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Abstract

Purpose – This paper aims to present findings from a research study to implement a career development framework within a large acute district general hospital facilities directorate. The findings of this study will provide points of interest in terms of the implementation of a career development framework and also a wider, more generalisable analysis relating to the use of Action Research in this context. The efficacy of career development frameworks and alternate recruitment strategies will also be considered.

Methodology/Approach –Action Research (AR) was utilised as the primary research methodology, with focus groups and semi-structured interviews employed as the main sources of data collection. NVivo qualitative analysis software was used to analyse the data. Interventions within the AR cycles have been categorised as micro and macro in terms of there complexity and level of personal and organisational involvement. Although micro interventions

will be briefly referred to, macro interventions have been evaluated within this paper in terms of both efficacy and transferability.

Findings

There were two main findings from this research project originating from AR interventions that may prove beneficial to other organisations in terms of both organisational and staff development.

- Development of bespoke career development pathways
- Creation of a fast track employability scheme within hotel services

Research limitations/implications – Some of the more longitudinal interventions will require further analysis to gauge long term efficacy.

Originality/ Value – This paper should prove beneficial to those involved with implementing organisational change and the potential use of AR within the facilities environment. The paper should also provide useful alternatives in the recruitment of staff and the use of career development interventions.

Keywords – Knowledge and Skills Framework, action research, professional development, appraisal, organisational development.

Paper Type – Research Paper

Introduction

Agenda for Change (AfC) is purported to be the largest reform of health service pay since the inception of the National Health Service (NHS) in 1948 (May et al., 2006). As a constituent part of the AfC process, a career development framework known as the Knowledge and Skills Framework (KSF) was implemented. KSF outlines the knowledge and skills that staff must apply in their various roles to deliver quality services (Department of Health, 2004). The process is symbiotic with methods of appraisal and progression is achieved by navigating incremental pay points and passing through pre-determined pay gateways. Processes for appraising the performance of clinical staff are common place, and in many cases essential for the on going maintenance of professional registration. Data published by the NHS Information Centre (2006) demonstrates that in 2005 31% of the NHS workforce were employed in a facilities capacity. Despite facilities representing such a large proportion of the NHS workforce, systems of appraisal and the utilisation of career development frameworks remain inconsistent.

Context

The annual NHS staff survey results[*] have, year on year, demonstrated how the NHS has struggled to utilise systems of appraisal, particularly concerning staff working within support roles (Healthcare Commission, 2008). The appraisal rate at the hospital in 2006 placed the organisation in the bottom 20% of acute Trusts nationally with only 46% of staff reporting that they had received an appraisal in the previous 12 months. When such data is analysed by directorate or occupational group, staff working within facilities are repeatedly in the lowest category in relation to appraisal and career development opportunities. The problems associated with introducing KSF within facilities became increasingly evident from the beginning of the implementation process. Most staff were unaware of the concept of appraisal or mechanisms of professional development.

Action Research

The AR model is becoming increasingly popular in the applied social sciences (Whyte, 1991), subsequently there are many definitions attempting to capture what 'Action Research' actually is. The concept of AR was originally formulated by John Collier, the US Commissioner of Indian Affairs in the 1940s (Bate, 2000), although Kurt Lewin (1946) coined the term 'Action

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[*] The NHS staff survey is believed to be the largest annual staff survey in the world. Almost 156,000 employees from all 391 NHS trusts in England (a response rate of 54%) responded to a questionnaire in 2007 asking about their views and experiences of working for the NHS.

The purpose of the survey is to look at the attitudes and experiences of NHS staff both nationally, because of the importance of the NHS, and by individual trust, so that employers can review any issues with their own staff and take action.

Research'. According to Bate (2000) the model went out of fashion in the early 1980s yet is now the subject of a resurgence (Goldstein, 1992, Hollingsworth, 1997, Zuber-Skerritt and NetLibrary, 1996) largely due to the growth of interest in organisational development and the contemporary interest in developing '*learning organisations* (Hayes and Dublin City University. Business, 1997, Senge, 2006, Senge et al., 1999, Stahl et al., 1993).

In its most simplistic representation AR involves a cyclical process of diagnosis, change and further research leading to furthermore ongoing cyclical processes. The results of the diagnostic phases are transformed into change processes and their effects gauged to inform further interventions. Coghlan et al (2005) describe the process of AR as four stage, planning; taking action; evaluating the action; leading to a higher stage of additional planning and so on. This sequential description illustrates the central idea of AR, using a scientific approach to study the resolution of important social or organisational issues together with those who experience these issues directly (Coghlan et al., 2005: 4). Rapoport (1970) highlighted how AR differs from other social science approaches in the immediacy of the researchers' involvement in the action process. Indeed, AR is a methodology in which the researcher becomes immersed in the process. The problem solving approach associated with AR, represents a significant investment in both time and emotional energies on behalf of both the researcher and research participants.

The Action Research Model Used in this Research

Bate (2000) presents a version of the AR model, set in both cultural and organisational change practices yet developed in NHS hospital and health care organisations. Bate's model can be interpreted from an anthropological or cultural perspective, but it is specifically about utilising ethnographic data for problem solving, issue diagnosis and action taking.
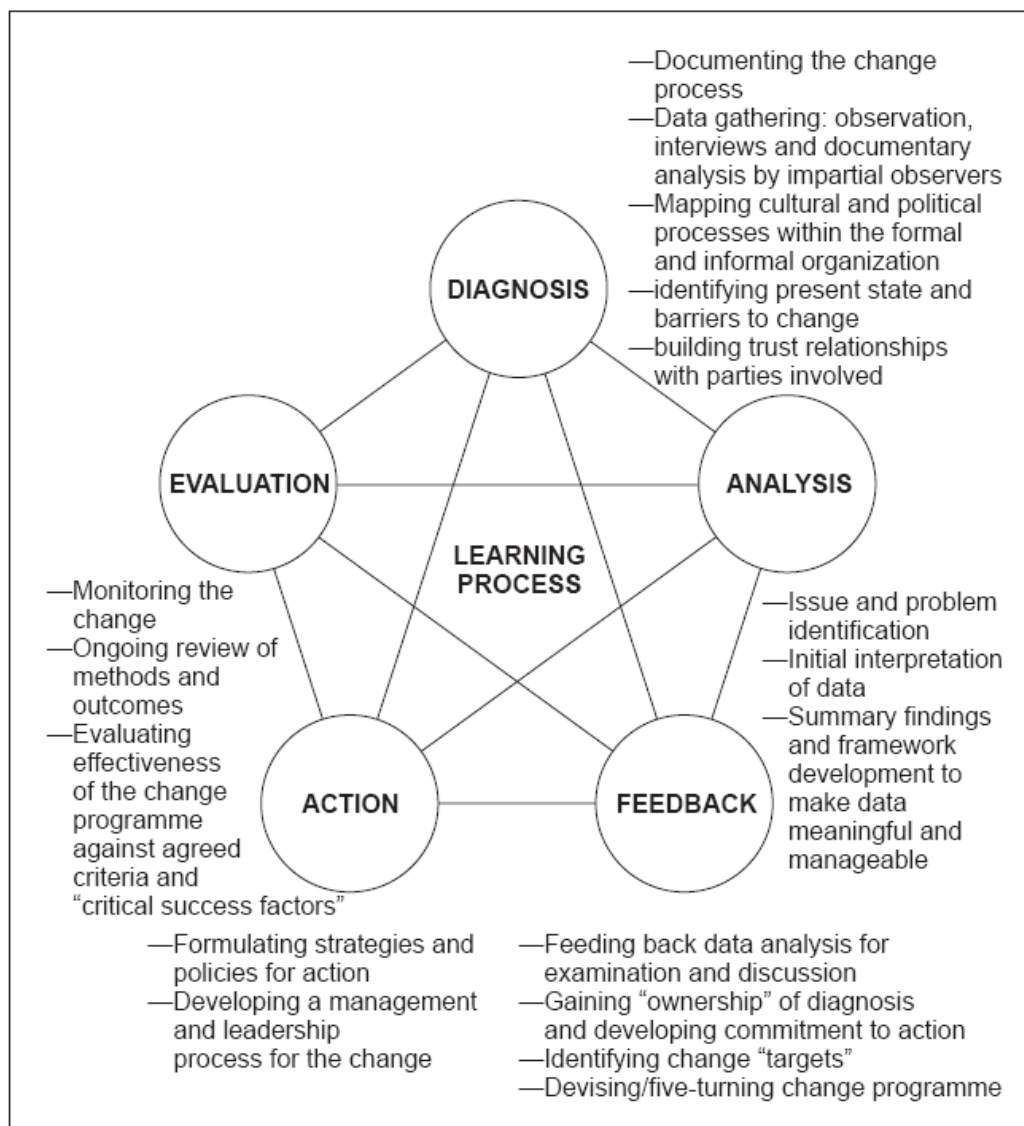
From Bate, P. (2000). 'Synthesizing Research and Practice: Using the Action Research Approach in Health Care Settings'. *Social Policy and Administration.* Vol. 34, No. 4, pp. 478-493.

A general overview demonstrates that Bate's model consists of a five staged approach involving diagnosis, analysis, feedback, action and evaluation. Central to these steps in the cyclical methodology is the learning process for both researcher and participants. This depiction offers not only a method of research and intervention, but also a model for change. Bate correctly describes AR as '*opportunistic, exploratory and emergent*' (2000: 491) and subsequently demonstrates the organisational implications of the process. For the implementation of KSF to be successful within facilities any research process would have to be flexible and evolving. Bate's model offered a variation of AR which enabled the introduction of KSF and also allowed learning from the implementation process. Findings from the implementation process have highlighted elements of study that are readily transferable to other organisations and a variety of clinical and non-clinical specialities.

Data Collection and Analyses

Throughout the course of the research 10 focus groups were conducted and 8 semi-structured interviews with individual participants over a 12 month period. The majority of data was collected to inform the diagnostic phase of the AR process, although information was also required to gauge the efficacy of research interventions. Recruitment to focus groups was via posters distributed within the directorate and interviewees participated on direct invitation. The membership of the focus groups remained relatively constant in terms of the same people attending each session. It was intended the groups should run in this way so that a social psychological dynamic could be

established. All meetings were digitally recorded and transcribed verbatim. Transcriptions were then imported into NVivo 7, qualitative data analysis software and analysed for trends. The NVivo software additionally served the purpose of a hub for the storage of data allowing large amounts of information to be analysed and compared simultaneously.

In recent years, there has been a notable growth in the use of focus group sessions to gain insight into the use of dynamic relationships of attitudes, opinions, motivations, concerns, and problems concerning current and projected human activity (Asquith, 1997). Millward (1995) succinctly described focus groups as a discussion-based interview that produces a particular type of qualitative data. The purpose of both the focus groups and interviews was to generate data from which plans could be formulated that would move the project forward. It was also found that information produced proved useful to those taking part and participants became 'agents of change', advancing the project locally. As the participant became more involved and subsequently better informed, they then had the capability of explaining pertinent issues locally, facilitating a greater level of peer understanding and enabling the project to evolve.

Brewerton and Millward (2001) described how focus groups are not geared to formally test hypotheses in the traditional hypothetically deductive sense, although they can be used for hypothesis formation and/or construct development. The information generated by focus groups and interviews in this study informed nearly all of the component parts of the AR cycles. In contrary to Brewerton and Millward's boundaries of focus group uses, there is actually a role for theoretical testing within the evaluation element of the AR

cycles. The focus groups became a forum for evaluating theory and enabled the project to focus on key issues which supported the productive actions of the study.

Stewart and Shamdasani (1990) commented on how the results of focus groups must be understood within the context of group interaction an how such units function on two continuums, group process and content. Brewerton and Millward stated that focus groups are '*communication events in which the interplay of the personal and the social can be systematically explored*' (2001: 82). For such interplay to be effective it was essential group members should feel comfortable within an environment in which they could share knowledge and experiences and in effect gain trust with each other.

Steward and Shamdasani (1990) also captured the essence of the moderators role when running such groups. They discuss gauging ones own level of self disclosure so that discussions are both on course and productive, yet not detrimentally influencing the group. They continued to describe the balancing of '*requirements of sensitivity and empathy on one hand and objectivity and detachment on the other*' (Stewart and Shamdasani, 1990 :69). Practicing detachment was the most complex element found in running such groups as members frequently attempted to introduce other areas of difficulties they were facing in their professional lives. This especially occurred as relationships were established and levels of trust grew on both sides.

The other mechanism of data collection utilised in this study was semi-structured interviews which include aspects of measured responses to set questions and the facility to probe and explore areas of interest (O'Leary and ebrary, 2004). Interviews were held predominantly with senior members

of facilities staff although some interviews were conducted with external Trust members as part of a wider data validation process. It was intended to 'separate out' more senior research subjects from focus groups due to the effect their presence would have on other participants. Placing senior members of the facilities management team in a group environment would most certainly have stifled debate. There were also negative effects on the validity of data collection if such participants believed they were being judged or alternatively if they led discussions in line with more personal agendas.

These interviews proved useful to capture key personnel's thoughts and impressions of KSF generally and the interwoven effects on service and career development. What needed to be done to facilitate KSF introduction was also discussed as were the drivers and barriers that would allow or prevent this from happening. Unlike the focus group membership which remained largely static, a varying cohort of senior facilities staff were interviewed, some only once and others a number of times. This allowed a comprehensive overview of the project to be established, from which interventions could be constructed. All interviews were also digitally recorded and transcribed using the same transcription service and data analysed utilising NVivo 7 software.

Initial Findings (Diagnoses phase of AR cycle)

During the planning phase of the project it was anticipated that resistance to KSF would be encountered as a secondary factor to the implementation of AfC for many reasons. Early suspicions emerged following disagreements over the allocation of pay bands witnessed in other areas of the Trust, with the

assumption there would be similar responses within facilities. For many staff, pre-conceived ideas of where jobs should be matched on the AfC pay scales led to disappointment when posts were graded at a lower level. A general lack of familiarity with methods of appraisal and career development frameworks, processes essential to the successful implementation of KSF, also proved problematic in facilities.

Findings at this diagnostic stage were, in reality, the opposite of what was initially expected. While some staff was unhappy with the pay band their job was matched against, hardly any viewed this as impacting on their involvement with the implementation of KSF. Indeed, some participants within this study did not equate AfC and KSF as being part of the same process. This raised questions over how and when awareness raising around such important issues should take place. Whilst the hospital had undertaken a large scale awareness raising campaign relating to KSF commencing in 2004, by the time the pay gateways became operational in October 2006, few- if any staff could recall the content of such sessions. Initially it would seem this was a product of natural erosion of memory, however also compounding the issue was the rate and volume of information currently being imparted within the NHS to all staff. It would seem many employees have either consciously or unconsciously given themselves permission to bypass such information as a defence mechanism from the deluge of data being imparted at all levels of the organisation (Weinstein, 1996). From listening to the views of facilities staff, they required concise information delivered locally at the time and point of implementation and commensurate with their role, otherwise retention of such information was highly unlikely. This also led to an evaluation of the reasons

for conducting such a large scale awareness raising campaign so early in the implementation process. Whilst undoubtedly well intentioned, it was markedly ineffective in this instance.

The majority of facilities staff proved extremely receptive to the idea of pay progression linked to the demonstration of occupational competence. Some staff offered limited enthusiasm due to being positioned on the AfC pay scales above the second gateway with no subsequent pay increments. Unlike other professions such as nurses and allied health professionals, facilities staff had minimal co-existing guidance from professional bodies or organisations requiring evidence that they were meeting occupational standards. Within clinical roles this was increasingly challenging, as staff struggled to interpret guidance and calls for evidence from a number of governing bodies and professional associations. Facilities staff invariably benefited from not being pressured to meet multiple strands of occupational competence in this way. Many members of facilities staff were pleased that the KSF afforded opportunities to all staff irrespective of job role or grade.

The main area of unease within this diagnostic phase was that of occupational alignment secondary to the allocation of pay bands. Perhaps for the first time in its history, the majority of staff within the health service is now on a single pay scale. This allows a common understanding of colleagues' salaries, subsequently allowing staff to compare their pay with that of colleagues like at no time before. This caused consternation amongst many groups of facilities staff (and indeed across the Trust) where some staff believed their pay band to be unjust when compared to that of others doing what they considered a comparable role.

Other findings at this diagnostic phase led to the creation of what have been categorised as micro interventions. These were relatively simple changes in processes that came about from information found in focus groups and semi-structured interviews with staff in the directorate. The micro interventions were relatively simple to implement, yet they led to large improvement in both the introduction and utilisation of KSF.

Micro interventions –

- **Changing appraisal documentation** – the KSF steering group at the hospital had developed an extensive booklet to record the personal development review process. This proved to be too cumbersome for most staff, with those staff in pay bands 1 – 4[*] commenting that its complexity prevented effective use. A simplified format was developed which concentrated on one or two pages and integrated the job specific KSF outline into the document. These simplified documents were produced for all jobs within facilities in pay bands 1 – 4 and have since been rolled out across the Trust to other staff groups in comparable pay groups.

- **Accelerated learning methodology for future awareness raising** – As previously outlined most facilities staff had trouble recalling information imparted regarding KSF. While this may be partially due to the volume of data shared in the course of work (and largely associated with the high volume of change experienced by NHS staff), the content

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[*] It is extremely rare that staff employed in AfC bands 1-4 require a professionally registered qualification to practice. Volumous appraisal documentation therefore proves over cumbersome and detrimental to its intention.

of such sessions were also called into question. It would seem that in the case of presentations which cover a limited timescale (15 – 30 minutes) there is a tendency to overload such sessions with too much detail in the form of complex information. From this observation a format has been developed which follows an accelerated learning methodology. In this instance, accelerated learning was defined as focusing on a maximum of 3 succinct take home messages. It focused specifically on how the subject matter would affect the audience, making it especially contextually relevant, and the medium of delivery did not exceed 10 minutes without a change. The 3 messages were also repeated (sometimes subliminally) on average every 10 minutes. It was found that this led to a more succinct mode of delivery which staff were attuned with, yet more importantly the re-call of information was much improved using this approach. In KSF terms the accelerated learning session focused on what KSF is, how to calculate your position on the pay bands and movement through pay gateways. The sessions used a short video of ten minutes and also an exercise to calculate pay band position. In total the session lasted no longer than 30 minutes.

- **Producing a flyer for self assessment of where staff are on pay bands** – many staff wanted some form of information sheet they could retain that allowed them to calculate their position on the pay bands from the information found on their pay slip. This was created and made available to all staff affected by AfC.

- **Cessation of sending KSF outlines out in job packs** – A number of managerial staff complained at this stage of the project that including KSF outlines in job application packs for new staff (external to the NHS) was potentially hindering recruitment. Applicants seemed confused and overwhelmed by KSF outlines, especially in more entry level posts. The practice of sending the outlines out pre-employment was stopped, although KSF was discussed at interview as were any potential developmental needs.

Macro Interventions

The macro interventions involved in this project formed the longitudinal action elements of the research. These interventions required careful planning, in many cases the investment of both financial and physical resources and the requirement to work with agencies external to the organisation. Although the macro interventions covered a comprehensive array of 'actions', two will be discussed here.

1. The creation of an employability scheme within the hotel service department
2. The creation of a bespoke career development pathway

1. Employability Scheme

There were departments within the facilities directorate who were reluctant to participate with the implementation of KSF due to the potential career development implications of the process. If utilised fully, KSF should not only develop individuals in their own job, but also provide a framework for further development to other roles. Nowhere was the apprehension of these aspects of KSF more apparent than the hotel service department who are responsible for providing both portering and domestic services to the Trust. Hotel services employ well over 500 service assistants, a role which has amalgamated traditional portering and domestic functions and has been in place since the early 1990s. Many service assistants view the role as a point of entry to the organisation, subsequently allowing them to apply for internal only vacancies. Alternatively, upon commencement of work as service assistants, individuals become aware of higher banded posts with more scope to develop and advance quickly. This leads to the department consistently having over 60 vacancies for service assistants at any one time. It also means that the service assistants that do remain in the position have done so for a number of years, therefore the age profile of the department is skewed towards staff within 10 years of retirement age. With recruitment such a problem, the thought of implementing a process which encourages the development of all staff was viewed suspiciously, and also as something that could potentially compound these issues.

After negotiation with the management of the service department, an employability scheme was considered appropriate for solving elements of the recruitment problems. If a source of new recruits could be secured to enter into the department on a regular basis, this made the introduction of KSF far

less onerous and also made the management of the department more willing to participate in its introduction. Indeed a large amount of management time is spent on recruitment issues; if this was reduced more time could be applied to developing staff, irrespective of if these people eventually move on. Also driving the search for an alternative recruitment strategy was the fact that current initiatives could not sustain the demand for staff; new solutions had to be found for old problems.

Employability schemes have traditionally focused on developing the skills base of the unemployed, therefore allowing such people to enter the labour market and remain employed (Clarke, 1997, Meister, 1998). It is hoped that people who enter employment through such schemes will eventually be able to navigate the labour market independently, therefore moving onto higher levels of paid employment. It was recognised within the service department that the hospital was frequently in competition with other external commercial organisations for entry level staff. The hospital is located in a district which is the base for a number of distribution warehouses, large supermarkets, food processing plants and an international airport. In nearly all these cases, the organisations referred to offer more expedited routes to employment than the NHS. Many of these organisations have no requirement to vet potential employees with the Criminal Record Bureau (CRB) and place a reduced emphasis on the availability and quality of references. Training for many positions is minimal and can be delivered once employment has commenced. Conversely, beginning work even with entry level positions in the NHS still requires CRB clearance and the production of satisfactory references in addition to a basic level of education and some form of interview

skills. These skills were frequently lacking from potential recruits, a problem that the employability scheme also sought to tackle.

To compete with such organisations in the recruitment arena, a fast track employability scheme was devised which offered employment in 6 weeks, a dramatically reduced timescale when compared with other programmes. As commissioners of the scheme, both the content of the course and the chosen educational provider who would deliver the programme remained the choice of the Trust. This had previously been problematic in other areas of organisational development where contracts sat with providers who were either unreliable or unaware of the finer nuances of working within a health environment. The course lasted for just under 16 hours per week, which would not jeopardise any benefit payments individuals may be in receipt of. The programme covered the following subjects over the 6 week period –

- Career opportunities within the NHS

- Interview skills

- Food Hygiene Certificate

- Numeracy & Literacy (specific to the role of service assistant)

- Information Technology

- Equality and Diversity

- Introduction to the clinical environment (with the utilisation of a high fidelity clinical simulation centre)

- Site tour of the hospital

30 people aged between 16 and 19 years old applied for the programme with 19 being offered a place. All 30 people who attended the initial information session at the local College and who wanted to apply to the scheme also completed a CRB form at this point. It was explained to potential candidates at this time that if they were unsuccessful in obtaining a position on the programme, the CRB form and any other personal details (held on the college application form) would be destroyed. If they were offered a position on the scheme the CRB form was processed, this then gave over 6 weeks to have the results of the check returned. This early commencement of the CRB process proved to be a major success of the employability scheme. With normal recruitment processes the CRB forms are processed following a successful interview and job offer. It then takes on average 6 weeks for the details to be returned, a time period few people requiring work as a serivce assistant (or other entry level positions) are willing to wait. At the end of the 6 week programme participants are guaranteed an interview only, a place on the scheme does not equate to definite employment.

In total 16 participants from the initial employability scheme have been offered employment as a service assistant from the initial cohort of 19 (84% success rate). 13 out of the 16 offered employment were on the register of school leavers Not in Education Employment Training (NEET). When the scheme was initially suggested there was some scepticism regarding the quality of potential applicants to such a programme. It has been recognised that through operating this scheme, that organisation has accessed a rich vein of enthusiastic, dedicated, and keen to learn employees who never considered working in the health service previously. This could be described

this as the NHS recruitment paradox, where individuals in non-clinical roles rarely consider employment within a health environment. This is largely due to a common misconception that hospitals employ only medical and nursing staff and also a lack of knowledge of the many allied professions which enable a hospital to function. To encourage applicants to the employability scheme we marketed the benefits of working in the NHS, the 'feel good' factor of working in an environment where you can positively impact on someone's wellbeing. For many of these new staff the salary, even at the bottom of Band 1 is more than the minimum wage which many factory and warehouse type employers in the region pay.

The programme has proved to be a large success in terms of impacting on the vacancy factor profile of the department, filling 28% of the hotel services vacant posts for service assistants from one cohort of participants. This alternative recruitment intervention encouraged managerial support mainly due to the opportunity to influence the content and delivery of the scheme. The employability programme also offered a greater opportunity over the 6 week period for managers to get to know each candidate, as opposed to a short formal interview which offers little insight to occupational suitability. From a cost analysis perspective the scheme proved comparable to traditional methods of recruitment, namely press advertising. The employability scheme has proved to be a catalyst for similar programmes which are now being developed to address recruitment problems in areas such as medical records, clinical coding and medical administration.

Bespoke Career Development Pathways

Many career development interventions target widespread audiences and aim to increase the skills base of all taking part, raising aspirations and encouraging career progression. Large volumes of staff at the hospital have been undertaking their professional role for a number of years and whilst occupationally proficient, many of these staff had minimal career aspirations. This raised the question whether using KSF as a career development tool in a wider context would be effective or even needed.

It became apparent that a more bespoke career development programme would prove increasingly effective at progressing the careers of individuals who wanted to develop, rather than marketing a widespread approach to all. This approach aimed at individuals realising their potential and provided those participating with an individual bespoke career development plan for up to 5 years. The model encouraged staff who wanted to develop their careers to come forward and participate in a project called 'Pathways to Progression'. In addition to the funding provided to support such career development plans, KSF was integrated as a development tool to guide aspirations in terms of both academic and personal development. This also provided answers to questions that had been raised by managers within facilities who wanted to know how KSF could be utilised to capture and develop talent.

The scheme has, so far, provided a bespoke career development package to 12 members of facilities staff. The development packages range in duration from 1 to 5 years and in addition to funding provided to pay for academic study, assistance is given on the more human factors of personal

development. These factors consist of communication skills, interview techniques, presentation skills and methods of increasing self confidence. This intervention has enabled the targeting of vital physical and financial resources to where they are needed and indeed valued the most.

Conclusion

The study is limited by a lack of understanding of the longer term effectiveness of the AR interventions implemented as part of this research, this is largely due to diagnostic data being available. Whilst the micro interventions were highly effective, it is yet to be proven if the macro interventions, specifically the employability scheme and individual career development frameworks will prove as beneficial in the future. Systems are in place to track participants, in terms of NHS service and the long term choice of career pathways should these people continue to work within the health and social care environment. Other factors that could potentially affect the transferability of this study; are the time involved with running an AR project and financial resources required with funding such schemes. Whilst most variations of the AR cycle are presented as being simplistic and easily useable, in reality, the process requires strict project management to prevent the procedure becoming overtly complex and unmanageable. The costs of such programmes are currently met by training budgets, yet in the financially volatile environment of the NHS, funds may not be available in future years thereby jeopardising such schemes from continuing.

Utilising AR to implement the KSF within facilities has enabled a more holistic approach to be taken to its introduction; enabling KSF to be supported in a directorate with minimal experience of career development or appraisal processes. The interventions that were introduced have not only facilitated the introduction of KSF, but have also enabled a deeper understanding of organisational development issues within the directorate. Interventions from this project can be utilised in other organisations by replicating the processes taken. Such changes in organisational development matters are imperative if the NHS is to recruit, develop and retain quality staff both now and into the future. Indeed, this research suggests that facilities directorates are receptive to such organisational and career development interventions even if they have been overlooked in the past.

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