Individual performance review in hospital practice: the development of a framework and evaluation of doctors' attitudes to its value and implementation

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▶ Additional material is published online only. To view please visit the journal online (http://dx.doi.org/10.1136/bmjqs-2012-001738).

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Received 3 December 2012
Revised 16 May 2013
Accepted 20 May 2013
Published Online First
8 June 2013

To cite: Trebble TM, Cruickshank L, Hockey PM, *et al*. *BMJ Qual Saf* 2013;**22**:948–955.

ABSTRACT

Background Appraisal, or independent performance review (IPR) is used in human resources management in the commercial and public sectors to evaluate the performance of an employee against agreed local organisational expectations and objectives, and to identify their requirements for development and effective management. IPR for NHS consultants may provide essential information for job planning, contribute towards medical appraisal for revalidation, and facilitate productivity and quality improvement.

Aims To develop a framework for IPR for consultants, and to determine attitudes on its value, process and content.

Method Information from commercial, public and voluntary sector models and published and other literature sources were used to develop an IPR framework. This was assessed through a three-cycle action research methodology involving qualitative interviews with 22 consultants (predominantly with medical management roles).

Results The domains of the IPR framework included: (1) performance against objectives; (2) behaviour and leadership; (3) talent management; (4) agreed future objectives. A number of themes were identified from the consultant interviews including: ineffective current appraisal systems reflecting a lack of valid performance data and allotted time; a lack of empowerment of medical managers to address performance issues; IPR as a more explicit system, offering value in evaluating doctors performance; and the dependence of successful implementation on the engagement of the Trust executive.

Conclusions IPR may have value for performance evaluation of consultants, contributing toward job planning and complementing medical appraisal. Support by their employing organisation and engagement with medical managers in design and implementation is likely to be essential.

INTRODUCTION

Appraisal is a process of formal review of an individual's recent performance with the intention of facilitating improvement.[1] It benefits employees by providing feedback on their strengths, weaknesses and potential, and benefits organisations by providing information on its management, training, resourcing and corporate planning. Appraisal in the commercial and public sector, often termed individual performance review (IPR), is a core component of human resource management with associated resourcing and consequences. It is traditionally viewed as a line manager-led (hierarchical) accountability process for organisational benefit albeit dependent on a constructive and mutually participatory approach with problem solving, and setting of appraisees' short-term goals.[1]

The process of evaluation of doctors' performance has developed since the early 1990s in response to formal and external reviews of its role and limitations.[2 3] This has been influenced by a number of key events that have fundamentally changed the UK's National Health Service (NHS)[4] including: market liberalisation, the introduction of New Public Management and the pursuit of efficiency and effectiveness;[5] changing social and political attitudes with greater challenge of the autonomy of

professional groups; and high-visibility scandals in the healthcare sector as a result of regulatory failure, most recently in Mid Staffordshire NHS Foundation Trust.[6 7] Throughout, two common themes have emerged. First, the distinction between evaluation methods as supportive and formative (eg, using feedback as a motivational tool to improve performance, education and personal development) or compulsory, summative and peer led (regulatory assessment confirming achievement of objectively set standards).[8–10] Second, the involvement of external, and not local, bodies (eg, the General Medical Council) to determine requisite standards of professional practice.[11 12] Introducing compulsory, summative appraisal with externally set standards for doctors within a regulatory framework[12] has the advantage of guaranteeing a nationally recognised level of quality of practice that is particularly important to maintaining confidence among patients, and is the basis of medical appraisal for revalidation.[4 13]

But the performance of doctors in their employing organisation may be viewed as poor despite achieving adequate standards of professional practice, for example, reflecting failure to achieve contractual agreements or local expectations of productivity, or engagement with departmental requirements or practice. In this situation, a supportive, formative process with locally set expectations of performance is more appropriate than summative methods that risk gaming and dysfunctional behaviour, sacrificing quality of care for activity, manipulation of data or focusing on measured activities at the expense of others. Such a process is consistent with commercial and public sector IPR, and is considered to be included within consultant 'job planning', a local and line manager-led process of establishing an organisation–employee agreement on the alignment of duties, responsibilities and objectives for the coming year, and with respect to contractual terms of service.[14] Although this process is more typical of a hierarchical accountability model, it is advocated to be complementary and potentially contributory to consultant medical appraisal.[11 13 14]

By comparison with medical appraisal, there is limited published guidance on the format of evaluation for job planning or evaluation of performance against expectations agreed with an employing organisation, the most appropriate domains to be used and a paucity of published studies relating to effective formats, processes, content or consultant attitudes to its practice.

The information obtained from an IPR process modelled on those within the commercial, public and voluntary sectors may, therefore, have value to both consultant job planning and medical appraisal for revalidation. The aims of this study, therefore, were to provide a framework for its use and assess consultant attitudes to its content, process and value.

METHOD

Establishing an IPR framework for consultants

The domains of IPR framework were derived from themes identified from three sources of information (appendix 1. Web only file):

1. A review of available medical evaluation systems.
2. A review of published literature relating to performance review and appraisal in non-healthcare systems.[15–19]
3. A series of studies of systems of performance review and appraisal within non-healthcare organisations from the commercial, public and voluntary sectors, and who had a reputation for advanced human resources management.

What is included in the proposed medical IPR framework based on identified themes?

From the organisational studies and the published literature,[15 20] it was concluded that the medical IPR framework would be based on a one-to-one formal documented review of a consultant by their clinical line manager and involving open discussion. The domains included were derived from four themes identified from the organisational studies (table 1). Although it was recognised that there would be an emphasis on developing and motivating individuals within a supportive relationship with their line manager (who would require dedicated training), it was also recognised that the results of the process

Table 1 Common domains relating to individual performance review from organisational studies across commercial, public and voluntary sectors

Domain	Content
Performance	Individual performance against agreed and contracted expectations, personal and organisational objectives, including level of achievement, reasons for failure and requirements for success (if applicable)
Behaviour and leadership (modified from[21])	(a) Demonstrating personal qualities; (b) working with others; (c) managing services; (d) improving services; (e) setting direction
Talent management	Career development, potential based on past achievements, organisational assistance in realising potential and personal preferences for career development. A 9-box model talent tool (potential compared with performance)
Summary and agreed action plan	Development needs; prospective objectives and milestones and indicators for future objectives; date and signature of both reviewer and reviewed consultant

should have 'consequences' as reward and recognition, or under performance strategies and an appeals process, but these were not defined further. The frequency of the review was proposed as a minimum of annually, but it was recognised that this could be more frequent for informal reviews and where performance issues were identified.

A draft medical IPR underwent pilot testing prior to the start of the study. This determined whether subject understanding of the questions was as intended (content validity) and understood similarly across different consultant groups (reliability). Subsequent suggested changes were reviewed and implemented by the project team. The framework was further modified as described with the final version shown (appendix 2. Web only file).

Determining consultant attitudes to the medical IPR framework

Study design

An action research, qualitative methodology was used, allowing both exploration of attitudes and the assessment of an intervention,[22] through a cyclical process involving the subject cohort, and with the researcher participating in data collection and evaluation.[23] This followed the action research principle of 'a change intervention geared to improvement and a process based on a continuous interaction between research, action, reflection and evaluation'.[24] The research paradigm shared perspectives with the interpretive paradigm, to allow the accessing of participants' understandings of situations. A traditional simple action research model[25] was used split into three phases of interviews. After each phase, the data collected was analysed and evaluated, and changes were made to the draft document and, accordingly, this allowed evaluation during the research process, as crucial to the action research methodology.[26]

The researcher (LC) was a Masters student in human resources management from the department of human resources, School of Management, University of Southampton. The researcher undertook all interviews and data transcription was, therefore, non-medical and external to the organisation (to reduce the risk of acquiescence or other bias), but trained in human resource management. Interim data analysis was undertaken with a management-trained medical consultant (TMT) not otherwise involved in the data collection or provision. The results of the consultant interviews and the proposed IPR framework were formally presented by the study team (LC) to senior clinical and medical managers not otherwise involved within the study design or data collection, and including the medical director to the Trust, appraisal-trained consultants responsible for medical appraisal and revalidation at the Trust, and senior human resources managers at the Trust and at the School of Management, University of Southampton. This was undertaken for their interpretation and views of the findings.

Subjects and data acquisition

The cohort was identified as representing individuals who would be likely to undertake IPR as both appraisees and appraisers through their current line management roles, or are involved in the development of such systems. This included consultants in current hospital clinical practice with medical management positions or with previous experience of medical management, in senior education or research positions, or in the doctor's representative committee at the Trust. All subjects were contacted by email with follow-up telephone calls to offer participation in the study.

The data acquisition involved formal, qualitative, one-to-one, face-to-face, semistructured, recorded interviews. The themes reviewed included: (1) attitudes to current or planned systems of evaluating consultant performance; (2) a comprehensive review of the draft IPR document, its overall aims and the proposed processes; (3) discussion on implementation including barriers; and (4) outcomes and benefits. Each of the domains of the IPR started with an introductory paragraph explaining its background and aims that were reviewed by the interviewee. These reflected the intention of the IPR document to be consistent with the models identified from the organisational studies undertaken. The IPR domains included a range of questions that were intended to provide comprehensiveness for different perspectives by interviewees, although it was recognised that the final document would be shorter and focused on proposed need.

Transcripts were systematically analysed into codes, clustered to form data themes.[27] The transcripts were treated as narratives and as perceptions of the interviewees.[28]

To ensure the accuracy of the interpretation, the individual narratives were triangulated with other data sources, observations and informal interviews,[27] allowing the identification of atypical and outlier views, methodological validity and comparisons of the individual narratives within a broader context.[29]

RESULTS

Subjects and setting

The study was undertaken at Portsmouth Hospitals NHS Trust, Portsmouth, between July and August 2012. A total of 35 consultants were contacted, of whom 22 agreed to participate (63% response rate). The cohort included six chiefs of service (CoS) (medical manager at divisional level typically responsible for more than one department), nine clinical directors (CDs) (medical manager directly responsible for consultants in a speciality or department) and seven consultants with previous management, education or research roles. The cohort was drawn from a

total consultant body of 11 chiefs of service, 23 CDs and 318 consultants. The cohort included 4 female and 18 males, who had been employed in the NHS for between 10 and 34 years.

Cycle responses

The same protocol was used for the three different cycles, the document was changed after each cycle following analysis of the information from the previous cycle. In cycle 1, five consultants were interviewed with respect to the draft documents and aims of the study. After feedback from the cohort, the behaviour section was modified from closed Likert scale responses (eg, >70% of the time to <30% of the time for each question) (V.1) to an open format (V.2) (requiring written examples of activities, actions and behaviours relating to each question, with supporting evidence and identified areas for improvement) (Appendix 2. Web only file). Subjects had felt that consultants would not consider the initial format of the questionnaire in a positive manner, and that it would not reflect their behaviour. In cycle 2, nine subjects were interviewed with respect to both versions 1 and 2 of the draft document. No further significant changes were made to the document as the subjects confirmed their preference for the second version. In cycle 3, 8 subjects were interviewed with respect to V.2 of the document only.

Identified themes

The analysis of the interviews identified three themes:

1. Consultant's experience of performance evaluation systems currently in place

The subjects who took part in this study unanimously felt that current systems of performance evaluation including appraisal, revalidation and job planning did not work effectively and needed improvement:

> I think the system doesn't really work…it is a bit of a shambles really (CD 6)

> I don't think appraisal is actually achieving what it's setting out to do. I think it's better than when it wasn't there…but I don't think it is happening properly (consultant 3)

There appeared to be an overwhelming feeling that the current processes were not standardised across the organisation, approximately half the cohort (10/22) referred to inconsistency that limited understanding of overall effectiveness.

> I think it is very variable…There is a lack of standardisation (consultant 1)

Furthermore, some of the participants described appraisal as a tick box exercise that was an unwelcome use of their time with limited visible benefits due to the way it was currently conducted. Some suggested that this was confounded by inadequate time for the process or training of the appraisers. However, the attitudes of appraisees was also noted.

> [People are] just desperate to get out of the room (consultant 2) and the consultants don't like to be performance managed (consultant 5).

2. Factors affecting the relationship between consultants and their employing organisation, and their influence on job planning and medical appraisal.

There was a mixture of views towards the management structures and their contribution towards the effectiveness of medical appraisal and job planning. There were also concerns of the detrimental effect of a lack of clearly communicated organisational strategy.

Some participants mentioned the divide between doctors who take on management roles and those who do not. This included both a lack of respect for management among consultants and suspicion of their motives.

> There is this terrible suspicion of leaders and leadership and management from doctors, and they do sort of see it as going to the dark side and you are not one of the team (CoS 2).

There was a feeling that many consultants do not want to accept the responsibility of management positions.

> Some of the doctors going into management is about bribing them to do a job they really don't want to do (CoS 3).

> One of the reasons it is difficult to get people to do those jobs [management] is because I think most consultants perceive that neither the organisation nor their colleagues value those roles (CoS 5).

Four recurrent subthemes were identified which impacted on the relationship between doctors and the employing organisation and with respect to performance evaluation. These were:

i. Lack of accurate performance data. The majority of the cohort, (17/22) complained of a lack of available performance data, that they would not know if someone was accurately describing their performance and would not always recognise how effective their own performance was.

> It is very difficult to look at their activity because of the poor data (CoS 1)

> The data needs to be much stronger and more robust (CD 9)

This was often cited as one of the main reasons for ineffective appraisal.

ii. Cynicism. This was expressed by some of the participants with respect to the introduction of performance evaluation including IPR. It was widely perceived that many improvement initiatives come and go without sustained changes and, as a result, there was an on-going reluctance

to engage with new initiatives. There was also suspicion around the purpose of new initiatives.

> I think there is a lot of suspicion from something like this and initially it will be met with a lot of cynicism and criticism (CoS 2)

> You will find people resist or mistrust so people will assume…it will be designed to take away their autonomy (consultant 2)

> At my most cynical I'd say thanks very much for asking all the questions, I'll fill it in again next year and nothing will have changed (CD 7)

> [People are] inherently cynical about anybody collecting data about their performance I suppose (CoS 5)

It was suggested this cynicism may be overcome for some through a transparent process (eg, what is involved, the aims and the evaluation methods used) and open communication. A couple of participants suggested there would be a group that would continue to resist this process.

iii. Misalignment of objectives between the Trust, departments and individuals. It was considered that this could be an issue when it comes to performance evaluation. This is relevant to IPR that examines congruence of departmental and individual's personal objectives.

> I think there needs to be a very firm idea of what the Trust objectives are, cascading down to consultants (CoS 2).

> There is a lack of clarity of what the Trust's expectations, objectives and priorities are. And how that maps down to the departments objectives, expectations and priorities and how that maps down to the individuals (consultant 1).

> It should be streamlined all the way up…I think there's conflict of interest between what the Trust might want and what a person wants (CD 8).

iv. Perception of disempowerment of medical managers. Views were expressed on the role of the immediate line manager of consultants and who, it was proposed, would be involved in undertaking a medical IPR. Consultants as a group were perceived as hard to manage.

> Consultants feel they don't have a boss and they can do what they like (consultant 5).

> I think having been CD (line manager), consultants are very good at finding things they want to do, but it is very difficult to be empowered and get them to do what you want them to do or what the Trust wants them to do (consultant 1).

> I find it easier now [that I'm a chief not a CD] to go and tell a colleague that they need to pull their socks up because they are not necessarily one of my colleagues that I am going back to (CoS 5).

3. Consultant's attitudes to performance evaluation through the IPR framework

There was a wide variety of opinions on the proposed IPR document, with positive and negative feedback. One of the main observations was that it asked questions more explicitly than any previous system, possibly making it clearer for the evaluator and consultant undergoing evaluation.

> We haven't necessarily had something as explicit before (CD3)

The principal issues raised were: (A) how would consultants assess their performance in terms of activity and quality of care, when as previously noted, most stated they did not currently have sufficient performance data to answer this question; (B) as a self-completed report, consultants may not be honest or properly reflect on their behaviour (therefore, that this could be incorporated into the 360° feedback undertaken for appraisal and revalidation, but conducted more regularly than every 5 years); (C) with respect to the section on talent and potential, responses were commonly that this would be 'useful' (CoS4), but would need management engagement in order to make the process effective.

Overall, respondents felt that the IPR framework addressed issues that would be of considerable value for evaluating consultants' performance but that there was some overlap with what was in place currently, and that it was too long and could be reduced to core, or essential explicit questions. Respondents suggested several measures which might facilitate a successful introduction of the IPR. Three of the key factors proposed were communication of the rationale, expected benefits and transparency of outcomes.

It was strongly felt that the benefits of the process had to be made explicit to consultants.

> You've got to be able to convince people that this is going to be good for the organisation and good for bringing value to them and their patients (consultant 6).

It was also considered important to communicate the goals of the process, and that it would actually transfer into action. Backing of the Trust executive was perceived as essential to demonstrate its commitment to improving performance management.

> I think it is basically around communication, it is describing exactly what it is you are trying to achieve and what the point of the process is (consultant 3)

> It needs to be carefully managed and put forward as a developmental thing rather than punitive and disciplinarian (CoS 1).

> I think some evidence that the Trust board is behind this…will lend it huge credibility (consultant 1).

A number of potential obstacles were noted relating to time, apathy and organisational culture.

Nobody around here has any time to do anything extra (CD1)

Just more paperwork (CD2)

Scepticism that it's actually going to make any difference (CD7)

DISCUSSION

This study aimed to develop a framework for organisationally led evaluation of consultant clinical performance, based on common themes identified in traditional IPR appraisal systems across the commercial, public and voluntary sectors. The results of a qualitative study of the attitudes of consultants in medical management roles to the framework suggested that the current performance evaluation system was considered ineffective, seen as a 'tick-box exercise' and regarded with cynicism. The system was hampered by a lack of available valid performance data, time, respect for management positions and a lack of empowerment of medical managers to address identified issues among their colleagues. With regard to opinions on the IPR framework, consultants felt that this may be useful and included areas not covered by existing systems. A number of obstacles to implementation were noted, and possibly reflecting consultant attitudes to management, but it was considered these could be overcome through transparency, clear communication and executive and management engagement with the process. Although criticism of appraisal by the cohort was within the context of the IPR framework, this may be seen as a criticism of the processes involved in general as opposed to any specific system, medical appraisal or otherwise. It is proposed from the results of this study that a requirement for organisationally led evaluation of consultant clinical performance, for which suitable frameworks have been previously limited, may be fulfilled by a system of IPR.

Studies in the published literature suggest that IPR may offer potential benefit to both doctors and their organisations. For example, for secondary care organisations, effective appraisal processes have been associated with reduced patient mortality,[30] an association that is stronger than for either training or team working.[31] It also offers the potential for more efficient use of a hospital organisation's resources that may be crucial for service development and financial sustainability.[32] For consultants, IPR provides an opportunity for direct and formal discussion with their medical line manager, and provides the capability for organisationally led, rapid, measured and local resolution of factors that may adversely affect an individual doctor's performance or well-being, and prior to any effect on their fitness to practice. This may include their relationship with their employing organisation, levels of individual demand, under-resourcing or support or inadequate development of individual talent. IPR provides individuals with feedback on their performance and opportunities for personal development and changed practice. For doctors and their employing organisations, IPR offers the opportunity to align objectives, confirm that agreed responsibilities to staff are fulfilled, identify where training, coaching or mentoring is required to improve efficiency and effectiveness of practice, and offer the motivational benefits of individual engagement. Furthermore, it can identify and address negative external influences on doctors' local working environment that may have a detrimental effect on their performance,[33] and provides a route of attributing recognition and reward to high-performing doctors, financial or otherwise.

Any attempt to introduce such a system must address consultants' attitudes to performance evaluation. Findings from the current study support those in the published literature that the response may be resistance to change, or treating such exercises as a 'tick-box game'.[34] The views of some may be that the process is an attempt to 'control' them, and would be obstructed by organisational culture and opposition to management processes,[8] uncertainty on what constitutes good performance[35] and scepticism over its contribution towards management.[36]

Resistance to, and cynicism of, 'change' by doctors is an established finding in the published literature. This relates to both new systems of human resources and information management, for example, the introduction of appraisal[8] and healthcare information technology,[37] respectively, but also evidence-based changes to clinical practice, for example, management of hospital-acquired infection.[38] It is argued that this may reflect a dysfunctional culture within medical practice that favours privilege, autonomy and disrespectful behaviour.[39] But, it is also argued that resistance to change is a wider issue within healthcare that requires communication, participation in decision making, support and negotiation.[40] Previous attempts to introduce appraisal practices into the NHS have met with variable success,[41] including among non-medical hospital staff where similar examples of resistance and obstacles to implementation were noted, including uneven application, poor managerial commitment and insufficient continuity.[42] Therefore, the failure to introduce such systems is likely to be reflective of wider cultural issues, and not minor difficulties in implementation or specific to medical staff. The introduction of effective performance evaluation systems may be facilitated by engaging consultants with their design and implementation,[35] valid performance measurement methods[43] and appraiser training.[44 45] Additionally, there is a requirement to demonstrate an evidence base, leadership and adequately resourced medical education.[46 47] It is proposed that doctors require both effective human resources management[48] and careful use of

motivational strategies to overcome cynicism and resistance to change.[49] This is supported by the findings of the current study.

A number of limitations are noted in this work. The first is that the study aimed to determine the value of IPR from a consultant cohort with dominant representation from the medical management stream as those individuals who are most clearly in medical leadership roles (required for its implementation), and would most likely act as evaluators. It may be argued that this cohort is more accepting of the introduction of IPR that could be seen as empowering their role. Secondly, the interviews were undertaken at a single hospital trust, whereas, alternative hospitals with contrasting cultures and structures may have different findings. As a qualitative study with in-depth interviews, the cohort size was restricted to 22 subjects but with new information obtained from the final two subjects suggesting that 'theoretical saturation' (the same systems and themes repeatedly seen) was not reached, and that a larger cohort may provide further useful data. The next stage in assessment of the framework would, therefore, be larger-scale evaluation of consultants receiving IPR involving a cross-section of secondary care environments. Finally, although the information sources were varied, models from the commercial and voluntary sector had a considerable influence on the IPR document, and it may be argued whether this is transferable to healthcare and the management of doctors.

In conclusion, the introduction of an organisationally led performance evaluation system, such as IPR, offers the opportunity to review, interpret and address issues within a consultant's performance, provide information that is essential to job planning and may contribute towards the process of medical appraisal for revalidation. Consultant attitudes varied on its value and the obstacles to sustainable implementation, but were in agreement about the need for reliable and valid performance data and support from their Trust's executive. The engagement of medical managers with the design and implementation of such a process is likely to be essential.

This study was undertaken within the Portsmouth Medical Management System (PiMMS) project, a collaborative work involving Portsmouth Hospitals Trust, South Central Strategic Health Authority, NHS, and the Department of Human Resource Management, University of Southampton.

Acknowledgements The authors would like to thank the following organisations: John Lewis Partnership (John Lewis Stores and Waitrose), IBM, Prince's Trust, ASDA, National Air Traffic Services, Office for National Statistics.

Contributors TT, LC, PH, NH, TP and NC were responsible for trial design and organisation, and for review of the findings. LC was responsible for data collection. TT and LC were responsible for manuscript preparation. All authors were responsible for review of the paper prior to submission.

Funding Funding was provided by a grant from the NHS South of England (Central), Leadership & Workforce Directorate.

Competing interests None.

Ethics approval The study protocol was provided with ethical approval by the University of Southampton Ethics and Research Governance Committee (ref. 2883).

Provenance and peer review Not commissioned; externally peer reviewed.

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