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Learning at work as a low grade worker: the case of hospital porters

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We are pleased to report this research which represents one of the projects for which LLAKES' researchers have secured external funding.

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Abstract

This research paper presents the findings from a project commissioned by Southampton University Hospitals Trust (SUHT) that explored the working and learning experiences of hospital porters. The overall aim of the project has been to increase understanding of the workplace as a learning environment and to identify ways in which it could enhance employees' learning and career progression.

The research has identified the dedication of staff working within the Trust's Portering Department. The porters place the patients at the centre of their work and many show aspects of job performance that go beyond the expectations or perception that may be held of staff working in this kind of role and grade in the NHS. Making greater use of the knowledge and ethical practices embedded within the daily work of the porters would assist greatly in elevating their perceived status and would be to the benefit of everyone involved, not least the patients.

The study was conducted over a ten month period from May 2009 to February 2010 by a team of LLAKES researchers. Evidence was gathered by a variety of qualitative methods and involved a wide range of participants from across SUHT. A conceptual framework (the Expansive–Restrictive framework) was applied to analyse the characteristics of the porters' existing workplace learning environment and to help indicate ways in which their learning opportunities may be enhanced and, hence, made more expansive.

This research has focused on the role of workplaces as learning environments in shaping opportunities for learning and career development for hospital porters. It makes an important contribution to debates central to the LLAKES research agenda by providing a concrete illustration of how work mediates learning and life chances in the contemporary work organisation.

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1. Introduction

This research paper presents the findings from a project which examined the working and learning environments and experiences of hospital porters in Southampton University Hospitals Trust (the Trust). The research has focused on issues such as, the organisation of the portering department and the occupational role, training provision, inter- and intra-departmental communications and relationships, formal and informal learning experiences, and the porters' views on the creation of NVQs for portering. It uses Fuller and Unwin's (2003, 2004) Expansive-Restrictive framework as a tool to analyse the characteristics of the porters' existing workplace learning environment and to help indicate ways in which their learning may be enhanced and, hence, made more expansive. The overall aim of this project has been to help the Trust think about the development of learning environments that will facilitate employees' career progression at all levels in line with the Trust's '20/20 Vision' to become an employer of choice and contribute to the Skills Escalator 'pillar' of the NHS' Human Resource development plan[1].

Recent research and policy interest in workplace learning has been focusing on the contextual factors shaping the character of the workplace as a learning environment, and the extent to which opportunities for learning vary by occupational level and group (Felstead et al, 2009). From a policy perspective, understanding how workplace learning can be fostered or inhibited is seen to be highly relevant to increasing skills and productivity across the workforce and, particularly, for those with low levels of prior educational attainment (UKCES 2010). The NHS, the UK's largest employer, has been focusing on the opportunities for learning provided for its non-clinical workforce, most of whom are located in the four lowest bands in the organisation's pay structure and who, historically, have had limited opportunities to 'upskill' and for career progression (Fryer 2006). This perpetuates the perception within the NHS and society more widely that portering is part of the 'unskilled' area of the labour market (see Unwin, 2009). Our

[1] For more details see http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Managingyourorganisation/Humanresourcesandtraining/Modelcareer/DH_4055527 (accessed 4 November 2010)

research on hospital porters for the Trust can be located then in wider debates, that are at the heart of the LLAKES research agenda, about the challenge for policy makers, institutions and organisations of designing strategies that can have both social and economic benefits.

Context

The factors shaping the workplace are wide-ranging: they include the underpinning political and economic context, sectoral characteristics and institutional arrangements, as well as organisational features such as size, ownership, history and culture. Conditions underpinning the workplace reflect the economic model employed by the State. In the case of advanced industrial countries this relates to the form of capitalism being pursued and the extent to which competitive trends in production are shifting patterns of work organisation from and between Fordist and post-Fordist models (*inter alia* Ashton and Green 1996; Brown, Green and Lauder 2001; Ashton 2004). The Anglo-Saxon model of capitalism, often characterised in terms of short-termism, skill polarisation and flexible (often casualised) labour markets has been linked to the prevalence of organisations in the UK that compete successfully within what Finegold and Soskice (1988) termed a 'low skills equilibrium' (see also Keep and Mayhew, 1999). In their study of workplace learning across eleven sectors of the UK economy, Felstead et al (2009) argued that a much more holistic picture of the factors shaping the relationship between workplaces and learning is required. They developed the Working as Learning Framework as an analytical framework for understanding the relationships between the specifics of workplace activities and tasks, the way work is organized and the broader 'productive system' (including national and international regulation) in which they are located.

One strand of the academic debate about the relationship between work, learning and organisational performance has revolved around employee management and particularly the extent to which different forms of working foster employee involvement and are: a) central to improved organisational performance; and b) are experienced as empowering and developmental by (sections of) the workforce. In this regard the debates relate, on the one hand, to the relationship between the organisation of work and production, the

way employees are managed and organisational outcomes and, on the other, to the nature of the workplace from the perspective of those who work in it (Butler et al, 2004). A workplace in which knowledge is distributed, shared, and jointly created requires a model of employee relations in which workers feel committed to a joint organisational purpose and enjoy a high level of trust within and between teams. The assumption is that under new technological and global conditions, organisations need to reconfigure their work processes and management styles so as to engender much greater emphasis on the involvement of all employee groups, the development of higher levels of skill and knowledge creation, and on the capacity of employees to innovate. A very different model of employee management is associated with workplaces organised along what are often termed, 'Taylorist' lines, where knowledge is seen to reside at the level of management and technical specialists, and jobs are designed to maintain a highly fragmented division of labour.

It is clear from the research literature that workplaces create different types of environments for learning. Fuller and Unwin (2004) have developed the concept of the expansive – restrictive continuum to help makes sense of this diversity. This identifies a set of features that, when taken together, indicate where a workplace learning environment can be located along the continuum. There are two broad categories of expansive and restrictive features: a) those that arise from understandings about organisational context and culture (e.g. job design, organisation of work, and distribution of knowledge and skills; and b) those which relate to understandings of how employees learn through different forms of participation. As such, the framework provides a broader conceptualisation of participation than that described by Lave and Wenger (1991) as it foregrounds both pedagogical and organisational features as being of relevance to the creation of workplace learning environments.

The framework can be used to analyse the nature of workplaces as learning environments. More expansive learning environments are ones that allow for 'substantial horizontal, cross-boundary activity, dialogue and problem-solving' (Fuller and Unwin 2004: 136), which generate multi-dimensional, heterogeneous and reflexive forms of

expertise. In contrast, more restrictive environments have little diversity. Participation in learning is limited to a narrow range of homogeneous tasks, knowledge(s) and locations. In these circumstances, learners acquire confined, hierarchical and unreflexive forms of expertise. Fuller and Unwin (2004: 127) argue that: '*expansive* rather than *restrictive* environments foster learning at work and the integration of personal and organisational development'. Thus, expansive environments do not separate personal and organisational goals, but see them as integrated within a symbiotic relationship. In this regard, a recent study focusing on the implementation and utilization of NVQs for ancilliary staff in the NHS, found that in the settings where an expansive approach was being taken to workforce development, 'Employees were *learning* in the process of gaining them and NVQs were successfully acting as a 'throughput' qualification, providing access to higher level roles and qualifications.' (Cox, 2007, p. 23)

We have drawn attention to the relationship between forms of work organisation, approaches to employee management and the production of different types of workplace learning environment and the related opportunities they create for employees. From the perspective of skills, such insights have tended to be viewed through a competitiveness lens: what are the implications for how individuals can contribute to the achievement of the organisation's economic goals? However, the argument emerging from this research is that there is also considerable potential in looking at these issues through a social lens. The NHS aims to use its Skills Escalator initiative as a strategy for widening participation in learning amongst groups with low levels of prior educational attainment and who previously have had limited opportunities for training and career progression. The commissioning of this research by the Trust is part of the NHS' growing interest in the role the workplace can play in enhancing learning, progression and involvement for a group such as hospital porters who are positioned in low bands within the NHS career structure. Our findings identify the potential benefits for, as well as the challenges of, creating a more socially inclusive and integrated approach to developing the porters' role and which we suggest have applicability for other employee groups in low grade jobs.

Research Design and Methods

The research involved a combination of desk and field work, utilising a range of methods and overlapping phases. The process involved five elements:

i) An initial period of desk-based research was designed to familiarise the researchers with the context in which porters work, and their roles and responsibilities.

ii) Interviews - 30 interviews were conducted with 10 key informants (including one joint interview) and 20 porters. The interviews with porters provided the opportunity for respondents to offer their perceptions of the portering role, their experiences of working as porters, their perceptions and experiences of training, workplace learning, and working with colleagues throughout the hospital. Key informants from the portering management team (including the Porter Manager, the Head Porters and two of the Supervisors) were invited to discuss their roles and responsibilities, the day-to-day operation of the portering function and the way its performance is monitored, the recruitment of porters, their training and development and how the department works with others across the hospital. Key informants from the areas within the hospital with whom porters work and liaise were invited to offer their perceptions and experiences of their organisational relationship with porters, the porters' role and skills, and the contribution the porters make to the operation of a large and complex hospital Trust. The main features of the interview phase were as follows:

- The interviews with the porters took place in June 2009 and the key informant interviews between June and December 2009.
- A broadly representative sample (in terms of age, gender, ethnicity, length of service) of 20 porters was developed.

- The key informants included members of the portering department management team and individuals from departments which have particularly close relationships with the porters (including theatre, radiology and emergency departments and the operations centre).
- Interviews lasted between 30 minutes and one hour and were recorded and transcribed.
- Participation in the research was voluntary. Interviewees were given the right to withdraw at any time and were assured that the information they provided would be treated confidentially and that they would have their anonymity preserved.

iii) The 20 porter interviewees were invited to complete a weekly learning log for a period of four weeks over the summer of 2009. The logs provided an opportunity for respondents to record aspects of their work routine and the opportunities they had to learn new skills as part of their daily activities. Eight porters participated, although not all completed all four logs.

iv) Task Forms – In the course of their work, the porters are required to work with various types of forms, which indicate the nature of the job including providing details about the patient and his or her transfer. An analysis of these contributed to the insights being generated through the interviews and learning logs.

Once ethical and research approvals were received, porters and members of the portering management team within the SUHT were invited to participate in interviews aimed at understanding the porters' working and learning experiences. Representative sampling ensured that the demographics of the sample group matched the broader portering department in terms of age, gender, ethnicity and length of service (the portering department has many staff with long employment records with the Trust). In order to protect informant identities, all interviewees were allocated unique identity numbers, to which only the research team had access. All interviews were recorded and transcribed.

The recordings and transcriptions are held on a secure University site accessible only by the research team. In transcribing the interviews, all names were allocated pseudonyms to protect their identity. In the writing of this report, individual identities have been further safeguarded by referring to the interviewees only by their position as Key Informant or Porter 1, 2, etc. In total, 30 interviews were conducted (20 porters and 10 key informants). Each interview lasted between 30 minutes and one and a half hours and was conducted within normal day-shift working times.

All of the porters interviewed in the study were subsequently invited to take part in the completion of four weekly learning logs in order that their working routines and experiences could be analysed. Thirteen porters initially agreed to complete the learning logs, of whom finally eight participated. We know that two of these individuals left their positions in this time and no logs were received from them.

Each porter's logs were identifiable via the unique identity number printed on the front of each log; logs were therefore specific to each porter. If a replacement log was required, the porters were given instructions to contact a member of their management who would then contact the research team. All logs were sent in sealed envelopes addressed to the individual porters and so no other person in the Trust or portering department would know the identity number.

A total of 23 logs were received: four porters completed all four weeks; one porter completed three; one completed two and two returned just one log. All eight completed the first log; six completed Log 2; five returned Log 3; and four completed the final log. The tailing off of responses in the latter weeks of the log completion suggests survey fatigue, although other possibilities may have impacted on the returns. Overall, the response rate for all returned logs based on the eight porters who took part on Log 1 was 72 percent, although this reduces to 44 percent if the total number of thirteen porters who originally agreed to take part are included. Given the two that left their posts, the first figure provides a better representation of the response rate.

The research paper is organised in seven sections. Following the Introduction, Section two outlines the organisation of portering in the Trust and the job roles of members of the department. Section Three identifies the key themes, using illustrative evidence from interviews with porters and key informants. Section Four discusses the major points emerging from the findings. We then (Section Five) review and comment on the layout and presentation of four of the task forms used by the porters and the implications they raise for training and performance. Section Six presents the Expansive–Restrictive framework and shows how it can be used to analyse the character of the porters' workplace as a learning environment. Finally, in Section Seven we present our conclusions and recommendations.

2. The Organisation of Portering within the Trust

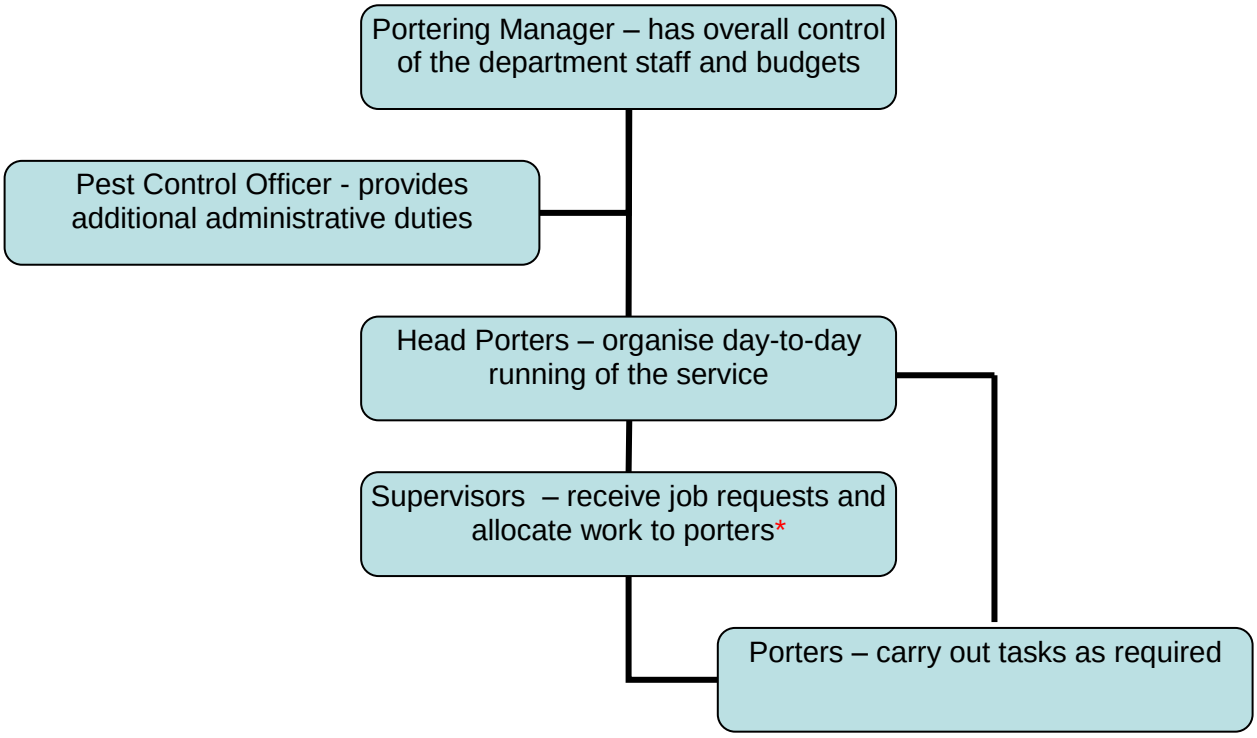
The Portering Department is contained within Division 5 (Non-clinical Services) of the Trust's operations[2]. It currently employs 93 staff (as of 18 November 2009) including porters, managers and administrative staff. General porters make up the vast majority of the department. The porters are required to provide patient transfer services within the hospital '24/7'. They are supervised and managed by three tiers of management - six Supervisors, two Head Porters and the Portering Manager, with further administrative support provided by the Pest Control Officer. In some cases, porters have their work allocated by staff in other departments (radiology, theatre and emergency) as outlined below.

The work of the Portering Department is overseen by the Operations Centre. The Operations Centre ensures that departments within the Trust operate effectively as a system, for example by minimising any 'bottlenecks' in workflow. The Operations Centre can intervene in the porters' work when there are logistical issues affecting the efficient running of the system, or if deadlines for Trust's targets (such as the four hour patient 'turnaround' target in the Emergency Department) are in danger of being

[2] The other Divisions are as follows: Division 1 is for Clinical Services; Division 2 covers Medicine and Unscheduled Care; Division 3 incorporates Women and Children; Division 4 is for Specialist Services.

breached. Interventions are generally made in telephone consultation with one of the porter supervisors or the manager about how particular jobs might be prioritised over others. Interviews with key informants confirmed that meeting Trust targets is key to the Trust's Foundation status. The portering department has its own targets (explained below) and it can be an operational challenge to ensure that the targets set for one department do not inhibit the achieving of targets in another, or for the Trust as a whole.

Figure 1: Portering Department Structure (Some portering tasks are allocated by individuals within departments – see below for details)



Portering Manager (PM)

The department is headed by the PM, who is on the highest pay band for porters: Band 5[3]. The responsibilities of the PM include: managing the portering department; ensuring performance targets, (most importantly in relation to task completion times) are met; monitoring staffing levels and sicknesses; calculating the numbers of agency porters

[3] Pay bands within the NHS range from Band 1, which is the lowest band, to Band 9, the highest. In the Portering Department these Bands range from Bands 1 to 5. The Bands create boundaries for pay.

required; and changing shifts to cater for the busiest periods. The PM also manages the department's budgets and has responsibility for the stocks, orders and deliveries of the Trust's medical gases, in addition to liaising with a range of departments (including the Operations Centre) within the hospital. As might be expected of a management position, the role is somewhat detached from the day-to-day portering duties and the task of overseeing the day-to-day running of the porters is delegated to the Head Porters and the Supervisors. The PM works closely with the Pest Control Officer (PCO), who also provides some administrative duties. The PM reports to the Care Group Manager. Since January 2010 the PM post has become part-time.

Pest Control Officer (PCO)

The PCO provides administrative support to the PM and is employed on a 37 and a half hour week. The main role is to deal with incidents of pests (mostly pigeons) within the hospital, all of which are reported to the PCO. The PCO then works with pest control contractors to resolve such problems.

Head Porters (HPs)

There are two HPs who act as a bridge between the PM and the general porters. HPs are on pay Band 4 and work Monday to Friday, sharing a rota of 8am to 5pm and 9am to 6pm. They are responsible for ensuring shifts are adequately covered, that attendance records are maintained, and deal with day-to-day disciplinary issues. They also conduct annual staff appraisals and induction training and are in charge of some mandatory training.

Supervisors

Supervisors work in the control room and, unlike the HPs, operate on a 24/7 basis involving three shifts: 'Earlies' – 6 am to 2 pm; 'Lates' – 2 pm to 10 pm; and 'Nights' – 10 pm to 6 am. There is one supervisor working at all times, with a further supervisor covering busy periods from 9 am to 5.30 pm. Supervisors are on pay Band 2, one Band up from the porters. The supervisors' job is largely sedentary: supervisors cover some portering shifts (approximately four days in every five week roster). Their main role is to

receive job requests via phone calls from wards and departments, log them on to the computer system and allocate the tasks to porters in the pool room or via radios or the VOCERA communications system[4] (the way tasks are organised, allocated and monitored is outlined in more detail below). Supervisors therefore require good communication and literary skills. Supervisors cover the times when HPs are not working and so will be required to make organisational decisions out of normal office hours. However, the opportunity for supervisors to take a 'hands on' approach to their role is limited as: a) in the normal day-shift they are stationed at the control room; and b) when they are able to work on the 'shop floor' they are themselves working as porters rather than porter supervisors. There was a perception that the way the supervisor's job is conceived and designed inhibits the ability of individuals to use their discretion to overcome the sort of day-to-day operational challenges that arise. The following comment is illustrative:

> *"If there was a problem on the ward, where the patient's delayed, or another department screams 'where's our patient?', we could go and find out why. Trouble shoot, if you like; we can't do that, because when we're on the floor, we're actually working anyway, so we can't even do that."* (Key Informant 2)

Porters

The Trust employs hospital porters with further support offered by agency workers as required (see below). The main role of porters is in the transporting of patients ('patient transfers') in and around the hospital. They are also required to perform other duties such as transporting blood products, taking the deceased to the mortuary, changing gas bottles and collecting specimens. Porters are on the lowest of the NHS Pay Bands, Band 1. The number of patient transfers has been estimated by the PM to be around 300,000 a year, which equates to around 16.5 patient transfers per porter per shift (this calculation allows for staff sickness, holidays, etc). The porters cover all areas of the hospital via the seven

[4] VOCERA is an electronic system which is somewhere between a radio and internal mobile phone and a unit is carried by some porters. The advantage of the VOCERA units is that Supervisors can communicate directly with the recipient, unlike the radios in which all transmissions can be heard.

day a week, 24 hour shift system. There are established arrangements for porters to work in the Radiology (X-ray), Theatre, and Emergency Departments as well as in the porter pool or relief teams.

- **The Pool**: The number of porters working in the pool varies according to the shift. Between 6am and 2pm, there are four porters plus a supervisor; between 2pm and 10pm there are eight porters plus a supervisor, and two of these porters are allocated to the Emergency Department; and between 10pm and 6am, there are five porters and a supervisor. Porters in the pool are allocated tasks by the supervisors and, along with the relief porters, are the most mobile of the portering staff as they may be required to work anywhere within the hospital. They have regular, long-term shift patterns.

- **Relief** porters work across all areas of the hospital. There may be as many as ten relief porters per shift but these will be distributed throughout the hospital – to the pool, theatres, radiology and so on according to staff absences and peak times. Unlike porters in the pool, their shifts are highly variable. They are generally given a week's notice of their impending shifts, which are likely to include earlies, lates and nights. This can be very tiring for some, as this porter explained:

  > *"I could do four 6:00 to 2:00s, have a day off, do a 2:00 to 10:00, have a day off, start nights for three weeks. We do a system where we do nights, we do seven nights, two nights off, five nights, two nights off, two nights, two nights off and then we're back on a 6:00 to 2:00 shift and you're just totally obliterated, you're just wasted for like a good three or four days."* (Porter 10)

- **Theatre**: Eight porters are assigned to the theatres, covering mornings and afternoons, with a further four porters working evenings, although there is a greater reliance on the pool porters during this period. Most of the porters

working in the theatres are regularly deployed in this department. The theatres can be in operation from 8am to 9pm. The work of theatre porters generally involves transporting patients to and from wards, but not within the theatres themselves. This part of the patient transfer is undertaken by theatre staff. There are 21 theatres located in different areas of the hospital. Portering tasks are co-ordinated with the Centre Block Theatre by the 'Portering Link Nurse', a designated auxilliary[5].

- **Radiology (X-ray):** There is generally a team of 11 porters working in Radiology. Five or six porters work regularly in this department and a further five or six are allocated there by the portering department to cover busy periods, often during the afternoon. Shifts are split between 9am and 5.30pm and 9.30am to 6pm during the week; on Tuesdays and Wednesdays two porters work between 8am and 4.30pm. Whilst the portering department has responsibility for the general management and training of these porters, radiology department staff issue tasks to the porters who have been assigned to them. Any patient transfer delays are reported back to Radiology rather than to the portering supervisor (as would be the case with the pool porters). The high volume of work in Radiology means that porters are expected to be fully trained before they begin work in this department. If porters are new to Radiology, they will be placed with a porter who is experienced in this area of the hospital until they are familiar with the work.

- **Emergency Department (ED):** Generally, the ED requests porters from the portering department via the central request system. However, there is a regular arrangement that each day the ED is allocated two porters from the pool by the portering department between 2pm and 10pm. These two porters are stationed in the ED and have their tasks allocated by the nursing staff. The allocation of two porters is not normally sufficient to cover demand and so the ED also requests help from the portering department in the usual way too.

[5] The portering link nurse is on Pay Band 2, the same band as the porter supervisors.

- **Agency staff** provide important support for the portering department and are used to cover busy periods or staff absences due to holidays and sick leave. Some agency staff may be sent repeatedly to the hospital, thereby building up experience of portering. As a result, agency workers can provide a reliable source of new recruits as they already have some experience of the job prior to starting although, as will become clear, they are not given the full range of training that Trust-employed workers receive. Six of the porters interviewed stated that they had previously worked as porters for agencies (from 3 to 18 months) before being taken on by the Trust. It was noted that agency staff do not receive the inoculations given to Trust-employed porters, despite being exposed to the same risks.

Organisation of the porters' work

As outlined above, when porters are allocated to Theatre, Radiology and Emergency, their tasks are distributed by staff within those departments. However, in the main they undertake work following the requests that come into the supervisors from wards or departments across the hospital. All jobs are logged onto the computer system by the supervisors and jobs are timed from the point they are entered to the time a porter reports that the task has been completed. Job cancellations and delays are also logged and monitored. Supervisors may sometimes use one of the porters attached to the theatres to cover emergencies and in such cases may also prioritise one task over another. Their work, like other departments in the hospital, is monitored by the Operations Centre, which may also advise on prioritisations if particular delays are noticed. Supervisors also make on-the-spot decisions about the running of the portering services, although there are some aspects in which they are required to consult the HPs, particularly when there are ward delays (such as the occasions when, for example, patients are not ready for collection when the porter arrives).

Porters are required to inform their supervisor if there are delays so that these can be logged and the reasons for them can be monitored by the PM and, if necessary,

investigated. A traffic light system is used to track the progress of jobs, with a green code given to those likely to be completed within the expected period and red to those which are in danger of exceeding 'the time allowed'. The target is to complete tasks within 40 minutes, but the actual time taken will depend upon the nature of the request. As a rule, each job will remain on green for around 15 minutes, but if it has not been completed within that time the status will change to amber, and then to red if it has not been carried out within a further 15 minute period. Jobs coded red are expected to be completed within 10 minutes, but if the department is particularly busy there may be an increase in 'reds':

> *"If it [increase in red codes] happened during certain periods of the day, you know, we're not going to get any go red before 9 o'clock, shouldn't do, but shortly after 9 there might be a sudden rush because clinics start. Towards a lunchtime, 12 o'clock-ish there might be a little bit of a rush."* (Key Informant 1)

Porters are required to carry radios but some prefer not to, which seems to be accepted by their managers. Those that prefer not to carry radios will phone back to the pool room on completion of a job or return to the room to await further instructions. Those porters who carry the VOCERA communication equipment with them are able to have instant and direct communication with specific porters, unlike those with radios through which all communications are heard.

Porter-patient interaction is clearly central to the porters' role. Porters must not ask questions of patients regarding the nature of their illness and porters seem to recount this almost as the 'golden rule' of portering: "You can't talk to people about what operations they're having, or anything like that. You talk about the weather or something like that" (Porter 7). Others, though, have their own ways of interacting with patients: "I usually go in and say 'okay, who wants a free op today, then?' They all say 'not me, not me!'" (Porter 4). But, if one thing stands out above all else, it is that porters view the patients as being their whole *raison d'être:* "At the end of the day the most important thing is the

patient's wellbeing" (Porter 18). Altruism was seen to play a part in many porters' reasons for doing the job and the contact with patients provided the opportunity for them to make a positive and meaningful contribution to the patients' experience: "A lot of people say they want to come here and give something back, because they've had an experience or whether that's a relative or self, it's nice to be hands-on with patients" (Key Informant 6).

Skills that porters bring with them from their previous occupations can play an important role in how they see and treat patients. Porters come from a variety of backgrounds, including sailors, cleaners, skilled trades people and factory workers. Educational backgrounds, too, are just as diverse, with interviewees ranging from those possessing no formal qualifications through to one porter holding a degree. Whatever their previous background, porters need to have the ability to the work with people and, hence, having experience of working with the public is deemed desirable in candidate selection.

3. Themes from the Interviews

The interviews with porters elicited their perceptions and experiences in relation to three main themes: the opportunities for participation in training and qualifications; the day to day experience of teaching and learning at work; and intra- and inter- departmental communication.

*Training and Qualification***s**

> *"So the training, if you like, is more or less on-the-job training, on-hands. We don't actually do classroom training. Once a year there is a classroom training; they call it 'Refresher' training."* (Porter 13)

The Portering Department is responsible for recruiting, training and managing the porters. All Trust-employed porters are required to take part in mandatory training, which covers subjects such as fire procedures, child protection, infection control, confidentiality, gas bottle changes, basic first aid, life support and patient handling. Most of the training

focuses on the practical aspects of portering. Despite this focus, some training is delivered via computer-based training packages available for use in the HPs' office rather than through 'hands-on' training sessions. The reason for using computer-based training is largely practical as it provides a way of making training available to staff who are difficult to release from their 'frontline' duties: The following quotation illustrates the logistical challenges:

> *"There's a hundred porters, we can only allow a few off ... it's really difficult to get them all trained in all these things because they could practically be doing just all these mandatory things and not doing the portering. So they brought it in that they could do it online, like a, you know, quick one, but I don't know that that actually gets in, because you can do tick, tick, tick, and not absorbing."* (Key Informant 4)

Porters also get annual 'refresher' courses, but there were concerns about the pedagogical approach. One senior porter said, "basically you run over a lot of old ground". A member of the portering management team said:

> *"...a lecture format; the only things that you actually get involved with is the patient transfer from the bed, from one bed to another ... making sure you're doing that correctly; maybe a medical gas cylinder. That's about it."* (Key Informant 3)

There is also a problem with fulfilling the requirements of the mandatory training in a department where the demands of the job are constant and where limits in capacity make it difficult to give workers time off-the-job to train. For instance, one porter commented that there are "[resuscitation] courses, you know, going on. But I haven't done it yet, but some of the porters have done it" (Porter 9). This means that some porters will have received training before others, as this porter observed:

> *"He'll teach me what it is that he thinks he's been taught. Not necessarily… coz, and some of the information I'm getting from some porters is different to the others because you've got a different, people remember things differently or people can't be bothered, you know, 'oh, don't worry', you know, that sort of thing."* (Porter 16)

Furthermore, there is often a time delay between when new porters begin work and when they receive the training:

> *"How you should perform some tasks and stuff like that should be given at the beginning of your job, at the beginning, … not like after six months or something."* (Porter 1)

A particular issue arose in relation to fire safety training. Porters stated that they were not made aware until they arrived at the class that by undergoing the training they would become responsible for the fire regulations within the department. There was also a question over the utility of the course for their needs: "We wouldn't have the time or the facilities to do it in our department" (Key Informant 2).

There are clear differences in the training given to the Trust-employed porters and the agency porters. For example, agency staff are not trained in the use of gas bottles and in how to change them. While this can be limiting in terms of restricting the jobs agency porters can perform, these workers are used as spare capacity to cover busy periods or staff absences. This porter said that prior to being employed by the Trust he worked as an agency porter, where he received:

> *" … one day's training. First I got here, I was put up in Theatres; I got half a day in Theatres. Then in the afternoon I was put in X-ray and you just go with a full time person and he shows you the ropes."*

Yet, since being employed by the Trust, the same porter reported that:

> *"You get training all the time; you are always going in for training sessions. You get First Aid, Life Saving, Fire, nearly – well anything that works in a hospital. You know, how to undo the oxygen and that."* (Porter 6)

Agency staff generally receive one day's training with the theatre porters before they begin work with the main portering staff: "…because it's quietest; it's not so intense. And just teaches you … the basics, really" (Porter 8). The limits of this training can sometimes be problematic for the Trust-employed porters in terms of the agency workers' lack of knowledge. Agency staff will not be given some duties such as changing gas bottles as these tasks are given only to experienced and trained porters.

A major issue for agency workers and also for new Trust-employed porters is the size of the hospital and getting to know the layout. Agency workers do not necessarily have the same time to learn about ward and department locations, thereby restricting the areas that agency porters can be placed. Uncertainty about the geography of the departments means agency staff are of less value in the pool, where the nature of the duties varies across the hospital. Therefore, they are often placed in the theatres and X-ray departments where the working area is more limited. As many agency workers as well as some Trust employed porters (see below) do not speak English as their first language, this can lead to issues of miscommunication or porters speaking in their own language across the patient, something which they are not permitted to do, but was reported in the interviews as happening frequently.

There was recognition that learning from more experienced colleagues can be extremely valuable, as this comment about shadowing highlights:

> *"… helps tremendously. Rather than just sitting in a room with someone telling you what's going to happen. So I think to follow someone around, to learn how things happen, that's more efficient."* (Porter 13)

Here, again, where English is a second language, there can be problems. Porters may not understand instructions fully or may only use a patient's surname instead of (as is required within the department), using both first and family names, in that order. In addition, there is some inconsistency in the way patients are referred to on task forms (see Section 5 for discussion). Confusion over the use of names can lead to time being wasted by porters looking for a patient by the wrong name.

Porters have significant, face-to-face dealings with ward staff and patients, which require different but equally important skills. Ward staff are often under pressures of their own, while patients will often be understandably worried about what is happening to them. Porters have to deal with the very real emotions of the patients and in this respect the training they receive is often felt to be insufficient: "I don't think there's enough about contact, remembering the patient. They're not like a factory line, it's a human being" (Key Informant 6). One of the porters agreed, saying that porters are, "Working with human beings. They could be my mum, my dad, my brother, my sister" (Porter 5). Helping porters think through these identity issues should be a part of their training.

It is part of the porters' contract that they are expected to perform mortuary duties (Online Recruitment Pack, General Duties: paragraph 2), although there is some discretion given to the supervisors in the allocating of mortuary jobs due to a porter's personal circumstances. Training for specific duties such as mortuary visits was reported as being minimal, despite the obvious potential emotional aspects that such duties entail. Mortuary calls form part of the initial induction: "Part of our normal induction is to take people to the mortuary and explain. We've had one or two people actually left because they've said 'sorry, can't go down there'. It is stressful" (Key Informant 6). However, one porter interviewed said that he had already been working in the department for two weeks before his induction training and observed that by then:

> *"…he's* [the Head Porter] *not showing you anything that you don't already know and haven't been doing, um, walk to the mortuary, say, 'there's the mortuary', he didn't even bother opening the door to go in, he says 'you*

know what they do in there, don't you?', and he didn't even open the door." (Porter 16)

Another porter was more philosophical about the mortuary duties, saying, "It's just whether you got the head to do it, if you know what I mean" (Porter 17). Only one porter reported having received training before being allocated mortuary duties, although he did not clarify the depth of the training he had received. However, once again there is a difference between Trust-employed porters and agency staff. Asked whether a porter might be expected to visit the mortuary without any training, one porter replied, "Probably would, if you were agency. But you would always be with somebody who's done it before, you know. It's one of those things" (Porter 3).

There appears to be a disjuncture between the formal training the porters receive and the potential of the training to support their longer-term career development and progression. For instance, two porters reported that they had either applied for or been promised further training, but neither had heard anything more. Other porters felt that there was a lack of an organised approach to training. In a previous workplace, one porter had received regular training updates because of the company's quality control system, "but there's nothing in stone at this place, it's all grey areas or I've never seen nothing written down" (Porter 10).

During the interviews, porters were asked whether a portering qualification, such as an NVQ, would be beneficial to their work and support the possibility of career progression. The responses were mixed: some welcomed the idea; some thought it would be without foundation if not connected to a step-up in the pay band; and others dismissed it out of hand. For example, one porter thought that, "if they want us to do like an NVQ level 2 or a 3 whatever, they should up our band level, I think, 'cause then we'd be more qualified than just run of the mill porters. If we put in, they should put out as well" (Porter 17). Another agreed:

"What do you need an NVQ in the portering department for? We do this job 365 days, 24:7, which they're right in what they're saying there, and I totally agree with them. I said to [the PM]*, I said, 'If there's an NVQ available to the portering department, are you going to move them up a band? Will we move up a band?' and he went 'No, you won't move up a band.' I said 'What's the point in having an NVQ, then?' I said, 'There's no goal; there's no incentive for anyone in that department to go for it.'"* (Porter 7).

However, other porters accepted there may be some benefits to a portering qualification which reflected the work they do:

"I think you should offer [an NVQ] *to* [the porters]*, but I don't think they should be forced to do it. I think the bit that should be forced upon porters is the actual rigorous on-site training.*" (Porter 19)

This view is supported by some of the porters who felt that they lacked sufficient training to do the job they do. Extra training which goes beyond portering was seen as unnecessary, particularly if it is not supported by improvements in their pay scales:

"I think a lot of the porters wouldn't be too keen on the qualifications …. because what incentive would there be with Banding? It's like we are on the lowest Band in the entire hospital. It's like, I've been here over 10 years and I'm still on Band One!" (Porter 19)

One of the portering department management team was sceptical about the value of an NVQ:

"It's questionable now whether it's [an NVQ in portering] *ever been relevant, because the job's changed; the head porters' has changed, the supervisors' position has changed to what it was… So the whole scenario*

has changed really; a lot of it's to do with infection control and also trying to make it a bit more professional service for moving a patient. And the movement of patients is what we do now; it's a lot of movement." (Key Informant 6)

Another porter thought that a portering qualification would be:

"Only a piece of paper saying that you're qualified to do this or that. Honestly, I don't know what there is to be gained, working as a porter. I'm speaking on this based on being a porter." (Porter 13)

One porter distinguished between the value of an NVQ and another type of vocational qualification that he felt would have worth: "If you said to me there's a national diploma for portering, I'd do it tomorrow. Because then I could take that certificate and say to another hospital, you know, I'm going to apply for a job here" (Porter 14). A few porters said that if they applied for another job, then they would simply ask the HPs for a reference. Porters also had practical reasons for resisting studying for a qualification. One said that the work can leave the porter feeling, "physically and mentally exhausted. All I want to do is go home and prepare myself for the next one" (Porter 13). Incorporating the physical demands of the job and the 24/7 nature of the work for shift workers, can impinge on people's desire to learn. This creates a tension in the balance between the needs of the Trust and the aspirations of the individuals. For instance, when asked whether the Trust encourages people to learn, one porter replied that:

"If you want to learn you will. If you don't, you don't. There are some courses advertised in our room, but not many people apply for them. So it's all a matter of hours of work. Some people who do like regular shifts, they have to have a permission to go for classes and sometimes when it's busy it's not too… easy, let's say." (Porter 1)

The observation was also made that, "some porters come in and think, 'I'm just gonna do portering and that's it'. Well, that's up to them" (Porter 10).

While there seemed to be few opportunities for porters to progress within the hospital system, there are instances where porters felt they wanted to move on to other departments and believe that they are able to do so. Two porters both stated that they saw portering as a gateway to improved careers in the hospital. Another recalled how one ex-porter became an auxiliary nurse in the Emergency Department, although it is rare for this to happen. When it comes to training individuals for more senior roles, again there is a balance between individual interest and the needs of the service. If a person is deemed suitable, for instance, for a supervisory role, then they will first be allowed to sit in with a supervisor: "There is a supervisory course, as well, that we would send them on. But we do the practical first, see how they get on, see if they like it, see if they can take the oppression!" (Key Informant1) While 'oppression' seems like an overly strong word, it perhaps goes some way to explaining the pressures faced by the supervisors. Supervisors also require different skills to general porters as the majority of their consists of telephone interactions, logging calls onto the computer and allocating jobs to the porters, yet they still have to be capable of taking responsibility for decision-making and undertaking general portering duties.

Porters receive certificates for courses they complete and these are generally held on their work files, but tend not to be displayed in the Department.

Porters as learners and teachers

While no formalised mentoring scheme is currently in place, initial training for new recruits will often see them shadowing a more experienced team member and many regard this as the best way to learn. One porter, however, stated that, although new porters are supposed to accompany an *experienced* member of staff, often, "they stick them with the normal, run of the mill porters; it sounds a bit daft but they stick them with any porters" (Porter 2). Experienced porters who are new to a department, such as

Radiology, will initially be placed with a regular porter in order to learn the specific requirements of that department.

Many porters take pride in the knowledge and expertise they have in changing the oxygen and gas cylinders. Some were critical that nurses were not trained in the basics of gas bottle changes and their correct usage. As a result, the porters tended to be watchful of nurses' practice and often acted as informal teachers to those nurses who were not fully competent. This porter's description of one encounter was not unusual:

> *"... the patient is wearing the mask and your oxygen is not yet on, the valve should be on, I said, so turn it anti-clockwise ... the valve should be, you have to turn it anti-clockwise to open the valve and so that the air will pass through."* (Porter 20)

Likewise, one porter reported how a nurse believed she had switched the valve on, but had failed to remove the safety tag (Porter 18). The porters we interviewed were well aware of the safety issues surrounding the use of gas bottles and received formal training in this task. Some would like the chance to extend their knowledge by visiting the gas company's worksite to "learn from them" (Porter 2). Some porters were also concerned about the quality of nurse training, particularly more recently qualified nurses, in moving patients across beds and trolleys. It was felt that patient handling was an area where shared training between nurses and porters would be highly beneficial. One porter commented: "If you're doing things like transfer, maybe put the porters and the nurses together on a course so they can understand our role in it and we understand theirs a bit" (Porter 8). The need for porters and nurses to work together was often expressed in the interviews, and is reflected in this comment: "It's not just like, 'oh, there's the porters; that's nurses'. If we worked as a team it would be a lot easier" (Porter 17). Training for patient transfers is important, otherwise if the nurses are not fully trained then "it's the patient who suffers; the 'be all and the end all' is not to make the patient suffer" (Porter 8).

Some porters clearly take an interest in the wider workings of the hospital. They are self-directed in their learning and have gained a lot of knowledge that is relevant to the health and well-being of patients:

> *"Like syringe pump drivers: we all, a lot of us take them mainly with us to appointments and things like that, but a lot of the medical staff or nurses or quite a few of the porters don't take the mains lead and on certain drugs, it's got to be kept going you know all the time, it can't be stopped; something to do with if it's stopped a few minutes, it quickly goes out of the blood system; that sort of stuff, and you think of, but a lot people don't, they just unplug it, take the mains lead out, and you're off."* (Porter 8)

Another example indicates how porters can act as teachers, this time in regard to working with agency porters: "…they are good guys I suppose, you know. I don't encounter any problems with them. As long as I can help them, show them what's the job, you know, and I tell them 'just do this', you know, 'remember this', 'like that'. It will be all right" (Porter 20).

There is no hospital map or department locator given to new staff, so some porters have created their own informal maps which they carry around with them and on occasion offer to new staff members or agency workers. One porter commented, "I just jots down little things, things like that" (Porter 6). Another porter compiled a list of ward locations and their phone numbers which he used when he first started and keeps with him still. However, he commented, "But now I don't use it, you know, because especially A&E, I know the number of A&E. It's a big help for a newcomer" (Porter 20).

Inter- and intra-departmental communication and respect

Another key theme to emerge from the porter interviews was the perception that the nature of their job and the contribution they make to the smooth running of the hospital and the patient experience are under-estimated and under-valued. Many of the porters felt

that a lack of understanding exists in the hospital, particularly on the part of ward staff, in terms of perceptions about what the porters do and their position within the hospital. One porter felt that portering is held in low regard within the hospital and he considered that feeding back his observations would not be well-received as, "it doesn't really matter what I say. Probably say this, coming from a porter…! They won't take it gladly" (Porter 13).

On the topic of how the portering department is perceived within the Trust, one porter commented that:

> *"It's not as bad as when I first started but say NHS hierarchy, you start off with your surgeons at the top and the porters are at the bottom. But I know if the porters weren't there, I know personally that a lot of the jobs wouldn't get done, so it's just changing other people's perceptions, not mine, but it's other people's."* (Porter 10)

Weaknesses in interdepartmental communication are highly problematic for porters, yet many think the situation could easily be remedied:

> *"When we are told to go and get the patient, when we go to the ward the patient is not ready and the nurses say 'no, you are supposed to be at quarter to twelve' and we are half an hour early, you know at quarter past. So radiology are supposed to, they should tell them to get the patient ready, so when we go up there won't be any delay … And they should know that we are coming."* (Porter 15)

A phone call from the department to the ward would help to ensure patients are ready before porters are despatched but, as one of the Management Team explained, "Theatres are supposed to phone a ward first before anyone goes up to tell 'em they're coming up for this patient. They swear they do, but I'm sure they don't in all cases" (Key Informant 1). Delays in one ward can then impact on further tasks:

"When we go up to wards; they say that they are ready and they are not, and we are delayed for about 10, 15 minutes… Otherwise, when you go to the next patient, they say "Oh you should have been in here five minutes ago, or 10 minutes ago", especially if it's a time job as well." (Porter 9)

The porters inform the supervisors of the delays, who log them onto the system. The results are then reviewed by the PM. It is the work of the supervisors to try and prioritise jobs and ensure work times are adhered to. The problem was described as:

"If someone phones up to get a patient moved and they've got nobody to do it, then generally they [the Supervisor] *say they'll do it as soon as they can and the customer will be happy with that, but it doesn't work like that. They want to know when it's going to be done, and you can't put a time on it. If it was a fairly routine job, well routine to us, you tell somebody that we'll have somebody free in ten minutes and in ten minutes, if Intensive Care phones up, or A&E patient to be moved, you may have to go first prioritise as well. And then our first customer gets a bit upset by that."* (Key Informant 1)

Portering is seen as a service provided to clinical staff and to departments and wards across the hospital. When the service is seen to have fallen short of expectations, staff in those departments may well complain either directly to the porters or to the porter supervisors or managers. However, the explanation for the perceived unsatisfactory service is often complex and the result of pressures occurring at various points in the system and which are often not within the control of the porters. So, for example, although as this manager observes: "The relationship between porters and nurses could be better" (Key Informant 1), the factors affecting the relationship need to be recognised. The following comment from another manager helps explain the competing pressures that exist between departments:

"When you come down on the wards, on the wards level, they are as busy as the porters are; they're as short staffed as the porters and that's where you get the frustrations building up. The frustrations are taken out in the phone calls, the abruptness of the phone calls, both ways, etc., but how you deal with that, I don't know, you know. So there is a problem but you can't blame that person, they're in that predicament same as we are. This causes delays. Our biggest problem is ward delays. You go to get a patient – patient isn't ready. We're probably up to 8 to 10 thousand delays per year. We actually record 3,000 just in the pool system last year." (Key Informant 6)

The poor understanding that other departments have of porters' workload was also explained as being due to:

"In the past I used to have groups of nurses come in and used to sit them down and talk about porters, specimens and post, and refuse and that. That doesn't happen any more ....Now whether that's because of the time, I don't know." (Key Informant 6)

The interview evidence also suggests that communication within the portering department could be improved, particularly with regard to the provision of positive feedback when it is merited. One porter said: "…more involvement with management sometimes, you know? Let you know that … you are doing a good job sometimes and things like that, 'cos sometimes you don't really know … You are not always given the information and everything" (Porter 9). Support and appreciation are important to the porters and some commented that they felt there was a lack of feedback from the management and staff elsewhere in the Trust:

"Well, I have to say we basically survive on rumours and the grapevine, really, what we do know; as I said, we don't get a helluva lot of feedback.

All we're told is we're looking to move forward; I think that's the line you get all the time." (Management 2)

Some porters commented on the helpfulness of the portering management team in settling them into the role:

"If something is wrong they won't just tell you off but they will tell you this was supposed to be done like that and if you need a help just call us, you know." (Porter 15)

The supervisors were mentioned a number of times in respect of showing empathy to porters over specific duties. Although the view is, "You can't refuse a job" (Key Informant 3), supervisors were aware of different porters' circumstances, particularly where mortuary duties are concerned and accordingly do try and accommodate the porters' needs when it is possible to do so.

One of the portering management team reported that he has tried to get more people involved by, for example, asking them to comment on rosters, but that there had been a poor response. There is a monthly opportunity for porters to take part in the 'team brief', but the response had been poor:

"*Basically, it's the supervisors, the head porter and portering manager, but we always say anybody can come along if they want to. But a lot of them, they don't bother; they're not that interested."* (Key Informant 3).

In order to attend the monthly briefs, though, porters require the permission of the HPs, and current workloads and staffing levels can impact on whether they are able to attend, as do the porters' shift patterns.

4. Key Points from the Findings

In this section, we draw out the key points that have emerged from the findings from both the interviews and the learning logs. Overall, our analysis of the learning logs (completed by eight porters) indicates that the data is broadly consistent with the porter interviews. The collection of data via the learning logs has augmented the interview evidence as the log provides a different and complementary way of eliciting data. Rather than being invited to respond to semi-structured questions in a one-off, face-to-face encounter, the logs invite respondents to respond in private to a structured instrument once a week over a period of four weeks. Consequently, the logs have enabled the researchers to see how the accounts porters gave in the interviews were reflected in their weekly working lives. The data also reveal that the day-to-day events and experiences at work can make important differences to individuals' sense of worth, job satisfaction, and awareness of the skills they are practising and developing, for example, by working with other porters as well as colleagues across the hospital.

Key Finding 1: The link between workplace relationships, job satisfaction and workplace learning

There is strong evidence to indicate a correlation between the nature of social relations at work, porters' job satisfaction and workplace learning. The interview accounts and the comments in the learning logs create a narrative which links together a) the way staff treat each other and communicate, b) the way staff feel about their own contribution and that of others, and c) their opportunities for and experience of workplace learning. These comments are indicative:

> *"As in other weeks it is the professional staff and some of the porters who help by, for example, holding lifts so that I/we can enter the lifts. This camaderie* [sic] *and being appreciated gives that confidence that I can't be doing too badly."* (Porter 5 – Log 1)

"I just feel more confident and satisfied with my work and communication skills. This has given me more pleasure in doing the job I do and love and the thanks from patients and relatives that I receive." (Log 3)

Key Finding 2: Learning at work

Overall, the evidence suggests that porters are learning informally through experience and through the teaching and learning that takes place between colleagues on-the-job, as well as more formally by participating in the mandatory training provision. In addition to learning from other staff, including from other departments, the logs revealed that the opportunity to work in different areas of the hospital with different colleagues and different tools and equipment provided the opportunity for new learning:

"This week has given me a chance to work with new colleagues and learn their way of doing things. Friendlier work atmosphere made a rather nice change to the usual stressful environment." (Porter 13 – Log 4)

The log invited respondents to report any new learning they felt had occurred during the week. Overall, porters' acquisition of new skills appeared to benefit from changes to their routines where they were stimulated to learn by the change of team or activity. On the other hand, there were benefits associated with gaining experience in one area, such as Radiology or Theatres, which helped porters become familiar with all aspects of that department's work.

As discussed in Section 3, there are weaknesses in the delivery of the current mandatory training including:

- The timing of porters training in relation to their induction and experience
- The matching of the mode of delivery, particularly the use of computer-based packages for practical skills training, with the focus of the training
- The limited capacity of the department to make staff available for off-the-training in a busy 24/7 service department
- The scope and content of what is covered in the mandatory training.

It is worth noting that virtually all interviewees reported that they were unaware of the existence of Individual Learning Accounts [ILA][6], despite porters being listed as "colleagues [who] have used an ILA towards learning" (IDEAL flyer for ILAs).

Key Finding 3: Inter-departmental training

There is some overlap between the work of porters and that of nurses, which means that the two departments are routinely required to interact with each other. There are, therefore, areas in which shared training would benefit both porters and nurses and could have positive effects on patient care. Porters often expressed the view that they felt as though they were seen as inferior by many of the medical staff. Trainers would need to be sensitive to this and recognise the work the porters do and their existing skills in order to create the conditions where nurses and porters are participating in joint training as equals.

Key Finding 4: Learning the layout

The hospital covers a large geographical area. As such, one of the biggest challenges facing new porters and agency staff alike lies in finding their way around the hospital. It can take weeks or even months for porters to familiarise themselves with the layout and this lack of knowledge can result in possible delays. It also means new staff are not given certain tasks as they are unlikely to find the locations and this places additional burdens on their experienced colleagues. The creation of a hospital 'map' or ward/department locator list would go some way to solving these problems.

[6] ILAs are courses available person to workers in Bands 1-4 who do not have registered or professional qualifications and for which funding is provided. Funding is currently up to £300 per (IDEAL information leaflet: http://www.suht.nhs.uk/Media/suhtideal/WHCTs/ILACriteria2009.pdf - Accessed 5 November 2009.

Key Finding 5: Giving feedback to the porters

The lack of positive feedback received by porters was felt to be undermining staff morale and was closely linked to the low status many porters felt they have in the hospital. Many porters interviewed expressed the view that they would appreciate departmental and senior hospital management feeding back any positive comments received, in addition to being thanked for work they had carried out. This would be relatively straightforward to put into practice and, as well as raising morale, would assist in engendering a broader hospital culture of respect. Intra-departmental communication could also be improved.

The way work is currently organised into general 'on the floor' portering duties and management roles has generated a clear division of labour between porters and managers which can allow gaps to occur. While monthly departmental meetings are held, the practical aspects of the work often prevent porters from attending them or at least makes it difficult for them to attend. Moreover, some porters feel unable or unwilling to put forward their views, believing they would not be taken seriously.

Key Finding 6: 'ownership' and belonging

The evidence suggests that there is confusion about which team porters can be said to belong. This is important as team identity has some relation to the quality of learning experiences. As one interviewee commented, porters are often placed:

> "*… in the lone-worker role ... You know their service isn't based within another service, I think portering is their team. I think that's probably broken down even further in terms of, I think you'll find, that the X-Ray porters will see themselves as a team with X-Ray porters, theatres will see themselves as a team, and you know the pool porters will see themselves as a team. They don't naturally fit into a team anywhere else, which is an uncomfortable thing, I think, to admit, you know, but because you get a different porter every time you phone for a porter, the wards don't*

encompass the porters as part of their team, because you know we could see any one of 57 different people, whatever the number is!" (Key Informant 7)

Yet, despite the view expressed here that, "They don't naturally fit into a team", the porters we interviewed appeared to feel more engaged when they felt included, albeit in more than one team. We would conclude, therefore, that porters would be happy to be identified with more than one team so long as their work and skills are valued by whichever team claims to 'own' them.

5. Analysis of Portering Task Forms

The following section examines the documents used to give porters information on their tasks within the hospital. Although this analysis was not originally included in the study methods, it became apparent in the interviews that the task forms are an integral aspect of the porters' day-to-day work. Examining how the forms are used and the issues that arise provided the research team with another window into the working and learning experiences of the porters. It helped to generate a more complete picture of their workplace environment. Four examples have been examined, including the forms used by theatres, radiology and blood product transportation, and a print out of the information received in the pool room by the porter supervisors. Each form was assessed individually and the conclusions are given at the end of the section. Identifiable details have been removed by the research team to protect staff and patient confidentiality.

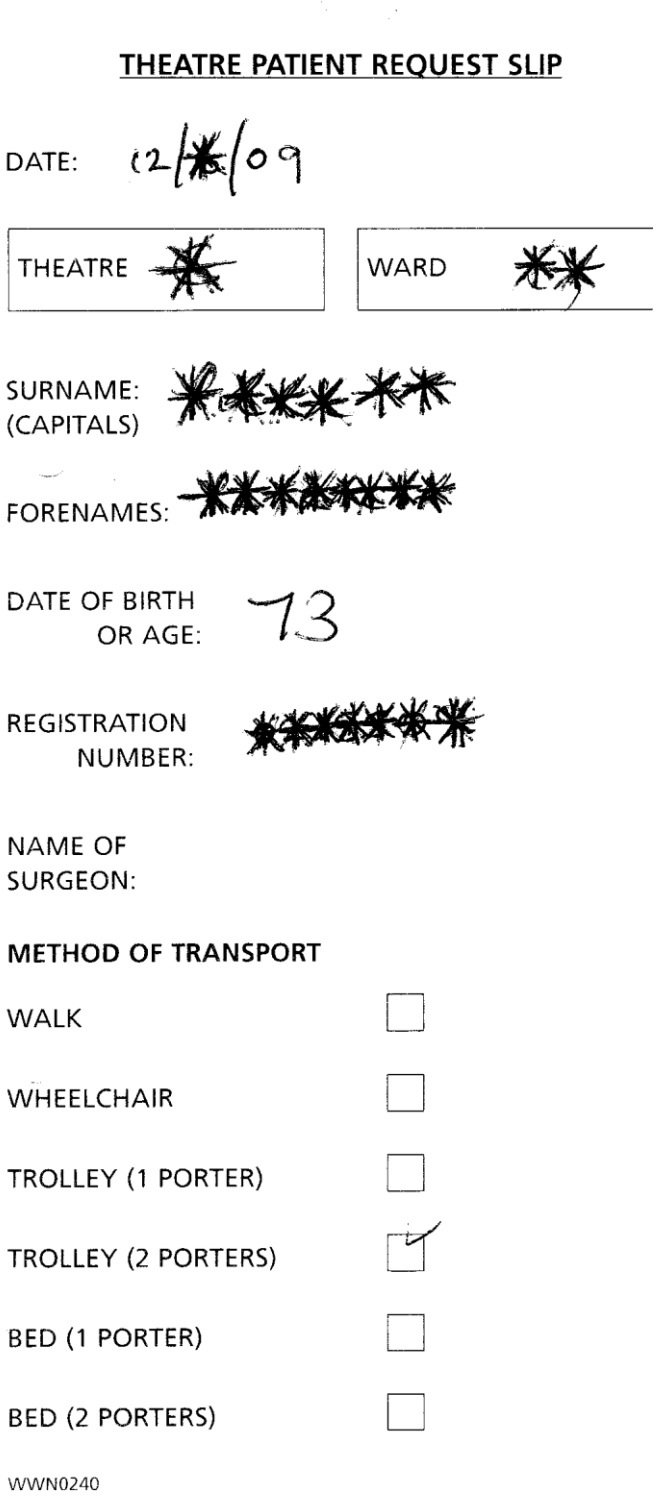
Example A: Theatre Patient Request Slip

Observations

The slip is clearly headed 'Theatre Patient Request Slip'. Of the two completed tickets reviewed, all sections in the top half were completed with the exception of the surgeon's name. The method of transport and involvement of porters was ticked in both examples (Trolley (2 porters).

The slip format is clearly laid out, appears easy to read and would take moments to complete. The slip requires details to be written by hand, rather than created electronically.

The Theatre/Ward sections give the porter the details of where to find the patient. The personal details and registration number allow the porter to match up the patient with the slip. There are four checks to ensure the correct
patient is identified and these are presented here as they occur on the form: Surname; Forename;



THEATRE PATIENT REQUEST SLIP

DATE: 12/[redacted]/09

THEATRE [redacted] WARD [redacted]

SURNAME: (CAPITALS) [redacted]

FORENAMES: [redacted]

DATE OF BIRTH OR AGE: 73

REGISTRATION NUMBER: [redacted]

NAME OF SURGEON:

METHOD OF TRANSPORT

WALK ☐

WHEELCHAIR ☐

TROLLEY (1 PORTER) ☐

TROLLEY (2 PORTERS) ☑

BED (1 PORTER) ☐

BED (2 PORTERS) ☐

WWN0240

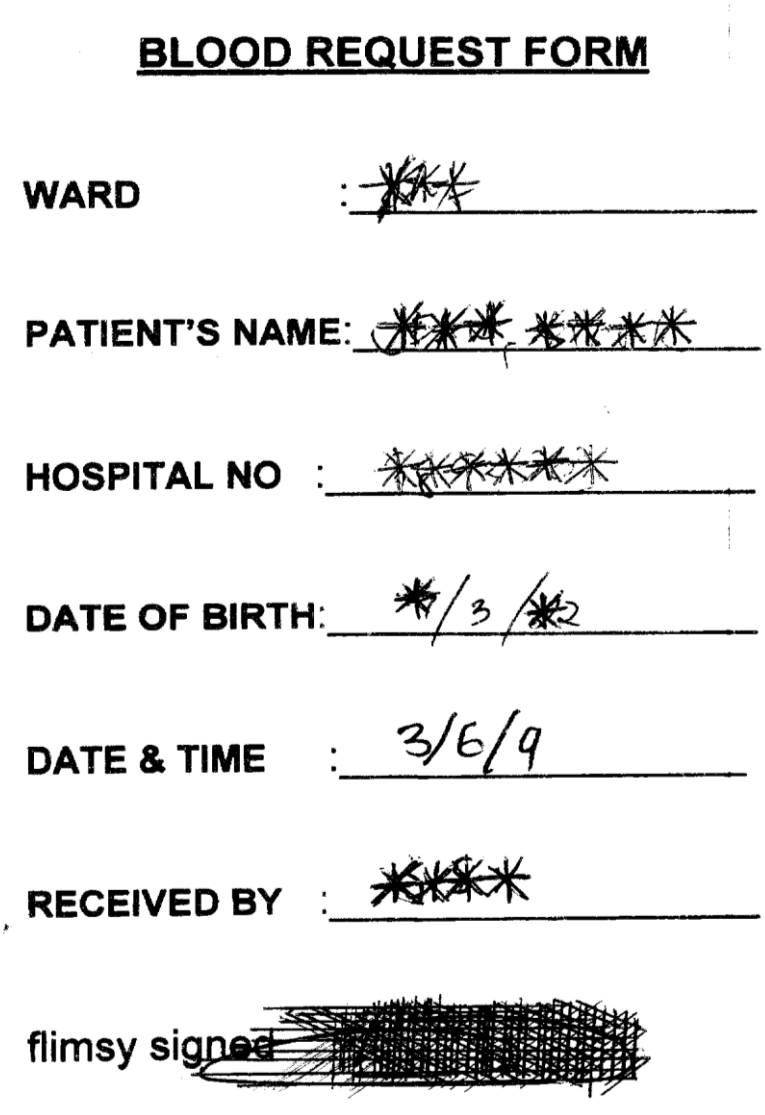
Date of Birth or Age; and Registration number. However, the placing of the family name before the first name is at odds with comments in the porter interviews, as it seems confusion can occur (and has done) when people give names over the radio or telephone in this order (last name/first name), with the possibility that time is wasted looking for a patient by the wrong name. The use of the unique registration number should assist the porter in this respect and can be the most important check if there are two patients with the same or similar names.

The lower section, 'Method of Transport', gives the porter the information necessary to move the patient and whether one or two porters are required. No signature is required by either the person completing the form or by the porter.

Example B: Blood Request Form (from photocopy of original)

Observations

In the example given, it is difficult to read the ward reference, but all sections have been completed and someone has signed the form. The form is clearly labelled and again requires instructions to be hand completed. However, unlike to the above Theatre Request Slip, the patient's name is written with the first name followed by the family name, which is the preferred method for the porters.



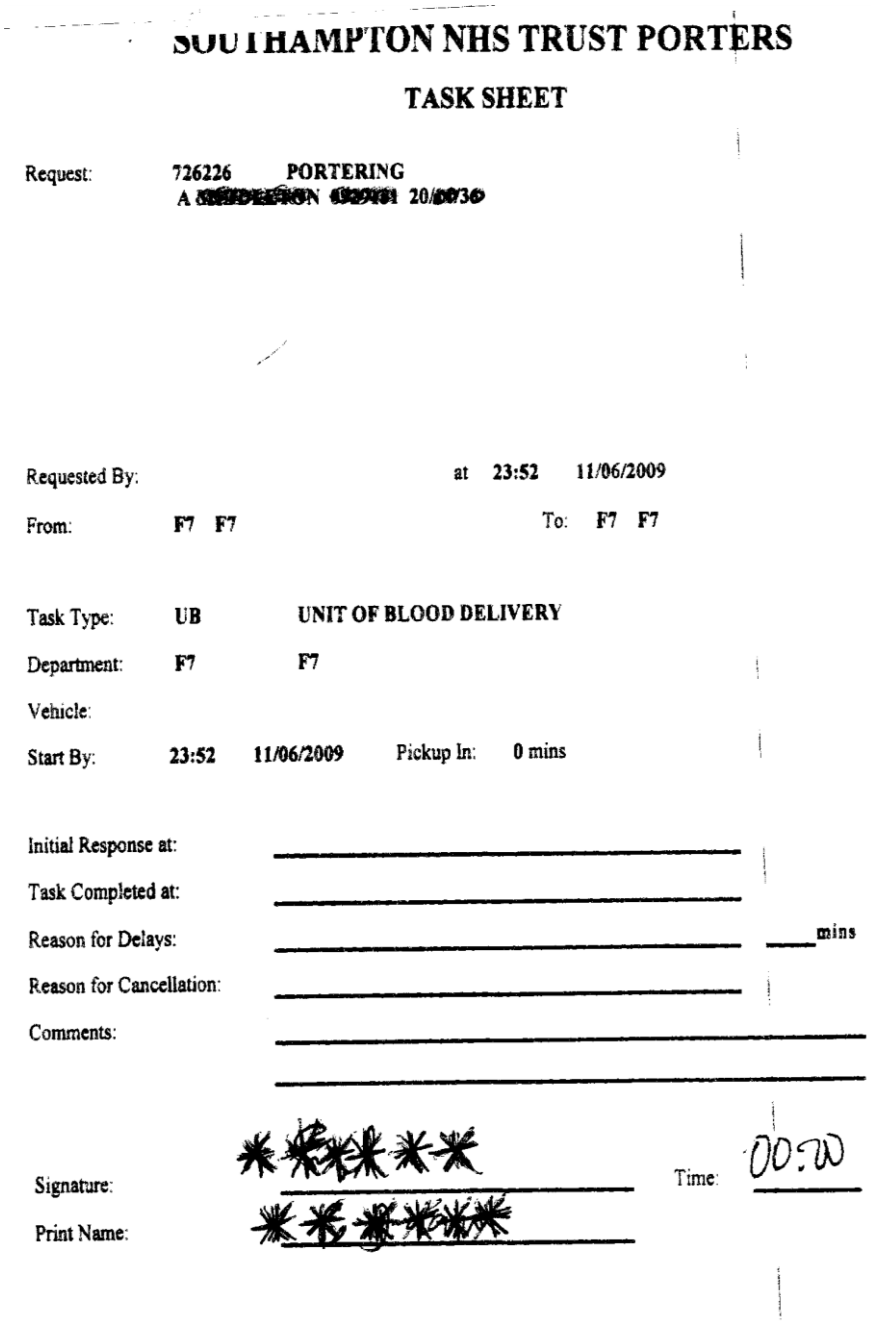
What appears to be the unique patient reference number is written here as 'Hospital No.', compared to 'Registration number' on the 'Theatre Patient Request Slip'. Although a simple difference, the porter would therefore be expected to learn to recognise the number, which then makes the section title irrelevant.

Example C: Porter task sheet (from photocopy of original)

Observations

This is the printed copy of the information supervisors have onscreen. This is not generally given to the porters, but instead forms the basis for what instructions the porters receive, communicated either verbally (in person or via the radio system) or the details are written on a slip of paper and handed to the porter.

A name is given, but it is not clear whose. Presumably it is the patient's name. If so, the first name is given as an initial followed by the family name. Again, this



SOUTHAMPTON NHS TRUST PORTERS

TASK SHEET

Request: 726226 PORTERING

Requested By: at 23:52 11/06/2009

From: F7 F7 To: F7 F7

Task Type: UB UNIT OF BLOOD DELIVERY

Department: F7 F7

Vehicle:

Start By: 23:52 11/06/2009 Pickup In: 0 mins

Initial Response at:

Task Completed at:

Reason for Delays: mins

Reason for Cancellation:

Comments:

Signature: Time: 00:20

Print Name:

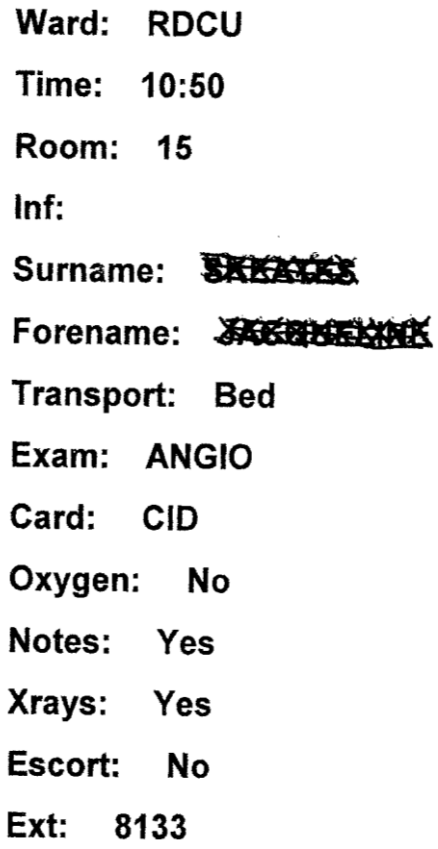
is at odds with the stated preferences of the porters interviewed who tend to use both first and family names in that order. The (patient's) name is followed by two numbers, which appear to be the patient's registration number and date of birth, although again it is not made clear. Unlike the previous two slips, not all of the sections are clearly labelled. There is a signature, but it is unclear who is required to sign or why, although porters do receive specific training on the collection and delivery of blood products and so will presumably be familiar with the requirements of the forms.

Example D: Radiology ticket

Observations

Although this ticket has no heading (e.g. 'Radiology Patient Request Slip'), this example from the Radiology Department appears to be the most clearly set out of the porter task sheets. It is electronically printed rather than hand written, each item is clearly labelled and the requirements are easy to read. Once again, the patient's name is written in the surname/forename format and there is no patient identification number, unlike the other slips.

The mode of transport required is mentioned, as is the patient's oxygen requirement.



Conclusions

The format of the task forms differs according to the department that issued them. The lack of standardisation within and between hospital wards and departments can have adverse effects. For example, it was mentioned in two of the portering interviews that confusion can and has occurred when names are given in the wrong order or someone believes the first name to be the family name. The forms contained in this analysis may unwittingly contribute to instances of miscommunication.

There are further inconsistencies in the information contained within the forms. The Theatre Patient Request Slip (Example A) and Radiology ticket (Example D) both detailed the mode of transport required for the patient and the number of porters required. Extra patient information such as a patient identification number was given in examples A, B and C, but was absent from D. The labelling differs across the forms; for example what appears to be a patient hospital identification number is referred to as 'Registration Number' (in Example A), 'Hospital Number' (in Example B) and, in Example C, a number is given with no label.

Not all tasks are allocated using written/printed instructions and porters will also be given jobs via the phone, radio or, if working in the Emergency Department, the VOCERA internal mobile phone system may also be used.

Experienced porters may be used to dealing with the differences between the forms issued by various departments and understand what and who they are looking for. However, a single and clearly labelled task slip might be a helpful development for all porters and particularly for agency staff and new recruits. There is also variation in the way forms are generated. Some are completed by hand, whilst others are mostly completed electronically. We understand from the portering department that the way that porters receive their instructions is being reviewed as standardisation would be beneficial.

6. Situating the Interviews in the 'Expansive–Restrictive Framework'

The following section considers the findings of the portering study in light of key components of workplace learning. The Expansive–Restrictive Framework has been adapted for the purposes of this study in order to develop insights into the learning experiences of porters within the Trust and the nature of their workplace learning environment. As Figure 2 (below) shows, the framework identifies a range of organisational and pedagogical features which can be differentiated in terms of their expansive or restrictive character along a continuum. Each feature has been allocated a code reference, which can be explored in relation to the findings from the study.

Figure 2: The Expansive–Restrictive Framework (adapted for the portering study from Fuller and Unwin, 2004)

EXPANSIVE	Code	RESTRICTIVE
Workplace is used as a vehicle for aligning the goals of developing the individual and organisational capability	C1	Workplace is used to tailor individual capability to organisational need
Porter and Trust share a broader vision: progression for career	C2	Vision for porters is static for the job; Trust does not possess or encourage a broader vision of portering
Porter has dual status as learner and employee: explicit recognition of, and support for, porter's status as learner	C3	Porter's status as employee dominates: status as learner restricted to minimum required to meet job roles
Porter makes a gradual transition to productive worker and expertise in occupational field	C4	Fast transition to productive worker with limited knowledge of occupational field; or existing, already productive, minimal worker development
Porter is treated as a member of an occupational and workplace community with access to the community's rules, history, knowledge and practical expertise	C5	Porter treated as extra pair of hands who only needs access to limited knowledge and skills to perform job
Porter participates in different communities of practice inside and outside the workplace	C6	Porter's participation restricted to narrowly defined job role and work station
Qualifications develop knowledge for progression to next level and platform for further education	C7	Qualifications accredit limited range of on-the-job competences
Porter has planned time off-the-job for study and to gain wider perspective	C8	Off-the-job simply minor extension of on-the-job
Porter's existing skills and knowledge recognised and valued and used as platform for new learning	C9	Porter is regarded as 'blank sheet' or 'empty vessel'
Porter's progress closely monitored and involves regular constructive feedback from range of employer and provider personnel who take a holistic approach	C10	Porter's progress monitored for job performance with limited feedback – provider involvement restricted to formal assessments for qualifications unrelated to job performance

Applying the Framework

C1 (Alignment of organisational and individual development):

The evidence suggests that a more restrictive approach applies as there is little attempt to think through how the development of porters could facilitate organisational development and performance, as well as enhance the job satisfaction, status and career prospects of individuals. Some porters perceived that their knowledge and skills were an under-utilised and under-recognised resource that could be built on to support and mentor colleagues and to develop the porter role and the contribution it makes to achieving organisational goals. 'Getting the job done' seemed to be the key and rather limited narrative characterising the portering function.

C2 (Post-induction training vision):

There seems to be no broader, expansive organisational vision for post-induction training beyond the training required to ensure porters have the minimum skills necessary to perform the job. The mandatory training provides some opportunity for porters to learn a range of skills, for example associated with first aid, resuscitation and fire safety as well as the tasks that are "focused on the job" (Porter 9).

The research found evidence that some porters are interested in developing their careers beyond the portering work they currently undertake. This includes moving to a different team in order to understand the broader workings of the hospital, and undergoing training to improve long-term prospects. In contrast, some porters do not regard learning beyond the requirements for the job as necessary.

C3 (Porters' learning status):

The restrictive approach currently applies to the porters' learning status. From an institutional perspective, porters do not have a dual identity status as learners and workers as would be the case, for example, with healthcare professionals who are expected to engage in 'lifelong learning' and continuous development. There is a tension between the focus on porters learning enough to carry out their function and going beyond this to add

value to the role and enhance the quality of the service to patients and the hospital more generally. Some individual porters are keen to learn and put themselves out to do so. They see learning as an important dimension to their work practice and, as a result, take personal responsibility for expanding their knowledge and developing their workplace capability, but there is little or no institutional recognition of this.

Our evidence suggests that there is a considerable degree of horizontal learning which occurs between colleagues in the course of daily work activities. So, although porters do not have a dual status as learner/worker recognised by the organisation, learning through working is understood by many of the porters themselves to be highly relevant to their ability to perform their duties. The development of a more expansive approach to workforce development would be one which recognised porters' workplace learning and created an environment better designed to support and encourage it.

C4 (Pace and nature of transition to productive worker):

New porters are expected to achieve a fast transition to productive worker. There is some evidence that many of the porters have knowledge and skills beyond the needs of the job and many porters bring with them relevant attributes, such as good people skills. However, few opportunities exist to develop these skills further and there is little reward or recognition for those porters who demonstrate wider awareness of how the porters can enhance the service provided to patients, the smooth running of patient movements round the hospital and the allied nursing role they also play. There seems then to be scope to improve the quality of support for the transition from new to productive porter. In addition, there may also be scope to build on the notion of productive worker to recognise those who are in effect already operating as 'advanced practitioners', and to enable others, who have the capability, to make this further transition.

C5 (Involvement in the occupational and workplace community):

Some elements of the expansive approach are apparent, such as the opportunity for porters to participate in the monthly staff meetings, but the existing environment, including the practical barriers of shift work, means it is difficult for many to attend such

meetings. Beyond the porters' own department there is scope to develop a more expansive approach to worker involvement in the workplace community for the benefit of individual and organisational performance. As the analysis of the empirical data has indicated, the work of porters and nurses often overlaps, yet in terms of training in areas where they work closely together the two fields remain divided. For example, regulations state that porters should not perform certain roles such as moving equipment (other than changing gas bottles). In reality they often do, in agreement with the nurses, due to the pressures on nursing staff. The evidence suggests that both groups could benefit from shared training on patient handling. Porters often reported instances of nurses failing to appreciate patients' needs during movements. They also felt unable to assist fully in certain techniques such as 'log rolls' because of their lack of training.

Porters' general perception is that they are not appreciated and that their work is not well understood by other colleagues. Key informants agreed with the porters' view. The development of a strong and integrated community of practice within the hospital is inhibited by this lack of awareness.

The logistical challenge of minimising delays associated with patient movements, either in terms of patients not being ready for collection or patients being ready and having to wait for porters, indicates that there is room to improve the capacity of departments to work together and, in so doing, create more expansive workplace learning environments for porters (and other staff). This would be facilitated by the identification and agreement across departments of shared organisational goals.

C6 (Access to broader communities of practice):

Despite the need for porters to work throughout the hospital and their resultant interaction with a range of departments, the more restrictive approach largely applies. The training porters receive is aimed mainly at their specific workplace tasks, although some training such as resuscitation and fire safety are more general and may introduce porters to staff from other departments.

The porters do not have any interactions with porters in other hospitals and so there is little official opportunity for sharing of knowledge and working practices outside their particular workplace. Creating the opportunity for such cross-fertilisation of ideas and experience may assist the portering department in improving certain aspects of their own operations and expand the capacity of the workforce.

C7 (Qualifications, work and progression):

There are no qualifications for portering, nor are qualifications needed to begin work. Nevertheless, applicants' previous work experiences are taken into account when recruiting; for example, customer experience is beneficial in dealing with patients and ward staff. Porters did not welcome a restrictive approach which associates qualifications with the accreditation of existing, or a limited range of, competences. They were wary of NVQs, which they perceived as representing the restrictive approach and, therefore, as having limited portability and worth. There may be scope for introducing a qualification that has clear benefits in terms of helping the porters to develop new knowledge and skills that is relevant to their work as well as providing a platform for career progression.

C8 (Allocation of time for off-the-job learning):

Planned time off-the-job for training and to gain a wider perspective is not generally available to porters, although there were occasional instances cited of where porters had been given the opportunity to pursue training that was not immediately connected to their portering role. In addition, there was an opportunity to participate in a one day off-the-job course relating to the handling and changing of gas bottles. The evidence indicates, therefore, a restricted approach for this feature.

C9 (Value given to existing skills):

From an expansive perspective, and as was noted above under C4, existing skills are valued in the portering recruitment process. On the other hand, the opportunity for porters to have their 'advanced' inter-personal skills recognised more formally through the pay and banding structure appears to be limited.

C10 (Provision of support and feedback):

The portering department operates a system of annual staff appraisals, conducted by the HPs, although it is not clear that all porters receive an appraisal every year. The appraisals provide the opportunity for staff to feed back their views and experiences and receive comments on their work. There was some evidence that porters occasionally received feedback, for example by email, from other departments commenting on their work. Overall, the perception was that feedback in the form of complaints (often about matters outside the porters' control) was more likely to be forthcoming than appreciation of good performance. This can be seen as indicative of the wider organisational (mis-) perception of portering as a 'low level' and low-skill role.

There appear to be few opportunities then, for porters to have their initiative and enthusiasm *officially* recognised. However, some porters mentioned the support they had received in response to requests to change their shifts. In this respect, the HPs and supervisors received many positive comments for recognising where porters needed their shifts arranged to coincide with family commitments.

7. Conclusions and Recommendations

This study examined 'portering', an area of NHS work that is central to the success of an efficient hospital and the delivery of good healthcare yet which has tended to have a generally low status. There has been a growing awareness in the NHS that some of its employee groups, particularly those on non-clinical grades, have previously been largely excluded from opportunities for training and development. This has prompted the creation of a new approach to workforce development which seeks to widen participation and offer progression opportunities to all staff including those with little or no prior formal educational attainment. Hospital porters, like other support workers on low grades, are an important target group for this strategy and the Trust was keen to understand more about porters' existing skills and the opportunities for learning they perceive they have. We have drawn a number of key conclusions from the analysis of the evidence collected during the course of the research:

i. Porters perceive their role to be under-valued and poorly understood within the Trust.

ii. Social relations form an integral and crucial dimension of portering, but the development of inter-personal skills is under-played in the mandatory training porters receive.

iii. Porter training focuses in the main on the practical skills required to 'get the job done', as well as on meeting mandatory health and safety requirements. The appropriateness of delivering this type of training via computer-based training packages was questioned.

iv. Finding ways to offer access to off-the-job training is challenging given the porters' job design and employment conditions. Given, however, the evidence of latent demand from porters to improve their skills and qualifications, ways should be found to combine both on and off-the-job opportunities for learning.

v. Porters value the opportunity to learn from each other during the course of their daily activities. There was strong evidence that porters help and support each other to learn in the workplace. Some experienced porters are regularly acting as teachers at work including to nurses as well as their porter peers.

vi. Porters regularly interact and work with nurses and clinicians. Overlaps or 'grey areas' exist between the responsibilities and tasks of the different groups, creating opportunities for co-participation in training.

vii. There are limited opportunities for porters to contribute their views (and to be heard) about the development of their role and contribution to organisational goals. This is part of a wider problem relating to the tangential location of the portering department in the hospital structure. 'Who owns the porters?' is a question that needs to be considered in order to help anchor their role more firmly in the structure.

viii. The categorisation of portering as a Band 1 job does not allow for differentiation between the performance of individual porters, or to recognise those porters who can be conceived as performing as 'advanced practitioners'. The inflexibility of the banding system, therefore, restricts opportunities for career progression within the portering function.

ix. Application of the expansive–restrictive framework has identified a number of key areas for management to consider in reviewing and developing the workplace as a learning environment.

x. The analysis shows that the contribution of the porters, particularly those who are highly experienced and effective, needs to be recognised, and ways found to develop their and capitalise on their expertise.

xi. The research suggests that a more holistic concept of the portering function and expansive vision of the porters' role would make a more positive contribution to the achievement of organisational goals.

The study has highlighted the dedication of staff working within the Trust's Portering Department. They care deeply about their work and how they perform it. The porters place the patients at the centre of their work and many show aspects of job performance that go beyond the expectation or perception that may be held of such a worker within the Trust. The opportunity exists to involve the porters more meaningfully in the evaluation of their work and design of their role. Making greater use of the knowledge and ethical practices embedded within the daily work of the porters would assist greatly in elevating their perceived status and would be to the benefit of everyone involved, not least the patients.

Recommendations

The following recommendations were suggested to the Trust as a way to create a more expansive workplace learning environment:

- Review the role porters play in the hospital in order to create a new vision which recognises their critical contribution to the hospital's efficiency and which offers more opportunity for them to be involved in thinking about how the work process can be continuously improved; not least to enhance the general well-being and satisfaction of patients and their relatives/friends.

- Create the role of Advanced Practitioner[7] to recognise and differentiate higher levels of expertise and experience and the ability to teach and mentor colleagues – particularly in relation to interpersonal skills.

- Introduce a mentoring system to help with the integration of the formal (and mandatory) training and the learning that occurs as part of everyday workplace activity. The role of mentor would also provide a new role to which experienced porters might.

- Create a hospital 'map' (including a ward/department locator list) for all new recruits and agency workers. This should be done with the involvement of porters who already have examples than could be drawn on. As the Trust has undergone a recent building expansion programme, the list should be held by the Head Porters/Portering Manager who would be in charge of ensuring the map is regularly updated.

[7] We have suggested the term 'advanced practitioner' to indicate both that the 'postholder' would have developed skills which exceed those normally associated with the performance of a competent porter and also that porters, as is the case with other groups of professionals in the NHS, should be conceived as practitioners belonging to a community of practice. We understand that the term 'advanced practitioner' is already used to refer to a specific group of senior clinical practitioners and our intention here is to raise questions about whether this terminology, as it captures important aspects of a senior role, can also be applied to other groups including non-clinical staff such as porters.

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