significantly closer to the dominant discourse and simultaneously increases the distance for older, non-academic qualified practitioners. Within this framework diploma-qualified practitioners are arguably better positioned in terms of accessing continuous professional development in particular formal programmes of study, promotional opportunities and financial benefits as cultural capital is also convertible to economic capital according to Bourdieu (1997).

And what of the benefits – the '*key to prosperity*' alluded to by the government in the earlier quotation? Other than maintaining registration what are the benefits of participation in lifelong learning? Despite the growing expectation and necessity for practitioners to undertake formal learning and attain degree-level educational status, the current financial constraints coupled with increased service needs have fashioned additional barriers to learning for both organisation and professional culminating in limiting promotional opportunities and support for study leave. With opportunities for promotion and associated financial benefits becoming increasingly limited the value attached to, and motivation towards, possessing a degree simultaneously becomes reduced. The necessity to engage in learning activities, however, still

remains a prominent feature of professional responsibility as well as meeting health organisation's objectives. These factors have created a shift towards more creative and accessible forms of continuous professional development such as in-house, work-based training and development, e-learning and self-directed learning in order for practitioners to fulfil their professional and organisational requirements. As a consequence the immediate workplace assumes a more prominent position as a learning environment for the practitioner. As Eraut (2006) pointed out, 'professionals continually learn on the job because their work entails engagement in a succession of cases, problems or projects which they have to learn about' (Eraut 2006 p.10).

The prominence of the workplace cannot be underestimated not only in terms of provision of learning opportunities but as an environment which is influential in shaping the individual's perceptions and participation in a range of continuous professional development activities. Lave and Wenger's seminal theory of '*communities of practice*' as applied to the professional group of Operating Department Practitioners is the subject of the next chapter and aims to present an insight into the factors which may contribute to shaping practitioner's views and choice of learning activities.

CHAPTER THREE

OPERATING DEPARTMENT PRACTITIONERS AS A COMMUNITY OF PRACTICE

This chapter examines Lave and Wenger's seminal theory of '*communities of practice*' as applied to the professional group of Operating Department Practitioners. In doing so it aims to present an insight into the factors which may affect or influence their engagement in a range of continuous professional development activities.

Lave and Wenger defined a community of practice as 'a set of relations among persons, activity and world, over time and in relation to other tangential and overlapping communities' (Lave and Wenger 1991 p.98). This theoretical model of learning focuses on social participation and positions the 'community of practice' as central to development of individual practices and offers a framework within which to examine workplace learning and participant's engagement in learning activities. Within this theory, Lave and Wenger posit that the community creates, possesses and transfers its own unique knowledge components through individual and collective participation within the everyday practices of a specific community. An additional dimension to this learning theory is the development of identity with particular reference to the specific communities within which individuals not only practise but are accepted and belong (Handley et al 2006).

Traditionalist views of learning and knowledge, according to Fuller's (2007) critical analysis, comprise five key related concepts: formal institutional learning being considered superior to informal learning; learning requires the presence of a

qualified teacher involving the transfer of knowledge from an expert to a novice with knowledge being acquired through formal written texts and deemed solely an individual process (Fuller 2007 p.17). Initially developed as a rejection through dissatisfaction with traditional behaviourist and cognitive views of learning, Lave and Wenger (1991) offered an alternative theory of learning which focused on participation in social practice which they deemed applicable to a wide range of social settings. Using observation of how newcomers learn, integrate and participate within communities, this model focuses on the interaction and facilitation of knowledge transfer between newcomers and experienced 'old-timers'.

In contrast to the traditionalist perspectives, learning as social participation focuses predominantly on the collective group as the unit of analysis rather than the individual with emphasis placed on shared and informal learning. It must, however, be acknowledged that learning begins with the individual and, although Lave and Wenger focus on the collective, the role of the individual learner cannot be overlooked. Knowledge within this context is more than the 'abstract and symbolic' development associated with cognitivist perspectives on learning but 'provisional, mediated and socially-constructed' (Handley et al 2006 p.642) which acknowledges the importance of workplace practices in construction and transfer of knowledge. Embedded within the transfer and development of knowledge and practice is the sharing of social, historical and cultural aspects of that community which contributes to ensuring its survival.

As a professional group, Operating Department Practitioners display characteristics of, and function, as a community of practice: the teaching, training and development of Student ODPs within the clinical environment bears similarities to Lave and Wenger's original situated learning theory of legitimate peripheral participation.

Although initially focusing on learning from a newcomer perspective this theory extends to encompass on-going learning for qualified practitioners where their immediate work area, and surrounding communities, provide a rich environment for engaging in a range of continuous professional development activities aiding in facilitating and maintaining clinical competences. With reference to Wenger's (1998) later in-depth critical extension of this theoretical perspective, communities of practice are deemed environments conducive to the construction of learning, meaning and identity both for newcomers and existing members.

The importance of community participation, cultural knowledge, views and beliefs are an integral component of practitioner's professional background which values the development and application of both practical knowledge and knowledge in action (Scribner 1999). The dynamically evolving character of healthcare naturally lends itself to practitioner learning becoming an innate and often subconscious process and further reiterates the growing importance afforded informal and workplace learning. As Wenger points out:

Engagement in practice... is both the stage and the object, the road and the destination. What they learn is not a static subject matter but the very process of being engaged in, and participating in developing, an ongoing practice' (Wenger 1998 p. 95).

The central concept within this theory is participation which, according to Wenger, extends beyond the physical engagement in certain activities to encompass a dynamic 'process of being active participants in the practices of social communities and constructing identities in relation to these communities' (Wenger 1998 p.4). Yet the concept of participation raises a number of issues, particularly in relation to the degree of participation the individual chooses to extend within their specific community. In stating that learning is an 'integral and inseparable aspect of social

practice' (Lave and Wenger 1991 p. 53) there is a much-held belief that practitioners become and remain full participants within their respective community. Wenger (1998), however, later suggests there are degrees of participation, identifying four forms: full participation, full non-participation, peripherality and marginality. With reference to the first two the practitioner is either an active participant inside the community or situated as non-participant outside of the community. Wenger further distinguishes non-participation into peripherality and marginality, the former being considered an enabling aspect to full participation. Marginality, he acknowledges, is a problematic area which directly affects or influences an individual's decision to engage fully within the community and which can ultimately restrict the individual to non-participation. Each of these degrees of participation is potentially a limiting or enabling factor towards practitioner engagement in particular learning activities.

His argument that older community members can be kept in a marginal position is particularly apt especially in relation to engagement in learning stating that 'non-participation may be so ingrained in the practice that it may seem impossible to conceive of a different trajectory within the same community' (Wenger 1998 p.168).

It could be argued there are different levels of marginalisation within the specific ODP community, some self-imposed and others which are imposed upon them. The tendency for older City and Guilds practitioners to solely practise within the anaesthetic remit creates marginalisation through lack of flexibility in non-participation within either recovery or surgery aspects of peri-operative practice despite being trained in these areas. In striving to provide a more efficient service, theatre managers are increasingly demanding more flexibility from their staff which arguably leaves this staff group as being highly specialised yet deskilled in some aspects of their role. There may also be an element of elitism as only those

practitioners holding a recognised anaesthetic qualification can practice within the anaesthetic remit (AAGBI 2010). Those practitioners holding a National Vocational Qualification were recognised as being more flexible and generic and were employed in wider roles. Their qualification, however, is considered inadequate for accessing higher education programmes and as such this group of ODPs became marginalised.

As a small group of Allied Health Professionals in competition with the larger professional body of nurses, access to certain training and development opportunities are scarce and directed solely at nurses, particularly formal learning activities. Additionally, as a then non-registered group of healthcare workers, there was a tendency for ODPs to be overlooked in relation to learning opportunities unless well supported by their manager. Furthermore, prior to moving to higher education, ODP training was managed and delivered by regional training schools and therefore many of these practitioners have had none, or very limited exposure to formal or higher education learning opportunities and the concept of CPD. Moreover there is a tendency for older practitioners to be more resistant to change, less inclined to accept the changes developing within their own profession and thus create self-marginalisation. All of this could be considered detrimental to their perceptions of and participation in lifelong learning.

In embedding the relationship of practice within the community Wenger (1998) identified three important dimensions which offer cohesion and structure to the particular community; mutual engagement, joint enterprise and shared repertoire (Wenger 1998 p.73). These dimensions furthermore aid in providing directionality and developing motivation for practitioner engagement in learning within their respective community of practice.

A joint enterprise indicates directionality of the group which, within this particular context first and foremost refers to the provision of high quality patient-centred care and service delivery. However, it could equally apply to the development and establishment of professional identity as well as the undertaking of continuous professional development as an intrinsic component of their professional responsibility for ensuring competence to practice. Responding to both internal and external change requirements and problem solving can be added to this alongside the important underpinning dimension of practitioner accountability of actions. The dimension of shared repertoire encompasses the importance of community participation, cultural knowledge, views, values and beliefs of specific relevance to the community of practice focussing on specific practical tasks, stories and concepts which ensures practitioner 'history remains both relevant and meaningful' (Wenger 1998 p.83). This shared repertoire extends to instil an awareness of the wider collective professional group as it responds and adapts to the impending wider external changes resulting from the introduction of all-graduate profession as well as imminent changes within the National Health Service.

The diversity and often complex relationships of members comprises the dimension of mutual engagement. Diversity of members extends to include the three current qualification levels as well as the group dynamics in relation to experience, status, skills mix, grading and roles. ODPs train to work within three areas of peri-operative practice and either specialise within anaesthetics, surgery and recovery or rotate between areas. In specialising, practitioners don the characteristics and identities inherent within their smaller internal communities whilst still maintaining wider community dimensions and identity. Furthermore practitioners can expand and

develop roles within the education remit or management which serves to increase the diversity and relationships with wider communities.

Although the community of practice is portrayed as an independent functioning unit, Wenger explicitly points out that 'it cannot be considered in isolation from the rest of the world, or understood independently of other practices' (Wenger 1998 p.103). By their very nature, communities overlap and exist alongside other communities and this is especially evident within a multi-professional healthcare context. These 'multimembership nexus of perspectives' provide opportunities for brokering or making connections and exchanging ideas across the boundaries which separate each distinct community of practice according to Wenger (1998 p.105). The ODP community exists within the wider community of the operating theatres sharing complex multiple and overlapping boundaries with a diverse range of healthcare communities including Nurses, Healthcare Assistants and Medical Staff. ODPs furthermore practice outside of their traditional theatre environment and thus share commonalities and joint enterprise particularly in relation to aspects of patient care which further increases opportunities for brokering, where practitioners can introduce elements of their own unique practice into another area of practice which shares a similar 'concern, set of problems or passion about a topic' (Wenger 1998 p. 4).

Whilst each individual community holds its own tacit and explicit bodies of knowledge, learning is not static and the world is in constant flux. Set against the day to day routines of practice within the ODP community, the dynamically changing nature of healthcare ensures that new procedures, ideas and working practices are continuously being introduced and up-dated. As such, connections and encounters with new communities and new knowledge present opportunities for

practitioners to 'deepen their knowledge and expertise... by interacting on an ongoing basis' (Wenger 1998 p.4). Boundary distinctions between other healthcare practitioners and their respective communities can furthermore contribute to establishing and cementing practitioner identity through recognising and valuing their expert inputs. Conversely as James (2007) indicates, operating within multiple communities can generate benefits but can also serve to dilute professional identity due to competing responsibilities and professional obligations (James 2007 p.140). Thus for the ODP their learning, practice and identity is negotiated and re-negotiated on a daily basis.

According to Lave and Wenger's theory, the community of practice is the centre for knowledge and learning. The active processes of production, re-production, connection, interaction and negotiation, which form the basis of social practice theories, are integral to practitioner's learning. Learning, which occurs on a daily basis through these processes, serves not only to increase the individual's cultural capital but equally to increase the collective knowledge or social capital held within the community. For Wenger there exists a 'pool of goodwill' or reciprocity where individual members of the community contribute their knowledge and skills to the wider community with the understanding that each member will benefit from the capital held (Wenger 1998 p.37).

These dimensions not only underpin the structural dynamics and characteristics of the community but also help influence and determine the learning needs within the community. In explicitly stating 'learning is not reified as an extraneous goal or as a special category of activity or membership', Wenger (1998 p.95) serves to cement learning as an on-going process rooted within practitioner's everyday practice.

Extending the boundaries to encompass wider external communities of practices it is

noted they are subject to the wider influences of organisational mandates, policies, procedures and professional 'constraints and pressures' (James 2007 p.140) which in turn exert an effect on the dimensions presented earlier affecting the bonds which hold the community of practice together. It could be argued that organisational mandates, particularly in relation to learning opportunities and the current appraisal system could have negative effects on the dimensional characteristics discussed.

Despite being recognised as a seminal and influential learning theory, Wenger (2002) acknowledges the limitations or weaknesses of communities of practice, arguing that 'the very qualities that make a community an ideal structure for learning... are the same qualities that can hold it hostage to its history and its achievements' (Wenger et al 2002 p.141).

Communities of practice reproduce their membership in the same way that they come about in the first place. They share their competence with new generations through a version of the same process by which they develop. Special measures may be taken to open up practice to newcomers, but the process of learning is not essentially different (Wenger 1998 p.102).

The above definition alludes to the existence of a stable community whereby profession-specific knowledge and practitioner identity is reinforced and learning is both continuous and continuously re-created through social participation. Yet communities of practice are acknowledged as far from static or stable, being portrayed as evolving over time as new members join and older ones leave which implies a relatively fluid workforce. Evolution implies a gradual change and continuing adaptation of a system which ensures survival of the fittest relative to their co-evolutionary partners. Rapid and successive changes within the profession, in particular the introduction of the Diploma (HE) Operating Department Practice, which although initially met with resistance by old-timers, will over time, become

the dominant group with the prospect of evolving into an active learning community. Co-evolution encompasses the mutual evolutionary influence of two (or more) systems which as part of their relationship exert selection pressures on the other which in turn affect each-other's evolution. In an environment conducive to supporting co-evolutionary processes the profession, the organisation and the practitioner should grow and develop synergistically. In reality, and applied to this context, the professional group of ODPs are subject to selection pressures from within both the organisation and professional body which could be accused of being antagonistic in their own evolutionary needs and detrimental to some practitioner's own evolutionary processes.

Due to the highly specialised nature of the ODP role, experience indicates there is often a tendency for practitioners, particularly those who are locally qualified, to remain at their local hospital creating a relatively stable core community of practitioners. Within such a close-knit community and relatively stable working organisation the historical and cultural aspects of the professional group are instilled from commencement of learning experience and constantly reinforced through shared meaning and joint enterprise. The reproduction and sharing of commonalities, culture, language and perspectives within a system can culminate in extremely slow evolutionary changes especially amongst the older, more experienced practitioners and this can to some extent severely limit adaptation and change. The opposition of practitioners to adapt to the inevitability change is also questioned, which arises primarily from the semi-isolated and situated nature of the community but could equally be attributed to the perception of erosion of professional identity.

Although accepting in part of the *academicisation* of the profession and subsequent professional responsibilities, there appears an element of sameness within the

teaching, training and development of both students and qualified practitioners which serves to anchor the community to the past and thus creates a less evolutionary community. Roberts' (2006) exploration of the limitations of communities of practice raises a particularly valid point in that such communities of practice may become static in terms of their knowledge base which contributes to resistance to change. She argues that knowledge which supports the identity of the community is readily adopted whereas knowledge which challenges practitioner identity may be met with opposition thus serving to increase resistance to change creating fundamentally an 'institutionalised' community (Roberts 2006 p.630).

Although Roberts reiterates the sentiments of Wenger in that communities of practice 'don't function in a vacuum' (Roberts 2006 p.624), operating departments are traditionally isolated environments and often due to their very nature are excluded from the wider over-lapping communities. Furthermore communities of practice are structures involving power relations which operate at multiple levels – at local level within departments, organisationally and from within the professional body, all of which are ultimately guided by wider healthcare policy and agendas. Wenger discusses power and power relations as contributory factors in shaping identity and negotiation. Although acknowledging external political and economic dimensions of power he presents power within communities of practice as 'not construed exclusively in terms of conflict or domination' (Wenger 1998 p.189). In concentrating on power, predominantly as a means of forming identities and negotiation, Wenger overlooks the wider implications of power relations, particularly within large structured organisations, which can equally serve to be destructive or detrimental to personal, professional and community identity.

Operating Department Practitioners, in comprising a relatively small group of Allied

Health Professionals in comparison to the more well-defined nursing professions, are often subject to indirect marginalisation and excluded from organisational policies and practices. These factors can also extend to include participation within continuous professional development activities.

The term *community* itself raises concern, being deemed problematic in its definition with particular respect to the assumption that a community implies harmony and togetherness according to Fuller (2007). It is further questionable when applied to the work-place as it assumes everyone shares common interests, but it is recognised that 'communities are never perfectly designed from the outset and that individual members have different expectations and performance' (Chalmers and Keown 2006 p.154). In focusing on the community as a collective learning group there is the tendency to overlook individual learning requirements which can be equally contributable to collective community knowledge and learning. Hinchliffe (2006) further challenges the community as a learning environment arguing 'situated learning cannot be lifelong learning if the effect of the former is to "lock" persons into particular situations' (Hinchliffe 2006 p.106).

According to Lave and Wenger, 'a person's intentions to learn and the meaning of learning is configured through the process of becoming a full participant in a socio-cultural practice (Lave and Wenger 1991 p.11). Handley et al (2006) argued that learning is more than the development of knowledge and practice and 'it also involves a process of understanding who we are and in which communities of practice we belong and are accepted' (Handley et al 2006 p. 644). Hager (2005 in Fuller 2007) is critical of the notion of participation, arguing it reflects continuity and reproduction rather than discontinuity and transformation. This can create a stagnant, isolated environment, which coupled with the self-reproducing cultural,

historical and social identity of the group perpetuates the contribution to practitioner resistance to change. Arguably is detrimental to the development of professional identity.

In contending that social participation is the central condition for learning, and knowledge is within the community, Lave and Wenger (1991) dismiss the value of teaching, learning and knowledge external to the community particularly formal institutional learning and thus present a restricted view of learning and knowledge. In adopting this position they appear to dismiss the value of contact with other communities and in turn contradict their own definition of what constitutes a community of practice. A further limitation of this theoretical model is the tendency for learning to be predominantly of the informal and work-based variety. Although beneficial for a practice-oriented community, the potential benefits of engagement with formal academic institutions cannot be underestimated. Fuller and Unwin (2003) claim individuals, who participate in multiple settings, particularly formal educational settings, had increased learning experiences. But the extent to which the clinical community and the academic community overlap can be called into question, particularly amongst the older qualified practitioners.

Although mistrust, scepticism and resistance surrounded the introduction of the diploma qualification, Lave and Wenger state that change both 'threatens the fulfilment of the other's destiny, just as it is essential to it' (Lave and Wenger 1991 p.116). The role of formal institutional learning and exposure to this alternate community of practice cannot be overlooked and the value of knowledge from within this external community can be deemed beneficial to both the individual as well as the community. Lave and Wenger, in dismissing the formal aspects of learning, particularly those outside of the immediate community environment,

further reject the idea of practitioner individuality and the value attributed to individually constructed knowledge.

Sfard (1998) identified two metaphors which serve to distinguish between two views of learning: acquisition and participation which display properties reflective of constructivist and situated theories of learning. Sfard, however, points out that they are not wholly separate as aspects of each perspective are apparent within each of the metaphors fostering what Scribner (1995) referred to as 'reciprocal relationship' between knowledge and action deemed more appropriate within a practically-oriented clinical environment. Knowledge from a constructivist perspective is uniquely self-constructed, specific to and interpreted by the individual with reference to their own world experiences. Both acquired and participatory knowledge are considered of equal importance particularly within a healthcare setting where personal and individually constructed knowledge, whether formally or informally acquired, enables participation within the community. Equally collective community knowledge embraces the integration of 'cultural and individualistic views of knowing' (Vygotsky 1978 in Roth 1990 p.10). The reciprocal relationship between the *knowing what* and *knowing how* of conceptual and procedural knowledge are valued within clinical practice which contributes to the very dimensions discussed earlier and which through the act of social participation provide the individual practitioner with both tacit and explicit knowledge in order to undertake their responsibilities.

Lave and Wenger's theory of learning through social participation within a community of practice has offered an insight into the factors which serve to shape the practitioner's relationship with learning and learning opportunities. Despite being an isolated group, they are influenced by wider organisational and professional

policies which further help determine their choices and access to continuous professional development activities. The role of lifelong learning policy and practice and its associate continuous professional development is the subject of the next chapter.

CHAPTER FOUR

LIFELONG LEARNING AND CONTINUOUS PROFESSIONAL DEVELOPMENT

This chapter focuses firstly on the concepts and practices of lifelong learning within a social and political context with particular reference to the relationship of policy and practice. Emphasis is afforded the perceived benefits of engagement in learning as well as the value attributed to the range of learning activities which are encompassed within the diverse definitions of lifelong learning. Secondly, special attention is afforded continuous professional development and its relationship to the professional and their practice.

Lifelong learning

Lifelong learning is by no means a new concept with its educational origins being traced back to the writings of Dewey, Lindeman and Yeaxlee in the early 20th Century (Jarvis 2007), although references to individuals taking responsibility for their own learning and contributing to society can be found in the teachings of Plato (Longworth 2003). Positive links between social welfare, the training of workers and increased productivity - which are the key fundamental ideals of more recent lifelong learning policy - can be seen in the work of 19th Century social reformists (Matheson and Matheson 2008).

Following a lengthy fallow period, lifelong learning re-emerged with renewed interest with the Faure Report (1972) which emphasised an all-inclusive approach of learning and was shortly adopted across multi-disciplinary parties for social, political, economic and educational gain. The driver for recent lifelong learning

policy was the emergence of a knowledge-based economy in an era of rapid globalisation (Hinchcliffe 2006) which, according to Longworth (2003), sought to embrace social mobility, economic growth and personal well-being. From an educational perspective lifelong learning was advanced on the premise of promoting a 'rational, enlightened and democratic society' creating a Utopian notion of an 'all-encompassing learning society' (Tuijnman 1999 p.7), considered a precondition of a high performance knowledge economy (Delors 1996).

But what is lifelong learning? A review of the literature indicates a wealth of disagreement in providing a coherent definition. Field (2006) portrays lifelong learning as a 'beautifully simple idea'. Superficially it is, as we constantly learn throughout our lives, encountering a myriad of learning opportunities on the way. The term *lifelong* recognises that learning is not confined to childhood schooling or a classroom situation but takes place throughout life and in a range of different situations with Lindeman, as long ago as 1926, stating that 'the whole of life is learning, therefore education can have no endings' (Lindeman 1926 p.4). As Tight (1998) pointed out in his discussion of the conceptualisation of lifelong learning what should be a simple idea has become a complex issue arising through 'a variety of different interest and uses' (Tight 1998 p.254). This is further complicated through its relationship to the changing economic climate, shifting priorities and lack of specificity of content within a much generalised proposal (ibid).

Despite Field's 'simple' portrayal of lifelong learning, a closer examination of the literature indicates that lifelong learning is in fact a complex and multi-faceted creature with chameleon-like characteristics. Its array of descriptions is reflective of its changeability, although on closer inspection it is found to be defined in either broad or narrow terms which both results from and contributes to its definitional

discord. Interested parties, furthermore, retain and defend their own ideas of what constitutes lifelong learning, how it should be implemented and the audience to which it is intended. These disputes ultimately lead to further disagreement surrounding the range of learning activities which come under the umbrella term of lifelong learning, and further examination indicates even these boundaries are less than defined. Furthermore there appears a tendency to separate formal and informal forms of learning with some policy makers taking a narrow view limiting lifelong learning to post-compulsory education and adult education. This separation appears to imply that learning and knowledge is complete at the end of the individual's formal educational experiences and furthermore infers that post-compulsory and lifelong learning has less value due to its unstructured nature and non-conferring of recognised awards or certificates.

In accordance with its original characterisation lifelong learning should be 'lifelong' and 'life-wide' (Tuijnman 1999) thus encompassing all forms of learning: formally structured compulsory education, higher education, informal learning, workplace learning, and incidental learning. Hargreaves (2004) also supports the principle that lifelong learning should be from 'cradle to grave' but emphasises the point that formal and compulsory education should help provide the individual with the tools to 'embrace both the content and the process' (Hargreaves 2004 p.1) to ensure its uptake and continuation throughout the individual's life.

Knapper and Cropley (2000) defined lifelong learning in narrow terms, referring to it as 'deliberate learning' which 'should occur throughout a person's lifetime' (Knapper and Cropley 2000 p.1). Despite acknowledging the importance of learning across the lifespan, in supporting *deliberate learning* a structured approach to its organisation and implementation is favoured viewing learning in restrictive terms

with four characteristics – learning is intentional, has specific goals, is goal-driven and will be utilised effectively. It could be argued that in adopting the term *deliberate learning* Knapper and Cropley appear to be indirectly aligning themselves more towards the formal, structured and educational dimensions of lifelong learning. Their model is furthermore suggestive of organisational input and control over learning opportunities. In terms of effective utilisation of learning the question is raised as to how this is actually measured as individual learner and the learner's immediate work environment may have differing levels of expectation of the value of the learning undertaken.

Longworth (2003) in contrast takes a broad, all-encompassing, holistic and individual-centred approach which reflects the philosophical intention of lifelong learning:

a system of lifelong learning in which everyone is targeted, which is continuous throughout life and which is focussed entirely on the needs and demands of the learner's themselves (Longworth 2003 p.12).

In offering the above definition Longworth pays particular attention to the two words *lifelong* and *learning* which when combined, he argues, has a diverse and widely out-reaching meaning. He states that lifelong should be from cradle to grave and further it is more than applicable to the adult parts of our lives and infinitely more than continuous professional development or the acquisition of skills and knowledge within the workplace. Offering a definition of learning, however, is more difficult as it encompasses social, political, economic, personal, cultural and educational dimensions (Longworth 2003 p.12) which results in differing perspectives hence distorting its definition. In emphasising the personal and cultural aspects of learning Longworth directly associates learning with the individual

stating: 'It means doing things in a different way...giving learners the tools and techniques with which they can learn according to their own learning styles and needs' (ibid).

Rogers (2002b) also presents lifelong learning in broad terms portraying it as a process in which individuals participate in everyday life and thus serves to include all forms of learning. His definition of lifelong learning as 'education built into the process of living rather than as separated into a range of special activities' (Rogers 2002b p.30) does however appear to be contradictory. In using the term education, as opposed to learning, he appears to position lifelong learning within a formally-structured framework despite acknowledging that lifelong learning is an inclusive process which also takes place outside of formal education systems. Positioning lifelong learning within a formally structured context does however appear to dissociate the learner from the centre of their learning experience. This subsequently shifts the emphasis of learning onto external factors, such as organisations and professional bodies, which exert a form of social control over both the content and context of the learning being undertaken. As a result this detracts from the original intention of lifelong learning being centred on the individual, as emphasised by Longworth.

Lifelong learning policy and practice

Often referred to as an '*elastic concept*', the meaning, nature and intention of lifelong learning alter depending on the context to which it pertains. Griffin (2006) refers to lifelong learning as a 'holistic concept' with 'abstract meaning' with Hinchcliffe (2006) calling it a 'contested domain'. This elusiveness, and sometimes contradictory, array of definitions resulting from policy makers' insistence in

lifelong learning being all things to all people, and manipulating it for their own ends, ultimately places it in danger of losing its 'purchase on reality' (Field 2006 p.2) and contributes to incongruence between policy discourse and practice reality.

Bartlett and Burton (2009) identify two lifelong learning ideologies: - progressive and instrumental, which reflect the two differences in definition presented above.

Within the progressive philosophy, learner's needs are foremost, focused on enhancing quality of life where learning opportunities are all-encompassing, self-directed, with emphasis on self-attainment rather than qualifications and which may or may not be beneficial to society or economy. The instrumental ideology focuses on economic benefits, enhanced employability and productivity which are indicative of current lifelong learning policy. Learning is directly linked to career development, qualifications benefiting both individual and society.

Although Bartlett and Burton argue the two models are capable of co-existing, it is particularly evident from exploring lifelong learning policy that the instrumental ideology predominates. Current dominant policy discourse sees lifelong learning as a lever for economic growth and global competitiveness amidst a rapidly changing social and political climate with emphasis towards attainment of formal post-compulsory education and qualifications (Biesta 2005). Policy, employing an enabling and inclusive approach, focuses on developing knowledge and skills, opening up opportunities for all individuals 'regardless of age, previous educational experience, employment status' (Tuijnman 1999 p.8). Benefits of subscription are advertised as being 'social cohesion... a sense of belonging, responsibility and identity (DfEE 1998a p.13) with economic prosperity and increased social status.

Despite the above statement and acceptance of lifelong learning as being considered beneficial to all, further examination indicates an over-whelming existence of disparity between policy and reality. Policy assumes all individuals will possess the necessary attributes, be suitably positioned to participate and that successful and capable learners will thrive within its non-discriminatory framework. In reality, as Field further argues, instead of increasing opportunities, creating social inclusion and equality, 'lifelong learning is actively reproducing inequality' (Field 2006 p.114). Individuals, particularly those of higher social status who are already in possession of increased cultural capital, are better situated to access learning opportunities (Tuijnman 1999) and will thrive at the expense of individuals in lower social groups (McGivney 1997 in Keep and Rainbird 2002) with poor educational attainment.

Lifelong learning policy further promotes participation on the grounds of increasing social inclusivity and mobility with financial remuneration for all. Yet despite the widening participation agenda, only a third of individuals from lower socio-economic groups had accessed higher educational establishments according to Watts and Bridges' (2006) review. The reasons indicated were academic failure within compulsory education which reduced individual's incentive to pursue further levels of study. Although focusing on school-leavers' intentions for entering (or not entering as the case may be in some circumstances) the higher education field similar reasons for not pursuing formal learning are equally attributable to post-qualifying practitioners.

Furthermore the link between education, employability and earnings is tenuous.

Policy states that 'graduates and those who have 'sub-degree' qualifications earn, on average, around 50 per cent more than non-graduates' and experience double the

number of job promotions (DfES 2003 p.59). This may be true in some areas of employment but it is far from applicable within the NHS. Entry level for newly-qualified practitioners (with or without a degree) is at band 5 with a well-defined career progression linked to Knowledge and Skills Framework under Agenda for Change. Engaging in lifelong learning or continuous professional development, particularly formal degree-conferring courses, offers a competitive advantage enabling practitioners to enter the promotional field but does not guarantee automatic movement through pay points and banding.

According to Hinchliffe (2006), 'what started off as an emancipatory ideal is transformed into a weapon of mass discipline' (Hinchliffe 2006 p.96), where the threat of economic and social exclusion hovers over those who do not subscribe to the dominant discourse. Coffield (1999) and Crowther (2004) were both equally critical towards policy discourse. Coffield argued that lifelong learning is not the universal panacea being advanced to 'solve a wide range of educational, social and political ills' (Coffield 1999 p.479), but a form of social control implemented by policy makers stating that:

both the state and employers... are using the rhetoric of lifelong learning first and foremost to make workers more flexible and more employable (Coffield 1999 p.488).

Crowther (2004) questioned the pre-occupation with developing 'flexibility' which he argued has multiple meanings; implying not only a degree of freedom for its workers, but a necessity to respond at short notice to change. For Crowther, flexibility equals control, utilised to make people 'compliant and adaptable' (Crowther 2004 p.125). As Field (1999) observes:

without anyone much noticing a great deal of professional development and skills updating is carried out not because anyone

wants to learn or is ready to learn but because they are required to learn (Field 1999 p.11).

Although lifelong learning was adopted and promoted with positive connotations and benefits for the individual, elements of subversion, coercion, and social control exist in its infrastructure. Engagement in learning of any form should, under the lifelong learning framework, carry benefits for the individual and the wider social networks including organisations. Yet the relative value attributed to the different learning activities which come under the lifelong learning umbrella is highly variable, as too are the professed benefits. The tendency to afford the formal, qualification-conferring learning activities higher status than work-place and informal learning contributes to the lack of a tangible definition of lifelong learning. This leads to confusion surrounding its perceptions, specifically in terms of which activities are available and accessible, as well as those which are considered acceptable and supported by the respective professional bodies and organisations. The apparent benefits associated with undertaking lifelong learning are also questionable. From an organisational perspective where working practices are changing and individuals are expected to take on new roles, flexibility and engagement in learning is associated with pay awards and progression. Yet, the extent to which learning and earnings is linked however, is tenuous according to Wolf (2002). Within a professional context where lifelong learning and continuing professional development forms an integral component of professional identity those practitioners who fail to meet their professional responsibilities are at risk of exclusion from the register with subsequent loss of economic status.

Continuous Professional Development

Continuous professional development is widely acknowledged as one of the defining characteristics of a professional, with the majority of professions having established policies for its members (Friedman and Phillips 2004). It has furthermore become synonymous with professionalism and development of professional identity, with learning and its subsequent monitoring governed by professional standards.

Particularly within nursing literature, and to some extent health policy, continuous professional development and lifelong learning are indistinguishable, sharing a close relationship and exhibiting commonalities. Yet to imply they are the same is to do injustice to their individuality and deny their uniqueness. Continuous professional development is arguably a category of lifelong learning and occupies a unique position on the lifelong learning continuum. Whereas lifelong learning is considered to encompass all forms of learning from cradle to grave and engagement is primarily voluntary particularly in adult life, continuous professional development is a process of structured, specific learning and development, determined and undertaken by an individual during the 'practitioner's working life' (Megginson and Whittaker 2007 p.5).

Although flexibility exists within the CPD framework, activities are usually structured, governed by professional standards and their relationship with wider organisational perspectives cannot be underestimated. Forming part of the professional regulatory framework, CPD ensures the individual registrant meets their professional responsibilities, and maintains their competence and fitness to practice. Its wider agenda focuses on meeting the growing demand for quality, competence and accountability, which is particularly apt in the current climate of NHS scrutiny

and litigation. In addition, it serves to help respond to on-going change both within the practitioner's immediate practice as well as the wider challenges of healthcare provision through embracing the ideals and principles of lifelong learning and learning to learn skills.

The term *continuous professional development* is attributed to Richard Gardner who was responsible for professional development within the building professions at York University during the 1970s. His intentions were the introduction of a framework of professional development which sought to re-establish the links between education and practice which he saw as lacking in post-qualified practicing professionals. Furthermore, he sought to integrate both formal and work based learning which did 'not devalue informal or incidental learning' (Gardner 1978 in Todd 1987 p.5) taking place within the practice settings.

Within which the purely educational element becomes one alongside others, a full professional life, good practice generally, career advancement, increasing capacity and well-earned profit. Professional development seems to suggest these things and to imply positive learning strategies for individuals, practising organisations, individual professions (Gardner 1978 in Todd 1987 p.5).

Gardner's 'definition' of continuous professional development not only quantifies the intended ethos of professional learning – aspects of which are still evident within the CPD philosophies of professional practice - but recognises the multi-dimensional nature of knowledge advocated by Schön (1983) which serves to encompass technical, process, professional and tacit knowledge. CPD was, in his view, also a formal and more public way of organizing what professionals did informally as part of their working lives and thus contributed to its monitoring by external agencies. Perhaps of importance within this definition is the acknowledgment of the wider

associations and perceived benefits of learning which echoes Tight's 'trinity'.

Recognising the value of continuous professional development led to the adoption and introduction of CPD policies across a number of professional bodies during the late 1990s.

A wealth of definitions of continuous professional development can be found in the literature from Earley and Bubb's simple and straightforward description as a process which 'encompasses all formal and informal learning that enables individuals to improve their practice' (Earley and Bubb 2007 p.3) to more in depth and profession-specific ones. Madden and Mitchell (1993) offered a more concise and structured definition whilst retaining Gardner's original intentions:

the maintenance and enhancement of the knowledge, expertise and competence of professionals throughout the careers according to a plan formulated with regards to the needs of the professional, the employer, the profession and society (Madden and Mitchell 1993 p.12).

The professional body for ODP - The Health and Care Professions Council (HCPC)

defines continuous professional development as:

a range of learning activities through which professionals maintain and develop throughout their career to ensure that they retain their capacity to practise safely, effectively and legally within their evolving scope of practice (HCPC 2012 p.3).

This profession-generic definition predominantly focuses on the individual practitioner, their responsibilities and obligations to practice within their defined roles under *The Standards of Conduct, Performance and Ethics* (HCPC 2006b).

Whilst other professions, such as medicine, are required to undertake a specific number of hours or gather a designated number points as evidence of their CPD activities, the HCPC decided to opt for a less prescriptive approach. It was their view

that due to the differing nature of the individual registrants and their diverse roles each practitioner would be able to dedicate different amounts of time to learning (HCPC 2004). Concerns were raised regarding the possibility that learning could become a points gathering exercise which in turn would negate any meaning or value attached to the learning.

Although broadness and flexibility exists regarding the 'range of learning activities' deemed relevant by the HCPC it further acknowledges the variation of practitioners' individual roles, responsibilities and learning needs whilst still adhering to the need to meet professional standards. The definition further alludes to wider contexts of practice and the increasing relationships within and outside of the organisation, in particular acknowledging the widening roles becoming increasingly evident within healthcare and moving beyond the current defined boundaries. The terms *future* and *evolving scope of practice* signpost not only individual's potential achievements but acknowledges and sanctions the changing healthcare workforce and practices. The practitioner as a 'knowledge worker' is required to adjust to new and evolving situations as government targets and initiatives challenge their existing roles and responsibilities. As changes are becoming more frequent the importance of measurable continuous professional development becomes more imperative. Yet there is an element of control on behalf of the professional group which echoes Coffield's view of lifelong learning as well as Knapper and Cropley's earlier definition of lifelong learning with its deliberate intention.

While the term and concept of continuous professional development is a recognised, accepted and intrinsic component of professional identity and practice, research concludes that it not a straightforward concept. Its ambiguous nature results from the 'definitional variety between professional associations' with respect to their body of

professional knowledge and practice (Friedman and Phillips 2004 p.363) and the dynamically changing traditions of professionalism (Friedman et al 2008).

Although definitions vary, common fundamental features can be identified in that they should be *continuous, profession-focussed and broad based* (Kennie 1998).

According to the Chartered Institute of Personnel and Development (Marchington and Wilkinson 2006) continuous professional development should exhibit the following features:

- *be continuous - professionals should always be looking for ways to improve performance*
- *be the responsibility of the individual learner to own and manage*
- *be driven by the learning needs and development of the individual*
- *be evaluative rather than descriptive of what has taken place*
- *be an essential component of professional and personal life, never an optional extra*

Comparing the above generic expectations of CPD to those specific to a healthcare context (Kennie 1998) sees a number of important additions including a departure from being wholly professional-centred and professional-led to one which incorporates organisational inputs and alignment to wider strategies.

- *Be patient-centred*
- *Responsibility for the management of learning lies with the individual practitioner.*
- *Involve participation on behalf of the relevant stakeholders (Practitioner / Organisation / Education Provider / Professional Regulator)*
- *Educationally effective*
- *Learning needs should be clearly stated and reflect the wider objectives of the organisation locally and nationally*
- *Enhance the knowledge and skills of the practitioner*
- *Involve the application of evidence-based research and practice*
- *Learning should be an integral part of everyday working practice rather than seen as a burden.*

The variations in definition and expectations are further compounded by a myriad of interchangeable terms: *continuing (professional) education*, *continuous professional development and lifelong learning*, each of which have a variety of conflicting definitions. A concept analysis undertaken by Gallagher (2007) which explored common meanings, uses and attributes of the various terms within a healthcare context concluded that the definitions are primarily the same and used interchangeably.

Continuing education is defined as 'formal educational programmes...usually short-term and specific' but not 'academic degree-granting programs' (Anderson et al 1998 p.393). Jarvis (2007) in his portrayal of the evolutionary processes of lifelong learning stated that professional groups adopted the term continuing professional education which relates directly to in-service training but still has associations with formal, organised learning through usage of the term education. Eraut (2006) viewed continuing education as 'formally organised' learning such as courses, conferences and educational events, and CPD as inclusive of these activities but extended to include work-based learning (Eraut 2006 p.11). Gopee (2005) defined continuing professional development as consisting of formal academic courses and professional short courses offered within the NHS, but exclusive of work-based learning.

Morgan-Klein and Osborne (2007) discussed CPD solely in the context of work-based learning, and in doing so dismiss the references to formal learning opportunities.

The one distinguishing feature which appears to separate the terms hinges on the value attributed to particular learning activities with formal academic learning being favoured particularly as it carries more weight and credibility than informal and work-based learning. Education, predominantly associated with formal, structured or

academic learning, is favoured within nursing literature because it carries more weight and credibility than work-based learning. The concurrent reorganisation of the NHS in terms of funding for learning and the shift in provision from in-house to external providers coupled with the 'upgrading of qualifications' has shifted the focus towards the academic (Hewison et al 2000 p.168) thus contributing to a devaluation of practical knowledge and skills. Gould et al (2007) support this view stating 'that longer courses with academic emphasis are being promoted at the expense of those intended to promote clinical expertise' (Gould et al 2007 p.603). Yet, by definition, healthcare practitioners *practise* within clinical environments delivering patient care, implying not just the acquisition of knowledge but the application of skills and a necessity for a balance of practical skills and academic ability, in effect developing what should be the gold standard of a 'dual economy' within a healthcare context.

Learning under the CPD umbrella and advocated by the HCPC in its earlier definition, takes an inclusive approach which serves to incorporate formal, informal, work-based and incidental learning. Within their Standards of Continuing Professional Development the HCPC provide a comprehensive but not prescriptive list of learning activities which offers guidance and ideas under five headings: work-based learning, professional activity, formal / educational, self-directed learning and other. From a practitioner perspective, and in accordance with the HCPC requirements of CPD, it is considered good practice to have a broad spread of learning activities. In adopting a 'context-driven' and outcomes-based approach to CPD the HCPC acknowledges that individual's engagement in learning activities are determined by a number of issues. Practitioners' roles, responsibilities, and practice interests vary; learning opportunities will differ between organisations, as too will

the learning styles and preferences of individual practitioners. Furthermore, it is important to bear in mind that practitioner's learning needs will vary depending on how long they have been qualified and the position they hold within their department – the learning needs of a newly-qualified ODP will differ considerably from a Senior Practitioner with management responsibilities. In addition practitioner's engagement in particular learning activities are influenced by their practice context, scope of practice as well as wider organisational service needs.

The Stakeholders and Continuous Professional Development

The relevance of continuous professional development within healthcare cannot be understated, being recognised as a valuable commodity across a range of healthcare professionals under the NHS plan (DH 2000). Three key stakeholders are generally identified as having vested interest in CPD: practitioner, profession and organisation.

For the practitioner, engagement in continuous professional development is multi-faceted, with an array of reasons being identified across healthcare professional groups. Sadler-Smith et al (2000) cited three main benefits for practitioners to undertake continuous professional development: maintenance, survival and mobility (Sadler-Smith et al 2000). Evidence from within the nursing literature affirms similar reasons: personal development, career satisfaction, increased confidence and a process of learning and updating of knowledge and skills (Murphy et al 2006). For some practitioners evidence indicates that CPD has become synonymous with 'credentialism' (Morgan et al 2008), obtaining academic qualification which provides 'a simple selection for recruitment and promotion' (Hewison et al 2000 p.170). Conversely some practitioners view CPD as a necessary evil 'to prevent themselves going backwards... rather than to advance themselves' (Murphy et al

2006 p.378) or through 'fear of being overtaken by less experienced but more academically qualified staff' (Dowswell et al 1997 p.546). Rothwell and Arnold (2005) focus on professional dimensions citing 'avoiding losing one's license to practice' and affirming the 'individual as a good professional' (Rothwell and Arnold 2005 p. 29). These aspects were not specifically identified within the nursing literature. No reference was made to the relationship of continuous professional development to enhancing patient care which within a healthcare environment should be implicit.

Moving away from learning as a means for personal gain such as promotion and maintaining registration, regular engagement in CPD activities is acknowledged as having a number of further benefits. It can help build confidence within the practitioner's roles and increases credibility as a registered practitioner as well as developing coping mechanisms to manage the changing environment and updating of skills. Regular reviews of learning and reflection highlights gaps in learning, knowledge and experience which enables the practitioner to take responsibility for developing a learning structure. Linking learning to the annual appraisal process enables measurement of achievements within the practice area and is furthermore acknowledged as promoting staff morale which contributes to development of a motivated workforce which ultimately results in enhancing patient care. As organisations have shifted responsibility for learning onto the individual, the ability of the individual to take that responsibility and plan their own professional development is seen as a significant strength. It furthermore aids the organisation in planning the learning needs of the workforce which align with wider business objectives and helps in linking theory to practice.

The role of the professional regulatory body serves to set and maintain standards for its members which are ultimately designed to protect the public. This includes continuous professional development which is seen as essential for ensuring members' knowledge and skills are kept up to date as well as maintaining professional competence and capacity to practise (Friedman and Phillips 2004). The majority of healthcare professionals are required to participate in continuous professional development although there is variance between professional groups regarding monitoring and which activities constitute CPD.

Madden and Mitchell (1993) identified two models of continuous professional development – the sanctions model and benefits model. The former focuses on undertaking often specified mandatory requirements which the individual must meet in order to demonstrate consistent professional competence. Participation is closely monitored, measured by inputs such as hours completed, activities undertaken and points accumulated. Sanctions for non-compliance comprise limiting practice, working under supervision or removal from their professional register. Professional bodies, including those regulating healthcare professions, predominantly subscribe to this model, often demonstrating stringent guidelines relating to learning activities considered suitable. The NHS also subscribes to a sanctions model where its employees are required to complete statutory and mandatory training appropriate to their roles and responsibilities. No enforced sanctions exist for non-compliance although engagement in learning is linked to pay awards, progression and in some cases access to further learning activities. The sanctions model, according to Jones and Fear (1994), is more often found in older, well-established professional institutions whose policies stipulate strict guidelines as to learning activities considered suitable and often engagement and completion has with legal

requirements attached. In contrast the benefits model focuses on voluntary participation where the individual makes a conscious decision whether or not to pursue some particular form of CPD, although the benefits of engagement are emphasised by the organisation or professional body.

Both models are not without their drawbacks with Williams (1994) arguing that if CPD were purely voluntary it would become minimal as its success and uptake relies solely on the self-motivation of the individual practitioner. If individuals do not see the benefits of CPD, or are insufficiently motivated to undertake such activities, then it may appear easier to adopt a mandatory approach than attempt to change people's attitudes. Williams further raises a pertinent point in that often it is those individuals who are most in need of CPD who are least likely to engage in learning activities and imposing a compulsory policy would have no effect on those people who would most benefit from undertaking learning. Morgan et al (2006) presented a valuable discussion regarding the practical problems of a compulsory system, or sanctions model, of continuous professional development highlighting firstly the difficulties practitioners may experience in maintaining a work-life balance set against a series of competing demands especially, although not exclusively, in relation to part-time / shift-worker and employees with family commitments. Adopting an impersonal, one-size-fits-all approach furthermore fails to recognise practitioner individuality and differing learning requirements, being deemed 'quite inappropriate as development needs are very personal and members must define these for themselves' (Williams 1994 p.37). As healthcare provision becomes increasingly specialised and tailored towards areas of excellence, practitioners are themselves becoming experts within particular fields. Generic continuous professional development opportunities fulfil basic requirements for

professional registration yet may fall short of organisational expectations in fulfilling their specialist roles and growing responsibilities.

The potential for learning to evolve into a points gathering exercise denigrates the value of the learning undertaken and knowledge acquired and is raised as a further area of concern. Equally mandatory CPD could be viewed as a chore which is seen as being imposed by the professional bodies which in turns fosters resentment and resistance amongst individuals and professional group (Jones and Fear 1994) becoming viewed as coercion or a form of social control. From an organisational viewpoint concerns are further raised with regards to the capacity of the organisation to provide support for practitioners in terms of resources, financial assistance and facilitating staff attending courses or programmes of study due to service requirements.

Despite Jones and Fear's earlier statement that the sanctions model is predominantly associated with older professional institutions the professional regulatory body, The Health and Care Professions Council (HCPC), opted to implement a sanctions model approach for all its registrants from 2006, a model which meets government's healthcare regulatory framework ensuring practitioner accountability and responsibility. Within this framework practitioners are required to complete a self-declaration indicating having completed sufficient learning opportunities in order to maintain competence to continue practicing every two years. As a moderation exercise 2.5% of each registered professional group are randomly sampled to present a profile of their continuous professional development activities measured against five specific standards. If, when, reviewed by a select panel at the HPC their activities are deemed acceptable in adequately meeting the appropriate standards the

practitioner is notified of their on-going competence to practise and renewal of position on the register. Practitioners subsequently deemed as not meeting the standards are requested to re-submit an improved profile indicating their continuing professional development or are suspended from the register pending further submission of evidence of their on-going activities. Non-selected registrants complete a self-declaration form stating they have undertaken a range of learning activities which meet the HCPC Standards and as such they consider themselves suitably competent to continue to practice. This does however rely on individual practitioner's honesty and integrity in their self-declaration and consequently raises questions regards the regulatory body's robustness of its monitoring system.

This chapter has explored the multi-faceted natures of lifelong learning and continuous professional development in particular its embedded relationship within healthcare practice and professional practice. The perceptions and definitions of CPD vary between practitioner, profession and organisation. The benefits of engagement in learning activities are also highly variable between the stakeholders, being viewed as positive by some practitioners and with scepticism by others. Although the professional body sets the standards for CPD, the role of the organisation cannot be underestimated and occupies a prominent position in dictating provision and support for its employees. Organisations and their influential relationship within the lifelong learning framework are explored further in the next chapter.

CHAPTER FIVE

LEARNING AND ORGANISATIONS

This chapter focuses on the role of the organisation as both providers of learning and participants within the lifelong learning framework. Particular attention is afforded the National Health Service which promotes itself as a learning organisation, committed to supporting learning opportunities for its staff.

Origins of the concept of the learning organisation can be traced within the literature to the 1980s (Wang and Ahmed 2003), although reference to the links between employee learning / training and increased company performance exist in the early 20th Century (Jones and Hendry 1994). Whereas emphasis within these early companies predominantly focussed on developing practical skills within its workforce, today's learning organisations place equal value on the development of knowledge and skills considered essential to ensuring organisational competitiveness. Yet support and provision of learning opportunities within organisations operate within a narrow framework, governed by wider external agendas which directly influence the type of learning activities required of its employees.

The term *learning organisation* is widely employed. A review of the literature, however, fails to provide a coherent, explanatory, functional definition with researchers stating that it is a problematic concept 'widely debated and frequently contested' (Boreham and Morgan 2004 p.307). Jones and Hendry (1994) argued that definitions fail to provide insight into what it is and how it works. This results from current learning theories being 'typically weak in spelling out the specific processes

or actions that make the learning process' (Engeström in Boreham and Morgan 2006 p.308), which they argued contributes to failings within the implementation of learning processes within organisations. A frequently cited definition of a learning organisation comes from Pedlar et al as one 'that facilitates the learning of all members and continuously transforms itself' (Pedlar et al 1988 p.3). This definition is suggestive of a reciprocal, mutually beneficial relationship between organisation and employee. It is furthermore reflective of lifelong learning policy intention in terms of investment in human capital with associated benefits of efficiency, profitability and flexibility and the necessity for organisations to adjust and modify practices in response to external pressures.

Providing a critique of the above definition Jones and Hendry (1994) questioned the concepts of 'learning' and 'transformation'. They raised concerns regarding the nature, levels and types of learning involved within organisations in particular how these are adequately recognised, especially amidst different staffing levels and groups. Regarding transformation, uncertainty surrounds its process, in particular the drivers for transformation in terms of what is being transformed – the individual and/or the organisation. One especially valid point raised surrounds the nature of the transformation process in so much as they argue it could be purely a mechanistic, developmental tool implemented as a means to an end without consideration of the wider implications and involvement of all levels of employees.

Marsick and Watkins (2002) presented four metaphors for understanding the changing nature of learning within organisations: machine, open systems, brains / holograph and chaos / complexity. These metaphors are discussed in the context of the changing nature of workplace learning whereby each metaphor is applied to a particular era of organisational development. Within the machine metaphor, which

they closely associate with the industrial age, organisations were bureaucratic and hierarchical with learning structured, identified, and implemented in accordance with defined company objectives. The open systems metaphor shifts the emphasis towards the learner, adopting Knowles' andragogical (Knowles 1975) approach to learning whereby learners are acknowledged as having differing learning needs and goals and whereby learning is negotiated with collaboration between individual and organisation. Reflective practice and experiential learning through critical or adverse incidents with an emphasis on informal work-based learning activities can be attributed to the brains / holograph metaphor whereby individuals are becoming more autonomous with elements of a 'bottom-up' approach to learning. Extending this image the chaos/ complexity metaphor represents an empowering organisation where learning is fluid and individuals work together in responding to environmental changes and subsequently initiating change within the systems in place.

Although discussed as separate, individual models, each metaphor encompasses and builds on elements of its predecessor. Interestingly these metaphors tend to focus exclusively on informal and work-based learning activities at the expense of acknowledging wider and formal learning activities which could be deemed as being of benefit to the organisation. Learning organisations, furthermore, do not fall into neat definable categories. Whilst a learning organisation may subscribe to a particular metaphor it is dictated to by prevailing 'global concerns about change and survival' (Tight 2002 p.43) which often results in adopting a different or more appropriate position in response to external pressures. Frequently two learning models may be employed which run concurrently depending on internal and external factors but which are still very much governed by the current social and political climate. Particularly during times of economic instability and uncertainty

organisations will exercise tighter control measures in order to achieve efficiency and sometimes at the expense of learning strategies altogether.

The NHS as a Learning Organisation

In an ideal world, organisations, in responding to global and economic change thus safeguarding their competitive edge, should value employees' individuality and contributions, utilise their collective knowledge and experiences through investment in training and development (Wenger et al 2002). The NHS is no exception to this, although its primary role is provision and delivery of an effective and efficient service for its clients. To achieve this it requires appropriately qualified and trained healthcare professionals with the right knowledge and skills. Integral to service delivery is the provision of suitable learning opportunities which directly contributes to its competitiveness in the healthcare market, and indirectly enables practitioners to fulfil professional development needs.

The Knowledge and Skills Framework

Traditionally the NHS has been regarded as a less than supportive employer particularly in areas relating to staff career development which has often resulted in staff leaving to find employment elsewhere (Sheperd 1995 in Gould et al 2006). Acknowledging the positive links between staff development, staff retention and effective health service delivery saw the implementation of a comprehensive staff education and training structure (DH 2000). Integral to this framework was the inclusion of a robust appraisal system which supports a comprehensive programme of staff development which is associated with better patient outcome and reduced mortality (West et al 2002).

Recognising these relationships the government set out to invest in healthcare professionals and sought to remunerate staff in accordance with their increasing clinical responsibilities, increased workload and rapid service changes (DH 2000). *Agenda for Change* was introduced as a mechanism of streamlining, restructuring and re-establishing control which outlined the new method of linking pay to performance. Integral to *Agenda for Change* is the Knowledge and Skills Framework (KSF) which 'describes the knowledge and skills with which NHS staffs need to apply in their work in order to deliver quality services' (DH 2004a p.3) and comprises pre-prepared national job profiles assessed through post evaluations which awarded points according to skills and knowledge deemed appropriate to undertake the job. The annual appraisal system was identified as key in assisting in identifying learners' needs which subsequently linked with organisational service objectives and government initiatives as well as contributing to training needs analysis. Gould et al (2006) provided a useful and critically constructive assessment of the advantages and challenges associated with the implementation of the Knowledge and Skills Framework raising some pertinent observations particularly in relation to its limitations. A number of key and complex inter-related factors were identified as being instrumental in directly affecting the outcome of the new system: practitioner, manager, organisation, professional body and higher educational institutions.

In order for the new system to be successful, a change in attitude was required at all levels within the organisation with more effective communication between practitioner and manager in executing the appraisal process. Recognition and closer alignment of practitioner's learning needs to their post outline was identified as an essential requirement. Provision of constructive and realistic opportunities for

undertaking learning as well as signposting prospective promotional opportunities was considered an important aspect of the manager's role. Alongside this was effective assessment of training needs both for the individual practitioner as well as their immediate working environment with direct links to wider organisational objectives and service requirements.

Despite substantial financial input into the implementation of this new and improved framework, evidence from the National Audit Office (NAO 2009) strongly suggested that it has yet to achieve its intended potential. A number of issues have been identified as complicating its success (Gould et al 2006). The expanding and specialist nature of some roles becoming more apparent within certain areas of healthcare practice, and to some extent within operating department practice, creates pressures at a number of levels particularly with respect to meeting the ever-increasing diversity of continuous professional development activities. The increasing diversity and specialist nature of practitioner roles, with the creation of extended and associate roles, often do not sit within the pre-determined and fairly broad post outlines. Experienced practitioners may therefore exceed their role dimensions and with limited promotional opportunities coupled with reduction in learning activities available may leave for better employment opportunities elsewhere.

Whereas responsibility for undertaking continuous professional development lies solely with the practitioner, it is acknowledged that the organisation has obligations to ensure their employees maintain currency and capacity to undertake their responsibilities. Under the clinical governance framework, of which risk management forms an integral component, and in conjunction with NHS Litigation Authority staff training and development, especially completion of mandatory

training, contributes to reduction of indemnity insurance for Trusts. Achievement of the Clinical Negligence Scheme for Trusts (CNST) risk management standards by Trusts means that they are putting into place systems for ensuring that the quality of healthcare is maintained and improved and reducing the scope for clinical negligence claims. Regular visits by representatives of this organisational body serve to determine the level of indemnity insurance for each trust depending on compliance with their framework. Within this framework responsibility sits with the Trust's Chief Executive who is responsible for ensuring that all staffs receive training suited to their current and future needs and career development and succession planning is identified for all staff.

Once considered a separate entity, training and development has come to be regarded as an intrinsic component of the Clinical Governance Framework which states that 'NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish' (DH 2000 p.6). As a learning organisation the NHS displays commitment to promoting and supporting learning and is an important stakeholder within the lifelong learning framework, with national policies promoting the continuing development of its staff. In supporting learning, it acknowledges the value different types of learning can bring to improving patient quality and care, and expects staff to hold the right skills and knowledge appropriate to their role. Whilst pre-registration qualifications for healthcare practitioners are now predominantly diploma and degree level, a review of person specifications for roles within the NHS recognises the importance of having a 'dual-economy' in obtaining the balance between knowledge and skills,

qualifications and experience, within its workforce, and thus endeavours to support both formal and informal learning activities.

Healthcare systems, as Parkin (2009) pointed out, are traditionally built on a dominant bureaucratic model comprised of multiple-tiered administrative structures which are bound by rules and routines. Learning within healthcare organisations similarly adopts a 'top-down' approach whereby 'responsibility, authority and power is vested at the top' (Koeck 1998 in Parkin 2009). An examination of educational strategies and learning policies indicates a '*semi-managed*' approach to training and development which echoes this bureaucratic model. As with most organisations its learning strategies are determined by wider external pressures and are thus closely aligned to specified standards, objectives and goals. Operating within this framework determines a criterion of expectations of its staff in terms of level and type of learning.

As a minimum, staffs are required to complete Statutory and Mandatory training pertinent to their role and level of responsibility on an annual basis. Completion of this training, with robust records of evidence available, ensures a minimum safe level of safety and quality which complies with the requirements of the framework's mandate with penalties existing for non-compliance (DH 2000). Wider lifelong learning and CPD such as formal, post-registration modules and pathways are considered valuable in enhancing service delivery and patient care. These forms of learning are funded and commissioned by regionally-based departments of Health Education England (HEE) in response to learning requirements identified by local Trusts.

Gould et al (2004) provided a critique of the Training Needs Analysis (TNA) concept which is employed by organisations as the 'initial step in a cyclical process' in contributing to the education and training of its employees (Gould et al 2004 p.471). Their review of the purpose of the TNA indicated fairly broad aims: career planning, meeting continuous professional development needs and improving service delivery. Learning needs should emerge from the individual practitioner through completion of their annual appraisal in conjunction with departmental and wider organisational objectives.

This process of commissioning appears to subscribe to an open systems metaphor exhibiting a 'holistic, integrated' learning organisation where learning is self-directed and participatory (Marsick and Watkins 2002 p.37) and where individuals are encouraged to take a responsible, proactive approach to the management of their own learning. But as Gould et al (2004) further point out evidence indicates that TNAs are not being appropriately utilised, leading to shortcomings in the commissioning processes. They attribute the weaknesses to disparity and lack of mutual cooperation between the stakeholders involved in the processes which results from their differing roles and interests, as well as time-consuming and ineffective communication processes.

Utilisation of a Training Needs Analysis and the semi-structured approach to staff appraisals in aligning individual learning with organisational objectives indicates an element of control which echoes the underlying principles of a machine metaphor. This refutes Marsick and Watkins' suggestion organisations have moved away from the 'compartmentalised, almost assembly line approach to learning' (Marsick and Watkins 2002 p.34). Despite criticism of the machine metaphor's controlling and instructional approach to organisational learning it could be argued that this model

provides the central foundation for learning within the NHS which strives for safety and quality within a rapidly changing environment. Specific learning for particular staff groups builds on completion of statutory and mandatory training requirements and thus serves to reinforce the foundations.

Padaki (2002 in Parkin 2009) claimed that successful learning within organisations is the product of interactivity of all its parts – individual, team and organisation. This ideology is echoed in the examination of learning within organisations undertaken by Wenger et al (2002) with a primary focus on the value communities of practice can have in developing organisations. Because communities share common goals and knowledge within their respective teams and hold multimembership outside of their normal environments, this creates a valuable learning loop which benefits all:

Organisations need to cultivate communities of practice actively and systematically, for their benefit as well as the benefit of the members and communities (Wenger et al 2002 p.12).

Senge, in his examination of learning organisations, displays acute awareness of the importance learning can bring to organisations stating that ‘Organisations learn only through individuals who learn. Individual learning does not guarantee organisational learning. But without it no organisational learning occurs’ (Senge 2006 p.129). He uses multiple examples of successful businesses whose former founders understood the importance of providing for their employees. He uses the term ‘personal mastery’ to explain the importance of personal growth which he argues encompasses more than competence and skills to undertake their role, and learning is more than the acquisition of knowledge and information.

People with high levels of personal mastery are continually expanding their ability to create the results in life they truly seek. From their quest for continual learning comes the spirit of the learning organisation’. (Senge 2006 p.131).

The development of a learning loop is founded on the commitment and interaction of the individuals within their communities which are driven by common aims and shared meanings (Senge 2006 p.307). Attunement of managers to the networks of communities and investing in learning and education produces both short and long term benefits for community members and organisations (Wenger 2002 p.15).

Investment in learning opportunities for employees fosters a learning society, which is considered to be the foundation of lifelong learning theory. Although a contested concept, the creation of a learning society serves to generate knowledge necessary for the work-force to compete in the global market (Jarvis 2000 p.345). Within a healthcare context this relates to having a workforce which is competent to practice, responsive to changes in service need and delivers high quality patient care.

Communities of practitioners further contribute to the development of a learning society through demonstrating both the technical and non-technical dimensions of professionalism described previously. The motivation and commitment of practitioners to embrace their professional qualities and responsibilities, in effect displaying 'personal mastery', increases the knowledge held both within the community and the organisation.

Within healthcare organisations, however, there is a tendency to focus on individual learning with the team or group being omitted. A review of healthcare learning undertaken by the Department of Health (DH 2000) acknowledged that focussing on the individual can at times be detrimental to systems learning, resulting in their becoming uncoordinated and lacking coherent direction. Although learning is taking place, and arguably valued by the individual as contributing to their own professional development, questions could be raised as how individual learning

contributes to wider organisational learning. This ultimately questions how well the organisation transforms itself in response to external pressures.

The predisposition of healthcare organisations in adopting a 'top-down' approach could arguably be detrimental to both individual and organisational learning. Its characteristics indicates a one way system which neglects the influence practitioner learning can have on changing practices and wider organisational transformation. In addition, this mechanistic model could be accused of reducing motivation and creating barriers to learning, as learning options are often limited, bound by organisational structures and meeting government targets. Carroll and Edmondson (2002) presented a pertinent case that healthcare organisations fail to foster a wholly progressive, continuous learning culture due to its pre-occupation with correcting poor practice and learning through mistakes. This leads to a reactive rather than proactive approach to managing learning activities and arguably contributes to the less-than-successful implementation of the Knowledge and Skills Framework. In addition are the numerous occupational and professional groups, whose cultural demarcations and distinctive roles exert opposing pressures to change and transformation within their organisation (Brooks and Brown 2002). The conflicts between organisation and profession with regards to provision of learning are acknowledged within health policy:

There is the possible tension between professional bodies...in managing CPD. Professional bodies set standards but service heads within Trusts determine what is to be done in line with local service requirements (DH 2004 p.9).

Wang and Ahmed (2003) acknowledged that a learning organisation is 'founded on the learning processes of the individuals in the organisation' and thus have a significant impact on the practices of organisational learning (Wang and Ahmed

2003 p. 9). In providing a critical review of organisational learning, they reinforced the point that learning is a multi-dimensional concept and not 'simply a collectivity of individual learning processes' (Wang and Ahmed 2003 p. 15). Although they acknowledged that individual learning does not necessarily translate into organisational learning the organisation should take steps to integrate individual learning into organisational learning.

For hospitals to achieve their goals and display evidence of continuous improvement, learning, according to Bohmer and Edmondson (2001), must occur at the individual, group and organisational levels. Examining the current state of learning within the healthcare sector, Carroll and Edmondson (2002) present three ideas for improving learning practices within the healthcare sector – recognising and enhancing individual employees' capabilities, more effective leadership from managers and recognition of interdependency of teams and cultures. Processes are already in place such as the training needs analysis and appraisal although as discussed have been found to be less than effective. In terms of more leadership and support from managers, Marsick and Watkins (2002) rightly observed that:

Managers were well suited to guide their employees...but their skills were in getting work done rather than in helping employees learn. (Marsick and Watkins 2002 p.35).

This shifts the onus onto the individual practitioner to shoulder responsibility in managing their own learning leads and take a more proactive approach alongside current existing mechanisms in order to foster an integrated learning culture.

Utilisation of a Training Needs Analysis and the semi-structured approach to staff appraisals in aligning individual learning with organisational objectives indicates an element of control which echoes the underlying principles of a machine metaphor.

This refutes Marsick and Watkins' suggestion that organisations have moved away from the 'compartmentalised, almost assembly line approach to learning' (Marsick and Watkins 2002 p.34). Despite criticism of the machine metaphor's controlling and instructional approach to organisational learning, it could be argued that this model provides the central foundation for learning within the NHS which strives for safety and quality within a rapidly changing environment. Specific learning for particular staff groups builds on completion of statutory and mandatory training requirements and thus serves to reinforce the foundations.

This chapter has explored the nature of the learning organisation and how learning is managed within some organisations, with particular attention given to learning within the NHS. The following chapter focuses on these experiences and influences as directly applied to the professional group of Operating Department Practitioners.

CHAPTER SIX

CONTINUOUS PROFESSIONAL DEVELOPMENT AND THE OPERATING DEPARTMENT PRACTITIONER

The relationship of continuous professional development within the professional group of Operating Department Practitioners forms the focus of this chapter. It explores the factors which influence and motivate practitioner engagement in learning activities and draws upon the concepts of disposition and motivation of learners towards their learning responsibilities.

Amidst an increasingly complex, politically motivated and economically driven healthcare organisation these words from Handy are especially pertinent when he states that 'change is a necessary condition of survival' (Handy 1993 p.291).

Arguably academicisation and professionalisation are prerequisite conditions for the survival of the Operating Department Practitioner. Change has undoubtedly elevated the practitioner's social status putting them on equal footing with other healthcare professionals and opened up new opportunities for personal and professional development. Particularly for those practitioners holding the diploma whose qualification could be viewed as being a valuable commodity in terms of mobility.

What if change, implemented for positive reasons, produces negative consequences and barriers to learning for the practitioner?

Continuous professional development, although not an unfamiliar concept, has taken on new meaning, urgency and relevance for the practitioner. Responsibility and accountability to the professional regulatory body confers expectation on registrants to engage in continuous professional development as a mechanism for re-registration ensuring not only 'fitness to practise' but enabling the individual to maintain

employment. Professional development formed an intrinsic component of the Knowledge and Skills Framework (DH 2004a) linked to pay awards and progression determined through annual appraisals. Completion of statutory and mandatory training by all staff members enables organisations to meet government targets for patient safety and service delivery.

Impending proposals of an all-graduate profession, considered more effective in delivering patient care (Davey and Robinson 2002), has increased the imperative nature of undertaking continuous professional development particularly formal academic programmes of study. Resulting from the shift to a knowledge-based society it also situates the practitioner amidst conflict regarding the value attached to particular learning activities. This arguably contributes to the devaluing of practical-based learning and development of clinical skills. Although government policy supports and encourages academic achievements, health policy is becoming 'increasingly focussed on skills' (DH 2004b p.13), taking a back to basics approach to patient care.

Just as change is an inevitable aspect of life, resistance could be viewed as an inevitable aspect of change. Parkin (2009) discussed three levels at which resistance can occur - individual, group and organisation. The individual, usually identified as the primary challenger, resists change through fear of the unknown (Paton and McCalman 2000) and loss of a comfortable, stable situation (Upton and Brooks 1995). Coghlan (1994 in Parkin 2009), however, criticised the tendency to focus on the individual as, by their nature, they exist within wider communities and organisations and are thus subject to often non-negotiable external factors. Professional groups, resulting from their own unique identities with deep seated cultural and historical characteristics, may obstruct the change process; a term

Brookes and Brown (2002) referred to as '*tribalism*'. Evidence of this concept of tribalism was especially apparent during the inception of professionalisation and academicisation for the Operating Department Practitioner where pockets of practitioners expressed their concerns with the then imposed changes. More recently resistance to future changes with the advent of an all-graduate profession can be observed.

Organisational factors such as management, communication and culture are significantly implicated in resisting change (Hoag et al 2002 in Parkin 2009). Of particular interest Ashford et al (1999 in Parkin 2009) contended that health service bureaucracies do not readily incorporate change due to their divergent commitments, multi-cultural differences and financial constraints. Organisational change is often implemented without thorough consultation with all affected parties or due consideration of immediate and future impact reflecting the ingrained bureaucratic management tendency to adopt a 'top-down' approach to change.

Paton and McCalman (2000) further claimed that resistance results from insufficient attention to the processes involved in implementing change, suggesting communication can serve to alleviate some aspects of resistance, but this may not always be effective. The Health and Care Professions Council initiated an extensive consultation process outlining plans for the introduction of continuous professional development. Of the 7,500 registered ODPs at the time only 0.1% responded to the consultation (HCPC 2005 p.7) displaying lack of engagement in the change process. Purdon (2003) questioned the consultation process on a number of fronts in particular the degree to which members were informed of the process and whether they 'really have a voice in...policy development' and:

while it cannot be disputed that most new... polices do involve an element of consultation with the profession, responding to consultation does not necessarily mean that respondents' views will be valued or taken on board (Purdon 2003 p.435).

Evidence from the first re-registration process for Operating Department

Practitioners highlighted similar problems in that 'the individual did not really understand what the HCPC CPD standards were' (Harper 2010 p.1), despite resources and support available to assist practitioners.

The Health and Care Professions Council requires all registrants to undertake a 'range of learning activities' (HCPC 2006). Their extensive but not exhaustive list of activities are sufficiently diverse to acknowledge the differing roles and responsibilities of individuals and as such recognise their 'different learning styles' and accommodate practitioners who prefer to 'learn through only one form of activity' (Rogers 2002a p.20). But there still exists the underlying assumption practitioners will possess the necessary attributes, whether academic credentials or self-motivation, to engage in learning as 'learning to learn skills are not innate' (Knapper and Cropley 2000 p.48). They further acknowledged that some adults experienced difficulties forming new frameworks especially engaging in formal learning activities, in particular those adults who are settled in their immediate situation which echoes Wenger's earlier discussion relating to marginalisation and peripherality. Friedman and Phillips (2004) add to the debate stating 'older and more senior professionals are more likely to resist participation in CPD programmes' (Friedman and Phillips 2004 p.367). Although Knowles (1975) argued adults are self-directed, the extent to which individuals are self-directed with regards to taking responsibility for their learning is highly variable. Importantly some individuals are only interested in learning activities directly applicable to their current or future role

(Hodkinson and Hodkinson 2004) or governed by their managers in relation to current roles, responsibilities and wider organisational agendas.

Participation, equally non-participation, and the learning activity undertaken, are influenced by a complex relationship:

A learner's current disposition to learning can be understood only through their past lives, including their position in relation to various fields that they occupied, together with their experiences and interactions with others, in the past' (Bloomer and Hodkinson 2000 in Hodkinson and Hodkinson 2004 p176).

The immediate work environment can also exert influence and change over individual's disposition towards particular practices such as engagement in learning. Applying this theory of society to the research context it could be suggested that the content of the current diploma programme, which has embedded within its curriculum learning to learn skills and continuous professional development responsibilities, instil this particular group or society of practitioners with a 'lifelong learning disposition'.

Associated with disposition is motivation which, according to Smith and Spurling (2005), is a multi-faceted concept. Motivation can be loosely defined as 'the personal experience of keenness for pursuing an intended action or goal' (Smith and Spurling 2005 p.2) and consists of 'internal processes and external incentives' which serve to satisfy a need (Child 2000 p.44). In his study into human behaviour, Maslow viewed motivation in terms of an individual striving for growth and explained it through reference to a 'hierarchy of needs' (Maslow 1962), which comprises five stages: physiological, safety, belonging, esteem and self-actualisation. A much held assumption within lifelong learning theory is that all individuals are motivated to learn. According to Maslow's research, in order for

individual's higher motivational needs such as esteem and self-actualisation to come into play, the lower physiological, safety and social needs are required to be fulfilled. Thus, for individuals to exhibit motivation to engage in any form of learning, the lower needs are necessary pre-requisites.

A number of factors are recognised as being responsible for directing an individual's pursuit of an intended goal. Two frequent forms of motivation are referenced within the literature, those of extrinsic and intrinsic. Extrinsic motivators focus on external stimuli and incentives. Factors which directly influence the individual to engage in a particular practice or goal primarily relate to results, rewards, competition, challenge and punishment (Child 2000). McGivney (1990) developed the expectancy theory which built on the argument that motivation is governed by the expectancy of reward or success by including a value system. According to this specific dimension individuals are less likely to engage in learning activities if there are no direct benefits or value attached such as career enhancement. Intrinsic motivators originate from within the individual and are driven by a need to succeed or survive. They derive from an internal desire and are considered stronger and more enduring than extrinsic factors (Rogers 2002b p.95). They often involve challenge, curiosity and control (Child 2000 p. 58) and relate to identity or a sense of belonging to a particular group as a way of establishing oneself amongst peers and colleagues.

Additional motivational and inter-related factors towards adults and their engagement in learning are cited within the literature: social influence (McGivney 1990); workplace, family and community (Smith and Spurling 2005). Exploring the influence of the workplace in developing individual motivation, Crumpton (2013) argues that the basic physiological and safety needs are beyond the realms of the workplace, although security of employment can serve to provide the basic level

needs. Changes in the individuals' employment status can affect the status of these two levels and thus affect the individuals' motivation.

Social factors associated with individual motivation build on the intrinsic factors discussed previously and relate to developing personal aspirations, being accepted and gaining respect by peers. Active social participation within a community of practice is recognised as having positive effects and fosters increased motivation amongst its members especially where the individuals are committed to their work (Ilacqua and Zulauf 2000). This is equally reinforced within organisations that invest in their employees, respect their contribution and recognise the value which committed and motivated team-working can bring. Understanding the social complexities and dynamics of the workplace can assist organisations and policy makers in developing a learning culture as well as directing individuals towards their own goals.

In discussing the roles which employer, manager and colleagues play with regards to providing support and motivation, Smith and Spurling (2005) portrayed them as being predominantly positive in their influence. However, they overlooked the possibility that they may be disadvantageous or have a negative influence on individuals, and hence potentially curtail the development of a learning community. For some nurses, they viewed their managers as 'gatekeepers' and considered them to be detrimental to learning (Gould et al 2007). The lack of organisational and managerial support coupled with the unavailability and inaccessibility of suitable learning opportunities could be considered de-motivating for the individual. According to this specific dimension individuals are less likely to engage in learning activities if there are no direct benefits or value attached such as career enhancement. Individuals may also experience negative motivation, or de-

motivation, for something that is necessary or enforced (Smith and Spurling 2005 p.5), such as the introduction of mandatory continuous professional development. Social factors can be equally limiting in such that the individual may only choose to undergo personal development within the social context to which they belong and neglect external or neighbouring influences. A less cooperative or dysfunctional community, where individuals are de-motivated or not supported by their organisation, could breed discord amongst its members.

Examination of motivational factors from within healthcare professions appears to be a combination of intrinsic, extrinsic and social factors. Extrinsic factors are varied within the healthcare sector according to McGiveny (1990) but are mainly driven by government policies and dictates such as service need, initiatives, target setting. Within the context of learning, external factors such as meeting organisational requirements as part of their employment status and maintaining competence to practice within their professional responsibility remit provide external motivation for the individual. Additionally, and with respect to the benefits associated with lifelong learning policy, social mobility and financial incentives through promotion are deemed as extrinsic motivational rewards.

Morgan et al (2008) identified three key motivational factors which influenced senior nurses to engage in continuous professional development. These were acknowledged as the need to remain competitive, both for themselves and for their respective organisation; to gain competence to pursue personal advancements within their role, and maintaining professional competence. Similar motivators were referred to by Murphy et al (2006) during their investigation into Nurses in Ireland who stated that their main reasons for undertaking continuing professional development related to improving self-esteem and confidence in their role and

expectation of promotion. Exploring motivation from within midwifery indicates that their primary reasons for engaging in learning were intrinsically driven by the philosophy of being a midwife which encompasses valuing their relationships with their patients and a need to provide the best care for their patients. For this group, supportive relationships with their peers were considered equally important in motivation (Gray and Barnes 2013).

According to Megginson and Whittaker (2007), successful learning is founded on a mutual relationship between employer and employee where both parties benefit. The learner is proactive in determining their own learning needs, is empowered by the process and learning becomes 'an integral part of all work activity' (Megginson and Whittaker 2007 p.5). Field (2006) alluded to 'a balance of responsibilities between individuals, employers and state' (Field 2006 p.206). Within the healthcare context, neither Megginson and Whittaker's holistic portrayal nor Field's synergistic ideal are feasible. Although flexibility and choice exists, 'neither the learning careers of individual workers nor the communities of practice that they inhabit can be separated out from the wider contextual issues' (Hodkinson and Hodkinson 2003 p.17). Organisational directives exert a form of social control over their employees which divide and shift responsibility for learning. This controlling influence could be accused of undermining the practitioner's responsibility and ability to engagement in learning opportunities. Managers themselves are governed by organisational mandates which can influence the practitioner's learning activities further serving to dilute individual responsibility. These obstacles furthermore can contribute to a less motivated workforce.

The primary function of the NHS is service delivery and high quality patient care, thus learning exists 'within a wider societal environment, which may or may not be

amenable to the improvement of organisational learning' (Keep and Rainbird 2002 p.81). As a result learning often dissolves into a 'marginal activity' (ibid p.68).

Training and development is determined according to organisational objectives and service needs, and is increasingly focused on essential knowledge and skills critical to delivering high quality healthcare. In line with organisational policy, practitioner's learning needs are identified, negotiated and agreed with their line manager through completion of an annual appraisal or Personal Development Plan (PDP). Whilst enabling practitioners to determine their learning needs for the coming year, it does not guarantee support or funding, nor does it make allowances for ad-hoc learning or changes in circumstances after completion.

Learning, according to Keep and Rainbird (2002), is further hindered by cultural, structural and organisational barriers which include class structures, lack of employer-employee relations, poor management and financial constraints.

Additional, and more specific, barriers cited within the literature include a lack of time to be released to attend learning coupled with an increased workload (Sturrock and Lennie 2009), lack of understanding of CPD issues (Bell et al 2001), shortage of staff and inadequate management support (Gould et al 2007). These issues are further compounded by 'protected learning time' and increased financial support for medical staff (Sturrock and Lennie 2009).

The current difficulties being experienced within the NHS, particularly the financial situation has served to create a less than ideal environment for engaging in continuous professional development. Whereas responsibility for learning rests with the individual, the professional body maintains overall control. The organisation, however, holds the purse strings which place the practitioner amidst almost perpetual conflict between professional accountability and organisational

obligations. In addition to the barriers previously cited ODPs' engagement in learning is furthermore inhibited through their smallness in numbers in comparison to the more dominant professions of Nursing and Midwifery. The lack of belonging or affiliation to a larger healthcare professional group such as Allied Health Professionals could be cited as a barrier to learning and learning opportunities. Recent re-structuring of the NHS has seen budgets for learning reduced which increases competition amongst all applicants. As a highly-specialised profession specific programmes of study for theatre staff and ODPs in particular are often limited, unavailable or inaccessible.

Professional education provides an additional barrier to learning through introducing selectivity, marginalisation and social exclusion, not only between professions but also within professional groups (Francis and Humphreys 2000). The move to higher education and introduction of a diploma level qualification has introduced three levels of ODP qualification each with their own capital. All practitioners hold an appropriate professional qualification and are deemed competent to practice. Yet those practitioners holding a non-academic qualifications could be excluded from accessing formal programmes of study as 'educational institutions may create a barrier to lifelong learning' (Francis and Humphreys 2000 p.153) through the setting of entry criteria and demonstrating reluctance and resistance to change (King 2002). In attempting to promote equality and inclusivity, and thus close the 'cultural distance', Francis and Humphreys suggested a flexible accreditation of prior learning (APL) based on practical skills and knowledge. The APL system may be viable on paper, and is acknowledged as being integral to NHS lifelong learning strategies (DH 1999, DH 2004), but Francis and Humphreys appear naïve in assuming that practical skills enable ease of access into higher education as

traditionalists' value propositional knowledge over process or practical knowledge. This further serves to highlight the elitism associated with higher educational institutions, academic credentialism and the disjointed relationship or theory / practice divide apparent between academia and clinical areas (Maben et al 2006).

CHAPTER SEVEN

ETHICAL CONSIDERATIONS

This chapter explores the ethical dimensions of research practice and their application within this research project. Furthermore, as a practitioner researching their own area of practice, the often contentious area of practitioner-research is discussed.

Ethics is the matter of principled sensitivity to the rights of others. Being ethical limits the choices we make in the pursuit of truth. Ethics say that while truth is good, respect for human dignity is better. (Bulmer 1982 p.3).

Bulmer's quote reflects the over-arching importance of ethical considerations associated with the research processes, which according to Creswell (2009) should not be limited to obtaining relevant ethical approval for the study but actively employed and reviewed throughout. Although primarily intended to protect participants from misconduct and impropriety equally important ethical principles can serve to protect the researcher. Ethical approval for this study was obtained through National Research Ethics Service (NRES) and the Open University's Research Ethics Committee.

Three fundamental ethical considerations are identified: privacy and dignity of the participant, avoid causing harm and maintaining confidentiality (Galliher in Bulmer 1992 p.152). Respect for human dignity infers that individuals are autonomous agents with capacity to make their own decisions regarding participation and exercise their right to withdraw at any point from the research (Polit et al 2001 p.78). Treating participants as individuals rather than providers of information and

acknowledge any form of research as an intrusion, threat or invasion of privacy is paramount. Cohen et al (2003) reiterate the importance levelled at researchers to 'strike a balance between the demands placed on them as professional scientists in pursuit of truth and their subjects' rights and values potentially threatened by the research' (Cohen et al 2003 p.49).

Confidentiality to within the limits of the regulatory body and the Law and anonymity are integral ethical considerations. Confidentiality can be defined as a 'promise that you will not be identified or presented in identifiable form' (Sapsford and Abbott 1996 in Bell 2005 p.48) with anonymity referring to the inability to identify the individual or site from the information provided. Although viewed as an ethical norm the degree to which confidentiality and anonymity can be guaranteed is questionable (Walford 2005). Barnes raised a pertinent observation in that once information is disclosed to the researcher 'confidentiality is at risk' (Barnes 1979 p.145). Extending this further once information is within the public domain and easily accessible through electronic means individuals and research sites can become identifiable.

Applied to this study confidentiality and anonymity was assured through non-identification of participants during the interview phase with the ODP Training Supervisors. Each was assigned a pseudonym, and their respective organisations were not identified. Following Hopkins' (2004) suggestion, the interviewees were offered the opportunity to read the transcripts of the interviews to comment on accuracy of reporting and ensuring no misrepresentation. For the questionnaire phase anonymity was assured as participants and their details were not seen by the researcher as the questionnaire was issued through the College's Professional Officer. Personal details were not considered a requirement of the survey and

through using the online survey for data collection anonymity for the respondent is further assured. This degree of anonymity proved beneficial in enabling respondents to be honest in their responses and opinions, eliminating the effects of personal bias (Denscombe 1998 p.107).

Robson (2007) extends Galliher's principles to include consent although debate surrounds its necessity and inclusion. Bowling (2002) argued that consent 'reduces the legal liability of the researcher' (Bowling 2002 p.157) serving to protect the researcher rather than the participant. Informed consent assumes participants have sufficient information regarding the nature of the research which can be either written or implied, although the extent to which participants are fully informed can also be questioned. Robson uses the '*principle of voluntary consent*' which implies the individual has given his/her permission by the act of taking part, in effect exercising their rights as autonomous agents. This principle applied to the quantitative phase of data collection whereby practitioners exercised their right to participate within the online questionnaire or choose not to do so. Obtaining written consent from a large sample would have been not only extremely time-consuming but also impractical. In order to provide sufficient information for prospective participants to make an informed decision a short covering statement accompanied the email issued to practitioners outlining the purpose of the research, their role and rights as participants as well as the researcher's responsibilities.

In accordance with ethical guidelines, written consent applied to the interview phase which aided in establishing a degree of trust between the researchers and the researched, ensuring honesty and integrity of the research. The Training Supervisors were firstly asked whether they would be interested in participating in the interview phase during a Placement Provider meeting. Those approached and agreeable were

later contacted by email with an accompanying participant information leaflet (Appendix A) outlining the overall intention of the study and their position within the research process. Providing sufficient information helped in the recruitment process whereby participants were able to make an informed decision in relation to their right to participate. Consent was obtained prior to the arranged interview date in order to provide sufficient time to read and re-read the protocol, clarify any issues and establish the roles and responsibilities of researcher and researched (Appendix B).

Practitioner Research

According to Hart (2005), ethical issues can arise at any point during the research process, being especially evident and particularly challenging within the role of practitioner-researcher.

The nature of the research which supports a mixed methods approach of combining both positivist and interpretivist philosophies situates the practitioner-researcher amidst sustained debate between two opposing, hierarchical, methodological approaches. Traditionalists observing positivist conventions endeavour to maintain the separation of research and practice arguing 'the researcher's role is distinct from and usually considered superior to the role of the practitioner' (Schön 1983 p.26).

Conversely advocates of interpretivist philosophies actively embrace the contributions practitioners can bring to their research field and thus establishes the researcher's role as integral to the inquiry.

The role of practitioner-researcher is a contested area with critics questioning the dual role particularly on the grounds of blurring the boundaries between roles (Fox et al 2007) which serve to create difficulties in establishing and maintaining a

workable balance between research commitments, maintaining objectivity, obtaining desirable outcomes and minimising the introduction of personal values and bias.

Fraser (1997) expands on the role conflict issue identifying potential discord between the various personas associated with practitioner-research, that of educator, researcher and healthcare professional. Shaw (2005) and Shaw and Lunt (2011) present a critique of the concerns surrounding the evolving role of practitioner-research including the obstacles which serve to marginalise it from 'mainstream research'. One main drawback, they argue, is the tendency to separate practice from theory due to the nature of practitioner-research being embedded within the realms of professional practice which fuels the argument for separation from mainstream research traditions. They further discuss issues surrounding the perceived lack of research experience on behalf of the practitioner which questions the quality of research undertaken.

Role conflict can further extend beyond the duality of practitioner-researcher to include wider roles and relationships with colleagues, service users and organisation introducing further potential ethical problems such as inducing scepticism, mistrust, uncertainty and questioning of the researcher's role and reasons for undertaking the study. Hart (2005) suggested addressing these potentially ethical tensions through adhering to professional values and working within professional codes of conduct, reflecting on action at certain points during the research, taking responsibility for choices made and importantly 'to see others as we would like ourselves to be seen' (Hart 2005 p.309).

Of particular concern within the field of practitioner-research is subjectivity, with advocates within the quantitative tradition questioning and dismissing findings as invalid and unreliable. Considered the 'stamp of approval' within research,

objectivity is a necessary regulative ideal for ensuring fairness and eliminating bias according to Phillips (1989). Yet research can never be entirely objective or value free as the researcher's personal values and beliefs are intrinsically bound up in the research:

It is recognised that no piece of social research can be entirely objective, since no researcher is value free. Even in an overtly rigorous quantitative, head counting study, some implicit decisions have already been made as to which heads are worth counting (Johnson 1994 p.7).

However rigorously the methodology is adhered to, research is constructed and interpreted within the researcher's own framework of social reality and cannot be completely eradicated. Eisner (1992) rejected the concept and pre-occupation with objectivity; likening it to a straitjacket preventing individuals seeing beyond our framework of presuppositions. Arguing no single truth or knowledge exists as the world is not static, Eisner favoured accepting 'the inevitable transaction between self and world' (Eisner 1992 p.55) aiming for a realistic, creative human face of inquiry. Fox et al (2007) suggested rather than eliminating researcher effects their position should be acknowledged from the beginning and integrated into the design. Stake displays a positive attitude towards subjectivity stating it is 'not a failing needing to be eliminated' but an essential ingredient to the understanding of both researcher and research (Stake 1995 p.45). Echoing Johnson's view, Scott and Usher (2003) state 'data can never be free of the preconceptions and frameworks of the data collector' (Scott and Usher 2003 p.3).

Despite censure, the 'human face of inquiry' undertaken by practitioners into their own practice can bring richness and depth to the research as well as prove a valuable research tool (Ball 1990). According to Jarvis (2000), research and audit is

becoming an increasingly more prominent dimension of practice (Jarvis 2000), which provides justifiable opportunity for the practitioner to engage in the research process as they are considered best positioned to undertake research within their own practice. Jarvis further adds that the changing face of knowledge, and in particular practice knowledge, is serving to increase the legitimacy of practitioner research within the research community and especially in aiding to bridge the theory practice gap (Jarvis 2000).

Although it is acknowledged that there lacks comprehensive research and evaluation into the evidence yielded through practitioner research (Shaw and Lunt 2011), there are a number of acknowledged advantages to this form of research (Fox 2007). As a professional researching their own practice there already exists a well-established relationship with the research area and other professionals, and are therefore best situated to interpret the complex relationships within clinical practice, areas of which are often inaccessible to an outsider. According to Fox et al (2007), professionals do not practice in isolation but operate within a context which is influenced internally and externally which bestows on the practitioner-researcher a unique advantage and insight into the micro-politics of the institution (Bell 2005) as well as the values of the profession and organisation. Furthermore the role may also include access to wider organisational players, professional bodies, policies and procedures which serve to contextualise the research adding a depth to the interpretation of findings and any conclusions being drawn.

The role and relationship of the practitioner-researcher to their area of study can be described as being an insider or outsider according to Hellowell (2006): where being an insider is depicted as someone who has prior knowledge of the community under investigation, its members and practices (Merton 1973 in Hellowell 2006).

Conversely the outsider is someone who does not have any familiarity with the research setting. Despite being portrayed as distinct opposites, which reflects the polarised relationship of interpretivism and positivism including the on-going debate between objective and subjective interpretations, Hellowell contends that there exist subtle and varying shades of *insiderism* and *outsiderism* (Hellowell 2006 p. 489). In addition he argues that as a researcher you can be both an insider and an outsider simultaneously during the research process depending on the context of the research, moving along the continuum between being situated close to the research and exhibiting distance.

Through his own observations Hellowell also presents a valid case in arguing that recognising the nature of the relationship of the researcher to their research area and reflecting on such can assist in developing a deeper understanding of the research context. Often the researcher's own position is 'rendered invisible' (Mauthner and Doucet 2003 in Gray 2009 p.498) being subsumed by traditional philosophical and methodological practices and an enduring necessity to reduce subjectivity. Briggs (1986) declares that 'the single most serious shortcoming' particularly within qualitative data analysis is a lack of reflexivity (Briggs 1986 p.102) which can be defined as 'the capacity of the researcher to acknowledge how their own experiences and contexts inform the process and outcomes of inquiry' (Etherington 2004 p.31). Social, organisational and professional elements of the research context similarly disappear into the background. Yet these form substantive aspects of the research on two levels being recognised as instrumental in shaping practitioners' perceptions of, and participation, in continuous professional development and influential in shaping the researcher's relationship towards the research context. Schön (1983), in his study of the *reflective practitioner*, argues reflection facilitates the formation of theories

which are based upon past experiences and in turn influenced by internal and external forces. The often contentious role of practitioner-researcher takes on a valuable and active role, even becoming an interpretive instrument within the research process particularly during data analysis, interpretation of findings and knowledge construction.

My own practitioner-researcher role could be viewed both as an insider and outsider in relation to this research context. As a Senior Operating Department Practitioner based within clinical practice, I am very much an insider with extensive knowledge of the profession and first-hand experience of the changes. This insider role proved valuable in understanding the language, values, context and cultural aspects of the professional group as well as their relationship as a community of practice within the wider healthcare population. The micro-politics and nuances peculiar to a small group of practitioners provided guidance for the development of the questions used for the questionnaire. As Schon (1986) points out, my insider role is ideally situated to understand the complex relationships which occur within the 'swampy lowlands' of clinical practice including the theatre dynamics and wider organisational structures. Insight in the community of practice helps to bridge the gap of *knowing what* and *knowing how* and brings into context an understanding and appreciation of the tacit knowledge inherent within a community of practice.

Being Educational Lead with responsibilities for teaching, training and development offered a different perspective towards the impact of the changes in particular the variety of views and expectations of continuing professional development from amongst my colleagues. With a responsibility for training, education and development I have observed the subsequent effects of the changes within the tight-

knit community of Operating Department Practitioners as well as the limited and sometimes ineffective response from the immediate theatre management structure.

Advantages of this aspect of my role were that it enabled access to wider Trust educational strategies, insight into their objectives and micro-politics, as well as witnessing Trust policies in action especially the commissioning processes for 'Learning beyond Registration' bids. Having established working relationships with the ODP Training Supervisors through regular placement provider meetings at the local HEI had built up a level of trust which helped in recruitment to the interview phase of the research. In addition these meetings provided opportunity for background research into the provision of formal learning opportunities from the local HEI as well as wider guidance from within the SHA. Developing a greater understanding and awareness of these wider influential factors served to create distance and objectivity, as well as a more rounded and informed position which helped shape the direction and analysis of the research. This, coupled with taking on the mantle of researcher, situated my role on Hellowell's continuum closer to that of an outsider.

As an Operating Department Practitioner researching their own practice, taking on the mantle of practitioner-researcher offered both challenges and advantages.

Although sometimes a difficult and conflicting position to occupy as I consider myself to be a clinical practitioner, my knowledge, understanding and experience of education and training issues both ODP-specific and at wider organisational offers a unique perspective of the ODP world. The initial challenge was taking on the role of researcher alongside being a Senior Practitioner and at times being conscious of maintaining two roles. As a registered healthcare professional, I am guided by my own professional codes of conduct and work within defined ethical guidelines.

These overlap and share similarities with research guidelines which aided in conducting the research, recruiting colleagues for the interviews and obtaining their informed consent.

Within the context of this research my role as practitioner-researcher was brought to question particularly during the ethical approval process which served to highlight the issues of role conflict described within the literature and discussed earlier. The original intended design was a case study approach to be carried out within my own Trust. Approval for the study was granted through NRES but conditions were applied: the research could not be undertaken as planned within my own hospital due to the 'conflicts of interest' such as those discussed by Fox et al above. No specific reasons were given but they may have resulted from the interpretive nature of case study research and the predominance of a 'medical model' and positivist approach associated with healthcare-related research. Despite the changes in methodology from a case study to that of mixed methods a number of advantages emerged in particular in providing a more-rounded picture of continuing professional development across the professional group. Whilst still possessing a level of subjectivity due to the nature of research being undertaken, the changes served to create personal distance from the focus of the research, introducing a degree of objectivity. This helped concentrate on the research processes, maintain impartiality and develop a balanced, non-judgemental approach whilst carrying out the research and during data analysis.

CHAPTER EIGHT

RESEARCH DESIGN

Introduction

Research, at a fundamental level, is acknowledged as being 'a process of steps used to collect and analyse information to increase our understanding of a topic or issue' according to Creswell (2008 p.17). Adopting a systematic approach requires justification of the researcher's position in relation to their research design.

Providing a conceptual framework for data collection and analysis research design comprises three fundamental components: philosophical viewpoint or paradigm, research methodology and research methods.

Within social sciences research two distinct, often conflicting and contested paradigms are identified: positivism and interpretivism. Each holds a philosophical basis comprising a set of values and beliefs relating to the nature of the world, the individual's relationship within that world and assumptions regarding the nature of knowledge being sought (Burgess et al 2006). Their individual ideological principles and underlying assumptions are instrumental in shaping the research process and conducting the inquiry. Yet their boundaries are not fixed, presenting opportunities to select or reject and question established viewpoints in order to choose the most appropriate methodological approach in addressing the research problem (Bell 2005).

Research strategies often involve a trade-off between the advantages and disadvantages of various approaches, each having particular strengths and weaknesses suitable for a particular research context, but as Bell points out:

classifying an approach... does not mean that once an approach has been selected, the researcher may not move from the methods normally associated with that style' (Bell 2005 p.8).

The research purpose is the investigation of lifelong learning and continuous professional development within the professional group of Operating Department Practitioners. Exploring practitioners' perceptions, experiences and engagement in continuous professional development situates the research within an interpretive paradigm. According to Tashakkori and Creswell (2007) the purpose of the study, the research questions and research design are intrinsically linked: the purpose shapes the research questions (Tashakkori and Creswell 2007) which in turn drive the choice of research design (Creswell and Plano Clarke 2010).

The complex nature of the phenomena under investigation lends itself to employing multi-faceted questions not only to investigate continuous professional development but also to acknowledge the importance of the individual's experiences. The questions posed for this study comprises both quantitative and qualitative elements: determining the range of practitioners' engagement in particular continuous professional development activities, exploring individuals' experiences of learning provision and the values and benefits of undertaking particular activities. This combination of '*what & why; what & how*' (Tashakkori and Creswell 2007) leans towards mixed-methods research. This approach is acknowledged as more than the selection of data collection methods, evolving to encompass all aspects of research design (Onwuegbuzie and Leech 2009) and endorsing pragmatism as its philosophical worldview.

Research Paradigm

Pragmatism, although not a new paradigm with origins derived from the work of Peirce, Read and Dewey (Cherryholmes 1992), has become synonymous with proponents of mixed methods research. Referred to by Johnson et al (2007) as the *third research paradigm*, pragmatism presents an alternative world-view to traditional philosophical disciplines of interpretivism and positivism, comprising its own assumptions of the nature of knowledge and understanding of the world. As an alternative paradigm pragmatism is a paradox, displaying both independence and dependence through its emergence as a third paradigm but still retaining links to established traditions. In offering itself as a 'bridge across the... adversarial divide' (Creswell and Plano Clark p.12) it rejects the dichotomy of interpretivism and positivism arguing the long-established dualism is ineffective in answering problems relating to the real world. Yet researchers accept and respect the wisdom each approach holds, drawing liberally from their strengths towards seeking workable solutions for today's research problems (Johnson et al 2007).

Whilst positivism affords discipline, structure, rigour and objectivity, it 'regards human behaviour as passive, essentially determined and controlled, thereby ignoring intention, individualism and freedom' (Cohen et al 2005 p.19). In dealing in the singular, it overlooks multiple possibilities, perspectives and variations emanating from diverse voices within differing settings and contexts. Knowledge, although deemed of high credibility, could be considered overly generalised for direct application to a specific context (Johnson and Onwuegbuzie 2004). Within an interpretive paradigm phenomena are studied and interpreted from multiple perspectives. Knowledge is constructed within the individual's own social and cultural context with emphasis placed on understanding their subjective meanings

and experiences (Creswell 2007). Pragmatism, as an integration of philosophical assumptions, draws on many ideas and diverse approaches, valuing objective and subjective knowledge and thus offers multiple viewpoints, perspectives and standpoints of knowledge, truth and reality according to Johnson et al (2007 p.113). Researchers, although not committed to either discipline, will often favour either a quantitative or qualitative prospect. But as Greene and Caracelli (1997) reiterated, it is important to honour the values, beliefs and underpinning principles of each approach and be conversant with their strengths and weaknesses.

The core principle of pragmatism centres on a practical *what works* approach in addressing everyday human problems (Taskakori and Teddlie 2010). Operating within the real world, individual's knowledge, perspectives and beliefs are influenced and altered through *transaction* with their immediate environment (Dewey in Biesta and Burbules 2003 p.10). Transaction implies a formal contractual exchange between individual and environment which reinforces the dynamic relationship between knowledge and action (ibid) and the consequences of such actions. Knowledge and understanding, truth and reality are neither 'static nor certain' (Plowright 2011 p.184) but provisional, constantly assessed and re-assessed and a product of the moment in time captured by the research (Johnson and Onwuegbuzie 2004). This is particularly apt within this context as practitioners are currently experiencing professional and organisational transition influenced by recent and impending educational changes coupled with financial and economic austerity measures. Set against this transition is the constant of lifelong learning, an essential requirement of professional registration and necessary condition of employment.

Operating in pluralisms, both single and multiple realities and truths of individual practitioner and collective professional group are of equal credibility providing richly diverse perspectives of continuous professional development. Social, cultural and historical elements add further dimensions to practitioner's knowledge, truth and reality which necessitate a multi-method approach to generate 'understandings that are broader, deeper, more inclusive' according to Greene (2007 p.21). The practical dimension associated with pragmatism and mixed methods research further serves to embrace the role of practitioner-researcher which blurs the dichotomy between researcher and 'human problem solvers' according to Tashakkori and Teddlie (2010 p.273). The ideally situated position of practitioner-researcher increases the problem solving capacity through constant questioning, evaluating and interpreting of the evidence similar to individuals encountering their own everyday problems to reach credible conclusions. Their values and beliefs add richness, honesty and representation to the research. Knowledge generated within this paradigm is also multi-dimensional: professional knowledge with respect to the particular educational discipline, profession-specific knowledge and organisational knowledge which will serve to evaluate lifelong learning.

Although pragmatism offers a holistic approach to research conduction it is not without criticism which primarily emanates from purists within traditional philosophical paradigms who endeavour to preserve their own principles arguing in favour of maintaining distinctions, preferring to focus on differences rather than similarities despite evidence to the contrary (Onwuegbuzie and Leech 2005).

Research Methodology

The methodological approach deemed appropriate in addressing the research problem and which is acknowledged as the philosophical partner of pragmatism is mixed-methods research.

At a minimal level, mixed-methods research is the combination of quantitative and qualitative methods within a single study although a review of the literature reveals no single workable definition of mixed methods research but a wealth of 'agreement and difference' according to Johnson et al (2007 p.123). A cross-case analysis of proponents' definitions undertaken by Johnson et al yielded common themes, but also variations within these themes created by researchers own backgrounds, experiences, methodological and philosophical orientations. Common themes identified primarily surround the guiding principle of this methodological approach – mixing, with much debate relating to what, where, why and how such mixing occurs. They further identify orientation or the driver for the research, taking either a *bottom-up* or *top-down* approach whereby the questions or specific focus direct the research respectively. Within this research context it is intended to apply a *bottom-up* approach whereby the research questions provide orientation for the whole research design which, according to Tashakkori and Creswell (2007) will naturally encourage integration throughout the whole project.

Despite a rich array of definitions as to the nature of mixed methods research Greene's (2007) definition offers a flexibility and intent which is considered appropriate to the purpose of this study in investigating continuous professional development within the professional group of ODP set against a dynamically shifting social and professional world. Greene further acknowledges methodological

and philosophical aspects of mixed methods research absent from some proponent's definitions:

Mixed methods inquiry is an approach to investigating the social world that ideally involves more than one methodological tradition and thus more than one way of knowing, along with more than one kind of technique for gathering, analyzing, and representing human phenomena, all for the purpose of better understanding (Johnson et al 2007 p.119).

The rationale for adopting a mixed methodology arises from differing methods generating distinctive data which serves to 'increase the knowledge about the world' (Denscombe 1998 p.84). Quantitative and qualitative methods hold contrasting, often competing positions; they are however not mutually exclusive with mixed-methods research offering both complementary and differing views of the same situation. The blending of words and narrative obtained through qualitative methods add meaning and depth to numbers generated through quantitative means. Conversely numerical data adds precision to descriptive accounts facilitating the answering of a broader range of questions. Justification in combining multiple theories, methods and data sources enables the researcher to overcome 'the bias inherent in any particular data source' (Denzin 1978 p.14) with benefits of improved accuracy, credibility and validity of findings. Despite their inherently perceived differences attention to procedural details within each approach can benefit the quality of the research process:

The qualitative imagination will tend to demand that quantitative analysis explains itself in terms of the non-statistical concepts that it is claiming to measure. The quantitative imagination will demand a degree of precision in definition that qualitative work may slide away from (Brown and Dowling 1998 p.83).

The use of between-method triangulation where different methods are employed to investigate the same subject results in 'a convergence upon the truth' according to Denzin (1978 p.14). Methodological triangulation further serves to increase the accuracy of conclusions through cross-checking of findings and allows compensation for limitations of either strategy (Bryman 2008). Triangulation, however, infers converging data intersect at a single point, a fundamental feature of positivism which subscribes to the idea of absolute truth. Within mixed-methods research, where emphasis is placed on investigating real-world phenomena, multiple realities and truths exist; findings therefore may point in a similar direction but not intersect leading to mismatch and conflict (Laws 2003 in Bell 2005). According to Denzin (1978), triangulation produces three outcomes: convergence, inconsistency and contradiction all of which, he argues, have value and provide superior explanations of the phenomena under investigation. Reflecting the true nature of social inquiry, acknowledging individual's differing perceptions of truth and reality through focusing on the 'humanistic conceptualisation' (Tashakkori and Teddlie 2010) of the research phenomena all findings are valid. Within mixed-methods research, which aligns itself towards real-world problems, non-convergence creates further areas for investigation with the potential to generate new knowledge relating to the phenomena.

Situating mixed-methods research on a continuum, as opposed to a third option, offers fluidity and choice enabling selection of a mono-method, partially mixed or fully mixed design. In doing so conceives options; variety and creativity; presenting opportunities for researchers to select from a growing plethora of mixed methods designs or diversify through integrating new combinations of techniques. The flexibility, inventiveness and adolescent nature, however, of mixed methods coupled

with the variability highlighted by Johnson et al (2007) provides foundation for limitation and weakness.

Despite its strengthening position as a third paradigm and emphasis of the importance of integration, a review of the literature indicates a number of barriers preventing this methodology achieving its full potential. Tashakkori (2009) answered tentatively in the affirmative when discussing the current state of mixed methods in his editorial – *Are we there yet?* Although acknowledging rapid progress, he states there are still challenges to overcome particularly surrounding conceptual / philosophical issues and integration. The persistence of treating qualitative and quantitative data as separate domains (Bryman 2008) and inexperience of researchers within mixed methods research (Yin 2006) are evidenced as two important limiting factors. Bryman's (2008) appraisal of mixed methods research further indicated practical and methodological barriers. Practical issues include timelines in carrying out different components of the research: methodological barriers surround the extent to which mixed methods is truly mixed with researchers displaying disagreement as to where mixing takes place; a common theme amongst mixed methods literature. Creswell (2009) focused on mixing at data collection, analysis and finding stages; Yin (2006) supported full integration from design to findings expressing concern studies risk decomposing into separate enquiries if mixing is not addressed throughout. Vrkljian (2009) identified 'design dilemma' in constructing the most appropriate model for her study due to incongruence between currently available mixed methods designs and the purpose of the study leading to the use of a hybrid methodology.

The typology selected for this study was a sequential explanatory design consisting of two distinct phases: quantitative phase followed by a qualitative phase (Creswell

2009). Considered simplistic in its approach and quantitative-dominant this strategy was appropriate in exploring continuing professional development within this particular context. It is, however, acknowledged that this approach can be time-consuming which echoes Bryman's earlier observation relating to practical issues. Within this design, quantitative data is first collected and analysed using a questionnaire. During the second phase, qualitative data is collected through a series of semi-structured interviews. Analysis of the qualitative data in the second phase aims to explain or elaborate on results obtained through the quantitative phase. Initially appearing separate the two phases are connected with phase two building on results obtained during the first phase. The rationale for adopting this approach emanates from quantitative data providing a breadth of understanding of the research problem, with the application of a questionnaire being advantageous in reaching a large sample of the professional group. Qualitative data obtained through the interviews helps explain the statistical results providing depth of understanding of practitioners' views.

Research Methods

Convention within mixed-methods research emphasises the use of one quantitative and one qualitative research method (Creswell and Plano Clarke 2010). Following this custom, and utilising a sequential explanatory strategy (Creswell 2009), a questionnaire was employed to collect quantitative data, with a series of interviews to collect qualitative data. A tenet of mixed methods research is the creation of designs to effectively answer the research questions, adopting what Johnson and Onwuegbuzie (2004) refer to as a 'not to be limited' approach contradicting traditional research strategies which are often restricted by their own methodological and philosophical boundaries. Embracing this principle and optimising the practical

nature of mixed methods research, supplementary data collection methods will be used: demographic information, documentary sources and critical incidents relating to the specific aspects of the investigation.

The Questionnaire

Phase one of the design comprised an online questionnaire. Small-scale piloting of the questionnaire was undertaken to test and evaluate the research tool in order to produce an instrument which would fulfil the three validities: - *face validity* (what it looks like), *content validity* (the form the question takes), and *construct validity* (questions relate to the focus of the research) according to Tarling and Crofts (1998 p.130).

Piloting of the questionnaire was important for a number of reasons; to 'get the bugs out of the instrument' (Bell 2005 p.147), to review wording and format in order to 'increase the reliability, validity and practicability of the questionnaire' (Cohen et al 2003 p.260). Determining completion time was critical as 'too long a questionnaire is likely to reduce markedly the percentage of responses' (Sharp et al 2002 p.156). Verma and Mallick (1999) argue the importance of maintaining a balance between 'the possible and the desirable in terms of size' (Verma and Mallick 1999 p.118), ensuring questions are concise enough to address the research issues and completion time does not impose on practitioners' clinical activities.

The questionnaire comprised closed questions which enabled the generation of data for comparison purposes between different categories such as qualification groups, diversity of roles and banding (Smith and Hodkinson 2005). Multiple choice questions, designed to capture the likely range of responses, provided respondents with a degree of flexibility (Cohen et al 2003) and identical questions yield

standardised data aiding analysis (Denscombe 2007). Demographic questions are conventionally presented at the end being considered 'uninteresting' (Sapsford and Jupp 1996) but for the purposes of the study they were presented at the beginning, providing valuable data for comparative purposes. The limitations associated with closed-questions are their structured nature of predetermined categories which focus on collecting facts rather than opinions. To overcome this restrictiveness and providing respondents with an opportunity to express their opinions, three open questions were incorporated into the questionnaire.

The pilot questionnaire was issued to seven colleagues, all Operating Department Practitioners. Each was representative of the target population, as Oppenheim (2005) suggested that 'respondents in pilot studies should be as similar as possible to those in the main enquiry' (Oppenheim 2005 p. 62). Some variations were apparent – two were ODP lecturers but still HCPC registrants required to undertake continuing professional development in order to maintain registration. The five further participants were clinical-based ODPs.

The responses to the questionnaire were secondary in this instance, the emphasis being on how well the questionnaire functioned as a data collection tool. An evaluation form was included requesting feedback on ease of completion, completion time, and wording of the questions. Munn and Drever (1993) suggested completion of the questionnaire with the individual, observing how they completed the questionnaire. This was carried out on two occasions and proved extremely valuable in offering opportunity to discuss and scrutinise wording for ambiguity and possible misinterpretation, as well as justifying their inclusion to meet the requirements of construct validity.

Content validity was assured through making minor alterations to some of the questions minimising risk of misinterpretation and ensuring reliability (Cohen et al 2003 p.260). One particular word was as altered as this was considered not to be in keeping with the character of CPD – *portfolio* was changed to *profile* which is the term used by the HCPC. Three questions were limited to one choice with the view of focussing participants' responses. Rank ordering was initially considered and piloted for one question but feedback indicated this was overly-complex and out of keeping with the rest of the questionnaire. Completion time was approximately ten minutes, which was considered acceptable recognising the possible impingement on clinical time.

Following revision, the questions (see Appendix 1) were then transferred to an online survey tool - SurveyMonkey™. This produced a workable, attractive and user-friendly survey which separated out the questions, used page logic in moving between questions and which helped address the issue of face validity. Having a tool which is 'interesting rather than complicated' (Cohen et al 2003 p.258) helps engage respondent cooperation and attitude towards completion (Denscombe 2007).

Additional advantages of using an online survey method are a faster response rate, efficiency in reaching a large sample across a wide geographical area and an increased response to the completion of open questions (Bryman 2008). The anonymity offered through the use of an online web survey, also facilitates a degree of criticality towards departmental / organisational and professional structures without repercussions (Coleman 2006).

Access to practitioners was facilitated through the professional body, The College of Operating Department Practitioners (CODP) who holds records and contact details of their members. Permission was granted from the President of the College subject

to confirmation of ethical approval for the study. A covering letter (see Appendix 2) was included in the email sent from the College alongside the web link to the survey, which explained the purpose of the research as well as reassurances of anonymity and confidentiality. The '*principle of voluntary consent*' (Robson 2007) applied within this context, whereby the individual gave their consent through the act of participation, as well as exercising their rights as autonomous agents to make their own decisions regarding participation, as well as being able to withdraw at any point from the research (Polit et al 2001).

Sampling Strategy

The survey was issued to a sample of Operating Department Practitioners using purposive sampling. This goal of this particular sampling strategy is the selection of participants which are relevant to the research intent and the questions being posed (Bryman 2008). The participants were also selected against set criteria with the intention of achieving a cross section of the ODP population (Gray 2009). The intended sampling traits were registered and currently practising ODPs. No inclusion or exclusion criteria applied as all practitioners, irrespective of their role, are registered practitioners and therefore subject to professional requirements of undertaking continuous professional development to meet their responsibilities for re-registration.

A recognised weakness of questionnaires is poor response rate (Cohen et al 2003). This is especially relevant when using an online survey (Bryman 2008) and was particularly evident within the context of this study. An initial 63, out of a prospective 300, respondents had completed the questionnaire within the first two weeks of issue. In order to increase the response rate and thus increase credibility of

findings a networking and cascade system was subsequently employed whereby ODP colleagues were contacted via email asking for assistance in participating in the survey with an added favour of cascading the survey details to their colleagues. This method proved useful in increasing the return to 89 respondents.

The interviews

Phase two comprised four semi-structured interviews with ODP Training Supervisors, who were also selected using purposive sampling. Their selection criterion was based on them being experienced and Senior Practitioners with responsibilities relating to training and development within their respective organisations. The intention was to provide additional data from ODPs who occupy both insider and outsider perspectives with regards to continuous professional development. Questions for this phase (see Appendix 3) derived from the initial research questions and through areas warranting further exploration or clarification following analysis of the survey responses. The Training Supervisors were best positioned to provide greater insight into the following key areas and build on the data obtained through the questionnaire: local organisational policies and processes in implementing training and development within the clinical practice area; funding processes; the role of the immediate line manager as the gatekeeper for staff learning; the role of the appraisal process in determining personal development and training needs and support processes for newly qualified staff entering the clinical area.

Following ethical guidelines, each of the Training Supervisors were approached individually to gain initial verbal consent to participate in this phase of the research. It was considered appropriate to give them two months' notice of the intended

interview and which included a participant information leaflet outlining the intention of the research which allowed them to read and re-read the specifics of the research in order for them to make an informed decision regarding their choice to participate. Written consent was obtained on the day of the interviews following further confirmation of the research intent, answering any questions which the participants may have had and reiteration of the roles and responsibilities of both researcher and participant. Hopkins's (2002) suggestion of offering copies of transcribed interview tapes were made to each interviewee but declined at point of consent.

The interviews were carried out at a suitable, convenient and pre-determined time for both the researcher and interviewee. The Training Supervisors meet regularly and therefore it was deemed appropriate to schedule the interviews for after the normal pre-arranged meetings. The interviews took place over a three-month period. Due to time constraints and difficulties in scheduling, two Training Supervisors were interviewed together. Both participants were agreeable to this. This impromptu interview technique proved valuable as both are employed within the same Trust but at different hospitals, and therefore offered contrasting experiences in terms of organisational learning and experiences. Of interest was the 'conversation' between the two Training Supervisors as they engaged in providing responses to the researcher's questions. This presented a further dimension to the data in enabling comparisons to be made between their own experiences of CPD and their respective organisational stance towards learning. The pre-determined interview questions as well as certain prompts were used as a framework but other avenues of interest or pertinent topics were explored where appropriate. Although not a planned aspect to explore, the topic of audit and auditing of training and development emerged as an important theme which was subsequently included in the latter two interviews.

Data Analysis

The process of data analysis 'involves the search for things that lie behind the surface content of the data – the core elements that explain what the thing is and how its works' (Denscombe 2007 p.247). More specifically within social inquiry data analysis serves to reduce and organise data into a manageable form to determine relationships, interrelationships, connections and trends in order to validate conclusions (Greene 2010 p.144). From within a pragmatic perspective which embraces a practical approach to real-world problems, 'the primary issue is to determine what data and analyses are needed to meet the goals of the research and answer the questions at hand' (Bazeley 2009 p.203).

Traditional distinctions existing between the pre-dominant paradigms of positivism and interpretivism extend to their respective methodological processes and thus imply distinctions regarding how their data are analysed (Gray 2009). Differences are identified in the preparation and presentation of their respective data; quantitative data analysis is primarily deductive using statistical approaches to identify numbers and qualitative analysis is predominantly interpretive, data usually being in narrative form (Gbrich 2007). Confidence and credibility of analytical processes as well as findings associated with each perspective are further regarded as distinct; credence afforded quantitative data through association with scientific rigour, application of statistical tests offering measurable credibility and objectivity rather than researcher values. Although criticised for lacking methodological rigour, as well as incurring researcher subjectivity, qualitative research can offer authenticity, transferability and theoretical generalisations.

A critical examination of the perceived differences indicates boundaries between the data sets are 'superficial' (Halfpenny in Plowright 2011), 'too simplistic' and far from watertight (Denscombe 2007 p.247). Their methodological and philosophical assumptions frequently overlap, particularly within a pragmatic paradigm and researchers often employ both approaches in order to achieve their goals. Allwood (2011), in his examination of these distinctions, concluded they are unclear, problematic, of limited value, and employing only one methodological and analytical process leads to 'simplistic thinking about complicated issues' (Allwood 2011). In highlighting the intentional and interactive nature of mixed methods analysis Greene (2007) raised a particularly valid point which serves to nullify some of the polarised arguments. She emphasised not only the relationship of analytical procedures to methodological decisions but stressed the researcher's position and their influence on all dimensions of the research process particularly analytical aspects:- 'the mix itself...and the interpretations of the meanings of the mix... reside in the cognitive processing of the inquirer' (Greene 2007 p.142). Despite concerted effort within a positivist ideology to promote objectivity and researcher detachment as a gold standard the researcher's influential position cannot be underestimated.

Bogdan and Biklen (2007) defined qualitative data analysis as 'working with data, organising it, breaking it into manageable units, synthesizing it, and searching for patterns' (Bogdan and Biklen 2007 p.159). This definition highlights the tenuous and superficial nature of the distinction where the systematic approach advocated is not exclusive to the qualitative domain but equally applicable to procedures associated with quantitative data analysis. An inspection of quantitative and qualitative analytical procedures indicate commonalities; preparation, exploration, analysis, representation, interpretation, and validation of the data and subsequent

results. These steps, often undertaken in a linear fashion particularly within quantitative research, can be implemented both simultaneously and iteratively within qualitative research (Creswell and Plano Clarke 2010). Similarities are further evident within their objectives with both concerned with answering research questions, relating the data to a theoretical framework and striving for validity, reliability and transparency of process and findings (Hardy and Bryman 2010 p.xiii).

Data reduction is additionally highlighted by Hardy and Bryman (2010) as a similarity which is described as condensing the wealth of data into concise, manageable and understandable statements. Debate exists within the literature as to the degree of reduction required in order to maintain a sense of holism and trueness towards the data (Cohen et al 2003) whilst adhering to analytical procedures in order to uphold credibility and transparency of findings. Strauss and Corbin (1990) favoured non-analysis preferring to allow data to speak for themselves; presenting qualitative data in its natural form establishes unity between data and context, a significant aim of mixed methods research. Miles and Huberman (1994) supported the process of data reduction in order to simplify data but reinforce the importance not 'to strip the data at hand from the context in which they may occur' (Miles and Huberman 1994 p.10). They further claimed that qualitative data have a value of 'undeniability', where words are more concrete, vivid and rich in their presentation bringing the research alive to the reader which is more appealing than the 'thin abstraction of numbers' (Robson 2002 p.455).

A comprehensive range of analytical strategies are identified within the literature, offering step-by-step guides to data analysis. Within a mixed methods approach where 'creative ideas and imaginative thinking' (Greene 2010 p.144) are a central feature these 'inflexible prescriptions' (Miles and Huberman 1994), particularly

associated with qualitative approaches, appear contra to this philosophy. It is therefore intended to be open-minded and flexible whilst undertaking data analysis utilising the most appropriate, and potentially a mixture, of analytical strategies whilst maintaining overall focus of the research.

Quantitative data analysis

Quantitative data analysis involves the organisation of data into categories which enables description, determination of frequencies and associations in order to ascertain any underlying causes. This is attained through employing a scientific approach of precision and control; achieved through reliable measurement from the application of statistical tests, and sampling and design respectively. The data generated can be classified into two types; categorical and quantifiable which determines the level of analytical treatment and precision applied to the data (Gray 2009) moving from nominal and ordinal (categorical) to interval and ratio data (quantifiable). It is important to recognise the type of data in order to recognise the possibilities and limitations associated with each data set which in turn affects the level of conclusions being drawn. Two forms of statistical analysis are identified; descriptive and inferential. Descriptive statistics attempt to show and describe what the data are (Wilkinson 2006), whilst inferential statistics endeavours to draw conclusions from beyond the data, test hypotheses and to infer what the population think (Gray 2009). The data obtained through the online survey will be subject to descriptive statistics.

Descriptive statistics

Descriptive statistics is a method of representing important aspects of a data set (Robson 2007), and tends to sit within the nominal and ordinal data categories;

nominal data being the simplest form which involves counting and categorising data; ordinal referring to a clear and ordered relationship indicating categories lower or higher than those within other categories. This form of statistics provides the opportunity to organise the data in a concise manner, summarise relevant findings, present the evidence, describe the findings and explore any simple correlations and associations, looking for patterns and trends in the data set (Dencombe 2007). Two common aspects of descriptive statistics are level of distribution and spread. Level of distribution represents the central tendency or average of the data enabling the summarisation of an entire data set in a single score, whereby spread measures the variability of the data or extent to which the data values are clustered or widely spread (Robson 2007 p.407). A limitation of descriptive statistics is that it only enables the presentation of simple summaries of the samples undertaken, providing a superficial overview of the phenomena.

With reference to the purpose of the study, in identifying *what* and *how* of the phenomena, the data collected through the online survey were analysed according to the purpose of the research questions. The type of questions employed within the questionnaire influenced how the data were analysed. Closed-questions were predominantly used within this context which enabled the range of continuous professional development activities being undertaken within the professional group to be determined, how their learning is identified and practitioner reasons for engaging in learning activities. Descriptive statistics was used primarily to describe one variable at a time but can be used to analyse the relationship between two variables in order to ascertain correlation or regression. To this end data were further analysed across the three qualification groups for comparative purposes to determine any correlations or differences between groups towards participation in and

identification of continuous professional development. The basic features of the data were presented using a range of charts and graphs (Gray 2009).

Qualitative data analysis

Qualitative analysis is acknowledged as the ‘most complex and mysterious’ aspect of qualitative research (Thorne 2000 p.68) resulting from a range of analytical and hybrid strategies coupled with the diverse multi-disciplinary subject matter being investigated. Often portrayed and implemented as separate methods with their own stages of analysis the different analytical strategies share what Rapley (2011) referred to as ‘family resemblances’ with similar and overlapping fundamental approaches to analysis. Caution is urged however in following these steps *ad verbatim* as their prescriptive nature may not be applicable to the procedure of data analysis when applied within this particular context.

The aim of qualitative research is to portray the reality of the phenomena under investigation and to enhance the understanding of the situation and the meanings and values attributed to this by individuals (Hewitt-Taylor 2001 p.39).

Associated with meanings and contexts, qualitative methods emphasise the value of individual’s experiences encountered within real-life situations. In order to peel back the layers and reveal the meanings, values and reality attributed to the phenomena of continuous professional development four semi-structured interviews were undertaken. These interviews, once transcribed, were subject to thematic analysis in order to discern *what* and *why* of lifelong learning.

Both the open question responses generated through the online survey and the interview data were collated and analysed using Braun and Clarke’s (2006) six stage method of thematic analysis. This strategy involves the search for prominent or

recurrent themes through 'identifying, analysing and reporting patterns within the data' (Braun and Clarke 2006 p.79), patterns which are deemed 'important to the description of the phenomena' (Fereday and Muir-Cochrane 2005 p.82). A theme according to Braun and Clarke (2006 p.82) 'captures something important... in relation to the research question' which can be repeated words or phrases through the data set, or evidence of responses consistent with previous research (Grbich 2007 p.32).

This theory-driven approach, combined with a pre-coded template strategy of organising data (Crabtree and Miller 1999) was employed. Utilising this hybrid strategy not only demonstrates rigour within thematic analysis, which is often accused of lacking attention, but also provides a deeper level of understanding of the phenomena. The template organising style employs a pre-coded template applied to the text. The template can derive from theory, pre-existing knowledge or defined by the researcher prior to data analysis.

The interview tapes were transcribed as soon as possible post interview whilst still 'fresh' in the mind of the researcher. Operating within qualitative traditions I was not only interested in what the participants said but also the language used, including non-verbal expressions. Notes were made during the interviews which helped contextualise the data. Although transcription is acknowledged as a time-consuming process, it proved invaluable in enabling engagement with both the content and the context of the responses. Listening to the recording alongside reading the transcript offered familiarity with the data and aided the identification of key themes and ideas (Bryman 2008).

This chapter has presented the research methodology used in investigating the experiences of lifelong learning with ODP with particular emphasis on the methods employed to generate the data required to answer the research questions.

CHAPTER NINE

DATA PRESENTATION AND FINDINGS

Introduction

The purpose of the research was the exploration of lifelong learning and continuous professional development through the experiences of the professional group of Operating Department Practitioners. To determine the *what*, *how* and *why* of the phenomena a mixed methods approach was selected, specifically a sequential explanatory design (Creswell 2009).

Convention within this approach is to separate data collection and data analysis components into their distinct quantitative and qualitative phases and presents them as such (Creswell and Plano Clarke 2010). This, however, can lead to separation rather than combination of data which detracts from the essence of mixed methods research. Acknowledging the importance of the relationship between data analysis, presentation and research questions (Burton et al (2009) provided a systematic approach to the format and structure of data presentation and analysis. Utilising a 'bottom-up' approach (Tashakkori and Creswell 2007) which recognises the importance questions hold within mixed-methods research, a holistic approach was adopted which breaks away from the convention of presenting distinct data components. Each research question and their respective sub-questions were used as a structural device whereby the quantitative and qualitative data were presented under each heading. Adopting this method served to strengthen integration of the research without losing sight of research intent or the phenomena under investigation.

Quantitative data was presented first providing a breadth of information, displayed through visual means with the use of appropriate tables, charts and graphs.

Qualitative data, through use of suitable quotes, obtained from both the open questions within the online questionnaire and the interviews with Training Supervisors was used to 'display the homogeneity (or diversity) of the data' (Grbich 2007 p.202), as well as used 'to illustrate and substantiate the presentation' (Bogdan and Biklen 2007 p.5). This served to offer depth of understanding and further supplements the quantitative data. Related past research findings, key theoretical perspectives, and any relevant documentary evidence, such as policies, which offer support and substantiate primary data (Burton et al 2009) were also presented.

Presentation of Data and Findings

Eighty eight practitioners accessed the online survey; seven were incomplete leaving a total of eighty one usable questionnaires.

Demographic information of the respondents indicating practice areas, current employment banding and status were collated and categorised according to professional qualification held which enabled comparisons to be made between categories. These details, along with the frequency of respondents, are displayed in table 1.

Table 1 Demographic information of respondents

	City and Guild 752 (n=30)	NVQ Level Three (n=17)	Diploma (HE) ODP (n=34)	Total (n=81)
Practice area				
Anaesthetics	12	7	12	31
Anaesthetics /Surgery	5	1	4	10
Anaesthetics / Surgery/ Recovery	5	2	7	14
Surgery	1	3	3	7
Recovery		1	1	2
Anaesthetics / Recovery	4	2	6	12
Education	2	1		3
Education / Practice	(2)	(1)	(4)	(7)
Education / Practice / Management	(2)	(2)	(1)	(5)
Education / Management	1		1	2
Management / Practice	(3)	(1)	(1)	(5)
Banding				
Band 5	12	5	21	38
Band 6	16	10	9	35
Band 7	1	2	2	5
Not disclosed	1		2	3
Employment status				
Full time	20	14	31	65
Part time	8	1	2	11
Other (Agency / Bank)	2	2	1	5

The bracketed data is used to illustrate the widening diversity of roles and responsibilities carried out by ODPs in conjunction with their clinical positions.

City and Guilds and Diploma qualified practitioners were similarly represented, 30 and 34 respondents respectively, with NVQ qualified ODPs being least represented (17). The majority of respondents (80%) were fulltime practitioners whose primary roles were within the clinical remit (94%) split between the three areas of peri-operative practice. Of the respondents 40 practitioners (49%) indicated they were employed within one specific area of practice with the majority practicing within the anaesthetic remit (38%). Despite historical associations with surgery the traditionalist practice area for ODPs has become the anaesthetic remit. In order to practise within this highly specialised area the Association of Anaesthetists of Great

Britain and Ireland (AAGBI 2010) stipulate anaesthetic assistants are suitably qualified, experienced and importantly regularly maintain their competence to practice within this field. Although ODP training encompasses all three areas of anaesthetics, surgery and recovery only 17% of practitioners rotated to maintain their clinical skills across the three specialities. The tendency and trend towards practitioner's becoming highly specialised within one field is indicative of current policy with organisations seeking to provide a highly efficient and effective service within specialised hospitals. Conversely it could be argued that those practitioners who choose, or are chosen to specialise, are at risk of becoming de-skilled over time and losing the flexibility of skills associated with Operating Department Practitioners.

The table further illustrates the diversity of roles and responsibilities undertaken by ODPs with a number of practitioners' roles encompassing education and management alongside their clinical responsibilities; these are indicated by the shaded area of the table. Five of the respondents identified themselves as primarily non-clinical occupying an educational related position (3) or management (2) within the theatre department.

In terms of banding, or pay grade, 60% of practitioners holding a City and Guilds 752 qualification occupied senior positions of band 6 or above. In contrast 62% of diploma qualified practitioners were predominantly within the lowest pay banding (band 5). Five respondents were agency or bank staff.

The Training Supervisors

Four Training Supervisors were interviewed for the second phase of data collection. They were selected using purposive sampling from the Placement Provider Group

who meets regularly with the local Higher Educational Institute responsible for delivering the pre-registration ODP Award. The Training Supervisors are designated clinically-based ODPs who are responsible for implementing the diploma programme within the practice environment and considered integral to the support of Student ODPs (CODP 2009).

Their selection for inclusion within the research was founded on their distinctive position within the staffing structure of theatres, where they tend to occupy senior posts and often have both clinical and managerial responsibilities. This unique position within the ODP community affords an equally unique perspective into learning and continuous professional development from multiple perspectives. As Senior ODPs their 'dual role' confers observation, familiarity and understanding of the cultural aspects of the ODP community including knowledge and experience of the changes endured as well as personal experience of continuing professional development issues. In addition their managerial responsibility which includes involvement in wider organisational and educational learning agendas within their Trusts, as well as the complexities inherent within the workplace, provides opportunity to explore the organisational aspects of training and development with respect to provision and implementation. The knowledge and experience of the Training Supervisors aims to provide a depth of qualitative information which complements and expands on the breadth of data obtained through the questionnaire.

No specific job description exists for these individuals who undertake their educational responsibilities usually on a part-time basis alongside clinical commitments. Their role and association in providing practice placement quality is acknowledged and accepted by the higher education establishments as well as the Health and Care Professions Council. The roles and responsibilities of the Training

Supervisors are relatively diverse, some limited to supporting and co-ordinating Student ODPs in the clinical environment whilst others have wider organisational relationships contributing to corporate educational agendas.

Advocated by CODP as an essential role in supporting Student ODPs and mentors within the clinical area (CODP 2009) as well as providing a vital link between the workplace and HEIs debate surrounds the level of qualification they should hold. Although CODP ask that Training Supervisors hold as a minimum a degree and evidence of professional development, this is not enforced. Yet having direct involvement and responsibility for supporting practitioners, learning and development places the Training Supervisors in a position of significant power and should therefore hold a relevant teaching or training qualification. O'Conner (2004) discusses whether those identified as workplace educators are suitably qualified and experienced to hold these positions and argued in favour of developing specific programmes of study which prepares them for the increasing complexities of their role. As a professional representative the Training Supervisors furthermore contribute to organisational learning offering a competitive edge to their respective organisation particularly in a rapidly changing healthcare environment.

In order to provide background information and insight into their roles and responsibilities their personal perspectives have been condensed into four small vignettes which are presented below. In accordance with ethical guidelines in maintaining confidentiality and anonymity they have been assigned pseudonyms and no reference is made to their respective Trusts.

Assessment of the four Training Supervisors interviewed indicates that they are all Senior ODPs, two hold City and Guilds qualifications, one has an NVQ and the

fourth a Diploma in Operating Department Practice. None hold a degree or a specific teaching qualification as advocated by O'Conner earlier although they each hold a mentoring qualification. Examination of their roles shows differences in their responsibilities in supporting staff and students. There is a general acknowledgement and acceptance of the importance of engaging in learning both for personal and professional reasons. Their CPD activities are reflective of their position as Training Supervisor's as well as Senior and experienced Operating Department Practitioners.

David

David holds a National Vocational Qualification and is employed as a Band 6 ODP / Training Supervisor within the same Trust as Jack although works at a neighbouring Hospital. His clinical responsibilities are predominantly within the anaesthetic remit. As Training Supervisor his responsibilities include support of all pre-registration students and he indicated that he was supported by a colleague whose role was facilitating post-registration training and development of all theatre staff.

David does not hold a degree although has gained the Mentorship Programme at Level 3. His continuous professional development activities undertaken during the past year were predominantly work-based / informal and In-house training. He attends placement provider meetings at the local university and participates in student assessments as clinical representative.

Jill

Jill works in a busy District General Hospital and holds a Diploma (HE) Operating Department Practice. She has recently been promoted to a Band 6 practitioner resulting from good constructive managerial support and interest in training related issues, and also practices within the anaesthetic remit. She shares her Training Supervisor role with a more senior colleague and like the other supervisors often finds it difficult to be released from clinical duties in order to fulfil her role within the education and training remit. She feels that the support from her manager is often insufficient for her to fully undertake the roles and responsibilities of supporting pre-registration practitioners and finds it frustrating. Despite admitting to being frustrated she did acknowledge that service needs and clinical responsibilities took precedent at times.

She appreciates the need to continue to engage in lifelong learning in order to develop within her professional remit and is considering enrolling on the degree-level pathway. Her continuing professional development activities were wide ranging and again occupied work-based and in-house training activities with attendance at the local delivering university to assist in interviews and assessments of students where possible.

Jack

Jack is a Band 6, City and Guilds qualified ODP employed in a large Trust who practices within the anaesthetic remit. His role as Training Supervisor extends to include support for both pre and post-registration practitioners including arranging placements for nursing students. Like the other training supervisors he undertakes his educational roles and responsibilities on a part-time basis alongside clinical duties. He is supported within the educational role by his manager but mentioned the need for effective management in requesting time to attend specific training supervisor meetings and activities at the delivering university.

Jack does not hold a degree although has undertaken the Mentorship Programme. He regularly engages in work-based / In-house training courses in order to demonstrate his continuing professional development and has undertaken assessment of Student ODPs and interviews at the delivering HEI.

Mary

Mary is a part-time, Band 6 ODP who holds a City and Guilds qualification and like her other Training Supervisor colleagues undertakes her clinical role within the area of anaesthetics. During interview she indicated that there was a lack of support for her role in facilitating and supporting training and development although did admit that her manager tried hard to enable her to attend placement provider meetings at the local university where possible.

Mary does not hold a degree although has completed the mentorship programme. Despite admitting reluctance and uncertainty with the proposed changes within the profession and the expectation to obtain a degree she is considering the degree-level pathway delivered at the local university. She further acknowledged the limited availability of post-registration routes specific to ODP. Her continuous professional development activities were predominantly work practice related - mandatory training completion, reading journals and attending an infection control conference which has enabled her to develop audits and best practice within her department.

Question 1

What are the experiences of continuous professional development within this group of Operating Department Practitioners?

a. What forms of continuous professional development is this professional group undertaking?

The learning activities selected for inclusion within the survey were a representative sample obtained from the Health and Care Professions Council's extensive but not exhaustive list of continuous professional development learning examples. An examination of their suggested activities indicates a sufficiently broad range which acknowledges practitioners' varying roles and disposition towards specific learning activities. It is important to acknowledge that although the majority of registrants are NHS employees, the Standards of Continuous Professional Development (HCPC 2008) apply to non-NHS workers and activities are thus sufficiently diverse but equally inclusive of variations in different organisational frameworks.

The HCPC classify learning activities into five distinct categories: work-based, professional, formal / educational, self-directed, and other. The learning activities selected for inclusion in the survey were a representative sample considered most likely to be undertaken by this professional group. These were determined through the piloting process and experience of practitioners' learning within clinical practice.

Table 2 Examples obtained from *Continuing Professional Development and Your Registration*

Work-based	Professional	Formal /educational	Self-directed	Other
Mandatory training	Lecturing / teaching	Courses	Reading journals	Public service
Supervision staff / students	Special interest group	Writing articles	Reading books / articles	Voluntary work
Secondments	Mentoring	Seminar presentations		
Reflective practice	Examiner	Conference attendance		

Table 2 above illustrates the link between learning activities and categories as determined by the HCPC and will be referred to by both category and specific learning activity. The range of learning activities undertaken by all responding practitioners (n=81) is shown in figure 1. Analysis of the data indicated that the responding practitioners are engaging in a range of learning activities which meets both the definition of continuous professional development and the requirements of the Health Professions Council standards for re-registration.

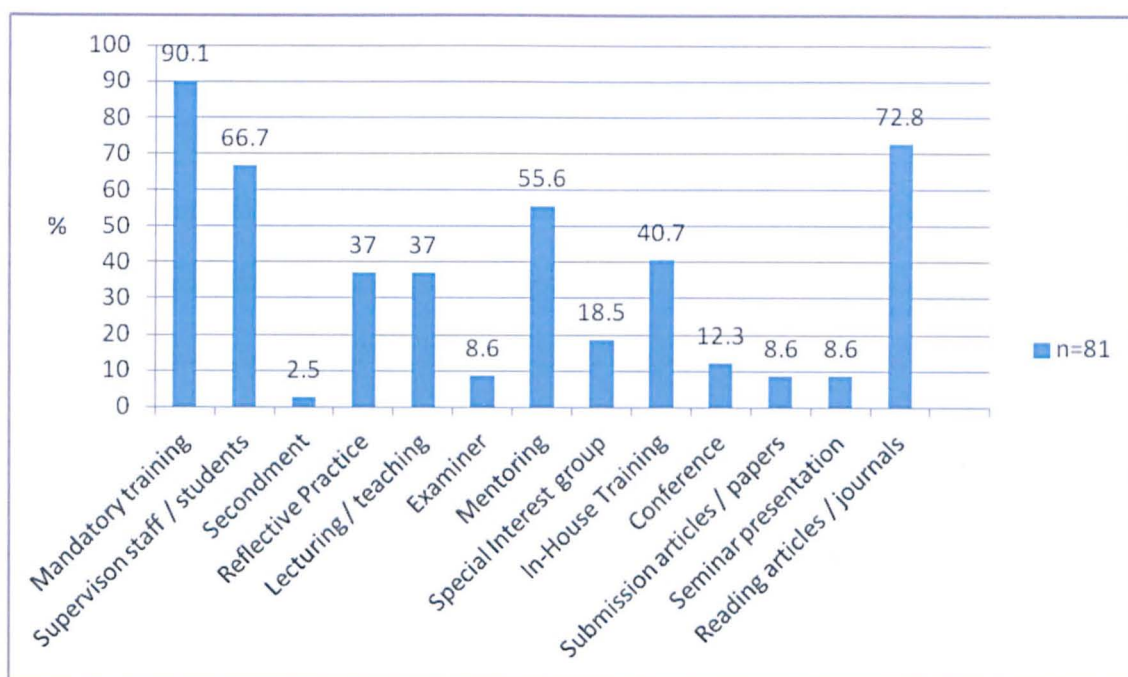


Figure 1: Continuous Professional Development Activities (all respondents)

As figure 1 illustrates, the majority of learning activities undertaken fell within the work-based category: mandatory training and supervision of staff and students comprising 90.1% and 66.7% respectively of all activities. Both these activities form contractual and clinical requirements of the practitioner's role. Respondents, in engaging in statutory and mandatory training, were acknowledging their organisational responsibilities and assisting their respective organisation in fulfilling their obligations under the Clinical Governance Framework. Supervision of staff and students, whether formally or informally, is an integral component of the practitioner's job description.

Professional activity constituted a number of formal activities both within and outside of the clinical environment. Teaching and mentoring of students takes place within the clinical environment and is conducted alongside clinical responsibilities with over half of respondents indicating they were actively mentoring students.

Lecturing and examining is undertaken in association with the local Higher Educational Establishment who advocate the input of clinicians in the delivery of healthcare programmes. Three practitioners indicated teaching advanced resuscitation skills within their organisation, with one practitioner indicating their role as an external examiner for the Diploma (HE) ODP programme. In-house formal learning, which 40% of practitioners acknowledged undertaking, comprise advanced clinical skills such as cannulation, airway management and enhanced resuscitation skills, which are extensions to a practitioner's normal daily activities but are not uniform across all Trusts being dependent on local service requirements.

With respect to the self-directed learning category 72.8% of respondents indicated they were engaging in the reading of journals and articles as part of their continuous professional development.

Examining the Training Supervisor vignettes indicates that their learning activities similarly fall within the work-based, professional and self-directed categories. Jill, David and Jack revealed that they had completed their mandatory training and attended some forms of in-house training. In relation to professional learning all four were active participants in the Diploma Award at the local HEI engaging in pre-registration interviews, clinical representatives during formal assessments and attending regular Placement Provider meetings. Mary had attended a formal conference which she indicated was linked to her role in undertaking audits within clinical practice. Only Jill and Mary were considering undertaking a degree pathway

Learning activities separated into their relevant qualification group, illustrated in figure 2, indicate a number of similarities and consistencies in learning but also some slight variations in the range of activities undertaken.

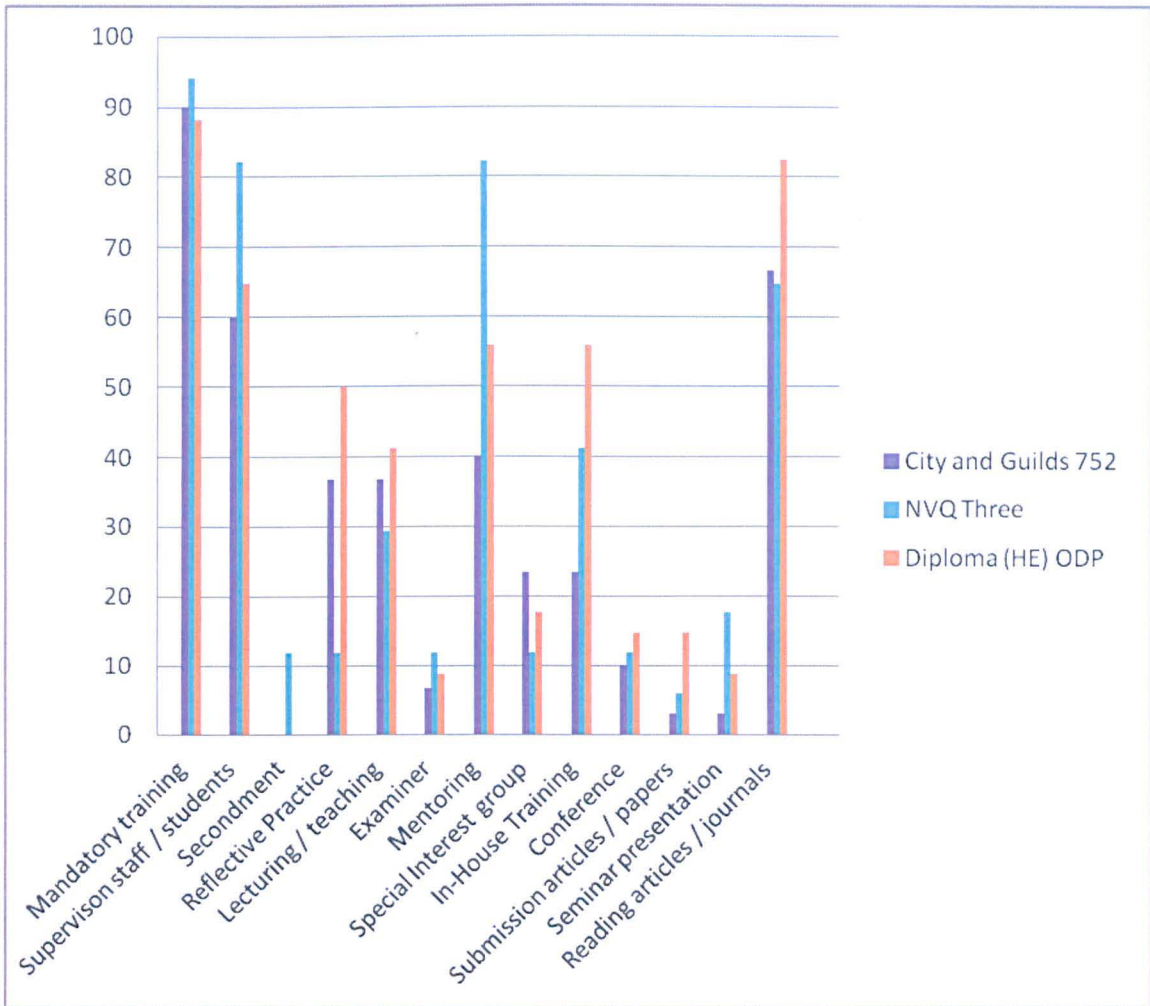


Figure 2: Continuous Professional Development Activities by Qualification

With regards to formal educational learning, 75% of practitioners indicated they were actively undertaking degree or degree-level programmes of study. These are highlighted in table 3 and adjusted according to professional qualification.

Table 3: Practitioner Engagement in Formal Academic Learning Activities

	City and Guilds 752	NVQ Level Three	Diploma (HE) ODP
Mentorship (Stand-alone module)	10	7	11
Mentorship with Degree pathway	4	4	14
Degree (non-role related)	2		1
Master's degree	2	1	3
Teaching Qualification	4	1	

The most commonly accessed course, either recently or acknowledged for future access is the mentorship programme which holds significance within the healthcare setting on number of levels. In order to facilitate the clinical teaching and summative assessment of students within the clinical environment practitioners are required to hold an appropriate qualification, attend regular mentor updates and be placed on the mentor register in accordance with professional guidelines (CODP 2009). Having sufficient and suitably-qualified clinical-based mentors forms part of the learning agreement between Health Education England (HEE) - the commissioners for training and development, the delivering HEI and Placement Provider.

For the practitioner, supervising and mentoring students is an intrinsic component of their job description across all levels of banding and contributes to the 'reproduction of membership' of newcomers within their particular community of practice (Wenger 1998). Undertaking the Mentorship module offers a stepping stone into higher education, particularly for those practitioners holding the City and Guilds and NVQ qualifications, providing the less confident, non-academically qualified practitioner an opportunity to experience formal learning. Arguably, undertaking formal learning ventures enables the older qualified ODPs to keep abreast of changes to within the profession through contact with the Students and the higher educational establishment. Ultimately this could lead to the breaking down of individual barriers and facilitate future professional development in effect serving to reduce organisationally-imposed cultural distance evident within senior practitioner's person specifications.

From table 3 it can be further deduced that practitioners holding a diploma qualification are arguably more aware of and proactive in their professional development with regards to accessing formal learning activities. Both the diploma

qualification and professional regulation were initiated at the same time, and have thus evolved alongside each other. The Diploma (HE) Operating Department Practice Curriculum incorporates the learning to learn skills alongside professional issues emphasising the importance of continuous professional development.

Diploma-qualified practitioners were more likely to link the mentorship module to a degree-level pathway whereas the older qualified ODPs accessed the mentorship programme as part of their job role and are least likely to continue with further degree-level study.

b. What factors motivate the practitioner to engage in their particular learning activities?

The Health and Care Professions Council defines continuous professional development as:

a range of learning activities through which professionals maintain and develop throughout their career to ensure that they retain their capacity to practise safely, effectively and legally within their evolving scope of practice (HCPC 2008 p.3).

This profession-specific definition was used as a framework from which to measure and determine practitioner's reasons for engaging in continuous professional development.

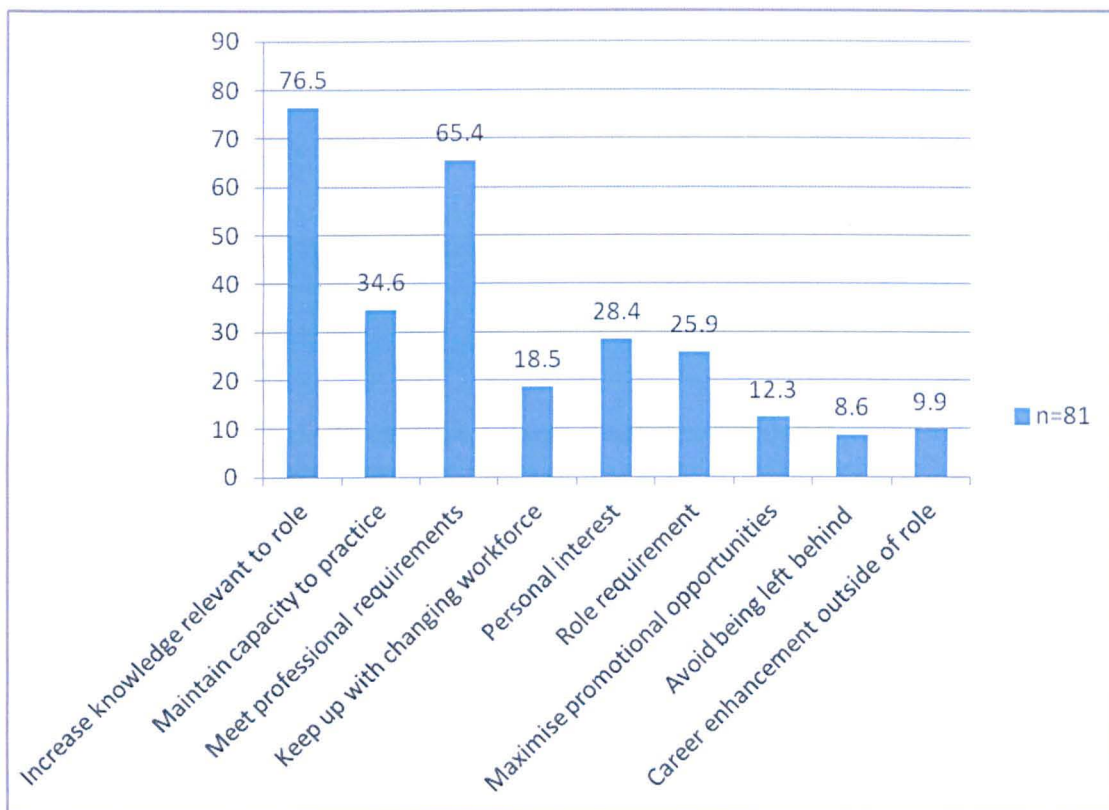


Figure 3: Practitioners Reasons for Engaging in Continuous Professional Development

As indicated in figure 3, practitioners are motivated to engage in continuous professional development for two main reasons - updating knowledge and skills (76.5%) and meeting professional requirements (65.4%). These categories, together with maintaining capacity to practice (34.6%), are consistent with the above definition of continuous professional development in reflecting an on-going, role-related process of learning in order to fulfil their professional requirements.

Coupled with the range of learning activities displayed previously in figure 1 it could be argued that practitioners' motivation to undertake continuous professional development were predominantly work-related in relation to their evolving scope of practice which in turn could be reflective of wider changing healthcare agendas. These factors are further consistent with studies carried out within the nursing profession which are suggestive of the individual practitioner's commitment to

continue to practice within their chosen profession as well as displaying commitment to professional development and learning (Murphy and Cross 2006).

Although more than half of practitioners indicated their newly acquired professional responsibilities as motivation for engaging in learning activities evidence from practitioners' responses suggests the existence of a reciprocal, mutually beneficial relationship between practice and learning. Evidence from analysis of the free-text responses confirms that the practice environment and the nature of the ODP's role in providing patient care are important motivational factors which contribute to the practitioner's selection of particular learning activities. As one respondent illustrated their immediate practice environment presented opportunity for personal development and learning opportunities - *'my first ever patient having a cardiac arrest on the operating table made me chose to go on the ILS for my own development'*

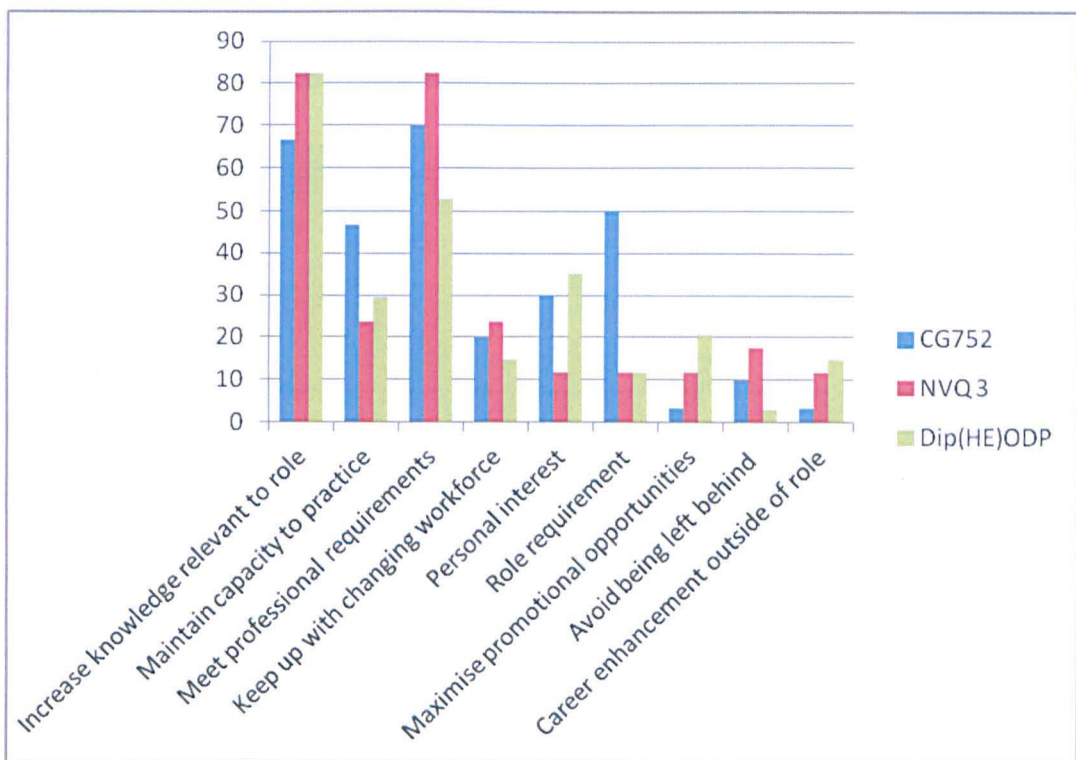


Figure 4: Practitioner reasons for undertaking CPD by qualification

Comparison across the three qualification groups (figure 4) indicates variations in the reasons for undertaking learning. City and Guilds qualified practitioners identified maintaining capacity to practice and role requirement as their main reasons for engaging in learning, where they were five times more likely to undertake learning related to their role when compared to NVQ and Diploma practitioners. Engaging in learning for personal reasons was cited by both City and Guilds and NVQ practitioners. In contrast practitioners holding a diploma qualification were deemed more ambitious in engaging in learning opportunities to maximise their promotional prospects. This group were also least likely to undertake learning as a means to avoid being left behind. This fact could be reflective of their confidence within their role and position within the ODP community as well as the importance learning holds in achieving personal goals including promotion.

Examination of the free-text elements within the questionnaire, using Braun and Clarke's (2006) method of thematic analysis, elicited three dominant themes. These are characterised as practical affiliation, theory/practice divide and barriers to learning and offer a depth of insight into practitioner reasons for engaging in lifelong learning.

Practical affiliation

The practical nature and affinity of the practitioner to the practical dimensions of their role emerged as a compelling and consistent theme. This is supported through the quantitative data whereby the majority of practitioner learning is firmly situated within the work-based category which extends to include advanced practical clinical skills associated with their roles. Practitioner comments such as *'it is a practical job that requires practical training'* and *'the role is very practical and hands-on'* served

to reinforce this relationship. Practitioners, irrespective of qualification, reiterated the relationship of their role to direct aspects of patient care with a number of respondents selecting practical tasks to illustrate and reinforce their point; '*check anaesthetic machines*', '*give rapid blood transfusion*' and '*do CPR*' holding greater significance, being considered more useful, applicable and beneficial than '*writing assignments*' – the somewhat derisory term a number of respondents used to refer to the predominantly theoretical or academic learning.

As indicated in figure 4, which depicts practitioner reasons for undertaking continuous professional development, updating knowledge and skills is very much an indicative characteristic of the practitioner's role and the leading motivator to undertake learning. Knowledge, within this context, arguably refers to practical knowledge which is, according to Guzman (2009), a multifaceted concept encompassing well-established theoretical ideas such as procedural knowledge, experiential knowledge, tacit and explicit knowledge and which importantly is 'simultaneously personal, situated and socially constructed (Guzman 2009 p.88). According to Wenger there exists a 'profound connection between identity and practice' (Wenger 1998 p.149) which is built up through 'participation and reification' of practitioners' roles within their respective community. From the array and consistency of comments divulged from across the three qualification groups it can be reasoned that practical skills and practical knowledge are an innate component of both individual and collective practitioner identity consummated through a process of experience and exposure and reinforced through language and repetition specific to their practice environment.

The theory / practice divide

The affirmation of practitioners towards the practical dimensions of their role has served to create a separation of the theoretical and the practical; the formal and the informal, although the degree of separation exhibits variation across the three qualification groups. Practitioners' views of formal academic learning emerged as predominantly negative, displaying mistrust towards both the current pre-registration diploma programme and post-registration formal academic learning. The majority of responses cited the inability to teach practical skills within a university environment as well as lack of relevant clinical-based programmes of study. Similar disquiet towards future proposals of an all-graduate profession were also observed with one practitioner stating that *'I feel the profession only changing itself in order for change sake'* in order to *'put us in line with our nursing colleagues'* (David, Training Supervisor).

This dualism of theory/practice divide is recognised within the literature and highlighted as an area of particular concern especially within the delivery of healthcare-related programmes. This phenomenon was first investigated by Bendall (1974 in Maben et al 2005) within the nursing profession and revisited within the realms of Project 2000. Although focusing on the apparent inability of newly qualified nurses to apply their theoretical knowledge within the clinical area it was found that rather than nurses lacking in knowledge application professional and organisational factors were instrumental in sabotaging its implementation (Maben et al 2005). Their views are arguably a by-product of the often insular theatre community where specific values and beliefs are held and expressed with respect to what constitutes knowledge and learning, with emphasis afforded practical knowledge and skills at the expense of theoretical knowledge.

Time-served practitioners particularly questioned the philosophy of formal learning especially the growing prominence afforded academic qualifications and the increasing academicisation of their profession. These comments are consistent with the disquiet and negativity displayed during the original proposal and move to an academic qualification as part of the professionalisation process. Concerns were further raised regarding the lack of clinical skills being delivered and assessed within the University which serves to support the theme of an increasing theory / practice divide becoming apparent

Although a degree is held out as the pinnacle of education, and a great source of theoretical knowledge, it suffers from lacking in education for clinical skills (NVQ ODP).

Although the theoretical component was acknowledged as being important the application of theory to practice, and the ability to practice clinical skills were deemed of higher standing:

I see many of the students that come through today and practically their skills seem to be lacking somehow as to how to apply their vast knowledge. It's no good in theory knowing something if it can't be put into practice. I sometimes think it's become a bit like the Project 2000 Nurses years ago who perhaps knew it on paper but had had little patient contact (City and Guilds ODP).

Experience within their respective practice area was considered an equally important dimension and referred to by a number of 'older' qualified practitioners. For those ODPs who trained under the apprenticeship model of the City and Guilds award there was a heavy emphasis on practice which could partially account for their anchorage towards the practical elements and the dismissal of the academic with one City and Guilds ODP stating:

I have carried out this role for 29 years to a high standard and believe my role is more practical and would benefit from more practical training and less, not more, academic training.

Similar attitudes towards formal learning at post-registration level were apparent throughout all respondents including the Training Supervisors. A number of diploma-qualified practitioners, who acknowledged their current undertaking of a degree, displayed an acute awareness of the importance of the practical dimensions attributed to their role. Although the value of theoretical knowledge was not undermined the general consensus can be summed up by one diploma qualified practitioner:

The role is very practical and hands on and although I'm studying for my degree, I don't think that my day to day performance will be significantly enhanced. There are less tangible benefits such as increased depth of knowledge which may bring subtle improvements to my performance (Dip ODP).

c. How are intentional learning activities identified and provided for? And what factors influence provision and participation?

Analysis of practitioner responses denotes learning activities are established through a number of mechanisms. These are presented in figure 5 and indicate they are predominantly established through two contrasting methods - formally through the appraisal system (49%) and the less formal route of self-sourcing (75%).

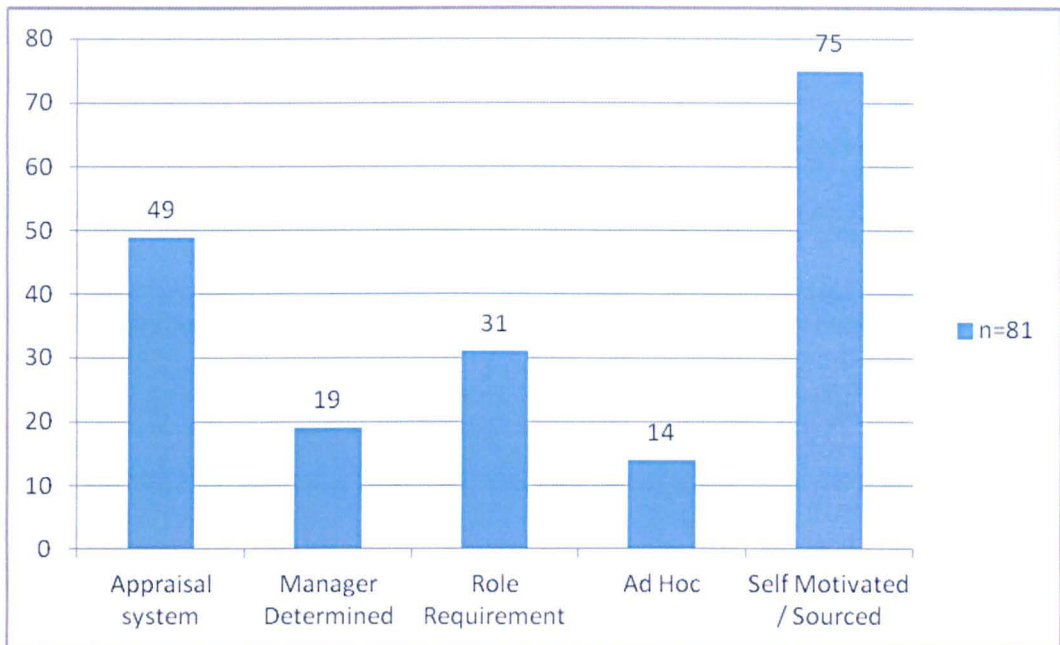


Figure 5: Practitioner Determinants of Learning

The formal and mandatory annual appraisal system constitutes a mutual discussion between manager and practitioner to determine learning requirements which are measured against organisational goals and linked to service needs. Within the NHS the current appraisal system links directly to the Knowledge and Skills Framework. Each role and banding has a specific post outline: a pre-determined criteria and level of expected performance pertinent to a banding level which the practitioner is requirement to achieve in order to move through pay banding and gateways (DH 2004b). Role requirement constituted the third determinant of learning with 31% of respondents indicating this method was used to establish their learning needs.

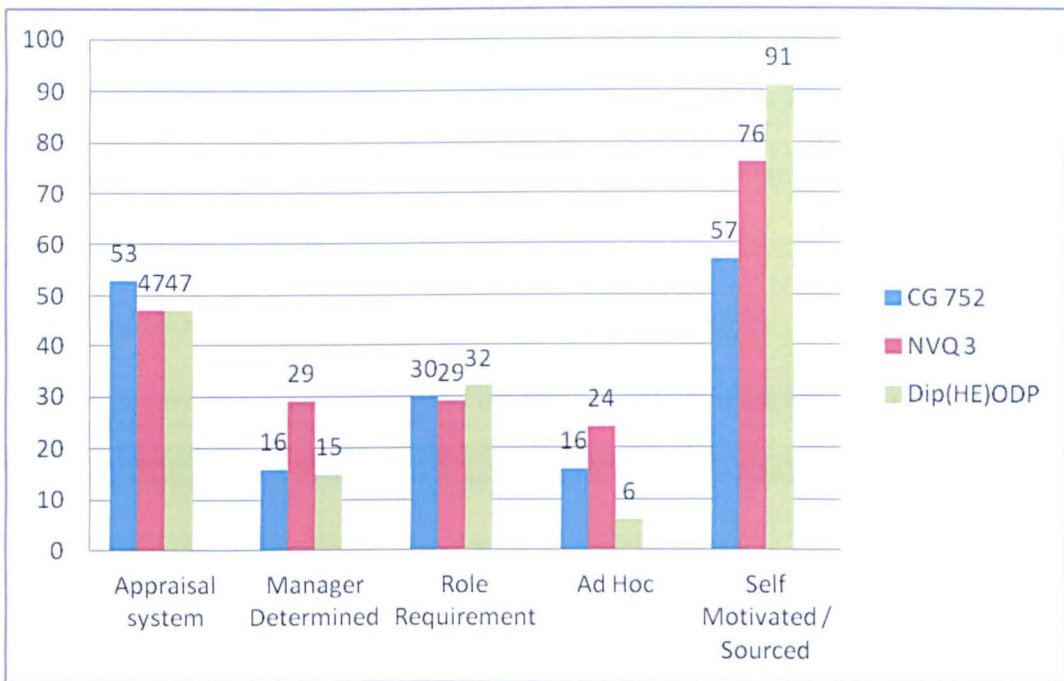


Figure 6: Practitioner Determinants of Learning by Professional Qualification

A review of how learning is determined across the professional groups indicates the appraisal system and role requirement are consistent methods of identifying learning needs (Figure 6). All qualification groups indicated their learning was predominantly self-motivated and sourced with diploma qualified practitioners (91%) taking the initiative more than their colleagues. This pre-emptive approach demonstrated by all respondents could furthermore be attributed to a heightened awareness of impending changes and challenges becoming apparent within healthcare as well as being attributed to the respective professional changes.

Learning to learn skills and the importance of engaging in continuous professional development which meets both professional and personal developmental requirements, and which forms the foundation of the diploma curriculum, arguably instils these practitioners with the knowledge, skills and disposition to be proactive in ascertaining their own learning needs. This is further reflected in the diploma-qualified practitioners' engagement in formal post-registration degree-level pathways.

Staff appraisals are a mandatory requirement in order to meet organisational obligations in line with the clinical governance framework (CQC 2010). Appraisals should aid in planning and commissioning education and training needs in line with organisational objectives linking ultimately into the future workforce planning (NHS West Midlands 2011). Parkin's (2009) claim that annual appraisal systems can contribute negatively to both team and organisational learning is both supported and refuted by evidence provided through practitioner's own experiences.

The appraisal system received mixed responses from respondents in the survey and supported by interview data from Training Supervisors. One Training Supervisor highlighted a positive experience eliciting from their appraisal stating that:

we have appraisals using this KSF framework. It was just a discussion with someone who was higher band than myself, what I wanted to achieve within the next twelve months. I've actually done two so it was quite good to see from one perspective to another one so twelve months ago I did one saying that I wanted to be more involved with student learning be involved with the university. (Training Supervisor, Jill).

Conversely, other respondents were heavily critical of the system describing their experiences of appraisals as being ineffectual or '*a waste of time*' (Diploma ODP) and considered a '*tick box exercise a lot of the time*' (David, Training Supervisor) which management and human resources departments use as a performance indicator of meeting required organisational targets.

Associated with the negative perceptions of the appraisal systems it must be added that these were directly linked to a number of barriers to learning which contributed to non-achievement of personal objectives. For two Training Supervisors (Jack and Jill) the appraisal system had positive connotations being viewed as a valuable

contributor to highlighting, developing and delivering training for all staff members not just the individual appraise:

I think the focus is definitely on development and training of the staff doing the appraisal process...however there are limitations on a member of staff's professional development due to funding but there is a lot of training which we can deliver of the back of an appraisal in house (Training Supervisor, Jack).

The appraisal system under the Knowledge and Skills Framework was introduced to support individual career planning, contribute to staff development and service productivity (West et al 2002). Despite major investment and general acceptance of the implementation of a new and seemingly beneficial process by healthcare workers Ellis and Nolan's (2005) small-scale study indicated that the intention falls short of its expectation. Their study found the appraisal process was time-consuming for both managers and staff due to increasing clinical commitments resulting in non-completion or deemed ineffective in establishing learning needs. One Training Supervisor (*Jack*) stated they would not receive an appraisal due to changes in management circumstances:

We're normally very good with appraisals, we've got a robust system in place however my manager has just left, just moved into another job and she decided not to do any appraisals on the team leaders because she had a very high workload to do. She did inform the senior management that this was the case because they were asking her to do lots of other things for them and she said she won't be able to get the appraisals done then. I won't be getting an appraisal this year.

Respondents further indicated that personal objectives identified within their appraisal were furthermore not followed up and often left unfulfilled. Evidence from staff surveys, undertaken by the Care Quality Commission (CQC 2010), questions the

effectiveness of the appraisal system as a mechanism for determining individual practitioner learning needs.

Manager input further contributed to a less than effective outcome resulting from differences in manager and practitioner expectations and identified goals. Keep and Rainbird (2002) pointed out that the manager is recognised as a significant barrier to both individual and organisational learning. Marsick and Watkins reiterate this view stating 'Managers were well suited to guide their employees...but their skills were in getting work done rather than in helping employees learn (Marsick and Watkins 2002 p.35). Although the manager was not directly named as being a detrimental barrier to individual learning, three of the four Training Supervisors alluded to their manager's role in supporting, sanctioning or opposing learning at departmental level.

Failure of managers to identify and acknowledge individual practitioner learning needs due to their increasingly preoccupied alignment with wider organisational and service requirements is an area of concern further raised by Gould et al (2006). This narrow-focussed attitude and top-down approach serves to create a one-size-fits-all approach to learning which neglects individuality, stifles creativity and is ultimately detrimental to team and organisational learning. Redman et al (2000) in their review of the appraisal system highlighted similar shortcomings with appraisees stating objectives were often imposed on them but reluctantly accepted as part of their job. Interestingly identification of specific training and development needs were secondary to establishing organisational objectives becoming almost an after-thought. Similar problems and attitudes to the appraisal system as those discussed are echoed by Training Supervisor, *Mary*:

I don't always think they are followed through efficiently to be honest. I think you know you articulate what your needs are but I don't think they are always met. A lot of the time the appraisal is just a paperwork exercise to say that the appraisal's been done. It's not actually followed through.

In contrast to the appraisal system, 75% of respondents stated their learning activities were self-motivated and self-sourced. This implies an informal, yet proactive process, on behalf of the practitioner in identifying specific learning needs. It could be argued that these particular activities are more valued by the practitioner in comparison to those chosen and governed by organisational mandates, being deemed less constrained by organisational objectives, more appropriate and beneficial to individual learning whether within their immediate or future roles.

d. What factors affect provision and participation of learning activities for this group?

From the evidence displayed in figure 1 it can be seen that practitioners are participating in a range of learning activities. This implies that there are sufficient learning opportunities available or being provided for this professional group.

Analysing the data further indicates differences in experiences and opinions with regards to the provision of learning. When asked if their respective organisations offered appropriate learning opportunities 51% of responding practitioners indicated yes and 47% indicated no, there were two non-responders to this question. Further examination of availability and accessibility of learning activities deemed specific to the Operating Department Practitioner are presented in table 4.

Table 4: Availability and Accessibility of learning opportunities for Operating Department Practitioners

(Three non-respondents in CG752 Group)

		Available and Accessible	Available Yes Accessible No	No availability or accessibility
CG 752	(27)	26%	26%	48%
NVQ Level 3	(17)	35%	28%	37%
Diploma (HE) ODP	(34)	32%	35%	33%
	(78)	35%	28%	37%

From the table availability and accessibility of learning opportunities were considered mixed from across all respondents and arguably dependent on the specific needs or requirements of the individual practitioner. Practitioners holding a City and Guilds 752 qualification (48%) considered there to be less learning opportunities available and accessible in comparison to their diploma and NVQ qualified colleagues. For one practitioner their location proved to be a limiting factor in accessing learning opportunities; *'As I live and work in Northern Ireland there are no opportunities for professional development or career enhancement' (City and Guilds 752 ODP)*.

Respondents indicated concerns regarding the unavailability of formal programmes of study aimed specifically towards theatre practitioners citing often post-registration courses were deemed too generic *'and directed at nurses' (CG752 ODP)* at the exclusion of other healthcare professions. Associated with the unavailability of specific courses an apparent undercurrent of marginalisation emerged which resulted from the acknowledgment of the highly-specialised nature of their profession; *'Often nothing available specific to ODP as we are very much a minority profession (City and Guilds 752 ODP)* and *'it tends to be NMC related rather than HPC. Nobody particularly worries about our development too much' (Training Supervisor David)*.

Allied Health Professions are often overlooked due to their small numbers and diverse roles within healthcare provision being subsumed by the larger professional groups of Nursing and Midwifery. They are, however, still expected to comply with Department of Health initiatives employed within organisations yet are frequently not included in communication or training briefs. None of the Training Supervisors during interviews indicated their Trusts had a specific Lead for AHPs. My own Trust has recently appointed an individual to this post who is actively bringing together the varied professional groups with the intention that their combined voices will prove greater together than singularly in approaching and embracing organisational and wider healthcare directives.

Barriers to learning

Although the evidence displayed in figure 1 shows that continuous professional development is being undertaken to varying degrees across the majority of practitioners a third theme was identified during analysis of the data which significantly impacts on ability of practitioners to engage in learning; that of a range of barriers to learning.

Figure 6 illustrates the barriers which impede practitioner access to and participation in learning activities.

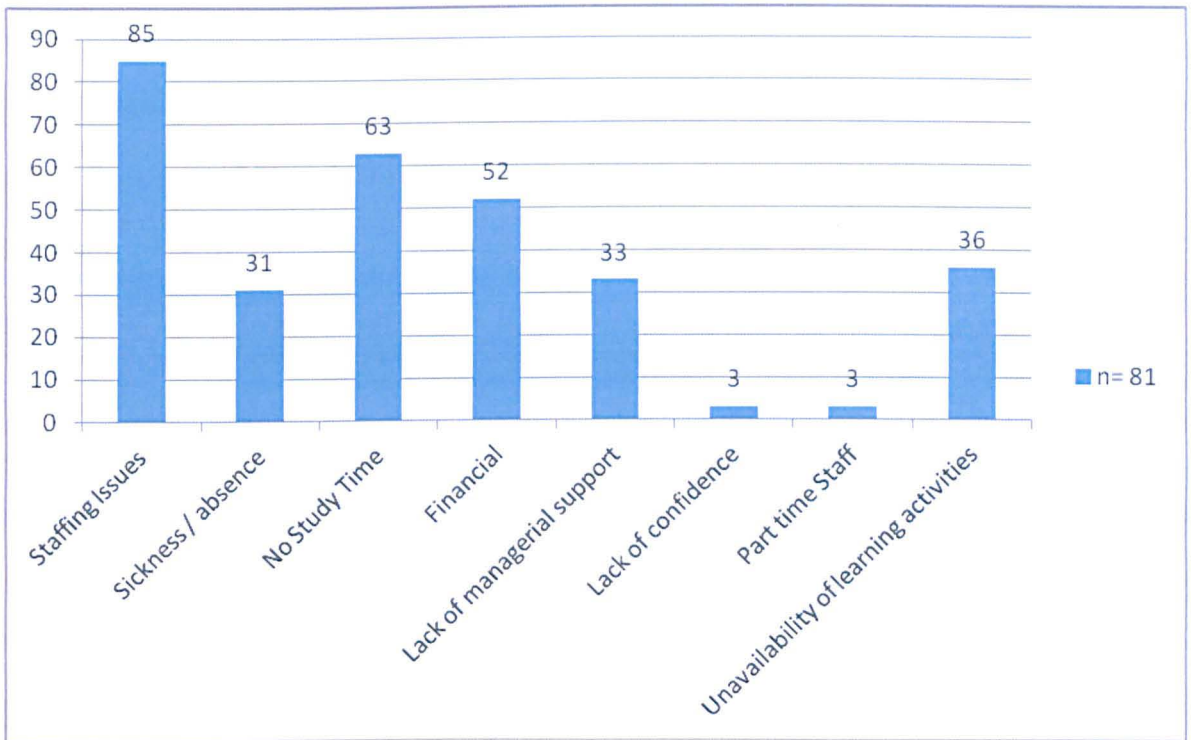


Figure 6: Barriers to engagement in continuous professional development activities
 – all respondents

A review of the barriers indicated they appear to be an interrelated combination of organisational and structural factors which are consistent with those identified within the literature (Keep and Rainbird 2002); staffing issues compounded by no study time and lack of managerial support which appears to originate from increasing or changing service need and provision. Financial factors constituted the third main barrier to learning. Personal barriers to learning such as lack of confidence in ability and being part-time staff were not considered by practitioners to be significantly obstructive.

Staffing issues were identified as the single most significant barrier (85%) to practitioners accessing and undertaking learning opportunities. Staffing issues are directly contributory to the lack of available study time and further compounded by staff sickness and absence. Restructuring of staffing and streamlining of services, increased service delivery resulting in changes to practitioner's working hours

including extended theatre sessions has significantly impacted on the ability to release staff to attend training events whether these are formal programmes of study or in-house training and development. Two respondent's comments served to highlight some of the common frustrations being felt: *'Can never get any funding or study leave and never enough staff to let you sit down and do folder therefore have to do in own time (City and Guilds ODP)* and *'I feel that I could do more to progress with my cpd, but with current issues at my trust, such as staffing and heavy workload I can't find the study time I would need which is disappointing (Diploma ODP).*

Financial constraints were acknowledged by 52% of respondents as an important contributory limiting factor in access and uptake of learning activities particularly in relation to formal programmes of study. Practitioners, when asked regarding who should take responsibility for funding and support, displayed reluctance to self-fund training which they deemed necessary to their role stating that the organisation should provide either full funding support (52%) or funding should be shared equally between practitioner and organisation (29%).

The current economic austerity measures and associated financial difficulties being experienced both within the National Health Service and from an individual practitioner perspective have served to compound the problem. Funding issues were consistently recognised as a substantial barrier to practitioner learning particularly by the Training Supervisors whose role incorporates planning and organising staff learning. Despite willingness to engage in formal learning activities financial difficulties were raised from both an individual practitioner and organisational viewpoint:

Quite a few people would like to go on degree pathways but certainly from my perspective with organising people's training

you can't put all funding into one person because that's unfair for the rest of the department (David, Training Supervisor).

One Training Supervisor (*Jill*) expressed concern that study leave within her Trust had a tendency to be turned down due to lack of funding availability and that often the allocated education and training budget for the department was insufficient to meet demands; *'the funding for one person to do a degree is probably the funding we get for the whole department'*. It became apparent during further analysis that there was a tendency to support study leave which was directly related to patient care indicating distinctions between different types of learning considered important within organisations. Comments made by Training Supervisors *David* and *Jack* supported this differentiation stating that support was made more readily available for activities *'that effect patient care... if there's a specific issue on patient care the funding will be there'* (*David*) and if *'the career development is not related to patient care... the people have to put their own money into the development of their career'* (*Jack*).

Commissioning for Non-Medical Education and Training (NMET) is determined by the regional authorities (Health Education England) following identification of training needs from relevant stakeholders. Ensuring that the region and Trusts have adequately skilled staff to meet the needs of the community relies on effectively ascertaining staffs learning requirements which are often done prospectively in conjunction with the appraisal system and approved organisational training plans. Failure to satisfactorily plan ahead can result in insufficient availability of financial support with the subsequent knock-on effect of compounding the existing barriers and practitioners being unable to adequately fulfil their learning needs leading to 'frustration and apathy' on behalf of the practitioner (Redman et al 2000). Despite

having educational policies and developmental career frameworks in place often these were considered ineffectual due to conflict between competing factors.

Acknowledgement of the increasing move to a service-led organisation and its potentially negative effects on training and development were reiterated by all Training Supervisors who expressed an acute awareness of the gradual constriction of organisational, structural and financial support:

Well it's always chicken and egg. If the funding's there and you can have the time out places will develop the training. But with service needs nowadays its very much service led...and finance led...getting time out and money will become very difficult in the future (Training Supervisor David).

Lack of availability of specific programmes of study was highlighted by 36% of respondents as a significant barrier to their learning. Even where programmes were available access proved difficult for practitioners. By professional qualification those practitioners holding a City and Guilds and diploma qualification considered there to be less availability of specific learning activities compared to the NVQ group.

Even the Training Supervisors, whose roles extend to include organising training and development for staff, were often being re-allocated to clinical duties particularly when staffing levels were low. Training Supervisor *Jill* sums up her role conflicts:

I would like are a bit more time to fully dedicate to my students at the moment. I do spend a lot of time in theatre and I find you know balancing that... I just find it a bit stressful trying to find time to look after all the students and plan everything ahead and then also to be on an anaesthetic role on a regular basis it's a bit of a juggle.

An examination of their posts did indicate that their roles as educational leads or Training Supervisors were honorary posts without substantive job descriptions; '*Not that it's a designated post. I'm a Team leader in theatres... and it's not funded as an*

extended post and I'm just in the figures' (Training Supervisor, David). It further became apparent that the Training Supervisors often worked beyond their remit expressing concern they were expected to '*organise and sort those things out which we're not really support on*' (Training Supervisor, Jack). Their roles furthermore differed greatly between Trusts; two hospitals under one Trust indicated that they had educational leads for their specific theatres but whereas one was fully supported, the other was not. Links with wider Trust educational teams were considered weak which could be contributing to some of the difficulties being experienced particularly lack of opportunity and marginalisation.

Lack of '*specific clinical courses*' and '*nothing specific to theatres at all*' (Training Supervisors, Mary and David), although further highlighting the practical affiliation of the professional group, serves to reinforce the unavailability of learning activities specific to the needs of this highly specialised group of healthcare staff. Respondents further raised concerns regarding length of formal programmes, cost of modules, and assessment methods whereby the academic component was assessed but its relationship to clinical practice and practical dimensions were neglected or overlooked.

These sentiments serve to echo the theory / practice divide which upon further inspection appears to exist both from within the practice area towards academia and equally from the university towards practice. Although an important stakeholder within the CPD commissioning process the universities themselves are contributory factors in creating their own barriers to learning. Higher Educational Institutions, particularly those involved with provision of healthcare programmes, are predominantly associated with delivery of accredited formal programmes of study and pre-registration awards. Frequently unaccredited skills-based courses which are

valued by clinical practitioners are overlooked. Small, specific and highly specialised programmes such as those identified by Gould et al (2004b) were deemed uneconomic to deliver as HEIs were more concerned with value for money than innovation and short-termism or limited uptake which can be disadvantageous to both the specialist practitioner and the organisation in relation to delivery of specific service requirements. An example of this short-termism approach was highlighted during the period of the research whereby the local University was approached by the Training Supervisors to develop a specific anaesthetic module. Identified as a specific training need aimed towards increasing staff flexibility, theatre efficiency and ultimately organisational service delivery, approval for funding and support was obtained from all Trusts across the immediate region. Despite the course being fully subscribed to for the first intake the university considered its future delivery as more important than the immediate needs of the organisations, including practitioners booked onto the course, and withdrew the programme.

An important reason for failure of commissioning processes was inaccurate or inadequate determination of educational requirements resulting from preoccupation with training needs analysis at Trust level rather than at clinical level (Gould et al 2004). Lack of communication between Trusts, Workforce Development Confederation and HEIs was further identified. Often changing external factors can impact on service need requirements which necessitate immediate training particularly at clinical level such as Department of Health and National Patient Safety Agency initiatives. Response time in implementing and cascading training to the relevant staff can be time-consuming and labour intensive within the timeframes often designated by the relevant bodies.

The majority of Trusts have specific educational or learning policies which serve to meet the above requirements, a review of which indicates activities and funding are allocated within a hierarchy which reflects local organisational objectives such as service needs and wider targets. They are also explicitly linked to the appraisal system which serves as an indicator of organisational future planning needs as well as financial support from Health Education England. In accordance with the Clinical Governance Framework Trusts are required to provide mandatory training and support staff development, evidence of which is regularly monitored. All four Training Supervisors indicated the use of regular internal audit to monitor mandatory training completion with educational leads expected to maintain accurate records often in electronic form which directly links to staff personnel records; *'they come down on you like a ton of bricks if they are not done nowadays'* (Training Supervisor, David).

Activities which fall outside of organisational directives may also be offered consideration provided they are deemed beneficial to either clients or staffs, an approach consistent with Martin's discussion in that only learning directly related to productivity would be encouraged (Martin 2002). A trade-off between funding and study was also apparent: if courses are funded then the practitioner completes them in their own time or if they choose to self-fund then study time maybe offered as compensation. This system, however, often proved futile in practice as Training Supervisor, David expressed:

if people want to fund it themselves then they can do that but unless they work part-time there's no way they will be able to get the time out as well as the funding in order to do that really.

Even when continuous professional development programmes were available and deemed necessary to support student learning, accessing them proved difficult in releasing staff due to clinical commitments and 'backfill' costs in terms of adequately skilled particularly in specialist areas and financial costs to cover those individuals on study leave.

we expressed an interest we needed a lot more mentors however there wasn't the funding to give us the places... and there wasn't adequate you know staff numbers in order to let people in and out so but we did push and I did say that we needed more number of mentors and the funding has been sought but sometimes that's just for mentorship you know in general (Training Supervisor, Jill).

Difficulties experienced in accessing learning opportunities were consistent across all three qualification groups. Although it can be argued that diploma qualified practitioners are better positioned to engage in all forms of lifelong learning with data supporting this, one respondent's personal views and experiences of endeavouring to undertake learning offers an insight into the frustrations and barriers which appear to be consistent across the professional group:

No prospects to develop any further in role. It's very hard to do be self-motivated. Appraisals are a waste of time. Staff sickness and staff levels means you can't go on study courses as they can't release you from the clinical area and never have the money for it. I help out on an in-house difficult airway course. I don't get paid and I don't get study leave I have to do it out of self-interest and for my own development and learning. Opportunities just don't exist and when they do you are not allowed to pursue them!

The above difficulties were compounded for one NVQ practitioner who, despite willingness and determination to access formal learning, encountered a range of barriers from within the higher education system itself;

I had to do a lot of research off my own back and certain universities looked down on my abilities because I "only" had an

NVQ. I felt my skills were not recognised and some universities had a rather snobbish attitude to people with a “lesser value” qualification. For this reason I am studying at Stafford but working in Gloucester, which is a challenge. I understand universities have an obligation to ensure students can work at a given level, but the fact I am well on the way to getting a first proves I am competent. Since it looks likely that in the future the standard qualification will be a degree I think there should be more help and support for people who have alternative qualifications to help them convert to a degree level qualification (NVQ, ODP).

The experiences of this particular individual serve to refute Francis and Humphrey’s (2000) argument that practical knowledge and skills provide entry to higher education. It further supports Wolf’s (2002) statement that NVQs are still considered of dubious value within the academic remit despite the widening participation agenda adopted by the HEIs.

e. What are the benefits of continuous professional development, and who are the beneficiaries of learning?

A review of lifelong learning policy reveals two distinct beneficiaries of learning: the individual and wider society where policy promotes learning as enabling mobility and increasing social inclusion. The HCPC Standards of Continuous Professional Development (HCPC 2012) reflect a similar philosophy in asking that the learning activities undertaken benefit both the practitioner and the ‘service user’. Exploring the term ‘service user’ indicates a wider audience than the patient, with the expectation that learning should be beneficial to the immediate department, the practitioner’s organisation and any other associated individual or establishment such as Students and HEIs. A review of lifelong learning policy from within the health service emphasises learning and continuous professional development as being directly beneficial to the patient in providing high quality care.

Analysis of the responses from the online survey and presented in figure 7 it can be discerned that responding practitioners considered the patient (46%) to be the primary beneficiary of continuous professional development.

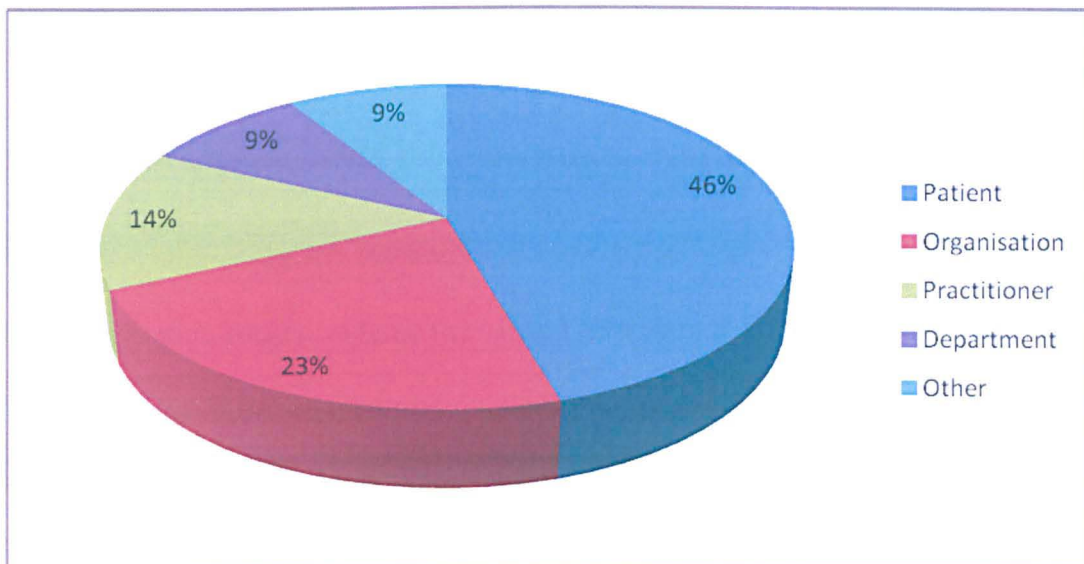


Figure 7: Beneficiaries of Continuous Professional Development

This theme is consistent with the over-arching practical affiliation of this professional group and the nature of healthcare policy and practice in being patient-centred. Similar comments were gleaned from the free-text comments where practitioners valued and related their learning activities to *'ultimately providing better care'* (CG, ODP) for the patient. One Training Supervisor (David) reiterated the need for relevance of learning opportunities: *'It's got to be seen to be beneficial to our clients which are the patients so... you've always got to relate it back to that'*.

According to Lave and Wenger's theory of learning through social participation within a community of practice, individual practitioners' learning contributes to the collective knowledge or social capital of their particular community. Whilst the immediate community of practice benefits from this reciprocity through provision of high standards of patient care and productivity, communities of practice by their

nature exist within wider community structures. Later explorations into communities of practice undertaken by Wenger et al (2010) emphasise the valuable contribution and benefits which collective community knowledge can bring to an organisation. They argue that 'knowledge has become the key to success' (Wenger et al 2010 p.4) for organisations, and as such communities of practice should be actively cultivated and their social capital treated as a valuable asset especially within the current changing business climate.

The organisation was considered the second important beneficiary of learning (23%) by respondents. From an organisational perspective the benefits of individual and collective community learning include having employees who are highly-skilled, possessing excellent clinical skills and who are motivated and committed to their roles. Further associated benefits for the organisation include provision of high standards of patient care which is demonstrated through the commitment of practitioners towards practical, work-based learning which is directly focussed towards patient care. Healthcare practice and individual organisations have more recently come under public scrutiny following the Francis Report (2013). Regular audits by the Care Quality Commission for patient service, quality and experience include examining the education and training of staff, recognising the positive links between healthcare education and safe patient care (NPSA 2004).

As a minimum requirement, all employees are expected to complete statutory and mandatory training. Completion of the relevant sections of mandatory training ensures that practitioners are keeping up to date with local policies and procedures which are subsequently employed within day to day clinical practice. As a consequence having a compliant workforce serves to ensure that the organisation

meets the expectations of the Care Quality Commission and importantly the NHS Litigation Authority who rewards the organisation's level of achievement through reduction in insurance premiums.

The mentorship programme, which is acknowledged as being the most accessed formal learning activity across all practitioner groups, provides a appropriate example of how one particular aspect of CPD can be beneficial to a range of 'service users' advocated by the HCPC. Beneficiaries of the mentorship include the practitioner, the student, the department, the organisation, the HEI and Health Education England.

A mutually beneficial relationship exists between the HEI and those practitioners who indicated in figure 1 that they engaged in lecturing, teaching (37%) and examining (8.6%). The four Training Supervisors interviewed have an established affiliation with their respective HEI, contributing to assessments schedules, curriculum design and course developments ensuring good levels of clinical practice teaching and training which ensures high quality practice placements. Two of the Training Supervisor specifically mentioned the benefits of involvement with their respective university, acknowledging the benefits as a mentor in supporting students in clinical practice:

An example I can give you is attending seminars and viva assessments of students so it gives me the viewpoint from the other perspective. So although I'm in practice a lot you know I get to see them practically, ensure that their skills are up to date and test their theoretical knowledge on the job. It's nice to see it from the other perspective to see how confident they can be, or not as the case may be, to do seminar presentations or you know how they deliver their knowledge (Training Supervisor, Jill).

...because of my role teaching students I need to make sure I know what's going on, what's in the now so that I could relay that

information and not only to the students but also to the team and the rest of my colleagues (Training Supervisor, Mary).

CPD should be a key element or determinant of future career planning and personal development (Morgan et al 2008) measured against organisational objectives and reflected in the individual practitioner's appraisal. Having a robust educational strategy in place, which aims to support all healthcare practitioners, ensures delivery of a highly efficient service recognising that having the right people in the right role with the right level of knowledge and skills contributes to improving the patient experience. Although responding practitioners found the appraisal system less than effective, investment in the workforce fosters a good working environment which is mutually beneficial to practitioner and organisation and contributes to recruitment and retention of staff, as one Training Supervisor indicated:

personally it gives me a clear plan of what I want to achieve within the next you know five years for example and I'm the sort of person that's quite organised and I like to have a plan about everything so that to me is good. For the workforce that's obviously better if someone's sort of keen to do extra things and want to learn which will further enhance their performance or knowledge base about certain things they can only gain from that (Training Supervisor, Jill).

From the chart (figure 7) practitioners were third (14%) likely to benefit from their learning activities which appear at odds with the intention of lifelong learning policy. Sadler-Smith et al (2002) focus primarily on the benefits to the individual identifying maintenance, mobility and survival as reasons for undertaking learning. Using these three identified benefits of engaging in continuous professional development the nine options for undertaking CPD employed in the survey were assigned to the most pertinent category as indicated in table 5.

Table 5: Categorisation of Continuous Professional Development Benefits

Maintenance	Survival	Mobility
<ul style="list-style-type: none"> • Maintain capacity to practice (28) • Updating knowledge and skills (62) • Role requirement (21) 	<ul style="list-style-type: none"> • Changing workforce (11) • Being "left behind" (7) • Professional requirement (53) 	<ul style="list-style-type: none"> • Promotional opportunities (10) • Enhance career outside of current role (8)
<p>Personal Interest (23)</p>		

Practitioners indicated their three main reasons or benefits of undertaking CPD were to increase their knowledge and skills, professional requirements and maintaining capacity to practice. A review of the total responses in each category signifies maintenance as the principal reason for engaging in learning activities, followed by survival and personal interest. Personal interest, although not acknowledged by Sadler-Smith et al (2002), is deemed important by a number of respondents and its prospective potential in benefiting practitioners cannot be underestimated.

Mobility, which constitutes enhancing promotional opportunities both within and outside of the current role, accounted for only ten responses. According to the philosophy of lifelong learning policy the benefits of participation in learning activities are linked to increased social status and economic prosperity (DfEE 1998a). Current financial and economic difficulties, set against upheaval, uncertainty and restructuring within the NHS, have contributed to a reduction in promotional opportunities, coupled with re-grading and down-grading of staff. Funding for learning beyond registration, inclusive of formal and informal learning activities, has

also been reduced which could explain the lack of practitioner acknowledgement of learning for career progression.

The majority of diploma-qualified ODPs are band 5 practitioners (62%) but, as previously indicated, possess greater commodity in terms of institutionalised capital in the form of quantifiable academic qualifications. In terms of 'cultural distance' they are significantly closer to the dominant discourse than non-academically qualified practitioners; job specifications for senior posts (Band 6) stipulate the applicant must hold or be working towards a degree usually in a health-related subject. Possession of academic capital facilitates and enhances access to the promotional 'field', which in turn increases social status and earnings potential. Despite possessing the necessary capital and experience the benefits in terms of mobility and promotional opportunities for the practitioner particularly during this period of financial difficulty are somewhat limited.

As a point of interest, the profession was not considered an important beneficiary of learning although undertaking CPD is considered a fundamental requirement of professional practice and one which is linked with the primary function in protecting the health and wellbeing of the public (HCPC 2005). Yet, through practitioners' engagement in a range of learning activities, the profession benefits from having registrants who are clinically effective, fit to practise and meeting their standards of proficiency. Internalising the characteristics of professionalism, of which CPD is considered an important dimension, the individual practitioner furthermore contributes to negating the less positive perceptions which have become associated with the newer professions. Thus, by association, the practitioner's own status as a professional becomes above reproach, serving to cement their position and reputation within the wider healthcare community.

Question 2

What is the nature of the relationship of continuous professional development to the professional? And how does the learning undertaken meet professional responsibilities?

Engaging in continuous professional development is recognised as an integral component of professional practice and identity according to Friedman et al (2006) as well as an expectation of the professional body, the individual practitioner and society. For professionals, keeping their knowledge and skills up to date or demonstrating 'good clinical care' (HCPC 2011) serves to demonstrate their professionalism and commitment to their professional responsibilities. Although there is an acceptance that the dimensions or characteristics of professionalism are important, Wilkinson and Wade (2009) point out that some characteristics are more dominant than others and some are easier to measure than others. Monitoring registrants' engagement in continuous professional development is one aspect of professionalism which can be measured.

The definition and expectations of CPD offered by the HCPC as 'a range of learning activities' provides a tool against which to measure the extent to which practitioners are fulfilling their professional responsibilities. Taking an overall view of the data, in particular the learning activities identified as being undertaken, it can be discerned that the responding practitioners are meeting their professional responsibilities in relation to meeting the standards of CPD.

Whilst the Health and Care Professions Council is not prescriptive with respect to the nature of learning activities required, there is an expectation of practitioners to engage in more than one form of learning. Although respondents are meeting their professional requirements, on further examination variations were apparent in

quantity and diversity of activities. One City and Guilds qualified practitioner indicated completion of mandatory training only with eight other respondents having completed eight or more forms of learning activities over the past twelve months. The average number of activities undertaken by practitioner group was determined as follows: - City and Guilds (4.37), NVQ Level Three (5.17) and Diploma (5.02). For all practitioners the average number of activities was 4.8.

From the data in figure 3 we see that all responding practitioners indicated that their main motivational factors for engaging in learning were not solely driven by their professional responsibilities to engage in continuous professional development. Although there exists an integral relationship between learning and professional identity, meeting professional requirements was identified as being the second most important reason for undertaking learning (64.5%). Respondents identified three main reasons for undertaking CPD: increasing their knowledge relevant to their role; maintaining capacity to practice and meeting professional responsibilities. The combination of these three main categories intimates towards the existence of a tripartite relationship between individual's clinical practice role(s), professional development and professional responsibilities.

Taking a wider view of the data, it can be seen that the combination of the three key reasons for engaging in learning activities coupled with the theme of practical affiliation serve to reflect some of the dimensions attributed to professionalism, particularly those identified by the HCPC (2011). Demonstrating 'good clinical care' can be seen through the practical and work-based learning activities undertaken by respondents (figures 1 and 2), as well as acknowledging the importance of keeping knowledge and skills up to date. Undertaking reflective practice, of which 37% of respondents disclosed, is also associated with this dimension. Arguably the actual

process of engaging in learning opportunities, whether provided as part of being an employee or being self-motivated to seek out specific learning activities, indicates a positive attitude towards study and an 'expression of self' (HCPC 2011). Accepting the changes to the profession and acknowledging that learning is integral to everyday practice posits a credible argument that engaging in learning is becoming a 'way of life' for this professional group as they internalise their professional responsibilities and exhibit professionalism.

During the interviews with the Training Supervisors, they were asked for their own definitions and thoughts of continuous professional development. One respondent, Mary, provided this concise characterization - '*obviously to maintain current practice, maintain your professionalism, your registration*'. Her own definition echoes the intentions of CPD as described by the professional body earlier and acknowledges the significant relationship of learning to professional responsibilities.

An integral dimension of continuous professional development and one which is associated with the re-registration process initiated by the HCPC is the keeping accurate and up to date records of learning activities (Parker 2014). Haywood et al (2013) in their research into CPD within a cross-section of allied health professionals highlighted the importance of keeping personal learning profiles. Whilst, practitioners understood the need to keep a portfolio of CPD experiences, concerns were highlighted around what they should look like and what they should contain. Of interest, their research indicated the different attitudes between senior practitioners and newer-qualified staff stating that 'newly-qualified staff members were good at recording learning in their portfolios as this had been recently emphasised during their training' (Haywood et al 2013 p.140).

Although keeping a 'profile' or portfolio of learning could be deemed a personal matter two of the Training Supervisors were forthcoming in discussing the nature of their own CPD profile:

I've built a portfolio of everything that I've achieved... I just keep records of all the certificates all the dates, courses that I've attended (Training Supervisor, Jill)

I keep a portfolio. It's not always as up to date as it should be but yes I do try and because you know I don't want to be running around if I get the letter saying that they want the evidence (Training Supervisor, Jack).

For the ODP, if selected by the regulatory body, registrants are required to submit an up-to-date and continuous record of their CPD for review which are measured against set criteria of standards (HCPC 2008). This specific profile required by HCPC registrants takes the form of a template which is easily downloaded from the HCPC website and comprises a framework aligned to the standards. Rather than submitting a complete portfolio of evidence the HCPC suggests a selection of learning activities with a relevant form of evidence are submitted.

Whilst acknowledging the logistical difficulties in requesting and reviewing all registrant's profiles, it could be argued that the current sampling system may be accused of unfairness and failure. Two respondents in the survey made direct reference to the Health and Care Professions Council's process for re-registration and monitoring continuous professional development. Although acknowledging that they cannot be generalised to the wider population, they are however particularly valid observations which serve to highlight a less than adequate system. Random sampling confers equal chance for all practitioners to be included in the sample (Robson 2002) and fashions an air of anticipation, trepidation and uncertainty during the re-registration period, however in practice two limitations arise. One responding practitioner in the survey indicated they had been selected on two successive

occasions and under the current process could be selected again at future cycles of re-registration.

I have been qualified for over five years and during that time I have been selected for my CPD portfolio twice by the Health Professions Council. I have been successful with both my portfolios and I have enjoyed completing them (Dip ODP).

Whereas the respondent admitted enjoying the challenge of completing their portfolio, and successfully met the criteria for continuous professional development, a degree of resentment towards the non-selected ODP population may be detected as under the current system a large number of registrants would not be audited. As Williams (1994) and Morgan et al (2008) point out some practitioners may not or will not be fully engaging with their professional responsibilities with regards to undertaking CPD either through resentment in the sanctions system employed or through lack of opportunity and will slip through the net. Similarly another respondent stated that the HPC '*should audit more*' (City and Guilds ODP). This could help ensure all registered practitioners are actively undertaking learning activities, maintaining competence to practice and thus demonstrating their worthiness, honesty and integrity as a registered professional.

CHAPTER TEN

DISCUSSION OF FINDINGS

This study set out to investigate the experiences of continuous professional development within a small, but emergent healthcare group of Operating Department Practitioners where a succession of changes have brought the concept and practices of lifelong learning to the forefront of their professional practice. The findings from the study, which are interpreted and discussed from within my own perceptions and experiences as a Senior ODP and Practice Educator, revealed a unique insight into the experiences, motivation and benefits of learning. In exploring the complex and multi-dimensional nature of lifelong learning the study further presented opportunity to appraise healthcare organisational policy and practice. And in doing so, a tale of contrasts between expectation and experience, and policy intent and practice reality were uncovered.

Practitioner perceptions of continuous professional development

The historical review of the Operating Department Practitioner indicates a series of changes to the profession. This included a move to an academic qualification which pre-empted attainment of professional status and the introduction of a sanctions model of continuous professional development as mechanism for re-registration. Despite the initial discontent and limited engagement in the consultation processes for the introduction of CPD (HCPC 2005), evidence from this study indicated that ODPs have risen to the challenges and accepted the changes.

Taking a broad view of the findings indicated that practitioners, irrespective of their professional qualification, were engaging in continuous professional development.

The respondents' acceptance and attitude towards the implementation of mandatory

CPD was positive, with recognition of the value and benefits which learning can bring for the practitioner, patient and organisation. From a professional perspective, the ODPs were participating in a range of learning activities as advocated by the HCPC in their definition of continuous professional development (HCPC 2008). In meeting this definition it can be reasoned that practitioners are meeting their professional responsibilities and maintaining accountability with respect to undertaking CPD as a mechanism for re-registration and ensuring their on-going competence and fitness to practice under their protected title. With respect to their professional status, the majority of responding practitioners exhibited a positive attitude and acceptance towards the introduction of a sanctions model of continuous professional development. And as such, the relationship of CPD and professional responsibility has become embedded within the day to day practices of this group of practitioners. Re-visiting the literature surrounding the nature of professionals, it can be suggested that by accepting the sanctions model of CPD and embracing it as part of their developing identity then ODPs are establishing themselves and exhibiting the characteristics of professionalism presented in the literature, and specifically relating to allied health professionals (HCPC 2012).

With regards to the motivational factors which influence practitioners' participation in continuous professional development these were determined to be primarily intrinsic, driven by the challenges of practice and the need to survive or succeed in a competitive and changing environment. Practitioner's identified that their main reasons towards engaging in learning was to increase their knowledge and skills relevant to their role which they viewed as a means of '*personal development and satisfaction of achievement*' (Diploma ODP). The learning activities identified by practitioners were predominantly work-based or directly related to their area of

practice. One area selected for particular discussion is the over-riding commitment all practitioners displayed towards the practical dimensions of their role with regards to the selection and undertaking of specific practical-related learning activities.

Respondents' primary motivation for undertaking any form of learning was centred on practical, work-related activities, which contribute to providing high quality patient care and which further indicate that the patient is central to their learning intentions.

Evidence from the findings further suggests that extrinsic and social factors may also be implicated for some of the respondents. From a social viewpoint, the majority of responding practitioners appeared proud of their identity not only as ODPs but as part of the wider theatre community. As a recognised healthcare profession, there was a sense of pride and belonging to their established heritage within the surgical remit. Associated with this position is an awareness of the changing nature of healthcare practice, as well as acknowledging the importance in recognising and responding to future challenges.

As an example of Lave and Wenger's (1999)'community of practice' the ODP's preference towards work-based and practical learning is arguably fuelled by a joint enterprise and shared repertoire in providing high levels of patient care. The reproduction and recreation of the cultural values and beliefs inherent within this thriving community are certainly implicated in the group's practical and patient-centred philosophy. Their focus and determination in undertaking learning which directly benefitted the patient serves to reinforce their affiliation towards the practical, and furthermore establishes their identity within the discipline of healthcare practice and provision. Their predominance, and indeed preference,

towards work-based and work-related learning activities serves to support their practical association and is furthermore consistent with the changing views of health policy in adopting what could be referred to as a return to basics approach across the healthcare sector. And one which furthermore refutes the observations made by nurses in Tanner and Timmons' (2008) research as the group increases their distance from their traditional technical origins.

The findings indicated that the majority of practitioners, irrespective of qualification, were participating in a range of learning activities. Further examination, however, revealed 'substantial variations in practice and experience' (Tight 2002 p.47) with respect to the quantity and diversity of learning activities being undertaken. These variations are attributable to a complex and inter-related range of factors such as practitioners' individual learning needs; disposition towards particular learning activities; motivation; role requirement; professional responsibilities and future career prospects. Variations were also apparent between ODPs holding different qualifications, with diploma-level qualified practitioners emerging as being better positioned in terms of motivation and disposition towards all forms of learning when compared to their colleagues holding a City and Guilds 752 and NVQ Level Three. There was also a greater tendency for the diploma ODPs towards formal learning which could be a conscious display of the potential rewards which formal and academic credentials can bring with regards to promotion.

If, in the near future, the profession moves to being an all-graduate profession and the expectation of employers is for their employees to hold as a minimum a degree then this group are significantly closer to the impending expectation. The capital value, and cultural value, of this academic qualification in opening doors and

creating opportunities is particularly evident and displayed by the number of practitioners accessing degree-level modules and pathways. The co-evolution of professional regulation and academic qualification has served to embed the value of engagement in lifelong learning processes within this particular group, and is reflected in the predisposition of diploma-qualified ODPs to 'top-up' to a degree. McLeary et al (2011) observed similar attitudes from recently-qualified mental health nurses, whose main reason for participation in learning was to raise their qualifications. Conversely they also observed that the older and more experienced nurses focused on maintaining their knowledge and skills and broadening their clinical practice.

The second major change for the Operating Department Practitioner was the move to higher education and the introduction of the Diploma (HE) Operating Department Practice as their pre-qualifying award. This change was less than accepted.

Respondents, especially the older qualified practitioners, but equally some of the more recently qualified practitioners, were less than complementary towards the *academicisation* of their profession. The elements of discord and discontent which were apparent from the inception of the professionalisation process appear to pervade. Practitioners displayed evidence of mistrust and scepticism with the growing value attributed to formal, academic and degree-level programmes, seeing these particular changes as an erosion and dilution of their well-established practical identity. Practitioners particularly felt that the profession was becoming too academic, with an increasing emphasis on the theoretical components of the training at the expense of practical, hands-on experience which they consider to be of higher value and considered a defining characteristic of their professional identity.

Although accepting mandatory CPD as an integral component of their professional responsibility, the effectiveness of the re-registration process was questioned. The current process is the random selection of 2.5% of all registered practitioners every two years who are required to submit a portfolio of their continuous professional development activities for the preceding two years which are measured against set criteria of standards (HCPC 2008). The remaining registrants complete a self-declaration form. Whilst acknowledging the logistical difficulties in requesting and reviewing all registrants' profiles, it could be argued that the current sampling system may be accused of unfairness and failure. Two respondents in the survey made direct reference to the Health Professions Council's process for re-registration and monitoring continuous professional development. Although acknowledging that they cannot be generalised to the wider population, they are however particularly valid observations which serve to highlight a less than adequate system.

Whilst random sampling confers equal chance for all practitioners to be included in the sample (Robson 2002) and fashions an air of anticipation and uncertainty during the re-registration period, the process raises two areas for concern which were highlighted by the respondents. One practitioner in the survey indicated they had been selected on two successive occasions and under the current process could be selected again at future cycles of re-registration. Whereas they admitted enjoying the challenge of completing their portfolio, and successfully met the criteria for continuous professional development, a degree of resentment towards the non-selected ODP population may be detected as under the current system a large number of registrants would not be audited. As Williams (1994) and Morgan et al (2008) point out some practitioners may not or will not be fully engaging with their professional responsibilities with regards to undertaking CPD either through

resentment in the sanctions system employed or through lack of opportunity and will slip through the net. Similarly another respondent stated that the HCPC '*should audit more*' (City and Guilds ODP). This could help ensure all registered practitioners are actively undertaking learning activities, maintaining competence to practice and thus demonstrating their worthiness, honesty and integrity as a registered professional.

Participation and Provision

The routes to qualification and registration vary across healthcare professional groups but the necessity to participate in continuous professional development is consistent (Ryan 2003). It is also important that practitioners are self-motivated regarding taking responsibility for their own personal and professional development. Whilst evidence indicates that ODPs are taking responsibility for their own learning and the perceptions were primarily positive, practitioner's experiences with regards to participation and provision were verging on negative.

Lifelong learning policy adopts an inclusive stance where all individuals should have equal opportunity to access and engage in a variety of learning. Examining the findings from this study indicates that opportunity, access and participation in learning are hampered by a number of structural and organisational barriers. The main barriers to learning highlighted by this professional group were staffing, time and financial. These issues are consistent with those observed across a range of healthcare groups (Ross et al 2013; Gibbs 2011 and Gould et al 2007). The role of the line manager was also raised within the wider nursing and allied health groups as a barrier to learning (Gould et al 2007; Ross et al 2013). Although not mentioned within this study as a direct barrier, the line manager was seen as a gatekeeper,

allowing or refusing practitioners participation in learning activities. They were considered detrimental to learning through controlling the amount of study time available, determining appraisals and pressuring the practitioner to justify the reasons for and benefits of their chosen learning activities (Haywood et al 2013).

Yet, for this particular group of healthcare practitioners, a distinct set of barriers can be identified which originate from their specialist nature and a lack of professional alliance as O'Dowd's (2012) review highlighted. Their 'smallness' as a professional group puts them in direct competition with the larger and more established healthcare groups in terms of financial assistance and support for learning opportunities. Furthermore, resulting from their specialist nature, releasing ODPs from clinical practice becomes increasingly difficult particularly where staffing levels have been reduced significantly in light of recent financial difficulties. The limited availability, accessibility and provision of suitably appropriate programmes of study for ODPs were also detrimental to practitioner engagement in learning. Morgan et al (2008) in their exploration of continuous professional development across a range of senior nurses were similarly critical of the insufficiency of opportunities for learning and development within the NHS.

Organisational Policy and Position

Lifelong learning remains a high profile initiative for the organisation: deemed integral to the National Health Service Agenda (DH 2012) as contributing to productivity, performance and enhancing patient care as well as ensuring registered practitioners maintain their knowledge, skills and competence to practice.

Organisations are key players with vested interest in both the process and product of continuous professional development. Yet evidence suggests that their input is

variable in terms of structural, managerial and financial support which is impacting on the ability of the practitioner and the community to participate fully in their learning responsibilities. In turn, this affects the organisation's standing as a learning organisation.

According to Sherman et al (2007) the internal environment is usually reflective of, or aligned with, the organisation's external position. If this is the case, then the experiences of the Operating Department Practitioner revealed through this study can provide an assessment of the organisation's current situation with regards to its lifelong learning policy. Taking all findings generated from the online survey and interviews and collating them into a SWOT analysis provides an indicator of the current state of learning within the largest organisation in the United Kingdom. These are displayed in table 6.

Despite the lack of research-based rigour and criticism of its limitations the flexibility and diversity of application associated with a SWOT analysis enabled a multi-level approach in exploring lifelong learning from an organisational perspective. It further provides a concise summary of the difficulties which practitioners are experiencing with regards to provision and participation in continuous professional development.

Table 6: SWOT Analysis of Organisational Learning

Strengths	Weaknesses
<ul style="list-style-type: none"> ➤ Highly-skilled and motivated workforce. ➤ Commitment to professional role ➤ Patient-centred focus. ➤ Delivery of effective / efficient patient care ➤ Collective knowledge and skills ➤ Evidence-based current practice ➤ Enhancement of patient care and patient outcomes. ➤ Recruitment and retention ➤ Educational policies with equal opportunities for all healthcare professionals. 	<ul style="list-style-type: none"> ➤ Unstructured education strategies / policies ➤ Complicated study leave application system ➤ No profession-specific education lead ➤ Ineffective appraisal systems ➤ Financial constraints ➤ No available specific courses ➤ Lack of motivation (staff) ➤ Lack of awareness of CPD / LLL policies ➤ Time-consuming in completing formal programmes of study ➤ Professional identity – erosion due to small profession. ➤ Competition of ODPs with Nursing and Midwifery applications ➤ Competing priorities organisation / practitioner / professional body
Opportunities	Threats
<ul style="list-style-type: none"> ➤ Support for promoted staff ➤ Effective Preceptorship programme for newly qualified staff ➤ Funding from SHA ➤ Proactive workforce ➤ Recognition of positive aspects / contribution of CPD ➤ Educational policies ➤ Retention of staff 	<ul style="list-style-type: none"> ➤ ‘Diploma disease’ ➤ Non-retention / high turn-over of staff ➤ Lack of coordination / educational lead for theatre staff. ➤ Financial constraints ➤ Service-driven / led ➤ Lack of staffing ➤ Limited support for post-reg pathways / non-essential learning ➤ Limited course availability / cost ➤ Political and economic influences ➤ Resistance to change / cultural stagnancy ➤ Multi-professional workforce ➤ Top-down management approach ➤ Job cuts / restructuring ➤ No forward planning – reactive rather than proactive ➤ Constant restructuring of services and organisation ➤ Changes in prioritisation of service needs ➤ HEI – cost efficiency in delivering small or practical programmes ➤ Prioritisation of pre-reg pathways ➤ Highly specialised service needs ➤ Conflict with professional regulatory body requirements.

The results of a SWOT analysis can lead to one of four conclusions which Sherman et al argue as being indicative of the current 'state' of the organisation in relation to the prevailing economic and financial situation. Their strategies are highlighted as follows:

Growth strategy – strengths outweigh weaknesses; opportunities outweigh threats.

Maintenance strategy – strengths outweigh weaknesses; threats outweigh opportunities.

Harvest strategy – weaknesses outweigh strengths; opportunities outweigh threats.

Retrenchment strategy - weaknesses outweigh strengths; threats outweigh opportunities

Using Sherman et al's (2007) identified strategies it can be determined that the current state of organisational learning sits within a retrenchment strategy whereby the weaknesses outweigh the strengths and threats outweigh opportunities. Although deemed a poor reflection of learning within the NHS, it does however reflect the current situation being experienced within the organisation. External factors such as economic and financial constraints are influential in how learning is managed within individual organisations and contributes to which particular learning model they subscribe to. This in turn directly affects the practitioner's ability and motivation towards participation in learning and serves to highlight that staff training and development is increasingly becoming a 'marginal activity' (Keep and Rainbird 2002 p.85).

Although acknowledged as integral to organisational strategies, learning appears to be increasingly regarded as an optional extra becoming subsumed by the need to increase efficiency and service delivery. The problem of an increased workload was identified as being a significant barrier to practitioner engagement in learning (Ross et al 2013; Gibbs 2011). This, they acknowledge, as being detrimental to the on-

going professional development of the staff and which ultimately impacts on organisational learning. The lack of structure and consistency being experienced on the ground floor could be reflective of deficiencies within higher levels of organisational management and conflicts in organisational goals and directives.

In an ideal world, organisations in responding to global and economic change thus safeguarding their competitive edge, should value employees' individuality and contributions, utilise their collective knowledge and experiences through investment in training and development (Wenger et al 2002). Keep and Rainbird (2002) raised a particularly pertinent point that sometimes organisations fear that employee's benefit from investment in learning rather than the organisation itself, with the net effect of staff learning and subsequently leaving. But there is a need to invest in staff training and development to ensure a viable, sustainable and competitive organisation in order to maintain a stable and skilled workforce (Jackson 2003). Shields and Ward (2001) in their investigation of nurse retention indicated that dissatisfaction with the lack of promotion and training opportunities outweighed increasing workload and improvements in pay stating 'the largest positive effect on job satisfaction, originates from being within a workplace where training and other forms of human capital development are encouraged' (Shields and Ward 2001 p.690).

This view supports the current situation being experienced within the clinical environment where evidence derived through this study indicates that there is little structure or consistency in the provision of and support for learning opportunities. Coupled with the range of structural and organisational barriers identified such as time, staffing and financial, this places added responsibility onto the practitioners to seek out more creative and accessible forms of continuous professional development

such as e-learning, cascade training and sessions delivered free of charge by medical company representatives. Informal and work-based learning was considered important to the Operating Department Practitioner. This form of learning, however, is often perceived by traditionalists as having less credibility than learning associated with the formal qualification-conferring domain but it is non-the-less valuable and cannot be under-estimated. Eraut et al (2006) make two valuable observations in relation to the underestimation of work-based learning stating that 'informal learning on the job was of greater importance' than formal educational learning but 'learning opportunities at work were not sufficiently used' (Eraut et al 2006 p.128). These alternate, specific and equally valuable learning activities both provide practitioners with basic but essential learning opportunities to fulfil professional requirements and subsequently reduce the burden on the organisation.

Policy, Practice and Continuous Professional Development

The incongruence between lifelong learning policy and practice became particularly apparent through this study, although it must be acknowledged that the multi-faceted nature of lifelong learning policy is built on shifting sands and changes depending on the current social, political and economic status. An underlying principle of lifelong learning policy implies that individuals who regularly engage in lifelong learning activities will be rewarded whether by increased social mobility and / or associated financial remuneration. Taken at face value, lifelong learning should be a precious commodity which ensures some degree of prosperity for all individuals who participate.

The fundamental reasons identified within the literature for individual engagement in continuous professional development are maintenance, survival and mobility

(Sadler-Smith et al 2000), and '*credentialism*' (Morgan et al 2008) which facilitates promotional opportunities. Similar principles apply within the NHS under the Knowledge and Skills Framework and Agenda for Change (NHS 2004a), whereby practitioners were to be similarly rewarded according to the knowledge and skills they demonstrated, and which serves to create a capital advantage in the promotional stakes. Under these conditions, and in accordance with policy intent, all responding practitioners hold sufficient capital to ensure some form of mobility whether within their current organisation or, as some practitioners indicated, to increase their prospects outside of the NHS. Sadler-Smith et al (2002) further argue that 'learner motivation is the essential pre-condition for effective learning; in order to be motivated an adult learner must anticipate some benefit' (Sadler-Smith et al 2000 p.253). But in the current climate where any direct benefits, incentives or rewards are temporarily suspended and funding mechanisms reduced, then it could be argued there is little motivation to engage in learning. Yet, according to the research findings, the majority practitioners are actively seeking out learning opportunities which indicates a base-level of motivation. This, arguably, is linked to their professional responsibilities and pride in delivering patient-centred care.

Despite this commitment, evidence indicates a degree of disenchantment and disquiet verging on negativity from within the profession particularly towards the current situation within the NHS. This negativity emanates from the multiple structural and organisational barriers to learning identified through the research, rather than through the changes imposed from within the profession. The barriers identified originate directly from the economic and political situation being experienced at national level whereby the need to deliver a high class service is in direct contention with financial cutbacks. Any incentives to engage in continuous

professional development are sadly being eroded as staff re-structuring in order to maximise service efficiency, as well as reduce escalating financial debt, is contributing to promotional stagnancy. They are furthermore restricting the organisation's ability to address the lack of implementation of their education and training strategies.

If the current situation persists, there exists a fear that the feelings of disillusionment may become ingrained within the culture of this professional group and sadly erode any existing motivation. Crumpton (2013) raises a particularly pertinent point in stating that it is often very difficult to motivate a de-motivated workforce especially during difficult times. The onus and motivation to engage in learning sits primarily with practitioner, therefore the individual practitioner has a number of options to ensure they endeavour to meet their professional responsibility. Ambitious practitioners may adopt a more creative and proactive approach to continuous professional development through engaging in learning in their own time or self-fund formal learning. This serves to maximise their opportunities and enhance their capital when entering the increasingly competitive recruitment and promotional field. This can lead, however, to the potential development of a two tier system where those practitioners who could not afford to fund their own learning through personal means are at serious risk of being disadvantaged (Haywood et al 2013).

Some practitioners, who have reached the top of their banding scale and with no opportunities available locally for promotion, may seek employment in other Trusts or leave the NHS completely as some respondents indicated in the survey. Older or less competitive practitioners and those who feel disillusioned with the current stagnancy may choose a maintenance option of doing the minimum to meet

organisational and professional requirements. Potentially practitioners, who are at present undertaking learning as a maintenance mechanism, may ultimately find themselves engaging in learning solely as a survival strategy with no foreseeable benefits. The consequences of this are two-fold. Practitioners will fall short in meeting their professional responsibilities with subsequent reality of social exclusion through removal from the professional register (HPC 2008). Due to organisations' insistence in subscribing to the 'diploma-disease' philosophy (Dore 1976), the wealth of knowledge and experience held by the older, and less academically-inclined practitioners, will be overlooked creating both a knowledge-vacuum and fostering internal professional jealousy and resentment. The advantages afforded the diploma-qualified practitioners perhaps comes at the detriment of the non-academically qualified practitioners. Practitioners holding a City and Guilds or NVQ qualification may be subject to exclusion or imposed marginalisation whereby they are excluded from engaging in certain learning activities through conditions imposed by external agencies, such as Higher Educational Institutions who consider the NVQ to have little academic value as one ODP discovered in the findings.

The Future of Continuous Professional Development

What does the future hold, not only for ODPs but for all healthcare practitioners, as the NHS faces more change in organisational structure and financial shortfalls? The current and pervading unsettled climate of national and local organisational change has major implications for practitioners. In addition the financial difficulties and resulting subsequent reduction in the education and training budgets made available to the organisations presents an equally uncertain prospect regarding support for future workforce training and development opportunities.

If, as policy argues, that learning is the key to prosperity both for the individual and organisation then the current retrenchment strategy apparent within the NHS is detrimental to the future workforce and service delivery. Recent publications from the Department of Health (DH 2012) display acute awareness of the potentially damaging impact of the imminent changes and the necessity of investing in education and training in order to achieve its own goals of a world-class healthcare service. Whilst acknowledging that CPD is the responsibility of the individual, they re-iterate the importance of shared responsibility on behalf of the employer (DH 2012 p.36). Yet they tender little in the way of how this 'shared responsibility' will be implemented. If lifelong learning is to continue to be seen as a mechanism for enhancing patient care, as well as proffering opportunities for personal and professional development, then a number of pressing questions need to be addressed. Firstly, how these extremely evident structural and organisational barriers are to be overcome. Secondly, how to achieve a viable and inclusive working policy where each stakeholder receives some benefit from their contribution.

The SWOT analysis in table six presents a poor picture of the organisation as a whole. The weakness and threats to both practitioner and organisational learning far outweigh the strengths and opportunities. The evidence generated through this study into the experiences of CPD within the professional group of Operating Department Practitioners indicates that there exists a wealth of obstacles in preventing the full creation of a learning society. Yet the evidence further suggests that despite these barriers opportunities are available for practitioners to engage in learning. The strengths, displayed through the group's commitment to practical and patient-centred learning, offers the potential for both parties to move forward. Nevertheless, in order

to realise this potential, there is a need for collaboration, cooperation and compromise.

As provision becomes increasingly service-driven and finance led, organisations will need to seek out new and creative ways of managing an increasingly essential but equally challenging education strategy. A more coherent, inclusive and flexible educational strategy is considered the cornerstone for ensuring future success (Leader 2003) which serves to encompass a more diverse range of learning provision and partnership working, and one which strives to overcome some of the complex barriers to accessibility. But this can only be successfully implemented through a radical change in culture and attitude on behalf of the stakeholders and which relies on organisational and financial input commensurate with future policy intent. Strategies are in place which helps determine education and training needs such as the Training Needs Analysis and the appraisal system. From analysis of the literature these appear to be severely under-utilised, ineffective and often retrospective as responses from the staff surveys have repeatedly indicated. Equally, however, the onus should be placed on the individual to take more responsibility for their own learning, recognising that compromise in relation to funding, provision and study support is required.

Flexibility and diversity of learning provision both within and outside of the organisation is crucial to encouraging participation, as too are new and innovative methods of delivery which enable wider accessibility for individuals. This may include provision and delivery of more teaching, training and development at local level, utilising work-based and informal learning as well as cascade training. The relative value and benefit of informal and work-based learning was highlighted by

the Department of Health (1999) who recommended accreditation of work-based learning, but this has yet to come to fruition.

Similarly, financial predicaments surround the HEIs resulting in increased fees for courses, streamlining of less-supported courses leading to competition for places on programmes between universities. In order to maximise training and development opportunities, greater links and collaboration between organisational education teams and local Higher Educational Institutions will become increasingly imperative and mutually beneficial. The inability to release staff on a regular basis to attend modules may result in providing alternate delivery methods such as developing more on-line programmes, discussion forums and workshops. But these, too, come with problems of implementation and accessibility.

And what of the future for ODPs? Although a degree in Operating Department Practice is available, its introduction is widely variable across the delivering HEIs with individual regional educational authorities choosing to support or reject its introduction. It could be argued that this variation may create a further hierarchy of jealousy, resentment and suspicion amongst this professional group, especially between the current vocational and academically-qualified practitioners and increasingly between those holding a diploma and the newly-graduated degree-level practitioners. This is partially fuelled by organisational expectations which are founded on the belief that degree-level practitioners contribute significantly to enhancing patient care and service delivery and to some extent through the professional body's pursuit of professional parity.

Yet the threshold entry qualification on to the professional register currently remains at diploma level for Operating Department Practitioners despite the sporadic

implementation of a degree-level pre-registration award. No differences or expectations exist between practitioners holding different levels of qualification; they are all expected to demonstrate competence and fitness to practice within their designated role which is measured by meeting their professional standards and through undertaking continuous professional development. This may, however, change in the future as the Health Professions Council has indicated that they will be reviewing the Standards of Education and Training which may culminate in the approval and adoption of degree-level entry. As a consequence this may result in shifting the requirements of practitioners in terms of depth and breadth of continuous professional development requirements. These future speculative changes may ultimately elevate the expectations of practitioners in serving to galvanise the professional group in increasing their capital or create further division and social exclusion: evidence, unfortunately, supports the latter of these two options.

CHAPTER ELEVEN

CONCLUSIONS, RESEARCH CRITIQUE AND RECOMMENDATIONS FOR PRACTICE

Conclusions

Lifelong learning and continuous professional development remain high profile initiatives within the National Health Service agenda, being widely acknowledged as contributing to productivity and performance, enhancing patient care and delivering the vision of a world class service (DH 2012a). For healthcare practitioners continuous professional development is an integral dimension of professional identity and responsibility in order to demonstrate on-going competence to practice. Whilst occupying an important and beneficial position for both organisation and professional, the literature and the evidence from this study suggests that the support for practitioners to engage in learning activities is inadequate.

This research study, which is the first to explore continuing professional development within the healthcare group of Operating Department Practitioners, indicates that policy intent is not always reflective of practice reality. Continuous professional development and lifelong learning are on the surface simple ideas, but they are complicated by the number of stakeholders each of which has a vested interest and different expectations in their potential benefits. Findings from this study highlight and reinforce the complex nature of learning within the healthcare environment which challenges the individual practitioner's ability to fully participate in their professional responsibilities.

The experiences of continuous professional development from with ODP share commonalities with the wider healthcare community. The motivational reasons for

participation in learning activities indicated from across a range of nursing and allied health professionals are to maintain their competence to practice through increasing their knowledge and skills relevant to their roles. For the Operating Department Practitioner similar reasons were indicated, but this particular group were found to be primarily motivated through a shared repertoire and joint enterprise in providing good quality care for their patients. This particular aspect of learning is also consistent with the intention of the NHS and their respective Trusts. Despite subscribing to the philosophy of continuing professional development, evidence from the literature points towards a number of structural and organisational barriers which present challenges for individual participation. Lack of time, staffing and funding for CPD were commonly reported barriers by nurses and allied health professions. As too were the inadequacy of managers in terms of their ability to support practitioner requests and the shortcomings associated with the appraisal system. These barriers are consistent with those experienced by Operating Department Practitioners respondents within this study.

The general-held assumption within lifelong learning policy is such that participation in learning holds some form of reward for the individual. Taken at face value, proactive engagement in learning should be a valuable commodity which has the capacity to contribute to increasing the individual's prospects – in effect a *Golden Goose*. In theory, both professionalisation and *academicisation* should be valuable commodities for the ODP, in terms of enhancing social inclusivity, increasing cultural capital and ensuring future prosperity. As the potential 'key to prosperity', as government policy advocates, the changes endured within ODP have to some extent been realised. Academicisation and professionalisation have undoubtedly increased the group's standing within the wider healthcare community

creating a degree of parity with other healthcare professions and gaining respect from within nursing, which Tanner and Timmon's (2008) research hinted towards. The current diploma qualification provides a passport to further learning ventures, particularly those of the formal nature, as well as instilling the value of learning to learn skills inherent within the ethos of academic programmes and the importance of the relationship of professional development and learning to professional responsibility. For the diploma ODPs this has opened up more avenues for personal and professional development, perhaps more so than the City and Guilds and NVQ qualified ODPs. For this particular group learning is a *Golden Goose*. Observations from within my own clinical environment of recent promotions support the theory that the diploma-qualified ODPs are better positioned to benefit from participation in CPD.

Whilst the changes endured within ODP were implemented for positive reasons and have presented opportunities for some practitioners, evidence obtained from this study supports the idea that continuous professional development is in fact erring towards being more of a *White Elephant* for the majority. This valuable, but burdensome possession is currently proving to be out of proportion to its perceived usefulness or value. The differences of perception, experience and expectations towards continuous professional development observed through this group are hampered through multiple barriers to learning and limited opportunities for personal development which is the complete opposite of policy intent. These in turn have been influenced by wider external factors such as the current financial austerity measures, which have ultimately affected the participation and provision of learning opportunities. And raises the question – is there any value for the individual in participating in continuing professional development?

Recommendations for education and practice

The study has provided an opportunity to explore the experiences of continuing professional development through the emerging group of Operating Department Practitioners, and in doing so has contributed to the development of profession-specific knowledge relating to this little-researched healthcare profession. The research has furthermore offered a tentative exploration of learning within the NHS at a time when the organisation is experiencing major challenges. Despite uncovering the values and motivational factors which drive the ODP to engage in particular learning activities, participation and progress is principally inhibited by a range of structural and organisational barriers. Yet the necessity for ODPs to engage in learning for re-registration pervades. This raises the question as to how, amidst the current unsettled climate, the practitioner can sustain motivation to learn and subsequently continue to meet their obligations. The findings from the study have implications for educational policy and practice particularly at organisational level where deficiencies in current educational strategies have been exposed.

The failure to provide adequate CPD in an inclusive manner which meets the needs of the professional could impact negatively on the organisation's ability to operate effectively given their reliance on having a registered workforce (Morgan et al 2008). This failure can also affect the motivation of the individuals towards participation in learning which will have subsequent repercussions on the functionality of the communities of practice, and hence reflect on the organisation as a learning organisation. As provision becomes increasingly service-driven and finance led, organisations will need to seek out new and creative ways of managing an increasingly essential but equally challenging education strategy in order to

address the gap between policy and practice, expectation and experience. From a workforce perspective, provision of relevant work-based education and training is deemed crucial to improving job satisfaction and retention of staff which should ultimately have a positive effect on patient care and delivery of a safe and effective service.

A more coherent, inclusive and flexible educational strategy is considered the cornerstone for ensuring future success (Leader 2003), which serves to encompass a more diverse range of learning provision and partnership working, and one which strives to overcome some of the complex barriers to accessibility. But this can only be successfully implemented through a radical change in culture and attitude on behalf of the stakeholders and one which relies on organisational and financial input commensurate with future policy intent. Strategies are in place which helps determine education and training needs such as the Training Needs Analysis and the appraisal system, yet analysis of the literature and supported by the findings of this study these appear to be severely under-utilised, ineffective and often retrospective. Equally, however, the onus should be placed on the individual to take ownership and responsibility for their own learning, recognising that compromise in relation to funding, provision and study support is required.

Flexibility and diversity of learning provision both within and outside of the organisation is crucial to encouraging participation, as too are new and innovative methods of delivery which enable wider accessibility for individuals. This may include provision and delivery of more teaching, training and development locally, utilising work-based and informal learning as well as cascade training. The relative value and benefit of informal and work-based learning was highlighted by the

Department of Health (1999) who recommended accreditation of work-based learning, but this has yet to come to fruition.

Similarly, financial predicaments surround the HEIs resulting in increased fees for courses, streamlining of less-supported courses leading to competition for places on programmes between universities. In order to maximise training and development opportunities greater links and collaboration between organisational education teams and local education providers will become increasingly imperative and mutually beneficial. The inability to release staff on a regular basis to attend modules may result in providing alternate delivery methods such as developing more on-line programmes, discussion forums and workshops. But these too are not without difficulties in implementation and accessibility.

Critique of the Research

The theoretical framework for this research comprised six key areas which helped in contextualising the factors which underpinned the relationship of the Operating Department Practitioner to continuous professional development. Although the subject and themes associated with the context and practices of lifelong learning are broad it was important to establish boundaries and focus on the key areas which directly influenced this study and importantly the ODP. The framework enabled the exploration of the complex network of factors which underpin and influence practitioners' expectations and experiences of continuous professional. The identified themes help shed light on the experiences of learning within this professional group through linking the theory to practice as well as comparing the experiences of practice back to the theory.

An important component of the theoretical framework was the inclusion of the history of the Operating Department Practitioner which served to chart the significant events of their growth into a registered healthcare professional group. This background information helped situate the practice of the Operating Department Practitioner within a theoretical context through exploring the changes in training and education as well as their professionalisation and development as a profession.

Examining the characteristics of a community of practice, and the theory of learning through social participation, provided a starting point for understanding the basics of learning within the ODP community. The concepts of this learning theory offered insight into how members negotiate learning and the motivational factors which drive their learning. Of importance are the interplay of the complex social factors which directly affect the individual with regards to participation and non-participation, elements of which are particularly apparent when applied to the ODP and their experiences of learning. Situating and comparing the specific ODP community to the wider theatre and healthcare communities reveals strengths and weaknesses within the learning organisation as it strives to develop a learning culture set against its own changing practices.

Lifelong learning and continuous professional development are established and integral components of professional identity, but are relatively new concepts within the ODP community and particularly the older qualified practitioners. Analysing and applying the key theoretical concepts to this little researched group enabled critical observations to be made with particular regards to the similarities and differences of experiences towards continuing professional development from across a range of healthcare groups. A comparison across the various healthcare groups indicates that

there are inherent problems with CPD and learning structures across the NHS, which is not unique to the professional group of Operating Department Practitioners. Examining the theory of lifelong learning within the context of ODP revealed discrepancies between policy and practice, some of which are unique to this professional group, and which result through a complex mix of variables. Within a dynamically changing healthcare environment the variables are themselves subject to change, being influenced by wider healthcare policies. The complexities and limitations of the models of organisational learning were useful in recognising which model is prominent within my own Trust, and how it impacts on practitioner learning.

A mixed methodology was selected to investigate this complex phenomenon. An online survey provided a breadth of data exploring the '*what and how*', with four semi-structured interviews offering a depth of explanation of '*what and why*'. The strengths of a mixed methods design supplied a flexible framework which aided in the execution of the research study. The two-stage approach of separate data collection methods promoted within a sequential explanatory design provided a logical direction. Whilst advocating a quantitative-dominant perspective, and in keeping with the philosophy of mixed methods research in attempting to maintain a balance of both philosophical viewpoints, it was deemed appropriate to incorporate a qualitative dimension within the online survey. Open questions were included in the survey which provided opportunity for respondents to offer their own personal views and experiences of continuous professional development and in turn maximised the amount of data collected in order to address the research questions.

Although only half of the respondents in the questionnaire phase chose to present their own personal thoughts, feelings and experiences of continuous professional

development, the richness and honesty of the free-text responses compensated for this, providing a valuable and personal insight into the current experiences of this professional group. Similarly, the data obtained through the interviews with the Training Supervisors served to not only supply an insight into personal and organisational experiences but helped to correlate and substantiate findings from the online survey which increased credibility of the overall findings.

The use of a mixed methodology was not without its challenges, particularly undertaking two separate data collections proved time-consuming and not without obstacle. Seeking permission from CODP in issuing the survey through their website took considerable time to arrange and was wholly dependent on the College in sending the request to members and those members participating. Conversations with the College after collection of the questionnaire data indicated that members' records may not have been as up-to-date as would be expected and many members did not have an electronic mailing address. The assumption that participants have access to, and were familiar with electronic techniques, is a recognised disadvantage of using online and web-based surveys (Bryman 2008). This limited the sampling population available and thus affected the response rate. An alternative method would have been to approach the HCPC in order to access the ODP register and registrants.

Additionally, the interview phase with the Training Supervisors was also challenging, particularly with respect to arranging and conducting the interviews. Due to the changing nature of clinical practice and the fact that many of the Training Supervisors undertook their training responsibilities on a part-time basis, it was not guaranteed that they would be available to attend the meetings, or did not attend as

planned. This resulted in interviewing two Training Supervisors together which, although challenging in transcribing, did prove valuable.

The limitations of this research study primarily arise through the limited number of respondents from the online survey which questions the validity, credibility and generalisability of findings to the wider professional ODP community. Bell (2005) suggests generalisations are a positivist trait, and citing Bassey, argues 'reliability ...is more important than its generalisability' (Bell 2005 p.202). Schofield (1989), although not dismissing generalisability as a means of external validity, favours the concepts of *fittingness*, *translatability*, and *comparability*; enabling identification of similarities between the situation studied and readers own practice (Schofield 1989 p.97). Adopting these viewpoints, it became apparent that the findings and experiences of learning occurring within my own Trust were not dissimilar to those within the wider ODP community. These similarities served to further substantiate the wider research findings which in turn helped to increase the credibility and reliability of the findings despite the limited scale of the research. Although unconventional, the use of the SWOT analysis provided additional credibility and generalisability to the study. The experiences of the ODP respondents were considered an indicator of the current situation in the NHS which in turn impacts across the wider healthcare community.

Areas for future research

This study has provided opportunity to generate knowledge and understanding of continuous professional development from within a relatively discreet healthcare profession and has thus opened up opportunity for future research. With further changes on the horizon for the Operating Department Practitioner, particularly the

implementation of all-graduate profession, it may be appropriate to re-visit the subject in the future and explore the impact of these changes on the practitioner and their on-going ability to engage in learning. With the impending move towards an all-graduate profession and the increasing emphasis on knowledge and formal qualifications as a mechanism for promotion the diploma-qualified ODPs they are in a much more prominent position where their academic credentials, critical awareness of organisational changes and all-round professionalism are opening doors. Recent promotions within my own clinical area are testimony to this group's drive and desire to succeed, but without losing sight of the nature of the profession in delivering good clinical care to patients which was alluded to in the findings from this study. This positive attitude, fostered through a robust curriculum which embraces professional practice, has the potential to shape the future of the profession. The current diploma students who are experiencing clinical practice and being mentored by diploma-qualified practitioners should learn from this proactive community, perpetuate the elements of good clinical practice and reproduce the values within this active community of learners.

A further particular area for research would be to assess the readiness and response of practitioners in the months preceding their two-yearly re-registration process and explore the differences in attitude and preparation, if any, between the qualifications practitioners hold. Observation of the most recent re-registration period for ODP within my own practice area has again indicated similar issues in not understanding the requirements for continuing professional development, lack of preparation for re-registration and limited engagement in learning activities over the two year re-registration period.

During the undertaking of this investigation a number of positive changes with regards to training and development have occurred. The appointment of a Practice Development Team for Theatres has raised the profile and importance of education, training and learning within my own clinical area. The remit of this new role is wide-ranging, including the design and implementation of an education strategy for all theatre staff. Examination of the SWOT analysis compiled through this research project, in particular the weaknesses, and comparing it to a similar one based around local experiences has provided a platform from which to develop the education strategy. Part of this role is the organisation and delivery of teaching and training sessions for all staff, with an initial emphasis on key work-based learning activities and mandatory training. Particular areas have been identified as priority from a managerial perspective which link in with wider organisational learning objectives such as mandatory training and comprehensive induction packages for newly appointed staff. Recognition of the strengths and the commitment of staff towards delivering patient-centred care indicate a baseline motivation towards learning. This underlying desire to learn presents opportunities for the team to build on and cultivate through offering a variety of work-based learning opportunities. It is anticipated that with learning activities being more available and accessible for all staff groups, a potential area for future research could be to monitor and measure the uptake and engagement of staff. Examining the role and impact of the Practice Development Team in helping to create a learning culture within my own department could be an associated area for future investigation.

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Appendix One

Survey questions used in the online questionnaire

Please indicate your Professional qualification

- City and Guilds 752
- NVQ Level Three Operating Department Practice
- Diploma (HE) Operating Department Practice
- Other (please state)

Please indicate your main area(s) of practice

- Anaesthetics
- Surgery
- Recovery
- Rotational
- Education
- Other (please state)

Please indicate your current band (Clinical Practice only)

- Band 5
- Band 6 (Senior Practitioner)
- Band 6 (Team Leader)
- Band 7

Please indicate your current employment status

- Full time
- Part time

Have you completed a Personal Development Plan / Appraisal in the last twelve months?

- Yes
- No

If no, please indicate the reason

- Undergoing Preceptorship
- Lack of opportunity
- Lack of motivation
- Insufficient time
- Started but not completed

If yes, was the system effective in establishing your learning needs?

- Yes
- No

If yes, have you achieved your objectives?

- Fully achieved
- Partially completed
- None achieved

If partially or none achieved please indicate the reason (tick all applicable)

- Time
- Sickness / absence
- Staffing issues
- Lack of funding
- Lack of support
- Lack of opportunity

Has study time been cancelled?

- Yes
- No

If yes, what was the reason (tick all applicable)

- Lack of staffing
- Sickness / absence
- Shift change
- Organisation cancelled
- Other (please specify)

Please list any Continuous Professional Development activities you have undertaken in the past twelve months?

Are you currently or have recently completed undertaking any of the following learning activities?

- Mentorship programme
- Degree-level pathway (relevant to role)
- Degree-level pathway (non-role related)
- Degree-level module (stand alone module)
- Masters level programme
- Teaching course (Cert Ed, PGCE, BA Ed)

Do you plan to undertake any of the above learning activities over the next twelve months? Please specify.

Do you consider a degree to be valuable in contributing to: (please select one response)

- Enhancing your practice
- Providing promotion opportunities?
- Neither

Please indicate your five reasons for undertaking Continuous Professional Development?

- To update / increase knowledge and skills relevant to current role
- To increase / maximise opportunities for promotion
- To maintain capacity to practice
- To meet professional requirements for registration
- To keep up to date with the changing workforce
- To avoid being 'left behind' by more qualified practitioners / colleagues
- Personal interest
- Career enhancement (outside of current role)

Does your organisation provide sufficient learning opportunities / CPD activities?

- Yes
- No

Who should take responsibility for supporting learning opportunities / CPD activities ie: financial / study time?

- Organisation (fully funded)
- Manager (study time)
- Practitioner (self-funded / own time)
- Part funded (Organisation / Practitioner)

Please provide any additional information in relation to your experiences of Continuous Professional Development.

Appendix Two

Dear Colleague

I'm emailing you to invite you to participate in a research project which I am undertaking as part of my Doctorate in Education and I would like to provide you with as much information regarding the project to enable you to decide to participate or not.

The intention of the study is to explore and evaluate lifelong learning, and I'm looking at this specifically through the experiences of our profession. Although much research has been undertaken within this area from the perspective of nursing and other allied health professionals, very little research has been undertaken within the professional group of Operating Department Practitioners. Your thoughts and experiences of lifelong learning / continuous professional development would be of enormous value both to me and wider educational and professional community.

As part of the data collection I'm looking for volunteers to participate in an online survey. The survey is completely anonymous, all data collected will be treated in complete confidence for the use of this project only and no data will be divulged to a third party.

If you are interested in participating, are currently practising as an ODP and have ten minutes of your time to spare please click on the link below.

<http://www.surveymonkey.com/s/ODP2011>

Many thanks for your valuable assistance in this project.

with kind regards,

A Fellow ODP

Appendix Three

Semi-Structures interview questions (Training Supervisors)

What does the term continuous professional development mean to you?

How has undertaking CPD benefitted your practice / the department / the organisation?

What motivates you to undertake any form of learning or professional development?

How do you maintain your learning records?

If you were selected for profile submission under the HPC CPD requirements how confident are you in compiling your profile and meeting the standards?

Have you has an appraisal during the last 12 months? How effective was it in establishing your learning needs or your professional / personal development?

What is the mechanism for applying for study leave?

How are training records kept within the department? And are there any auditing processes?

What do you consider to be the strengths / weaknesses / opportunities and threats to undertaking continuous professional development?