Summary report on the impact of NVQs and VRQs in the healthcare workplace.

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- Oxford and Buckinghamshire Mental Health Trust
- Oxford Radcliffe Hospitals Trust
- Oxfordshire PCT
- Portsmouth Hospitals Trust
- Portsmouth PCT
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- Royal Berkshire Hospitals Trust
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<tr>
<td>APEL</td>
<td>Accreditation of Prior Education and Learning</td>
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<tr>
<td>CPD</td>
<td>Continuing Professional Development</td>
</tr>
<tr>
<td>DfEE</td>
<td>Department for Education and Employment <em>(Became DfES)</em></td>
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<tr>
<td>DfES</td>
<td>Department for Education and Skills <em>(Now Split into DIUS and Department for Children Schools and Families)</em></td>
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<td>DIUS</td>
<td>Department for Innovation, Universities and Skills</td>
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<td>FE</td>
<td>Further Education</td>
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<td>GNVQ</td>
<td>General National Vocational Qualification</td>
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<td>HCA</td>
<td>Healthcare Assistant</td>
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<td>HE</td>
<td>Higher Education</td>
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<td>HEPI</td>
<td>Higher Education Policy Institute</td>
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<td>HR</td>
<td>Human Resources</td>
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<td>IT</td>
<td>Information Technology</td>
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<td>LSC</td>
<td>Learning and Skills Council</td>
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<td>NADQ</td>
<td>National Database of Accredited Qualifications</td>
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<td>NCVQ</td>
<td>National Centre for Vocational Qualifications</td>
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<td>NVQ</td>
<td>National Vocational Qualification</td>
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<tr>
<td>OfQUAL</td>
<td>Office of Qualifications and Examinations Regulator <em>(Former OFSTED)</em></td>
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<td>OFSTED</td>
<td>Office for Standards in Education <em>(Now Ofqual)</em></td>
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<tr>
<td>OVQ</td>
<td>Omani Vocational Qualification</td>
</tr>
<tr>
<td>PDP</td>
<td>Personal Development Plan</td>
</tr>
<tr>
<td>QCA</td>
<td>Qualifications and Curriculum Authority <em>(Now QCDA)</em></td>
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<tr>
<td>QCDA</td>
<td>Qualifications and Curriculum Development Agency <em>(Former QCA)</em></td>
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<tr>
<td>SVQ</td>
<td>Scottish Vocational Qualification</td>
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<tr>
<td>VRQ</td>
<td>Vocational Related Qualification</td>
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1.0 Executive Summary

National Vocational Qualifications (NVQs) and Vocational Related Qualifications (VRQs) are vocational qualifications that are widely used by SC Trusts for the development of the healthcare workforce. NVQs in particular are a very popular means by which to train bands 2 to 4. An important proportion of NVQs are funded by NESC, and some are also funded through Train to Gain. The only source of funding available for VRQs is NESC. There are different levels of NVQs (2 to 5) used for training. There are also a wide range of awarding bodies and providers offering different variations of the same qualification. This disparity between NVQs has led to confusion and questioning of their value in developing the workforce. Some of SC SHA Trusts have achieved NVQ centre status and offer in-house NVQs that are internally verified and accredited by a specific awarding body. The introduction of apprenticeships in the healthcare sector prelude a change in the current structures used for vocational training. NVQs and VRQs are to provide part of the structure for apprenticeships.

The exact impact of NVQs and VRQs in the healthcare workplace was uncertain. Many studies tend to be carried out on small samples and focus on gathering attitudinal data for the purpose of curriculum development and therefore do not provide a clear picture of the impact that these qualifications could have in the workplace. The aim of this evaluation was therefore to explore the impact and use of these qualifications by Trusts in terms of patient care and service delivery.

Trusts tend to use a number of providers depending on the location of the learners with different allocated budgets and demand for training. Participants from 20 Trusts in focus groups, discussions at meetings, interviews and questionnaires included educational leads, current and previous NVQ level 2 and 3 learners, line managers and trainers/assessors providing rich data and evidence for the use and impact of NVQs. Different Trusts required slightly different evaluation methods to meet their needs. This evaluation also includes a case study on the impact of VRQs in community mental health care levels 2 and 3 at Oxford and Buckinghamshire Mental Health Trust.

This report provides an insight into how Trusts are currently supporting workforce development via NVQ and VRQ training for bands 1 to 4. There were some issues reported with NVQs that need to be address such as the quality of assessment, line manager support, backfill, and the need for clear progression pathways. VRQs also required wider recognition as a standalone qualification. The impact of NVQs and VRQs in patient care and service delivery is very broad and diverse. Learners report that NVQs and VRQs increased their communication skills, leadership skills, creative skills, patient safety, and understanding of organisational structures and policies. They were also reported to increase the overall productivity of teams.
2.0 Introduction

Vocational training (NVQ and VRQs) for workforce development

Our modern concept of workforce training encapsulates factors such as organisational development, change management, evidence based knowledge transfer and skills development (Roche, 2002). Workforce development requires a broad approach involving systems, learning environments and people. The systems have been reported to consider competences, skills, knowledge, mentoring, structure for delivery, incentives, performance monitoring, job specifications, management priorities, support mechanisms, recruitment and retention, legislation and policy, funding, etc. (Roche, 2002). In their review of the characteristics of the workforce, The Future Healthcare Workforce initiative by the DH in 2001 found that the workforce was fragmenting, career structures were inflexible, the workforce profile and age was fast increasing, and service delivery was fast changing. It is expected that there will be a shortfall of 15% of 18 to 20 year olds entering the workforce between now and 2020 (Leitch, 2006; Beckhradnia, 2008). It is expected that the decrease in young people entering the workforce will increase the requirement for flexible training (up-skilling and side-skilling of the adult workforce) that should be coupled with an increased acceptance of vocational qualifications into Higher Education (HE) as the current number of young students decreases (Leitch, 2006; Beckhradnia, 2008).

In 1996, the Department of Education and Employment (DfEE) commissioned research to find out how employers were using vocational qualifications (DfEE, 1996). Researchers found that from a sample of 590 employers, vocational qualifications were offered by 58% of the employers surveyed. Only 42% of these employers offered NVQs. Other vocational qualifications included BTEC, and SVQs. It was calculated that NVQs were being offered to 3.3 million employees or 20% of the workforce in the UK. It took about 3 years for the qualification to be offered to about 50% of the workforce. The breakdown of NVQs offered was:

- 15% skilled labour
- 12% office grades
- 9% manual labour
- 3% management

The NVQ review recommended by Beaumont (1996) included a simplification of the language and structure, elimination of the unnecessary bureaucracy, and better communication of best practice. By the first half of the twentieth century discontent with vocational forms of training had grown and NVQs had been modified to include the following features according to West (2004):

- NVQ framework (NVQ level 1 to NVQ level 5) covered all occupations at all bands to constitute a single system for vocational qualifications. This was believed to assist with progression and credibility linking one band with the next (Table 1 shows the equivalent qualifications for the different levels of NVQs).
- The modular structure encouraged flexibility to allow specific mixes of interest
- NVQs allowed employers to assist in specifying standards of achievement

There is evidence to suggest that employer’s lack of understanding for government-led vocational initiatives might have acted as a barrier to their take up. Sims et al (2000) found that employer’s knowledge of some vocational schemes was limited. Some confusion has also
prevailed regarding the introduction of Foundation Degrees where their demand had not been carefully thought through (Gibbs, 2002). NVQs are currently the most popular award used for training for bands 2 and 3 (NADQ, statistics, 2008-2009). There seemed to be a modest rise in vocational qualifications between 2004 and 2006 (from 14,000 to 44,000) but most of the growth was due to a rise in VRQ level 3 qualifications and as a result of improved data collection methods. About 65% of NVQ candidates are aged 25 and above (DfES, 2003). In 2006 Mulder et al. still reported that NVQs were not being used enough for workforce development in the UK.

From those that do obtain an NVQ level 3 qualification only 40 to 50% of learners enrol in HE institutions (LSDA, 2004; Beckhradnia, 2008). In the report ‘Vocational A levels and university entry: is there parity of esteem?’ HEPI (2007) informed that some HE institutions disregarded vocational qualifications for entry. This posed problems for the career progression of learners that were motivated to move on in their careers.

Furthermore, the White Paper 21st Century Skills: Realising Our Potential (2003) and Skills: Getting on in business, getting on at work (2005) provided an outline on the poorer skills and performance of the UK workforce when compared to other countries. In continental Europe vocational qualifications have more currency, take longer to achieve and have more robust practical and written assessments (Prais, 2001). This led to an increased focus in ensuring that lower skilled adults had appropriate qualifications, the NVQ 2 being seen as the basic platform for employability and progression.

Motivation to learn and ‘school phobia’ seemed to be the major barriers in the take up of qualifications by the lower bands. Fearfull (1997) found that care workers had mixed feelings about NVQs. On the one hand they felt that doing the qualification meant they were unqualified, and on the other it gave them the opportunity to gain recognition for the skills they had already learned on the job. The nursing profession was seen as resistant to the introduction of NVQs as they were seen to erode salary and status differentials between healthcare workers and nurses. Rosenfeld (1999) argued that the changes in the nursing profession and increased demands meant that healthcare workers’ responsibility had increased in the area of patient care. Sargeant (2000) found in his study of the impact of NVQs in the healthcare workplace that there was very little evidence to suggest that NVQs improved practice. He concluded that NVQs had a positive effect with employees understanding what constitutes good practice.

Motivation to learn is a crucial factor in the wide spread use of the qualifications for training the workforce. Thornbill (2001) found in his study that the reason for non-completion of NVQs was mainly due to candidates moving between employers. In his study Warmington (2003) found that adult learners with few previous qualifications felt qualifications were important for generating employment opportunities, and a degree was seen as making a distinction between jobs and careers. More importantly, early leavers from higher education felt they had been pressurized into higher education instead of following a more appropriate vocational training route (Davies and Elias, 2002).

The use of higher level NVQs for training appears to be low in the whole of the UK. The lower participation of Britain in vocational training when compared to European countries focused research on the barriers for the uptake of higher level vocational qualifications (Swailes and Roodhouse, 2009). NVQs level 4 equate with undergraduate study and NVQ level 5 with postgraduate study. One of the barriers to their up take was found to be the notion of competence at higher education. Some models for competence distinguish between threshold and superior performance (Swailes and Roodhouse, 2009). Another barrier was the lack of clear
career progression pathways. Finally, vocational training does not have the reputation that degrees have. The most popular higher NVQs are offered in accounting and management up to a level 4 (source of data, QCA).

There is very little information in the literature on the cost returns from vocational qualifications. According to recent research carried out by the DIUS (2007), the average wage returns to key academic qualifications are around to be about 29% for first or foundation degrees, 14% for 2 or more A levels. This is similar for NVQs at levels 1 to 3 (13% for level 3) and for levels 4 and 5 it is 30 to 35% (DIUS, 2007).

It is very difficult to extract information regarding VRQs as these qualifications have been mixed together with other vocational qualifications such as OVQs (Omani Vocational Qualification) by the LSC (2003). This has led to a recent re-classification of awards (Unwin et al., 2006). Currently, about two thirds of VRQs are awarded to males. VRQs are important stepping stones for the achievement of BTEC certificates and Modern Apprenticeships. VRQ certificates are required for a number of professions. It is envisaged that the uptake of VRQs level 2 will swell by the new re-introduction of Apprenticeships as they provide the technical certification required by some professions that forms part of the award.

The NHS is currently undergoing a number of changes that are to affect the way that people are being recruited as well as workforce development and planning. The NHS Constitution launched in January 2009, advocated that high quality education should meet the needs of the staff irrespective of grade, role and seniority. Also stemming from High Quality Care for All, (2008) there is to be a commitment to support the educational needs of staff by commissioner and provider NHS organisations. Regional workforce planning is therefore to be driven by a demand in skills that are to be commissioned without losing clarity of roles, homogeneity, and a standard and equity of training across South Central SHA. According to the draft strategy ‘Shaping the Future workforce’ (NHS SC, 2009), it is expected that workforce development and planning will be based on the delivery of the clinical care group improvement programmes. This would mean that there is to be a focus in the development of skills in; promoting staying healthy, end of life care, mental health, learning disability and motivational skills (NHS SC, 2009). The new clinical care pathways will result in new roles and the need for flexible forms of training for side-skilling and up-skilling the workforce will therefore be increased. The introduction of apprenticeships in the healthcare sector also prelude a change in the current models used for vocational training. At the time this evaluation was carried out there was some anxiety over the incorporation of all these changes at Trusts, particularly where NVQ and VRQ training issues remained unresolved.

These government drivers will change the current way by which vocational qualifications are used for workforce development. It is therefore important to understand how these qualifications are currently being used to implement the changes.
Table 1. Showing the Breakdown of NVQ Levels by target and equivalents (Source from Unwin et al, 2006; West, 2004; QCA website, AimHigher website)

<table>
<thead>
<tr>
<th>NVQ Level</th>
<th>Target Candidates</th>
<th>Competence levels</th>
<th>Equivalent</th>
<th>National Statistics*</th>
</tr>
</thead>
<tbody>
<tr>
<td>NVQ1</td>
<td>Rarely used in the workplace</td>
<td>Occupational competence in performing a range of tasks under supervision</td>
<td>Foundation level GCSE grades D-G</td>
<td>Awarded 11% of vocational qualifications</td>
</tr>
<tr>
<td>NVQ 2</td>
<td>Skilled Staff</td>
<td>Occupational competence in performing a wider range of more demanding tasks with limited supervision</td>
<td>Intermediate level GCSE grades A* to C</td>
<td>Awarded 57% of vocational qualifications</td>
</tr>
<tr>
<td>NVQ 3</td>
<td>Craft or Supervisory, technician</td>
<td>Occupational competence required for satisfactory, responsible performance in a defined occupation or range of jobs</td>
<td>Advanced level A level BTEC Ordinary National</td>
<td>Awarded 28% of vocational qualifications</td>
</tr>
<tr>
<td>NVQ 4</td>
<td>Professional or managerial Mainly used by accountants.</td>
<td>Competence to design and specify designed tasks, products or processes and to accept responsibility for the work of others</td>
<td>Higher Level Graduate Degree</td>
<td>Awarded 4% of vocational qualifications</td>
</tr>
<tr>
<td>NVQ 5</td>
<td>Specialist professional Mainly used by accountants.</td>
<td>Competence at professional level with mastery of a range of relevant knowledge and the ability to apply it at a higher level than previous.</td>
<td>Master and Post-graduate level Degree</td>
<td></td>
</tr>
</tbody>
</table>

* Data from Statistics in Education: Vocational Qualifications Bulletin (2003)
3.0 Methodology

This evaluation uses a qualitative approach to explore the perceptions from learners, trainers, assessors, and SC Trust educational leads regarding VRQs and NVQs used in healthcare. The evaluation follows the NVQ and VRQ evaluation proposals that were agreed to by Trust educational leads at meetings in November and December 2007. This is a service evaluation/audit on the impact of these vocational qualifications on service delivery and patient care and uses feedback from participants to report on their perceived impact on patient care. This evaluation therefore did not require the participation from patients. The participants for this evaluation included all educational leads form SC Trusts and PCTs as well as learners and trainers from randomly selected organizations that had expressed an interest to participate in the evaluation.

The selected Trusts that participated further in the evaluation include:

- Hampshire Partnership Trust
- Southampton University Hospital Trust
- Oxford and Buckinghamshire Mental Health Trust (OBMH)
- SC Ambulance and Emergency Services
- Oxford Radcliffe Hospitals Trust
- Hampshire PCT
- Berkshire West PCT

The approach chosen for the design of the evaluation was adapted to the needs for each Trust.

The evaluation was therefore designed to include as many participants as possible. The data collected reached saturation as the same themes were seen to emerge from the data. All participants received a written and oral explanation regarding the purpose of the evaluation and were informed of their rights to withdraw at any point during and after the evaluation without offering a reason, according to the Human Rights Act 1998. Participants were also informed that all transcripts would be anonymised and held in accordance with the Data Protection Act 1998. Informed consent was therefore sought for participation in interviews, focus groups and/or questionnaires.

3.1 Data collection

Participants on the evaluation included:

- 531 current and past NVQ learners and 12 VRQ learners (in interviews, questionnaires, and focus groups)
- All SC educational leads (data was collected from meetings and some educational leads also participated in focus groups and interviews)
- About 20 NVQ and VRQ assessors and trainers (focus groups and interviews)
- About 50 line managers (focus groups, interviews and questionnaires)

The responses from participants on the evaluation were generated through focus groups, interviews and questionnaires. All the data was subjected to content and thematic analysis in an attempt to triangulate the data with the responses received from other participants thereby resulting in the themes presented in the Results section of this document.
3.2 Data Analysis

The questionnaire data was analysed together with the data from questionnaires, interviews and focus groups in an attempt to triangulate information received from all the participants in the study. Strategies from a grounded theory approach (Strauss and Corbin, 1998) were employed along with discursive analysis for the analysis of the data. All transcripts were carefully read (and in some cases transcribed by the researcher) for familiarisation purposes. Emergent themes and sub-themes are presented in the Results section of this report.
4.0 Summary results on impact and use of NVQs at SC Trusts

This section only offers a breakdown of the main results from the evaluation. Please refer to the full report for more in-depth information and examples of quotes (Zolle, The impact of NVQs and VRQs in the healthcare workplace (Dec 2009)).

4.1 NVQs and workforce development in SC Trusts

4.1.1 NVQs are used at Trusts to develop workplace skills and competences in a variety of subjects and levels for bands 1 to 4

4.1.1.1 NVQs are used by Trusts in clinical and non-clinical areas.

They are currently being provided in South Central the following areas:

- Management and Administration
- Catering and hospitality
- Healthcare
- Healthcare scientific disciplines (including lab assistant and pharmacy)
- Customer service
- Social Care
- Support Services (including engineering)

A detailed breakdown of the figures for SC SHA over the period 2008-09 may be seen in the Appendix of this report.

NVQs have become essential components of job descriptions and are seen by learners to ‘open new doors’ (reported as meaning; new jobs, new ways of seeing the workplace, new opportunities for more responsibility, and a career direction).

4.1.1.2 NVQs are offered also at levels 4 and 5 (non-clinical areas; please refer to page 39)

NVQ levels 4 and 5 (competence based training equivalent to a degree and postgraduate level training respectively) are also being used to train the workforce. NVQs offered at levels 4 and 5 tend to be recognised by professional bodies (particularly in Management, Accountancy and Engineering). NVQs level 4 in Management have also been completed by long serving staff members in high banding roles with no previous qualifications. Some individuals prefer vocational courses for ‘on the job’ training to academic courses.

4.1.1.3 NVQs and workforce planning

Many Trusts and PCTs rely on employees and line managers to come forward and drive the demand for NVQ training. Lack of progression pathways sometimes act to deter staff from accessing NVQs. Workforce planning and workforce development through NVQs have been reported to require going ‘hand in hand’ as part of an appropriate Trust workforce development strategy. NVQs allow the flexibility to develop skills-led training.
The possibility of advancing careers is seen as one of the sources for motivation to learn by non-registered staff. If not supported by adequate workforce planning, learners are reported to leave their roles for more adequate positions either within the Trust or jobs found elsewhere.

There are therefore important links reported between workforce development and planning that need to be carefully considered to increase motivation and staff retention. A choice of progression routes and opportunities for career development are important.

Trusts with NVQ centres are more able to provide progression routes for learners. They are also able to design and deliver NVQs to reflect service need. NVQ centres utilise the skills and competences of Trust staff to assess for NVQs which mean they can often provide the most relevant fit for purpose clinical qualifications.

4.1.2 Recognition and acceptance of NVQs for training

4.1.2.1 NVQs are increasingly accepted by all bands of Management at Trusts

Although NVQs have been nationally accredited since the 1970s, it has taken some time for Trusts to accept NVQs as adequate vocational training tools. Educational leads claimed that these qualifications are now recognised by Trust boards. NVQs are seen to offer appropriate alternative learning to more academic qualifications.

Management have been engaged in the training by offering NVQ levels 3 to 5 in Management appropriate to this workforce. NVQs are seen to promote leadership skills for all bands through an increase in self-confidence and better understanding of organisational structure. NVQs allow staff to understand their commitments to others in the team. They are also reported to increase communication skills that are ultimately essential for the well being and care of patients.

4.1.2.2 NVQs are important in validating skills of long serving staff members

NVQ learners report that the qualification validates skills that they have been employing at work. In some cases NVQ learners had been in their roles between 10 to 15 years before obtaining the qualification. Learners report a need to gain recognition for the skills and knowledge used in their job. This is felt important as workforce roles vary within Departments and Trusts. Lower level NVQ learners also report feeling under team pressure to have an NVQ qualification.

Band 3 HCAs have reported feeling inadequate to join in discussions about patients that are under their care with other more qualified team members. The NVQ provides the confidence to talk to these team members benefiting patients in a variety of ways, mainly by influencing better patient outcomes. NVQs are seen as a means to break down the perceived divide between ‘qualified and non qualified’ staff members.

4.1.2.3 NVQs level 2 are offered to new staff members to ‘bring them up to speed’ and this may raise equity issues with the longer serving team members.
Line managers reported that NVQs were particularly useful for bringing new staff members quickly up to speed. Learners with a longer serving history at Trusts reported that they had seen new members of staff being put forward for the qualification while they had been placed on a waiting list. Putting forward a new member of staff to do an NVQ may therefore raise equity issues within a team.

4.1.2.4 Line managers use mandatory NVQs to identify skills and competence gaps of staff.

Some NVQs level 2 (and 3) are mandatory for a number of roles such as within pharmacy and social care. Line managers reported providing support where gaps had been identified by the learner. Mandatory NVQs are used as a means to understand the strengths and weaknesses of individuals and the degree of their ‘fitness to practise.’ Mandatory NVQs should be (some are) linked to workforce regulation by an appropriate professional body.

4.1.2.5 Progression from NVQ2 to NVQ3

In contrast to NVQ 2 qualifications, NVQ3s are seen as being more ‘academic’ developing critical thinking and problem solving adequate for this level of training. Learners reported there being an important learning ‘jump’ from an NVQ 2 to an NVQ 3. Some felt the NVQ 3 was very demanding, and learners reported having to apply more the knowledge to practice.

4.1.3 ‘Side-skilling’ the workforce with NVQs

NVQs were widely recognised at Trusts for up-skilling the workforce. There was evidence for a role for NVQs in side-skilling the workforce. Individuals experiencing changes in their careers found that previous qualifications e.g. a degree in media studies, were not relevant to the job. An important fraction of the workforce studying for an NVQ 3 already have higher qualifications and those interviewed claimed to be willing to take their studies forward after their NVQ 3 in appropriate subjects relevant to their jobs. Interestingly, this fraction of the workforce chose competence based learning as the most appropriate means of training.

Providers should recognise APEL systems for the transfer across of credits in areas within already attained qualifications. It has been reported that some providers will not APEL a degree qualification for an NVQ 2/3 or Foundation Degree. This may de-motivate and demoralise the workforce to learn.

4.2 A gap in provision: a demand for NVQs in South Central Ambulance Services

The Ambulance Services workforce are currently unable to benefit from NVQs in clinical areas. In general, clinical NVQs are related to long term care or care in a residential basis. Since ambulance services see patients for a maximum of 40 minutes new specific NVQs should be developed to reflect this. The assessment of competences whilst dealing with an emergency seems difficult to achieve. The Fire Brigade has successfully developed an NVQ for their emergency workforce. It therefore seems appropriate that similar type NVQs are developed for the ambulance and emergency workforce that are currently trained in-house. This Trust currently offers non clinical NVQs to its staff.
4.3 Identifying Learners for NVQs

NVQ learners are generally identified by line managers through appraisals and PDP. Line manager support for workplace learning is crucial for the successful completion of an NVQ. Learners do not usually identify themselves with NVQs as being a form of training that is pertinent to them and their development. They are usually unaware of there being any other training opportunity. For many learners career pathways become clearer during their training. Selection of staff for NVQs usually depends on the line manager’s professional judgement and availability of staff for backfilling. When the training is driven by the learner then the reasons for doing the NVQ are for personal development rather than due to a demand in skills. This approach is reported to lead to a poor retention of the workforce.

Some NVQ learners report studying in their own time, receiving the minimum protected study time available. This creates an inequity issue with respect to other learners that have more line management support. In order to receive maximum line management support, some line managers have been asked to become NVQ assessors. This also helps deal with problems in finding adequate assessors at Trusts.

The identification of potential learners through appraisals and PDP may change in the near future. Provider NHS Trusts reported feeling vulnerable about the new NHS commissioning arrangements where skills are to be commissioned according to perceived service needs and requirement for new skills by an outside organisation, without having looked carefully into the provider organisation’s workforce planning needs and potential progression routes available for the learners. Provider organisations felt that motivation of learners to embark on vocational courses could be problematic, as well as the retention of learners within the organisation in a market place that has not as yet been established. Similarly, commissioning organisations felt that this task was overwhelming requiring special guidance from the SHA.

4.3.2 Waiting lists for an NVQ

Waiting lists for NVQs are quite long (longest reported waiting time was 15 years as revealed in a focus group).

4.4 Delivery of NVQs

There are important variations in the delivery of NVQ training even for the same type of NVQ e.g. Health and Social Care; (this may be done solely in the workplace, it may combine classroom/workshop learning with workplace learning and assessment through observations at work, or it may be done entirely in the classroom with classroom based assessment of the portfolio of evidence submitted for competences). This poses questions about the standards and adequacy of the training. The focus of the NVQ training may also vary depending on the commercial provider. One provider may therefore be more apt for training for a particular workforce role than another for the same type and subject of NVQ. Participants felt that learning in the classroom was useful as learners met peers for different Departments doing different roles.
Mentoring is seen as a useful tool for NVQ learners. Including a mentor assists communicating NVQ demands and other issues between line managers and learners. Mentors are generally used as part of NVQ 4s and are less used for NVQs 3. A mentor will act as a guide for the learner and line manager. Other forms of delivery include distance learning, and through a selection from an option of NVQ modules for the completion of a specific NVQ.

The underpinning knowledge that is provided as CPD with some NVQs is also seen as providing the underpinning knowledge required for an apprenticeship. This is of great value for staff who require some underpinning knowledge (as provided through the technical certificate).

The structure of the learning depends on the training provider. Some providers allow the classroom learning to happen in a one week block over a period of time. Other providers offer one study day a month. Participants reported that it was easier to backfill and attend sessions that were delivered in one block. Learners reported having to work twice as hard when the sessions are delivered once a month as they find it difficult to remember what was learnt a month ago.

The content of the NVQ and terminology for the performance criteria has been reported as being too difficult to understand and requires simplification. It takes learners a long time to understand what they need to achieve. This is felt to impact on the time it takes to complete the qualification.

4.5 Assessment of NVQs

The quality of assessors is believed to affect the quality of the NVQ and the time taken for its completion. It may be difficult to find an appropriate time slot for assessment in the workplace. The unpredictable nature of some of the roles requires flexibility from line managers, learners and assessors. Assessors must be adequately trained to a specific standard. There are no current incentives to become a trained assessor. There is also no current backfill for assessors, as the role is carried out in their own time.

4.6 Impact of NVQs on Patient Care and Service Delivery

NVQ learners reported being more ‘creative’ in their jobs and applying new approaches to patient care. They reported being consulted more by other team members on decisions pertaining to patients that are directly under their care. This enhanced the quality of patient care. NVQ 3 learners reported reflecting more about their practice. The NVQ influenced other team members by stimulating them to learn more in their jobs. It motivated peers to learn for an NVQ. It promoted patient safety and increased patient satisfaction. It also increased the team’s productivity as the learner is able to take on more tasks alleviating the workload from other team members. It increased the manager’s confidence in the learner. Learners also reported having more up to date information on policies and legislation. Learners reported feeling more motivated in their jobs and feeling more tolerant towards others in the team. Communication skills are also reported to increase with better patient outcomes and enhanced team productivity.
NVQs level 2 and 3 have the following impact in the healthcare workplace on patient care and service delivery;

• Learners reported validation of skills, and development of communication skills with patients, customers and other team members (e.g. a learner reported being 'more tolerant' and having modified communication skills with other team members after completing the NVQ 3)

‘... I was in a situation where doctors, physios, or anyone from the multidisciplinary team would not come to ask me for information about the patient I was taking care of. They would always go and ask the registered nurse even though I am the person looking after the patient all the time. Absolute frustration. As soon as I was on the programme and achieved my award they recognised who I was and then asked me about the patient. I became this person that was not just looking after the patient and their care needs and communication etc. but I was now recognised as a person that someone would ask; ‘How did Mrs X mobilise today? Are there any needs for changing the patient’s programme? Let’s discuss this.’ My involvement in patient care grew.’ (NVQ 3 learner)

• Learners reported increased self-confidence at work and being more creative, putting new learnt skills and ideas into practice

‘We had to look at our own development and our weaknesses and that helped me a lot because I always tended to focus on my weaknesses and it wasn’t until we did that that I realised what my strengths were. Every shift I am doing, I am doing activities and getting them out. I am now trying new things. I have got the service users doing new things too. They had not realised they could do them. It is working so I am trying new things which is nice.’ (NVQ 3 learner)

• Increased leadership skills.

‘It has made me more ready to manage the household I am in and has given me more self confidence and personal development for the future.... I realised I was more capable than I probably thought I was.’ (NVQ 3 learner)

• Increased responsibility

‘I was asked to take other members of staff under my wing who were either being trained or were untrained. I went through the process of what goes on the ward with them. The NVQ helped me develop myself. It helped me help others develop and enhanced the care that I was giving to my patients.’ (NVQ 3 learner)

• Increased customer empathy.

‘From a customer care point of view the front line is the bottom line. If you are on the reception desk and you really hack someone off you can really have an impact on everything that happens after that. It is about realising that bit of customer interfacing wherever you are whether clinical or non clinical. It can have a huge impact on how the public view you and the organisation.’ (Educational lead)
Learners reported increased knowledge and understanding of the organisational structure, policies and guidelines leading to better patient outcomes.

‘... policies... I know more about where we stand in patient care. We have a gentleman with cataracts and we have been told for 15 years that he couldn’t be operated. I asked why. And now he is going to have an operation which could have been done 15 years ago and his quality of life could have been so much better in that time.’ (NVQ 3 learner)

Increased confidence reported by learners and line managers were reflected in the learner’s behaviour at work.

‘Increased knowledge leads to improved care and more collaborative working as a team that involves the patients, the healthcare support worker and the nurses and all the other members of the team. I think it increases the healthcare supporter’s confidence because they have a greater knowledge and are more likely to take on extra roles. X has taken on extra roles since she completed her NVQ. She does a baking group with females and that is something that has improved the delivery of the unit and patients get great satisfaction from it.’ (Line Manager)

Increased patient safety

‘You are more aware on how to handle clients with mental health problems... I don’t bruise patients... I have seen others coming in new without this knowledge that have done this...’ (NVQ 3 learner)

Increased satisfactory patient outcomes and quality of care through increased ownership of care.

‘You have their lives in your hands so for example if someone has a bad hip and the GP said you cannot go through the operation. Obviously we need to be compliant but I would be thinking if this person has a learning disability, I can say so? That is our problem to ensure that he is able for the operation. We have had one chap that has just had an operation done. And he has waited so long to get it done. Because we know that this is our role, we can now advocate for them. I think it has made me more aware that I can do that.’ (NVQ 3 learner)

It increases confidence from a management perspective that a worker was ‘fit for purpose’

‘It gives me a certain level of confidence to know that I am sending a certain level of support worker at somebody’s home to take out their son or daughter who have a disability so it gives me confidence to know that they are at that level of competence and skill.’ (Line manager)

Increased team productivity

‘You support the team. I think it makes you more tolerant of the people you work with. You work with certain people and they are not always doing what they should be doing. They have got their own agenda. You have to say to yourself you know how things are done...’
properly. I can now say: ‘Do you think you should be doing this that way? I think it makes people more tolerant.’ (NVQ 3 learner)

- The majority of NVQ 2 participants went on to further study – mainly NVQ 3. The majority of NVQ 3 learners reported willing to go on to do further competence based NVQ (level 4) learning and some wanted to go into nurse training. It should be noted that NVQ 3 learners chose further NVQ training as opposed to other academic routes (such as Foundation Degrees) for a variety of reasons:
  - Preferring more work based vocational learning approaches to academic qualifications
  - Not knowing about Foundation Degrees
  - Not knowing that only a few NVQ level 4 qualifications are currently being offered (none available in clinical areas – although some NVQ 3 learners in Health and Social Care perceive that an NVQ 4 in Management as being the logical progression route for them).
  - Not having clear progression routes at Trusts for the different roles

Note: It would be interesting to find out the percentage of NVQ 3 learners that went on to HE learning. HEPI (2007) suggest that the proportion of vocational learners entering HE is minimal. Note: Neither level 2 nor level 3 were directly linked with an increase in wages – this lack of incentive to learn is reported to be an influencing factor in the low retention and motivation of the workforce.

4.7 Barriers to the learning

Barriers include; work/study/life balance, not having English as a first language, lack of clear communication between training providers and line managers affecting the delivery or assessment of the training in the workplace, facing competition from Local Authorities (LAs), lack of motivation to learn, lack of assessors, perception amongst team members that the learner poses a threat to their job security, accountability as the learner’s ability to take on more tasks on the job increases, and lack of trust from line managers that the learner will use the protected study time for learning. Possible solutions include engaging line managers in the learning by becoming assessors or mentors.

Line managers and learners report requiring clear progression pathways for NVQs. A career in education is also seen as a possibility open to learners who are sometimes asked to become NVQ assessors or be involved in NVQ co-ordination.

4.8 Support from line managers

NVQs are competence based vocational courses where the learning occurs in the workplace. It is therefore expected that line managers provide an adequate learning environment at work, without affecting service delivery. Support is required for the release of staff to attend study sessions and to allow protected study time. Bands 2 to 4 reported difficulties of being released from work. This was not perceived to be a problem with higher bands (according to educational leads). There were reported differences between Trust policies, even between Departments of a same Trust regarding protected study time.
This raised issues of equity of training. Some line managers reported not trusting that staff members would take the allocated time to study, particularly if this was to be allocated at home. Trusts have developed a number of tools to assist with the problem, such as using contact records as evidence that a learner has met with their assessor.

Support was also required to reduce the amount of waiting time for an NVQ. Line managers reported requiring support for backfill. Educational leads reported that line managers should realise the importance of their role to provide support to their members of staff. It is therefore important to engage line managers in the NVQ experience. Some Trusts offer line managers the opportunity to become NVQ assessors. Other Trusts offer line managers the opportunity for further development through the completion of an NVQ 4 in Management.

4.9 Support from external NVQ training providers

Some training providers external to the NHS offer individual mentorship for each independent NVQ learner. All NVQ providers open their doors to learners allowing them access to their IT computer suites, libraries and other facilities. Providers are required to support learners according to learning needs, for example, where a learner has a learning disability, such as dyslexia this should be identified and tape recording and other digital recording material should be used to support the learner.

Providers were responsible for maintaining good communication links with all stakeholders and to offer detailed information to line managers and Trusts about the course.

4.10 Career pathways for NVQ learners

The lack of clear progression pathways means that some but not all of the NVQ learners reported knowing what they were going to do after completion of their course. The motivation of learners was an important contributing factor to their learning. Progression pathways, workforce planning and development affect the retention and recruitment of NVQ learners. It was reported that learners and line managers should be clearly informed of the progression pathways available to the learners. A large proportion of Health and Social Care learners in the evaluation were willing to embark on further learning in nursing and support work.

There was a disparity reported between HE institutions where only some would accept an NVQ 3 for entry into a nursing degree even within the same geographical area. There should therefore be an indication of the HEIs that would accept the qualification for further learning.

Interestingly, Trusts reported asking previous NVQ 3 learners to embark in a career in education by becoming assessors, and teachers (in the case of NVQ centres). There were examples where this route had developed individuals into Managerial positions as NVQ co-ordinators and other educational roles such as NVQ trainers and Vocational Training Managers.

Many NVQ learners reported that they would carry on learning if an NVQ level 4 was available to them. The most frequent NVQ 4 that is currently being completed is in
Management (page 38). This qualification was deemed useful where individuals from clinical backgrounds had become Managers.

5.0 Summary results on impact and use of Community Mental Health Care VRQ (levels 2 and 3) at Oxford and Buckinghamshire Mental Health Trust (Case Study)

Like NVQs, VRQs are nationally accredited certificate qualifications that offer a standard of training. VRQs are different vocational qualifications to NVQs for the following reasons;

- VRQs are completed in 6 months (VRQ 2) or 10 months (VRQ 3) compared to 12 to 18 months average for NVQ (2 or 3 respectively).
- VRQs are classroom/workshop based with theory to be applied at work
- VRQs are not competence based qualifications.
- VRQs use exams as a means for assessment. NVQs use the submission of a portfolio of evidence showing that the performance criteria have been met.
- NVQs may involve assessment through observations at work.
- Service users and carers are involved in the delivery of VRQs in mental health. Service users and carers are also VRQ learners.
- VRQ assessment examines the ability of the learner to apply the theory to practice through imaginary situations. It uses a similar model of assessment for medics applying for specialty training.

Unlike NVQs, VRQs are not as widely used. Many learners referred to the VRQ qualification as their ‘NVQ’. Line managers also have some expectations that the outcomes of the VRQ will be the same as for the NVQ. Both NVQ and VRQ qualifications are recognised only by some HE Institutions for further learning raising equity issues across the SC patch.

Please refer to the Appendix for a quantitative analysis of the figures.

5.1 Why use VRQs to train the workforce in Mental Health?

VRQs have a reflective component for the delivery of critical thinking skills to learners.

VRQ learners reported feeling able to cope with uncertainty in the workplace. Mental health can be a very unpredictable field in which to work. NVQ learners in this study do not mention having gained this same ability which may be related to the acquisition of more critical thinking skills via a VRQ, but the data collected in the evaluation is not conclusive.

Both VRQ and NVQ learners reported that their qualification validate the skills that they have for the job that they do.

VRQ learners reported that the level 2 qualification should be mandatory as it provides an important insight into mental illness and deals with the ‘stigma and myths’ associated with mental health.

As found with NVQs, some VRQ learners already possessed higher level or similar level qualifications, including A levels, NVQ3s, GCSEs, and degrees. This also provides
evidence that VRQs, like NVQs, are also being used for side-skilling the workforce as well as up skilling. These learners felt that the VRQ provided them with the knowledge required for the job. There is a need to reinforce APEL systems for cross accreditation of qualifications.

A VRQ learner felt that the NVQ 3 qualification she had completed prior to the VRQ was less ‘proper’. The learner reported that the VRQ was more theoretical;

‘Within my role I did not actually have a qualification. It was more of practical experience because what I did was working with home care in the community. That is one of the reasons why I got the job. I have been doing the job for 8 years now. So, back then it wasn’t necessary to have a qualification. I had done an NVQ 3 a couple of years ago in Health and Social Care but that was to do with my previous employer that was [...] a county council. Obviously, we were seconded across the community. And then the opportunity arose to do the VRQ level 2.... it wasn’t a case that anybody made me do it. It was an option that was there and because I had not done any studies since school. It was an opportunity to try and prove myself that I could actually study for a qualification. It has consolidated what I have learnt on my job and put it into something for a qualification... I had my line manager support, because, obviously I didn’t want to apply for something that wasn’t appropriate or wasn’t going to fit in with my job and within the team depending on what was going on with the team. The VRQ was a lot of theory work and we had to do a lot of writing and reflecting on our own practice. I found the VRQ a lot harder than the NVQ. I am more of a practical person. So going back to pen and paper was very difficult for me. .... I got a pay rise after completing the NVQ. The VRQ felt like the first real proper study that I had done for years. (past VRQ 3 and NVQ 3 learner, interview)

VRQs were also seen to disperse the ‘qualified versus non qualified’ divide within teams and equipped learners with communication skills and the confidence to talk more openly about patients with the team.

5.2 Identifying learners for VRQs

VRQ learners that participated in the study are healthcare assistants, support workers, support time and recovery workers, rehabilitation officers and others from a variety of Departments at OBMH including the Welfare Department (dealing with service user finances) and Physiotherapy Departments. All learners were studying for a Certificate in Community and Mental Health level 2 or level 3. All the learners that had been studying for their VRQ 3 have completed their VRQ 2.

At OBMH, HR provides the names of all the newly appointed to bands 1 to 4. Every new person to the Trust is provided with a letter and a leaflet of information introducing learners to vocational training and VRQs.

Other candidates are identified through the appraisal process and PDP.

Motivation of learners and retention issues apply for both VRQs and NVQs. Learners claimed that their peers were somewhat reticent to learn for a VRQ due to their academic nature.
5.3 Delivery of VRQs

OBMH has a Learning and Development Centre that generates its own income. OBMIH funds trainers and assessors. VRQs are classroom based. Learners attend a workshop every month and are expected to carry out some tasks related to their jobs. As for NVQs, classroom learning provides peer learning opportunities and help widen perspectives and understanding on different roles for the same bands. This can lead to better understanding of the role of the learner within the multidisciplinary team. VRQ level 2 learners attend an induction day and a total of 5 study days. Learners are required to submit an assessment after each study day. Classroom learning provided a safe environment in which to learn outside work.

Some learners reported expecting more competence based learning and less theoretical learning.

5.3.1 Service Users and Carers as peer learners and teachers

One of the clear differences between NVQs and VRQs is that service users and carers can become peer learners. The use of service users as part of the delivery of the VRQ is a very successful approach leading to a number of learning outcomes:

- having a better and deeper understanding of mental health from the service user’s perspective

'I was very fortunate... I had an ex service user as my class partner so I would go in and have a discussion about various aspects and I had to justify why I said what I said. And then he’d come with things from a different angle, from a service user’s angle and say to me; ‘If you say that I might feel this way’, and that just put everything into perspective for me.’ (VRQ 3 learner 2, FG2)

- finding new ways of working with service users/patients for their recovery

5.4 Assessment of VRQs

There are different assessment criteria available for the different VRQs. There is an option to assess VRQs in the classroom or through workplace assignments based on each taught unit. All assessors for VRQs are required to have their CRB and Health and Security training according to the Trust’s policies. Unlike NVQs, there are no actual observations or assessments of the learner carrying out their work in practice. The questions asked as part of the written assessment are designed to test the candidate’s understanding of mental health in a workplace context. Written answers try to apply a scenario experienced at work related to the question. Undertaking exams is seen to increase the learner’s credibility and overall preparedness to undertake further academic work. Learners reported that assessor continuity is an important influencing factor on how they feel they have progressed throughout the training. Learners also reported requiring more feedback from tutors on the results from their assessments. The assessments were reported as being crucial for the...
development of reflection in practice. Some learners reported difficulties in relating imaginary scenarios in assessments to real life situations.

Kinaesthetic learners claimed that they would have liked a more competence based ‘hands on’ approach to assessment. Taking exams was difficult for some learners that described themselves as ‘school phobic’.

VRQ level 2 learners may receive one to one support from the assessor (as for NVQs) if all the units are to be verified by the accrediting body. Certification occurs when all the assessments for each unit are completed. Depending on the qualification, trainers comment that some level 2 learners might have to take an exam. Some exams are available on line and learners must also use their IT skills.

5.5 Support from line managers

Line managers reported that VRQs are to ‘improve and maintain clinical standards’. Being more familiar with NVQs, some line managers appeared to have expectations that the VRQ qualification would also be competence based. This meant placing false expectations on the learners that would never be met. Line manager support for VRQs is important but not as important as for NVQs. This is because the qualification is not assessed in the workplace in the same way as for NVQs. The length of study for a VRQ is also substantially less than for an NVQ. It may therefore be somewhat easier to provide adequate backfill.

Line managers were required to support the learners by allowing them to access protected study time. As with NVQs, there were equity issues where some learners were allowed the minimum time and others were allowed less than the minimum. Protected study time is particularly important for writing assignments and studying for exams;

‘I devote my time, my personal time to learn everything on my own. My line manager sent me on this course and then he forgot about it. He told me I should have finished things by now; ‘How long is it going to be? I need you on the ward.’ And I feel it is quite demoralising that you do it to improve your work, you put a lot of effort into it and then get no support. I find it off putting.’ (VRQ 3 learner)

Some learners reported not feeling supported by peers and other team members. Learners should feel safe to make their line managers aware of when this happens as support may be required for backfilling and assistance in the completion of work related assignments. Waiting times are not as long as those for NVQs. Learners however reported having ‘to pester’ their line managers for a long time before they could get on the course.

Some learners and line managers reported that NVQs were rated higher than VRQs. Learners reported that this view discouraged peers from accessing VRQ training. It seems that line managers and learners require further information on VRQs, the differences with NVQs and potential impact in the workplace. Some line managers also reported being well informed of the progress their member of staff was making on the course.
5.6 Impact of Community Mental Health Care VRQs on patient care and service delivery

There is no clear indication from the literature on the effects of any impact from VRQs in the workplace. In this evaluation line managers and learners reported **increased confidence and sensitivity in dealing with mental health patients/clients**. Learners and line managers offered concrete examples of impact listed below;

- Learners reported developing communication skills with patients/clients and other team members (e.g. learners reported being able to interact with patients at a different level with more awareness of their condition)

  ‘I will never forget the role-play. The three men role-play where somebody would be hearing voices and then trying to engage in conversation with someone else. I was the person with a mental illness and had somebody behind talking to me. I felt I was hearing voices. I tried so much to engage with the person in front of me, talking to me, trying to block the voices I was hearing and it was incredibly difficult and very frustrating. It was an eye opener for me. I learnt I should be more careful and it taught me empathy for when they become irritable and tell me they are hearing voices. I felt the person in front trying to have a conversation with me was becoming more and more frustrated and I thought they were becoming aggressive with me but I couldn’t hear them. Their intention was never ever to be aggressive. It is what is going on in their head that you cannot see. That you cannot even remember or have a clue about. I tried to raise my voice above the voice I was hearing in the background. This aspect is totally oblivious to you as a mental health worker. I would make it mandatory to make everyone go on it. It motivates people.’ (VRQ 3 learner, interview)

- Learners reported being more creative at work, putting the new learning into practice (an example was the use of the woodwork room for creative activities undertaken by clients)

- Increased critical thinking skills and reflection during practice to a point where it affected patient outcomes. Learners reported doing things differently for the sake of the patients and reported being more able to cope with on the job uncertainty).

  ‘...when they finish the course you can tell they are more assertive. Their communication is better and they are beginning to question things like ‘Why are we practising this way but we do it this other way? And this has an impact on the sharing of experiences as well as a group. For me those are quite significant benefits.’ (VRQ trainer and assessor)

- Increased mental health service user engagement with improved patient outcomes

- Increased consideration about service users and better understanding of the different departments in the organisation and how the organisation can help service users in a more holistic way

  ‘I work with assertive outreach service users who have no motivation to do anything because they have been in the system for so long. Now they believe that the system is pushing them to do things that they don’t want to do. You wake up at 9:00, go to the
gym, go to the Occupational Therapy... then nobody asks them what they want. Nobody actually says; ‘This person has been drinking. Let’s put him back in the ward.’ But then if he is back in the ward we give him a lot of methadone or a substitute and nobody asks him; ‘Do you want to stop drinking or not?’ So I think it is quite useful for me to talk to people and ask them; ‘Have you asked the patient what they want? Because the psychologists are right there and the psychiatrists are right there in the Trust. So this is what you do but some more qualified don’t understand because they are not there with the patient. So now we can use our small knowledge during the preparation of ward rounds and you can say, this is what I discussed, this is what this person wants and this is what this person wants to do.’ (VRQ 3 learner, FG2)

- Increased awareness of policy and confidentiality issues with carers and service users

‘Confidentiality was for me a big grey area and that was clarified for me on this course. They gave some useful examples. I have taken that back to the ward and that has been quite helpful... in discussing patient information with carers like what to say, what not to say... or getting the relevant information from the patient, asking the patient if they don’t mind sharing the information with the carer and things like that. That has been quite helpful. It has had a huge impact on the patient’s welfare and finances. It also helps set boundaries with the carers which is important.’ (VRQ 3 learner, FG2)

- Increased leadership skills. Increased confidence reported by learners and line managers were reflected in the learner’s behaviour at work.

- Increased self-confidence in carrying out academic assignments.

‘I had the opportunity to facilitate a course where there was somebody in the group who was dyslexic and it had never been picked up before until she came into the course. She was doing a VRQ level 3 and she did struggle to the point where she couldn’t cope anymore and it came out in the class that she was dyslexic. In trying to organise and put strategies in place to support it so she could finish the course, it was challenging but achievable and she managed to pass the course and move on. So for me, watching a learner progress through that, where she actually came to terms with her condition and knowing there was support, it was really good... I felt the seed for learning had been planted.’ (VRQ trainer and assessor)

- VRQs also provided a better understanding of the role of the learner as part of a multidisciplinary team

‘In physiotherapy I feel the VRQ has confirmed things for me like boundaries and making sure that people are aware of why you are involved and the fact that you are only there to do the physical, holistic care rather than the role of the nurse. So you have to confirm the boundaries and also confidentiality. If you find something that you feel is in conflict of their care then you have to now that you can talk to the nurse about what they just told you and justify why it is happening.’ (VRQ 3 learner, FG2)

- Increased confidence in using IT, literacy and numeracy skills
I learnt how to use PowerPoint for presentations and you have to use Microsoft Word and other things like that... and for someone who only has GCSEs who has limited skills in how to use a computer that is a golden opportunity to learn these skills. And even for those who have been away from school for a long time and have lost touch with those things that would be an opportunity for them to catch up on IT and computer skills.’ (VRQ 3 learner, interview)

- Improved note taking. The improved writing skills and note taking of VRQ learners have been claimed to be a favourable learning outcome.

‘There was an exercise within the course about note writing and writing up clinical notes. We were given an example of badly written clinical notes and we were given the task to correct them and make them better and then an example of part of the assignment of writing our own notes. That was useful and had a direct impact because you don’t always get that training within your job so that was quite useful to have. That directly transferred over.’ (VRQ 3 learner, FG1)

- Some line managers reported that VRQs had an important impact in staff retention.

5.7 VRQs and Career Progression

A large proportion of VRQ learners that took part in this evaluation had not had any education and training since they had left school. VRQs are therefore seen as ‘setting people in a learning path’ where progression opportunities are expected. Career progression pathways with VRQs are less well known than for NVQ. Learners are known to access nursing and social work degrees with a VRQ 3. Information about these pathways is required. Unlike NVQs, there are no VRQ level 4 qualifications;

‘There is an issue with career pathways and access criteria to courses which we have raised with the SHA. They are about to start a project to map career pathways for commissioning purposes the options available and what you need to access those different options. We are struggling at the moment in making sure that staff understand what they can use these certificates for to progress. The VRQ is an accredited national qualification that is portable and recognised nationally.’ (Educational lead)

The majority of VRQ 2 participants went on to further study – mainly VRQ 3. The majority of VRQ 3 learners reported willing to go on to do further learning and a few wanted to go into nurse training and social work.

Note: It would be interesting to find out the percentage of VRQ 3 learners that went on to HE learning. HEPI (2007) suggest that the proportion of vocational learners entering HE is minimal. Note: Neither level 2 not level 3 were directly linked with an increase in wages – this lack of incentive to learn is reported to be an influencing factor in the low retention and motivation of the workforce. Workforce planning and development as well as career progression opportunities therefore appear to have a role to play in motivating and retaining learners in the workplace.
6.0 NVQs and VRQs in apprenticeships

NVQs and VRQs are now (in the time of writing) also embedded within apprenticeships. There were some mixed feelings regarding how apprenticeships might suit the needs of the workforce. There was some confusion regarding the use of CPD and/or VRQs as the technical certificates required for apprenticeships. Trusts without a prior history of using VRQs were not entirely clear on whether this could be used interchangeably with CPD. Trusts that have been offering both VRQ and NVQ qualifications feel that the result of embedding both in a longer apprenticeship may decrease the number of learners that are currently trained. It was felt that it would exacerbate current problems reported in this study of; protected study time, line manager support, backfill issues, provider homogeneity, motivation to learn and availability and quality of assessors. Apprenticeships were also seen by some as potentially jeopardising the need for national recognition of standalone VRQ 2, 3 and NVQ 2 and 3. This view would however contradict the fact that both VRQs and NVQs still exist as standalone qualifications. In general, main concerns about apprenticeships are related to not having solved the issues reported in this evaluation regarding NVQs and VRQs. Trusts have reported on the need to maintain flexible qualifications for both up-skilling as well as side-skilling. Longer apprenticeships might detract learners that already possess higher level qualifications willing to side-skill. Since demographic data shows that the population is rapidly ageing with a decrease of 15% of the total young population entering HE, the demands for side-skilling have been shown to be on the increase (Fryer, 2007). This means that there is a need to provide increased flexible training and review the current training provision and APEL systems for all levels and roles to allow side-skilling.

Trusts felt that as employers they should have been informed about the development of apprenticeships. Trust reported not having seen the evidence base or pilot results for this important educational intervention and reported not being aware of any pilot studies carried out in any healthcare organisation to ascertain the exact impact and advantage that apprenticeships might have over the single qualifications (NVQs and VRQs). Pilots were also seen as important to inform the delivery of novel educational interventions. These factors may influence how the different Trusts might engage in the process of implementing apprenticeships in the future. At the moment apprenticeships in healthcare are seen by Trusts as lacking in vision and understanding of the issues related to workforce development reported in this study. It was strongly felt that the promotion of apprenticeships should be driven by the SHA.

The evidence in this report shows that learners are able to adapt to both NVQs and VRQs and suggests that both qualifications have an important impact on service delivery and patient care in quite distinct ways. Combining the two qualifications might help clarify issues related to accreditation of learning for the two single qualifications. This report suggests that the combination of both qualifications could extend the benefit and impact of a single qualification.

Apprenticeships in engineering are seen as a way forward for the training of bands 2 to 3. There is a long history in this area of healthcare for the use of apprenticeships for training. Apprenticeships in engineering currently include training in mechanical, biomechanical, electronic, plant engineering, etc. There is therefore a need to link with BTEC training (takes 2 years to complete) and career progression pathways for engineers if the aim of apprenticeships is to increase flexible training.
7.0 Discussion

The data collected since January 2008 shows that NVQs are recognised as competence based stand alone qualifications for workforce development. NVQs are often referred to as ‘the nationally accredited qualification’ to take in the workplace. VRQs are less well known vocational qualifications that are not competence based and use exams as a form of assessment. The findings from this evaluation suggest that both qualifications have an important impact on service delivery and patient care and are therefore adequate and appropriate forms of training in healthcare Trusts.

Complexities around the design for this evaluation and the need to accommodate Trust needs meant that a qualitative approach was suitable for the evaluation. If a more quantitative approach had been taken the diversity and variation of NVQs, VRQs, providers, subjects and differences in Trust policies would have rendered it impossible to provide any true generalisation of the data. A qualitative approach provides insight into the participants’ perceptions. There was some overlap in the data collected from Trusts. The qualitative data collected reached a saturation point where no more novel themes were identified for NVQs.

In one of the largest quantitative studies on vocational qualifications for the Office of National Statistics (n=60,000) Goddard and Greenwood (2007) reported that the average age for an adult learner obtaining an NVQ 2 qualification was 32 years. The main motivation factor reported in their study was to improve work related skills (62%). It could take more than one year to complete an NVQ2 (as reported by 44% of participants). Only 25% of the sample had acquired another qualification since the completion of their NVQ 2. Finally, 40% of the sample had moved on to a different job. These findings therefore corroborate the difficulties reported by participants in this report regarding motivation of the learners, retention difficulties, need for clear progression pathways and reasons for undertaking further study. This study however provides an in depth evaluation of the problems and impact at Trusts associated with NVQs and VRQs.

The main problems associated with NVQs are the quality of assessors, line manager support (protected study time), and career progression. The main problems associated with VRQs are line manager support, wider recognition of the qualification and career progression. The Skills Task Force (2000), argued for a ‘separate assessment underpinning knowledge and understanding through related vocational qualifications… within publicly funded apprenticeships’ which has now become the aim of the technical certificates in current apprenticeships. The development of Modern Apprenticeships could therefore allow stronger career routes into HE.

There is evidence in this report to suggest that motivation for bands 1 to 4 to learn is a major barrier to identifying NVQ and VRQ learners. With the introduction of apprenticeships and the increased length of training it has been commented that the motivation to learn may become a challenge. In European Law, the role of the European Commission is defined as supporting the responsibilities of member states and developing a Vocational Training Policy that will enable mutual learning and facilitate benchmarking (European Commission, 2005). It is the responsibility of the employer to develop the workforce and it has been reported that lower workforce might see training as an instrumental process that helps preserve their jobs (Konrad, 2006). The Leonardo Da Vinci project (Konrad, 2006) aimed to collect data from 24 member states to find out the factors that influence participation in Lifelong learning. The findings reported by Konrad (2006) show that the lower banding workforce would engage in learning if they felt that the qualification was useful to them, and if they believed they were able to
complete the training. A major factor was having an opportunity for advancement possibilities and career progression. The report mentioned that self-concept, and methods for learning are also likely to support motivation.

The motivation levels of this workforce were found to be quite negative with current job dissatisfaction and low expectations for the future. The work environment was also felt as a crucial influence as it had to provide the motivation for individuals to develop new skills. The European survey therefore denotes the importance of career progression and workforce planning as being detrimental factors influencing motivation for personal development. It does not seem to be enough to identify a demand in skills without a proper plan for workforce planning as this has been reported to decrease retention and recruitment of the workforce to learn.

This report provides clear examples on the impact and benefits of NVQs and VRQs in healthcare organisations. It therefore seems appropriate to try and disseminate these benefits to help increase the number of learners, and decrease the waiting lists for NVQs with support from line managers and Trusts.

The current financial pressures experienced in the UK at the time of writing means that Trusts are experiencing no difficulties in recruiting, even for roles where specific skills are required. This is a clear change from previous years when it was difficult to recruit individuals with the exact skills for the roles. It is therefore impossible to predict how the current financial climate might affect workforce development and training.

The key message stemming from this report is the need to provide flexible vocational forms of training; VRQs, NVQs and apprenticeships to assist with the workforce development of bands 1 to 4.
8.0 Recommendations

1. **Creation of flexible career pathways**

High Quality Care for All (2008) advocates for increased flexible forms of training adequate for developing the workforce. There is evidence in this report to suggest that NVQs and VRQs provide a flexible means for training. Modern Apprenticeships also ensure an increased flexibility of training that incorporates the benefits of the two qualifications. NVQs may be specifically developed to match the exact demand of skills at a local and national level. These may be developed by NVQ centres or specific training providers.

The need to provide clear career pathways in an increased flexible training market suggests that there might be a niche for the creation of competence-based training using NVQ level 4s and 5s as an alternative to academic training at this level. This form of training is not currently available in clinical areas. Interestingly, NVQ 3 learners in this evaluation with higher qualifications (such as degrees) report a preference for vocational training when it came to training on the job. Trusts have reported that NVQ 4s in non clinical areas have been useful in providing an alternative form of training for learners with no previous qualifications. The wider use of NVQ 4s could also increase the retention of the skilled workforce. This recommendation should also be linked to increasing the effectiveness of current dissemination of training options and career pathways to the workforce (including line managers).

Apprenticeships in engineering already belong to a career pathway and have a framework of their own. It would therefore seem logical to increase the numbers of apprenticeships offered in this sector of healthcare.

2. **Train the whole healthcare workforce to an NVQ/VRQ level 2 or equivalent - to reflect the promises on the Skills Pledge, signed with LSC.**

Learners report feeling peer pressure to become qualified. They do not feel comfortable discussing patient outcomes with qualified staff even when they are more involved and informed about patients under their care than their colleagues. Training the whole healthcare workforce to an NVQ level 2 or a VRQ level 2 would ensure that standards are maintained across disciplines, Departments and Trusts. This will also assist in dissolving the qualified versus the non qualified barrier to multidisciplinary team working and achievement of high quality patient outcomes. This would enable Trusts and PCTs to fulfil the commitments made when signing the Skills Pledge.

All mandatory NVQs and VRQs should be linked to regulation by an appropriate professional body.

3. **SHA assistance in the commissioning of services that could affect the workforce planning and development of NHS provider organisations**

There was some confusion regarding differences between the commissioning of services and the commissioning of skills. Provider NHS Trusts reported feeling vulnerable about the new NHS commissioning arrangements where new skills for novel services were seen to be ‘commissioned’ according to perceived service needs. It was considered that commissioning organisations should look carefully into progression routes and provider organisation workforce planning for learners. It would make little sense for a provider organisation, for example, to train
HCAs in new skills for novel services if there were to be no clear progression routes for the learners within the provider organisation. Provider organisations felt that in these instances, motivation to learn could be problematic. Retention of the newly trained staff was also considered to be important. Similarly, commissioning organisations felt that this task was overwhelming requiring special guidance from the SHA. Commissioning for roles that do not exist for bands 2 and 3 requires competence-based knowledge, clear progression routes and direct negotiation with NVQ providers.

4. Improved engagement with stakeholders for implementing workforce development and training initiatives

There is evidence in this report from educational leads to suggest a need for improved stakeholder engagement for the successful implementation of educational initiatives such as apprenticeships and the development of assistant practitioners. Many participants questioned whether apprenticeships and Foundation Degrees were really the way forward for their workforce. There are collected reports for the need of ‘short, sharp skills based qualifications’. Increased length of training, as with apprenticeships, is usually equated to increased cost. Trusts have advocated the use of flexible ways of training, perhaps through the use of modular NVQs, to attain a certain standard of skills.

Many Trusts are not using the skills and competences of their staff effectively. Many Trusts have not develop the assistant practitioner role. Band 3s need progression pathways to develop and recognise their skills and competences. It is therefore necessary to ensure that the band 3 workforce is adequately trained to deliver high quality services. Many Trust leads commented on not having been informed of the initiatives and also on not having seen the evidence base to prove that the initiatives would be cost effective. There is therefore a need to improve stakeholder engagement to ensure that there is an adequate consultation by the DH that includes those who will be implementing the changes.

5. Increase the current quality of provision for vocational qualifications through increased line manager engagement

There is evidence in this report to suggest that line manager support and availability of assessors are fundamental barriers to the educational experience and impact of vocational qualifications. Both VRQ and NVQ learners require a protected learning environment in the workplace. There is evidence in this report to suggest that the quality of the learning experience can be enhanced by increasing line manager engagement. One of the proposed solutions has been to request that line mangers also become assessors for the learner.

6. Increase the current quality of provision for vocational qualifications through assessor training, backfill funding and increased recognition of the assessor role

Internal assessors were the preferred option for assessment of NVQs. There is a need to ensure that assessor training is regularly updated and that there is a record of all available assessors kept by the Trust. The Care Quality Commission has begun ensuring that there are adequate updated assessor training records for, for example, assessors for cannulation (CQC, http://www.cqc.org.uk/). Assessors usually carry out their roles in their own time with no personal incentives. There are therefore a limited number of appropriately trained assessors. A proposed solution has been to increase the funding available for assessor training and provide backfill funding.
7. Increase the motivation to learn in bands 1 to 4

There is evidence in this report to suggest that low motivation is a factor affecting the uptake of any form of training. One of the proposed solutions has been to incentivise training. Another has been the creation of clear career pathways so that this may act as an incentive to learn. Line manager support also needs to be strengthened to

8. Ensure adequate transferability of skills (Side-ways skilling)

One of the current challenges facing workforce development is the loss of young trained people entering the workforce (Leitch’s report; 2006). Today’s workforce requires the transference of skills from one discipline to another. Many individuals are known to change careers and the current systems for training must be prepared to allow APEL and similar accreditation transference when and as required. There is evidence in this report to suggest that this is not the case. Providers in some instances have specifically requested that all learners must do an NVQ 2 before an NVQ 3 regardless of their prior knowledge. This can inhibit motivation to study for an NVQ in those individuals that already possess higher level qualifications. It has also led to confusion as to whether an NVQ 3 learner should also study for a VRQ level 3 as both qualifications are theoretically equal.

9. Guidance and support is required by Trusts to help align the needs of the service and workforce development.

The performance criteria and overall design of NVQs may be accommodated to serve the needs of Trusts. This requires a dialogue with accrediting and professional bodies for regulation. A dialogue between these organisations will enable the provision of a standard of training and would address concerns regarding accreditation of vocational qualifications linked to regulation. This could be led by the SHA and involve a group of organisations. There as aspects of the vocational qualifications that can only be dealt with awarding bodies such as a simplification of the terminology of the performance criteria in NVQs and the time it takes to complete the qualification.

10. Dissemination and increase an understanding of how VRQs and NVQs complement each other in apprenticeships.

This report provides evidence to show how VRQs and NVQs complement each other in apprenticeships are indeed excellent vocational packages for training. There were however some issues that required addressing such as the level of VRQ and NVQ provision. It is now possible to APEL a VRQ 3 and an NVQ 3 for an apprenticeship.
9.0 References


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Appendix – Quantitative data analysis on vocational qualifications for 2008-2009

Overall Figures

The total number of NVQs used over the period 2008-2009 was 1,069. The total number of LAs used for training over the same period was 1,159. Table 1 shows the actual breakdown of funded NVQs:

Table 1. NVQs funded by level

<table>
<thead>
<tr>
<th>NVQ level</th>
<th>Number of NVQs</th>
</tr>
</thead>
<tbody>
<tr>
<td>NVQ 1</td>
<td>1</td>
</tr>
<tr>
<td>NVQ 2</td>
<td>356</td>
</tr>
<tr>
<td>NVQ 3</td>
<td>650</td>
</tr>
<tr>
<td>NVQ 4</td>
<td>57</td>
</tr>
<tr>
<td>NVQ 5</td>
<td>1</td>
</tr>
</tbody>
</table>

Care should be taken in assuming that each NVQ corresponds to training for specific bands, for example, the qualitative data shows that some band 3s are being trained on NVQ 4s. Therefore the level of NVQ does not necessarily correspond to type of band that is being trained.

A total of 64 NVQs (47 NVQ2s and 17 NVQ3s) were funded by Train to Gain.

Table 2. Types of NVQ 2s undertaken in SC SHA (2008-2009) of clearly reported NVQ level 2s to NESC

<table>
<thead>
<tr>
<th>NVQ</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>NVQ 2 Support Services in Healthcare</td>
<td>23</td>
</tr>
<tr>
<td>NVQ 2 Pharmacy services</td>
<td>23</td>
</tr>
<tr>
<td>NVQ 2 Perioperative Care Support</td>
<td>6</td>
</tr>
<tr>
<td>NVQ 2 Clinical Lab Support</td>
<td>1</td>
</tr>
<tr>
<td>NVQ 2 Basic Plumbing Studies</td>
<td>1</td>
</tr>
<tr>
<td>NVQ 2 Social Service in Healthcare</td>
<td>4</td>
</tr>
<tr>
<td>NVQ 2 Health and Social Care</td>
<td>60</td>
</tr>
<tr>
<td>NVQ 2 Business and Administration</td>
<td>41</td>
</tr>
<tr>
<td>NVQ 2 Customer service</td>
<td>76</td>
</tr>
<tr>
<td>NVQ 2 Children’s care, learning and development</td>
<td>1</td>
</tr>
<tr>
<td>NVQ 2 Team leadership</td>
<td>23</td>
</tr>
<tr>
<td>NVQ 2 Engineering</td>
<td>5</td>
</tr>
<tr>
<td>NVQ 2 Decontamination</td>
<td>4</td>
</tr>
<tr>
<td>ITQ 2</td>
<td>13</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>281</strong></td>
</tr>
</tbody>
</table>
Table 3. Types of NVQ 3s undertaken in SC SHA (2008-2009) of clearly reported NVQ level 3s to NESC

<table>
<thead>
<tr>
<th>NVQ</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>NVQ 3 Buttercups</td>
<td>1</td>
</tr>
<tr>
<td>NVQ 3 Business Administration and Finance</td>
<td>1</td>
</tr>
<tr>
<td>NVQ 3 Pharmacy Services</td>
<td>38</td>
</tr>
<tr>
<td>NVQ 3 Pharmacy Support</td>
<td>3</td>
</tr>
<tr>
<td>NVQ 3 Healthcare</td>
<td>4</td>
</tr>
<tr>
<td>NVQ 3 Hospitality</td>
<td>1</td>
</tr>
<tr>
<td>NVQ 3 Physiotherapy and Occupational Health</td>
<td>3</td>
</tr>
<tr>
<td>NVQ 3 General Health &amp; care</td>
<td>81</td>
</tr>
<tr>
<td>NVQ 3 Maternity/Paediatric support</td>
<td>7</td>
</tr>
<tr>
<td>NVQ 3 Health Allied Health Profession Support (Physiotherapy)</td>
<td>1</td>
</tr>
<tr>
<td>NVQ 3 Clinical Healthcare Skills</td>
<td>15</td>
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<tr>
<td>NVQ 3 Health and social care</td>
<td>124</td>
</tr>
<tr>
<td>NVQ 3 Perioperative support</td>
<td>7</td>
</tr>
<tr>
<td>NVQ 3 Oral Health</td>
<td>1</td>
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<td>NVQ 3 Business administration</td>
<td>79</td>
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<tr>
<td>NVQ 3 customer services</td>
<td>9</td>
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<tr>
<td>NVQ 3 Management</td>
<td>64</td>
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<td>NVQ 3 Decontamination</td>
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<tr>
<td>NVQ 3 Business administration and IT</td>
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</tr>
<tr>
<td>NVQ 3 Business administration and finance</td>
<td>1</td>
</tr>
<tr>
<td>NVQ 3 Healthcare (Mental health)</td>
<td>2</td>
</tr>
<tr>
<td>NVQ 3 Engineering</td>
<td>11</td>
</tr>
<tr>
<td>NVQ 3 Hospitality Supervision</td>
<td>1</td>
</tr>
<tr>
<td>ITQ 3</td>
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</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>468</strong></td>
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Table 4. Types of NVQ 4s undertaken in SC SHA (2008-2009) of clearly reported NVQ level 3s to NESC

<table>
<thead>
<tr>
<th>NVQ level 4</th>
<th>Number of NVQs</th>
</tr>
</thead>
<tbody>
<tr>
<td>NVQ 4 AAT (accountancy technician)</td>
<td>2</td>
</tr>
<tr>
<td>NVQ 4 Business &amp; administration</td>
<td>11</td>
</tr>
<tr>
<td>NVQ 4 Customer service</td>
<td>4</td>
</tr>
<tr>
<td>NVQ 4 Management</td>
<td>7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>25</strong></td>
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</table>
Table 5. Types of NVQ 5s undertaken in SC SHA (2008-2009) of clearly reported NVQ level 3s to NESC

<table>
<thead>
<tr>
<th>NVQ level 5</th>
<th>Number of NVQs</th>
</tr>
</thead>
<tbody>
<tr>
<td>NVQ 5 Management</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 6. VRQs funded by level

<table>
<thead>
<tr>
<th>VRQ level</th>
<th>Number of VRQs</th>
</tr>
</thead>
<tbody>
<tr>
<td>VRQ 2</td>
<td>36</td>
</tr>
<tr>
<td>VRQ 3</td>
<td>36</td>
</tr>
<tr>
<td>Total</td>
<td>72</td>
</tr>
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</table>

Table 7 Types of VRQs funded in SC SHA (2008-2009)

<table>
<thead>
<tr>
<th>VRQ level &amp; type</th>
<th>Number of VRQs</th>
</tr>
</thead>
<tbody>
<tr>
<td>VRQ 2 Community Mental Health Care</td>
<td>37</td>
</tr>
<tr>
<td>VRQ 3 Community Mental Health Care</td>
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<tr>
<td>VRQ 3 Health Trainer</td>
<td>19</td>
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<td>Total</td>
<td>74</td>
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Table 8. Cost to NESC of vocational qualifications

<table>
<thead>
<tr>
<th>Vocational Qualification</th>
<th>Cost</th>
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<tbody>
<tr>
<td>NVQ level 2</td>
<td>~£550</td>
</tr>
<tr>
<td>NVQ level 3</td>
<td>~£550 to £1,000 in administration</td>
</tr>
<tr>
<td>NVQ level 4</td>
<td>~£700 NVQ 4 in accountancy ~£1,380 NVQ 4 in Management</td>
</tr>
<tr>
<td>VRQ level 2</td>
<td>~£583 and £744</td>
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<tr>
<td>VRQ level 3</td>
<td>~£583 and £744</td>
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