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Appraisal: a guide for medical practitioners

British Medical Association
Board of Science and Education
November 2003
www.bma.org.uk



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A publication from the BMA science and education department and the board of medical education

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ISBN: 0 7279 1848 6

Printed by the BMA publications unit:

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Approval for publication as a BMA policy report was recommended by BMA Board of Professional Activities on 24 September 2003.

Acknowledgements

The Association is very grateful for the help provided by the BMA committees and outside experts. We would particularly like to thank Mr Rodney Peyton (Royal College of Surgeons of England) and Dr George Cowan FRCP (Medical Director, Joint Committee on Higher Medical Training, Royal College of Physicians) for their help and expertise in producing this report.

Foreword

The board of medical education, a standing committee of the British Medical Association, provides an interface between the medical profession, the government, the educational sector and the public. One aim of the board is to provide evidence of best practice and promote the highest standards of medical education. The board provides up-to-date information resources for students applying to medical school, as well as careers information for doctors.

With the annual appraisal for medical practitioners well under way in most hospitals and primary care trusts (PCTs), this report serves as a resource for doctors interested in learning more about the principles and practice involved in the annual appraisal process.

This report addresses appraisal from both appraiser and appraisee perspectives and looks beyond the standard definition of appraisal as simply a structured formal meeting between an employee and their supervisor in which the work performance of the employee is examined and discussed.¹ Instead, it looks at appraisal as a component of lifelong learning, emphasising that it is vital for personal professional development. Examples of current appraisal technique and case studies highlighting good practice illustrate ways in which doctors can make the most of the appraisal process. In addition, it looks at the theory underlying appraisal and the objectives of the appraisal process, and practical details about preparation for appraisal are included.

Intended to be used as a living document, the report also makes recommendations and provides links to other websites that provide further details on appraisal.

A handwritten signature in black ink, appearing to read 'Peter Dangerfield', written in a cursive style.

Dr Peter H Dangerfield
Chairman, board of medical education
November 2003

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Introduction

Effective appraisal is an essential part of a doctor's continuing professional development. Although appraisal has long been used informally in postgraduate medical training, it was only in 1999 that the chief medical officer for England proposed that **all** doctors employed in or under contract to the NHS should participate in regular appraisal.³ Annual appraisal was confirmed as a contractual obligation in the *NHS Plan*, published in June 2001. To fulfil this contractual requirement for GP principals, PCG/PCTs began introducing the scheme in April 2002. Additionally, employers were expected to put in place arrangements that ensure that all career grade doctors were appraised by 31 March 2003.

Appraisal is now also to be linked to revalidation, which a doctor must achieve every five years. For the purposes of this report annual appraisal is considered as a self-contained process and its relationship with revalidation is not considered. For a doctor to get the most out of appraisal it is important that he or she has a good understanding of the purposes of the process and how it can be used for personal and professional development.

The main focus of this paper is the annual appraisal process and the general principles of appraisal will be examined as part of this. It looks at the theory underlying appraisal and the objectives of the appraisal process. A guide to annual appraisal is presented with links to sources of further help and information. The 'best practice' section provides accounts of how the appraisal process has been implemented in different settings and gives examples of good practice. It also highlights available appraisal techniques, which doctors may wish to use to gather additional information to aid personal and career development, either as part of the annual appraisal or outside this process.

It is hoped that the information in this document will supplement doctors' understanding of the aims of appraisal and direct them to sources of more detailed guidance on the annual appraisal process. Appraisal for doctors is still in development and trusts and other healthcare organisations are currently working out the most effective way of undertaking appraisals. The information on different methods of appraisal and examples of best practice should assist in this process.

What is appraisal?

Appraisal is a well-established procedure in many sectors and organisations. It is an ongoing, two-way process involving reflection on an individual's performance, identification of education needs and planning for personal development. Appraisal allows doctors to take time to reflect on their performance and skills and examine how successes in particular areas can be transferred to other areas of their work. If no formal appraisal process is in place, doctors may be too busy to take the time to do this. A formal process should ensure that doctors are provided with the time and means necessary to achieve their appraisal. There should be no requirement to participate in appraisal unless proper resources, time and support are provided.

There is often confusion between assessment and appraisal. These are two distinct processes with different aims. Assessments measure progress based on relevant curricula, while appraisals provide a complementary or parallel approach which focuses on the trainee and his or her professional needs.³ Assessment involves the measurement of an individual's performance at a particular point in time, usually against predetermined standards. Different types of assessment measure different aspects of being a doctor.

Recently, assessment methods have been developed to assess not only factual knowledge but also other areas such as communication, clinical skills, attitudes, ethics and professionalism.⁴ The Junior Association for the Study of Medical Education (JASME) has produced an excellent guide to medical student assessment.⁴ There are several different types of written exams designed to test knowledge, and sometimes also the student's ability to critically appraise information. They all assess knowledge of basic clinical science, patient investigation and management, health promotion, clinical reasoning and judgement. In addition to written assessments, medical students will also encounter many forms of assessment designed to assess their practical skills.

Results of assessments can feed into appraisals if appropriate.

The School of Health and Related Research (ScHARR) report 'Appraisal for GPs' defines appraisal as a process for:⁵

- exploring role expectations, negotiating relative priorities, and setting and aligning individual and organisational objectives at a local level
- reviewing progress towards achieving previously agreed objectives and agreeing future objectives
- recognising, acknowledging and valuing achievements
- exploring what is needed from the organisation to help and support the individual in making the best contribution they can.

The appraisal process links individual objectives to those of the organisation. Appraisals allow the appraisee to register a formal request for resources for refining skills and exploring new areas. It provides an opportunity for the appraisee to discuss changes that could be made to working practices and procedures and also links individual objectives with those of the organisation.

Appraisal should generate a personal development plan, which is an opportunity to register a desire to participate in development opportunities. It can be used as a bargaining tool with an employer or trust for protected study time or appropriate resources.⁶ Appraisals are also closely related to the development of job plans. The appraisal process provides an opportunity to draw together information from which the job plan can subsequently be reviewed.

Appraisal is not designed to identify poor clinical performance. That is something that may, however, arise in an assessment. If performance problems are highlighted they must be dealt with outside the appraisal process.

How is appraisal used in medicine?

Both doctors in training and career grade doctors take part in appraisals. The emphasis of appraisal for doctors in training is on the educational progress of the doctor usually within a structured programme, whereas for career grade doctors the emphasis is self-reflection and personal development. A mix of behavioural competencies, such as communication skills, and skills-based competencies, such as pain relief, are reviewed during the appraisal. For doctors in training, a senior colleague, who has the greater experience necessary to support a trainee's professional development, will always conduct the appraisal.⁷ There is no such hierarchy involved in the senior doctor appraisal process.

Doctors in training

- Appraisal for doctors in training is often referred to as 'educational appraisal', in that it concentrates on their educational progress, as opposed to the 'performance appraisal' of trained doctors, which concentrates on personal development and self-reflection.
- The educational appraisal is a planned review of educational progress, needs and objectives.
- An educational appraisal should be conducted with an educational supervisor from the same specialty who need not be the clinical supervisor.
- Educational appraisals should be regular, every three to six months.⁸ The first meeting should take place very soon after starting a post to establish previous experience, aspirations and expected standards. This should culminate in an educational plan that sets the objectives for the forthcoming post.
- An effective educational appraisal will help the doctor in training in working towards formal assessments, as it will help to identify areas for extra study and develop effective learning strategies.⁷
- Doctors in the specialist registrar grade have indicated that feedback from consultants has increased since the introduction of the Calman reforms of higher specialist training.⁹ However, a recent study found that 70 per cent of doctors in surgical training did not participate in any appraisals during the majority of their training posts.¹⁰ Suggested reasons for this were the lack of formal guidelines to aid the educational supervisor in carrying out the appraisal and the lack of protected time for conducting appraisals. Providing adequate resources to support an effective appraisal process is important to help the educational

development of the trainee and to identify any limitations of the training programme.

Senior doctors^a

- The groups of doctors who are now contractually obliged to take part in the annual appraisal scheme are:
 - consultants, including clinical academic consultants and public health consultants
 - career grade doctors, including staff grades, associate specialists, clinical assistants, hospital practitioners, community and senior medical officers, trust doctors and others on local contracts
 - GP principals and non-principals
- Appraisal for other groups of doctors, including locum doctors, will be introduced in due course.¹¹
- The introduction of the annual appraisal process as a contractual requirement is part of the clinical governance agenda, which is aimed at maintaining the public's trust in the delivery of healthcare and safeguarding high standards of care. An integral part of the clinical governance agenda is the opportunity for clinicians to reflect on their practice¹² and for their performance to be monitored and reviewed.¹
- Under the General Medical Council's (GMC's) new licence to practise and revalidation scheme, doctors who work in an established healthcare organisation and who participate in the appraisal process can submit their appraisal documentation as evidence of their ability to hold a licence to practise¹⁴.
- Appraisal is based on the GMC's document *Good medical practice*¹⁵ that describes the principles of good medical practice and standards of care, competence and conduct expected of doctors in all aspects of their professional work.

a For the purposes of this report senior doctors include all doctors who are no longer in training.

Principles of good practice in appraisal

Many of the principles underpinning good practice in appraisal first emerged in the business sector and have been adapted and refined in other professional sectors, including medicine. The general principles discussed here should be integrated into all doctors' appraisals, including the annual appraisal process. Although appraisal in the NHS is now established and procedures exist to guide its practice, there is still a need to develop and refine them in the light of local circumstances.

Development

Successful appraisal requires obtaining commitment from senior management and maintaining that commitment is crucial to the development of a successful appraisal scheme. Involving staff and line managers in designing and implementing the overall appraisal scheme is also key to achieving cultural change and is more likely to lead to a sensible and workable scheme. People tend to support what they have created, and involvement from the start will help build commitment to the appraisal scheme itself. Engaging doctors in all stages of development and implementation might also carry a useful message about management approach. Evidence suggests that introducing a generic appraisal scheme without seeking consultation with doctors may encounter resistance.¹⁶

The aims, objectives, frameworks and protocols of appraisal could be established in a series of interviews and workshops where key issues and concerns can be addressed. It is important that such workshops identify what is required of the appraisee and the appraiser, clarify roles and responsibilities and develop mechanisms for appraisal.

Research suggests that successful appraisal systems need to be designed locally to fit the native context. Although it is argued that 'ready-made' systems imported from other organisations rarely function satisfactorily, nevertheless, lessons can be learned from other organisations. The best approach is to develop appraisal in terms of the given environment and conditions taking into account general principles. In doing so, local circumstances need to be understood and feedback given accordingly.^{17,18}

Implementation

Appraisal systems cannot be introduced without successfully engaging all those directly involved in implementing the system, and often take time to establish within an organisation. Many appraisal systems that have been introduced as a top-down approach have tended to either collapse within three to five years or have evolved into a formalistic bureaucratic ritual of ticking boxes.⁷ For example, in an attempt to gain acceptance of appraisal and its benefits amongst GPs in North Peterborough, a study day for appraisees was organised. The day aimed to provide as much information about the process as possible, how it works, benefits, rates of remuneration and how to manage expectations. This proved to be very effective in gaining acceptance of the process by local GPs.¹⁹

Training of appraisers and appraisees

Good quality appraisal systems are those in which there has been initial training and development of appraisers and appraisees. Appraisers must be sufficiently skilled to ensure that appraisal activities benefit patient care rather than simply meet administrative needs. Appraisals that have ignored this principle have usually been unproductive meetings of little benefit to either the appraisees or the organisations in which they are employed.⁷ Evidence suggests that badly conducted appraisals depress rather than improve performance.²⁰

As an example of good practice, before GP appraisers in North Peterborough conducted a single appraisal, they all had their own appraisal, conducted by the clinical governance lead, thus ensuring they all had prior experience of being appraised.¹⁹ In other schemes, appraisers first appraise each other in pairs and then work together in facilitated groups to share their experiences, discuss problems, agree procedures, and refine their skills.

A useful educational interactive package for appraisal skills has been developed to provide medical trainers and trainees in hospital medicine and general practice with the opportunity to use web-based technology to help develop skills in appraisal (www.appraisal-skills.com).

Role of appraisee

Appraisees should assume ownership of the process. It is also important that appraisees demonstrate commitment to their own performance, training and development and are prepared to talk. It is suggested that as a rough guide, appraisees should do 80 per cent of the talking during an appraisal meeting.

Preparation

Preparation is key to a successful appraisal. The meeting should be arranged well in advance to allow the appraiser and appraisee ample time to gather the necessary data to support a constructive dialogue at the meeting. In a review of hospital consultant appraisal in Wales,²¹ preparation was found to be a key facet of an effective appraisal system. One trust had dedicated an administrator to support appraisers by preparing paperwork and meeting schedules. Protected time and support should also be given to appraisees to prepare for their appraisals.

Confidentiality

Within the ethical framework, appraisal is a confidential process. Appraisal meetings are private conversations between two individuals, which should be held on the basis of honesty, mutual trust and respect. Anything discussed in the appraisal meeting should not be discussed with any other person without the appraisee's explicit permission and the completed documentation will at all times be treated as confidential.⁷ A much more open and frank discussion is likely when the appraisee is assured that the discussion is confidential.

Whilst the content of the appraisal is confidential between the appraiser and appraisee, some doctors have found it useful to send an agreed summary and development plan to a lead appraiser. This can then be used to develop an anonymous summary of doctors' learning needs and hence help to plan educational resources and training programmes.²²

Outcomes

The appraisal should conclude by setting down action points for the appraisee. Often the appraiser will have action points too. These action points should include the support and resources needed. The action points will constitute the basis of the personal development plan, from which key development objectives for the following year and subsequent years can be formulated. The PDP is meant to support and help the appraisal process. It should be a dynamic and developmental document that over time encourages learning and professional development. Ideally, the PDP should contain four

or five objectives to be achieved by the appraisee during the period until the next appraisal.⁷

The agreed objectives should be SMART:²⁵

- *specific* – relate to specific tasks and activities, not general statements about improvements
- *measurable* – it should be possible to assess whether or not they have been achieved
- *attainable* – it should be possible for the doctor to achieve the desired outcome
- *realistic* – within the doctor’s capability
- *timed* – the next appraisal date, or earlier, should be agreed as the time for reviewing the achievement of the objective.

Review

To remain successful, appraisal systems need to be regularly reviewed and rejuvenated. It is therefore important to build into the system’s design a review process that includes seeking the views of those involved in it. Failure to live up to promises made during the design and implementation phase, as well as during the actual appraisal interview, can lead to disillusionment.⁵ The review system should monitor whether the appraisal process is successful in achieving its aims of improving patient care and assisting doctors’ career development. Potential barriers to achieving these aims should be highlighted and strategies developed to overcome them. It is most appropriate for review systems to be developed locally and designed to reflect local circumstances and needs.

How is the annual appraisal process carried out?

The annual appraisal, introduced by the *NHS Plan*, is a continuous process of self-reflection and personal development planning. The annual appraisal meeting provides a focus in which appraisee and appraiser discuss how the doctor perceives his or her performance and development during the preceding year and the aims for the coming year. There is standard documentation that must be completed, and there is flexibility in other aspects of the appraisal process, for example, what information is brought to the meeting, the agenda of the discussion and how the appraiser is chosen. Some trusts and primary care organisations will have pre-existing appraisal processes. These can continue to be used as long as the process can be adapted to incorporate the new standard documentation. Whatever system is adopted it is essential that it is periodically evaluated by human resources or an external organisation to ensure that it is useful and effective.

Guidance on how to carry out the appraisal process is available on the joint Department of Health (DoH) and GMC website 'revalidationuk' (www.revalidationuk.info). This contains advice on all aspects of the appraisal process from how to prepare, to what follow-up action should be taken. The information available is specific to different groups of doctors in the four countries of the UK. In addition, online toolkits are also available for GPs in England and consultants in Scotland and more may follow. Toolkits provide guidance and practical tools to aid the appraisal process, including online versions of the documentation, interview agendas and a breakdown of appraisal activities. Appraisal toolkits are also available on the website www.cybermedicalcollege.com.

The common features of the annual appraisal process that apply to all groups of doctors obliged to take part in annual appraisal are as follows:

Documentation

In order to encourage consistency within the appraisal process standard documentation must be used. Some of these forms are to be filled in and passed on to the appraiser before the discussion and others are to be filled in during and after the discussion. The documents provide a structure to the process and also facilitate record keeping. The forms differ slightly between the different groups of doctors but they generally follow the pattern shown in table 1.

Table 1: Annual appraisal documentation

Form 1	Background/personal details	This is a straightforward record of standard personal details.
Form 2	Current medical activities	This is a factual record of the work the appraisee does.
Form 3	Evidence and information to be used for appraisal	<p>Information in this form is the focus of the appraisal discussion. It is generally organised around the headings found in <i>Good medical practice</i>.¹⁵ Documents can be submitted to substantiate the information given by the appraisee. Evidence may include any of the following:</p> <ul style="list-style-type: none"> • a personal CV which provides evidence of qualifications and experience including a record of publications • peer review as recorded by meeting agenda, discussion notes, diaries, job plan entries and action plans. • data from hospital information systems such as risk management, work load, complications, outcome, clinical audit and results from internal auditors • feedback from external audit by colleges, deanery and the Commission for Health Improvement • outcome of investigated complaints^b

^b complaints under investigation should not be discussed at this meeting

		<ul style="list-style-type: none"> • review of outcome of any patient survey information • letters (compliments or complaints) from the public • feedback from 360 degree surveys.
Form 4		Summary of appraisal discussion with agreed action and personal development plan. This will be completed by the appraiser and agreed by the appraisee. Copies of the completed form should be passed on to the trust or primary care organisation chief executive.
Form 5		Detailed confidential account of appraisal interview This is an optional form that can be filled in if the appraisee would like to record a more detailed review of the appraisal meeting. It does not have to be passed on to anybody else.

There is flexibility on the data that can be used as evidence in form 3 and different methods can be used to gather the information. Detailed information on the documentation for each group of doctors can be found at www.revalidationuk.info and each of the forms can be printed from here.

Timing

To be done effectively, appraisal arrangements will require a significant investment of time by both the appraisees and their appraisers. This is likely to be greatest in the initial year when doctors are preparing their appraisal folders for the first time. There is an understandable reluctance on the part of doctors to give up time for a time-consuming process when faced with an already heavy workload. Protected time should be given for preparation and completion of follow-up documentation. Department of Health research has suggested the whole appraisal process can take 4.5 to 6.5 hours.¹¹ This includes between two and four hours for preparation. However, a recent survey of consultant

appraisal found the average time taken was 10 hours, including six to seven hours' preparation.²⁴

The appraisee should be given adequate notice of when their appraisal discussion is to take place. Two months has been suggested as a suitable notice period.¹¹ The information and paperwork to be used in the appraisal discussion should be exchanged two weeks beforehand. This allows for preparation of the discussion and checking of the supporting information. The appraisal discussion should be scheduled for a suitable time within normal working hours. It should be instead of, not as well as, normal duties.

The appraisal discussion must be uninterrupted, with pagers turned off and no incoming telephone calls. There should be enough time allowed so that the appraisal discussion takes place in an unhurried atmosphere. The amount of time suggested as good practice for an appraisal meeting varies from 30 minutes to several hours. The level of experience of both the appraiser and appraisee should be taken into consideration when planning the first appraisal meeting.⁷

If it appears that the discussion needs to continue beyond the allotted time then a suitable time for a second meeting should be decided upon rather than trying to rush to finish on time. It is also a good idea to have a follow-up meeting at an appropriate time to discuss progress towards reaching objectives and any specific barriers in the way of reaching these objectives.

Where to undertake the appraisal discussion

The appraisal discussion should take place in a private and quiet room that will be free from interruptions. The room should be set up informally in order to create a non-threatening and friendly environment. An interview style should be avoided.

Who should carry out the appraisal?

Guidance for each different group of doctors is available on the DoH/GMC revalidationuk website. Generally, a senior doctor who is on the medical register should undertake the appraisal. Different healthcare organisations have adopted different methods of selecting the appraiser. If the appraisee wishes they can

c The Beeches is a management centre that provides a range of management and organisational support, primarily to the Northern Ireland Health and Personal Social Services.

request that a different person be appointed. For the appraisal process to work effectively the appraiser must be someone the appraisee trusts and respects. The appraiser must satisfactorily complete training prior to commencing any appraisals. In Northern Ireland, GP appraisers must undertake a two day residential training programme, led by the Northern Ireland Council for Postgraduate Medical and Dental Education and The Beeches.⁶

Establishing a wide pool of appraisers so that the workload for each is not overwhelming is essential. It is suggested that recruiting ‘grass root’ doctors as appraisers, who are motivated and respected as peers in the medical community, is crucial. It is also important to match the right doctor to the right appraiser,¹⁹ although this requires a wide cross section of appraisers.

The issue of establishing trust between appraiser and appraisee is possibly more complicated in the case of senior doctors being appraised than doctors in training, since suspicion about their relationship with whoever appraises them may be inevitable. The process of appraisal has been borrowed from the world of business, where hierarchies in management are much more clearly defined than in medicine. One way to overcome this difficulty would be to offer senior doctors a choice over who appraises them.⁷

Special arrangements have to be made for the appraisal of doctors who regularly work in more than one trust/NHS board. In these cases, the doctor concerned should still only have one appraisal and one appraiser, but there should be input from the other trust/NHS board. There may be other circumstances where third party input to the appraisal process will be required. For example, a singlehanded practitioner in a unit is likely to have an appraiser from a different clinical specialty. In these circumstances, arrangements should be made to identify a professional peer from another unit or trust to contribute to the specialist professional aspects of the appraisal. In any situation where a third party is involved, discussion should take place between the nominated appraiser, the appraisee and the third party, as to how this contribution will be integrated into the appraisal process. This may be through consultation and discussion before the appraisal meeting or on the basis of an agreed contribution to the meeting itself.²⁵ Furthermore, concerns about doctors who hold joint NHS/university posts and those who undertake private work, as well as NHS work, should be addressed.

Doctors' views on annual appraisal

One survey found 82.4 per cent of GPs in Lothian thought annual appraisal would be beneficial. Respondents emphasised that appraisers must be trained and that time should be protected for the appraisal.²⁶ A recurring theme was the importance of feedback and implementing the plans made at appraisal. Although there were concerns about the time the process would take and the need for resources and training, many doctors saw it as an opportunity for constructive feedback on their work and an aid to personal and practice development. They felt it important that the process did not turn out to be a paper exercise and those developmental needs and organisational difficulties identified by the process were seen to be addressed by management and targeting resources appropriately.

The concerns regarding appraisal that have been raised frequently by doctors are resourcing issues, particularly lack of time to carry out the process properly. Sufficient time, space and, in some cases, money are needed to carry out the appraisal process properly. Another barrier to the success of appraisals is the perception held by some doctors that appraisals are a 'policing' measure and a knee jerk reaction by the government.¹⁶ However, a study that introduced a consultant appraisal process found consultants came to regard appraisal positively.¹² A successful appraisal system will be one that is developed with the involvement of doctors and that is properly resourced.

Examples of best practice

There is no single ideal way to conduct an appraisal interview or collect the necessary inputs. Appraisal will be most effective when it is seen as an opportunity for doctors to appraise themselves, to review their learning and professional development and identify their own requirements.

Examples of available appraisal systems

Appointing appraisers

Two commonly adopted frameworks for appointing appraisers include the 'Ballot and Bank' framework and the 'Line Manager or Hierarchical' framework.

'Ballot and Bank' framework for appraisal

This model involves forming a bank of appraisers built upon a ratio of one appraiser for every six doctors. The bank is established through a ballot. All doctors are asked to nominate for the bank and an internal election is then conducted. The successful doctors become the first to be included in the bank and should expect to remain in the bank for between three to five years. The appraisee has the choice of three appraisers, and the same appraiser may be used from one year to the next at the discretion of both the appraiser and the appraisee. It is perceived as being more democratic, more about professional career development and about supporting doctors. However, it has also been criticised for being separate from job plan reviews and the business planning process.¹⁶

'Line Manager or Hierarchical' framework for appraisal

This model follows the simple formula of the direct supervisor of a doctor at any level conducting the appraisal. In this system, appraisal is linked to job planning and business planning and risks being seen as a management tool, as performance review and as a threat to professional development and good clinical practice. The appraisee has little choice as to their appraiser. Further, by employing a line manager-led approach, appraisal risks becoming evaluative, instead of a reflective process aimed at developing individual effectiveness. The line manager system assumes a hierarchy that does not exist among senior doctors and would therefore not be appropriate. Furthermore, it is not flexible enough to be used by all specialities.¹⁶

Carrying out the appraisal process

NHS appraisal toolkit

The NHS appraisal toolkit²⁷ is based on the principle that a single portal should be available to both appraising and appraisee GPs and consultants in the NHS. The toolkit (www.appraisals.nhs.uk) is a secure password protected site, which combines the benefits of using the electronic forms with accessibility via the internet. It is easy to navigate and gives access to advice, guidance, best practice and practical tools at any time and from any location. One of the key benefits of the toolkit is that it automatically generates a summary statement based on the information entered, including personal development plan (PDP), saving considerable time and effort during the preparation and appraisal itself.

According to doctors who have made use of the toolkit, the biggest attraction is the lack of paperwork and the ease with which sections can be completed. Information is more likely to be complete, legible and laid out logically, making the whole process more streamlined for both appraiser and appraisee. Doctors using the toolkit have completed the forms more thoroughly, with supporting documentation filed logically and in a more accessible format than those using the paperbased model. When completing the forms by hand, legibility can be an issue, changes are difficult to make and all entries need to be repeated every year for successive appraisals. Completing electronic versions of the forms means that information can be saved electronically, is legible and allows changes during preparation. Despite the many advantages, further refinements are still possible. The registration process could be simplified and some of the language is seen to be 'educationalist jargon'. Nevertheless, the general conclusion is that the NHS appraisal toolkit serves as an excellent user-friendly model of appraisal for all doctors.

Collecting evidence

There are a number of ways in which to collect evidence for an appraisal. In addition, some appraisal schemes, like the 360 degree survey, are built around the collection of evidence.

The GMC recommends collecting evidence for appraisals under the following headings:

- good medical care
- maintaining good medical practice
- teaching and training
- relationships with patients
- working with colleagues.²⁸

360 degree surveys

The 360 degree survey is a technique used to collect evidence from those who work with the doctor, such as other medical colleagues, nurses, administrators and patients. The term 360 degree appraisal originated in the commercial sector and refers to ‘full circle’ feedback from bosses, peers and those more junior. It is also often referred to as ‘multi-source feedback’. The method evolved as the limitations of the more traditional ‘top-down’ approach became apparent – namely that it was perceived as unfair, biased, limited to one person’s perspective and often demotivating. The 360 degree appraisal has the potential to overcome these problems, and over the past decade it has been used extensively in industry and introduced in some general practices and hospital departments.²⁹ It has been suggested that using multiple sources, and applying a variety of methods to appraise doctors on multiple dimensions will improve the objectivity of the exercise. Feedback obtained from superiors, peers, juniors and patients is a good way to test interpersonal and communicative ability.³⁰

Methods of 360 degree appraisal in the health service are varied and include open ended, unstructured interviews, statements with a simple rating scale and structured questionnaires based on items from focus groups with GPs or consultants about what they consider to be indicators of good performance. It is argued that it is harder to discount the views of several colleagues or patients than the views of just one or two. However, it is time consuming to collect ratings from a range of people and it may be difficult to get a representative

sample of patients. It is suggested that 360 degree surveys are most useful when used in combination with other sources of evidence.

In order for the 360 degree feedback method to be successful the information gathered must be fed back to the appraisee in a constructive and sensitive manner. It is best practice for the appraisee to go through the feedback with someone who can help them to interpret the results.³¹ It is also important that there are resources for support following feedback, not least the need for mentoring and counselling. This support should be provided as soon as possible after giving the feedback, otherwise there is potential for negative consequences.

As with any type of appraisal, the outcome of the 360 degree process must be followed up. There is potential for the 360 degree process to be damaging for the individual and the organisation if it is done in isolation. The 360 degree appraisal must be facilitated and resourced. If it is not then the process will be viewed negatively because the expectation of change has not been fulfilled.

There are a number of principles that must be borne in mind if 360 degree appraisal is to be successfully introduced:²⁹

- the tool must be well validated and easy to administer, analyse and interpret
- feedback must be anonymous
- it should be used only for developmental purposes, not performance management
- any decision affecting a doctor's career should not be based on 360 degree feedback alone. It is part of a broader array of evidence about a doctor's performance, from which appraiser and appraisee can identify overall patterns, themes and messages
- training must be given to appraisers and appraisees about how to make the most of the feedback.

Some have argued that the notion that 360 degree feedback is somehow more objective and accurate is difficult to support. It is certainly fairer in that it represents more than one view point on an individual's performance and it does provide a more rounded picture. But the various groups tend to make somewhat different assessments from their own subjective standpoints and the psychometric qualities of 360 degrees rating may be no better than those typically found in top-down appraisal.³²

Peer and 360 degree appraisal methods will clearly not work in dysfunctional departments and general practices. The culture of the organisation must be sufficiently open to deal with employees criticising and commenting on each other.³³

The DTI has produced detailed best practice guidelines on 360 degree appraisal which, while not being specifically targeted at medical professionals, contain a great deal of useful guidance.³¹

Case studies of good practice

The following are examples of appraisal methods that have been adopted in different healthcare organisations.

Consultant peer appraisal

A system of consultant peer appraisal has been developed in the North Bristol Department of Anaesthesia that has explicit criteria, involves the use of portfolios and the collection of data from colleagues and a structured interview leading to the production of a personal development plan. The system seeks to combine support with challenge. A total of 117 criteria were identified by which a consultant anaesthetist could be appraised.³⁴ These cover five different areas of activity (eg clinical teaching) and five groups of attributes (eg attitudes, interpersonal skills). Only 12 criteria are specifically related to anaesthesia. Attitudes and team work are seen to be particularly important. Each consultant compiles a portfolio, which includes audit data from the hospital clinical information system as well as personal details, evidence of continuing education and other relevant material. Each doctor also nominates three or four colleagues who can be approached by the appraisers for comments about them (eg surgeons, theatre nurses, secretaries). All consultants in the group have previously attended a two-day appraisal training course, which includes interviewing and feedback skills. Each consultant selects two colleagues as appraisers, as evidence suggests that consultants choosing their own appraisers does not significantly alter the results of the appraisal.³⁵ The use of two appraisers allows more detailed analysis of the appraisee's comments than might otherwise have occurred. In this instance, one appraiser from a different hospital site is assigned to each appraisee. The process has been proved to be motivating and preliminary evaluation shows that confidence among appraisers and appraisees has increased. The main concern with this approach is the time needed. This has to cover the construction and maintenance of a portfolio, the collection of colleagues' views and an appraisal discussion involving two or three people

lasting about 90 minutes. Effective, accurate and easy-to-use hospital audit and information systems are essential. A climate of support rather than blame must exist if appraisal is to succeed.¹²

Peer appraisal among GPs

Peer appraisal in most practices in the Northern Deanery had evolved from staff appraisal and its format is either one-to-one interviews or a group process involving doctors and sometimes the practice manager.³⁶ The content of peer appraisal varies a great deal and perceptions of its value are mixed. The three broad themes included in the appraisal: clinical areas, educational needs and the performance of the individual and the team, are clearly not mutually exclusive. While some practices seek to embrace all three within peer appraisal, most explicitly exclude clinical issues. Most practices that sought to address clinical issues found it difficult to define just what was being appraised in the very wide spectrum of clinical practice.

The process itself is undertaken differently by various practices. Some give all staff questionnaires to review the appraisee's 'team performance' in terms of time-keeping, communication in the team, relationships with patients and so on. In other practices, the practice manager gathers data informally from team members on these issues and feeds back a composite assessment at the appraisal interview. The appraisee and sometimes the other practice partners, also fill in a pro-forma listing areas of good performance and areas in which competence could be increased. This combined information is discussed at the individual or group appraisal meeting and some form of personal learning or development plan are usually the outcome of the process. Advantages of peer appraisal include the beneficial effect on team functioning, cohesion and mutual support. Other benefits for individuals include the facilitation of personal development and stimulation of reading and reflection. Perceived disadvantages centre on time constraints and the difficulties inherent in a process that voluntarily submits doctors to self and peer criticism.

Away day appraisal

An effective approach to appraisal adopted by GPs general practitioners in Wallasey was an away-day.³⁷ Initial concerns among GPs surrounding appraisal included protected time, inadequate funding, and the lack of locums or cover within the practice. In response to these difficulties, the idea of a weekend away was suggested. Each appraiser was to carry out two or three appraisals in one day, reducing the time spent away from individual practices. Despite some initial reservation from GPs who thought that appraisal should be conducted in practice time, rather than at weekends, there was a good response. Appraisals averaged one and a half-hours in length and the PCT provided logistical support and organised funding. The feedback was very positive, with many choosing to attend for the whole day to take advantage of the networking and teambuilding opportunities associated with these meetings.

The consensus was that the away-day approach was a success as it offered a chance to accomplish appraisals in an efficient and positive manner, while ensuring that they did not encroach on practice time and result in a backlog of work. According to one doctor who had attended the away-day, the key to a successful appraisal process is providing enough protected time. He also suggested that the supportive environment of this away-day approach was one of several advantages. The fact that it was out of work time was not an issue, not least because the time was remunerated. More importantly, the whole process was not a rushed job in snatched time. The presence of colleagues who were also participating in their appraisal offered mutual support as well as a chance to socialise. However, a key aspect of the success of this approach was that this was a group of GPs who had worked well together for many years and had a very supportive management structure.

Implementation of a local system

Oxford Radcliffe Hospitals Trust, one of the largest trusts in the country, developed a four-stage process to the implementation of a local system of appraisal.²⁴ This system involved:

- finding out consultants' views
- organising training
- producing a local version of the national policy and procedures
- agreeing a system for distributing, collating and archiving appraisal documents.

Before implementing new appraisal arrangements, a survey was sent to all consultants. Respondents identified a total of 347 ways in which appraisal could be made easier, with more than half requiring time set aside to prepare for and undertake appraisal and a quarter stating that a clear framework and guidelines would be helpful. The feedback received helped design a workable system. It was argued that consultants would use flexible sessions where possible. If appraisal meetings could not be scheduled without compromising patient care, the directive chair had discretion to agree extra sessional payments or time in lieu to compensate.

Recommendations

- 1 In order for the process to be effective, there must be consultation between management and doctors in the development of appraisal systems and it must have the commitment and support of both groups.
- 2 It must remain a profession-led process to ensure that it maintains the support of doctors, so that the profession can monitor and adapt appraisal. This will ensure that it is useful and relevant to their needs.
- 3 Appraisal schemes must be regularly reviewed to ensure that they are effective and relevant. They must be updated to reflect changes in the organisation.
- 4 There should be a review at a suitable midway point between appraisals to monitor whether an individual's objectives are being met and to identify any barriers that might be in the way of reaching them, with a view to removing these.
- 5 The appraisal process must be fully integrated into the training and development procedures of the organisation, with links between the outcome of appraisal and the provision of training and development resources. A lack of resources available for meeting objectives will lead to disillusionment.
- 6 The appraisal process must be adequately resourced in terms of money, time and space. Sufficient protected time must be provided for preparation, the appraisal discussion and any follow up actions. Appraisal must be instead of, not as well as, normal work activities.

Conclusion

Appraisal is now an established part of a doctor's career, both during and beyond the training grades. Appraisal helps to provide the transparency and accountability demanded of the health service, but in addition, an insightful appraisal will be an important aid to the development of a doctor's skills and career. Gathering information using the methods discussed here will aid discussion during the appraisal and provide a more thorough picture of the competencies of the doctor.

An effective appraisal is helpful to the employer as well as the doctor. It will encourage better communication between staff and employer, and help each understand the other's needs and aims. Staff morale may be increased if it is felt that the employer is paying attention to an individual's development needs and that they are working together to reach objectives. However, the appraisal process must be developed in consultation with the staff and have the backing of doctors for it to be accepted and useful. The process must also be properly resourced, in terms of protected time, space and money if necessary, and effective training must be provided for both appraisees and appraisers.

Appendix 1: Sources of guidance and further information on appraisal

<p>www.appraisal.co.uk</p>	<p>This website contains information on different appraisal methods and how to implement them.</p>
<p>www.appraisal-skills.com</p>	<p>This is an education package to provide medical trainers and trainees in hospital medicine and general practice with the opportunity to use web-based technology to help develop skills in appraisal.</p>
<p>www.bamm.co.uk</p>	<p>The British Association of Medical Managers (BAMM) provides training courses on appraisal and its website contains links to the standard documentation used for the annual appraisal.</p>
<p>www.bmjcareers.com</p>	<p>The <i>British Medical Journal's</i> career section archive contains useful articles on appraisal.</p>
<p>www.cybermedicalcollege.com</p>	<p>This website provides information for those involved in providing healthcare and includes information on appraisal. It is backed by the Royal College of Physicians and Surgeons of Glasgow and the Royal College of Anaesthetists.</p>

<p>www.doh.gov.uk</p>	<p>The Department of Health website contains information on the annual appraisal and links to the documents that announced the launch of the scheme.</p>
<p>www.gmc-uk.org</p>	<p>The General Medical Council's website has information on maintaining good medical practice and the booklet <i>Good medical practice</i>, upon which form 3 of the annual appraisal is based, can be accessed from this site.</p>
<p>www.revalidationuk.info</p>	<p>This website is a joint DoH and GMC resource. It is designed as a support tool to guide and assist doctors throughout the processes of the revalidation and annual appraisal.</p>

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