NHS Staff Council
Review of the NHS Knowledge and Skills Framework

Duncan Brown

Mary Mercer

James Buchan

Linda Miller

Catherine Chubb

Annette Cox

Dilys Robinson

ies

The Institute for Employment Studies

The Institute for Employment Studies is an independent, apolitical, international centre of research and consultancy in public employment policy and organisational human resource issues. It works closely with employers in the manufacturing, service and public sectors, government departments, agencies, and professional and employee bodies. For 40 years the Institute has been a focus of knowledge and practical experience in employment and training policy, the operation of labour markets, and human resource planning and development. IES is a not-for-profit organisation which has over 70 multidisciplinary staff and international associates. IES expertise is available to all organisations through research, consultancy, publications and the Internet.

Contents

Executive Summary

Introduction

The Institute for Employment Studies has undertaken an independent review of the NHS Knowledge and Skills Framework, the personal development and progression strand of the Agenda for Change pay reforms. The study was undertaken on behalf of the Executive of the NHS Staff Council in the second half of 2009.

The aims have been to identify barriers to the implementation of the KSF and to make recommendations to support more widespread and effective use.

The work has been guided by a Project Management Group and has involved stakeholder interviews, an extensive literature review, a series of case study visits and a wider practice survey.

Stakeholder Interviews

■ There was near unanimous support expressed for the principles of the KSF and the view that the current inconsistent application was unacceptable. However, there were widely differing opinions on the changes required.

■ The majority felt that the KSF was an over-engineered and complex process which needs to be simplified and operated in a more flexible manner. A minority argued for the KSF's removal.

■ Others believed that the KSF had largely suffered from poor implementation and so higher prioritisation, improved guidance and training support were necessary.

■ The KSF was felt to have worked well where senior management made it a priority, there was an appraisal culture, it was well integrated with other appraisal and development processes and was supported by effective training.

Literature Review

■ Earlier studies have highlighted that the KSF is key to delivering on the objectives of AfC. But they also found implementation hampered by the complexity of the process, low prioritisation and weak management skills. The volume of criticism of the process has grown.

■ There is powerful research evidence in the NHS and externally that staff development and appraisal processes can have a major positive impact on service outcomes. But a significant number of large employers, from all sectors, are similarly frustrated with these processes for being complex and resource-intensive.

■ Common changes made externally include: incorporating organisation and personal performance goals; simplifying the core process and competency frameworks; focusing on development rather than pay outcomes (competency-related pay progression is still not common); involving and supporting line managers and employees; and allowing for local flexibility.

■ The KSF is unusual in that there is no personal objective setting component or link to wider goals. The use in the NHS of both job profiles for job evaluation purposes and KSF post outlines for development processes is also uncommon.

Case Study Findings

■ Case research was carried out in 11 trusts from around the country. They were selected using national data on the incidence of appraisal and PDRs, with the first six having high rates of coverage, and the second five relatively low rates.

■ The experiences and advice from the first phase trusts centred on *"the universal basics"* of good appraisal and development practice, pursued consistently and persistently. They all found KSF initially challenging, but senior management example-setting and regular monitoring helped to ensured widespread implementation.

■ KSF was positioned as an integral part of a wider performance appraisal process in these trusts, closely tied to personal and departmental and trust goals, helping to give direction and meaning to the KSF.

■ The KSF was also generally linked effectively to other development and HR processes, such as professional competency frameworks and NVQs.

■ They had also practiced a partnership and two-way approach to the process, with extensive communications and staff involvement and training.

- The approach to implementation and operation was described as *"practical, pragmatic"*, with simple, clear route maps provided. Most had simplified and standardised post outlines and concentrated on the core KSF dimensions.

- A number had introduced variations to the national process to suit managers and more junior staff. Some had also developed their own operating rules.

- The second phase trusts had often faced difficult financial and operating circumstances, but some had historically had high rates of appraisal coverage.

- Most had attempted KSF implementation *"by the book"*, with less attention to simplification and prioritisation. The complexity of the KSF and unclear relationship to appraisal had reinforced management scepticism of these types of process.

- Often in conjunction with new leadership, the majority of the second phase trusts were already planning or making changes, introducing simplified appraisal and development processes to support the trust vision and goals.

- In doing so they had at best adapted the KSF and used it in an optional, supporting role, in some cases moved away from it altogether, devising alternatives they believe are more relevant and useful.

Survey Findings

- An internet survey was carried out to secure the views of a wider range of stakeholders and trusts. 330 respondents took part. More than two-thirds believed the KSF requires change, but they do not want it to be withdrawn.

- The poor quality of appraisals, PDRs and PDPs was seen as at least as important an issue as the levels of overall coverage of the KSF.

- Only 36% of respondents felt KSF was well integrated with appraisal, and 87% felt that it was not well integrated with other training and development.

- Communication and employee understanding of the KSF was felt to be weak. The complexity of design and operation was by far the largest perceived barrier to implementing the KSF.

- Desired changes were most commonly about simplifying the KSF, for example by removing the additional dimensions. Obtaining stronger senior manager commitment was also seen as important, with greater 'consequences' for failure.

- The KSF's link to pay was not felt to operate in practice. More respondents wanted to see a strengthening of this link, rather than removing it. Stronger links to CPD and revalidation processes were also regarded as key, along with training of employees and reviewing managers.

Conclusions on the KSF

- This study has confirmed and extended the findings from earlier investigations to demonstrate that, five years after the principles of the KSF were set out, the gap between the intended policy and the actual practice remains unacceptably wide.

- In at least one-third of trusts key aspects of the KSF and appraisal processes are simply not happening at all, and the rate of expansion in coverage has been slow in recent years. Even where these processes operate, our survey found that they cover more than 75% of staff in only one in three organisations.

- We also found commonly expressed concerns with the quality of the process. A quarter of those surveyed rated the quality of PDRs and PDPs in their trusts as low.

- Given that almost everyone consulted supports the core principles of KSF – essentially, to support service development by investing in the development of all employees – then change is essential, in order to better achieve these intentions and overcome the current barriers.

- The service and performance benefits of operating appraisal and development processes in healthcare settings are strongly evident from research studies, and in this study we encountered plenty of examples of mangers we interviewed and staff we spoke to who had realised the benefits of using the KSF and were strongly committed to the process. But there needs to be far more of them enabled to do so.

- Changes to the KSF and its use are also essential to reflect changes in the NHS since 2004, particularly the devolvement of authority to the local level and the growth of Foundation Trusts. This in our view renders as outmoded an implementation strategy based on securing compliance with a totally uniform, detailed and relatively inflexible, NHS-wide KSF model.

- Our case research clearly shows that an increasing number of trusts are modifying, or even abandoning the KSF. Without changes, then this trend will undoubtedly intensify.

- The juxtaposition of the sophisticated KSF system and the reality of the management and operating processes and cultures in the NHS has led to it's, at best, patchy implementation. The operational challenges at the individual trust level have to be addressed by this review's outcomes.

- It is also in the area of policy objectives and intentions that we see some of the most important barriers to KSF implementation. We identify three key policy questions to address.

1. How does the KSF relate to wider performance appraisal/management and should it form a part of one integrated process? It could be argued that all of the central effort behind KSF has in recent years has been akin to trying to move the whole 'horse' of performance management forward by just pulling one of its legs, the KSF competency framework. In future, a more effective approach may be to:

   □ commit in principle to every NHS employee having an at least annual appraisal meeting and a personal development plan; and

   □ develop a national model for a fully integrated performance appraisal and development process (with KSF embedded in it).

2. Is the KSF primarily a developmental or a pay-related process? We would support making the KSF unequivocally a support system for staff development. If any pay link is retained then this should only occur at the second gateway.

3. Is the KSF to be implemented as *"tablets of stone"* or used flexibly *"as a supporting framework"*? We believe that KSF needs to become the latter, for people to use and adapt because it is useful and saves them time and effort, rather than because they feel that they are forced to. Trusts should in future adhere to and be able to 'buy in' to the approach at a number of levels:

   □ at a minimum to adhere to the core principles of the KSF;

   □ optionally to use an improved KSF process, or to use an alternative which meets certain common standards. National frameworks could also be developed to address necessary differences in practice efficiently, for example, how the KSF could be applied in a team context.

Recommendations

Our recommendations are classified into three categories. These are to:

1. Clarify the strategy, policy direction and principles of the KSF and related appraisal and development processes.

2. Simplify the design and streamline the KSF components, paperwork and process, while also supporting greater flexibility and adaptation to suit local circumstances.

3. Increase and improve support to deliver the principles of KSF into operating practice at the local level.

The specific changes recommended under each heading are described below.

Recommended Changes and Actions

Strategy: Clarify the policy direction and principles of the KSF and related appraisal and development processes.

1. **Either** define and promote a new integrated appraisal and development model approach, that can be tailored and adapted locally; or clearly specify how the KSF and PDR/P ideally should link in with other aspects of performance management.

2. Ensure in either case a new 'front end' of trust and personal objectives on the KSF process.

3. Update the KSF principles and specify that all AfC staff should have a two-way appraisal discussion and PDR/PDP at least once per annum, and KSF or an equivalent competency framework needs to be an integral component. Clarify the common aspects of the national framework and those which can/should be tailored/adapted locally.

4. **Either** remove the direct link between KSF and pay, or make it only operate at the second gateway point. Produce more specific guidance on when and how increments can be withheld.

5. Conduct work nationally to facilitate links at the local level between use of KSF and other CPD, revalidation and training frameworks and initiatives.

6. Strengthen accountability. Senior national NHS figure to write to all trust chief executives to reinforce need for all managers and staff to have appraisal and PDR/P using KSF or similar quality framework, and establish this as a KPI for trusts. Work to improve monitoring arrangements eg through specific question in National Staff Survey

Design: simplify and streamline the KSF components, paperwork and process, while also supporting greater flexibility and adaptation to suit local circumstances.

1. Make explicit that the specific dimensions are optional and decide if the core dimensions are to be compulsory or voluntary. If voluntary, decide whether and how some type of quality approval process for alternative competency frameworks might operate. Focus on the core dimensions moving forward.

2. Review and refresh the core dimensions. In particular consider the need to incorporate more behavioural language/criteria and possibly re-brand them as competencies; whether a leadership/management dimension should be included; and whether the equality and diversity dimension differentiates adequately.

3. Consider moving from levels and detailed examples of each dimension to a simpler indicators/contra indicators format. Move away from detailed examples of application in post outlines and in PDRs, relaxing the requirement for each

example to be evidenced in favour of a broader, all round assessment of competence/contribution.

4. Design a compressed/shorter, summary post outline format. Develop model national band outlines and suggested post outlines for the most numerous jobs. Longer-term, consider the integration of job profiles for evaluation purposes and the KSF post outlines.

5. Form a small national working party to update/improve/streamline the KSF/PDR/P paperwork as a whole.

6. Make explicit that flexibility from year to year and between different types of job is desirable within the national KSF framework, rather than not permitted. In particular emphasise the need for quality two-way conversations.

7. Develop a team- based adaptation of the KSF and PDR/P process.

Operation: Increase and improve support to deliver the principles of KSF into operating practice at the local level.

1. Produce national training packages for KSF/appraisal for managers and staff that can be used/adapted locally.

2. Produce a series of communication and operating guides to the KSF process which can be used/adapted locally, targeted specifically at:

   - boards and chief executives (why it is important, how to achieve high coverage)

   - reviewing managers (route map through the process, do's and don'ts, tips)

   - staff (how to use it to best personal advantage).

3. Continue with improvements to the functionality and flexibility of the e-KSF. Target marketing of it to trusts that are already improving coverage of appraisal/KSF. Consider the development of a range of alternative and simpler administration options eg using existing HRIS, spreadsheet packages etc.

4. Develop and promote national operating best practice guidelines eg no more than 10 staff reviewed by any one manager, reviewing managers have to be trained, etc.

5. Establish a re-launch communications campaign with national material development but emphasis on regional and local delivery. Follow up with regular progress reports and guidance in newsletters, etc. Develop and provide model communications packs for managers and staff to use on appraisal/KSF.

6. Refresh the structure and resourcing of KSF support and decision making. Create smaller, more focused implementation teams with clear targets for increasing coverage and quality of the KSF/appraisal process. Attempt to increase resources at the local level and encourage and promote web-based, self-help networks. Promote regional 'buddying' of high and low coverage trusts and creation of regional 'hit squads'.

Next Steps

In order to move forward we would envisage two further work phases being involved:

■ a re-design and development phase; followed by

■ a re-launch, communication and implementation phase.

Immediate next steps might be as follows:

■ Discuss, agree and prioritise recommended changes at national level with all stakeholders. Develop detailed development and implementation plan.

■ Reform national KSF structure into a tighter policy group and series of small action teams, with one focused on the re-design recommendations and one on the operating improvements.

■ Each team is briefed on the nationally agreed changes and then works through an intensive and compressed process of approximately three meetings to work up the agreed recommendations into actionable proposals.

■ Policy group agrees and integrates proposals and agrees final implementation plan. It also establishes success measures and monitoring arrangements for the revised KSF process.

■ Re- launch campaign and communications, probably with phased implementation of the changes.

1 Introduction

1.1 Background and Aims

The NHS Knowledge and Skills Framework (KSF) is the personal and career development and progression strand of the Agenda for Change (AfC) reforms that were made to the NHS pay systems for non-medical staff, the national implementation of which commenced in December 2004.

The KSF is a generic competency framework that was intended to: define and describe the knowledge and skills that NHS staff need to apply in their work to deliver quality services; provide a single consistent framework for staff reviews and development; and influence the pay progression of non-medical staff. Other key principles were that it was intended to be equitable, capable of linking with other competency frameworks and simple and feasible to implement.

While the job evaluation and banding aspects of the AfC reforms were completed relatively swiftly, progress on the implementation and use of the KSF aspects has been slower than and not as widespread as had been expected by the national stakeholders, despite the fact that they are part of the national collective agreement.

Several reviews of the implementation of AfC have been commissioned since then, highlighting the slow progress and various barriers to full implementation, while also emphasising that the full benefits of AfC will not be realised without the KSF. The KSF process has been re-launched, yet progress apparently remains slow, leading some to criticise the system and question its ongoing value and practicality. A brief chronology of events concerning the KSF is presented in Table 1.1.

The parties on the Executive of the NHS Staff Council therefore agreed to undertake a joint review in partnership of the workings of the KSF and its associated development review process in England. The Institute for Employment Studies were commissioned to carry out this independent review in July 2009, and

this report presents the major findings and recommendations from the study that they have undertaken.

The overarching objectives of the review were to identify the barriers to the successful implementation and use of the KSF, and to make recommendations for change and improvement to support widespread adoption and effective usage. In particular IES were asked to consider:

■ the format of the KSF and allegations of complexity and impracticality;

■ whether the KSF can effectively be used to identify the training and development needs of staff of all types working at all levels;

■ how the KSF is and can be effectively linked with local appraisal practice;

■ the views and real-life experiences of managers and staff;

■ whether there is any trade off between simplification of the KSF to aid take up and the quality and benefits of using the process.

1.2 Work and Report Contents

This work has been overseen by a Project Management Group with representatives from the Department of Health, NHS Employers and trade unions, which has met on a regular basis. A larger Project Reference group of employer and trade union representatives has also provided valuable insights and perspectives to the IES researchers.

The major stages involved in the review have been as follows.

1. Project planning with NHS Employers and the Project Management Group in August 2009.

2. Stakeholder Interviews. With a process that has been in place for over 4 years, there is a wide range of experiences, views and opinions on the KSF and it has been vital to tap into this knowledge as part of this review. A summary of the findings from the many interviews and group discussions we have carried out is contained in Section 2 of this report.

3. Literature and Good Practice Review. A body of research has also already been carried out on AfC and the KSF and we have reviewed a wide range of academic and practitioner literature about the KSF as part of this review. We summarise this literature in Section 3 of the report, as well as placing this in the wider context of contemporary trends and experiences with similar processes in other large UK organisations.

4. Initial Case Studies. On the basis of their rates of appraisal and KSF coverage, we selected from a group of 'high coverage' trusts five which gave us a reasonable spread of different types of NHS employer. We visited each trust for a day, met with directors and managers and staff. Our aim was to find out how they had achieved high coverage of appraisal and use of the KSF, the barriers they had faced and how they had been overcome. We asked for their advice for other trusts which have been less successful in using the KSF. We also included a PCT in this phase of the research. These findings are presented in Section 4.

5. Second Five Case Studies. In a similar manner, we then visited a second set of trusts with much lower KSF usage and appraisal coverage as identified in national statistics. We discussed the barriers they faced and found that most had already taken actions to address the situation which we recorded. These experiences are summarised in Section 5.

6. E-survey of NHS Trusts. In order to test our emerging ideas on a broader basis, we surveyed a much wider sample of NHS trusts and stakeholders in November 2009, focusing on the major barriers to progressing the spread of KSF and the key actions required to make this happen. The survey results are summarised in Section 6.

7. We then summarised all of our findings, drew out the key implications and developed a series of recommendations to address the identified issues, which are contained in section 7.

The report was drafted in January 2010 and is designed to act as a basis for discussion and the agreement of a practical action and improvement plan by relevant parties.

Throughout the process of this review we have been impressed by the commitment and energy of the many managers and employees that we have met, however critical they are of the current KSF, to address this set of issues and ensure that in future all NHS staff have effective appraisals and personal development. We would like to thank all of these people for their considerable enthusiasm, energy, ideas and input, which have provided us with the bulk of the content for this review. We would also in particular like to thank NHS Employers for their excellent support in carrying out this research.

Table 1.1 Chronology of Key Milestones for Agenda for Change and the Knowledge and Skills Framework

September 1997	Exploratory Talks on a new NHS pay system began
December 1997	White Paper on modernising the NHS was published
February 1999	*Agenda for Change: Modernising the NHS Pay System* was published
December 2002	Framework agreement published
January 2003	Agreement and three year pay deal announced
June 2003	Early implementer sites began to implement AfC in England
December 2004	National roll-out of AfC started in England
September 2005	Original deadline for assimilating staff onto new pay and conditions
October 2006	Original deadline for implementation of KSF
2007	Kings Fund Review of AfC, *Realising the Benefits,* published
November 2007	DH in partnership with trade unions re-launched KSF. By then, 41% of staff had had a KSF development review in the prior 12 months
May 2008	Parliamentary Under Secretary for Health Services writes to all trust chief executives emphasising the need to fully implement the KSF. By Autumn 2008, 54% of staff had received a KSF development review.
January 2009	National Audit Office report on Agenda for Change published.
June 2009	House of Commons Public Accounts Committee publishes report, *NHS Pay Modernisation in England: Agenda for Change*
July 2009	IES commissioned to carry out current review and report

2 Stakeholder Interview Findings

2.1 Introduction

With a system that has been in place for over 4 years now, and with a wide range of experiences and publicised opinions and views on the KSF, engaging with and learning from key stakeholders has been a particularly important part of this project. Without some measure of agreement on the current issues and what needs to be done to address them, then it is unlikely that any improvement plan will be fully successful. In this section, we summarise our findings from these interviews.

Prior to our field research, we interviewed 29 people and also held a number of group discussions with another approximately 50 people representing the full range of interest groups and experiences with KSF, including

■ representatives on the Staff Council, Project Management Group, KSF Group, SHA KSF group and Project Reference Group;

■ relevant staff at the Department of Health and NHS Employers;

■ a sample of major trade unions and of the professional bodies;

■ a number of Trust chief executives and HR directors in the field;

■ health regulators and other knowledgeable and influential bodies.

Many also provided us with supplemental information and the written views of colleagues. The full list of interviewees is shown in Figure 2.1 below.

Figure 2.1: List of Stakeholder Interviewees

Organisation	Contact
NHS Employers	Geoffrey Winnard – Head of Agenda for Change, Gordon Fleck – Project Manager KSF Review, Janet Thacker, Norma Bateson
Unison	Mike Jackson, Senior National Officer
Department of Health	Julie Badon – Section Head, Education, Commissioning and Quality
	Carl Vincent – Deputy Director Education Policy Branch
	Simon Arden-Davis – Deputy Branch Head Pay
Royal College of Nursing	Josie Irwin, Head of Employment Relations and Gary Kirwan, Senior Employee Relations Adviser
GMB	Sharon Holder – GMB National Officer for the NHS
Nursing and Midwifery Council	Meriel Hutton, Interim Head of Quality Assurance
Chartered Soc of Physiotherapists (CSP)	Penny Bromley, Research and Policy Manager
Health Professions Council	Marc Seale – CEO and Michael Guthrie – Director of Policy Standards
KSF group	Group meetings
SHA KSF leads	Group meetings
Trust CEOs	Matthew Kershaw – CEO and Alan Denton HRD Salisbury NHS Foundation Trust
	Andrew Foster, Chief Executive Wrightington, Wigan and Leigh NHS Trust and former Director of Workforce, NHS
HR Directors	Mary Douglas Head of L&D Salford Royal NHS Foundation Trust
	Danny Mortimer, HR Director, Nottingham University Hospitals NHS trust
	David Amos HRD UCLH (currently seconded to Cabinet Office)
	Ali Mohammed HRD St Bartholomews and the London NHS Trust, who chairs the Association of UK University Hospitals.
Care Quality Commission	Karen Wilson, Senior Policy Lead – Effective Care
Skills 4 Health	Anne Eaton, Director Standards and Qualifications Strategy
Think Associates (eksf)	Tim Newham, Director
Consultant to the KSF group	Lindsay Mitchell
Country KSF Leads	Anne Campbell (Scotland), Robin Arbuthnot and Francis Douglas (Northern Ireland), Deb Lomasney (Wales)

The interviews were held either in person or by telephone and followed a defined structure, progressing through:

■ the history of KSF;

■ the current situation;

■ what action is required to improve the spread and quality of application of the KSF.

Each interview typically lasted around half an hour, with the group discussions generally taking more than an hour.

Clearly a wide range of opinions were expressed and the interviews were held on an individually confidential basis in order to encourage openness in the views and ideas discussed. In this section we therefore attempt to summarise the most widely shared and common views amongst the majority of our interviewees, as well as highlighting where opinions appeared to be most sharply divided. We use anonymous quotations where possible to emphasise some of the points made.

We would just emphasise that the views expressed in this section are those of the interviewees themselves and do not necessarily reflect the views of IES.

2.2 The History and Development of the KSF

Our interviewees provided a very consistent set of descriptions of the development and implementation of KSF, even if there was much wider divergence in the opinions on the causes and importance of specific barriers and difficulties. It was a set of circumstances which has meant that as one interviewee put it, *"KSF has never really been given a proper chance"*.

Key stages mentioned to us included:

□ the development of KSF by a central team with limited input from the field, and with some very optimistic assumptions made about the extent of coverage and of the quality of performance appraisal and development planning and delivery across the NHS – *"there is often a weak appraisal culture, especially in the lower grades"*;

□ the abandonment of a parallel project to develop a national performance appraisal approach across the NHS – *"it was developed in isolation"*;

□ the overwhelming attention devoted initially to developing and then implementing the job evaluation and grading structure aspects of Agenda for Change in a fairly centralised manner, somewhat at the expense of the KSF aspects;

☐ once the grade structure had been implemented, a series of reorganisations across the NHS, the restructuring of SHAs and devolvement of responsibilities to the local level, creating disruption to attempts to implement KSF, and a general devolvement of power and responsibility which effectively weakened the ability to centrally 'push' KSF implementation;

☐ and more recently the major budget deficits which put pressure on training budgets and weakened the emphasis on personal development initiatives.

"There was organisational exhaustion".

"Senior managers, SHA's, trade unions at the local level, nobody has given it sufficient priority".

"NHS organisations didn't see training and development as a priority in the implementation of AfC: the focus was on pay … they put KSFon the back burner".

The two re-launches of KSF designed to re-prioritise it and speed implementation more widely were generally described as relatively weak and *"half-hearted"*, with little obvious sense of priority in the wake of other competing initiatives and a lack of sanctions for failure to comply in implementing this aspect of the nationally agreed terms and conditions.

"The relaunches didn't deliver a streamlined system, people are cynical, think it's a dead horse".

"It has a tarnished reputation".

The nature of the link of KSF to pay progression was also often described as a problematic issue, with initial suspicions that it might be used as a tool to restrain pay growth meaning that the progression criteria were so weakened that as one put it, *"it has meant the KSF has no link to pay progression which in practice is automatic,* and another *"the pay gateways are not effective".*

"A hard link to pay would have given it more teeth".

Some interviewees also referred to a wider lack of trust and suspicions about the system initially, possibly being used as a way to restrict training spending as well as pay progression. This was felt to have increased the complexity of the design and implementation.

"We over-complicated it from the start".

"Some worried that it wasn't specific enough, others that it would be used as a management tool to hold pay down".

"There's still confusion about the link with pay … in practice it's ignored".

Views on the eKSF were quite polarised, with a minority of users describing it as a very effective administration tool heavily used by "converts", but the majority characterising it as cumbersome and slow in explaining the very limited take up, alongside of the difficulties of access for particular staff groups. In particular the development of the Electronic Staff Record system alongside it was described as being poorly integrated, and a period when the two systems were presented as being in competition particularly unhelpful.

"Unfriendly and complicated".

"It can be slow and there are access issues for some groups, but basically it's a good administrative tool".

"The eKSF is a secondary issue".

2.3 The Current Situation of KSF

2.3.1   The Principles

All of our interviewees unequivocally and unanimously supported the principle that all NHS staff should have some type of regular appraisal and development discussion, in which the skills and knowledge that they need to do their jobs and develop their careers are specified and plans made and actions taken to develop those skills. There was also agreement that at present this does not take place anywhere near universally and so both the quantity and quality of such discussions need to improve. Some described the incidence of appraisal and use of the KSF as having *"plateaued"* and some even described it as *"going backwards"* in certain important respects.

"Something like KSF has to be a good thing".

"Appraisal is a powerful tool".

"The principle is good, the execution does not work".

"The NHS generally is weak in respect of non-mandatory training and development".

"It's part of a much wider failure with non-mandatory training which can have serious consequences for delivering safe and effective care".

"Support for staff to fully develop their skills and contribution generally is not good".

2.3.2 The Issues

The patchy coverage and varied application of KSF by occupational groups was also described by almost all interviewees. KSF was felt to suit some of the professional groups, such as the physiotherapists and pharmacists which already had a history of appraisal and experience with competency frameworks. By contrast, it was regarded by a number of interviewees as being difficult to apply to two groups in particular:

☐ lower graded staff where there was felt to be much less experience with appraisal and development planning; *"it is too complex and deep for those who have been in these same roles for many years"*.

☐ management staff, due to the absence of any management or leadership dimensions, – *"KSF does not suit leadership roles"*, *"even a simplified KSF doesn't' suit executive roles, they work from objectives"*.

"It's tougher for those with no experience of appraisals".

"KSF is more suitable for some groups than others, but there is a big issue about the general level of understanding of staff and managers".

Some felt that even for the professional roles, the system fell between the two sets of requirements of neither being a simple enough common approach, or being tailored sufficiently for staff in different occupations to relate their tasks and skills to it effectively and easily.

"Can they see enough to do with nursing in it, in the language, to justify the time and effort involved?"

"It works for us because of the effort we have put in to making it real and understandable for people, and because we apply it very flexibly".

"Staff need to be able to identify it properly".

Diametrically opposed views were evident in terms of how this could be achieved and the extent to which the design of the KSF was a help or a hindrance in this process.

Some felt that the KSF was a well-designed and tested system which suffered from low prioritisation, bad implementation and execution. They tended to emphasise as the major barriers to the effective expansion and use of the KSF:

☐ the lack of central drive to implement and absence of sanctions; the NHS in Scotland was often cited as an example of how stronger enforcement from the centre rapidly increased usage; we were also given some examples of

how increased pressure could be applied, for examples SHA's making project funding conditional on KSF;

☐ the low level of seniority of those with KSF lead responsibilities in some trusts –*"lack of seniority and lack of priority locally"*,

☐ the weak appraisal and line management skills in many NHS organisations.

"It is a part of the nationally negotiated system, people have to use it … we shouldn't be making it seem optional".

"We need to dispel the myths that it's too complex".

"The quality of management is questionable in many settings".

"Trusts haven't resourced it properly".

The majority of interviewees, particularly those in operational roles, regarded the KSF as an over-engineered and excessively detailed, overly generic, complex and bureaucratic process which is difficult to understand and to put into practical effect, and was insufficiently related to the goals and needs of each trust and occupation. The issues were described much more in design terms in respect of:

☐ excessively lengthy post outlines,

☐ an excessive and confusing number of dimensions,

☐ a *"paper-chase"* of evidence gathering and presentation,

☐ a lack of flexibility to vary the process, to *"miss out"* some parts and focus on others, according to the nature of the job-holder, and varying demands and needs on individual job-holders from year to year,

☐ the absence of a clear link to appraisal in the KSF process, and particularly the process of setting individual objectives in the context of Trust and team priorities and goals;

"It just takes too long".

"Many feel it's not a good use of their time with so many other priorities".

"The language and guidance is impenetrable".

"It results in a great thick file that doesn't fit people's needs".

"The evidence becomes an end in itself, not a means of facilitating a conversation about development, which is what it should be".

"The post outlines have developed a life of their own … not well done in most Trusts".

"It's just too big and unwieldy".

"Too many dimensions, too many layers, too many levels".

"We couldn't see where KSF fits into the work on improving performance across the Trust".

"We encouraged people just to get something usable, to get started. not every element of every dimension has to be in place … but there was a fear that every little variation had to be negotiated, people were scared of the process".

"The level of detail and all the consistency checking between staff in grade is too much".

"The core dimensions are fine, it's then selecting further specific dimensions that people find hard".

"They say, if the dimension doesn't say 'nurse' then it's not for me".

"Beyond the core dimensions people get lost or prefer their own frameworks".

"Too many people are over-complicating it, making it too complex and bureaucratic".

"There are too many examples of 30 page post outlines and the like".

"Job outlines are too complicated and disconnected from job descriptions … the link to appraisal isn't clear enough".

The vast majority of interviewees commented on the operational difficulties for carrying out any process of this type, such as the lack of management and review skills across the NHS, wide spans of control of 20 plus staff for some managers and supervisors, the limited influence of some reviewing managers on training expenditure, geographic separation, etc.

"Middle managers are being asked to do the impossible".

"It is hardest to apply in ambulance trusts".

2.3.3 Improvements

KSF was generally held to have been applied successfully by our interviewees where some of the following conditions were in place:

- □ a senior management team that gives it priority/a new senior management cohort; *"leadership is critical to KSF and getting appraisals done".*

- □ where work has been done to link KSF to other aspects of development such as professional and occupational standards;

- for some, where the approach has been simplified, edited and made more flexible; – *"the people who have made most progress have simplified it, reduced the dimensions"*;

- where it is supported by effectively trained managers.

Linking in with other performance management and development processes was generally seen as a positive way in which the KSF could be made more relevant and effectively applied. However, many interviewees also referred to "competing" competency and development initiatives and frameworks which were liable to confuse people and take their attention away from KSF.

"They could have done a better job in pulling the professions in behind it".

"It was never clear enough how it linked to appraisal and work objectives, there was no real link to the job specification".

"We need to do a better job of hooking it in to other NHS initiatives".

"The talent plan barely mentions KSF".

"JIF was a perfect (missed) opportunity to reinforce KSF".

2.4 Learning from the Other Countries

Our interviews with the national KSF leads in Scotland, Wales and Northern Ireland highlighted the different approaches that had been taken to the implementation of KSF. But they also reinforced some of the learning and implications drawn from the experience in England. In particular we noted:

- Targeting KSF implementation for NHS trusts (and equivalent eg NHS Boards in Scotland) and chief executives was generally felt to have been an effective approach in increasing coverage, although concerns about the quality of PDRs remain. In Scotland for example a target of 100% completion for PDPs was set for March 2009 and this had been achieved by July.

- NHS reforms and reorganisations have disrupted implementation, but also highlighted the inconsistencies in, for example, the KSF post outlines for the same jobs and different assessments of the levels on various dimensions in different locations. Common template post outlines and simplified dimensions and levels with a focus on the core dimensions could therefore, it was felt, be a way forward.

- Generally the views expressed were that the KSF was too complex and needed greater standardisation and simplification but not radical changes. Many of the interviewees were *"loathe to back track"*, but reinforced that simplification, such

as a focus in the future on the six core dimensions, might help to improve the operation of the process.

- Practical operating barriers at the local level were highlighted – dealing with large numbers of flexibly employed and temporary staff, securing access to computers, helping managers make time to carry out reviews, etc.

- Because of their smaller size, the other three UK countries felt that they were better able to share best practice and reduce unnecessary duplication, possibly pointing to a way forward in England.

- Evidence on the benefits of the KSF needs to be compiled and promulgated. Northern Ireland for example is working with Richard Griffin at London South Bank University to evaluate the six core dimensions against productivity metrics and levels of staff attendance.

- The paperwork and language of the KSF and guidance on it could, it was felt, be improved further.

- Linking the KSF to related performance management and training and development processes was seen as vital. In Northern Ireland in Bands 1-4 KSF has been linked to the opportunity for staff to work towards an NVQ level 2 qualification, and the KSF is being anchored in a wider Personal Contribution Framework including a personal contribution plan. In Wales it was positioned as part of the whole e-learning management system

- Improved manager and reviewer training is key to improving the quality of the application of the KSF, as lack of reviewing manager competence and competence is a key barrier to improving quality.

2.5 Future Needs and Desirable Outcomes of this Study

"Trusts have to cotton on to the fact that if staff do not have the required skills and knowledge then their delivery of care will suffer".

"It needs bringing to life".

"I don't want it to disappear altogether but it has to be simplified".

"It has to be different to now".

"We need a completely fresh approach".

"It has to be seen as part of a bigger picture".

"We need both stick and carrot"

"We have to change the culture, not just the system".

"It needs more clout behind it".

"There needs to be a more fluid approach … you don't need to spend four hours capturing every element of your job and including every dimension".

"Getting something real and workable in place is more important than covering everything in great levels of detail".

"*It needs to be more flexibly applied. We've learnt a lot over the past four years and a lot has changed in the NHS over that time. We need to be able to reflect that in how we take KSF forward".*

"A big questions is the DH's role in this going forward, who leads the policy on this?".

"You can't just beat up people for not doing it".

"The outcome not the input needs to be the focus".

"We need fewer, simpler and more integrated building blocks".

"Slim the elephant down".

"People have got to identify with it".

"Consider rebranding it".

"We have to do more to engage the people who aren't using it rather than just communicating with those who are".

"Make sure something happens, take away all the excuses"

"A looser common framework with local ownership".

"What's needed is a more realistic middle ground".

"What's really needed is a way of engaging managers and staff".

"To really embed KSF it would have to be strictly linked to the pay system".

We received many ideas and suggestions to extend and improve the application and operation of the KSF, as illustrated by the range of quotations above. It is important to note that almost everyone we spoke to, however critical of the KSF, supported the concept of a common NHS-wide approach and the need for at least a minor degree of change to KSF and its operation, for reasons including the needs to:

☐ support career development across the NHS, not just within single employers;

□ ensure the total NHS training spend is co-ordinated and invested in the best possible manner;

□ avoid duplication and everyone "re-inventing the wheel" by designing their own system at address a reasonably common set of needs;

□ ensuring that the development planning and delivery process does actually occur.

"We would be worried about Foundation Trusts declaring UDI on it".

While views on the current KSF as the foundation for this common approach differed widely, our interviewees could broadly be categorised into four groups in respect of both the level and the nature of reform:

□ the 'Revolutionaries' argued for a radical overhaul of the whole KSF design which some described as itself a barrier to the extension of good appraisal and development practice, while the majority of 'Revisionists' favoured a lesser degree of incremental change to reflect changes and learning over the past four years; almost nobody felt that no change was required and the majority felt that at least minor changes in all the aspects of strategy/positioning, design and operation would be necessary;

□ the 'Simplifiers' emphasised the need for the simplification of the KSF design and process to match the realities of life on the ground in the NHS, while the 'Implementers' were much more likely to support the existing approach but emphasise the need for action on enforcement and local-level implementation.

The Simplifiers suggested changes including:

□ reducing the number of dimensions, and allowing greater flexibility to focus in on the ones most relevant to each job-holder, and even to add any others which are relevant; some supported tailoring KSF more to each profession and occupation – *"if KSF was less generic and cumbersome and more targeted then all the career and development dimensions could be better integrated;.*

□ radically reducing the number of, and content contained within, the post outlines;

□ allowing flexibility in how the process is applied from job to job and year to year;

□ and the ability to tie it more closely to specific Trust needs;

□ having a "lighter touch" process every other year and/or at lower grades;

□ focusing on the training and development planning and delivery aspects;

"KSF has to be made usable for those on the ground … at the moment it is just impractical".

"Make it easier to happen".

"We've got to convince people that it is, and make it more, user friendly".

"It's clunky and laborious: it needs to be smooth, simple, quick and easy".

"A new simplified appraisal system".

"There's not a lot wrong with it but there has to be some changes and simplification as a result of this review".

"We need to make it more usable and avoid people opting out, so nobody has any excuse not to use it".

"Show the successes, how a porter or nurse got promoted though the KSF".

"We need a flexible attitude – if in one year you want to focus on one dimension, that's fine. The KSF doesn't really encourage this kind of flexibility and it should, and the eKSF doesn't enable it, but it should".

"Dimensions that aren't so catch-all, and more specific".

"You shouldn't have to put evidence against all the dimensions every year".

"Do a lighter touch version every other year".

The Implementers emphasised the need to address:

☐ leadership priorities, with a stronger central "dictat" and "big stick" approach described in Scotland recommended by some as being what is also required in England, *("the desirable approach until managers realise it's important and have the skills to do it"),* and harsher penalties for non-compliance eg non-registration or training budget withdrawal – *("we need higher-level central drive, not letters from junior ministers");* opponents of this approach argued that it was inconsistent with the devolution of authority to the local level – *"we shouldn't be in the business of telling them how to manage their inputs, we have to make organisations more responsible and accountable for delivering patient care"; "being prescriptive won't help as most people will find a way around it".*

☐ greater targeted support to help struggling Trusts and/or locations, as occurred with the job evaluation aspects of AfC implementation, from good practice locations for example;

☐ improved and simplified guidance and implementation support, for example phasing implementation in a location;

□ better recognition, publicity and promotion of the uses and successes with KSF;

□ local line manager skills enhancement through training (which in fact was mentioned by many interviewees, whatever their views on the KSF design);

□ gathering and promoting good practice examples showing a link between the use of KSF and performance and care outcomes, such as improved communications, lower complaints, etc.

"All organisations who signed up for AfC should be using it".

"Organisations say they don't use it as they have their own approach, but that's usually just an excuse".

"Those who have got to grips with it have found it a good tool".

"Networking groups are needed where people can learn good practice from one another".

"Give special attention to bands 1-4; professional groups are used to managing their own CPD".

"There needs to be training focused on 'how to' support".

"We have to address the soft appraisal skills of managers".

"There needs to be a link in to other training initiatives, so it's not seen as something else on top".

"We need to phase implementation and give more local support, like with the job evaluation".

"Train, train, train the appraisers".

"Invest heavily in appraisal skills".

"We have to make staff make better use of it with training and development".

"A much more specific and smaller set of guidance".

"Make much clearer links to appraisal in the guidance".

"It's not about the process but improving services".

Almost all interviewees agreed with the need to integrate KSF more effectively with other NHS, HR and particularly competency and development initiatives, and many mentioned all of the work underway on revalidation and CPD as an opportunity to link in with the KSF and reinforce its application to the relevant professions.

"It has got to be seen to be reinforcing QIPP".

"A way to incorporate CPD, revalidation and KSF".

"The KSF should be used in revalidation".

"Consider withholding money for CPD unless they are KSF compliant".

"We need it to dovetail with national occupational standards".

A number of our interviewees also mentioned the need to focus in future on the developmental and PDP aspects of KSF, rather than on the link to pay and the post outlines, both as being the most important aspects of the process and the ones where there would be most evident return for a given and realistic investment of time.

Many interviewees also spoke of the need to be realistic in the current and future economic climate and to make recommendations and changes which were practical and affordable.

"We've got to recognise we are in a devolved NHS and be pragmatic, realise that there isn't a fortune to spend on it, help managers and staff to use it and use it sensibly".

"We need board level buy in with a much more pragmatic approach to implementation".

2.6 Section Summary

We interviewed nearly 30 stakeholders during the course of our research, and held group discussions with almost twice that many, with a specialist interest, skill or stake in the KSF. The interviews were held in order to build up an understanding of their experiences with and views on the process, what any issues with it are and what improvements they feel are needed, prior to our field research.

In terms of the history and development of the system we heard a common story of a strong job evaluation focus to the implementation of Agenda for Change, followed by a series of reforms and re-organisations which disrupted the implementation and progress of the KSF.

Support for the principles of KSF was expressed virtually unanimously by our interviewees. There was also a common view that the current "patchy" implementation of it was unacceptable and that some degree of change to the KSF was required. But there were widely differing views on why this situation had come about, and on the level of necessary change.

The majority, 'the Simplifiers' as we have termed them, felt that the KSF was an over-engineered and excessively complex and bureaucratic process which is difficult to understand and to practice. They argued for solutions including shortening the post outlines, reducing the number of dimensions and allowing for much greater flexibility in the application of the process from job to job and year to year. The more radical amongst them argued that the KSF was now so tarnished that it needed to be replaced by alternative, simpler and locally developed approaches, but this was very much a minority view.

'The Implementers' on the other hand felt that the KSF has suffered from low prioritisation, bad implementation and execution, and lack of incentives and sanctions for non-compliance. They advocated holding chief executives more closely to account for implementation and looking at other penalties for non-compliance such as reducing their training spend; greater support to help struggling trusts; improved guidance and implementation support such as line manager training; and better good practice sharing.

Focusing on the practicalities, the KSF was felt to have worked well where senior management genuinely made it a priority, where the approach had been made more understandable and flexible, where work had been done to link the KSF to other aspects of development, and where it was supported by effectively trained managers and reviewers. Many interviewees also spoke of the need to be realistic in the current and likely future economic climate and to make recommendations which are practical and affordable.

3 Literature and Practice Review

3.1 Introduction

In the four years since implementation, there has already been a considerable amount of research and reviews of Agenda for Change carried out, and this has included consideration of the Knowledge and Skills Framework. It has been important on this review, therefore, to draw on this literature and avoid 're-inventing the wheel' so to speak with our current research.

In this section we attempt to summarise some of the learning derived from these studies in terms of the barriers to and possible means of progressing the widespread and quality application of KSF. We also attempt to place this learning in the context of more broadly-based experiences with and trends in performance appraisal, competency and skills frameworks and development planning amongst other large employers.

We have carried out a brief literature review of academic research and studies carried out to date on AfC and the KSF, as well as a wider practice study of relevant trends using in-house IES research and other relevant national surveys and studies.

In line with the nature of our research proposal and specification, the following questions are addressed in this literature review:

- What is the background to AfC and the Knowledge and Skills Framework(KSF) and where are we now with the use of the KSF?

- Why has there been a lack of progress in implementing the KSF across all Trusts?

- What are the barriers to implementing the KSF fully?

- What are the possible solutions to the slow progress in implementing KSF?

■ What are the wider trends and what appear to be the keys to success in effectively implementing competency and skills-related performance management and development systems?

3.2 Background and History on Agenda for Change and the KSF: The Potential

Although driven in many respects by the recognition that the long-standing Whitley Council pay scales had outlived their utility, Agenda for Change (AfC) was always intended to be far more than just a new pay system. The Department of Health announcement in 2002 made clear the fact that, in addition to pay and banding, AfC also embraced aspects of working conditions such as job evaluation, appraisal, career development and career progression linked to the KSF. The Knowledge and Skills Framework was to be central to the scheme, with two "gateways" provided within each of the AfC career bandings to allow for pay progression contingent based upon the assessment of knowledge and skills.

As Edwards et al. (2009) have commented: *"There was also a clear expectation that the new KSF would be integral in steering annual development reviews and personal development plans. It would permit staff to receive clear and consistent development objectives, plus development opportunities linked to identification of the extra knowledge and skills needed for career progression"* (Edwards et al., 2009, p. 8).

The final agreement reached was that personal development plans would be implemented for all NHS staff, based on annual reviews against the KSF. These would provide an annual documented record of performance assessed against the KSF post outline. It should be noted however, that although AfC was introduced from 2004, the deadline for NHS organisations to implement this last component was extended to October 2006.

At the outset, there was enthusiasm amongst many of the professional groups regarding the aims and intentions of the KSF. For example, Beesley (2004),writing in the *British Journal of Perioperative Nursing*, explained the way in which the KSF was envisaged as working and the improvements this would bring, for both practitioners and patients. He wrote: *"The Knowledge and Skills Framework has been developed to support the consistent application of standards for all jobs in the NHS. Essentially it is a development tool which will provide the basis for pay progression within the eight pay bands which are integral to Agenda for Change. The KSF has strong links with a number of other skills-based initiatives, such as the lifelong learning framework in England, and it will be important in developing quality patient-centred care and service improvements"* (Beesley, 2004, p.249).

A year later, Crisp (2005), an assistant director of human resources in the North East London Strategic Health Authority writing in *The Nursing Standard*, stated

that *"By pioneering an NHS-wide system of annual development reviews and career opportunities for every member of NHS staff, the [KSF] framework is intended to support staff so that they can be as effective as possible in their jobs. It also gives them opportunities to progress and develop during their time in the NHS"* (Crisp, 2005). Since then, Gould, Berridge and Kelly (2007) have gone so far as to comment that, if found to be effective in the UK, the Framework potentially is of interest as a model internationally for nurse development.

But this potential does not appear to have been realised. In evidence submitted to the Public Accounts Committee (PAC), the body which examines government spending, Michael Griffin, Executive Director of Human Resources at King's College Hospital commented on the failure of KSF to be implemented across the NHS (PAC, 2009). He stated that KSF is *"a complex piece of work and it came in part way through the implementation of AfC. In itself it would have been a major piece of change to implement … coming straight on the back of AfC made it particularly difficult for Trusts to focus on it … "*.

However, in the evidence he submitted, Griffin also stressed the importance of ensuring the implementation of KSF, regarding it as an essential element of AfC and suggesting that *''one of the real areas of benefit comes from successful implementation. It provides a way of analysing our work. It provides us with a way of having performance management discussions with our colleagues. It provides a development framework within which people can plan their future careers. It has been a hugely important piece of work. The fact that it has been slow to be fully implemented is not a reason for despair but a case for greater perseverance in completing the implementation of it"*.

The aptly titled review from the Kings Fund, *Realising the Benefits* (2007) concluded that *"effective use of the KSF has great potential to improve staff productivity"*, but also that:

> *"so far, the costs of AfC are more obvious than the benefits … longer term benefits will not be realised unless more systematic efforts are made to facilitate and reinforce improvements in staff skills, roles and motivation, leading to improved patient care".*

3.3 Lack of progress

However, set against the initial enthusiasm in such quarters, much of the subsequent research has highlighted this disappointment at lack of progress in implementation of the KSF. In 2006 a survey of nurses found that less than a third of respondents, just 29 per cent, had a completed KSF outline for their post, while a further 23 per cent said that one was in progress (Ball and Pike, 2006). Some 37 per cent said that they did not have an outline.

A year later, Buchan and Evans (2007) analysed the NHS annual staff survey data and found that while by that time just over two-thirds (67 per cent) of staff had a full KSF job outline, nonetheless just a third (33 per cent) reported having a KSF personal development plan and only 27 per cent believed that they had received a development review using the KSF.

A further survey conducted by *The Nursing Times* in 2009 showed a continued lack of monitoring of the use of KSF, as some 15% of respondents did not know how many of their staff had appraisals in the last year, some 17% of trusts did not know how many staff had received a PDP after appraisals and 12% had no information on whether staff had KSF outlines (Staines, 2009).

The NAO's assessment of AfC (NAO, 2009) reported on progress made since the re-launch of KSF in November 2007. They found that the numbers of staff who had had a knowledge and skills review had increased by 13% to 54% over the 12 months following the research (which was conducted in August and September 2008), with more gradual increases reported in the NHS staff survey in the numbers of staff who had had an appraisal discussion (up to 64%).But in a survey of staff carried out as part of the research, only 18% felt that the KSF had helped improve how they did their job.

Like the Kings Fund, the NAO report concluded that *"for most trusts AfC largely stopped at the point when staff transferred to their new pay bandings"* and *"failed to grasp the development agenda to support staff working differently to deliver improvements to patient care and improved productivity in return for better pay"*. Therefore *"the KSF is key to realising many of the benefits from AfC"* more widely, and four of their six recommendations for full AfC realisation relate to the Framework.

3.4 Barriers to implementation

Ball and Pike (2006) reported that the main reasons given to explain the lack of progress on KSF reviews at that time were that the KSF was time-consuming to implement and that line managers did not understand it. This is perhaps understandable given that, as Parish (2006) has commented, *" … even a cursory glance at the 270 page document explaining the KSF shows it is an extremely complex system. There are six core 'dimensions' – categories of skills on which all staff are assessed. And there are a further 24 dimensions that could be used depending on the nature of the nurse's job"* (Parish, 2006, p.14).). Also some KSF outlines held on the e-KSF run to a minimum of 9 to 10 pages and can be more than 20 to 30 pages, which some employers view as far too lengthy (see Amos 2009 for example).

At the same time, Parish notes, NHS staff were told that *"the KSF has been designed to be a 'simple and easy to explain' tool"* (Parish, ibid., p. 14). Buchan and Evans reported that the KSF was built on the two principles: that it should be *"simple,*

easy to explain and understand" and be *"operationally feasible to implement"*. However, they commented that *"some argue the first principle has been lost and therefore the second has not been achieved"*, (Buchan and Evans, 2007, p.5). Faced with a document of the size and level of detail of KSF it is perhaps not surprising that staff reported *"an element of fear about the KSF, especially among healthcare assistants and other staff who are not used to appraisal"* (Parish, ibid., p.15). The complexity of the KSF has been described as *"unmanageable in practice for many managers and staff"* and it has been recommended that a simplification of the KSF locally is required (South West London Trust, 2008) in order to address this.

Employers' opinions on the current design of the KSF reflects some of the reasons for the failure in the full coverage of KSF across Trusts. It has been suggested, for example, that staff at all levels find the language used in the KSF *"impenetrable"* and that it is seen as difficult to get managers to produce individual examples of application for each KSF outline. Also as pay progression is automatic, except at pay gateways, the incentive for managers to ensure staff receive a performance review is reduced (Amos, 2009).

As a result – and again perhaps understandably given all the other changes and priorities within these employers- there appears to have been a general lack of confidence and understanding of how the KSF itself was meant to operate or be used. The National Audit Office report commented that some managers and staff viewed the KSF as complex and burdensome, while an earlier survey of unionised workers within the NHS, including nurses and allied health professionals, found there was uncertainty about the KSF and how it would work in practice (MORI, 2006).

In some cases there even appears to have been active 'scare-mongering' about the approach: for example, a presentation to a NHS Employers' annual conference in 2007 suggested that the KSF could be used to 'downgrade' nurses who had initially been placed on bands perceived as 'too high' for their clinical skills and ability (Harrison, 2007).

3.4.1 Communication

There is a general view evident within the research literature that in general the KSF had not been well-communicated. This does have to be set against evidence that some of the professional groups have very actively communicated information about the KSF (for example see Beesley, 2004; Ong, 2005; Pirie, 2005). Some, such as the Association of Perioperative Practice and Royal College of Nursing, have also sought in their communications to explicitly link the aims, objectives and learning outcomes of their own CPD modules to the KSF dimensions, (Milton, 2008).

However, whether the problem is a lack of communication *per se* or arises more from challenges in translating the Knowledge and Skills Framework into competency frameworks and/or practice assessments is unclear from present evidence. But there does appear to be a problem. While the KSF was designed to provide national benchmarks, these in turn require translation into competency frameworks (DH, 2003) and practice assessments for the different specialist groups. Reed (2008) has noted that one criticism of the KSF is that it is too broad, but that this is a necessary feature if it is to apply across all NHS jobs. Reed also observed that there are reports of variation in local interpretation of the KSF.

Because of the breadth of the KSF in applying to so many different occupations and roles, linking the aims, objectives and learning outcomes of development activities or programmes for specific professional groups to the relevant KSF dimensions still appears to be a challenging and resource-intensive process. Reed (2008), reporting on a university CPD programme developed at the University of Southampton for senior staff nurses and linked to the KSF, described how specific KSF dimensions were selected as targets for the development activities, but then *"required significant interpretation into practice-based performance"*(Reed, ibid., p.31). The translation into practice appears to have been quite resource-intensive: focus group discussions were used to enable the transfer of knowledge and skills into practice settings. However, once this had been undertaken, staff then saw the KSF benchmarks as *"achievable"*.

These issues with applying KSF to professional staff, as a number of authors and many of our research interviewees pointed out, can become yet more difficult when applying the process to lower graded non-professional staff, where there appears to be much less experience with carrying out appraisals and development planning, (see Amos, 2008 for example). As we shall see in later sections, most employers would apply this type of approach to all of their employees, but it will often be designed so as to be flexible in content and language to suit the needs of particular types and levels of staff. Thus a number of local authorities for example specify a maximum number of staff for any individual to appraise and for spans of control beyond that then team appraisals operate.

3.4.2   Resourcing

The implementation of the KSF undoubtedly requires, at least initially, a great deal of investment of staff time and effort. The PAC (2009) suggested that many individuals and managers are yet to be convinced that this effort is worthwhile. In the oral evidence to the PAC, a comparison was drawn between the resources required to implement AfC and those required to implement the KSF. Griffin stated *"implementing AfC involves a number of people but not the same volumes of people*

that are required to get actively involved with the KSF. There is a big investment in time and resource by every manager to make it work" (Griffin, PAC 2009, Ev.6).

Griffin also commented on the support needed for managers to ensure the success of the KSF, stating managers need to be encouraged to *"put in the effort … to put in the training to develop the programmes when they start"*, (Griffin, ibid.) in order to build a solid foundation of people who have implemented it who can encourage others to follow suit. Where the KSF is *"supported by Trust management, staff have been given sufficient time to prepare for annual reviews and with their managers allowed to develop the skills and the culture needed to conduct appraisals as part of wider performance management"* (PAC, 2009, p.13).

Morley (2007) reported on an action learning project at one of the early implementer sites for AfC which culminated in the development of a preceptorship programme for newly qualified occupational therapists. The programme that was developed is compliant with AFC requirements, linked to the KSF and draws on best practice relating to new practitioners. A range of components were incorporated, including the standards of practice and professional behaviour expected, the setting and monitoring of objectives, observed practice and constructive feedback, and the recoding of continuous professional development. The programme includes regular development review/appraisal and the tracking of progress against the NHS Knowledge and Skills Framework.

However, although development of the programme was viewed as a success (Morley, 2009), there was a view that the development required went beyond that needed to equip novice occupational therapists with the knowledge and skills set out in the KSF Framework. She notes that *"Any standards of practice would need to take account of the complexity of practice and to provide mechanisms of review and feedback that maximise opportunity for growth. This suggested that the preceptorship standards should extend beyond the narrow perspective of the NHS Knowledge and Skills Framework, which is mandatory, and reflect a definition of competence … which sees competence as a 'combination of knowledge, skills and professional behaviour'"* (Morley, 2007, p. 335).

3.4.3   Linkages to Learning and Demonstrable Outcomes

Reed and Morley appear to have been examining different sides of the same proverbial coin. While Reed looked at how the KSF sat within the overall professional requirements, Morley looked at the KSF requirements and explored how the other demands made of practitioners within their work environment added to the overall requirement for professional development. Understanding of how the KSF is contextualised within practitioners' wider responsibilities and

activities appears to be an issue that has to be addressed for each occupational group, and as these two articles suggest, this can be a resource-intensive process. Devolving this process down to local level rather than engaging with professional bodies to undertake this process at a national level means, perversely, that more, rather than less, resource is required, as the process is played out in different locations across the country.

As an illustration of the level of resource intensity that can be required at local level, Ruddle (2009) has described the process of implementing the KSF across all staff groups within a Learning Disability NHS Trust. Ruddle reports that it took five months to formulate outlines for each post in the trust, with a further three months being taken up with reviewing the post outlines and ensuring consistency. This work was undertaken in the absence of any additional resourcing to support KSF implementation.

There are of course good practice examples of working with KSF, as well as these barriers and difficulties that we are highlighting. The NAO report includes a selection of implementation case studies, and elsewhere implementation of KSF has been successfully linked to the other initiatives such as the Widening Participation agenda.

One example of this comes from Northern Ireland, where the Beeches Widening Participation Unit (set up to support Widening Participation in health and social care trusts) has used the KSF as part of the 'Unleashing Talent' initiative, aimed at introducing new learning approaches and programmes for Trust support staff and their supervisors. All reviewing managers and staff were trained extensively in the process, with a link also established to the award of externally accredited qualifications through the process.

An evaluation was conducted of the scheme by London South Bank University, which reported many improvements to support staff's skills occurring as a result. There is one noteworthy difference between the approach taken at the Beeches Unit and the approaches reported by other commentators: few difficulties appear to have been experienced here in relating the KSF input to the learners' work roles. Griffin comments:

"The HSCPC learning programme is designed around the six KSF core competencies. It is apparent that this approach has a number of benefits that are likely to contribute to service improvements:

■ *Core job related skill requirements (such as Safety and Quality) are addressed.*

■ *Learning is directly and easily related to student's work demands and experiences assisting the application of learning".* (Griffin, 2009)

One of the factors to which this programme's success was attributed was that, rather than simply being an 'add on' process, learning was aligned to direct service delivery and linked with other human resource and organisational strategies such as appraisal, incorporated within the KSF. Specifically, the evaluator commented:

*"There are a number of reasons why the [Unleashing Talent learning programme] has resulted in gains for employees, their teams, the organisation and clients and carers. The partners have developed a supportive organisational and learning culture for widening participation, specifically aligned learning to organisational strategy and patient/client care needs **and ensured that learning is competency based (by using the KSF**)".* (Griffin (2009) Executive Summary p. 2, emphasis added).

The evaluation reports that understanding and attitudes towards the KSF and appraisals had become more positive amongst the staff participating in the programme. Griffin notes that the programme had allowed the trust to develop its staff, increase capacity and plan its workforce more effectively; in addition, and in contrast to the situation apparent in England, the trusts participating in the Unleashing Talent Learning Programme had collected data which allowed them to demonstrate the savings made:

> *" … the UTLP students have a sickness absence rate a third less than non-UTLP students – representing a minimum annual saving of £272 per trained employee. The learning has also resulted in a range of improvements in client care including a greater recognition by care workers of hazards in client homes. This is likely to result in fewer trips and falls and hospital admissions". (Griffin, 2009, Executive Summary p.2).*

By contrast in England the NAO (2009) has noted: *"The Department did not put in place the necessary arrangements with trusts, so the Department has limited evidence to show what impact pay modernisation has had on productivity. The Department's Business Case in 2002 estimated that Agenda for Change would result in net savings over the first five years of at least £1.3 billion. Specifying a level of savings in this way was unrealistic since the Department placed no requirement on trusts to achieve efficiency or productivity improvements locally as part of implementing Agenda for Change. While in this period the Department can show some efficiency savings generally, as recorded by the NAO in its report "The Efficiency Programme: A Second Review of Progress Report" (HC156, 2007), the Department cannot demonstrate the contribution that Agenda for Change has made to their achievement".*

Evidence can be found then that the systematic incorporation of the KSF into development plans, and design of learning programmes focussed on the KSF requirements for different staff groups can bring about the sorts of benefits that were originally anticipated by the Department of Health. At present though, these

examples apparently remain in the minority. Given the way in which many trusts have approached implementation of KSF, it is perhaps unsurprising that, overall, the National Audit Office (2009) concluded that:

> *"For most trusts, the Agenda for Change programme largely stopped at the point when staff transferred to their new pay bandings, with the Knowledge and Skills Framework being seen as a subsequent exercise that not all trusts have completed. Consequently, the Department re-launched the Knowledge and Skills Framework in November 2007 and emphasised the need to use the Framework again in May 2008".*

The conclusion of the NAO was therefore that because of these and other barriers,

> *"Agenda for Change cannot yet be shown to have enhanced value for money. The Knowledge and Skills Framework is key to realising many of the benefits from Agenda for Change more widely, but has not been implemented by all trusts and for all staff. The Knowledge and Skills Framework is only one part of the picture; and the opportunities presented by Agenda for Change need to be combined with clear leadership and management if trusts are now to achieve the full potential of the programme". (National Audit Office,(2009), p.8).*

3.5 Appraisal and the KSF

As we have noted above, the National Audit Office has observed that Agenda for Change and the Knowledge and Skills Framework " … *were expected to facilitate new ways of working within the NHS, which would contribute to improved quality of care for patients and delivering services more efficiently and effectively"* (NAO, 2009, p.7).

Implementation of the Knowledge and Skills Framework was seen as key to attainment of the intended benefits of AfC. The main link between the KSF and development is through the appraisal process and therefore regular staff appraisal was intended to be a key part of the AfC. However, as with the KSF itself, in many cases this aspect of AfC failed to materialise. The 2007 National NHS Staff Survey revealed that just 61% of staff had received an appraisal or performance review in the previous 12 months, little different from the proportions of staff who had received appraisals in 2006 (58 per cent) or in 2005 (60 per cent) (Healthcare Commission, 2008). It is clear, then, that irrespective of intentions, AfC had little impact on rates of staff appraisal. Furthermore, although staff are supposed to receive a development review based on the KSF, just 41 per cent of respondents to the staff survey said that this had happened. Although the remaining 20 per cent had received some type of appraisal, they did not believe it was based on the KSF requirements.

Following publication of these figures a letter was sent out to all health organisations in Autumn 2007 from the Parliamentary Under Secretary for Health Services on this issue as part of a re-launch initiative. £14 million was made available to fund improvements. Subsequently, by September 2008, the percentage of staff who reported receiving a KSF development review rose from 41 per cent to just over half, 53 per cent (National Audit Office, 2009).

The 2008 National NHS Staff Survey showed 64% of staff had received an appraisal or performance review in the previous 12 months. However, just over a quarter (27%) of all staff (up from 24% in 2007) felt that their review was 'well structured' in that it improved how they worked, set clear objectives and left them feeling that their work was valued. Some 55% of those staff who received appraisals said that their appraisal was well-structured. Only a third (34%) said that they received clear feedback on how they were doing (32% in 2007 and 30% in 2006). The survey showed 55% of staff had agreed a personal development plan as part of their review, up from 52% in 2007 and 48% in 2006. However, only half (49%) of these staff said that they had received the training, learning or development identified within the plan (a further 29% said it was "too early to say").

The NHS Staff Survey also showed that ambulance trusts had the lowest incidence of appraisal, with 41% of ambulance trust staff having had an appraisal. Only one in 10 (11%) of them felt that the review had been well-structured and only a third (35%) said that they had received the training identified in the review. The Healthcare Commission stated that the proportion of staff having an appraisal has increased in all other types of trust (from 58% in 2006 to 64% in 2008), while rates among ambulance staff have fallen from 46% in 2006 to 41% in 2008. This may indicate the importance of taking operational circumstances on the ground into account when applying any skills- based appraisal system, and the difficulties of applying a detailed and uniform approach like KSF to a highly mobile workforce, often with little prior experience of appraisal.

The Healthcare Commission commented on the results of the NHS Staff Survey, stating it showed a *"widespread investment in the NHS workforce with high levels of training and appraisal, and a commitment to the development of staff. While an increasing proportion of staff are receiving appraisals, the majority feel that these could be more effective. The investment in training seems to be better targeted, with an increasing number of staff saying that training had helped them to do their job better or to keep up to date."*

The precise proportion of staff receiving an appraisal therefore varies between staff groups. Recent work by Edwards and her colleagues (Edwards et al., 2009) looking at the situation of radiographers post-AfC has indicated that the majority of this staff group have received appraisals, although not necessarily on an annual

basis. In this survey with 2,373 respondents, 59 per cent of diagnostic radiographers reported having had an appraisal in the past year, and 72 per cent of therapeutic radiographers. Where appraisals were reported they largely did use the KSF – some 60 per cent of diagnostic radiographers, and 61 per cent of therapeutic radiographers said that this was the case. A particularly interesting finding from the work was that respondents in higher bands were far less likely to say that the KSF had been used in their appraisals than respondents in lower bands.

Although these figures put radiographers amongst the highest groups for implementation of appraisals, nonetheless some 14 per cent of the diagnostic radiographers who responded, and 7 per cent of therapeutic, claimed that they had not had an appraisal in the four years since AfC was introduced. In keeping with much of the previous research on this topic, the most frequently-cited reasons given for non-appraisal were that appraisals were not taken seriously in their department and that managers were not interested in completing them.

There is emerging evidence that the lack of interest by managers in conducting developmental appraisals based on the KSF is increasingly receiving support by higher level decision-makers in NHS trusts as a barrier to implementing the KSF, and the process is just not realistic in this context. Although all nurses at University College London Hospitals NHS Foundation Trust have been given an annual appraisal and development plan (Snow, 2009), the Director of Workforce at the Trust has been quoted as saying that *"fully implementing the framework at [this] trust would actually distract from [the] wider goals of improving the skills of his workforce …. I am worried that if we put energy into implementing the KSF we will miss massive amounts of work with people sitting down with their leaders and having quality appraisals"* (Anon, 2008). While he has said that he supports the career development aspects in principle, in practice he feels that they are not feasible.

He is not alone in this regard. In 2006 Chesterfield Royal Hospital NHS Foundation Trust decided against use of the KSF. Their explanation for this decision was that they *'could not justify the extra time and cost involved for [their] staff and managers'* (Snow, 2009). Chesterfield has in fact developed its own appraisal system because, the Trust claims, it could not justify the cost of the KSF. Instead, a spokesperson said, they had *"concentrated on improving our existing appraisal system and tailoring that more closely to the needs of different staff groups"*.

3.6 Possible Solutions

Suggestions for improving the practical implementation of KSF have been documented in the literature; although assessed research examples such as the

Beeches Unit are comparatively rare, and in most cases these are largely gathered from employers' views on how the KSF could be reformed.

These suggestions included in the research, surveys and papers we have reviewed range from:

- building up from briefer post outlines through the appraisal and personal development planning process;

- reducing the emphasis on detailed examples of application in job outlines and when conducting reviews and reducing the necessity for each example to be evidenced;

- ensuring that learning and development is designed around the KSF to encourage transparent links between the job, learning and the KSF;

- allowing more flexibility in the framework for managers and staff to use it in a way that works for them, for example, removing the need for every competency dimension to be reviewed and evidenced each year;

- removing the distinction between 'foundation' and 'full' competence against the KSF, with just one set of competencies for each post, reducing the number of foundation competencies or removing the additional dimensions altogether;

- the adaptation of the Framework to suit the differing requirements of the various grades of employees and types of roles;

- measuring progress and outcomes rather than just the process, for example, how many staff have passed or not passed through the Gateways to ensure that it is being actively managed, and the effect of the process and skills enhancement on patient care outcomes (in one trust for example we know that general improvements on the communications dimension has contributed to a reduction in complaints);

- ensuing the publication of best practice KSF development review forms for a variety of roles which would enable staff to understand how they should interpret KSF;

- improving the technology and support for managers and staff in the process, with communications, training, advice, etc.

The NAO report for example, recommended:

- □ the appointment of board level champions in trusts;

- □ explicitly linking the KSF to service improvement;

- □ simplifying the available guidance;

□ sharing best practice more effectively;

□ clarifying the functions of the e-KSF and ESR.

The twin issues of simplification of the process and paperwork, and greater flexibility in application, along with improved prioritisation at senior levels and better local support, regularly emerge in respect of KSF. In the evidence submitted to the PAC's review (PAC, 2009), NHS Chief Executive David Nicolson, stated *"sometimes how something that might apply very well to a highly technical job does not always apply so well to a more generalist job"*. Amos posits that KSF is less applicable for bands 8a or 1 to 3 and so a recommendation could be to apply a leadership competency framework for band 8 and above which could complement or replace KSF, and using NVQs (which are already linked to KSF and national occupational standards), as the main route for competency assessment for bands 1-3 (Amos, 2009, p.4). But very few of these suggestions have been tested or proven in any field setting.

Based on her research in Tees, Esk and Wear Valleys NHS Foundation Trust, Hurst (2009) makes the following recommendations focusing on practical actions:

□ review and reduce the paperwork further (to a two page form);

□ make it a Trust policy to have protected time for KSF;

□ re-launch and re-communicate KSF;

□ align clinical supervision and KSF policies;

□ link KSF appraisal to the Trust mission;

□ address leadership and management styles;

□ monitor KSF usage;

□ reduce evidence collection;

□ make training on the KSF mandatory and including 'myth busting';

□ HR department should increase their role and visibility on KSF;

□ set an upper limit on how many people a person can appraise.

The RCN has pointed to a lack of training for managers in appraisal as a major obstacle to implementation of the KSF, a common issue found by Hurst and in employer research more widely. Wyatts and Green (2004) reported an initiative at Guys and St Thomas's Hospital in which all line managers were trained in appraisal, to ensure that both appraiser and appraisee would understand the process. The same occurred in the Beeches Unit project.

At Guys, however, even with the training, they reported that appraisals had taken up to two hours each to complete (although it should be noted that many people outside of the health sector may not think that this is an excessive amount of time for undertaking a thorough appraisal). Wyatts and Green attributed the length of time taken to lack of familiarity with the system, and reported that managers believed that the time required would decrease once managers became more familiar with the process.

However, three years later, Buchan and Evans (2007) in their review for the Kings Fund, reported that managers across the NHS were still complaining that the KSF was cumbersome and costly to implement. By the time Buchan and Evans undertook their review the e-KSF tool had been created to help NHS organisations develop, maintain and record KSF post outlines and PDPs. Originally developed as a stand-alone system, Buchan and Evans reported that the e-tool was by that time capable of being linked to the Electronic Staff Record and it was hoped that this would make the tool easier to use and the KSF easier to implement.

While most of the respondents interviewed by Buchan and Evans were supportive of KSF, some expressed concerns about its future and there was some suggestion that support for implementation of the KSF by some SHAs was being 'wound down'. They cited one manager at one of the case study trusts who commented that *'we need a "lighter touch" KSF'*. Buchan and Evans also pointed to suggestions that some NHS organisations had *"over-complicated"* the framework by, for example, *"using too many dimensions for posts or requiring portfolios of written evidence where this was not appropriate"* (Buchan and Evans, 2007, p. 23). However, they also noted that, despite the current limitations on full implementation of KSF, the Department of Health (2006) review of future regulation of non-medical staff in the NHS had suggested that in the longer term, one option would be to use the KSF to support the revalidation process for NHS staff.

They also noted that recent work had identified the need for NHS organisations to *"keep the operation of the KSF as simple as possible and not to overcomplicate it"* (Buchan and Evans, ibid., p. 26). They suggest that any attempt to use the KSF to support the revalidation process for staff would be undermined, *" … as the lack of full support and implementation for KSF prevents it from being used as a universal tool for revalidation. This highlights the importance of reviewing progress with implementation and learning the lessons from experience. It is likely that further modification [will be] needed to ensure the KSF can achieve its intended role as an integral element within Agenda for Change"* (Buchan and Evans, ibid., p.26).

The willingness to put time into the KSF though also relates to the perceived benefits of so doing, and linking in the KSF with other processes has been suggested in some of the literature as a future direction. A recent report on revalidation noted that *"the KSF-based development review process generates valuable*

evidence … that is reasonably contemporary to any call for revalidation" and *"would require only limited finessing and demand little additional time if the evidence already collected was to be used for revalidation",* although this might have additional *"time and cost consequences",* (Prime Research and Development Ltd, 2009). Hurst (2009) calls for mechanisms to be set up to measure and record the improvements in care resulting from the application of the KSF.

Elsewhere, initial experience has led some trusts to revise their original plans for the use of appraisal against the KSF. At the Ridgeway Partnership (Oxfordshire Learning Disability NHS Trust) it was originally planned that individuals would have two KSF meetings annually with their manager (Ruddle, 2009). In the first, a personal development review would be undertaken; in the second, the learning and development undertaken against the personal development requirements identified would be assessed.

However, the Trust found that arranging two meetings a year was cumbersome and impractical. As a result the meetings were scaled back to one a year, at which both a review of personal development needs and an assessment of the learning undertaken are made. The project group also made changes to the personal development plan format so that it now linked directly to the framework. Ruddle (ibid.) reports that this helped to link the PDP to operational policies which in turn helped to streamline induction, support and supervision and preceptorship.

Another important finding emerged from implementing the KSF at this Trust. Although the trust had evidence to demonstrate that all their staff had received a framework review/appraisal in the previous 12 months, nonetheless a staff survey revealed that some 90 per cent of staff believed that they had not had an appraisal in the previous year. Ruddle points to the potential for confusion if different parts of a Trust use different terminology for the same process – for example, 'appraisal', 'annual KSF review' or 'personal development review' (Ruddle, 2009, p46).

This is much in line with the comments made by Buchan and Evans (2007) as part of the King's Fund review of implementation of AfC. Although they reported that the Healthcare Commission's annual national NHS staff survey had suggested that significant numbers of staff were not receiving the regular performance reviews or agreeing the PDPs required to operate the KSF, they also noted that the staff survey questions did not mention the KSF while the KSF documentation does not mention the term 'appraisal'. They concluded therefore that it was possible that the use of different terms may have affected the responses given by some staff and note that at least one of their case study trusts had commented on the significant differences between the results of its own monitoring of appraisals/performance reviews and PDPs (which showed nearly all staff having

these on a regular basis) and the results of its staff survey (which suggested much lower levels of occurrence).

More recently some NHS trusts have come out and stated their opposition to use of the KSF to appraise staff. Comments made by trusts such as Chesterfield and UCL have come to the attention of MPs on the Commons Public Accounts Committee (PAC). The RCN has called for a tougher line to be taken on this issue and argued that NHS managers should be given a deadline by which time all of their staff must have received an appraisal using the KSF. A number of the research interviewees in our study also supported stronger compulsion to use KSF, with penalties for not doing so.

However, this has to be taken in the context of organisational reforms devolving power within the NHS ever since KSF implementation began. Any hope for a unified approach to implementing KSF across trusts is constrained by the advent of foundation trust status and the autonomy that now confirms – the National Audit Office (2009) noted that the changing situation in the NHS regarding foundation trust status could soon serve to make the national AfC system redundant, as trusts take up the option of implementing local terms and conditions of service. As noted below, employers seem to be concluding that without the active support of management and staff enabling them to drive and shape the process, then any KSF-type system seems doomed to fail to achieve its aims.

3.7 Does Performance Appraisal and Skills Development Matter?

Some people might question whether performance appraisal and the application of the KSF in the NHS are really worth the amount of attention being paid to them at present. However, there is a considerable body of research evidence now in healthcare and the wider economy that suggests that it is worth the effort. Combs et al. (2006) summarise more than 90 studies indicating a relationship between HR practices such as appraisal and personal development and organisation outcomes and performance. They identify three sets of influential HR practices: those that increase skills, empower employees and improve motivation. Appraisal and the KSF might be interpreted as contributing to all three of these categories.

Research evidence suggests that appraisal in particular is directly related to the performance of employers in a healthcare setting and specifically to patient outcomes. One of the most significant pieces of research looking at the impact of HR management practices in the NHS was undertaken by Michael West and his team at Aston University. West et al. (2006) investigated the relationship between high performance HR management and healthcare outcomes in 52 hospitals across

England, focussing on a 'high performance bundle or system' of HR practices and the effects that such systems had on patient mortality. Scores were assigned to each hospital across a range of HR practices and then combined so that each participating hospital had one overall score. After controlling for influential factors (such as the prior mortality rates at each hospital), the researchers found that the HR system variables accounted for almost eight per cent of the variance in mortality rates.

Once West et al had demonstrated that there was an impact on patient outcomes attributable to improved HR systems they then looked at the contribution made by each of the individual elements of the HR system. This analysis revealed that there were three individual HR practices that were the most influential – the presence of a sophisticated appraisal system, employment security and Investors in People status (which focuses on training and development practices and outcomes). Of these, appraisal was the most important.

Earlier work by this research team had already started to point to the centrality of effective appraisal systems. In 2003 Borrill and West had reported a ' … *strong association between the sophistication and extensiveness of staff management practices in NHS hospitals and lower patient mortality'* (Borrill and West, 2003:3). In that work they had found a number of key HR management practices which had an effect on patient mortality, and prime amongst these was having an appraisal system in place. They concluded that:

> " … *a hospital which appraises around 20 per cent more staff, and trains around 20 per cent more appraisers, is likely to have 1,090 fewer deaths per 100,000 admissions." (Borrill and West, 2003:6)*

3.8 Practices and Trends in Other Sectors

Having analysed the experiences with the KSF in the NHS and considered evidence to suggest that KSF-type appraisal and development processes can have a strong impact on organisation performance, we now move on to look at the evidence on appraisal, skills and competency frameworks and personal development practice across the UK economy as a whole. To what extent are the experiences and difficulties indicated in our KSF review evident amongst other large employers and to what extent are the trends and solutions being advocated and used comparable?

3.8.1 Performance management and appraisal

3.8.1.1 Incidence

A CIPD survey of performance management and appraisal (2005) found some 87% of respondents operated a formal performance management or appraisal process, and that they are universally applied in large organisations in public and private sectors. Around one-third, (31%) used competency and skills assessment as part of that process using a KSF-style framework: of these, some 39% thought it to be effective. About two-thirds – 62% of respondents – reported that they used personal development planning and of these over four-fifths (81%) believed these to be effective. One in three – 31% – reported that they also operated a link between the appraisal process and pay progression.

3.8.1.2 The Shift in Emphasis

In their book on the subject, Armstrong and Baron (2005) note the shift in terminology from performance appraisal to performance management, which they believe indicates a wider shift in the philosophy and content of this process:

> *"Performance appraisal has a reputation as a punitive, top-down control device, an unloved system. Performance Management is a holistic, total approach to engaging everyone in the organisation in a continuous process, to improve everyone and their performance, and thereby the performance of the whole organisation".*

Bryman et al. (1994) studying UK universities found a top-down, controlling approach to the process simply produced *"procedural compliance"* rather than making an effective contribution to improved performance.

The CIPD performance management survey showed that in the UK, while there has been this broadening in purpose and the linking of some of these different processes designed to impact on performance, the performance management process largely still revolves around personal objective setting and appraisal against objectives. This is included in the process in 90% of cases, although interestingly and unusually, not within the KSF process. Trends that have continued since the previous 1997 survey showed that there is an increasing focus on the development aspects of appraisal, and also devolvement of control and operation of the process from HR to line managers (CIPD, 2005).

Armstrong and Baron (1998) also comment that "(*development*) *inputs such as competencies, approaches and understanding have become as important as outputs such as products, goals attained and objectives achieved"*. They draw a distinction between the bureaucratic appraisal systems imposed on line managers by HR in the past to the move to reduce the bureaucracy of performance management:

"Everyone had to conform to the same procedure and the most important output was a set of ticks on an elaborate form that, once completed, was forgotten unless it was used to determine the size of someone's pay rise. Now the focus is more on how performance is managed than on the outcome" (Armstrong and Baron, 1998).

Despite this shift and the advent of more powerful HR information systems, the CIPD's survey of performance management still found that over a quarter (26%) of respondents thought performance management continued to be bureaucratic and time consuming (CIPD, 2005), so the NHS is far from being alone in their criticisms.

3.8.1.3 Common Changes

E-reward's survey (2005) of performance management provides a clear picture of the changes that organisations are making to support the shift towards a performance management approach, but also to address problems such as over-complexity and bureaucracy. Criticisms of performance appraisal type processes are not new. Writing in *the Harvard Business Review* in 1959, Likert observed that: *"Performance review interviews as a rule are seriously deflating to employees' sense of importance and self worth. Not only is the conventional review failing to contribute, in many executives' opinion it can do irreparable harm"*. Grint writing more recently (1993) was even more scathing: *"Rarely in the history of management can a system have promised so much and delivered so little"*.

More than two-thirds of organisations in the E-reward research had either changed their systems in the past three years or were planning to make changes in the future. The commonest changes are shown below in Figure 3.1.

Figure 3.1
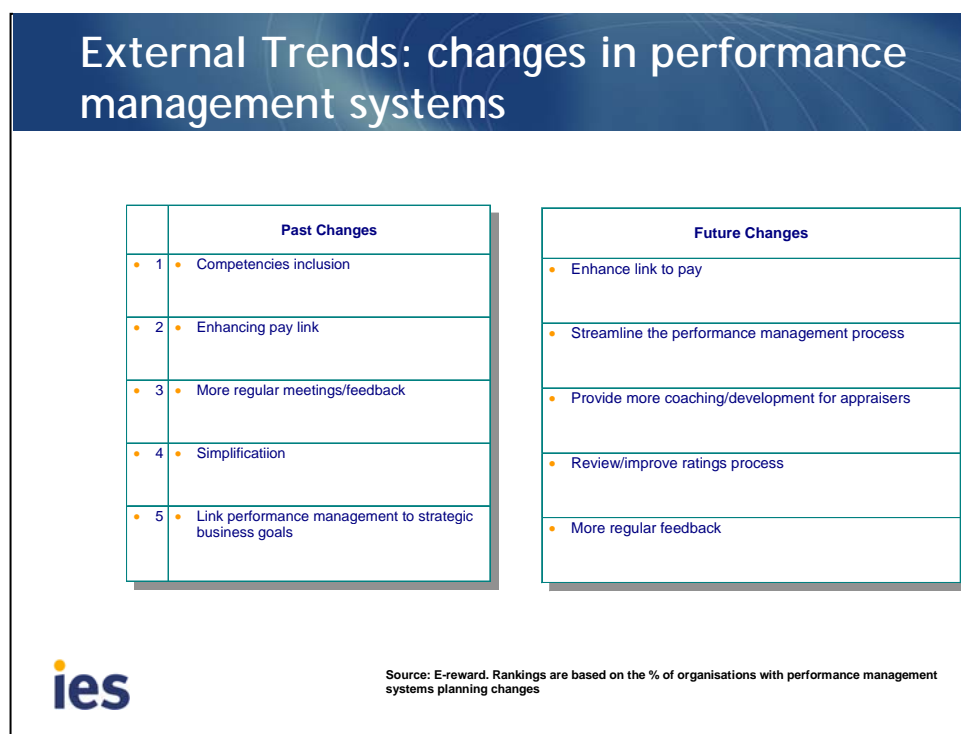
Despite the move to adopt an all-encompassing approach, the recent trend towards simplification is also evident from this survey, with better support and training being provided as greater focus is being put on how these systems actually work in the reality of the organisation, rather than in respect of the many intended policy intention and outcomes. A number of our NHS interviewees referred to the perception that the KSF had been developed in something of an isolated "bubble".

Just under half of the respondents to the CIPD performance management survey (48%) had similarly proposed to make changes to their performance management arrangements over the forthcoming year, with a similar direction evident (CIPD, 2005). IES's experience over the last twelve months is that the economic recession has further encouraged this trend, with one large private sector employer consolidating six separate appraisal and personal development systems it operated around Europe into one system with a simple common core, and the ability to add on additional components at the country and business unit level.

Coens and Jenkins based on their experience in North America recommend *'Abolishing Performance Appraisals'* (2000), citing regular failings in development planning, objective setting and 360 degree feedback. They advocate instead broader performance management approaches focused on customer outcomes and decoupling the complex mix of processes often tied up inside performance appraisal. They cite the Police Department in Madison, Wisconsin which replaced

traditional appraisals with a system of individual goal setting, leadership training and employee involvement that let officers choose who they want to work with and who supervises them. A US Department of Justice comparative study found that Madison had the highest levels of citizen satisfaction following the changes. But as we have seen, most organisations have not taken their changes in systems this far.

3.8.1.4 Making Improvements

Strebler (2001) provides useful comment on the practical application of performance management systems, suggesting that an important element of effective performance management is 'user friendliness', stating *'users satisfied with their performance review system believed it did not cover too many purposes to be effective, irrespective of how many objectives it was trying to achieve and whether it was separated from assessment for pay or not. While overloading appeared a useful concept, it is perception of overloading that matters'* (Strebler, 2001, p.xi).

Good practice in performance appraisal systems, she suggests, is that they should have clear aims and be simple to understand and operate, which appears in contrast to employers' views of the current design of the KSF. They should also have their *'effective use core to all managers' performance goals and be closely allied to a clear and resourced training and development infrastructure'* (Strebler 2001). Strebler also sensibly recommends that designing a system that satisfies users may encourage them to use it effectively.

Developing the commitment and the capability of managers has been identified as an important consideration in the design and implementation of a performance management system, again as mentioned by many of our NHS interviewees and in the Kings Fund review. Purcell's research at the University of Bath identified this as key in *'bringing HR policies to life'*. The focus of performance management is now on elements such as recognition, constructive feedback, personal development and career opportunities (Baron, 2004). Aside from training Baron commented that organisations are winning support from line managers through ensuring there is strong leadership from the top of the organisation; involving line managers in the development of performance management processes and including performance management as a criterion in assessing line managers' own performance. This research also supported the widely held view that performance management needs to be 'owned' by line managers (Baron, 2004).

Good practice in performance management was summarised by Armstrong and Baron through comments made by case study organisations that they visited. These provided some interesting insights into developments in performance management. For example:

'We expect line managers to recognise it [performance management] as a useful contribution to the management of their teams rather than a chore' – Centrica

'The principles behind performance management are career management and better performance' – Cranfield University

'Making the management of performance an organic part of everyday life, not a series of mechanical tasks and processes' – Halifax

(Armstrong and Baron, *2005, p.20)*

Effective appraisal systems are inextricably linked to the control over the complexity of the scheme. Strebler (2001) states the *'increasing complexity of some of the systems might be a barrier. To make the process work, managers themselves have to be motivated to want to use it'*. Strebler, in a study of performance review systems, found that one in three managers agreed that *'if the system was made more user friendly more managers would actually complete it'* (Strebler et al., 2001, p.18).

Performance management and appraisal schemes also need to be adequately co-ordinated and monitored which requires staff to be trained on how to operate the scheme. Rees and Porter (2004) state that the role of HR needs to be stressed in co-ordinating and facilitating, but for a scheme to *'have any prospect of success it needs to be owned and driven by line management'* (Rees & Porter, 2004, p.31).

A common problem with appraisal schemes reported in these studies and surveys is they have too many objectives, which makes them complex and 'cumbersome', and schemes therefore often require a considerable commitment in terms of organisational resources to be implemented. Both the NAO and Kings Fund reviews made this criticism of the KSF. It requires time commitment as both appraisers and appraisees have to spend time preparing for appraisal interviews and collecting information. Appraisers also need to spend time on follow-up actions (Rees and Porter, 2004).

An IRS study (Wolff, 2005) also showed that training given to those conducting reviews was key to making the appraisal system work well. In some 61% of employers formal training was provided, while HR provided guidance to managers in 25% of companies.

A further key to the success of embedding effective performance appraisal appears to be its integration into the culture of the organisation; building a culture of continuous performance appraisal, not as Martin and Bartol (1998) state *'a periodic ritual that proves unpleasant for employees and supervisors.*

'In addition to evaluating employees on a regular basis, organisations should assess the effectiveness of the appraisal system periodically' (Schraeder, 2007, p.23).The Civil Aviation Authority recommends that the appraisal process should be regularly

reviewed and adjusted if necessary, but warns against continually changing the scheme (Wolff, 2005). It suggests the key to success is keeping the process simple and ensuring senior management commitment.

Simpler process and paperwork may be supported by more regular meetings, although each meeting is often more focused and shorter than using the one meeting per annum model. At a major charity there are now a minimum of four meetings a year, with each having a distinct focus. The first is for objective setting, the second for development planning, the third for ongoing coaching and the fourth to review performance and pay. There is also a trend towards more people inputting into the end-of-year review to try to improve the quality of assessments. Surveys suggest that between a quarter and a third of employers are using some aspect of 360 degree appraisal, collecting input from colleagues and reports, and sometimes from customers.

Rees and Porter (2003) also suggested that adapting a scheme to suit the different requirements of the varied employees within an organisation is often necessary, taking into account differing organisational needs and priorities, levels of managerial expertise, styles of management and the sophistication of employees. Igvarson and Chadbourne (1997) go further and argue, based on the ineffectual experiences of implementing appraisal for teachers in Australia that the active support of staff, and adapting systems to meet local needs, are both essential requirements for success. Chandra (2004) reinforces the importance of employee involvement in healthcare settings, while O'Conner and Lee (2007) document how when home care workers were involved in tailoring an appraisal system to suit their own needs, it became a success.

3.8.1.5 Management and Employee Involvement

However, dissatisfaction with appraisal systems continues to be reported and is often expressed by UK employers (Fletcher, 1997). The problems of managing formal appraisal schemes are typically greatly under-estimated, with *"the minority of schemes that work usefully … usually [are] those with limited objectives, a high level of investment and a sophisticated management"* (Rees and Porter, 2003, pg.281). Strebler (2001) believes the widespread application of performance management shows it stretches managers who often lack the skills and motivation to deliver it effectively. According to Egen (1995) most performance management is about control rather than development and most line managers do not have the skills to make performance reviews work effectively (Strebler et al., 2001).

A study by IRS (2005) on the use of appraisals found a common concern was that if managers are not adequately trained and committed to the appraisal system, the performance review becomes *"just a paperwork exercise"'*. And as we have seen, this is regarded as no small task by NHS managers and staff, with the paperwork

involved for KSF appraisals being described as *"daunting"*, *"confusing"* and *"death by paper"*(SW London Trust paper, 2008).

While this illustrates the need for managers to be committed to the appraisal process, it is equally as important for managers to possess the skills needed to conduct effective appraisals. In the IRS study (Wolff, 2005), Virgin Mobile reported good training of appraisers and appraisees was key to making its appraisal system succeed, along with positive communication to *"pitch it as a benefit"*. The Student Loans Company also commented that *"training of managers in carrying out appraisals is essential to the success of appraisal systems"*.

While it is acknowledged that individual managers must have the skills required to conduct appraisals effectively, only just over half (57%) of respondents to the CIPD's survey of performance management reported that they train appraisers. Some 34% train all staff, however a greater proportion of all staff in the public sector (49%) are likely to receive training (CIPD, 2005).

Better communications and staff involvement is also often an important goal as well as improved line management of the process, and the trend towards renaming appraisal systems indicates this, with apparently more positive names such as Excel, Feedback and Performance Partnerships evident in particular example organisations.

Technology again is being used to help to try to engage employees more to trust and even enjoy the process. McGregor, (2009) reports that *"employers are trying out social networking-style systems that aim to improve – and take the dread – out of annual reviews"*. Accenture has developed a Facebook-style program called Performance Multiplier that lets employees post status updates and personal weekly goals. Rypple lets people post Twitter length questions about their performance in return for anonymous feedback, and has software to replace the standard annual review with quick monthly surveys and discussions. By prompting people to document and adjust their goals and learning constantly Accenture hopes that the formal process discussions will also improve.

3.8.1.6 Having Conversations

Grattan and Ghoshal (2002) similarly argue that at all levels, the emphasis should be on the core of the appraisal and development process, that is *"improving the quality of conversations"*, rather than going through *"dehydrated rituals"*, with open and honest leaders setting the example for a culture of curious, creative learning organisations.

At Standard Chartered Bank the appraisal process is called 'Conversations that Count'. The aims are to increase staff engagement, develop staff and deliver better results. Managers have four conversations with their staff during the year:

perform (the appraisal against personal objectives; learn and develop (planning learning required to perform their job); careers (building the potential to take on larger roles); and engagement (where managers ask staff how well the organisation knows them, cares about them, helps them to focus and develops their strengths).

This ultimately is perhaps the aim of the switch to a performance management philosophy and the simplification that is underway: engaging employees more in the process and engaging them in working on performance towards key organisation goals, rather than an excessive focus on individual details. Beesely's research in the Western Health Trust was about *"delivering high quality care through effective widening participation"* and perhaps a focus on those two aspects indicates a future direction for KSF.

Hurst (2009) discerns two strands in the performance management literature: a very structured and controlled backward-looking review approach which is "done" to employees (Grote, 2000), and a much more inclusive, forward-looking approach involving the individual, supports their development and links in to the organisation's needs and values (Spangenburg and Theron, 2001). Her analysis supports the view that KSF has been too much linked to the first approach and needs to move further in the direction of the second.

3.8.2   Competency frameworks

3.8.2.1 Incidence

Competencies are described by Whiddett and Hollyforde (1999) as the descriptors of skills, knowledge and behaviours that employees are expected to have to perform their roles effectively in an employer. A survey of 100 of the UK's largest employers showed that appraisal systems are widely used, with seven in ten organisations appraising employees once a year, and competencies were a common component (IRS, 2003). Performance and development needs were found to be measured against competencies in 56% of these organisations and in the vast majority of organisations surveyed a job description was provided for the jobs being appraised. But while personal development plans were almost as common in these appraisal systems as personal objective setting, no organisation appeared to operate with detailed post outlines for development purposes as well as job descriptions, as occurs within the NHS. Indeed we can think of no single employer who uses both of these methods together.

3.8.2.2 Simplification

This may partly be explained by the trend to encourage greater flexibility in people's jobs and to adopt the concept of briefer role profiles rather than extensive job descriptions and development plans. Plachy (1993) defines a job as a common definition of tasks that are the same whoever carries them out, while a role is a broader definition of requirements covering the contribution people make in achieving objectives, reflecting the different contribution individuals make, as well as the purpose of what they are doing. This move has supported the inclusion of competencies in appraisal and development processes. It has also encouraged some employers to link job tasks and competency development in a single role profile document.

A simplified example of this integrated role profile format from a multinational PLC is shown in Figure 3.2 below. The single document is used for job description and job evaluation purposes, as well as to identify competency requirements and skills development planning. An appraisal form is bolted onto it focusing on annual objectives and performance against them. The spread of more effective HR information systems has meant that these different systems – of appraisal, development, pay, recruitment etc. – are easier to link up and often can enable managers and employees to administer them more effectively.

Figure 3.2

Example role profile format from large UK PLC

Role indicators
- Key purpose
- Key performance measures
- Reporting structure
- Financial impact
- Decision making

"Need to do"
- Primary Accountabilities

"Need to know"
- Specific experience/ knowledge
  - in your area
  - in other areas
  - across functions
- Qualifications/work experience

"Need to be"
- Competencies
- Level of competency

ies

A study by Incomes Data Services commented that competency frameworks should not become *"unwieldy and consequently fall out of use. Competency frameworks need to be flexible so they can be adapted easily in line with organisational changes and remain fit for purpose"* (IDS, 2008, p.1)and *"whatever form competencies take, their overriding purpose is to add business benefit"* (IDS, 2008, p.2). Competencies and behaviours have become key to performance management to establish how goals should be achieved and to contribute to development planning (IDS, 2008).

The IDS study recommended that when an organisation is revisiting or replacing a competency framework, a first step should be to identify the strengths and weaknesses of the current system. It looks to the large retailer B&Q as an example of this, where consultations with key stakeholders have helped identify what are the elements of the existing competency framework that are working and what should be included in the new model. IDS recommends that employers review and adapt their competency frameworks on a regular basis.

As with the KSF, which has six core dimensions with a further 24 available, the IDS study found there are six to ten core competencies in a typical framework, with an equal number that are optional. Each core competency is usually supported by a brief definition, which *"provides clarity for employees and line managers"* (IDS, 2008, p.3). The study also found that the most useful competency frameworks were not completely comprehensive *"which risks over-complication, but are short, simple in structure and, above all, understandable"* (ibid., p. 4). The behavioural indicators at different levels also contribute to personal development planning through benchmarking and assessing the gaps in an employee's abilities.

The number of competencies contained within frameworks have reduced in recent years. Whiddett and Hollyforde (1999) commented that whereas it was once common to find frameworks that contained 30 or more competencies, it is now more usual for frameworks to contain no more than 10. Many users find between six and 12 competencies to be the most useful range for a framework. Larger frameworks were often developed because organisations attempted to include all the information required for all applications and all roles, including information on job tasks, outputs and behaviours.

But experience has shown that it is often more effective to produce generic frameworks, with guidelines on how to apply it to a range of applications. The more competencies that a framework contains, the more difficult it can be to implement (Whiddett and Hollyforde, 1999, p.11). Among the most common competencies included in these six to 12 core competencies are communications and other interpersonal skills, problem analysis and challenge, innovation and creativity, and management, leadership and supervision.

And a simplification in the levels and descriptions of each competency or dimension also seems to have also been occurring. So for example, rather than multiple levels described on each competency from the highest to the lowest degree of application, now it is relatively common to simply have lists of indicators and contra-indicators for each competency, and to leave managers and employees more flexibility and discretion in applying these to specific jobs.

The guidance needed to advise on the application of larger frameworks also becomes very lengthy and *"off-putting to users"*. Whiddett and Hollyforde (ibid) state that the *"thickness of a document is usually inversely related to the number of people who read it"*. They provide the example of a government agency that had a framework with over 60 competencies, each with five levels of complexity. Users found it impossible to apply, and the 200 page reference document *"undermined any confidence they might have that they could make the framework work"*.

The agency addressed this problem by identifying the behaviours common to all roles in the organisation and produced a second framework with 12 competencies, accompanied by a 12 page guidance document. This was found to meet users' needs adequately and the original framework was never re-introduced (Whiddett and Hollyforde, 1999).

Splitting competency frameworks into a core set of common, often behavioural competencies such as communications and management skills, alongside of an additional set of technical or professional competencies, which are generally now tailored by the local unit or occupational group, rather than attempted to fit within a common corporate framework, is also now very common in large organisations. It seems to be a means of getting some consistency in definitions without restricting local units or occupations to specify some of their specific requirements. It is interesting that the KSF appears to have this structure, but then also centrally specifies the additional dimensions, rather than letting different occupations develop their own.

3.8.2.3 Effectiveness

The most comprehensive competency framework, *"no matter how well designed and appropriate, will not make a bad process good, nor will it compensate for poor training, poor techniques or unskilled users"* (Whiddett and Hollyforde, 1999, p.18). Ensuring the success of competency frameworks requires them to: be sufficiently flexible to adapt to organisational change; have support from the top of the organisation and from the stakeholders who will influence it the most; have a high profile champion who promotes the use of the framework; keep it simple, rather than overly comprehensive; descriptors that are understood by employees; the use of relevant behaviours; the setting of clear boundaries between the different competency

levels and a framework that has a clear purpose that is understood and welcomed by employees and managers (IDS, 2008).

The CIPD survey of performance management found that management buy-in and the communication of objectives were considered to be the most critical factors in the introduction, maintenance and improvement of a performance management system (CIPD, 2005). The survey found a great deal of consensus among respondents about the need for performance management to be integrated (98%), owned by line managers (93%) and fully understood (94%) by everyone involved. Armstrong & Baron, (2005) note that these findings reflected the results of the previous survey they conducted in 1997 but, the levels of agreement, particularly on issues such as integration and ownership, were much higher in the more recent survey, suggesting that some learning has taken place.

3.8.2.4 The Link to Pay

While competencies have become a foundation for many HR processes in virtually all large employers, their use for pay determination has been limited and more controversial. O'Neal (1993/4) describes competency-related pay as *"the way tomorrow's organisations will pay"*, supporting a shift from paying for the 'what' to rewarding the 'how'. But Sparrow feels that *"pay determination requires a precision that could stretch the theory of competencies to breaking point"* and damage the development objectives in their use.

The CIPD's reward management survey (CIPD, 2008) finds that fewer than one in five employers link pay progression directly to competencies, although half of those which link performance and pay include considerations of skills and competence, as well as other factors such as affordability and results achieved. Brown's (1998) review of links between competencies and pay found that two main methods were being employed. First, competency criteria were being used to help to evaluate and grade jobs in banding structures, often through descriptions of the common characteristics of the jobs in each band. Second, competencies and skills were being linked directly to pay progression within a band or pay range.

His review of research on the links found that:

- linking skills and competencies to pay is often popular with staff;

- it generally 'works' in terms of supporting and promoting the up-skilling of employees;

- however this can create problems in that staff may progress more quickly through pay gateways than was planned and so budgets to fund this may be stretched, while issues of how higher skills can be fully utilised may also emerge;

- and there also appears to be a 'peaking out' effect after a few years once employees have developed the required skills and have reached their pay ceiling.

Brown's advice on making links between competencies and pay effective includes the following points:

- develop, test and use competencies for purposes such as recruitment and training and development before the link to pay is made, as the definitions and measures need to be robust once pay is being influenced;

- *"do it properly or don't do it at all"*, that is, if there is a fear that development may be compromised or pay progression limited then the pay link should not be attempted; correspondingly if the links are made, there should be robust assessment in place that genuinely tests whether or not individuals have obtained and are using the defined skills in their workplace;

- generally competency frameworks are simplified further for pay purposes, so that often only a limited set or selection of the full competency framework or menu is used.

3.8.3 Personal development planning

All of the organisations in the IDS study (2008) were using competencies to assess and plan the development needs of employees, with development planning generally following directly on from the appraisal process. The CIPD found that some 71% of respondents to its performance management survey agreed that the focus of performance management is developmental (CIPD, 2005). The assessments of competency gaps inform the learning requirements for the employee's development plan. For ambitious employees or those wishing to make lateral moves across the organisation, being aware of the competencies and levels of performance required to perform another role facilitates the creation of development plans to gain those competencies required (IDS, 2008).

As development goals are typically informed by the gaps in competencies or behaviours there must be a fundamental link between development planning and the performance management process. IDS reported that some organisations separate the performance assessment and development planning processes to place greater emphasis on each. However, IDS states that this can *create a more complicated or unwieldy structure and blur the link between development activities and the achievement of performance goals"* (IDS, 2009, p.6).

Personal development plans are a well established feature of performance management. Tamkin et al.'s research (1995, p.5) shows that personal development plans are most commonly focused on job or career development or a

mix of both. They state that *"personal development plans which focus solely on skill development for the current job will not be welcome by many employees. Those which take a broader view of the individual and their future may be more effective for encouraging flexibility and have a higher impact on employees"*. The CIPD survey of performance management found that over two-thirds (67%) of respondents agreed that the most important aspect of performance management is that of setting challenging and stretching developmental goals.

The use of personal development planning and the need to revisit performance management systems was highlighted by comments made by First Direct, which stated that personal development planning *"details the skills required for different roles based on core competencies. It's an in-house system so it needs constant refreshing, and we need to make sure that that is up to date and reflecting skills required in the business now and in the next five year"* (Armstrong & Baron, 2005, p.97).

Armstrong and Baron (2005) also found that most organisations indicate that they expect employees covered by the development planning process to prepare and implement plans. However, in some organisations PDP is encouraged but it is not obligatory *"on the grounds that to insist too strongly on the completion of forms seems to be inconsistent with the principle of self-managed learning"* (ibid., p.99). Not all employees are interested in career progression, but steps are often taken to encourage these employees to look at what development is available to them, whatever their level. And a number of research studies have shown links between career and skills development and flexible working and levels of customer service delivery.

As with appraisal, some organisations have different approaches to PDP as well as to appraisal for different types and levels of staff. It is relatively common for example to have distinct development arrangements and competency frameworks for senior managers and leaders, although management and supervisory skills would still be a very common component in generic competency frameworks. Approaches will often be simpler too, at lower levels in an organisation. But although surveys do show that levels of PDP coverage decline for lower paid and skilled jobs, generally employers with these types of process endeavour to apply them to all of their employees.

3.9 Section Summary

This section has had two objectives:

- to summarise the research literature on KSF, highlighting the barriers and enablers to its successful application, and

■ to profile wider trends in similar processes covering performance appraisal and competency and skills development in UK and other major employers.

Initially, there appears to have been widespread support and even enthusiasm for the concept of KSF. But given the subsequent slow and decidedly patchy progress on implementation, many would agree with the respondent to Edward's (2009) survey who commented *'The concept of AfC remains a good one. The implementation of it is a positive disgrace … ''*.

Studies highlight the detail and complexity of the process, the inflexible application, poor communications and understanding, and perceived high levels of resource required, combined with weak management skills and low senior-level prioritisation, as key barriers to its widespread and successful use. Just as some progress was being seen in the proportions of staff receiving developmental appraisals based on the KSF there have started to be some high profile complaints about the process, combined with an increase in the numbers of trusts exploring the option of adopting local terms and conditions, as they acquire Foundation Trust status. This is particularly unfortunate given that Buchan and Evans suggest that *"full benefits realisation is not achievable without a fully functioning KSF"* (Buchan and Evans, 2007, p. 11).

Possible solutions advocated in the literature and tried in places include heavy simplification of the KSF mechanics and more flexible application, along with improved management support and training, and as well as links to other training frameworks and delivery, and to service and performance outcomes and their measurement.

Externally, we have seen powerful evidence that performance appraisal and related staff development matters: it can have major impact on service outcomes, and large employers almost universally have some type of performance management process. But our external overview has found that at least a quarter of employers are similarly disappointed with their KSF equivalent as are many in the NHS, with complaints at over-proceduralisation and heavy resource input for limited output.

A significant proportion of large UK employers have changed their equivalent process in the past three years and many plan further changes. But, although some American writers may herald the death of performance appraisal, some type of process with similar objectives typically remains in place, if in a different form and guise. Change is apparently almost inevitable amidst the realities, speed and pressure of organisational life today, and a route to improved impact, rather than an admission of failure.

Common changes and apparent keys to improvement in appraisal and development processes externally, highlighted in research, include:

- simultaneously focusing more broadly on organisational performance and on initiatives required to support that, whilst also simplifying and speeding the core processes;

- providing more support and training in the use of the system to line managers and ensuring senior management commitment and example-setting; while also

- giving employees higher levels of understanding and involvement and allowing them to drive and shape the process to a much greater extent;

- focusing on development and performance outcomes and measuring and demonstrating them; and

- allowing for greater adaptation and flexibility to tailor a simpler common framework to suit diverse local needs and cultures within major employers.

The KSF process is particularly unusual compared to the systems used by other big employers in at least two significant ways: first in not having a personal objective-setting component in the process; and second in employing both detailed job descriptions and detailed developmental post outlines. We could find no equivalent dual descriptions externally, and indeed the trend is towards briefer and integrated role profiles including competency dimensions that are used for job evaluation and development purposes.

In respect of competency frameworks, we have profiled similar trends towards simplification and more user-friendly and user-driven approaches in other sectors, with for example, only common core competencies often now being specified, and the professional and technical skills left to occupations and functions to develop themselves locally. Again, support from the top and through excellent training and communications are critical enablers.

Their use in determining pay progression is one of the least common applications of competency frameworks. Experience from other sectors suggests that caution is required in making the linkages, and there is a need to 'do it properly or don't do it at all'. Personal development and a future focus on development, rather than on past performance rating and reward, are also commonly apparent.

Our research review therefore would suggest that action needs to be taken with the KSF and changes made before any further momentum is lost. As Buchan and Evans (2007) conclude, *"further modification will be required to ensure that the KSF can achieve its intended role"*. The need to help NHS organisations with the process of implementation forms the context for the work undertaken and reported in the subsequent chapters.

References

Amos, D (2009). *Improving the Skills of the NHS Workforce*. NHS London Partnership Board, 28 January 2009

Anon(2008). Appraisals and Development Reviews. South West London Trust

Anon, (2007). 'KSF Must Improve Patient Outcomes'. Nursing Standard, vol. 22(2) p. 7

Armstrong, M and Baron, A (1998). 'Out of the tick box' People Management, Online article, 23 July 1998. CIPD

Armstrong, M and Baron, A (2004). 'Get into Line', *People Management*, vol 10, issue 20. CIPD

Armstrong, M and Baron, A (2005). *Managing Performance*. London. CIPD

Beesley, J (2004). 'Making Knowledge and Skills Pay within Perioperative Care'. *British Journal of Perioperative Nursing,* vol. 14 (6) pp 249 – 252

Borrill C, West M (2003). *Effective Human Resource Management and Lower Patient Mortality*, Aston Business School

Brown, D. (1998). *A Practical Guide to Competency-Related Pay*, Financial times Management, London.

Bryman, A., Haslam, C., and Webb, A. (1994). 'Performance appraisal in UK universities: a case of procedural compliance?' *Assessment and Evaluation in Higher Education,* Vol 19 (3), pp 175-187.

Buchan, J and Evans, D (2007) *Realising the Benefits: assessing the implementation of Agenda for Change.* Report commissioned by the King's Fund.

Chandra, A. (2004). 'Utilisation of performance appraisal systems in healthcare organisations'. *The Health Care Manager*, Vol 23 (1), pp 25-30.

CIPD, 2005. *Performance Management Survey Report*. September 2005, CIPD, London

CIPD, (2008). *Annual Reward Management Survey*, CIPD, London

Coens, T, and Jenkins, M. (2000). *Abolishing Performance Appraisals and What to do Instead*. Berrett-Koehler

Combs, James, Yongmei Liu, Angela Hall and David Kecthan. 2006. 'How Much Do High-Performance Work Practices Matter? A Meta-Analysis of their Effects on Organisational Performance.' *Personnel Psychology*. Autumn: 501–528.

Crisp, J (2005) 'Ladder of Success'. *Nursing Standard*, vol. 19 (34) pp 69 – 70.

Department of Health (DH) (2003) *Getting the Right Start: National Service Framework for children: Standard for Hospital Services*. TSO, London.

Edwards, H, Vosper, M, Miller, L, Price, R, Herbland, A, Le Masurier, S, Cherrill, R and Smailes, E (2009). *Effect of Agenda for Change on the Career Progression of the Radiographic Workforce 2009*. Report to the Society and College of Radiographers.

E-reward , (April 2005), *What is Happening in Performance Management Today: Part 1 – Survey Findings*, Research report no. 32, E-reward.

Fletcher, C (2001) Performance appraisal and management: The developing research agenda. *Journal of Occupational and Organizational Psychology*, 74, p.473 -487

Grattan, L. and Ghoshal, S. (Winter, 2002), 'Improving the Quality of Conversations', *Organisation Dynamics*.

Griffin, R (2009) *Delivering high quality care through effective widening participation.* A report to the Western Health and Social Care Trust

Grint, K. (1993) 'What's wrong with performance appraisals? A critique and a suggestion'**,** *Human Resource Management Journal*.

Grote, D. (2000) 'Public Sector Organisations'. *Public Personnel Management*, Vol 29 (1), pp 1-21.

Harrison, S (2007) 'Trust bosses use 'red herring' of KSF outline to downgrade staff'. *Nursing Standard*, vol. 22 (6) p. 6.

House of Commons Public Accounts Committee (2009) *NHS Pay Modernisation in England: Agenda for Change*. Twenty-ninth Report of Session 2008-09. London: The Stationary Office Limited.

Hurst, J. (October, 2009) *An evaluation of the effectiveness of the national KSF system for NHS staff*. Doctorate of Education thesis (unpublished).

Igvarson, L. and Chadbourne, R. (1997). 'Will appraisal cycles and performance management lead to improvements in teaching?' *Unicorn*, Vol 33 (1), pp44-64.

Incomes Data Services (March 2008). 'Competency Frameworks', *IDS HR Study* 865, IDS, London.

Incomes Data Services (January 2009). 'Performance Management', *IDS HR Study*, 886,IDS, London.

Industrial Relations Services (2003), 'Annual appraisals are the norm, despite doubts about line managers', *IRS Employment Review*, 768, IRS, London

Likert, R. (1959).'Motivational approach to management development'. *Harvard Business Review*, Vol 37, pp 75-82.

McGregor, J. (March 12th 2009), 'Performance Review Takes a Page from Facebook', *BusinessWeek*.

Milton, S (2008) 'The AfPP introduction and guide to Notional Learning Hours', *Journal of Perioperative Practice*, vol. 18 (2) pp 50-53

Morley, M (2009) 'An evaluation of a preceptorship programme for newly qualified occupational therapists', *British Journal of Occupational Therapy*, 72(9), pp. 384-392.

Morley, M (2007) 'Developing a Preceptorship Programme for Newly Qualified Occupational Therapists: Action Research,' *British Journal of Occupational Therapy*, vol. 70(8), pp. 330 – 338,

O'Conner, M. and Lee, S. (2007). 'Authentic performance appraisal when home is the workplace'. *International Journal of Palliative Medicine*, Vol 13 (12), pp 606-609

O'Neal, S. (Winter 1993/1994) 'Competencies: the DNA of the Corporation', *ACA Journal.*

Ong, G (2005) 'KSF and the midwife' *Midwives*, vol. 8 (7) p.302

Parish, C (2006) 'Step Change'. *Nursing Standard*, vol. 20 (29) pp. 14 – 15

Pirie, S (2005) 'The AfC Reality'. *British Journal of Perioperative Nursing*, vol.5 (2) pp 62 – 72

Plachy, R. and Plachy, S. (1993), *Results-Oriented Job Descriptions*, AMACOM, New York.

Prime Research and Development Ltd (March, 2009). *NHS KSF Revalidation Project.* Report commissioned for the Department of Health Working Group for Non-medical Revalidation.

Reed, S (2008) 'Ward management: education for senior staff nurses'. *Paediatric Nursing*, April vol. 20 (3) pp. 27 – 31.

Rees, D.W, Porter, C (2003) Appraisal pitfalls and the training implications – Part 1. *Industrial and Commercial Training*, Vol 35 (7), pp.280-284

Rees, D.W, Porter, C (2003) Appraisal pitfalls and the training implications – Part 2. *Industrial and Commercial Training*, Vol 36 (1), pp.29-34

Ruddle, D E (2009) 'Implementation of the NHS Knowledge and Skills Framework' *Nursing Standard*, 24 (1), pp 42 – 48

Schraeder, M, Becton, J, Portis, R (2007) A Critical Examination of Performance Appraisals – An organisation's Friend or Foe?. *The Journal for Quality and Participation.* Spring 2007, p.20-25

Snow, T and Doult, B (2009) 'College supports MPs' call for staff appraisals deadline'. *Nursing Standard*, 23 vol. (42) p. 9.

Spangenburg, H. and Theron, C. (2001) 'Adapting the Systems Model of Performance Management'. *South African Journal of Business Management*, Vol 32 (1), pp 35-48.

Sparrow, P. (5th December 1996) 'Too Good to be True?' *People Management.*

Staines (4 August 2009). 'Trusts still falling short on KSF commitment'. *Nursing Times, Online.*

Strebler, M, Robinson, D, Bevan, S (2001). *Performance Review: Balancing objectives and content*. IES Report 370, Brighton: Institute for Employment Studies.

Tamkin, P., Barber, L, Hirsh, W.(February 1995), *Personal Development Plans: Case Studies of Practice.* Report 280, Institute for Employment Studies.

West MA, Guthrie JP, Dawson JF, Borrill C S, Carter M (2006), 'Reducing patient mortality in hospitals: the role of human resource management', *Journal of Organisational Behaviour,* Vol.27(7), pp. 983-1002.

Whiddett, S. and Hollyforde, S. (1999). *The Competencies Handbook*. London. Institute of Personnel and Development.

Wolff, C (2005). Appraisals 1: not living up to expectations. *IRS Employment Review,* 828, IRS, London.

Wyatts and Green (2004) 'Valuing Your Skills'. *Nursing Management* vol. 11 (2) pp 16 -17.

4 Findings from the First Phase of Case Studies

4.1 Introduction and methodology

The first phase of case study research in this project was designed to focus on a small sample of different types of trust which appeared to have made significant progress in using the KSF and related appraisal processes. The aim was to learn from them how they had implemented the KSF, any barriers they had experienced in using it and how these barriers had apparently been overcome in order to achieve relatively high levels of coverage. This knowledge could then be used to provide insights into how other trusts might make similar progress.

In this section of the report, after briefly explaining our methodology and profiling the case study trusts, we summarise the findings from each of these trusts before drawing general conclusions from this stage of the project.

We selected the trusts by reviewing the annual National NHS Staff Survey data on the incidence of appraisals and rating of those appraisals, supplemented by data on the use of the various aspects of KSF drawn from a recent survey conducted by *The Nursing Times.* Then from the top 20% of the different types of trusts nationally on this basis, we selected trusts that would be broadly representative of the different parts of the country and different types of organisation. The six trusts we selected are listed and briefly profiled in Figure 4.1. They typically had rates of staff appraisal coverage and KSF utilisation in excess of 70%, although the figures are somewhat lower nationally for PCTs and ambulance trusts.

Figure 4.1: Profile of Participating Trusts

Trust	Profile
Greater Manchester West Mental Health NHS Foundation Trust	Delivers a range of mental health services in the Manchester area, employing approximately 3,000 staff across a variety of sites and units, some community oriented and including some recently merged units. Increased coverage of KSF since 2007 from 27% of staff to 83%.
Kings College Hospital NHS Foundation Trust	One of the largest and busiest teaching hospitals in London with over 6,500 staff providing a wide range of specialist and local hospital services to a population of over 700,000. Falls within the top 20% of trusts nationally on ratings for training, appraisals and PDP's, with 94% of staff having had an appraisal.
Plymouth Hospitals NHS Trust	Provides general hospital services to a population of 450,000, with 6,600 employees. In *the Nursing Times Survey* they achieved 83% coverage on all three aspects of KSF, and their annual report describes the fact that almost all staff had received an appraisal in the past 12 month as "a major achievement".
Rotherham Primary Care Trust	Employs approximately 1500 staff, 65% in direct patient care and remainder in commissioning and health improvement activity. Estimate KSF coverage in the mid 60%s.
Salford Royal NHS Foundation Trust	A foundation trust since 2006, it provides numerous national specialist services and is the only trust nationally to receive four successive 'excellent' annual review ratings from the Healthcare Commission. Appraisal coverage had fallen below 50% of staff but is now over 70% using a modified version of KSF.
Sandwell and West Birmingham Hospitals NHS Trust	An acute trust working towards foundation status, operating from two main sites with 1450 beds and approximately 6,500 staff. Latest staff survey coverage figure was 86% for appraisal and 88% for PDRs

In each trust we spent a day in discussions and interviews with managers and staff to find out:

■ how they had implemented the KSF;

■ the current situation regarding KSF utilisation and perceived strengths and weaknesses;

■ how they had achieved high coverage and their advice for other trusts with lower levels of utilisation.

In each case study trust we aimed to interview the director responsible for KSF, typically the HR/OD director, and hold group discussions involving reviewing managers, trade union representatives, professional and non-professional staff. This did not prove possible in all settings, but in total we interviewed ten directors/Heads of HR and OD, along with six other senior HR and/or learning and development managers, and held ten focus groups involving more than 50

reviewing managers and staff. We also reviewed a variety of trust-specific written materials, primarily related to the appraisal processes and KSF application.

The interviews and discussions were held on an individually confidential basis to encourage open and honest dialogue. However, in the succeeding sub-sections we briefly recount the story of each trust's journey with KSF and appraisal as described to us, before drawing out the common learning points and their advice for other trusts.

4.2 Greater Manchester West Mental Health NHS Foundation Trust

Greater Manchester provides one of the best examples of a trust which has radically increased its take up of KSF over the past two years. Two years ago according to Deputy HR and OD Director Stella Clayton, KSF was being used as *"a booklet rather than as a template to improve staff performance"* with take up at just 27% across the trust. Staff described it too us as "too complex, too unwieldy and not used … wasn't a two-way process". Now usage is up to 83% and 76% of staff in a recent internal survey responded positively about the system.

So how has this turnaround in the usage of KSF been achieved? Participants in one of the focus groups described the change as *"giving it more teeth and linking it to the performance framework"*, ensuring that it "*meant something" to staff, "focused on the individual and their contribution"*.

Key components of the turnaround were as follows:

■ KSF has been made an integral part of a common appraisal process that applies to all staff, except medics and senior executives, who all have to have an annual appraisal discussion and a six-month follow up review. The KSF framework has become a *"guide to use during appraisal discussions"* and the post outline *"assists with appraisal discussion"*.

■ The process has a common timetable, with business planning in the last quarter of the year, planning appraisals and holding directorate and team meetings in the first quarter, appraisals held in April to September and annual training needs analysis carried out in October.

■ The process itself involves the following:

  □ all staff complete a pre-appraisal questionnaire;

  □ the appraisal discussion involves the use of three coaching 'wheels': one covering job performance, one relating to KSF and where relevant, one on management/leadership;

□ an objectives template is also completed

□ as well as a PDP.

■ These coaching 'wheels' are the most visually distinctive aspect of the process that guide the discussions. The job performance wheel involves the employee and reviewer agreeing their level of performance, scored out of 10, against eight criteria including 'getting along with colleagues', 'staying organised' and 'team participation'. The KSF wheel contains the six core dimensions, plus up to two relevant specific dimensions. The management/leadership wheel for people managers is based on the NHS Leadership Qualities framework (see Figure 4.2 below). "Wonky wheels" indicate areas where development is required and the documentation says that managers *may refer to the KSF manual to support your discussion and to get ideas for appropriate development for your PDP"*.

■ Clear responsibilities in the process and widespread staff involvement. The Staff Health and Well-being group developed and agreed this new approach, and local service champions were designated in each area.

Figure 4.2 The Greater Manchester West Appraisal Wheels
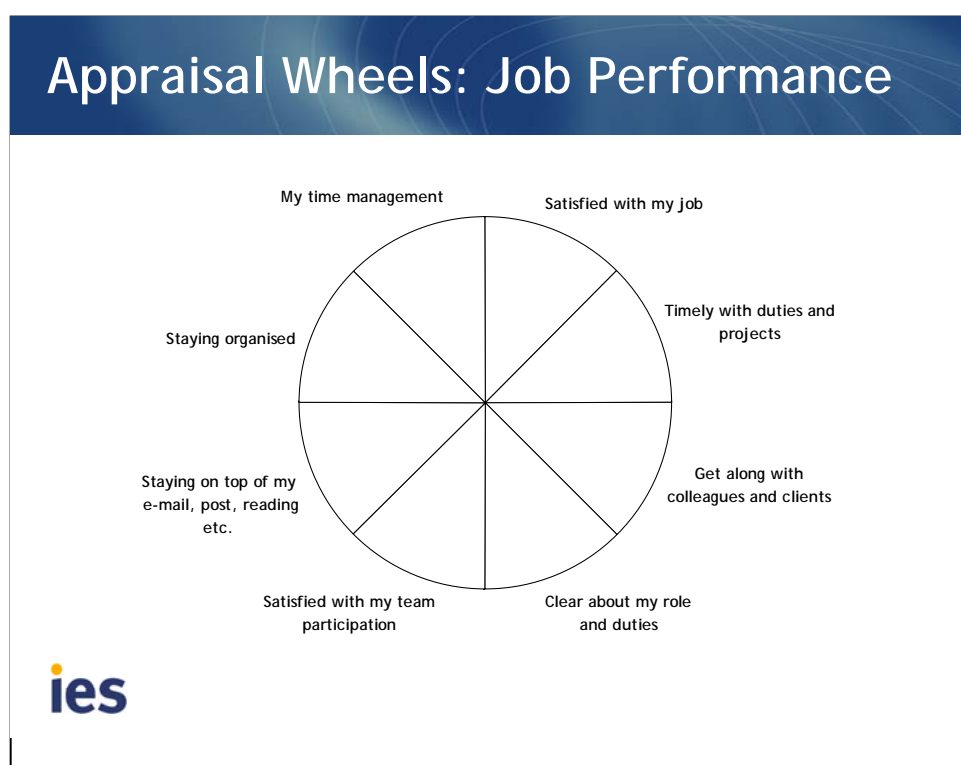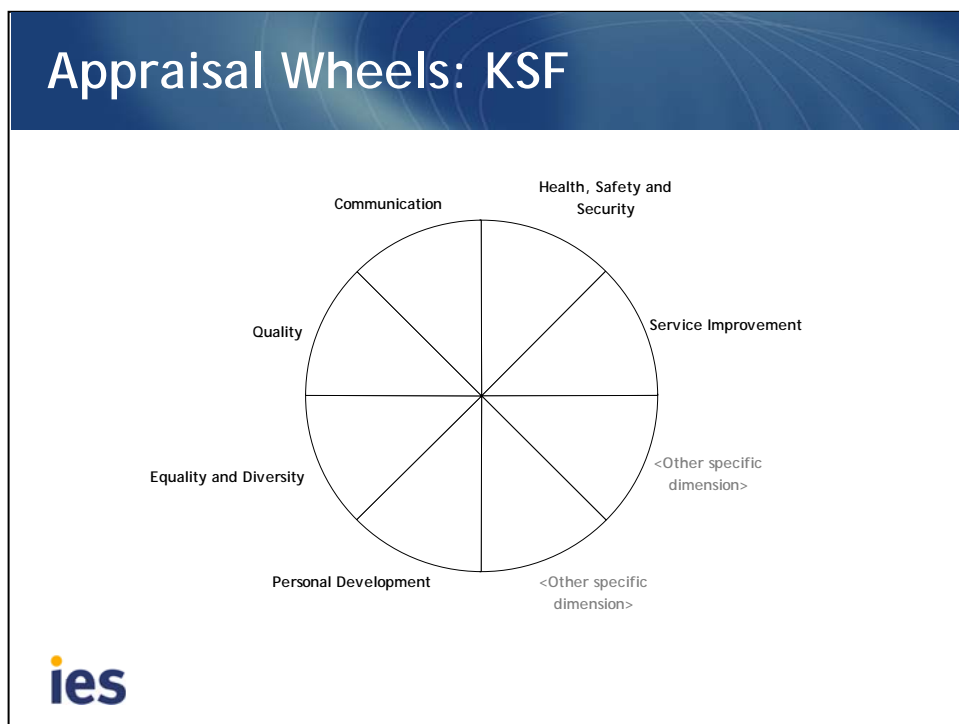
The systematic and straightforward approach with an emphasis on communications appears to have won managers and staff over to the process, which has apparently benefited in comparison with the 'old' style time-consuming KSF. Staff in the groups described to us the wheels as *"easy to use … they focus it quickly"* and *"less rigid, more user-friendly"*, while the process reflected *"more of a partnership approach"*.

Interestingly, the administration of the process has not been a major area of concern, and only a "few" managers are using the eKSF, although staff noted the paper-based training needs analysis was a constraint.

A Unison representative referred to early *"concerns that the proposals would undermine the principles of KSF … however we do not believe this to be the case"* and was particularly positive about the effects in shifting attitudes to personal development and training for non-professional staff, where in the past appraisals may not have happened at all. The positive impact of the training in KSF and appraisal provided to all staff was also referenced. One manager though did feel that the link to the original KSF is a *"bit tenuous … more tenuous than the Trust wants to acknowledge"*.

The Trust is currently looking to link the appraisal approach to the Constitution pledges and improved use of, and links to, training outcomes related to the management/leadership wheel. A number of local trusts have expressed interest in replicating the approach developed at Greater Manchester.

4.3 Kings College Hospital NHS Foundation Trust

Kings started from a very different place with KSF compared to Greater Manchester, with a good foundation in appraisal and a widely acknowledged *"appraisal culture – a culture of transparency and feedback"* as recounted to us. Staff appraisal was already a factor used in determining the pay increases of managers, and 'grandparents' were in place to encourage and check appraisal practice, which continued after KSF was implemented.

Nonetheless, a lot of effort and resource was put into the KSF launch, including:

■ roadshows about what KSF meant and was;

■ training 100 staff as local champions;

■ a half-day refresher course for managers on appraisal, as well as boardroom sessions on aspects such as how to collect and use evidence.

In terms of the process and accountabilities, it is reinforced from the top of the organisation that managers and staff need to make the time to prepare for and carry out the appraisal and PDR. Management of staff and completion of appraisal, including KSF, is delegated to Band 6 with targets set for completion. Reviews are staggered during the year to a set timetable to enable completion. And somewhat unusually in our wider experience, the pay link at the Gateway points does seem to operate as intended – we were given examples of progression being held back as staff did not meet the required standards.

The managers' focus group told us that they were *"overwhelmed at first"* by the complexity of KSF and the *"big up-front bit"* was the hardest. As well as the champions and the training, two other factors which are common to Greater Manchester and the other trusts we visited were evidently critical: positioning KSF as part of the wider performance management and appraisal process in the Trust; and providing a route map through, and simplification of, the KSF aspects of the process.

Each of the Trust's seven divisions has a scorecard for performance management, with managers reporting monthly, and this includes appraisal coverage. Then KSF itself has been fully integrated into the appraisal process – KSF is seen as only part of the story and so has been linked to performance objectives and outcomes and tied into the Trust's values in this way. So as well as KSF evidence, in preparation, staff are asked to consider questions such as:

■ what have you done well over the prior period?

■ what have you struggled with and why?

■ do you think your contribution is properly valued by me and the team?

■ what aspects of the job do you want to focus on improving next year?

Simplification of the process, rather than going through all the detail each time of full KSF, is also evident and seen to be an important factor in successfully operating the process. Relatively generic job profiles were developed *"never in a full KSF way"* with relatively little attention to the detailed indicators.

The six core dimensions are used, with up to a maximum of six others, but the focus tends to be on the headlines rather than the detailed indicators. There has been a focus in each role on how that role adds value, and *"what good looks like"*, with real examples to make the process come alive and be obviously relevant to people. The Trust is finding that the reviews focus on fewer and fewer dimensions with each successive year as experience is gained. The focus now we were told is more on improving skills and performance, rather than all the paperwork. The KSF book itself is only used as reference point, for example if there is a performance problem.

All staff receive a simple six page guide to this Performance Assessment process, *"a process of constructive dialogue where the employee has a structured opportunity to reflect on their work, receive feedback on their performance, to identify ways in which performance can be improved, to identify training and development needs and agree plans as to how these needs can be met"*.

As in all of these trusts we visited, Kings is not complacent and always looking to improve. 94% of all staff had an appraisal review as at March 2009, but the proportion of staff reporting a quality review in the staff survey has declined recently. This is felt to be because of work pressures, and the same finding is evident for medical as well as AfC staff. The eKSF is widely used but the Trust would like to be able to book people straight onto training courses from it, as currently there is no direct link.

4.4 Plymouth Hospitals NHS Trust

Until 2008, the management at Plymouth accepts that KSF did not have as high a profile amongst staff as they would have wished.

They therefore put their appraisal completion success in moving up to 83% coverage across the Trust in 2008 down to two factors: as in the first two case examples, positioning KSF as part of the wider Trust and individual performance management process; and secondly, targeting, monitoring and actively encouraging implementation throughout the trust.

Given the Trust's vision and values, *"to be the best in everything we do"*, and declared ambition to be a "learning organisation", prompted by the HR director at the time, the senior management team decided that the staff survey results on

appraisal were unacceptable and that appraisals for all staff had to become a priority.

The Board therefore set a standard with a deadline of October 2008 and as acting Director of HR Martin Bamber put it, *"the target helped to focus people's attention, we created a sense of urgency, reported monthly, and raised the profile"*. Appraisal became one of the key performance statistics looked at around the trust, stimulating progress, even if it was *"extremely time-intensive for the HR staff"*. A manual system was used to record progress initially. In the current year the ESR system is being used to report on further progress as this contains a number of other HR statistics, such as staff turnover, that are reviewed in management meetings. The Trust will be moving to use the eKSF as this allows more automation of the process and better and easier analysis of coverage and progress in different parts of the Trust. They are also creating a clearer link between appraisal and other operational performance metrics, as opposed to appraisal being seen as an "HR issue".

The performance monitoring activity is supported by extensive staff communications across the Trust, in newsletters etc., about the aims of the process, reminders on deadlines and so on. In fact Bamber warned about the detrimental impact of being *"too dictatorial"* about KSF and stressed the need to create a demand for managers and staff wanting to do it because it is important for them.

As with the other trusts just described, KSF has been positioned as an integral part of the appraisal process. The emphasis has been on doing it because it is critical to better patient care and high performance, not just because you are told to. The simple appraisal guide written for all staff and reviewing managers has the Trust's vision to *"be the best in everything we do, providing leading-edge, high quality health services"* on the front-cover. The process incorporates the KSF *"and does more"* including *"discussing the Trust's plans and priorities"*, *"reviewing previous objectives"* and *"developing objectives for the next year"*. Performance and personal development receives the emphasis throughout, and also the need to recognise staff achievements, not just highlight weaker areas for improvement.

A rolling programme of appraisal training, one day for reviewers and half a day for staff, is provided and is apparently over-subscribed.

In terms of the design and paperwork of the Appraisal and KSF process, the Trust still thinks there is scope to streamline it, which is work in progress

Staff in the Trust we met had all had an appraisal in the past twelve months, and there was some very positive feedback – *"it made me proud of my achievements"*, *"it gives you the opportunity if you want to try and broaden your skills"*. In some parts of the Trust informal rules such as no manager could appraise staff without having the relevant training, and no more than 10 staff to be appraised per manager, had been implemented to ensure quality of the process. Inevitably though the quality

will vary across any large organisation, and one member of staff's appraisal had only lasted 15 minutes and the KSF elements had not been used.

The Trust is far from complacent. In 2009 appraisal completion rates have been running behind the 2008 levels, but the Trust feels this is largely due to other changes in the organisation and that final results will be similar to 2008. As well as more automation to improve the encouragement and monitoring process, they are looking at doing more work on improving the quality and consistency of appraisals, using their own in-house survey tool initially to drill down into some of the findings from the National Staff Survey in more detail.

4.5 Rotherham Primary Care Trust

Relative to other PCTs, Rotherham have achieved a good level of appraisal coverage and use of the KSF. They do not consider themselves to be experts by any means, but they do feel they have got some aspects of the implementation and operation right, while others have not been so successful, and were happy to share this learning with us. PDR coverage is in the mid 60%s and increasing every year.

Rotherham began with KSF by developing a strong partnership working process between the staff and management sides and KSF and its progress remains a regular agenda item in joint meetings. Joint training on KSF was offered to staff in the form of one-day workshops (the co-facilitation between management and staff side gave a strong message) and there were quality assurance panels to review job outlines, again co-managed by both parties. This has also ensured that approval for job outlines is very high when they are developed.

Rotherham had quite a good person-centred performance and development review process (PDR) before KSF was introduced, so the concept of appraisal wasn't new. However, in developing the job outlines, according to Head of OD Andrew Cribbis, they *developed something unwieldy which was too big for the PDR*. Managers and staff were essentially left to come up with their own outlines and PCTs have fewer standard roles than most NHS organisations. By incorporating lots of dimensions and using all the correlating examples, job outlines ran to 15-20 pages. People then found they were impractical to use – *"we have services where KSF outlines exist, but they are unused at the PDR because they are too cumbersome, or the process appears too formal and complex"*.

Using the eKSF they feel magnified the problems of excessive length, with the common format meaning that necessary differences by level and type of job were not taken account of. The apparent inability at that time to link the ESR and eKSF also created issues for them.

In retrospect the Trust feels there should have been a set of centrally-developed, high quality standard outlines for all roles nationally, as with the national job evaluation profiles under AfC, with the opportunity for some local adaptation. The trust has also tried to insist that without a post outline, then vacancies would not be filled, but this caused some resentment amongst managers.

Rotherham decided therefore to create "top line" outlines for posts that needed filling, equivalent to the front sheet on the key dimensions. This approach is now being considered for all job outlines and not just those for new joiners or vacancies. The PCT has two pilots underway working on doing this for other roles. The hope is to create *"condensed and pragmatic"* versions of the lengthy post outlines.

Rotherham have developed a PDR pack to guide managers and staff through the process, which involves:

■ agreeing work priorities going forward;

■ reviewing progress against priorities previously set;

■ discussing what areas need developing;

■ completing a PDP from this that links to the KSF outline.

This connection between the development needs identified and the KSF should be made at all review meetings, and not just at the point when staff reach a Gateway. The Trust believes this ensures a consistent process and body of evidence to be used in the PDRs.

For initial implementation, Rotherham had appointed champions for the KSF, who were trained advisers and points-of-contact on all aspects of the process – the production of outlines, evidence gathering, holding PDRs etc. These were run down, but the Trust now appears to regret this and feels it should have kept the network going to support and ensure ongoing improvement in coverage and quality.

Rotherham also feels that the KSF focuses on the required skills and knowledge but misses out on the "how" of performance and how skills and knowledge translate into effective job performance. Competencies could perhaps have provided this more effectively than the dimensions.

We discussed whether the PCT could support the use of KSF in trusts and organisations they commission services from. They felt that trusts providing services would expect the PCT to pay for support in rolling out the KSF if they demanded KSF compliance. But they said that there should be a forum or network, perhaps locally with the SHA, where trusts (and PCTs) can say frankly

what their problems with KSF are, find out who can help and how. People are not open, they felt, at present with the issues they have, which limits the ability to address them.

The Trust felt that this review should be bold in acknowledging that KSF is a flawed initiative and the NHS should accept the consequences of revising or replacing it. Andrew Cribbis felt the DH could provide a small amount of additional financial resource to each trust to support a re-launched initiative, with the financial award outcome-related to successfully achieving improvements in coverage and quality.

4.6 Salford Royal NHS Foundation Trust

Salford's appraisal journey in recent years has been a different one from some of the other trusts profiled here, and although coverage has now gone back up to over 70%, the initial effect of using the KSF was actually to reduce it. So as one senior manager told us, *"KSF is like using a sledgehammer to crack a nut, so we shaved bits off the sledgehammer"*.

Although KSF was fully implemented in the intended manner, appraisal rates fell to below 50% and so the Trust's board reviewed the situation, as part of its preparation for applying for Foundation status. Managers fed back that the process was complicated and that the promised benefits of KSF were not being realised, with no link to performance objectives nor to subsequent training delivery. In our focus group, managers said it had taken up to five hours to go through the levels and dimensions for each role, meaning that appraisal time was all taken up by this. The wording was described as too subtle and ambiguous as it had to cover so many levels and types of job. A further concern with the national KSF was that the competency levels for ostensibly the same job differed from Trust to Trust, hence the idea that there was a national, standardised system was one of concept and not reality.

So a modified, simplified version has now been designed, tested and implemented, one that the managers and staff in our focus group were highly supportive of. The project leader of the changes feels that the Trust has *"kept the principles of the KSF, not the complexities"*. The new system was introduced in 2008 and, following support from the Board, fully implemented by April 2009.

The dimensions have been adapted under the new approach into four core competencies that apply to all staff covered by Agenda for Change: attitude, safety, quality and communications. A fifth, leadership and management applies only to those who manage or supervise staff. Managers felt that the attitude staff display in their work was critical to their performance. All technical knowledge

and skills sit under the safety category, and references to equality and diversity are now spread across the other competencies.

Instead of levels on each of these competencies, there is a standard statement and staff provide example of evidence under each heading. But staff are given an overall performance score resulting from their appraisal, ranging from 'excellent' through to 'unsatisfactory'.

In some departments paperwork is sent out to the manager and employee's home four to six weeks before a meeting is due and they then fix the timing, with the timings and sequencing of meetings varying to suit the different time demands and working patterns in different parts of the Trust. Because the system is simpler and meetings can be shorter, we found examples of managers meeting with their staff three or four times a year to hold performance and development discussions. In one area there is a dedicated appraisal room with access to online e-learning and the records system, plus other learning resources. An e-learning appraisal course is available to all.

While this was a more significant level of change to KSF than the other case studies discussed so far, a similar effort was made to link the process to Trust and personal objectives, in order that KSF can be seen to mean something in the context of service delivery. Trust and divisional objectives are linked in a ladder to team and individual ones. The whole system is administered using a local Snowdrop Learning Management System that, for example, triggers the advance warning of meetings and records completion of the appraisal documentation.

The managers in our focus group described the approach as *"brilliant", "simple" and "easy to understand"*. In particular they stressed that the *"quality of dialogue"* had improved, with a real opportunity to reflect on achievements, *"it makes people of all grades feel they're important to the Trust"*. Attitudes were mixed on the overall four-fold performance rating and not all managers use it. But overall, managers were very supportive of this new approach, and even worried that this project might lead to its withdrawal.

The facilities group we spoke to were similarly positive about the new approach, whereas the original KSF *"just sat as a big fat book on the desk"*. Some staff though are still nervous of the evidence-producing and performance-judging aspects of the process. The process was also still seen as too formal for these types of jobs and the process has become repetitive from year to year. And we heard of examples of staff having to wait a long time for the identified training needs to be addressed.

Monitoring of use of the new system takes place through a monthly HR reporting dashboard and six-monthly service review of every department. The Trust is aiming at 80% appraisal coverage and is achieving over 70%. The Head of

Learning and Development fixes meetings in any areas with low coverage. The most common issue appears to be areas with higher staff turnover and more new starters who need the system explained to them. Coverage is also lower for corporate services and senior managers, who tend to work off Trust objectives and rely on 360 degree feedback.

In terms of the pay link, this was never applied in the Trust, with only people going through the capability procedure having increments withheld. The eKSF is not used. But to strengthen the link to training, any funded course will not be approved without evidence of a PDP using the simplified KSF dimensions.

The Trust accepts there are some downsides in the approach they have adopted, and it risks every trust "re-inventing the wheel", as well as creating barriers to mobility if they all followed Salford's example. They suggest some national standards are set and a core of content agreed, which can then be modified as necessary locally.

Some trade union opposition is evident to the inclusion of attitude as a dimension of the KSF as they believe it should be a development, not a performance tool. The Chief Executive also supports a stronger link between incremental pay progression and performance.

4.7 Sandwell and West Birmingham Hospitals NHS Trust

Sandwell and West Birmingham has worked hard to ensure complete coverage of the KSF. As at September 2009, their 'traffic light' monitoring report found an 88% coverage for PDRs, while the latest NHS Staff Survey findings showed an increase from 60% to 86% coverage over the past twelve months, with the numbers reporting a well-structured appraisal also up from 25% to 33%.

The managers we spoke to appeared to be almost shocked at the suggestion that the KSF dimensions might be changed. Staff are profiled on the six core dimensions and most staff have at least one additional dimension. But many of the ways in which Sandwell has worked to ensure wide and quality usage of the KSF reflect the experiences and methods adopted by the other trusts we visited.

All staff have a post outline and a post cannot be advertised or filled without one. The Trust has worked hard to simplify and standardise these, setting up a working group for example to look at improving the outlines for nursing posts. The Learning and Development Programme Manager felt that it would have been very useful to have had national KSF post outlines, in the same way as national profiles were completed for job evaluation under AfC.

For most staff the PDR is scheduled in advance and they complete a PDR1, a personal preparation checklist, and a PDR 2 form, a personal SWOT analysis, in

advance. In the PDR meeting a PDR 3, consisting of the KSF analysis and a second section on personal objectives, is completed, along with a PDR 4, the summary personal development plan. A PDR 5 form is then used afterwards for ongoing monitoring.

The process in practice does vary for different types and levels of staff. Professional staff, they find, are used to assembling evidence for the PDR and it can be used for a variety of other purposes. Their PDR meetings can take up to two hours.

Others, for example in support and facilities roles, follow a simpler and more streamlined process. Their KSF evidence is typically much simpler and the manager will often help them collect it. The PDRs tend to be much shorter for these groups, up to half an hour in length. As one manager told us *"if you're an operative in the kitchen, it's hard to see the purpose of setting objectives and gaining competencies in the same way"*. Another told us their approach to KSF was *"pragmatic, capturing the essence without labouring the issue"*.

In the Facilities area they have developed a log book approach to the process, to make structuring and recording the process much simpler. For ambulance crews, the manager we spoke to tended to catch staff between calls or straight after a shift and uses the same post outline for them. He has developed a simple checklist of questions which he covers in about 15 minutes with each employee: how are you getting on? Do you have any problems? Do you understand the job? Do you need any training?

Management posts have KSF outlines in the main, although some of the managers we spoke to felt *"it's not appropriate for senior management, because jobs and objectives are highly individualised"*.

The KSF is used as intended to identify the skills and knowledge needed to carry out each post effectively and individuals are assessed against this profile. Attitude and behaviour do not form part of this assessment but are seen as important and managers are encouraged to recognise positive attitudes and achievement on a day-to-day basis and during the PDR.

All new starters receive the two page DH introduction to the KSF, and the Trust has its own simplified 11 page guide for reviewing managers. The guidance and documentation is available on the Trust intranet. A variety of forms of training in the process are provided, including short sessions at team meetings and half and one-day courses.

Although the process has been streamlined, particularly for those in non-professional roles, the documentation is currently being further revised to make it even simpler and less repetitive. The managers and staff we spoke to do find the

KSF part of the PDR time-consuming, particularly those managers with a lot of staff. A manager in one of our focus groups managed to complete an incredible 123 PDRs in the year!

One director described himself as *"fairly critical over the years"* of KSF, despite the major efforts they have put in to get widespread usage, and felt *"we really need KSF lite or KSF Made Simple"*. In terms of using the KSF template, one manager told us that *"it's the same every year, it can be repetitive"*, while another said *"99.5% is the same, so I skip a lot of questions and focus on what people want to talk about"*.

But managers in the focus groups also thought the PDRs were essential and worthwhile, *"it's really good"*, *"it's valuable"*, *"it teases out new skill requirements"*, *"it's a chance to say well done"*, *"it's fair, it gives everyone a say"*, *"it gives staff something to work towards"*, *"it gives clarity for a new starter"*. The KSF is also related to the Trust's 'Listening into Action' staff engagement drive to improve services by listening to, involving and developing staff – *"it shows you care about staff"*.

Streamlining the required evidence as far as possible and making sure it can be used for a variety of purposes has obviously been successful, and the managers we spoke to also emphasised the importance of commitment from the top – the Chief executive takes a personal interest and leads by example – while the Executive Team receive and review a monthly monitoring report broken down by division. Currently the Trust used the PDR part of the ESR for monitoring, and has developed its own monthly report in traffic light format.

In terms of linkages, Bands 2 and 3 are mapped across to NVQ competencies, and Band 5 is linked to NMC competencies and the Trust's own preceptorship scheme for newly qualified nurses.

But directors and managers also recognised that a lot of the weaknesses in appraisals and PDRs cannot be blamed on the KSF, such as lack of management time and attention. One reviewing manager told us that *"the effectiveness of the PDR depends mostly on the manager"*, and *"some managers are scared to talk to people"*, while others *"see it as a waste of time"*. Management training and development therefore, according to one director, is *"a significant part of the answer"*.

All of the people we spoke to were also were very wary of being described as "exemplars" on KSF. feeling that *"we're a trust that's had some success in getting people through appraisals"* but very aware that the quality of these are not always what it could and should be, and that if the pressure is not kept up and *"the eye taken off the appraisal ball"*, then coverage could easily fall back again.

4.8 General Lessons and Advice for other Trusts

This section has summarised a considerable body of information and material that we gathered in visiting some very different NHS trusts, although all appeared from national data to have made significant progress in their use of the KSF and related appraisal and development processes.

While they almost all resisted any suggestion that they might be exemplars, nonetheless we asked each of them for the advice that they would give, based on their own experiences, for other organisations who wanted to improve their use and coverage of appraisal and the KSF. Their suggestions are contained in the table below.

Figure 4.3: Summary of Learning and Advice for Other Trusts

Trust	Summary Advice and Learning Points
Greater Manchester West Mental Health NHS Foundation Trust	- Focus on appraisal and on ease of use, with genuine two-way communications and involvement. - Design a simplified pathway and clear guidance to help managers and staff through the process: staff 'get' the wheels used at Greater Manchester. - Use KSF as a reference tool to support a common appraisal process i.e. lead on appraisal, not KSF for its own sake. - Make KSF relevant, link in to trust and personal objectives and performance. - Allow some flexibility in application, to "pick and mix" to suit.
Kings College Hospital NHS Foundation Trust	- Position KSF as part of the wider performance management and appraisal process, with a focus on organisation objectives and outcome-focused objectives for the individual, as well as consideration of training plans and needs. - Focus in on how a job adds value and the most relevant dimensions only. - Train and support the process, especially initially, use champions and run regular sessions on the aspects people find difficult eg evidence. - Set timings and targets, make the time for it, delegate but hold mangers to account.
Plymouth Hospitals NHS Trust	- "*Put the Trust objectives up-front, show how it makes a difference to patients … link it to the values of the organisation*". - Package KSF up as an integral part of the appraisal process. - Set the example from the top, make sure managers take it seriously, train them. - Set targets, monitor progress, hold managers accountable. - *"Make it as easy as possible for staff to understand"*, provide extensive communications and clear guidance. - *"Recognise it is a long-term thing, not a sprint"*.
Rotherham Primary Care Trust	- Leadership provided by, and buy-in of Heads of Service. - Active local involvement of 'champions' and TU reps. - Good, clear collaboration between management & staff reps.

	- KSF outlines made a requirement at recruitment. - Briefer, more focused and centrally developed post outlines, with minor local tailoring. - Sharing good practice within and between trusts, provide national exemplars. - Providing a small amount of additional financial resource to each trust to support a re-launched initiative, with the financial award outcome-related to successfully achieving improvements in coverage and quality.
Salford Royal NHS Foundation Trust	- Tailor it to suit your own needs, "make it real for each organisation". - Simplify: develop some core national standards and then let Trusts adapt and modify. Focus on the quality of dialogue and conversation rather than the paperwork and process. - Link it to other HR systems – the job specification, Trust and personal objectives, career development, recruitment criteria etc. - Use early exemplars to encourage/support others.
Sandwell and West Birmingham Hospitals NHS Trust	- Simplify, standardise and streamline. Reduce appraisal and KSF documentation to a few straightforward pages and include simple guidance. - Design practical training and ensure that all reviewing managers go on it. - Link KSF to other sets of competencies eg NVQs, professional bodies etc. - Communicate early and often – tell staff about KSF and post outlines at induction, remind managers and staff at team meetings. - Drive from the top and don't fill posts unless there is a KSF outline. - Use successful areas as examples/buddies to help others. - Show commitment from the top, and report and monitor progress and performance on PDR coverage on a monthly basis. - *"Relate to wider programmes to involve and develop staff's contribution"*.

While as you can see, there are some suggestions for national initiatives and additional resources, the interviewees in these trusts were generally almost apologetic to us for not coming up with fantastic and radical ideas to totally transform the KSF. **In the main their suggestions focus on what one director referred to as *"the universal basics"* of good appraisal and personal development**: having effective two-way conversations in meetings, having well-trained and skilled managers, achieving positive outcomes in a reasonable time-frame, setting the example from the top of the organisation and monitoring progress and outcomes, and so on. But doing the simple things well and consistently in any organisation today in our fast-changing world is far from easy.

Our external research has similarly highlighted simplification and doing the core components really well as being at the root of successful appraisal and personal development. These same points have been emphasised by other trusts and

individuals who have kindly submitted their experiences and ideas on how to improve KSF to us, including Knowsley Health and Wellbeing and Cambridge University Hospitals NHS Trust.

Synthesising these suggestions on how to improve the quality and coverage of KSF across the NHS in a slightly different way, we would summarise them in three categories: the strategic and policy direction in the organisation; the design of the KSF and related processes; and the actual operation of them in practice and support and guidance for them.

In terms of **strategic approach**:

■ all these organisations stressed the importance of leadership and drive from the top, not just having a board director formally responsible for it, but the chief executive and all directors genuinely setting the example on using the KSF, and regularly reviewing and monitoring and if necessary taking action to continue to improve coverage and quality of usage; some had also put formal rules in place to ensure adherence to the use of KSF, for example by not filling vacant posts if there was no KSF outline written;

■ partnership and a two-way approach to KSF was also emphasised by many, and was evident to us from our visits, be that through formal partnership structures with trade unions, extensive and regular staff communications, training for staff as well as reviewing managers; an acknowledgement that successful appraisal and personal development cannot be imposed from above; and formally relating the KSF to other programmes for involving staff;

■ KSF in almost all cases was clearly positioned as an integral part of a wider appraisal process, which also included aspects of personal objectives and performance, in some cases wider attitudes and behaviours, and often also departmental and trust goals; in this way KSF was clearly not seen to be something to be done for its own sake or because it was mandated, but because it genuinely made a difference to what people did, how well they did it and how the trust performed and delivers its services;

■ many of the trusts emphasised also that this process is a marathon rather than a sprint and were very aware that usage could quickly decline in the busy environment and competing priorities which they faced; while they did all point to an initial hurdle of getting through all the KSF detail in the first year of operation before there could be widespread recognition of any real value in it, they also mentioned the need to retain training and project support networks such as local champions and advisers thereafter;

In respect of the actual **design of the KSF** and related processes:

■ while some had make some fundamental changes to the KSF dimensions, for us an overall simplification of the whole process and the production of a pragmatic and workable way through the detail of KSF was the more widespread response in these trusts; as one manager told us *"taking a practical, pragmatic approach is critical otherwise people find it confusing and over-complicated, which completely distracts from the value of the process"*; concentrating on the core dimensions and not going into all the detail behind them was a commonly practiced approach, for example;

■ they were all also providing a simple and clear route map and guidance through the KSF process for managers and employees, something of size and scope which fitted between the 2 page DH summary and the almost three hundred page KSF manual; Manchester's steering wheels were perhaps the most visual example of this, which also served to link KSF in with the related aspects of personal performance; none of these trusts were insisting that all managers and staff covered went through the full detail of the standard national process every year;

■ these trusts have also worked hard to link KSF to other related training and HR processes, for example professional competency frameworks and NVQs; they emphasised that this serves to improve the evident usefulness of KSF and also meant that more 'outputs' were evident from the same amount of KSF work and time, for example using the evidence gathered for the KSF-based PDP for other purposes; *"make it real and relevant"* was something we heard on many occasions; a number of the people we met though still had concerns about the links between the personal development plans and subsequent delivery of training in their trust;

■ KSF post outlines are the first step in the process and most of these trusts reported that they had initial difficulties with these, because this had produced overly-lengthy and impractical 'outlines', which jeopardised the whole process founded on them; most had therefore worked to streamline and standardise these outlines in their trust, and a number suggested that this should be done now on a regional or national basis;

■ 'flexibility' was perhaps the other watchword from these trusts, in allowing for variation in how KSF was operated and applied in the varied parts of their organisation and from year to year; while a number had introduced some variations to the national design for managers and more junior staff, more common was to allow flexibility in operation and allow for adaptations to emerge in response to local needs, like the Facilities log books example; the focus in these organisations appeared to be on ensuring the PDRs happened and then working to improve the quality of conversations in these meetings,

rather than focusing on the paperwork and 100% completion of every detail of it;

■ there was surprisingly little discussion about pay in our case study visits; one trust is planning to strengthen the links between the assessments based on KSF and pay progression, but most appeared to be very much emphasising the use of KSF as a development process, with pay progression a subsidiary linkage that was only relevant in a small number of unusual cases.

And in respect of **operation:**

■ all the trusts reported that any problems they experienced were not just to do with the design of KSF but with managers who did not have the motivation or skills to effectively appraise and plan and deliver development for their staff, and so training and coaching and supporting these managers was felt to be critical; we were given many examples of successful and practical ways in which this training was being delivered;

■ a number of these cases had formally or informally introduced "rules" to support the quality of the process, such as no manager should appraise more than 10 staff, no manager can appraise without receiving the relevant training, and so on;

■ sharing and publicising good practice across the trust was practiced and recommended by most, with a number also extending this principle to recommend broader networks across the NHS for doing so;

■ we also talked surprisingly little in these trusts about the eKSF and KSF administration; this is not to say it was not an issue and the perceived inflexibility of the eKSF in conjunction with the over-detailed design of KSF was regularly mentioned as a barrier, particularly early in the implementation of KSF; a number reported that they were moving to the eKSF to cut paperwork and improve monitoring, but only once they had got the PDRs and related processes reasonably well-established in their organisations; administrative solutions also seemed to vary according to the existing information and performance management and HR infrastructure in each trust – using an existing performance scorecard system to attach KSF to for reporting progress, or encompassing within an existing Snowdrop HR information system for example.

These were some of the key suggestions and ideas that we took forward in later stages of this review to test more widely in our e-survey and also to trial with those trusts which had reported lower levels of KSF and appraisal coverage and usage.

5 Findings from the Second Phase of Case Studies

5.1 Introduction

The second phase of case study research again involved us focusing on a small sample of different trusts, but this time characterised by comparatively low levels of reported appraisal coverage and use of the various aspects of the KSF, as indicated by national survey figures. The aim was to examine how and why the circumstances and experiences with the KSF in this sample of trusts was different from our first phase trusts. This could give us insight into what would be required to improve the coverage and quality of PDRs and appraisals.

Perhaps not surprisingly, securing the participation of organisations in this phase was more difficult and a number of trusts declined our invitation. However, five trusts agreed to take part. They are briefly profiled in the table below and we are very grateful to them. Again, we tried as far as possible to ensure a diversity of types and locations. Generally, fewer than 40% of staff in this sample of trusts had had an appraisal in the last twelve months, around half of the level evident in the initial trusts.

Adopting the same methods as for the first phase trusts, we interviewed the head of HR/OD/Learning and Development with overall responsibility for the KSF as well as meeting samples of other directors and senior managers, HR and training staff involved in operating KSF, reviewing managers, professional and non-professional staff, staff-side leads and Union Learning Representatives. Where action was not already being taken to address the relatively low take up of KSF and appraisal, we also held follow up meetings to consider and plan possible improvements.

In total across the five trusts we spoke to ten directors/managers/KSF leads in HR/Learning and Development, three other directors/senior managers, eight

reviewing managers, three trade union representatives and 31 other members of staff.

We felt it appropriate to keep the identity of these trusts confidential and so in the rest of this section, we draw out the key common learning points across them, describing their situations, their experiences with the KSF, and what they are planning or actually doing to address low coverage.

Figure 5.1: Profiles of the Second Phase Case Studies.

Trust	Profile
A	Acute trust in the North providing secondary hospital care from multiple sites. Approximately 5,000 staff. In the 2008 NHS Staff Survey the low proportion of staff agreeing they had had a well structured appraisal was one of three findings that the Trust committed to addressing, and coverage increased in 2009 to 42% of staff.
B	Ambulance trust created as result of a number of mergers with approximately 3,000 staff. Overall appraisal coverage is 32% but this masks wide variations across the Trust. Around 90% of roles have KSF post outlines – it took approximately two years to integrate and finalise these.
C	Large acute trust in the South operating from two main sites with over 1,000 beds and approximately 6,000 staff, and highly varied socio-economic mix in population served. Appraisal coverage is in the low 20%s and 18% of staff had a KSF-based PDR.
D	Acute trust in the North operating across multiple sites with nearly 2,000 staff. Appraisal and PDR coverage was low in 2007/8, with 18% of staff receiving a KSF-based PDR, but following a series of changes in approach, by April 2009 appraisal coverage had increased substantially to almost 80%.
E	Large acute trust in the South East with three main hospitals. The Trust had a 70% appraisal rate but in the first year of KSF's introduction this fell to 40% and went subsequently as low as 8%. Following a re-design, the appraisal coverage in 2009 is back up to 43%.

5.2 Context

5.2.1 Performance and Operating Pressures

An initial interpretation of why trusts such as those we looked at in this phase of the research had low rates of appraisal and KSF usage might have been that they were challenged more generally in their financial and general management and had more broadly-based performance issues. But this was only partially borne out by our case findings. Two of the trusts had been subject to a series of major re-organisations and senior management changes, and another noted in its annual report that there has been considerable turnover of senior managers and directors in recent years and that this has been detrimental to the organisation.

Two of the trusts had been formed from a series of mergers in recent years, giving them a legacy of markedly different policies and practices for appraisals and PDRs

(seven different systems were reported in one of the trusts). Trust B had been affected by capacity issues and staff shortages, and two trusts acknowledged they were not clear about the overall trust purpose and goals and were still searching for a successful business and operating model. A number of the trusts rated their large size and *"busy-ness"* as being key barriers to KSF and appraisal, the *"very pressurised environment"* being they felt both a genuine barrier and a good excuse for managers for not carrying out these processes.

Even in our relatively short-term research, in two of the trusts in particular the day-to-day operational pressures and related difficulties this presented for effectively operating any KSF-type system were very obvious. The ambulance trust was operating well over capacity. In one trust which had scheduled paid time to hold appraisal and PDR discussions, staff told us that you might come in for that purpose but then be rostered to work immediately to cover a shift absence. Another told us of the difficulties of booking rooms for meetings and accessing terminals in order to use the e-KSF.

The debates we had held with our stakeholder interviewees about the finer details of KSF dimension definitions and other aspects of the system appeared somewhat academic in this context, when the struggle to find the time and facilities to hold a PDR meeting were so obvious. One HR manager we spoke to contrasted the situation in this trust with her former employer in the South West. Here the KSF and e-KSF had been introduced with *"no problems"* in *"a completely different environment"* which was *"small and stable"*, and where there had been the resources for two HR staff to spend *"six to nine months of solid work"* to work with managers and *"hold their hands"*.

Trust D received a rating of 'fair' for quality of services and 'inadequate' for financial performance in its latest Annual Health check. But we saw in the earlier case studies that operational pressures and challenges in securing time and space to hold PDR meetings were not restricted to these lower coverage trusts, and nor were all these trusts underperforming on other service quality and financial dimensions. Trust A for example received 'good' and 'excellent' ratings on these aspects of performance in their latest annual check, and two of these trusts had won national awards in the past twelve months.

5.2.2 Cultural Barriers

As in the first phase case studies the idea of an "appraisal culture" was mentioned to us by interviewees in most of these trusts. At Trust C for example we heard that since the 1980's there had been *"a culture of not doing appraisals"*. The history and inheritance of PDRs and appraisal obviously affected how the KSF was received, not just in these trusts but right across the NHS.

In one Trust we were told about the dual problems of long serving managers who had never done appraisals combined with manager turnover in some areas of the trust which meant that there was a regular influx of new managers who did not know the system. In another we heard that though the percentage of staff having full KSF-based appraisals was 18%, *"a lot of managers are doing non-KSF appraisals"*. And in another, *"a single KSF lead, who has other responsibilities simply cannot turn around decades of non-appraisal culture"*.

In one case the staff side representative told us that a full KSF review took at least one and a half hours to complete and so was impossible to carry out under current operating pressures. He felt that *"it has to be done properly or not at all"*. Someone else there told us that *"operational staff are in the ambulance – they cannot take time off to do appraisal"*.

A history of low use of appraisal was not the case in all five trusts however, and the overall coverage masked some significant internal variations. While Trust A told us that appraisal coverage had historically always been an issue and *"very patchy"*, Trust E had had a 70% coverage before the introduction of KSF. In the majority of these Trusts, whatever the overall coverage, people described the practice as *"very varied"* and *"patchy"*. In one of the trusts for example 94% of Bands 7 and above had had an appraisal in 2009 but only 28% of other bands, and we heard of divisional and functional variations ranging in one case from 11% to 44% appraisal coverage and variations by staff grouping ranging from, in another example, 20% to 90% coverage.

Nurses in the one trust were described as *"always a challenge"* for this type of process, due to the wide spans of control and pressurised working atmosphere on the wards. Other groups such as medical secretaries in one trust and ancillary staff in Trust D faced unchanging job roles from year to year and reportedly had little interest in personal development due to the lack of opportunities for career development.

But by contrast, in another trust we were given positive examples of how the KSF had worked well for HCAs, some of whom had acquired skills and competencies, been sponsored through training and had achieved RGN status. There was also evidence that some specialities such as pathology and pharmacy departments had engaged fully with the principles of KSF if not the system itself, and were making use of professional frameworks to support related appraisal processes.

5.3 Experiences with the KSF

5.3.1 The Implementation Approach

The reported experiences in these five trusts were not that other performance and financial issues had prevented any serious attempt to implement the KSF. Indeed, they had generally approached implementation as one director told us *"100% by the book"*, with none of the apparent simplification or taking of 'short-cuts' that we saw in some of the first phase trusts. *"It's a national framework that shouldn't be changed"* was the view of the KSF lead in one case, *"we used KSF like tablets of stone"* in another. In Trust D two employees in a group discussion who were relatively new expressed surprise at the literal interpretation applied to the KSF post outlines and volume of evidence that was assumed to be necessary. In another of the trusts the implementation was described as *"rushed"* with a *"tick the box for having done it"* emphasis.

But all these trusts had appointed KSF champions, they trained managers and staff and commenced writing post outlines in the specified manner. Indeed, one of the trusts had apparently been described as an exemplar for KSF by NHS Employers. They had a number of KSF leads, job holders were involved in the development of post outlines and the detailed post outlines generally included six or seven additional as well as the six core dimensions.

5.3.1 Excessive Detail and Bureaucracy

The majority of these trusts therefore had tried to implement a comprehensive and detailed approach to personal development and pay progression under the KSF, often in a challenging set of financial, operating and performance circumstances. This was a combination which in the views of our interviewees meant that, as one put it, *"KSF was just too big and cumbersome … it would never have worked in a million years in a trust like this"*, it was *"just unworkable"*. In another of the trusts KSF was described to us as *"too complicated and bureaucratic"* with *"far too much paperwork"*, so managers and staff *"got lost choosing amongst all the other dimensions and levels"*. *"You didn't have to write War and Peace under the KSF, but we did"* was how one HR director characterised the literal approach adopted in their trust.

In another the Head of Learning described the KSF process as *"clunky, unwieldy, wordy and not user-friendly: managers do not like the KSF"*. They told us that common manager complaints included, *"it takes too long"*, *"I forget how to do it"* and *"I have to look at the screen rather than the individual"*. In Trust E appraisals were reportedly taking up to five hours as managers and staff discussed, evidenced and ticked off examples and illustrations. As pointed out to us in Trust A, taking ten minutes to discuss six aspects of each of the six core dimensions of itself could take six hours,

although there only a minority of managers appeared to have tried and become disillusioned with the process.

In Trust D we were told they had *"had great difficulty in choosing the right number of dimensions and the levels of competence for each dimension"*. According to one interviewee, *"the quality of the conversation had gone"*. In Trust E, referring to a key requirement highlighted by the first phase trusts, we heard that *"staff came out of these lengthy sessions without any clear idea of what they were to do, how they were doing, or how they fitted into the organisation"*.

The majority of these trusts had not attempted to use the e-KSF, and in one that did, managers apparently also struggled with this as it *"did not allow any flexibility"* and *"managers spent too long filling in the online form rather than talking to people"*.

Some of the people most closely involved with implementation told us that KSF *"wasn't as bad as it looked"* and the e-KSF had *"some excellent features"*. A KSF lead told us that *"you need to get them past the 'Oh my God, I've got no time' stage"*. But we sensed the system in these trusts never got enough of a foothold to get past this stage in order for these potential benefits to become evident. It seemed that the HR and Learning and Development staff, at least initially, had been keen, but that they were pushing against an increasingly reluctant and unreceptive organisation.

HR, operating managers and staff struggled with working through the details of KSF outlines and the appraisal system generally, appraisal rates fell and confidence in the new approach declined with it. There was perhaps less confidence and competence in some of these trusts to make modifications or to simplify and focus initially only on parts of the process, so as to at least get the KSF up and running and establish a platform for future extension and improvement.

5.3.2   Senior Management Direction and Management Capability

Senior management changes in a number of the trusts also often meant that there was no clear and consistent expectation from the top that KSF had to be done, nor systematic monitoring of rates of usage. In one case we were told *"the lead in HR left the trust, so the momentum was lost and the KSF outlines (were) never used properly"*. In another it had *"never been a priority"*. Corporate objectives and performance targets in some of these trusts had become opaque and there was no clear cascade of objective setting.

The managers we spoke to in Trust D for example, even at fairly senior levels, saw the appraisal and KSF paperwork as too complicated and essentially a bureaucratic chore to go through, rather than seeing the real benefits of investing time in the process to improve skills and performance – *"a paper and pen exercise to*

keep managers happy". In Trust B, at one point senior managers had put a hold on KSF reviews being carried out due to operational pressures.

Management structures were not always helpful to the KSF process in these trusts. In Trusts B and D there were some very wide spans of control, in some cases exceeding one hundred staff and managers had very limited contact time with their people. In Trust B, when asked if the process could not be delegated to supervisors, we were told that adding this responsibility to their role would raise their job banding and was not possible.

Management capability was an issue raised in our trust visits, not just by HR staff, but also by line managers themselves. In one trust we heard that there was *"no clear understanding (by managers) of why KSF is worth doing"*. In Trust D some managers we spoke to described themselves as nervous about their appraisal skills and wanted more coaching and support. In one trust staff in a focus group also told us that they saw little point in KSF as *"the paperwork went back in the cupboard"*, and they had heard stories of staff being asked to fill out the paperwork themselves.

The majority of these trusts had only had KSF champions in the first year of implementation, and told us that having the role continuing for longer would have been very helpful in extending understanding and usage of KSF. Mergers and re-structuring meanwhile introduced the additional complexity of relating the KSF to a diverse range of appraisal systems and cultures, served to put KSF *"way down the list of priorities"*, as well as highlighting inconsistencies in how the KSF had been introduced. In Trust B, one of the merging trusts had almost 100% appraisal coverage and when we asked why the difference with the other parts of the organisation, we were told that the managers there prioritised it and *"were onto it"*. But the coming together showed that for some jobs there were differences in the bandings, and in others differences in the KSF dimensions and levels described on very different job outlines. The harmonisation process in this merged trust had taken two years.

5.3.3 The Pay Link

We heard much more about the issue of the pay link and the impact of KSF on pay in these trusts compared with the trusts covered in the first phase research. In those trusts we visited formed from mergers, the differences in the post outlines and bandings for the same roles in their previous organisations had quickly became evident.

According to a training officer we interviewed, *"people didn't like the KSF as part of AfC, they saw the whole process as unfair"*. A senior manager believed that the link to pay had been *"a big mistake, it gave KSF no chance"*, and in another trust the Head of

Learning's view similarly was *"we were rolling it out as people got their banding results and opposed the whole thing"*. So the pay aspects, which were perceived to be unfair, had prejudiced the reception of the developmental aspects of KSF.

In the opinion of the HR director in Trust E the pay link had also necessitated the heavy and unworkable level of detail in KSF as *"if the KSF was not done thoroughly, line by line, then how could the pay decision be made?"* The impression created was that *"the bigger the post outline, the more the pay"*. She also said that progression for some staff there had been held back in the first year of implementation.

However, we were told that in the majority of these trusts, partly because of low rates of KSF usage, pay progression through the gateway points continued to be automatic, (as it reportedly had been in the first phase trusts as well). In one of the trusts where the Learning and Development function did monitor progression, they found five individuals where the reviewing manager had initially recommended the next increment be withheld. But in every case subsequent investigation found there to be a lack of evidence to justify this and so the progression went ahead anyway. In another of the trusts we were told that the gateways were always "open" because the payroll system would not permit a "closed" position.

5.4 Changes to the KSF

Another possible interpretation of these trusts, that they would be struggling with the KSF and appraisal and would benefit from help in action planning improvements, was also rapidly found to be false in our field research. All had made some changes already to address the situation, in two cases working with the existing KSF, but in three cases this had involved introducing a new appraisal system which either replaced the KSF process or only used it in a supporting role. In two of the trusts we did help to discuss their initial actions and plan out other possible initiatives.

The figure below summarises the changes made and actions taken by these five trusts.

Figure 5.2: Changes to KSF and Appraisal in Phase 2 Trusts

Trust	Changes Made and Proposed
A	- New chief executive involved staff in developing Trust values and *"the expectation from the top now is that everyone should have an appraisal on a regular basis to help deliver on our service objectives - it's moved to the top of our agenda"*. - Objectives cascaded down often with team discussion eg focusing in facilities on absence. - New Performance and Development Appraisal introduced and being progressively implemented with *"less emphasis on the KSF … it's in a supporting role"*. KSF really only relevant now at pay gateways and not part of the standard staff training. - Three components are: reflect/prepare; behavioural evaluation; work and development objectives. - Emphasis on conversations: *"as long as they are having good conversations, we are not too worried about the paperwork"*. - Dimensions replaced by five behavioural competencies eg patient focused, achieving results, working together, with indicators/contra-indicators against each, varying by staff group. - No overall rating, but self rating on four point scale on each behaviour and they would like to move to *"full performance management system, with consequences"*. Also introducing rating of potential for succession and career planning purposes. - Investing in leadership development programme with appraisal defined as being a key part of the management role.
B	- Board monthly monitoring of coverage by grade/Division and target date for 100% appraisal completion. - Recognition of need to sell the benefits of KSF more strongly to managers and staff. - Plan to introduce KSF to new staff during induction - Team appraisal approach being piloted. - Possibly will delegate appraisal responsibilities down to supervisors. - Acting to build time for KSF reviews by not rostering people and/or carrying out some reviews in employees' home. - Want to establish stronger links with career planning and other training initiatives eg professional bodies, and share experiences on KSF with other trusts.
C	- New chief executive and HR director appointed within the last two years – *"appraisal is seen as key, it is being pushed heavily"*. Trust performance is improving and the level of complaints declining. - Cascade of objectives and targets from the top, often with divisional/team discussion of objectives prior to individual appraisal. Development linked to objectives now. - Removal of link of the KSF and pay – purely about personal training and development. - Tightening and tidying up KSF post outlines. - Simplification of KSF documentation to *"six punchy questions"*. - Delegated KSF and appraisal by agreement. - Learning and development is not funded unless an appraisal has been carried out and mandatory training is up to date.
D	- New HR Director appointed 2009, who has set 100% appraisal coverage as a key

Trust	Changes Made and Proposed
	target, with a dedicated project manager.
	- New system of Performance and Development Review introduced. Five components are: preparation form; PDR form for personal objective setting and review; mandatory training form; personal development plan; and completion form which goes to HR and is entered onto ESR.
	- Team meetings and objectives set in some areas.
	- Paperwork is simpler and shorter than the KSF (though some managers told us it was still too long and complex).
	- KSF in optional supporting role eg optional question on KSF post outline.
	- Interest in learning from other trusts and in better links of KSF with other professional competency frameworks and NOS.
E	- New HR director 2009, and KSF was assessed as being *"burdensome, lengthy and of no benefit"*.
	- New appraisal system introduced which is called Annual Appraisal Review. It aims to ensure that everyone *"has objectives which contribute to key departmental and service priorities"*; *"are clear about your performance"*; *"receive feedback"*; and have development needs identified.
	- The three components are: pre-appraisal questionnaire; objective setting; and personal development planning. The PDP/ learning needs section in the appraisal is where the optional link to KSF is retained. The three main areas covered in the discussion are: commitment and behaviours (commitment, professionalism, personal communications, attendance, timekeeping), rated on a three point scale; performance at work; and potential (for leadership. education and research).
	- New system is *"KSF-related"* but *"not an integral part of the process"* and only on a voluntary basis. Many nursing and other professional staff have continued to use it, but others have not. KSF post outlines are no longer being written and maintained.
	- The emphasis is on the quality of the conversation in appraisal meetings.

As with the first phase trusts it can be seen that **there is fairly high degree of consistency in the actions taken, amongst these trusts and with those in the first phase,** including:

■ a stronger drive for appraisal completion from the chief executive/board, usually following a senior management change;

■ linking the development planning process into personal objective setting and making both part of an integrated appraisal process. As one HR director told us *"with KSF, you go through all of the individual dimensions and people still didn't know if they were doing the job properly"*;

■ in the context of a much clearer sense of trust purpose and objectives and cascading of objectives down to teams and individuals. As someone in Trust A told us, *"you've got to bring it to life, it won't happen if it's not meaningful for the person, the department and the trust"*.

- the simplification of paperwork and process , *"a shorter and smartened up KSF"* and associated changes to reflect operating realities, such as delegating reviewing responsibilities and team objective setting where necessary;

- de-emphasising and in some cases removing the link to pay and making the appraisal process focused on personal objectives and development;

- combined with linking KSF and appraisal more clearly to other training initiatives and other competency frameworks;

- paying increased attention to the quality of the appraisal process and the conversations going on, rather than just the level of coverage. There was also a move in two of these trusts away from skills to using behavioural competencies to help make the process more relevant to trust performance and meaningful to individuals. One trust told us, *"the direction of travel is towards simplification and focusing on how people act and behave, rather than what they know – that is what most complaints relate to"*.

Whilst we have only examined a small sample of trusts in each phase of this research, **there was a higher degree of change evident in these second phase trusts,** with the KSF relegated to a supporting and optional role, possibly because of the greater level of operating difficulty experienced with it. While they may have talked about operating KSF *"more flexibly and pragmatically"*, in reality in at least two of these trusts, with no induction or training or maintenance activity, then the likelihood must be that the KSF process will cease in future.

The second phase trusts were divided on the wisdom of moving away from a national system. While some were concerned at the loss of career mobility that this might present, and most were interested in sharing experiences and learning from other trusts, others felt a national and *"inflexible"* system was no longer relevant in an NHS comprising of foundation trusts. As the lead in one told us, *"we soldiered on with KSF in the early days as we had to. Now as a foundation trust, we can do what we like"*.

When asked if they could have retained the core KSF dimensions and modified these to retain an element of national read-across, the two trusts with totally new approaches reported that it was simpler and easier, given their history, to start with something new. And as they pointed out, given the different bandings and post outlines for similar jobs evident under AfC and KSF across the country, there was not any national consistency in the approach at present.

However, even these trusts were not beyond advocating the national input of more financial resources to make appraisal processes work more effectively, which perhaps not surprisingly, we heard more frequently from these second phase case studies.

Were these changes being made to the KSF and appraisal having an impact? In most cases the new appraisal system and other changes were still being rolled out so it was too early to make any assessment. In Trust E appraisal rates had increased back up to around 40%. In Trust D appraisal coverage had increased significantly with the new system up to 80%, but interestingly managers and staff in the groups we spoke to there still tended to describe the process as too complex, perhaps illustrating the difficulties of turning around management cultures which had not historically regarded appraisal as a good investment of time, with limited resources and facing demanding operational pressures.

In Trust A managers and staff had found that *"they can relate more to the behavioural competencies, it's about what they do every day in their job".* But even here, the learning and development staff we spoke too felt that appraisal implementation would probably continue to be *"patchy"* and related to the predisposition of individual managers. Hence two of these trusts advocated much heavier investments in management training and coaching to drive and embed the required improvements.

5.5 Section Summary

> *"It was a tick box exercise to see have you met all the detail of your lengthy post outline … people still didn't know if they were doing the job properly".*

Our second research phase case trusts with lower rates of appraisal coverage and KSF usage than those we visited in the first phase generally faced tougher financial, operating and managerial environments than those trusts with higher coverage and usage. They in the main faced some major performance issues and most had experienced disruption from senior management changes and re-organisations. But the lower coverage was not the result of not having attempted to implement the KSF at all in these generally more difficult contexts, but in fact quite the reverse.

These trusts had generally, initially at least, attempted implementation absolutely *"by the book"* as a central 'dictat', rather than because of the clear and explained service benefits KSF could offer. Compared to the higher coverage phase one trusts, there appeared to have been less attempt to provide simplified guidance, to take short-cuts and focus on priority areas in the process, and perhaps most of all there had been less integration with other appraisal and training and development processes.

As a result, the second phase trusts tended to experience all of the worst aspects of the KSF – the lengthy meetings, the detailed paperwork, the box ticking – and few of the benefits. Where there was existing low appraisal rates it simply reinforced management – and in some cases staff – prejudices that in whatever guise, these

types of process were a waste of time. Where there had been higher rates of appraisal, implementation of KSF had led to a decline in usage and disillusionment had then set in.

However, these second five trusts generally have not waited for the KSF to be re-designed as a result of reviews like this. Instead, often in conjunction with new leadership and a clearer vision and set of trust objectives, they have consciously planned or already introduced re-designed and simplified appraisal processes as the basis for better objective setting and personal development in the trust. The majority are already reportedly showing signs of improvement in coverage, although they, like the phase 1 trusts, recognise the continuing challenges to ensuring quality conversations take place.

They have attended to the basic requirements for effective appraisal and development planning to take place, and in two cases they are even extending this new system to encompass succession and career planning. They can also see the potential for further improvement through the allocation of more resources (of course), better management training and support, and more experience sharing between trusts.

While the direction of change towards simplification and relating to what staff actually do in their job is fairly obvious, the extent of the move away from using KSF, to at best retaining it in a supporting role, surprised us. As one trust told us *"it's not fair and equitable unless it's done thoroughly – any dilution makes it not worth the effort"*. Facing up to the task of harmonising and simplifying a myriad of post outlines had led another trust to the conclusion that it was simpler to start from scratch with a new and locally-developed and owned process. They have adapted at best, or removed KSF, and re-designed an appraisal and development process to suit their own purposes, coming up with revised systems that they believe are much more relevant and useful, with buy-in from local line managers.

While these trusts have given us many ideas and examples of ways in which the KSF can be improved and streamlined, they also illustrate some of the **key strategic and policy dilemmas** in moving forward with the approach. These include:

■ should the KSF be operated *"like tablets of stone"* to support an integrated approach to personal development and careers across the NHS in England, or *"as a supporting framework, in a way that works for you"*, tailored and varying to suit the different needs and characteristics of each trust?

■ should it become a purely training and development planning and review process, which links in more effectively with other national, professional and local training initiatives, or does the link to pay progression need to be not only retained but strengthened?

■ should KSF link into performance appraisal and if so, how – as the leading element, an integral component, a supporting process or an optional extra?

We move on to consider these policy issues and make recommendations for improvement in the final section of this report.

6 Survey Findings

6.1 Introduction and Respondent Profile

Having developed our knowledge and thinking on the Knowledge and Skills Framework in our case study trusts, a wider survey was carried out in order to

■ better understand the factors that have prevented the full adoption and use of the KSF; and

■ investigate on a broader basis in the NHS the changes required to improve the coverage and quality of its application.

The survey was carried out using the internet in November 2009. A questionnaire was developed and tested in conjunction with NHS Employers and the Project Management Group. This was primarily designed in a 'tick box' multiple choice format, with space for respondents to add additional information and comments. The final questionnaire is contained in the Appendix. It was hosted on the IES website for a two week period for individuals to complete.

The various parties and individuals involved with KSF at the national and regional level were invited to complete and circulate on the survey questionnaire. For example, NHS Employers informed their members in HR roles through their regular newsletter and placed a link to the survey on their web site. An invitation was also extended to the KSF Help on-line community.

In total we received 330 completed responses of which 46% were from Acute Trusts, 7% from Mental Health Trusts, 2% from Ambulance Trusts, 29% from PCTs and 16% of responses were from other types of NHS organisations. Of those respondents that worked in trusts, some 28% were from Foundation Trusts.

We also asked respondents about their position within their organisation. Some 3% of respondents were HR Directors, 12% were HR managers, 21% were trade union representatives; 16% were learning and development/training managers; 15% were within the physiotherapy service, 6% were other clinical specialists

including nurses; 6% were KSF leads and 21% were respondents holding various other job posts within the NHS.

In this chapter we look at the results of the survey covering the following issues:

- the coverage of the KSF within the NHS organisations surveyed;

- the quality of components of the KSF;

- the KSF's links to pay progression, wider appraisal and performance reviews and aspects of training and development;

- the communication and understanding of the KSF within trusts;

- the main barriers to the use of the KSF, considering on policy/strategy, design and operational issues

- suggested changes or improvements in terms of how successful they would be in embedding KSF usage within the NHS;

- additional comments from respondents about improving the take-up and effective use of the KSF

6.2 Survey findings

6.2.1 Coverage of the KSF

As in the NHS Staff Survey, the coverage of the appraisal and use of KSF was reported to be fairly low across the respondents' organisations, with its use lowest amongst the Ambulance Trusts and highest across Primary Care and Acute Trusts. Only around a third (37%) of all respondents stated that more than three-quarters of their staff had received an appraisal over the past 12 months.

Primary Care Trusts had the greatest proportion of staff that had received an appraisal, with 45% of PCT respondents stating between 76% and 100% of staff have been appraised over the past year. Ambulance Trusts had the lowest proportion of staff receiving appraisals with 33% of respondents stating less than half of their staff have received an appraisal (however half of respondents from Ambulance Trusts provided no data for this question).

Table 6.1 Proportion of staff who had received an appraisal in past 12 months

	0-25%	26-49%	50-75%	76-100%	No response
Acute Trust	5%	13%	32%	36%	14%
Mental Health Trust	4%	4%	33%	29%	29%
Ambulance Trust	0%	33%	17%	0%	50%
PCT	6%	3%	23%	45%	22%
Other	11%	7%	13%	36%	33%
Total	6%	9%	26%	37%	21%

Source for all tables: IES survey, n = 330

Reported use of the KSF post outlines was greater than appraisal coverage across the respondents' organisations. Across all respondents over half (53%) reported that more than three-quarters of their staff now have KSF post outlines in place. Acute Trusts had the greatest proportion of staff with KSF post outlines, with 59% of these respondents reporting that more than three-quarters of staff had them. More than half of respondents at Mental Health Trusts and PCTs also reported that over three-quarters of their staff had a KSF post outline. Ambulance Trusts reported the lowest use of post outlines, with only 17% having more than three-quarters of staff with post outlines in place.

Table 6.2 Proportion with a KSF post outline

	0-25%	26-49%	50-75%	76-100%	No response
Acute Trust	4%	7%	10%	59%	20%
Mental Health Trust	0%	4%	8%	50%	38%
Ambulance Trust	0%	17%	17%	17%	50%
PCT	6%	3%	15%	51%	25%
Other	13%	2%	9%	47%	29%
Total	6%	5%	11%	53%	25%

Reported use of the KSF based personal development reviews (PDR) was lower than coverage of the KSF post outlines. Only around a quarter (26%) of respondents stated that more than three-quarters of staff have had a KSF based personal development review in the past year. Primary Care Trusts had the greatest proportion of staff having had a KSF PDR, with 32% stating over three-quarters of staff had received one; this was followed by Acute Trusts at 27%.

Mental Health Trusts and Ambulance Trusts both had the lowest proportions of staff having had a KSF PDR.

Table 6.3 Proportion who have had a KSF based personal development review

	0-25%	26-49%	50-75%	76-100%	No response
Acute Trust	16%	13%	21%	27%	24%
Mental Health Trust	8%	4%	33%	17%	38%
Ambulance Trust	0%	17%	17%	17%	50%
PCT	18%	5%	20%	32%	25%
Other	22%	11%	13%	20%	33%
Total	16%	10%	20%	26%	27%

Use of Personal Development Plans was again relatively low but there was higher reported use of PDPs than of PDRs in total. Overall over a third (35%) of respondents stated more than three-quarters of staff had a Personal Development Plan (PDP). Some 60% reported more than half of staff had a plan. Almost two-fifths (39%) of respondents from Primary Care Trusts reported over three-quarters of staff had a PDP, followed by 36% of respondents at Acute Trusts. Again the lowest proportions with PDPs were found within the Ambulance Trusts.

Table 6.4 Proportion with a Personal Development Plan

	0-25%	26-49%	50-75%	76-100%	No response
Acute Trust	7%	13%	27%	36%	18%
Mental Health Trust	8%	4%	38%	25%	25%
Ambulance Trust	0%	17%	17%	17%	50%
PCT	8%	6%	22%	39%	24%
Other	18%	4%	16%	31%	31%
Total	9%	9%	25%	35%	23%

6.2.2 The quality of components of the KSF

National surveys provide some data on the coverage of KSF and appraisal processes but are less effective in highlighting some of the quality concerns raised by our case investigations. The patchy coverage of the KSF in our survey was accompanied by evidence of the poor quality of some of the elements that have been completed within organisations. The vast proportion of survey respondents

(62%) judged appraisals to be only of 'medium' quality (as opposed to 'high'). Across the different types of organisations generally around half to two-thirds of respondents judged appraisals to be of medium quality, except for respondents at Ambulance Trusts, where only 17% thought appraisals were of a medium quality. A large proportion (67%) of respondents at these trusts believed appraisals to be of low quality.

Table 6.5 Quality of appraisals that have been carried out

	Low	Medium	High	Non-response
Acute Trust	9%	66%	16%	10%
Mental Health Trust	17%	63%	8%	13%
Ambulance Trust	67%	17%	17%	0%
PCT	13%	62%	14%	12%
Other	11%	56%	13%	20%
Total	12%	62%	14%	12%

Slightly greater confidence was expressed in the quality of the KSF post outlines than in the quality of appraisals, with over a quarter (27%) of respondents overall stating post outlines were of high quality. Overall, the majority (45%) of respondents judged KSF post outlines to be of medium quality. Almost a third of respondents at PCTs and Acute Trusts judged the quality of their post outlines to be high, yet a third of respondents at Ambulance Trusts thought completed KSF post outlines were of low quality.

Table 6.6 Quality of KSF post outlines that have been written

	Low	Medium	High	Non-response
Acute Trust	17%	43%	30%	11%
Mental Health Trust	4%	63%	25%	8%
Ambulance Trust	33%	50%	17%	0%
PCT	15%	43%	31%	12%
Other	18%	49%	11%	22%
Total	16%	45%	27%	12%

Generally KSF based personal development reviews were judged to be of 'medium' quality. Overall over half (51%) of respondents judged these to be of medium quality and around a quarter judged them to be 'low' quality. Some 67%

of respondents at Ambulance Trusts thought the PDRs at their Trust were of low quality.

Table 6.7 Quality of KSF based personal development reviews that have been carried out

	Low	Medium	High	Non-response
Acute Trust	24%	53%	11%	13%
Mental Health Trust	21%	58%	8%	13%
Ambulance Trust	67%	33%	0%	0%
PCT	23%	49%	13%	15%
Other	27%	44%	7%	22%
Total	25%	51%	11%	14%

Around half (48%) of respondents said that the Personal Development Plans that have been completed within their organisations were of medium quality. Over a quarter thought that the PDPs were of low quality, however, within the Ambulance Trusts over four-fifths of respondents stated that completed PDPs were of low quality. Overall only a little more than one in ten stated that PDPs were of high quality.

Table 6.8 Quality of Personal Development Plans that have been completed

	Low	Medium	High	Non-response
Acute Trust	27%	48%	15%	10%
Mental Health Trust	21%	54%	13%	13%
Ambulance Trust	83%	0%	17%	0%
PCT	24%	49%	14%	13%
Other	22%	47%	7%	24%
Total	26%	48%	13%	13%

Half of respondents thought that there were particular groups/types/bands of staff for which the application of the KSF was proving particularly difficult or for whom coverage was low. Within Ambulance Trusts this proportion rose to 83%, mostly citing operational and emergency controls staff as being the most difficult. Across all respondents the lower bands (band 4 and below) were most frequently mentioned as being the most difficult groups, in particular administration and

clerical staff, those in estates and facilities and ancillary staff. Senior managers were the next most frequently mentioned group, followed by nurses.

Table 6.9 Responses to the question, 'Are there any groups/type/bands of staff for which application of the KSF has been particularly difficult or coverage is particularly low?'

	No	Yes	No response
Acute Trust	34%	56%	10%
Mental Health Trust	54%	38%	8%
Ambulance Trust	17%	83%	0%
PCT	40%	45%	15%
Other	38%	42%	20%
Total	38%	50%	12%

6.2.3 KSF links to pay progression, wider appraisal/performance reviews and training and development

Participants were asked if they thought that pay progression was genuinely linked to the attainment of KSF requirements within their organisation. Four-fifths of all respondents did not think that there is a genuine link. More respondents from Mental Health Trusts, compared to other organisations, thought there was a genuine link, yet the figure here was still less than a quarter (21%). The largest proportion stating there was no genuine link was within the Ambulance Trusts at 83%.

A larger proportion of trade union representatives thought that there is a genuine link between pay progression and the attainment of KSF requirements, at 21%, compared to only 9% of HR Directors and only 5% of HR managers.

Some respondents named the groups of staff for which they thought pay progression was genuinely linked to the attainment of KSF requirements. Some examples of these are: nurses, bands 3 to 5 staff, qualified clinicians, new starters to the Trust, groups where staffing levels are adequate, groups where there are links to preceptorship reviews, occupational therapy, pharmacy and physiotherapy, paramedic practitioners and bands 5 to 8 staff.

Table 6.10 Responses to the question, 'Would you say that pay progression is genuinely linked to the attainment of KSF requirements for relevant staff in your organisation?'

By type of organisation:

	No	Yes	No response
Acute Trust	81%	14%	5%
Mental Health Trust	79%	21%	0%
Ambulance Trust	83%	17%	0%
PCT	77%	17%	6%
Other	80%	9%	11%
Total	80%	15%	6%

By employee group:

Across all types of organisation	No	Yes	No response
HR Directors	91%	9%	0%
HR managers	90%	5%	5%
Trade union representatives	73%	21%	6%
Other job titles	79%	15%	6%

Participants were asked if KSF was integrated into a wider appraisal and performance review process within their organisation. Over a third (39%) of respondents agreed that KSF was fully integrated and an integral and essential part of the performance appraisal process. Almost half (46%) felt that KSF was only partly integrated with the appraisal process. The largest proportions stating KSF was fully integrated and an essential element of appraisal were within the Mental Health Trusts (46%) and PCTs (44%). Again the Ambulance Trusts had the highest proportion of respondents stating KSF was not used within the appraisal process at 17%, compared to 11% across all respondents.

Table 6.11 'Is the KSF part of a wider appraisal/performance review process in your organisation? '

By type of organisation:

	Acute Trust	Mental Health Trust	Ambulance Trust	PCT	Other	Total
KSF is not integrated/used with our appraisal process	9%	4%	17%	14%	13%	11%
KSF is partly integrated with our appraisal process	50%	38%	50%	40%	47%	46%
KSF is fully integrated, an integral and essential part of our performance appraisal process	38%	46%	33%	44%	29%	39%
Not relevant/applicable/No answer	3%	13%	0%	2%	11%	4%

A lower proportion of trade union representatives saw the KSF as being fully integrated with the appraisal system, at just over a quarter (26%), compared with 36% of HR directors and 44% of HR managers. HR managers mostly believed that the KSF is fully integrated with appraisal, while the majority of union representatives thought it had only partly been integrated. HR directors were equally divided between those who perceived full and those who perceived part integration into the appraisal process.

By employee group:

	HR Directors	HR managers	Trade union representatives	Other job posts
KSF is not integrated/used with our appraisal process	18%	15%	17%	8%
KSF is partly integrated with our appraisal process	36%	41%	53%	45%
KSF is fully integrated, an integral and essential part of our performance appraisal process	36%	44%	26%	43%
Not relevant/applicable/No answer	10%	0%	4%	4%

Participants were also asked how well the KSF had been integrated into other aspects of training and development within their organisation. Almost half (46%) of all respondents thought that the KSF had been 'partly' integrated and co-ordinated into other aspects of training and development. Over two-fifths (41%)

thought it had not been well integrated at all and only one in ten thought that it had been 'very well' integrated.

Across all organisations, integration was perceived to be greatest within PCTs, yet the proportion agreeing it has been integrated 'very well' within these organisations was still low at 15%. Ambulance Trusts and Acute Trusts had the largest proportions of respondents stating it had not been well integrated at all, at 67% and 44% respectively.

Around half of HR directors and trade union representatives thought the KSF has not been very well integrated at all. A greater proportion of HR managers (56%) thought it had been 'partly' integrated and co-ordinated, than the other groups, with only 36% of HR directors and 42% of union representatives feeling similarly.

Table 6.12 'How well integrated would you say that the KSF is with other aspects of training and development across your organisation?'

By type of organisation:

	Acute Trust	Mental Health Trust	Ambulance Trust	PCT	Other	Total
Not well integrated at all	44%	42%	67%	36%	36%	41%
Partly integrated and co-ordinated	47%	46%	33%	45%	42%	46%
Very well integrated	8%	8%	0%	15%	9%	10%
Not relevant/applicable/No answer	1%	4%	0%	4%	13%	4%

By employee group:

	HR Directors	HR managers	Trade union representatives	Other job posts
Not well integrated at all	55%	36%	50%	37%
Partly integrated and co-ordinated	36%	56%	42%	46%
Very well integrated	9%	3%	6%	13%
Not relevant/applicable/No answer	0%	5%	2%	4%

6.2.4 Communication and understanding of the KSF

The survey found that the communication and understanding of the KSF within these organisations was not particularly strong, with almost two-thirds (61%) of

respondents saying the KSF was either only partly or not well understood at all. Only 6% of all respondents thought the KSF was well communicated and fully understood by most employees. Views across the employee groups did not differ greatly on this issue, with the highest proportions of HR directors, HR managers and trade union representatives stating KSF is only partly understood within their organisations.

Table 6.13 'How well communicated and understood would you say the KSF is in your organisation?'

By type of organisation:

	Acute Trust	Mental Health Trust	Ambulance Trust	PCT	Other	Total
Not well understood at all by most staff	22%	33%	17%	18%	27%	22%
Partly understood by most staff	44%	25%	50%	35%	40%	39%
Mostly understood by most staff	29%	29%	17%	38%	20%	30%
Well communicated and fully understood by most/all employees	5%	13%	17%	6%	2%	6%
Don't know/No answer	0%	0%	0%	3%	11%	2%

By employee group:

	HR Directors	HR managers	Trade union representatives	Other job posts
Not well understood at all by most staff	27%	20%	29%	20%
Partly understood by most staff	37%	41%	44%	38%
Mostly understood by most staff	27%	31%	24%	32%
Well communicated and fully understood by most/all employees	9%	8%	2%	7%
Don't know/No answer	0%	0%	1%	3%

6.2.5 Major barriers to the use of the KSF

At the heart of this survey were questions about the main barriers to the effective use of the KSF and related processes and ways in which these barriers might be

overcome. Participants were asked their opinions on the main barriers to the use of the KSF within their trust or more widely in the NHS, focusing on policy, design and operational issues. They were asked to choose from pre-identified factors that we had drawn from our literature review and case research as being the most important barriers to effective use of the KSF and to rank them on a scale of 1 (minor barrier to use of KSF) to 5 (major barrier).

6.2.5.1 Policy issues

Within the perceived barriers around policy issues, the concept that there are no 'consequences' or penalties for failing to use the KSF was identified as being one of the main barriers to the use of the KSF, chosen by 32% of respondents. This was followed by the issue that senior managers do not practise the KSF and do not tell others how important it is, rated as major barrier by 22% of respondents.

The issue that appraisals and the KSF are not seen as sufficiently important or prioritised was also seen as a significant barrier, with 38% of respondents rating it as a significant barrier (either a 4 or 5 score). The view that the KSF is perceived as having no relationship to Trust unit or personal objectives was also seen as being a significant barrier, with 38% of respondents rating this as a significant barrier. It was also thought that the issue of the KSF not supporting or reinforcing CPD and revalidation processes was a significant barrier to its use, with 35% of respondents rating this as a significant barrier.

The pre-identified factors in the survey which were least chosen as barriers were the lack of a director being accountable for the KSF (not an issue for 40% of respondents, largely because most trusts now had such a director following the 2008 re-launch); and the KSF not being operated or implemented in partnership with trade unions (not an issue for 41% of respondents).

Table 6.14 Policy Barriers to the use of the KSF

	1: A minor barrier to the use of KSF	2	3	4	5: The main barrier to use of KSF	Not an issue
The KSF is not clearly linked to performance appraisal	15%	20%	19%	16%	9%	21%
Appraisal and KSF are not seen as sufficiently important/prioritised	12%	15%	24%	22%	16%	11%
No director is clearly accountable for KSF	11%	8%	11%	14%	16%	40%
There is no measure of	14%	13%	15%	12%	14%	31%

	1: A minor barrier to the use of KSF	2	3	4	5: The main barrier to use of KSF	Not an issue
KSF coverage						
Information on KSF coverage is not reviewed regularly	13%	13%	18%	13%	13%	29%
Senior managers don't practise it and don't tell others how important it is	9%	11%	18%	24%	22%	17%
KSF is perceived as having no relationship to Trust, unit or personal objectives	13%	13%	20%	21%	17%	16%
KSF does not support and reinforce CPD and revalidation processes	14%	14%	20%	22%	13%	17%
There are no 'consequences' or penalties for failing to use KSF	10%	10%	14%	23%	32%	11%
KSF is isolated from other HR and management processes	14%	16%	18%	15%	16%	19%
KSF is not being operated or implemented in partnership with trade unions	17%	16%	8%	7%	11%	41%
There are low levels of manager awareness of KSF	17%	20%	17%	10%	11%	25%
There are low levels of staff awareness	16%	21%	17%	16%	11%	19%
Other policy issues	2%	2%	1%	2%	14%	79%

6.2.5.2 Design issues

With regard to design issues acting as barriers to the use of the KSF, the complexity and detail of its design were considered to be significant barriers. Some 60% of respondents stated the overly complex design is a significant barrier to its use (a score of 4 or 5). Alongside this, some 55% also stated the detail and complexity of the KSF paperwork is a significant barrier. The issue that pay progression does not in reality relate to the KSF was also seen as a significant barrier by 55% of respondents. The large proportion of respondents rating this as a

significant barrier reinforces the finding that four-fifths of respondents also believed that pay progression was not genuinely linked to the attainment of KSF requirements within their organisation.

Views were divided regarding the KSF dimensions. While it was not generally thought that there are too many KSF *core* dimensions, with 31% of respondents not regarding this as an issue, 38% of respondents did believe that the existence of too many KSF additional dimensions is a significant barrier to its use. The issue that the KSF dimensions are not tailored to reflect key areas of work or skills was also perceived to be a barrier, with 37% rating this as significant (a 4 or 5 score).

Table 6.15 Design Barriers to the KSF

	1: A minor barrier to the use of KSF	2	3	4	5: The main barrier to use of KSF	Not an issue
It's an over-complex design	7%	11%	14%	21%	39%	8%
The KSF post outline format is too detailed	11%	11%	17%	23%	30%	8%
There are too many KSF core dimensions	19%	13%	11%	12%	14%	31%
There are too many KSF additional dimensions	13%	12%	15%	18%	20%	21%
The KSF dimensions aren't tailored to reflect key areas of work/skills	14%	14%	18%	15%	22%	17%
The KSF paperwork is too complex and detailed	9%	12%	15%	20%	35%	9%
KSF is a uniform approach when needs vary across the trust	15%	16%	20%	15%	14%	20%
Pay progression doesn't in reality relate to the KSF	8%	9%	17%	20%	35%	11%
Personal Development Review meetings using the KSF take too long, are too repetitive	11%	6%	15%	22%	35%	11%
Other design issues	1%	1%	1%	4%	9%	85%

6.2.5.3 Operational issues

Considering the operational issues that might have acted as barriers to the use of the KSF, the main barrier identified in this survey was the time-consuming and bureaucratic nature of the KSF process – almost three-fifths (59%) of respondents rated this as a significant barrier. The inflexibility and complexity of the e-KSF tool is also seen as being a contributory factor, with 47% of respondents rating this as significant. A concern that people just do not know where to start with the KSF process was also rated as a significant barrier (43%).

Table 6.16 Operational Barriers to the KSF

	1: A minor barrier to the use of KSF	2	3	4	5: The main barrier to use of KSF	Not an issue
There is a lack of management/appraisal skills to use the KSF effectively	14%	21%	21%	16%	16%	12%
There is a lack of or poor guidance and tools on the application of KSF	17%	18%	22%	14%	11%	19%
The KSF process is too time-consuming and bureaucratic	7%	14%	14%	19%	40%	6%
The e-KSF tool is too complex/inflexible	10%	7%	15%	18%	29%	22%
People just don't know where to start with KSF	16%	17%	16%	20%	23%	8%
The culture here does not support the application of appraisal and the KSF	17%	14%	18%	12%	12%	26%
Other operational issue	2%	1%	1%	2%	7%	88%

6.2.5.4 Top 10 barriers to effective use of the KSF

Taking into account all of the policy, design and operational barriers to the effective use of the KSF, the top ten barriers across all of the issues identified by the survey respondents (1) were:

1. It's over-complex design (60% of respondents rated this as a significant barrier[1])

2. The KSF process is too time-consuming and bureaucratic (59%)

3. Personal Development Review meetings using the KSF take too long, are too repetitive (57%)

4. Pay progression doesn't in reality relate to the KSF (55%)

5. The KSF paperwork is too complex and detailed (55%)

6. There are no 'consequences' or penalties for failing to use KSF (55%)

7. The KSF post outline format is too detailed (53%)

8. The e-KSF tool is too complex/ inflexible (47%)

9. Senior managers don't practise it and don't tell others how important it is (46%)

10. People just don't know where to start with KSF (43%).

6.2.6 Level of change required to the KSF

Most participants did not express the view either that the KSF should be withdrawn or conversely kept in its current form. Most thought that it needed some changes to make it successful. Some 27% of respondents agreed that significant changes are required (as opposed to 15% who favoured radical change) while 28% agreed that only a few minor changes are required to make it successful. Just 15% believed that the KSF requires no change. Within the Ambulance Trusts, which frequently scored the lowest in terms of coverage of the KSF, a third of respondents thought the KSF requires significant change to make it successful, although a larger proportion in the Mental Health Trusts (46%) think it requires such significant change.

The most common view among HR directors and HR managers was that the KSF requires some significant changes to make it successful – 46% and 38% respectively. The most common view among trade union representatives was that the KSF requires just a few minor changes (30%). Of those that thought the KSF should be withdrawn, this view was held most strongly HR managers at just over a quarter of respondents in this category(26%).

---

[1]   by giving a score of 4 or 5 in the ratings scale

Table 6.17: Level of change required to the KSF

By type of organisation:

	Acute Trust	Mental Health Trust	Ambulance Trust	PCT	Total
The KSF should be withdrawn	17%	8%	17%	12%	14%
The KSF needs radical change to make it successful	17%	4%	17%	14%	15%
The KSF needs some significant changes to make it successful	25%	46%	33%	24%	27%
The KSF needs a few minor changes to make it successful	30%	21%	17%	34%	28%
The KSF needs no change in order to be successful, it just needs people to make more effort to implement it	11%	17%	17%	16%	15%
No response	0%	4%	0%	0%	1%

By employee group:

	HR directors	HR managers	Trade union representatives	Other job posts
The KSF should be withdrawn	18%	26%	8%	13%
The KSF needs radical change to make it successful	36%	10%	18%	14%
The KSF needs some significant changes to make it successful	46%	38%	20%	27%
The KSF needs a few minor changes to make it successful	0%	23%	30%	30%
The KSF needs no change in order to be successful, it just needs people to make more effort to implement it	0%	3%	23%	15%
No response	0%	0%	1%	1%

6.2.7 Suggested changes or improvements

Participants were asked to rate possible changes or improvements in terms of how successful they would be in embedding KSF usage within the NHS, on a 0 (no discernable impact) to 5 (a major positive impact on uptake and use of the KSF) scale.

6.2.7.1 Changes focused on policy

Suggested changes focussed on policy revealed participants thought that linking KSF more strongly to CPD and revalidation processes would have the greatest positive impact on the uptake and effective use of the KSF, with 56% of respondents rating this as having a significant positive impact (score of 4 or 5). If trust directors were to specify all AfC staff must have an appraisal with KSF included, some 47% of respondents thought this would also have a significant impact.

In contrast to the questions on barriers to the use of KSF, almost half of respondents (47%) thought that making a director accountable for KSF delivery would have a significant positive impact on uptake and effective use of the KSF, (despite some 40% thinking the lack of a director being clearly accountable for KSF was not a barrier to its use).

It was not generally thought that changing the name or merely re-branding KSF would have a significant positive impact (54% felt that this would have no discernable impact).

Table 6.18 The impact of policy changes to the KSF

	1: A minor positive impact on uptake and effective use of the KSF	2	3	4	5: Major positive impact on uptake and effective use of the KSF	No impact
Trust directors specify all Agenda for Change staff must have an appraisal, with KSF included	13%	11%	13%	15%	32%	15%
NHS Chief Executive and NHS Director of Workforce specify that all staff must have an appraisal with KSF included	13%	11%	14%	14%	30%	18%
Show senior managers evidence of the impact on performance of appraisals in the NHS	9%	12%	21%	18%	30%	10%
In each Trust, make a director accountable for KSF delivery	12%	12%	15%	17%	30%	14%
All Trust should have KSF action plans agreed with	14%	14%	14%	20%	24%	14%

	1: A minor positive impact on uptake and effective use of the KSF	2	3	4	5: Major positive impact on uptake and effective use of the KSF	No impact
Board/SMT						
Set a target for appraisal coverage for all trusts and a date for its attainment	15%	11%	14%	21%	24%	16%
All trusts to provide monthly progress reports on KSF usage to the Board/SMT	17%	15%	17%	16%	16%	19%
Re-launch and establish a powerful communications campaign for KSF	15%	10%	17%	17%	22%	19%
Secure stronger support for KSF from professional bodies	13%	14%	13%	23%	21%	16%
Link KSF more strongly to CPD and revalidation processes	8%	11%	16%	23%	33%	10%
Work with trade unions to establish a more effective partnership approach to KSF implementation	14%	17%	17%	14%	20%	19%
Make the allocation of aspects of training budgets dependent on evidence of KSF completion	13%	13%	18%	19%	25%	13%
Regulators focus more on KSF completion rates as a metric	16%	16%	21%	14%	10%	23%
Change the name/re-brand KSF	16%	9%	8%	6%	7%	54%

6.2.7.2 Design changes

Considering possible changes to the design of the KSF, respondents thought that improving and simplifying the paperwork would have the greatest positive impact on uptake and effective use of the KSF, with two-thirds of respondents agreeing that this would have a significant impact (a score of 4 or 5 on the scale). A

simplification of the KSF dimensions was also thought to have the potential for a major positive impact on the use of KSF, with some 61% of respondents rating this as significant.

Other possible changes thought likely to have a major positive impact were ensuring the discussion of personal objectives are undertaken alongside discussions of KSF and development needs (57%) and also ensuring pay progression is genuinely linked to the attainment of the KSF (57%). However, it was thought that completely abandoning the link of the KSF to pay would have limited impact, with 41% of respondents believing this would have no effect.

Table 6.19 The impact of design changes to the KSF

	1: A minor positive impact on uptake and effective use of the KSF	2	3	4	5: Major positive impact on uptake and effective use of the KSF	No impact
Ensure discussion of Trust objectives is undertaken alongside discussion of KSF/development needs	9%	16%	20%	22%	22%	11%
Ensure discussion of personal objectives is undertaken alongside discussion of KSF/development needs	7%	8%	20%	30%	27%	8%
Simplify the KSF dimensions	4%	11%	14%	20%	41%	10%
Reduce or change the core dimensions	13%	11%	16%	14%	20%	26%
Drop or improve and simplify the KSF post outlines	9%	8%	14%	22%	31%	16%
Make the core dimensions the main/sole focus of KSF	14%	9%	15%	18%	26%	19%
Use other relevant frameworks (eg professional or management competencies) in place of the specific dimensions	11%	11%	16%	20%	23%	19%

Improve/simplify paperwork	6%	7%	12%	23%	43%	9%
Tailor the paperwork and process more to suit specific occupational groups/ units eg KSF Nurse	11%	9%	16%	20%	29%	17%
Ensure that pay progression genuinely relates to attainment of the KSF	7%	11%	14%	22%	35%	11%
Drop the link of the KSF to pay	21%	7%	7%	9%	15%	41%
Join up the KSF more effectively with other HR and management processes	7%	11%	20%	25%	25%	11%

6.2.7.3 Operational changes

Consideration of possible changes to the operation of the KSF reveals that most respondents thought that the provision of training would have the greatest positive impact. Providing more and improved management training in appraisal and development planning skills was believed to have potentially a very significant positive impact, by over half of respondents (54% gave a score of 4 or 5 on the scale). The provision of training for appraises as well as appraisers was also thought by over half (55%) to have a substantially positive impact.

Allowing variation in the application of the KSF process from year to year and local experience-sharing networks between Trusts were the potential changes on the list thought to have the lowest potential to impact by respondents.

Table 6.20 The Impact of Operational changes to the KSF

	1: A minor positive impact on uptake and effective use of the KSF	2	3	4	5: Major positive impact on uptake and effective use of the KSF	No impact
Allow variation in application of the KSF process from year to year	19%	14%	20%	11%	8%	28%
Focus only on the most relevant and important aspects of KSF	9%	10%	21%	25%	20%	15%

	1: A minor positive impact on uptake and effective use of the KSF	2	3	4	5: Major positive impact on uptake and effective use of the KSF	No impact
Provide more/better management training in appraisal and development planning skills	8%	14%	14%	22%	32%	9%
Provide training for appraisees as well as appraisers	10%	12%	12%	23%	32%	11%
Set up and train unit/occupational champions and advisors	12%	13%	15%	24%	21%	14%
Provide more/better guidance in implementation and operation	12%	11%	19%	22%	25%	11%
Set up/join local experience-sharing networks with other trusts	17%	17%	14%	16%	15%	21%
Successful trusts to provide support and guidance to other trusts	18%	15%	19%	15%	15%	18%
Use the e-ksf, ESR or similar system more widely to administer the process	13%	9%	17%	21%	20%	19%
Trusts supported to develop own local admin system	16%	11%	14%	14%	18%	27%

6.2.7.4 Top 10 suggested changes to the KSF

Taking into account all of the suggested changes to policy, design and operation of the KSF, the top ten suggested improvements by respondents were:

1. Improve/simplify paperwork (66% of respondents rated this as potentially having a major positive impact[2])

---

[2]   [2]by giving a score of 4 or 5 in the ratings scale

2. Simplify the KSF dimensions (61%)

3. Ensure discussion of personal objectives is undertaken alongside discussion of KSF/development needs (57%)

4. Ensure that pay progression genuinely relates to attainment of the KSF requirements (57%)

5. Link KSF more strongly to CPD and revalidation processes (56%)

6. Provide training for appraisees as well as appraisers (55%)

7. Provide more/better management training in appraisal and development planning skills (54%)

8. Drop or improve and simplify the KSF post outlines (53%)

9. Join up the KSF more effectively with other HR and management processes (50%)

10. Tailor the paperwork and process more to suit specific occupational groups/units eg KSF Nurse (49%).

6.2.8 Additional Comments

Lastly, we asked participants for any further comments on things they would do to help improve take up and effective use of the KSF. Some of the most frequently mentioned actions included simplification of the KSF and e-KSF and focusing only on the core dimensions.

Increased accountability of senior managers through inclusion of the KSF in KPIs for managers, and better support for the KSF process through board level leads or KSF champions was also frequently mentioned.

The need for more training in the KSF was mentioned regularly, alongside better links to CPD and education. The ability to tailor the KSF to suit local circumstances and integrate with organisational values, and the need for a moderate degree of change in the KSF, were also common themes within the comments.

We include a representative selection of actual comments below – all of the received comments can be read in the Appendix to this report.

6.2.8.1 Increased accountability of senior managers

"The implementation of KSF needs to be pushed from the top down and needs to be given a realistic timeframe to be implemented fully and at a quality level, not just a quick, rushed,

tick-box exercise. More support from management/director – get them to 'talk up' the process at every opportunity (not to use as 'beating stick' approach with threats of not going through pay progression). KSF and appraisal not to be viewed as 2 separate entities, as much integration as possible should occur in the training stages."

"Trusts providing monthly reports to Trust Board, SHA and DH. Take action against Trusts, Departments and Managers who do not use KSF's".

"Make the implementation, management and monitoring of the use of KSF a KPI. Ensuring via the KPI that the entire annual review process is embraced by organisations Boards and used from senior management downwards. Provide evidence of the financial benefits".

"Top level support is going to be another key success factor. In the absence of national directives around this aspect, the push to use e-KSF in our trust has been a slow process of demonstrating benefits".

6.2.8.2 Improved support for the process

"KSF needs to have it's own department/group of staff solely focused on staff support and training needs at least until the process is fully ingrained in the culture".

"Each KSF interview would be performed by expert or trained peers/ colleagues/trust champions and not the line manager. This would allow a certain amount of objectivity, mirror what happens with Medical consultants and in many academic /educational settings, plus promote KSF as a competency development tool".

"Trusts either singly or as part of a network would train assessors to assess against the KSF and its cross over to other related competency frameworks/standards".

6.2.8.3 Tailoring to suit local circumstances

"Each trust must prepare appropriate localised guidance documentation. KSF should be an assessment of generic but relevant work competency similar to other national/occupational standards but separate from actual job performance appraisal-a sort of wider personal/professional development approach rather like a fit to work in the NHS standard rather than an specific job/work performance measure".

6.2.8.4 Making moderate levels of change to the process

"In my opinion what is missing is design thinking. Establish what is needed to be done and prioritise. Employ 'Usability/Design' expertise to design forms which are simple to use and capture essential information. E-KSF is part of the solution but it is too complicated. So to sum up get some design talent, as well as HR talent to redesign, simplify and humanise the process"."

"Some documentation that illustrates best practice of how to use the KSF would be great and may prove to make the job of implementation easier".

"To be effective KSF must be made much, much simpler to use. It must be made much less bureaucratic. There should be an end to this absurd concept of drawing up individual KSF outlines for individual post-holders, with hundreds of thousands of staff throughout the country "re-inventing the wheel". There should be an assumption that there are standard KSF outlines, linked to AFC national profiles perhaps (and/or Skills for Health competences) which can be plucked, off-the-shelf. Outlines from other Trusts should be readily available, whether by e-KSF or a simpler web-site".

6.2.8.5 Links to CPD/education

"The PDP would become a document that describes learning designed to support performance and the KSF, but not necessarily be one that is set and reviewed annually; rather there would be a requirement for all staff to have one that is current and updated at appropriate intervals. The line manager would remain the person who agrees and reviews this. However the impact on salary should be maintained if achievement against the KSF/gateway is not demonstrated".

6.3 Section Summary

From this analysis of the e-survey results, the key findings and messages were as follows:

■ Most respondents thought that the KSF requires change in order to make it more generally successful; however the vast majority do not wish to withdraw it altogether, nor do they want to continue with it in its current form.

■ The reportedly poor quality of appraisals, PDRs and PDPs was at least as important an issue as that of the relatively low levels of overall staff coverage of the KSF.

■ The KSF was not generally perceived to be well integrated with associated processes. Only 36% of respondents felt that KSF was a well and fully integrated part of the appraisal process, and 87% felt that it was only partly or not well integrated at all with other aspects of training and development.

■ Communication and understanding of the KSF by employees within the surveyed organisations was felt to be relatively low.

■ The complexity of design and operation of the KSF was by far the largest perceived barrier and desired changes were most commonly about simplifying the KSF, for example by removing the additional dimensions rather than changing the core dimensions.

- Obtaining greater senior manager commitment to the KSF was seen as important in making progress, alongside introducing greater consequences for failing to use the KSF.

- The KSF's link to pay was seen as problematic and not operating in practice, but more respondents want to see a strengthening of this link to pay, rather than for the link to be abandoned.

- Stronger links to CPD and revalidation processes were seen as key to improving the uptake and effective use of the KSF.

- Training of employees and particularly reviewing managers was also seen as being critical in securing improvement in the effective uptake and use of the KSF.

7 Conclusions on KSF and Recommendations for Improvement

This project has been concerned with identifying barriers to the successful implementation of the Knowledge and Skills Framework and making recommendations for change and improvement. In this section we:

■ describe why our findings indicate that modifications to the KSF are essential;

■ highlight what we have found to be the major barriers to implementation;

■ raise some critical policy issues that need to be addressed;

■ make recommendations for improvement; and

■ provide initial thoughts on how these recommendations might be taken forward.

7.1 The Essential Requirement to Change

Almost all large employers have a declared policy intention regularly to appraise and continually develop the capabilities and contribution of all of their employees. Yet most struggle to implement this in practice in their increasingly fast-moving and often resource-constrained contexts. The NHS is a very large and very complex organisation and so the fact that it has experienced implementation issues with the KSF is not surprising. Indeed, the original 2004 Department of Health guidance document mentions most of the potential implementation issues this review has found, ranging from over-zealous and excessively detailed application, through to recalcitrant and inadequately skilled reviewing managers.

But this study has confirmed and extended the findings from earlier investigations to demonstrate that, five years after the purpose and principles of the KSF were set out, **the gap between the intended policy and the actual practice of KSF in the NHS remains unacceptably wide**:

- in terms of coverage, in at least one-third of NHS employers key aspects of the KSF and appraisal processes are simply not happening at all at present;

- the rate of expansion in coverage has been slow in recent years;

- even where these processes are in operation, our survey found that they are applied to more than 75% of staff in only one in three of these organisations;

- just as significantly as limited coverage, we found commonly expressed concerns with the quality of the processes in practice, with a quarter of those in our survey rating the quality of PDRs and PDPs in their trusts as low.

Given that almost everyone we have consulted supports the core principles of KSF – essentially, to support service development by investing in the development of all employees – then change is essential, in order to better achieve these intentions and to overcome the barriers that have prevented their widespread delivery through implementing the KSF effectively. The service and performance benefits of operating appraisal and development processes in healthcare settings are strongly evident from research studies, and in this study we encountered plenty of examples of mangers we interviewed and staff we spoke to who had realised the benefits of using the KSF and were strongly committed to the process. But there needs to be far more of them enabled to do so.

Changes to the KSF and its use are also essential to reflect changes in the NHS and its context since 2004, and virtually every other large organisation we have looked at have made changes to their equivalent processes over that period. In other sectors the trend has very much been towards briefer, faster, slicker processes and competency frameworks with greater employee involvement. In the NHS perhaps the key change has been the devolvement of authority to the local level and the growth of Foundation Trusts. This development, in our view, renders as outmoded an implementation strategy based on securing compliance with a totally uniform, detailed and relatively inflexible, NHS-wide model.

Our case research clearly shows that an increasing number of trusts are modifying, or even in a few well-publicised cases abandoning the KSF. Without changes, then this trend will undoubtedly intensify. While it is not surprising that some trusts facing a tough set of operating and financial circumstances have struggled with the process, what is perhaps most worrying is that some of the trusts looking to move away from the KSF are comparatively well resourced and managed and had attempted a textbook approach to implementing the KSF.

Research strongly suggests that appraisal and development processes only work effectively where local management and staff buy into their operation and have the flexibility to adapt them to their own needs. **In future, a changed and improved KSF needs to operate on the basis that people use it because they find**

it useful and can deliver on its objectives, not because they are compelled to from the centre. The compulsory approach has not worked in the past in many trusts, and given changing circumstances, seems even less likely to do so in the future.

The vast majority of people consulted in this study do not want to abandon KSF: most believe that there are significant components of good practice contained within it and a lot of resource and effort has already been invested in its application. But most do support changes to overcome the existing barriers and make improvements to the process; indeed management and staff in many trusts are already working on such changes at a local level.

These improvements can in our view be accelerated and better co-ordinated at lower overall cost by more aligned actions within a national framework. Even with the moves in the NHS towards greater local autonomy and Foundation trusts, most of those we have consulted in this study see a value in at least a national framework for appraisal and development along the lines of the KSF, even if views differ significantly in terms of the contents and specificity of that national framework.

7.2 The Barriers to an Effective KSF

We have already provided in this report lengthy lists of the barriers to KSF implementation highlighted by our research. Unfailingly we found that the over-complexity and excessive detail of the paperwork and process was the first issue that everyone raised with the KSF. Four of the top five barriers highlighted in our survey were of this nature – too detailed paperwork, excessively lengthy post outlines and PDR meetings, e-KSF complexity and inflexibility, etc. Rather than there being any trade off between simplification and quality, we believe that **simplification of the KSF design and paperwork is an essential action in future, in order to improve both the coverage and quality of the process.**

However, just simplifying the paperwork and process will not, on its own, achieve improved delivery of the policy aims of the KSF. Our external research has highlighted that as well as top class paperwork and designs, effective appraisal and personal development processes require two other elements: unambiguous, shared policy objectives and world class, consistent operating processes and support.

The original design of the KSF could possibly have worked successfully in some organisations. **But the juxtaposition of this sophisticated system and the reality of the management and operating processes and cultures in the NHS has led to its, at best, patchy and mixed implementation**. In our view, a major failing was that KSF was based on some heroically positive assumptions about these existing

processes and cultures in the NHS, assumptions which have been shown to be grossly over-optimistic in many NHS settings.

In this review there has been a stark contrast evident in this investigation between our discussions with policy experts on the details of KSF design and the practical realities and challenges in some of the trusts we visited. The operational challenges at the individual trust level would have severely tested even the simplest of appraisal and development system designs – for example regular and disruptive changes in senior management, reluctant and under-trained managers, under-resourced HR and training staff and systems, lack of time and facilities to hold PDR meetings, and so on.

These operating processes have to be addressed and improved by the recommendations and actions resulting from this review. Otherwise the KSF will continue to fail to deliver on all of its objectives. The capacity and standards of management in some parts of the NHS are simply not at the level required to operate the current, relatively complex KSF process effectively, and more realistic ambitions need to be adopted in this context.

7.3 Key Policy Questions

It is also in the area of policy objectives and intentions that we see some of the most important barriers to KSF implementation and also the underlying reasons for the complexity and in some cases confusion in its design and operation. How these questions were originally answered helps to explain the KSF situation now, and how they are answered now can have a major influence on the recommendations and changes that need to be and will be made.

1. How does the KSF relate to wider performance appraisal/management and should it form a part of one integrated process? While we can understand the concerns in some quarters within the NHS at what is perceived to be a management-driven performance management and appraisal process, the failure at the outset to specify just how the developmentally-focused KSF and the appraisal process inter-relate has, we believe, been a major cause of ongoing implementation and operating problems. The KSF guidance may talk about them *"working seamlessly together"*. But trusts have been left to work this out for themselves, sometimes in situations in which a number of different appraisal and learning and development systems were already in operation, and different trusts have developed some very different approaches.

This has meant that in too many cases PDRs and the other components of KSF have been considered in isolation from the actual content and objectives of the job-holder and the wider goals and values of the trust, encouraging a lack of focus and perceived lack of meaning and value in the whole process, to the individual

employee and the trust. It has also led to significant extra workload and effort. For example we could find no other external organisation which operated with both job descriptions for evaluation and appraisal purposes, and post outlines for development purposes.

The most successful trusts, our research has found, are those that have made KSF and PDR's an integral and fully integrated part of their wider appraisal process, in a manner simply illustrated in Figure 7.1. Development is planned and delivered in the context of what the trust and the individual needs to, and wants to, achieve, rather than it being just a mechanical process of wading through numerous dimensions to work out which are relevant, at what level and how. It also addresses the practical aspects of the process, such as how many and how different meetings are held.

Figure 7.1: Integrating Personal Development and wider Appraisal Processes

The Performance Development and Appraisal
Cycle

Employer values and goals

Personal objective setting

Personal
development
planning

Review and   Personal   Ongoing   Ongoing work and
evaluation of   development   development and   performance
performance   review   learning
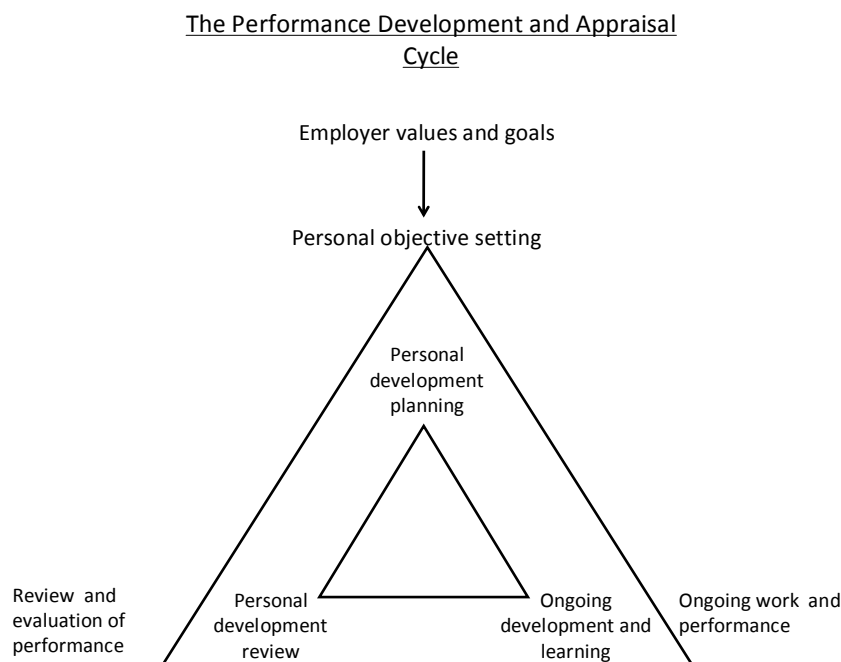
It could therefore be argued that all of the central effort and 'push' behind KSF has in recent years has been akin to trying to put the proverbial cart before the horse, or perhaps move the whole 'horse' of performance management and development forward by just pulling one of its legs, the KSF competency framework.

In future, a more effective approach may be to:

■ **commit in principle to every NHS employee having an at least annual appraisal meeting and a personal development plan, and use this as a trust**

KPI, so as to deliver on the Constitution pledge of staff development (with trust senior managers held to account for this); and

■ **centrally to develop a national model for a fully integrated performance appraisal and development process (with KSF embedded in it), which trusts can use and/or modify to suit their own needs.**

2. Is the KSF primarily a developmental or a pay-related process? The principles and aims of the KSF are very much about staff development, yet its genesis as part of Agenda for Change means that it has always been developed and operated in the context of pay and collective bargaining. Performance and competency-related pay progression can be a controversial topic. The association with pay progression initially contributed to fears about KSF's use and perceptions of unfairness. This may in turn have encouraged the type of evidence-paper chasing and attempts at excessively detailed application by managers and staff we heard described, for fear of pay progression being withheld.

Attempts to enforce the KSF as part of the national terms and conditions have at best been ineffective, and probably for the more able trusts, counter-productive and served as an encouragement for them to develop their own alterative system.

Somewhat ironically we are now in a situation where virtually everyone agrees that the compromise arrangement originally reached, of the KSF only affecting pay progression at two points in the scale, is simply not operating in practice and pay progression in reality is automatic. We still fail to understand the logic for developing a sophisticated competency framework and then trying to simplify it so it can be used as an assessment tool at the foundation gateway.

The link between the KSF and pay may also have diverted attention and resources centrally away from the development agenda and from looking, for example, at how links with other training and development initiatives and frameworks of the type developed in the NHS in Northern Ireland could be more widely established and promulgated. A majority of participants in our survey did not feel KSF was well integrated with other training initiatives, again contributing to a sense of an isolated and bureaucratic process that as to be gone through but delivers little return. The KSF Group commissioned study in 2009 highlighted the potential for the KSF to support the developing processes of professional revalidation, and this is an exciting and positive development to continue to monitor and exploit.

As well as being a significant policy/practice gap, this also means that individual trusts at the moment are unclear how this pay relationship should be managed and communicated, and some are moving in diametrically opposed directions. Amongst our case study trusts, one had abandoned the pretence of any link to pay and made progress with the KSF purely as a developmental process, whilst another was intending to strengthen the links to pay progression beyond the

original two points. This surely is an untenable and undesirable situation moving forward, particularly when a likely future scenario is that budgetary constraint and public sector pay restraint could put a lot more pressure on the incremental pay progression process.

Our recommendation therefore is to make the KSF unequivocally a support system for staff development, following the lead set by the DH in moving responsibility for KSF from the Pay to the Education branch and. If any pay link is retained then this should in our view only occur at the second gateway. We describe some other recommendations resulting from this shift in emphasis below. Broader objectives such as improved staffing patterns and productivity and recruitment are all potentially deliverable, but in our view the emphasis needs to be very heavily on exploiting the potential of the KSF to improve staff development.

De-emphasising the pay and collective bargaining components does not in any way imply moving away from a partnership approach to KSF, which remains an essential component of successful operation, but moving out of a negotiated setting into one which engages trusts, managers, unions and staff in a joint effort to develop all staff fully so as to best deliver on service and personal objectives. KSF is a process that should be based on frequent and good quality, two way conversations between staff and their managers in terms of how best to enhance their personal skills and contribution. Currently in too many trusts the process either doesn't happen at all; or if it does, the manager simply follows through a set script (on-line if using the e-KSF) of skills definitions and requirements, with the employee passively offering up robust evidence that these have been displayed or not.

3. Is the KSF to be implemented as *"tablets of stone"* **or used flexibly** *"as a supporting framework, in a way that works for you"***?** Here the DH guidance on the KSF was and still is unequivocal: an individual trust *"cannot just change the national agreement locally"*. A uniform and inflexible approach to implementation was probably always unrealistic in such a large and diverse organisation as the NHS, never mind one in which local autonomy has been increasing in recent years. External research clearly demonstrates that developing local understanding and commitment to this type of process and a degree of local adaptation is vital to success.

Attempting to encompass and to shoehorn such a huge diversity of skills and roles in the NHS into the uniform specific dimensions of the KSF was always going to have a high risk of failure. Yet this approach served to significantly complicate and extend the whole process, particularly the drafting of post outlines, which is where many trusts got initially bogged down in trying to implement the KSF and only established weak foundations for the subsequent components of PDRs and PDPs. Many of the trusts with higher appraisal and PDR coverage appear to have had to redo their post outlines to strengthen this foundation.

The additional dimensions and attempt at a uniform approach may also have weakened the linkages with other relevant skills and competency frameworks, and encouraged those trusts now developing their own approaches to abandon the core dimensions as well, even though in most cases we believe that they could quite easily have been incorporated in their new trust-specific approaches. And now with some trusts publicly abandoning the process, the majority seem to be confused in terms of whether they can or can't modify the nationally specified KSF process to make it more effective in their own setting, and can publicly admit to doing so.

Ironically, on some aspects of the KSF which were not mandatory and specified on a uniform basis, we believe greater consistency and certainty would have been helpful, as organisations have in many cases "re-invented the wheel" on their own and sometimes struggled without guidance and support. These areas include:

■ the KSF post outlines. Using the e-KSF database to specify shorter, common profiles for at least the most numerous jobs, and as some trusts have done, putting single band profiles together for non-clinical and clinical posts, to be adapted locally for specific posts, would have and could still save considerable time and effort at the trust level and would support greater consistency across the NHS in England in the process, to foster career development;

■ developing step-by-step guides and 'short cuts' for managers and staff through the KSF process, which trusts have had instead to do for themselves;

■ making the PDP form, somewhat surprisingly, 'optional' in the original process and guidance, hardly implies that this is a vitally important part of the whole process.

We believe that in future the experience of those trusts that have adapted and successfully utilised the KSF without radically changing or abandoning it needs to be recognised and extended. **This means moving to a national approach which is more, (in the words of someone in a case study trust),** *"a supporting framework"* **for people to use and adapt precisely because it is useful and saves them development time and effort, rather than because they feel that they are forced to.**

Trusts should in future adhere to and be able to 'buy in' to the approach at a number of levels:

■ at a minimum to adhere to the core principles and requirements of the KSF, such as that people will have at least annual PDRs and a regularly maintained and discussed PDP, based on consideration of their skills and behaviours;

■ optionally to use an improved KSF process, or to use an alternative which meets certain common standards to demonstrate that the core principles are being delivered. The extent to which the core dimensions are required or

optional is an area that needs to be fully debated and agreed. Our view is that a refreshed version of the core dimensions could still be applied nationally. But it needs to be recognised that some trusts have already moved away from them to using their own competency frameworks and it would presumably be difficult to pull them back.

National frameworks could also be developed to help address common and necessary differences in practice effectively and efficiently, for example, to demonstrate how the KSF could be applied in a team context where spans of control make individual reviews almost impossible. And national standards or guidelines on operating appraisal and development processes, (as developed individually in a number of trusts we visited), could also be defined, such as that reviewing managers have to have attended KSF/appraisal training, that no manager should have to appraise and PDR more than ten employees individually, that meetings should not need to last more than one to one and a half hours, etc. Even if they were only applied as guidelines rather than required standards, then we believe that many trusts would see the good sense in them and apply them.

In Figure 7.2 we suggest how a balance of compulsory and optional elements of a revised KSF might be designed, although which aspects are required and which optional will of course need to be debated and agreed by the stakeholders.

Figure 7.2: Outline Framework for Agreeing Compulsory and Voluntary Aspects of the KSF

	National Requirements	Optional Elements
Policy	- Core principles of the KSF eg everyone has a PDR/P - Link to appraisal - Link to pay - KPIs linked to KSF/appraisal	
Design	- Use of refreshed core dimensions	- Specific dimensions - Other competency/skills frameworks - Model national band/post outlines - Re-designed KSF paperwork - Team-based KSF module
Operation	- National communications campaign	- Operating guidelines - National training package - Range of admin options including e-KSF - Communication guides - Self help networks

It is for the national stakeholders to address and answer these three policy questions, rather than an external research organisation such as IES. But assuming that they are answered in the direction indicated, we move on to make a series of more specific change recommendations.

7.4 Recommended Changes

We have identified during the course of this research literally hundreds of ideas and approaches to improving staff appraisal and development in the NHS through the use of the KSF; many of these are indeed already being used to improve the process in individual trusts. It would be easy for us to simply list dozens of these changes; but there needs to be a high degree of sensitivity to what is already a complex and varied situation, and to the future economic scenario in which there is likely to be relatively less resources to support the KSF's operation in the next five years' of its life compared to its first five. As many stakeholders we spoke to emphasised, the recommendations and changes need to be practical, delivering the maximum possible benefit for the minimum investment of time and resources.

Therefore our recommendations are classified into three categories of what we regard as essential changes, though within each category, there are a number of alternatives which can be prioritised as desired and agreed. These are to:

1. Clarify the strategy, policy direction and principles of the KSF and related appraisal and development processes.

2. Simplify the design and streamline the KSF components, paperwork and process, while also supporting greater flexibility and adaptation to suit local circumstances in their use and application.

3. Increase and improve support to deliver the principles of KSF into operating practice at the local level.

The specific changes recommended under each heading are described in Figure 7.3 below.

Figure 7.3 Recommended Changes and Actions

Strategy: Clarify the policy direction and principles of the KSF and related appraisal and development processes.

1. **Either** define and promote a new integrated appraisal and development model approach, that can be tailored and adapted locally; or clearly specify how the KSF and PDR/P ideally should link in with other aspects of performance management.

2. Ensure in either case a new 'front end' of trust and personal objectives on the KSF process.

3. Update the KSF principles and specify that all AfC staff should have a two-way appraisal discussion and PDR/PDP at least once per annum, and KSF or an equivalent competency framework needs to be an integral component. Clarify the common aspects of the national framework and those which can/should be tailored/adapted locally.

4. **Either** remove the direct link between KSF and pay, or make it only operate at the second gateway point. Produce more specific guidance on when and how increments can be withheld.

5. Conduct work nationally to facilitate links at the local level between use of KSF and other CPD, revalidation and training frameworks and initiatives.

6. Strengthen accountability. Senior national NHS figure to write to all trust chief executives to reinforce need for all managers and staff to have appraisal and PDR/P using KSF or similar quality framework, and establish this as a KPI for trusts. Work to improve monitoring arrangements eg through specific question in National Staff Survey

Design: simplify and streamline the KSF components, paperwork and process, while also supporting greater flexibility and adaptation to suit local circumstances.

1. Make explicit that the specific dimensions are optional and decide if the core dimensions are to be compulsory or voluntary. If voluntary, decide whether and how some type of quality approval process for alternative competency frameworks might operate. Focus on the core dimensions moving forward.

2. Review and refresh the core dimensions. In particular consider the need to incorporate more behavioural language/criteria and possibly re-brand them as competencies; whether a leadership/management dimension should be included; and whether the equality and diversity dimension differentiates adequately.

3. Consider moving from levels and detailed examples of each dimension to a simpler indicators/contra indicators format. Move away from detailed examples of application in post outlines and in PDRs, relaxing the requirement for each

example to be evidenced in favour of a broader, all round assessment of competence/contribution.

4. Design a compressed/shorter, summary post outline format. Develop model national band outlines and suggested post outlines for the most numerous jobs. Longer-term, consider the integration of job profiles for evaluation purposes and the KSF post outlines.

5. Form a small national working party to update/improve/streamline the KSF/PDR/P paperwork as a whole.

6. Make explicit that flexibility from year to year and between different types of job is desirable within the national KSF framework, rather than not permitted. In particular emphasise the need for quality two-way conversations.

7. Develop a team- based adaptation of the KSF and PDR/P process.

Operation: Increase and improve support to deliver the principles of KSF into operating practice at the local level.

1. Produce national training packages for KSF/appraisal for managers and staff that can be used/adapted locally.

2. Produce a series of communication and operating guides to the KSF process which can be used/adapted locally, targeted specifically at:

   - boards and chief executives (why it is important, how to achieve high coverage)

   - reviewing managers (route map through the process, do's and don'ts, tips)

   - staff (how to use it to best personal advantage).

3. Continue with improvements to the functionality and flexibility of the e-KSF. Target marketing of it to trusts that are already improving coverage of appraisal/KSF. Consider the development of a range of alternative and simpler administration options eg using existing HRIS, spreadsheet packages etc.

4. Develop and promote national operating best practice guidelines eg no more than 10 staff reviewed by any one manager, reviewing managers have to be trained, etc.

5. Establish a re-launch communications campaign with national material development but emphasis on regional and local delivery. Follow up with regular progress reports and guidance in newsletters, etc. Develop and provide model communications packs for managers and staff to use on appraisal/KSF.

6. Refresh the structure and resourcing of KSF support and decision making. Create smaller, more focused implementation teams with clear targets for increasing coverage and quality of the KSF/appraisal process. Attempt to increase resources at the local level and encourage and promote web-based, self-help networks. Promote regional 'buddying' of high and low coverage trusts and creation of regional 'hit squads'.

7.5 Moving Forward

In order to move these recommendations forward into practical and effective improvements to the KSF we would envisage two further phases being involved following this research investigation:

■ a re-design and development phase; followed by

■ a re-launch, communication and implementation phase.

We feel that the structuring of responsibilities for the development and implementation of changes is vital, as well as a focus on changes which are realistic and achievable in the current climate. Prioritisation will be key, both in respect of importance of contribution to progress and ease/simplicity of implementation

Immediate next steps might be as follows:

■ Discuss, agree and prioritise recommended changes at national level with all stakeholders. Develop detailed development and implementation plan with allocated responsibilities, resources and timescales.

■ Reform national KSF structure into a tighter policy group and series of small action teams, with one focused on the re-design recommendations and one on the operating improvements. Involve relevant managers and trade union staff from trusts with high coverage and use local examples of what is being recommended nationally.

■ Each team is briefed on the nationally agreed changes and then works through an intensive and compressed process of approximately three meetings to work up the recommendations into actionable proposals.

■ Policy group agrees and integrates proposals and agrees final implementation plan. It also establishes success measures and monitoring arrangements for the revised KSF process.

■ Re- launch campaign and communications, probably with phased implementation of the changes.

Appendix 1: Survey Questionnaire

Survey of coverage of KSF across trusts in the NHS

🖶 print-friendly page

Thank you for taking time to complete this survey that IES is undertaking on behalf of NHS Staff Council. It should take you only around 15 minutes.

The deadline for completion is **27th November.**

About you

First a few questions about you and your position:

1. What is your post/job title? choose: ⌄

   *please specify: _____

2. In which type of trust do you work? choose: ⌄

   *please specify: _____

3. If you work in a trust, is it a foundation trust? ○ yes ○ no

Implementation in your Trust

Next, some questions about the extent to which you have implemented KSF and related appraisal and personal development planning within your trust (ignore this section if you do not work in a trust).

4. For your trust, please complete the table below showing the coverage of various aspects of KSF use and appraisal over the past 12 months. Please type in the approximate coverage for each aspect, entering the percentage of staff covered in the past 12 months:

Proportion who have received an appraisal	Proportion with a KSF post outline	Proportion who have had a KSF-based personal development review	Proportion with a Personal Development Plan
___ %	___ %	___ %	___ %

5. And how would you assess the quality of the application of these same processes across all of the staff in your trust: high quality (carried out effectively for most staff); medium quality (acceptably but variably carried out for staff), or low quality (not well carried out for most staff)?

Quality of appraisals that have been carried out	Quality of KSF post outlines that have been written	Quality of KSF based personal development reviews that have been carried out	Quality of Personal Development Plans that have been completed
choose: ⌄	choose: ⌄	choose: ⌄	choose: ⌄

6. Is/are there any groups/types/bands of staff for which application of the KSF has been particularly difficult or coverage is particularly low?

   ○ yes* ○ no

   *please describe which groups

   _____

7. Would you say that pay progression is genuinely linked to the attainment of KSF requirements for relevant staff in your organisation?

   ○ yes ○ no ○ only for some groups of staff*

   *please describe which groups

   _____

8. Is the KSF part of a wider appraisal/performance review process in your organisation?

   ○ KSF is fully integrated, an integral and essential part of our performance appraisal process

   ○ KSF is partly integrated with our appraisal process

   ○ KSF is not integrated/used with our appraisal process

   ○ Not relevant/applicable

9. **How well integrated would you say that the KSF is with other aspects of training and development across your organisation?**

   ○ Very well integrated

   ○ Partly integrated and co-ordinated

   ○ Not well integrated at all

   ○ Not relevant/applicable

10. **How well communicated and understood would you say the KSF is in your organisation?**

   ○ Well-communicated and fully understood by most/all employees

   ○ Mostly understood by most staff

   ○ Partly understood by most staff

   ○ Not well understood at all by most staff

   ○ Don't know

Barriers to use of KSF

In the next section we would like to hear your opinion on the main barriers to use of the KSF in your trust or more widely in the NHS.

11. **The factors in the following list have been indicated to be barriers to the use of the KSF within some trusts by prior studies. Please choose the factors that you believe to be the most important barriers to effective use of the KSF and rank how important they are on a scale of 1 to 5.**

   If you feel any are not an issue, then tick no issue. And please don't give them all a 5: reserve 5s for those you think are the really key barriers to its effective use.

   1 = a minor barrier to use of the KSF : 5 = this is a main barrier to use of the KSF

Policy issues	no issue	minor 1	2	3	4	main 5
The KSF is not clearly linked to performance appraisal	○	○	○	○	○	○
Appraisal and KSF are not seen as sufficiently important/prioritised	○	○	○	○	○	○
No director is clearly accountable for KSF	○	○	○	○	○	○
There is no measure of KSF coverage	○	○	○	○	○	○
Information on KSF coverage is not reviewed regularly	○	○	○	○	○	○
Senior managers don't practise it and don't tell others how important it is	○	○	○	○	○	○
KSF is perceived as having no relationship to Trust, unit or personal objectives	○	○	○	○	○	○
KSF does not support and reinforce CPD and revalidation processes	○	○	○	○	○	○
There are no 'consequences' or penalties for failing to use KS	○	○	○	○	○	○
KSF is isolated from other HR and management processes	○	○	○	○	○	○
KSF is not being operated or implemented in partnership with trade unions	○	○	○	○	○	○
There are low levels of manager awareness of KSF	○	○	○	○	○	○
There are low levels of staff awareness	○	○	○	○	○	○
Other*		○	○	○	○	○

*please specify: [   ]

Design issues	no issue	minor 1	2	3	4	main 5
It's an over-complex design	○	○	○	○	○	○
The KSF post-outline format is too detailed	○	○	○	○	○	○
There are too many KSF core dimensions	○	○	○	○	○	○
There are too many KSF additional dimensions	○	○	○	○	○	○
The KSF dimensions aren't tailored to reflect key areas of work/skills	○	○	○	○	○	○
The KSF paperwork is too complex and detailed	○	○	○	○	○	○
KSF is a uniform approach whereas needs vary across the trust	○	○	○	○	○	○
Pay progression doesn't in reality relate to the KSF	○	○	○	○	○	○
Personal Development Review meetings using the KSF take too long, are too repetitive	○	○	○	○	○	○
Other*		○	○	○	○	○

*please specify:

Operational issues	no issue	minor 1	2	3	4	main 5
There is a lack of management/appraisal skills to use the KSF effectively	○	○	○	○	○	○
There is a lack of or poor guidance and tools on the application of KSF	○	○	○	○	○	○
The KSF process is too time-consuming and bureaucratic	○	○	○	○	○	○
The eKSF tool is too complex /inflexible	○	○	○	○	○	○
People just don't know where to start with KSF	○	○	○	○	○	○
The culture here does not support the application of appraisal and the KSF	○	○	○	○	○	○
Other*		○	○	○	○	○

*please specify:

12. Next, select from the following statements the one that most closely reflects your views:

○ The KSF needs no change in order to be successful, it just needs people to make more effort to implement it

○ The KSF needs a few minor changes to make it successful

○ The KSF needs some significant changes to make it successful

○ The KSF needs radical change to make it successful

○ The KSF should be withdrawn

Encouraging the take-up of KSF

In this final section we would like to hear your views on what might encourage thorough application and take-up of the KSF.

13. Again, please rate these suggested changes or improvements in terms of how successful they would be in embedding KSF usage within the NHS, on a 1 to 5 scale.

Please tick **no impact** if you do think the suggestion would have no discernible impact.

1 = this would have a minor positive impact on uptake and use of the KSF : **5** = this would have a major positive impact on uptake and effective use of the KSF

Changes focussed on policy	no impact	minor 1	2	3	4	major 5
Trust directors specify all Agenda for Change staff must have an appraisal, with KSF included	○	○	○	○	○	○
NHS Chief Executive and NHS Director of Workforce specify that all staff must have an appraisal with KSF included	○	○	○	○	○	○
Show senior managers evidence of the impact on performance of appraisals in the NHS	○	○	○	○	○	○
In each trust, make a director accountable for KSF delivery	○	○	○	○	○	○
All trusts should have KSF action plans agreed with Board/SMT	○	○	○	○	○	○
Set a target for appraisal coverage for all trusts and a date for its attainment	○	○	○	○	○	○
All trusts to provide monthly progress reports on KSF usage to the Board/SMT	○	○	○	○	○	○
Re-launch and establish a powerful communications campaign for KSF	○	○	○	○	○	○
Secure stronger support for KSF from professional bodies	○	○	○	○	○	○
Link KSF more strongly to CPD and revalidation processes	○	○	○	○	○	○
Work with trade unions to establish a more effective partnership approach to KSF implemetation	○	○	○	○	○	○
Make the allocation of aspects of training budgets dependent on evidence of KSF completion	○	○	○	○	○	○
Regulators focus more on KSF completion rates as a metric	○	○	○	○	○	○
Change the name/rebrand KSF	○	○	○	○	○	○

Design changes	no impact	minor 1	2	3	4	major 5
Ensure discussion of Trust objectives is undertaken alongside discussion of KSF/development needs	○	○	○	○	○	○
Ensure discussion of personal objectives is undertaken alongside discussion of KSF/development needs	○	○	○	○	○	○
Simplify the KSF dimensions	○	○	○	○	○	○
Reduce or change the core dimensions	○	○	○	○	○	○
Drop or improve and simplify the KSF post outlines	○	○	○	○	○	○
Make the core dimensions the main/sole focus of KSF	○	○	○	○	○	○
Use other relevant frameworks (eg professional or management competencies) in place of the specific dimensions	○	○	○	○	○	○
Improve/simplify paperwork	○	○	○	○	○	○
Tailor the paperwork and process more to suit specific occupational groups/units, eg KSF Nurse	○	○	○	○	○	○
Ensure that pay progression genuinely relates to attainment of the KSF	○	○	○	○	○	○
Drop the link of the KSF to pay	○	○	○	○	○	○
Join up the KSF more effectively with other HR and management processes	○	○	○	○	○	○

Operational changes	no impact	minor 1	2	3	4	major 5
Allow variation in application of the KSF process from year to year	○	○	○	○	○	○
Focus only on the most relevant and important aspects of KSF	○	○	○	○	○	○
Provide more/better management training in appraisal and development planning skills	○	○	○	○	○	○
Provide training for appraisees as well as appraisers	○	○	○	○	○	○
Set up and train unit/occupational champions and advisers	○	○	○	○	○	○
Provide more/better guidance in implementation and operation	○	○	○	○	○	○
Set up/join local experience-sharing networks with other trusts	○	○	○	○	○	○
Successful trusts to provide support and guidance to other trusts	○	○	○	○	○	○
Use the eKSF, ESR or similar system more widely to administer the process	○	○	○	○	○	○
Trusts supported to develop own local admin systems for KSF	○	○	○	○	○	○

14. Lastly, we would welcome any further comments you would like to make. In particular, we would welcome your views on up to three key things you would do to help improve take-up and effective use of the KSF.

Appendix 2: Survey Comments

We asked survey participants for any further comments on things they would do to help improve take up and effective use of the KSF. The main themes were:

- Simplification and modification of the process

- Changes to e-KSF

- Links to pay

- Re-launch of the KSF

- Local variability

- The link to CPD

- The role of senior management

- KSF champions

- Training

- KSF as a mandatory requirement

Verbatim comments within each of the themes can be read below.

Simplify and modify the process

"- Simplify outlines – either drop specific dimensions or drop areas of application, in most cases these are not well written or copied from framework which does not assist with assessing competence. The indicators in the framework are really well written and can be used alone. Give clearer guidance and communication and remove the pay link (I hadn't considered that before this survey!) this would remove the fear for appraisees, appraisers and managers".

"Simplify the KSF – the explanatory text it needs to be shorter than 267 pages. Review the dimensions to make them more relevant for example, including a dimension on leadership".

"Reduce to just include core dimensions. Simplify paperwork and process. Dedicated resources to support KSF (not project roles)".

"It is very complicated. The recording is very repetitive and so tends to become meaningless as time goes on. It does not focus on competencies enough".

"It needs to integrate with doctors/directors appraisal in some way. Stick to Core Dimensions (these might need tweaking) – there are far too many specific dimensions. Need some measure of behaviours as well as knowledge and skills".

"Simplify the 'examples of application' process (this appears to be the main problem for managers non-compliance)".

"Simplify the language. Focus on core dimensions only with specific dimension content being incorporated into JD's and person specs. Remove the 2nd gateway as the emphasis would be on achievement of KSF, objectives, performance and attitude at all times".

"Simplify the process. Tackle mass duplication and inconsistency. Monitor (KPI)".

"It needs to be simplified and then re-sold with the focus on how this links to a variety of POSITIVE PURPOSES for the Trust, the department, the manager and the individual".

"The KSF Outlines are easily confused with AFC Job Evaluation factors where staff believe that 'points make prizes'. Simplification of the KSF Outlines and Dimensions would help with this. The application of the KSF is very complex and requires a very detailed appraisal to be carried out with every member of staff. Some professional staff groups currently use similar systems to evidence CPD, but other staff groups (e.g. ancillary and admin) get lost in the detail and also get hung up on the need to produce 'evidence'. Too complex, too time consuming, needs to be simpler'".

"KSF must be profession specific, with fewer dimensions for it to be successful. The current matrix is a complete farce with far too many irrelevant subsets within each dimension".

"Change the paperwork, it is repetitive. We fill out boxes on paper because we have to, it has little meaning".

"A clear steer on use of E KSF v ESR for admin of KSF would give clear direction. KSF dimension descriptions are so complex it is hard to make them meaningful to job roles. This needs an overhaul to aid development of post outlines. Current system takes too long and is time intensive. The format should be designed so the KSF is linked to trust /team objectives".

"Drop the specific dimensions and standardise the core dimension levels. Link objectives directly related to KSF and ensure the results of KSF development feed directly into an annual Learning needs analysis".

"Find that KSF dimensions do not link easily with organisational objectives and therefore do not assist with the setting of personal objectives. Feel that it is a very bureaucratic process that does not add value in improving patient care and the driving organisation forward".

"Simplify dimensions and indicators. Simplify recording mechanisms".

"Have a very clear link to the trust and team objectives. Simplify paperwork to record PDR and develop PDP. Use intranet to advertise good practice and quick ways of recording evidence without creating a paper trail".

"I think the main issue of how staff relate to the KSF framework and applying it to their work. I think they find the language quite complex. As a trust we are starting to use specific examples of application for new post outlines to help staff as a starting point to collecting evidence for their appraisals. Also we are including evidence gathering discussions and activities in both appraiser and appraisee training. Also I think that KSF appraisals should be promoted/advertised in a more relaxed manner- I think that the rigidness of the framework/ language used created a barrier for some staff".

"All components of the KSF system should be simple to implement and manage and the benefits of KSF should be easy to identify and quantify".

"It is too bulky, too much micro detail and does not align to main development objectives that are easily recognised by staff or managers to make it more useful. It is not user friendly and e-KSF is not liked by appraisee's or managers".

"KSF documentation is very wordy and difficult to interpret. Each organisation has been responsible for writing their own KSF so lots of subjectivity and lack of standardisation".

"KSF is complicated and unwieldy for managers and staff. Reduce the number of specific dimensions. The core dimensions should be kept they underpin the requirements of every role. The principle of KSF is good however in practice it needs simplifying so it is operable for the workforce".

"Too much detail in the KSF for lower bands".

"My 3 key suggestions would be to make the whole KSF system/structure far less complicated and time consuming; less structured (which would allow more focus on personal development and objectives) and lastly if we are to stick with KSF, we would really benefit from a re-launch!"

"Overall, KSF a useful tool. Would suggest simplification eg reduce number of HWB dimensions to avoid confusion and overlap, as well as qualitative statements instead of indicators and examples of application".

"Reduce the number of dimensions, and therefore the amount of evidence required".

"To be effective KSF must be made much, much simpler to use. It must be made much less bureaucratic There should be an end to this absurd concept of drawing up individual KSF outlines for individual post-holders, with hundreds of thousands of staff throughout the country 're-inventing the wheel'. There should be an assumption that there are standard KSF outlines, linked to AFC national profiles perhaps (and/or Skills for Health competences) which can be plucked, off-the-shelf. Outlines from other Trusts should be readily available, whether by e-KSF or a simpler web-site".

"Amend the process so that KSF is only utilised until an employee is deemed fully competent – for experienced and competent staff continuing to review against the KSF becomes pointless. The tool is most useful for new recruits".

"Simplify the process, especially the paperwork, Focus on core dimensions – consider dropping the specialist ones (add clinical core dimension for clinical roles), increase support in implementing across the organisation don't beat with a stick, use LQF for Bands 8 and above".

"Simplify. Eliminate use of numbers. Have a user friendly universal template".

"Simplify; focus should be on service and personal objectives and less emphasis on recoding evidence; to re-establish the appraisal time as something helpful and useful, which KSF process has taken away from our previous established and workable appraisal model".

"Stop repetition of evidence, people printing out the same thing for several areas if a waste of paper. Make it quicker and simpler to complete by linking or reducing core and specific dimensions".

"The philosophy behind KSF is fundamentally a positive one – particularly in terms of equity across staff groups. However it is wordy and complex, and although it is strongly promoted as a development tool it is viewed by some as having the potential to be used as a performance management tool – a result of gateways perhaps? Review and reduce specific dimensions. Language is complex and needs to be simplified. Review gateways and links to pay progression".

"The process is far too complex and nurses haven't got the time to even complete a PDR – never mind spend time on this added complexity. If it was user friendly – it would certainly be used far more than at present".

"Allow trusts to develop their own admin systems for appraisal not just the KSF. Get rid of the specific dimensions and ensure all staff are obliged to follow the core dimensions including doctors and executives (lead by example)".

"Keep it simple – people made outlines too complicated by including too many optional dimensions; a limit of 4 would be fine for almost all posts; keep the core dimensions as they are; they have stood the test of time".

"Simplify the paperwork to ensure the KSF outline lists practical examples of application that staff understand which is linked directly to the dimension indicators and it focuses the appraisal more to a 1:1 discussion and when paper is used for evidence it is naturally available evidence i.e. staff not having to spend hours writing it up".

"Simplifying the KSF may go some way to stop managers being put of by its complexity and make it easier to use during the Review process. Take up would be improved by raising its profile and ensuring organisations understand its importance".

"It is over complicated and the gathering of written evidence is time consuming. Managers have differing approaches to what is acceptable as evidence and guidelines on this need to be clearer".

"Keep core dimensions. Scrap lengthy paperwork to support examples of application".

E-KSF

"E-KSF is one of the main barriers to implementation of KSF at this Trust – the format, layout etc. is poor and this makes it off-putting for staff. It takes too long to load/refresh pages and it becomes a box-ticking exercise".

"E-KSF access and use to be simplified, enabling viewing of e-KSFs already set for similar posts nationally, with support of levels from professional bodies".

"In my opinion what is missing is design thinking. Establish what is needed to be done and prioritise. Employ 'Usability/Design' expertise to design forms which are simple to use and capture essential information. E-KSF is part of the solution but it is too complicated. So to sum up get some design talent, as well as HR talent to redesign, simplify and humanise the process".

"Mandate KSF and E-KSF Tool".

"Use e-KSF as much as possible to record & monitor progress & learning needs & the link with ESR".

"E-KSF usage by all trusts, involve staff and managers from the start of their employment".

"Get rid of the e-KSF it is clunky and unreliable".

"I've found e-KSF impossible to do, get thrown out before I've completed an entry. The paperwork is repetitive & doesn't relate to my job and development needs".

"E-KSF is a waste of time because of its complexity and flexibility".

"Merge the admin training tools (AT-L and OLM) so that they feed into ESR and e-KSF tools better. Staff do like to see their training courses appearing in e-KSF, not lost details on some other learning & development admin system. Saves paperwork record keeping everywhere".

"Once people are familiar to e-KSF most find it a useful tool to engage with the process but I believe managers are resistant to its implementation because it removes staff for whatever period of time away from the coalface. A new campaign aimed at staff and users needs to be implemented".

"PLEASE leave the e-KSF alone! I know you'll have many people saying it's too complex and should be scrapped, but used correctly, it's invaluable. We also shouldn't focus too much on paperwork – the e-KSF should and can be used instead of paperwork. The paperwork, which can and ought to be simplified, should be used more on an exceptional basis. If appraisee and appraiser are encouraged to use the e-KSF and populate it 'little and often', then they just need to run the paperwork off straight from the e-KSF – its all ready filled in then, and you can make notes on it".

"Provide more memory space on e-KSF so it can become portfolio for professional body and regulator evidence".

"Re-implement e-KSF locally".

"Stop using e-KSF and record on ESR. Having two systems increases the workload".

"I think the e-KSF should be compulsory for Trusts to use and that there should be investment in training to teach staff to use the e-KSF. Those people that do use the electronic version, like it and I know others would like to learn to use it. We have had some problems when staff have moved Trusts that they have not been able to take their electronic KSF with them".

"There is resistance at Director level to implementing e-KSF as a reporting tool, the HR Director is known to have said that he does not want it, so I think to implement and embed KSF and e-KSF fully will require a suitable stick and carrot".

"E-KSF has been the problem in this PCT where staff were expected to use a system that is not user friendly, the paper-based system works well in disciplines where appraisal is imbedded. A different system is more appropriate for some work groups, eg porters, cleaners, admin".

"Drop the e-KSF in its present form – it seems to be a major barrier to appraisal. There have been reports of some appraisals not involving a conversation – just being 'done' on the e-KSF".

"Re-design e-KSF to have just one front screen from which a manager can see a summary of their staff and progress against KSF and with one click amend details – rather than the numerous and complexity of e-KSF. Manager could just log on to view any completed self assessments by staff and provide feedback. Thus meaning KSF reviews can be completed remotely – and without the need for lengthy review meetings unless there is an identified reason to have a review meeting".

"E-KSF is too complicated and the shared outlines on there are useless not providing areas of application to the post as people just seem to have kept the areas of application from the book which are just EXAMPLES".

"Develop further training and support around e-KSF".

"The computer recording of e-KSF is inconsistent, hard to manage and the system is difficult to get data to save at times. It requires much more training than is available".

"Register all appraisors for e-KSF and other tools".

Link to pay

"Remove the link to pay. Staff who are not performing should be managed through a performance framework".

"Clear and simple link to performance AND pay".

"The KSF shouldn't be linked to pay progression but rather support the natural progression of staff up the pay band. Instead, we tell managers that the performance policy should be used if there are performance issues that may halt pay progression. The KSF should not be used as a management tool; it is most definitely a development tool for the individual, the team and the trust as a whole to ensure the appropriate use of training resources".

"The KSF has not enabled a reward system for staff who performs above and beyond their role and more senior staff (i.e. nurse consultants) are paid a higher band for seemingly less responsibility and have on the whole less clinical skills than for example our roles".

"Pay scale shouldn't be linked to this unless it's truly going to reflect people's experience and skill levels. Currently you can't attain the maximum pay scale unless you've been working years in the trust".

"There is no protected time to do these so making it more difficult by incorporating KSF can only lower the number of staff getting a development review. There is also reluctance from staff to take on new skills and they have expressed an opinion they would go without

an increment by preference than take on new skills. We also have a significant percentage of staff through upper gateways as a result of not applying KSF for over 5 years so there is no incentive left".

"Consider the framework to become a performance framework and ensure it is linked directly to Pay through gateways, (make this mandatory)".

"Clarify the position regarding linking KSF with pay. At present, the linkage to pay is limited. Either pay should be very closely linked with performance or not at all".

"Pay progression down the incremental points should be based on performance and KSF review".

"Link KSF to pay more directly-once pass the second gateway people don't take it seriously".

"Ensure KSF relates to job and career progression, successful completion of KSF actually relates to pay with incentives, if this is unachievable, scrap the scheme".

"For those at the top end of their bands it has little relevance as they are not going to have a pay progression. KSF has been taken up only as a requirement; majority of opinions is that it is not a good use of our time".

"Withdraw the link to pay – stop scaring people off to use it".

"It must not be linked to pay until it works".

"Create a stronger link between KSF and pay profession".

"Nurses re-banded at the very top of a band have no upward mobility for pay and no skill gateways to progress through and therefore no incentive to understand or implement KSF".

"Relating it to pay progression creates inequity as staff that don't receive appraisals still progress".

Time commitment

"Ensure trusts are committed in word and deed to allow for time in year to enable appraisers /appraisees to carry out IPDR/ KSF and formulate PDP to inform annual training programme and setting and allocation of training budget. i.e. acknowledged time away from clinical caseload reflected in activity targets".

"Time allowed to write up experiences and reflections. Staff to be able to discuss the KSF in a group meeting for support, help, suggestions and advice. Dedicated protected time allowed for this meeting of staff supporting each other".

"Reduce the time required to record appraisal and development review process – focus on core dimensions".

"Have formal training for staff in all areas to be able to understand and allocate KSF. Provided protected time for some staff".

"When it comes to the appraisal they [managers] need to practice what they preach and ensure that they spend time to help and ensure an individual has time to complete and maintain KSF Documentation. Where evidence is given the managers should look at the merit of the evidence and provide feedback. The KSFs have all been very brief, no member of staff has a full outline and on occasions where evidence was proved it wasn't looked at. I think to improve uptake you need people other than managers to be able to help the staff on the ground i.e. ULR's to be able to have the time with staff (protected) to help any individuals and spend time to make the process happen. This way uptake will increase year on year".

"It takes far too long to appraise with KSF properly and you lose the will to live if you have a number of appraisals to do".

"The developers need to remember that staff have full time jobs to do and are now being asked to be more effective, efficient and to do more in less time. Expecting staff to produce evidence to show that they can do their job is a non-starter. It is a manager's responsibility to ensure that staff are doing their job and provide evidence if their staff are NOT performing well enough. The system needs to make appraisal and review more efficient and effective, not more time consuming!"

"Too long a process and just learn to 'fill the boxes' rather than real personal development. Should be more individualised and linked to CPD/HPC requirements".

"Make the process less time consuming and repetitive with less paperwork – it is just so unwieldy to do. The other problem is capacity. We struggle to have the capacity to meet the demand on our services without having to pick up KSF reviews. We have targets imposed so do mini-KSF's to meet targets but the quality goes so it does not result in improved performance. Improve the process – don't add more performance metrics as the data will only be fudged. The idea is sound – it could make staff feel invested in and valued – enhance their development and improve performance if the process was improved".

"The big plus point with KSF is that it can be applied to every post, i.e. all staff included. If we start using more of the 'professional' type standards or measures it will become inaccessible to staff who do not have a professional background. The main problem I hear about is that the appraisal and KSF review 'takes too long to do' and that is mainly from the nurses. Personally, I think it works well and as for the time it takes – well I just think that if you value your staff you should invest the time in their development".

Re-launch of KSF

"A re-launch would be useful but NOT changing the name as this would totally confuse organisations".

"Don't rebrand it and do more of the same all over again; it will only be taken up when it's properly monitored and people start to use it and see the benefits for themselves".

Scope for local variability

"I think the NHS has to accept that there will be local variability in applications of KSF. Why not acknowledge this and allow Trusts to work with Staff Side within their organisations to simplify the application of the KSF and tailor it to their needs? Centralised approaches will be ignored and do not sit well with the advent of Foundation Trusts".

"Every trust should be required to use the assessment of the 6 core competencies to address their corporate values. The KSF assessment review would become a vehicle for staff to demonstrate both their commitment and demonstration in the workplace to these. This would mean that each trust must prepare appropriate localised guidance documentation".

"Individual Trusts should engage with their own staff to set relevant KSF dimensions for their particular trust".

"Make the KSF a generic framework which can be applied locally as required by individual trusts to meet their need".

"Regional networks should be supported by the relevant SHA".

"Professionally relevant, applicable to local Trust and service developments, easily transferable with the individual throughout career".

Link to CPD

"Linking it to CPD requirements of regulatory authorities".

"Make links between KSF and HPC CPD requirements more explicit. Provide funding for training based on analysis of learning needs via KSF, demonstrating the role of KSF to deliver learning needs".

"The main push is to get staff more fully involved and make this a tool to assist in delivery of service, improved CPD and to support staff in their terms and conditions".

"Link KSF to CPD and revalidation – this is not given enough recognition or time in trust, without registered staff the trust cannot function".

"Encourage universities to link learning of pre-registration Healthcare students to KSF during their training and continue to encourage mapping of KSF for CPD modules".

"It currently exists in addition to CPD and appraisal, not as part of it. Anyone can find a good set of clinical notes to put in their KSF folder – this does mean your notes are consistently good. The 'evidence' provided does not prove anything, but it takes a lot of time to collect. It is a total waste of time – and I work in a department which has tried to do this properly, everyone has a KSF outline and a KSF folder".

"I sense it is much more valuable to ensure that staff have relevant education for their jobs, and can be deemed truly competent. If we were to ensure that all staff had access to a qualification i.e. NVQ/BTEC/ core clinical programmes, then the outline for the role would be incorporated into the programme and all staff would achieve their outlines if successful during the programme. Most organisations are supporting all staff bands to be formally qualified, so would seem the most suitable approach to ensuring competency of application particularly as the NHS move to provide a more vocational education route. At the moment what is time consuming is referencing evidence against the framework".

"Provide guidance on what counts as evidence for different staff groups by staff group (linked to professional competency requirements)".

"With nursing becoming a graduate profession from 2012 outcomes related to university education would encourage participation".

"Include KSF as a Quality Care Commission Standard under professional development C11c and also link KSF (where appropriate to the post) to National Patient Access Standards under the Core Dimensions Quality and Service Improvement".

Role of senior management

"Sell it to CE's and Directors no support just seen as another HR bureaucratic process. Needs to be linked to the values and aims of the organisation more closely"

"Educate all areas including senior managers to ensure application is consistent across organisations".

"Ensure senior managers prioritise along with other national priorities".

"Ensure senior management can see clear links to other assessment processes they undertake".

"The implementation of KSF needs to be pushed from the top down and needs to be given a realistic timeframe to be implemented fully and at a quality level, not just a quick, rushed, tick-box exercise. More support from management/director – get them to 'talk up' the process at every opportunity (not to use as 'beating stick' approach with threats of not going through pay progression)".

"For KSF to be effective it needs to be supported and championed at Board level, and sufficient resources need to be made available to implement it operationally".

"Make the implementation, management and monitoring of the use of KSF a KPI. Ensuring via the KPI that the entire annual review process is embraced by organisations Boards and used from senior management downwards. Provide evidence of the financial benefits. This lack, coupled with a view that KSF is complex and unimportant has meant that Boards and senior managers have no desire to know how it has been implemented, its quality or its relevance to performance. As long as we have evidence a review has taken place that is all they want. Make KSF a mandatory part of the recruitment process. Senior managers pay lip-service to embracing its use at annual reviews and staff do not see the relevance to their daily role or how it can improve service provision".

"All managerial job descriptions to include responsibility for KSF".

"Director commitment to KSF and use of KSF with their direct reports".

"Employ people managers who actually engage with the individual rather than 'go through' so many motions, ticking boxes, saying thank you once a year, or there isn't any money for that training, or that they don't see training requested is relevant for job they've got. Employ skilled (people) managers who create a positive environment for staff to work in which has obvious knock on benefits. Where an individual's personal development is seen as a Trust resource, rather than very narrow service one".

"Link managers lack of carrying out KSF as a dismissible offence- it is common knowledge that many mangers avoid giving staff proper appraisals, bringing in KSF has not changed that notion".

"CEOs/Senior Execs held to account – setting them targets".

"Ensure Director sign up and accountability for KSF".

"Enforcement, enthusiasm and encouragement from the top".

"I feel the problem with KSF is that managers do not understand the importance of it, staff have too much pressure to see patients all the time and no-one checks that appraisals are being done".

"I think KSF is a useful tool, unfortunately, I find that it is the more senior managers that have a dislike of it through a lack of understanding on how it all works. It should be mandatory for all staff to have KSF with their appraisals in order to show competencies and identify gaps and training needed. Also to link it to pay increments would be a good incentive, protected time in order to obtain evidence and training for those that appraise and those being appraised".

"Include carrying out of KSF development reviews as a KPI for managers. Ensure managers are trained to carry out effective KSF development reviews (make this mandatory)".

"Individual staff need to be encouraged to take ownership of their own personal development requirements including KSF, and request this process from their managers. Many staff wait to be spoon fed, and inexperienced, pressured managers do not put a high priority on the process, if they actually understand it themselves".

"Make a Board Director accountable, and CHECK that they are doing what they say".

"Make it responsible at Director level as needs to come from the top; set managers targets to achieve appraisal completion and show the benefits as people just see it as a paper based system with no value. It was sold as one of the benefits from Agenda for Change and we need to focus on that and get something good from it".

"Making senior managers/directors more accountable. Many lack commitment to KSF and therefore they undermine the enthusiasm of others. Training can de-mystify the KSF, but some managers over complicate it so that they have an excuse not to deal with it, 'takes too much time' etc. Managers can now blame the KSF for their poor management practice. More management development to encourage good management practice is still required".

"The problem is at the top inasmuch as senior staff/directors don't acknowledge that extra time and staff are needed to implement all this. Get over that hurdle and the rest will fall into place easily".

KSF champions

"KSF needs to have it's own department/group of staff solely focused on staff support and training needs at least until the process is fully ingrained in the culture. KSF should be bigger focus in the organisation (e.g. at induction, on going training, general regular awareness, discussed regularly)".

"DH to help fund for all Trusts to be able to have a permanent KSF lead/project manager who is suitably qualified (not just an administrator) who is passionate about staff development and patient care and is solely focused on KSF ie. KSF not tagged onto another HR role. Once KSF is fully embedded the KSF Lead should be looking at quality assurance i.e checking 7% of appraisals each month from each division, linking KSF with skills for health developments and regulators, helping managers to focus on giving staff Key Performance Indicators which link to the departments 12 month plan and KSF and Training new managers that join the trust on KSF".

"Each KSF interview would be performed by expert or trained peers/ colleagues/trust champions and not the line manager. This would allow a certain amount of objectivity, mirror what happens with Medical consultants and in many academic /educational settings, plus promote KSF as a competency development tool".

"Have a Lead/ Champion in each unit".

Training

"When jobs are advertised KSF Outlines should be included so people know what competencies they need to meet. Newly appointed managers should be given training on the KSF and audited to see if they are implementing it effectively to their staff".

Trusts either singly or as part of a network would train assessors to assess against the KSF and its cross over to other related competency frameworks/standards. Line managers would continue to set performance /work role objectives and review every year as part of the local performance appraisal process".

"We provide training for appraisees, which I have found, makes them better prepared, and keen to be appraised".

"Mandatory training for all new starters on PDR and e-KSF".

"Much better training needed, KSF generates vast amounts of extra work for staff. Managers completely misunderstand the reason for KSF and treat it as an academic exercise without much connection to the work place".

Mandatory requirement

"Make KSF a mandatory requirement at Induction for all levels of staff. Bring out a national training package to support this, to ensure uniform delivery of KSF training throughout the country".

"Make trusts use KSF, set targets for uptake. Make trusts use all aspects of KSF and not just the aspects that help them save money".

"Statutory requirement of trust to fully implement KSF as a contractual obligation".

"Unless there are penalties or consequences for not using the KSF progress will not be made. There needs to be some kind of reward system. The idea of the gateways opened or closed is not strong enough and is very misunderstood by managers and staff".

"Really make it Mandatory, with Trusts providing monthly reports to Trust Board, SHA and DH. Take action against Trusts, Departments and Managers who do not use KSF's".

Other comments

"Do not change too much – it will give people an excuse not to use it as they will view it as another changing policy and give people deadlines to complete it".

"Focus on what is important-having an appraisal not KSF. Appraisal should be about the responsibilities/accountabilities described in the job description. It doesn't work/it's been re-launched -if it were a good idea it would be used by now".

"Redesign KSF into a self assessment tool for staff i.e. manager develops the post outline; member of staff assesses themselves/ provides their own evidence against the outline and submits to the line manager for sign off or feedback. This can be undertaken on-line".

"Effective use of the KSF gateway process to enable performance management and performance development. Promote the value of competence models in general – research showed correlation between increased sophistication of appraisal and reduced mortality rates. Any competence model would feel complicated to begin with".

"Generic set of outlines linked to main job roles, rather than individual services/ departments creating own; option to edit generic outlines through examples of application to ensure relevance to specific job role. Develop e-learning packages to illustrate application of KSF to support initial and refresher training for appraisers and appraisees. Ensure all staff receive their KSF outline on appointment or when changing post so they can prepare for and use the framework effectively day to day".

"Each trust would be required to make a policy decision on how frequently they would want their staff reviewed against the KSF -a bit like mandatory training when they decide how frequently to recall staff to training in topics where the frequency is not determined by statute or external professional CPD. For example it might be a minimum of 4 years and individuals are assessed against all 6 core at the same time".

"If an individual is required to be assessed as fit for practice in line with other professional standards or where the local trust operates another framework, then the KSF review would be absorbed into this. Where an individual remains in the same job, then they will have to produce new /different evidence displaying how they have applied their competency successfully in different situations and statements as to how they competencies remain best served/maintained in that same environment. Trusts should then produce regular risk assessments on KSF review rates which could be included more overtly within assessment like Standards for Better Health and NHS LA".

"Linking clinical objectives with KSF links has helped me to begin to meet corporate objectives in regards to appraisal. This in turn has helped staff begin to collect evidence for CPD and HPC registration. Trust now has specific lead for KSF which is helping to focus and support managers to achieve KSF/ appraisal targets for trust. Needs more training and development with paperwork that is easy to complete and submit".

"Prefer a talent grid-many staff meet their full outline very easily. Link to other professional frameworks (avid repetition). Exempt training grade staff if their course frameworks cover similar ground. Put in a system to quality assure across the NHS. We looked at two early implementer sites for assistance and they were radically different. Resource for training and developing guidelines. Do not use stick approach as will lead to high uptake but poor quality appraisals".

"The dimensions do not reflect the changing nature of organisations and KSF is a static not a dynamic system. The dimensions do not reflect the nature of our work in Commissioning and the 'competencies' are difficult to apply. The need for in depth training is acute, but the time is not there".