UNIVERSITY OF SOUTHAMPTON

APPRAISAL AND PROFESSIONAL FULFILMENT OF NURSING STAFF IN OXFORDSHIRE

by Nigel F Northcott

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ABSTRACT

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This case study explores appraisal and professional fulfilment of nursing staff in one Health District in England (Oxfordshire). The national and local context are set out in advance of a description of the experiences and views of appraisal of the nurses in the case study. The evidence is collated and analysed using the technique of cognitive mapping, and is considered in conjunction with the established literature.

Central to the findings is the perception of the nurses of the value and importance of appraisal as a developmental activity. Appraisal is acknowledged as an investment that should be recognised as an important feature in the professional fulfilment of nurses. Appraisal is considered to be a dynamic activity that should be conducted in parallel to clinical supervision, and in a way that reflects holism. This ethos should be recognised by the records of appraisal being accepted as components of the professional portfolio and as such held by the nurse.

The study concludes with a set of guide-lines on appraisal that are also designed to stand alone from the research, to assist the profession at large to optimise the potential of appraisal.

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The Nurses in Oxfordshire who met with me, and shared their experiences.

INTRODUCTION

Over a number of years the place and value of appraisal for nurses, and in particular nurses as professionals, has concerned me. I had worked as a nurse a total of 22 years, 3 of those in Oxfordshire, before starting work on this research. The espoused developed professional status of nursing in Oxfordshire finally propelled me, with my career-long interest in appraisal, into undertaking the research.

Oxfordshire had a widely celebrated nursing work-force, with a number of nationally recognised pioneers of the profession working within the Authority. It had attracted funding for two prestigious King's Fund Nursing Development Units (NDU's) and was host to the internationally acclaimed Burford Nursing Development Unit. It had a national reputation for pioneering in nursing, with primary nursing, lecture practitioners, a flattened hierarchy and 'nursing beds', as some of the key developments. The District Guide-lines on Professional Nursing Practice (Appendix I) set the scene for a liberated and empowered nursing work-force, and specifically drew attention to appraisal as a feature of such developed professional nursing. However, in the time I had spent in Oxfordshire I had not become aware of appraisal either occurring more frequently or in any more satisfactory way for the nursing work-force than in my previous nursing experiences elsewhere. My research, therefore was designed to ascertain how the guide-lines on appraisal were being followed. I undertook it with a feeling that the guide-lines were excellent rhetoric, but might not be representative of the practice reality. If this suspicion was confirmed, the absence of appraisal might compromise the potential for professional fulfilment that the guide-lines and the culture offer, as well as compromising the contribution of nurses to the 'business' of their employer. This raised for me major questions about the value and impact of appraisal in relation to the quality of nursing practice - a relationship which is schematised in Figure 1 - a two-by-two matrix which emerged during the research.

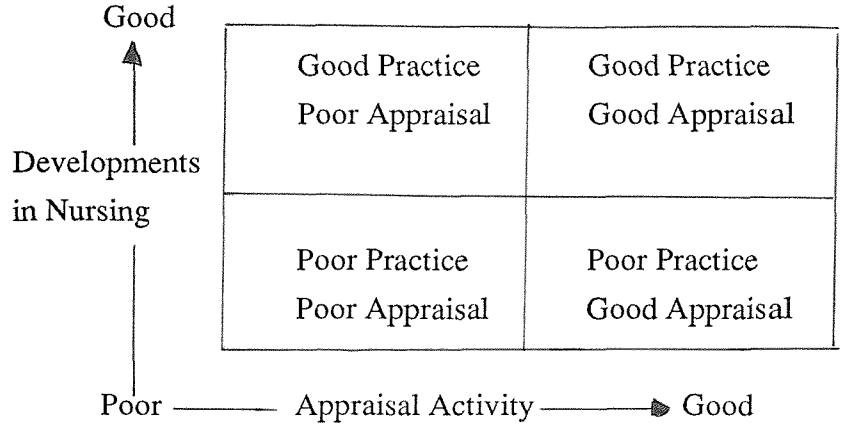


Figure 1 Nursing Development/Appraisal Correlation Matrix

My suspicions about the availability and the impact of appraisal were framed during a discussion with peers as part of the auditing of this research (reported in this research on page 59). My peers raised the possibility of the combination in the top left box, a combination which I had not fully considered before.

I was keen to discover, especially since coming to Oxfordshire, whether the good nursing practice I had become aware of in the District, was associated with good appraisal. If it was, then how could it be expanded and disseminated to develop practice throughout the District and the profession? Also, in the light of my own unfulfilled desire for feedback by way of appraisal, I wondered if such a desire exists in other nurses and whether it was similarly unfulfilled.

In my readings on research methodology I encountered the following quotation that finally provoked me into undertaking this research:

> "What is it you want to say something about at the end of the study ?"
> (Paton 1980:100)

I wanted to say something about appraisal and its impact on the professional fulfilment of nurses within the somewhat unusual professionalisation of nursing in Oxfordshire. This might also help me explain the unique nature of nursing within the District, as well as unravelling the concerns that had been with me from the outset of my nursing career about the impact of appraisal on professional fulfilment for nurses.

The research was conducted at a time when the National Health Service was undergoing major changes that would not only affect the provision of health care, but as Palmer (1993:45) suggests could herald change everywhere.

> "There is no question that a new era of management has arrived in what was formerly called the NHS. The signals of this profound change are everywhere."

This opening sentence of Palmers' article on the art of management in the contemporary National Health Service (NHS) advocates the benefits of the "organic organisation" as proposed by Ouchi (1981). Palmer further suggested that health care may be facing "macho-style" management in the new NHS of the late 1990s. The term "macho", with its etymological root in masculine, describes a management style akin to autocracy, with a power-based authority. A "macho" management approach,

Palmer (1993:45), claimed would in part assert bureaucratic authority over established professions such as nursing in order to achieve effective and, in particular, efficient working in the new NHS.

Resource management is one of the keystones of the new NHS, and rightly identifies the work-force as one of its most costly resources, with nurses the largest group of staff in that resource. In part my research arose from fear that unless the profession established appraisal for nurses, it might be imposed upon us in the macho way warned of by Palmer. This required nursing to establish appraisal in such a way that was facilitative of good practice and to ensure poor appraisal was not impeding professional development. The research was undertaken in a Health District that was unusual in its creative nurse managerial style, in its advanced nursing practice and in its apparent apathy towards formal appraisal activity. The study would also satisfy my own belief that appraisal was an essential and legitimate feature of any personnel-costly organisation.

The research sought to investigate the invitation by Burgess (1989) to consider appraisal not only as a practice underpinned by a hierarchical, authoritarian, power ideology, but also as one that could operate in an alternative mode - that alternative being non-hierarchical, non-judgemental, research-based, and focused upon development. This approach reflected the culture of nursing in Oxfordshire, where appraisal is identified as a means to increase both effectiveness and efficiency in a way that taps into the personal responsibility of individual professionals. The research is focused on appraisal for the nursing staff of the Oxfordshire Health District, where "nurses" is taken to mean qualified nurses, midwives and health visitors as covered by the Nurses Act of Parliament.

I had suspected, from my extensive contact with nurses in Oxfordshire as the District Education Adviser (later as the head of the Oxfordshire Clinical Education and Practice Team, OXCEPT), that the level of professional development and fulfilment in the District may have risen in the absence of, or even in spite of appraisal. I anticipated the research would help substantiate this and establish whether the practices of appraisal met the needs of the profession, the organisation and individual nurses.

It was important at the outset to register my personal disquiet at the status of appraisal activities in the NHS and in particular for nurses. There had been an increased interest in appraisal during 1995 which appeared to be promoted by the interest in mentorship,

clinical supervision, and preceptorship for students and particularly for newly qualified nurses. As I had feared, Performance Related Pay (PRP) was also on the agenda of the National Health Service Management Executive and many of the newly formed NHS Trusts. The use of appraisal as one of the ways of deciding upon the level of PRP reward was being mooted.

A variety of settings, schemes and energies had given rise to many individual approaches to appraisal in nursing. I had been left, after 22 years full-time as a nurse, convinced that the majority of nurses would wish for and benefit from a comprehensive appraisal scheme, but that many get either a poor scheme or nothing at all. I acknowledge a degree of personal antagonism to the 'prescribed' NHS appraisal scheme, namely Individual Performance Review (IPR), first from my own exposure to it and also to the way in which it was presented - as a managerial mandate. It had been none too surprising to me that the scheme had only had limited success. This lack of success is well documented by the Institute of Health Service Management (IHSM), in a report (1991) that also notes that IPR is largely confined to higher ranks and is not accepted among clinical staff. It is of course among the clinical staff that the vast majority of nurses are found! The poor degree of uptake is borne out by De La Coeur (1992) who identifies local initiatives to develop IPR but suggests these are not widespread.

My research sought in part to explore the extent to which professional accountability is underpinned by appraisal. It set out to clarify to what extent professional autonomy could be legitimated by appraisal, and how the profession might benefit from the safeguards and support of appraisal if it was not already taking place. Sue Pembrey (1992), a senior nurse who had worked in professional development in Oxfordshire, suggests that for some nurses the relationship between autonomy and accountability is not fully appreciated nor were the procedures in place to accommodate it. She also identifies the place reflection on performance plays in helping the nurse to cope with the pressures of autonomous practice. Moves for nurses away from the top-down external control that previously Senior Nurses, the NHS and Governing Bodies wielded, to the autonomy of the "new professional nurse" (Salvage 1990), requires the development of internal control to allow for personal growth, managerial satisfaction and, most importantly, optimum levels of care. This I believe has contributed to the interest in clinical supervision that has recently been seen in nursing (Butterworth and Faugier 1992, Johns 1993). The use of clinical supervision as a professional activity, I anticipated, would arise during this research either as a feature of, or in lieu of, appraisal. The drives both in the nursing press and from professional initiatives to

promote clinical supervision as an aspect of performance management, I believe also helped bring appraisal back onto the nursing agenda.

There is evidence to support the place and value of appraisal to the nursing work-force. Lathlean et al. (1986) identify the distinct need in newly qualified nurses, and Darbyshire (1988) and Menzies (1960) are clear on the benefits to nursing of developing working relationships by means of appraisal. Marcellison et al. (1988) also adopt the basic premise that strong social support, including appraisal, could assist workers to cope with "job stressors". The suggestion that carers such as nurses experience great pressure is well documented (Wolfgang 1988, Cooper 1988). Hingley and Harris (1986) compound this by asserting that the nursing profession at times neglects support for nurses, seeing it as a concern of the individual.

This is of particular significance in a Health Authority such as Oxfordshire where a greater degree of autonomy for its nurses is promoted and which purports to have, as part of its culture, appraisal operating as a developmental activity and not merely as a bureaucratic feature or act of judgement. The District guide-lines on Professional Nursing Practice (Nursing Policy Group 1993), Appendix I, clearly set out this approach, and furthermore suggest:

> "It is District policy that each nurse should have a regular opportunity to formally review her progress and plan her development with her senior nursing manager. The responsibility for arrangements lies equally between the individual nurse and her line manager."

The present research was undertaken at a time when the Oxfordshire Health Authority was becoming a purchasing body and by April 1994 all the Units of the Authority had become NHS Trusts. This relative independence of the Trusts ('provider' units) precipitated a division of the hitherto united Nursing in Oxfordshire into separate management units with their own views on performance management, including appraisal.

Paradoxically the contemporary developments in nursing that had arisen in Oxfordshire appeared to have been in the relative absence of appraisal. I had to question whether more widely available schemes would serve or stifle professional growth. If the new Trusts enacted the rhetoric of appraisal for all nurses, I anticipated the research would be able to inform whether such moves ensured continued development of nursing, or indeed advancement from its established base.

Finally the publication from the Department of Health, "Vision for the Future" (Department of Health 1993), containing encouragement to consider clinical supervision, and the UKCC Post Registration Education and Practice Project ((PREPP), UKCC 1990) statement on preceptorship, put renewed pressure on the nursing profession to address performance management. In the light of this it was timely to investigate the practices of appraisal for nurses.

The first chapter of this research locates my interest in appraisal within my own experiences. This is followed, in Chapter 2, by an examination of the published material on appraisal in order to provide a framework for the empirical research. Chapter 3 locates the context of the research in one Health District (Oxfordshire) and an exposition of the methodology employed to undertake the research concludes the first part of the thesis. Part 2 is comprised entirely of the evidence that was gathered, and is set out in one Chapter (5). The concluding part of the research is broken up into two chapters: Chapter 6 which offers further analysis of the evidence, and Chapter 7 which sets out eight reflections drawn from the research. Chapter 7 ends with a set of guide-lines that are offered to assist nurses to establish schemes of appraisal. These guide-lines along with the whole thesis reflect the events of the period of time during which they were written and represent part of, but not the end of, the journey.

PART 1
CHAPTER 1
THE SEEDS OF INTEREST

The seeds of interest in the subject of performance awareness and, in particular in appraisal and professional fulfilment, were sown for me almost from the outset of my nurse training in 1971. It soon became clear that the feedback I would get on my performance would be of limited value, if of any value at all. Subsequent experiences of appraisal have maintained that interest, and certain recent events, such as the spread of autonomous practice for nurses, along with my current role, have strengthened it. In a study conducted within four Oxfordshire hospitals (Kimblin 1992), it was found that 52% of the nurses surveyed perceived they did not receive regular feedback on their performance and only 27% had regular formal performance feedback. In this first chapter I not only reflect upon a sample of the events that have kept my interest in the topic alive, but also identify some of the recent changes that have precipitated the need for this study.

It is vital I feel to record these reflections in advance of any data collection in order to be clear about some of the preconceptions I held at the outset of the research and to identify some of the experiences that have influenced me and might have influenced this work. The assumption I start with is this: that feedback, evaluation, appraisal or whatever other term is used by nurses for the evaluation of performance, has always been a vital component of their practice, and that this process is, and has been, far from satisfactory for the majority of nurses. Why this situation has arisen is by no means clear. This research sets out to try and find an explanation.

The events described here take the form of critical incidents, along the lines described by Benner (1984) and Brookfield (1987). They are recalled from memory, and on the whole were not subject to analysis soon after they occurred. They are also included as examples of the reflexivity that is vital to research based on naturalistic enquiry (Hammersley and Atkinson 1983).

The following incidents that occurred during my nursing career alerted me to the paucity of performance feedback that was to become a feature of my professional career.

Incident 1

At the end of a 9-week allocation of nursing practice on one ward I asked the Sister for my Ward Report. This was a standardised document used for all trainee nurses to record their performance during the placement.

" Golly Mr Northover, have you been here that long already?"

Who was Mr Northover I asked myself. However, without once addressing me again the Sister ticked the boxes she felt best indicated my skills, and wrote no comments. I stood there not sure whether the sister knew who I was, let alone whether she was equipped to comment on my performance. She quickly completed the task, and without looking up from the desk, said:

"There, take that to the school if it'll keep them happy."

Feeling a degree of dissatisfaction about the experience, I showed the form to one of the senior staff nurses, who gave me some assurance about my performance, but not about the form.

"You're keen to learn and the patients like you. Mind you the report's nothing to go by, Sister always ticks those boxes, I'm surprised she knew your name. Oh I see she didn't!"

Incident 2

One afternoon I was stopped by a Nursing Officer who, in the middle of a busy ward, said:

"Your shoes seem to be brown, you've a button undone on your tunic, and your hair needs cutting!"

To this day I have no idea whether she felt I was a good nurse or not. Nor do I recall taking much notice of her comments.

Incident 3

Following a 9-week ward placement towards the end of my training, I received a somewhat disappointing report. It suggested I still had much to learn. I asked the Sister to expand on her criticism so I would know what aspects I should improve.

"I have had to down-grade the whole report, because of your lack of professionalism."

Somewhat surprised at this I asked for clarification, and was startled to discover my "sin" was to be going out with one of the ward staff nurses, a totally unacceptable action as far as the Sister was concerned. My look of surprise led her to add,

"it totally compromises a nurse, to mix work and pleasure."

Despite these episodes, I completed my nurse training (with honours), but again as a staff nurse I experienced similarly uncertain appraisal events.

Incident 4

"You're the best staff nurse this ward's had recently."

was a welcome comment from an otherwise distant ward sister. However, when pressed to expand to give me greater insight, or suggest ways to improve, she suggested we were too busy for that.

Incident 5

"Did you know the Sister is leaving? You should apply for her job."

Fortunately I had the insight to realise this compliment was an evaluation of my performance, on the back of which I applied and got the job.

Eight years later, as a tutor in a School of Nursing, my experiences of unsatisfactory feedback were deepened.

Incident 6

"Take my advice, give a "B" when you mark assignments, I find it causes less hassle. Students carry on working to get an "A", but are happy they passed, but do avoid writing too many comments. The odd tick is OK, but students always argue if you put comments."

Incident 7

"There's disagreement, I know, but I like the work to be typed and grammatically correct; it's just as important to me as the content. Mind you I'm not sure the students or all my colleagues agree."

Most cutting were the comments I received from a peer when I asked about appraisal in my new role as a nurse tutor.

Incident 8

> "You'll get informal feedback if you're lucky, but remember if the students pass, you're doing the job well, if they fail, they're a bad group!"

Incident 9

A year of sabbatical leave allowed me to study for an MA(Ed) in 1987, and gave me the chance to explore assessment and evaluation in greater depth. In part-fulfilment for this award I undertook a study into the newly introduced scheme of continuous assessment of theory in a school of nursing. There were a host of comments, made by the correspondents in the study, that led me to question the formative and summative value of the scheme. These included:

> " I don't really know how I'm getting on."
> " I think they'd let me know if I wasn't getting on."

Comments of this nature were expressed most commonly by the students, and similar uncertainty was echoed by the tutorial staff (Northcott 1988). I acknowledge this study was not directly about appraisal, but its subject, "Continuous Assessment of Theory in Nurse Education", was closely related to performance evaluation.

Incident 10

Two years later as a senior nurse in an education department, I was offered Individual Performance Review (IPR), and in this, performance appraisal was only dealt with superficially, to ensure that the objective-setting (or cascading) could be focused upon.

> "Don't set too many objectives, make sure they're achievable, and include some you've already achieved"

seemed to be the culture of this exercise. It commenced with a self-evaluation of current performance, which seemed quite appropriate, as my line manager only had limited direct knowledge of my performance. I of course only had a very subjective personal view, and therefore so did he! This activity was to occur annually as an organisational directive but it did little to assist me to evaluate my performance. It

certainly didn't occur according to the prescribed timescale, and was barely better than nothing.

REFLECTION

These incidents, which are only some of the experiences in my career as a nurse, might all loosely be classified as performance evaluation. They did paradoxically help me to appreciate my performance at work, and thereby I hope, to improve it. They became foci for my learning, as Brookfield (1987) suggests, by creating an atmosphere of disequilibrium. Brookfield devotes the whole of this text to the notion of developing critical thinkers, and sees the challenge of "critical incidents" as a central agent to change. He suggests this may occur independently, but he also examines the role of the "helper" - an identified second person with whom the experiences are explored to facilitate making sense of them. The "helper" also provides support, to facilitate what may be a difficult activity. I can only speculate how much more significant and how much more a learning opportunity the incidents would have been if a process of exploration had existed.

In examining one's own reflections there may be a risk that uncomfortable feelings could lead to a selective exploration, where unpleasant experiences are overlooked. The selectivity could lead to undue focus on the encouraging experiences or even bias towards only the negative. The helper can ensure that the more demanding experiences are explored, perhaps by bringing about the disequilibrium that Meyers (1986) also sees as so valuable. This approach to learning is given credence by the expansion of Adult Education theories, such as andragogy (Knowles 1980), wherein the notion of self-aware reflective learners is explored. This approach to education is likened to a journey, with the more experienced adult leading the less experienced, and is an approach that could offer much to nursing and appraisal.

Literature on appraisal, for example Swan (1991) and Holly (1989), identify the importance of a second person to enhance a self-reflective process. Furthermore, it has been strongly argued by Daloz (1987) that the support, challenge and vision this person might provide has great value to the process of personal development.

The experiences described in this chapter remain embedded in my memory but they are incomplete, in the sense that although they provoked significant changes in my practice, they have remained as unfinished business. They occurred at a time when neither the opportunity, the encouragement nor the helper was available, to facilitate the evaluation and exploration of the situations, to optimise their learning and

developmental opportunity. They have also, along with many more experiences, led me to try and decide if appraisal was one way to help me establish if I was a good nurse. This was a question, which I have asked myself on many occasions, and was one that I would ask the nurses in the present research. This would help me explore the issues surrounding appraisal and performance feedback for them and in particular the impact of appraisal on their professional fulfilment. The role that the helper can provide is well served by the following grid by Daloz (1987:214).

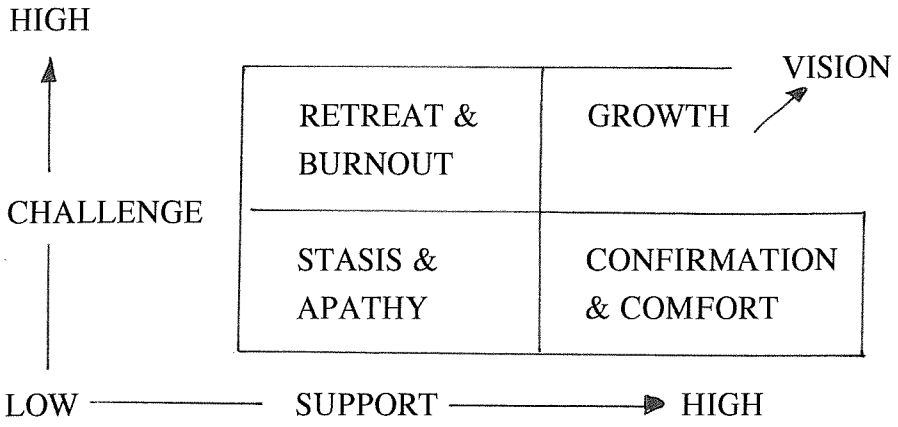


Figure 2 The Challenge and Support Dimensions and their Interactive Results (after Daloz 1987:214)

In Figure 2 the two dimensions of challenge and support are seen together with regard to the level of each. It might be argued that mentor, appraiser, preceptor and clinical supervisor should all operate from the two high perspectives, to ensure that growth and professional vision arise. The incidents explored during the early part of this chapter were occasions when both these levels were low for me, which failed to promote growth and also generated uncertainty if not stasis and disinterest in my performance. The situation that I experienced, matches the matrix shown in figure 2.

The work of nurses has experienced major organisational change in recent years, as traditional autonomy for decision-making once invested in the ward sister (Ersser and Tutton 1991), has been devolved to the individual practitioners within the philosophy and practice of primary nursing (Vaughan 1989). The moves to autonomy and accountability are clearly set out in the pioneering text by Manthey (1980) and are reiterated by many contemporary writers, including Wright (1990) and Hegyvary (1982). These have significant relevance here. The Code of Conduct (UKCC 1992) and Scope of Professional Practice (UKCC 1992), both clearly identify the extent and significance of autonomy and are prescriptive documents for

appraisal. The evaluation of performance, together with support and challenge will underpin practice, as well as, assisting with the fulfilment of the professionals. Johns (1993) identifies the development of practitioners and Supples (1993) the identification and management of substandard practice in work, in recognition of the impact on performance of (appraisal) feedback.

By virtue of my educational opportunities after basic nurse training I have learnt to be reflective, self-reliant and to provide self-appraisal to help me develop my potential and achieve professional fulfilment. However, I am also able to recall a number of occasions when soliciting the assistance of a helper enabled me to explore and learn from my practice experiences. The absence of regular helper activity (appraisal) to assist me to evaluate my performance, has led to a large amount of experience going unexplored. This leaves me to speculate on the likelihood of repeated errors, missed opportunities and incomplete development of potential in my career to date, a situation I suspect in part may exist for the majority of nurses. Chapter 2 explores the concept of appraisal and the factors that influence it, both in a general and in a nursing perspective.

CHAPTER 2
APPRAISAL: NUMBER ONE MANAGEMENT PROBLEM?

INTRODUCTION

Peters (1989) in his handbook for the management revolution, Thriving on Chaos, opens the section on "Revamp the Chief Control Tools - S-2" as follows:

> "W. Edwards Deming has contended that performance appraisal is the number one American management problem. He says it takes the average employee six months to recover from it."

To set the scene for how I wish to explore appraisal and professional fulfilment for nurses, the concept of performance evaluation requires clarification. A concept analysis of the terms used under the umbrella of performance evaluation is given; these concepts are then explored in relation to nursing and other professions.

From the outset I had hoped to achieve clarification of the terminology and to appreciate the meaning of concepts such as appraisal and performance review etc. that were relevant to this study. This proved difficult. It therefore became an aspiration of the study to gain this clarity as one of the outcomes. However, it is important to give some indication here as to the range of perspectives in the literature.

There is no apparent consensus about the terms used to describe appraisal of performance. Appraisal is said by Attwood (1985:81) to be

> "...the process of valuing the employee's worth to the organisation, with a view to increasing it".

Along with 'employee rating', the terms 'performance review', 'personnel performance review', 'supervision' and 'performance evaluation', are all used to signify the activity of appraisal, but with no clear distinction between them. Most of the terms mentioned appear to be interchanged indiscriminately. The Arbitration and Conciliation Advisory Service (ACAS) in 1983 identify three objectives for appraisal, namely "performance review, review of potential and reward review", which may in part help explain the difficulty in reaching consensus. These objectives, I contend, are as likely to obfuscate attempts to reach consensus as they are separate purposes for appraisal that have a degree of mutual exclusivity.

The term supervision seems to stand alone from the others. This is especially the case when used in the context explored by Hawkins and Shohet (1990), where supervision is used not in the hierarchical sense of superior, but in a collegial sense, with qualitative (super)-vision. However this term is also the subject of differing interpretations, with Morton-Cooper and Palmer (1993) cautioning about it focusing on punishment and monitoring. It is possible that appraisal and supervision will need to interact and therefore the term 'supervision' will also require clarification. In exploring the notion of performance review, I will, in this chapter, use appraisal generically, as indeed does Elliott (1989), in order to minimize confusion. The least contentious aspect of appraisal would appear to be its purpose. The literature explored is drawn mainly from within the context of this research, i.e. from nursing, but to clarify some of the issues of appraisal I include reference to other professions.

I begin with the central question: Why appraise?

THE NEED FOR APPRAISAL

The need for appraisal might best be summed up by a quotation from 'Troilus and Cressida'.

> " All lovers swear more performance than they are able, and yet reserve an ability that they never perform." W. Shakespeare

Authors such as Handy (1985a), Fitzgerald (1989) and Trethowan (1991) uniformly suggest the need for appraisal. This need is summed up by Eggert (1993) who states that without feedback, either positive or negative, there is unlikely to be any change in behaviour. All nurses will receive some feedback, but whether they consider its significance, appreciate the implications or act upon it, is more problematic. Observations by Yankelovich and Associates (1983) suggest, within the American non-managerial work-force that:

* 50% do not put in effort above what is required to hold onto the employment
* fewer than 1 in 4 job-holders are working at full potential
* 75% said they could be significantly more effective.

I am not implying that such figures also apply to nurses in the United Kingdom, but they are nonetheless challenging and might bear consideration by all professionals. If substantiated, they would suggest major personnel difficulties that might be addressed by an appraisal system that provides appropriate feedback to inform practice.

Anderson and Barnett (1986) furthermore suggest that appraisal as a feature of effective management has never been so important. In 1986 the National Health Service Training Authority (NHSTA 1986), now directorate (NHSTD), introduced Individualised Performance Review (IPR) as part of the then NHS reform. It was declared mandatory for all Senior Managers, with the intention of extending it eventually it to all staff with managerial responsibility. It might be argued that all professional staff have a managerial component in their work, even if it is only managing their own time and workload.

Attwood (1985:81) gives a further reason for such a managerial approach:

> "If employees' performance is scrutinised and feed-back given, the motivation to work more effectively should increase."

Within the NHS this value is reasserted by the National Health Service Training Directorate paper "Managers Working for Patients" (NHSTD 1992:15). The quotation also gives strong support to the National Health Service Management Executive (NHSME)'s, Management Development Strategy which suggests appraisal of individual performance as being at the heart of any growing organisation.

Clearly an organisation like the NHS which invests its greatest resource in people, needs to ensure they are both efficient and effective. It might be argued it is not merely a need but perhaps it is an obligation to the public, to evaluate and enhance the work-force by means of appraisal. In 1989 the Nursing Division of the Department of Health produced a document A Strategy for Nursing (DoH 1989), which received critical acclaim for its insight. The document has been revived by the new Chief Nurse at the Department of Health (DoH 1993), reflecting its value to the emerging profession of nursing. Target 42 for leadership and management, in the original document, spells out that:

> "Practitioners should be afforded appraisal of their performance and potential, advice on career options and appropriate training opportunities."

The re-launched Strategy, A Vision for the Future (DoH 1993), again clearly charges the profession to ensure individuals are in receipt of evaluation of their performance, to enable them to enhance it. The document does not precisely prescribe a particular appraisal scheme, but sets out as good practice the presence of a process by which appraisal is provided as a vital component not only of quality care, but also to help

ensure professional fulfilment. The Vision also includes, in target 10, the need to have discussions on the range and appropriateness of models of supervision.

There are difficulties with appraisal that are to some extent unique to professionals. Fletcher (1993) lists, amongst others, autonomy, self-discipline, internal control and power and authority by virtue of ability, as key features of professional practice. The management ethos of hierarchy, bureaucracy and legitimate organisational power conflicts strongly with the ethos of the professions. The role-conflict that professionals, whether doctors, teachers or nurses experience, arises from the clash of professional expectations, organisational expectations and organisational demands that are found as much in appraisal as any other aspect of their work. The suggestion that appraisal and professionalism are mutually exclusive, or at least extremely difficult to reconcile, is one that Fletcher (1993) explores. It may be that moves in nursing towards clinical supervision is an attempt to find a collaborative solution to this problem.

That organisations are far from satisfied with their appraisal system, is noted by Dimmock (1985:54):

> "It is rare to find an organisation happy with the way its appraisal scheme operates."

This concern is also manifest in literature relating to the NHS:

> "...the NHS has major problems with the implementation of IPR"
> (Poundsford and Rowland 1991:27)

> "The history of performance appraisal in the NHS is one littered with valiant attempts that have died a fairly early death." (Gourlay 1986:35)

> "By and large appraisal systems have failed to gain universal acceptance,"
> (Walton 1985:30)

Given these sentiments it seems odd that Walton (1984) suggests nurses are among the front-runners in the professions in using appraisal. This may not necessarily mean they have had extensive success. It may be that other professional groups have done less well, or that nurses were among the first to utilise appraisal of performance, or that they were naive enough to embrace something they did not understand.

An indication of the quality of the process of appraisal for nurses is offered by Chellel (1993:50):

> "Improvements in patient care are rarely the product of individual effort and the IPR is not an appropriate forum for their development."

These sentiments give cause for concern, given the assertion that appraisal is thought to be so important in achieving organisational goals (Swan 1991). This is an issue that has taken on greater importance in the 'market orientated' National Health Service of the 1990s, where productivity and efficiency have become keywords. Appraisal, it is said can help an organisation reach strategic objectives (Handy 1985b), either as a form of management control, or, as Herbert and Evans (1991) suggest, by providing evaluation and developmental opportunities to assist the staff to develop. They in turn can ensure that management objectives are reached. It is likely that conflict between staff-focused and management-focused schemes will continue to exist. There also appears to be a fascinating paradox here: without a scheme of appraisal, management objectives are unlikely to be maximised; without organisational goals, individual objectives might be inappropriate. The need for staff and their managers to enter into regular negotiation and discussion is essential to ensure that individual and organisational goals are co-ordinated and mutually supportive. The universally agreed formula for a successful scheme has yet to be discovered within the NHS and in particular for nurses, as is illustrated by the contemporary proposals of Herbert and Evans (1991) and the Mid Staffordshire Health Authority. The former suggests continuing professional development (CPD) and the latter, a modified individualised performance review (IPR).

I intend to explore this issue for Nurses in the Oxfordshire District Health Authority in the light of such summative comments as those of Philp (1990:1), in his book Appraising Performance for Results (which is focused upon manufacturing companies):

> "When it comes to the most expensive resource companies invest in, namely people, the job of appraising performance against results is not very often carried out with the same objectivity, if indeed it is done at all."

This quotation also points to the fact, that despite its perceived value, the likelihood of successful appraisal schemes seems uncertain. If a scheme does exist, Trethowan (1991), in setting out the necessary stages for teacher appraisal, asserts that no amount

of legislation can successfully ensure the relationship necessary to make the process work. He goes on to point out that success is dependent upon relationships. Nicklin (1994) also suggests that criticisms about appraisal are more likely to be about how it is conducted than its presence in an organisation. He proposes the use of appraisal of managers by their staff, to complement the conventional "top down approach", to try and bring about appraisal as a two-way dialogue and thereby help overcome the difficulties of relationships. In quoting the work of Randall, Packard and Slater (1984), Nicklin summarises the position of appraisal for many people:

"The sadness of much staff appraisal activity is that what should be a positive occasion for improving the interaction between individuals and their employers frequently turns out to be dysfunctional, in that relationships would have been better if the appraisal had not taken place." (Nicklin 1994:46)

The relationship between the employee and the organisation is one that generates the expectations and dimensions of the 'psychological contract' (Mullins 1989). Handy (1985b) identifies this as the organisation satisfying certain needs for the individual in exchange for utilisation of the skills and energies of the employee. In turn the individual has certain requirements they must fulfil for the organisation in exchange for reward. Appraisal should be underpinned by a co-operative psychological contract wherein the organisation cares for its nurses to the same extent that it expects them to care for patients. This clearly indicates the need to conduct appraisal in such a manner that it develops nurses without threatening their well being. The very existence of appraisal and in particular the way it is conducted, will inform the employee of the integrity of the psychological contract as well as affirming their caring intentions as a nurse. French et al. (1985) identify a number of requirements within the psychological contract where individual and organisational expectations may conflict. It may be that this is at the root of the difficulties that have been experienced with appraisal. The ideology, culture, expectations and requirements of management and staff will significantly inform the practices of appraisal both overtly and as features of the psychological contract. Violation of the psychological contract is reported by Robinson and Rousseau (1994) to have a detrimental impact on the employer-employee relationships. Appraisal is one context where it would seem crucial to establish appropriate relationships to avoid this happening.

The extent to which the organisational culture and the psychological contract affect both need, benefit and perhaps success of appraisal will be considered further in

Chapter 3 on the context of this study and in Part 2. With such a foundation it will also be possible to establish how vital appraisal is seen to be, as well as some of the difficulties in bringing it about. However, before considering the details of appraisal schemes, it is essential to be clear about their purposes, which may provide clues about the difficulties reported.

THE PURPOSE OF APPRAISAL

Pidgeon and Yates (1969) using the broad term assessment generically, state that it serves the following five functions:

Diagnosis
Assessment
Evaluation
Prediction and
Placement.

A sixth, Guidance, is added by Macintosh and Hale (1976).

Stake (1989) and Randall et al.(1984) are more precise with statements on the purpose of appraisal. They specify:

to help assess training needs
to improve current performance
to set outcomes for the future
to assist in planning, by reviewing achievement and performance
to assist in selection.

Two further somewhat contentious purposes are alluded to by Burgess (1989). These are "weeding out" and assessing value, which could be developed into elements of Performance Related Pay (PRP). These would extend the list of purposes contentiously by two more;

to assist in disciplinary action
to assist in deciding reward strategies.

These final two purposes are those that generate the greatest degree of unease for staff and managers alike, and give rise to particular concern if appraisal schemes are used predominantly as management tools. Such purposes have yet to become wide-spread as features of appraisal systems for nurses in the NHS, although the relationship with pay has been mooted (Mason 1992, IRS 1992). By virtue of being promoted by The Citizens Charter, PRP has become a live issue for nurses and resulted in a substantial report commissioned by the Royal College of Nursing (Institute of Health Service

Management IHMS Report 235, 1992). Dutfield and Eling (1990) report on three American studies that suggest the majority of companies saw pay as the main purpose of performance review. (The term performance review is used in preference to appraisal in American literature as it is in the NHS). On the other hand, the National Union of Teachers (NUT) (1991) in their pamphlet on appraisal, advocate a clear separation between appraisal and discretionary pay awards.

The spectrum of appraisal techniques is, at one end, primarily an assessment of performance orientated around comparison: whilst at the other end is a system based on goal-setting and development of the individual (Fletcher 1993). It might also be that these two contrasting approaches help to explain the confusion about terminology, the former approach being more accurately described as appraisal, while the latter is more likely to be identified as performance review.

It is interesting to note here the report by the Institute of Health Service Management (1991) which suggests the Health Service IPR scheme has been moderately successful. It goes on to suggest the scheme has an emphasis on performance at the expense of development, planning and job satisfaction. This might contribute to explaining the poor uptake amongst clinical nurses, as the latter would be more in tune with their mode of practice. Dove and Brown (1993) identify the difficulty of combining the purposes of appraisal schemes, and they advocate the retention of developmental rather than judgemental systems. The problem of combined purposes is compounded by the time-framing of the appraisal, with the need to verify whether past, present or future performance is the focus for the event. In summarising the benefits and potential of appraisal, Dulewicz and Fletcher (quoted in Fletcher 1993:7) reverse the argument and clearly identify appraisal as a mutually (psychologically) contracted activity - as they claim:

> "If performance appraisal is to be constructive and useful, there has to be something in it for the participants - both the appraisers and appraisees."

Although not a declared purpose, interesting spin-off benefits of appraisal are noted by Metcalfe (1985), who asserts that the skills of analysis, of clarifying objectives, of motivating staff and of communication that involvement in appraisal brings, are a bonus to the planned purposes. He further acknowledges the importance of these particular skills to staff in the NHS of the 1990s and beyond.

Central to enabling these purposes of appraisal to be met are appropriate methods of rating performance and clarification of what is appraised.

WHAT IS APPRAISED

There are a variety of features that may be considered in appraisal, and one early distinction that needs to be made is whether it is the performance or the person that is being valued. Elliott (1989) is quite clear that you cannot separate appraisal of performance from appraisal of the person. His belief that "professional development in short implies personal development" and his insistence that quality (of teaching) can only be assessed in terms of the personal qualities displayed in the performance, substantiate this view. Blanchard and Johnson (1983) in a text on management reinforce the idea that it is people that you manage and not just their (recent) behaviour. The issue of what to assess also relates to whether the performance should be criterion or norm referenced, or both. It is essential if the appraisal activity is to benefit the individual and/or the organisation, that agreement on precisely what will be valued is identified and agreed. A process of negotiation and discussion will also be needed to agree on how the appraisal will be conducted as much as what is to be appraised, but first I wish to consider a number of the general methods used in appraisal schemes.

METHODS OF RATING PERFORMANCE

Several different methods have been used to classify appraisal strategies, and a useful list is given by Swan (1991:19-30). The methods he identifies are;

* Global essays and rating: This is an annual (or other chosen time-span) generalised summative statement of performance, often set against a simple ranking scale which is most likely generated by the subjective view of the line manager.
* Trait Rating: This commonly used technique lists a series of personal traits against which the individual is 'measured'. However, this tends to rate what people are, as opposed to what they do, and may well be seen only as challenges to personality and not to performance.
* Peer Ranking: 'Peer' is used in the sense that the manager who conducts it makes a peer comparison, or preferably is a true peer. This is held to be a fairer system, as the manager ranks against peers and not their own expectation. However it is unlikely in a large organisation that any manager could know all their staff well enough to achieve this.

* Organisational Data: This relies upon the hard data of the organisation, in terms of productivity, performance and quality, as indicators of an individual's performance. It works on the assumption that the individual contribution can be isolated.
* Critical Incidents: These are used to evaluate performance. The positive and negative incidents of behaviour are recorded and by pile height (or difference), performance can be evaluated.
* Behaviourally Based Scales and Behaviourally Anchored Rating Scales (BARS): These combination methods use critical incidents and their analysis to identify key performance dimensions which the organisation sees as important: this method can be used to evaluate performance.
* Objective and Goal setting: Unlike the noted subjectivity of the BARS system, this relies upon 'objectives' or goals that are negotiated and can be reviewed. They are most often set within a time frame and operate by hierarchical cascades.

Within nursing, the last method, that of setting objectives has been quite widely used and is clearly the thinking behind the NHS Individualised Performance Scheme (IPR). The critical incident analysis of the BARS approach is used but not the whole scheme.

What this list does not include is the notion of self-evaluation, which can be a feature of all or any of them. It may also be the case, as is my own experience, that this is the main appraisal activity that occurs. Although informally derived, my reflections provided a useful appraisal (self-evaluation) activity. The link between such self-reflection and improved professional nursing practice is established by writers such as Gurney (1987) where he noted that such a range of methods gives opportunities to produce schemes that are either based on normative or criterion referencing. However, in the case of some schemes both types of referencing may be incorporated. Alternatively the objectives may be set as criteria to be achieved, but with appraisal as a normative process. The system that is most widely used in the NHS is the Individualised Performance Review (IPR) (NHSTA 1986). This scheme is presented either in the prescribed or in a modified mode. For example, Mid Staffordshire Health Authority has a strategy entitled Individual Performance Review, an objective-setting scheme with elements of a BARS system incorporated. In Oxfordshire, one of the District sub units (now an NHS Trust) has devised its own Staff Development Plan, based upon an objective (within an action plan) format, that is similar to the IPR scheme.

There are also moves in nursing to produce schemes along the lines of "Self-Development Contracts" as proposed by Handy (1990). It is fundamental to identify whether this is only a titular change, or whether the organisational culture has also changed to focus on the staff development end of the continuum. Handy, in the same book, suggests the term appraisal sounds judgemental and is more in tune with authority than with the partnership he advocates between the members of a work-force. That again reflects the significance of the organisational culture. However like teachers, nurses have to work within at least two distinct cultures, local and national, with the national demands to an extent reflecting political aspirations as well as current thinking. What is undeniable is the need to ensure that, if objectives are set out directly or in the guise of a Development Contract, the resources needed are also in place.

The BARS system as used by the London Metropolitan Police Force was introduced to the nursing literature by McKenzie (1988), and reported to be in use in America by Bushardt and Fowler (1988), but I have no experience or knowledge of its use in nursing in this country.

What is clear is that, both in the design and in the operation, a number of influences on appraisal schemes become evident. These need to be considered alongside the context in which the scheme is set. These influences may not only affect the outcome of the appraisal but also the feelings of the staff involved.

INFLUENCES TO BE CONSIDERED WITHIN APPRAISAL SCHEMES

A number of particular issues influence appraisal schemes and they include;

Gender
Who is Appraised?
Who Appraises?
Time and Timing
Record Keeping
Reliability, Relevance and Validity
Use of Appraisal
Clinical Supervision

1. Gender

Given the fact that more than 90% of the sample in this research were likely to be female, it was vital the issue of gender was acknowledged. The issue of male managers and a largely female work-force is identified by Burgess (1989) with regard to the teaching profession and is one that also exists in nursing. Specific reference to

gender issues is given by the NHSTD (1992) report, which suggests that the NHS IPR scheme...

> "...seemed to be working unwittingly against women."
> (NHSTD 1992:15)

The report also suggests, as does the IHSM (1991), that women have significantly more difficulty with the scheme. They are less likely to be ranked highly and have difficulty setting objectives, but they are more likely to view appraisal as positive than their male colleagues. This has particular significance for nursing, a predominantly female profession with a disproportionate number of men in its senior positions.

2. Who is appraised?

Many current schemes focus on the individual, as in the NHS IPR scheme. Hutchings (1992) in a critique of the Oxford Polytechnic appraisal scheme, draws specific attention to the insufficient consideration of team work within appraisals. Nurses, like lecturers in Higher Education, are frequently team players and as such might be better appraised with this in mind. He draws attention to a scheme based upon a four category appraisal, that of Queensland University of Technology. This takes into account the broader influences and effects of the individual's performance.

It may be that appraisal should include reflection of the collective skills that an individual contributes to, but, as in all peer and collective assessment, separating out the individual contribution and being fair to that individual and the team members, may be troublesome. The activity, however, has the useful benefit of helping the team to appreciate and recognise the contribution of the individual members.

3. Who appraises?

The literature on appraisal focuses mainly on methods with little attention to context and even less to who applies them. Appraisal in the UK as Redman and McElwee (1993) note is predominantly 'top down', with the difficulties of reliability and bias that this creates (Latham 1986). The failure of managers to acknowledge the need for anyone other than themselves to provide feedback is well recognised. Fear of losing control, not perceiving the need, and the economic advantage of only using one person are possible reasons for this. Such hierarchical systems may be less favourably viewed not least of all because of the logistics. The senior ward nurse, the Sister, with some 20 plus nurses to appraise, may find it an excessively time-consuming activity, and thereby not give adequate priority to it.

Attempts to orientate the appraisal around staff development as well as management control will require, as Herbert and Evans (1991) suggest, a degree of self-evaluation to contribute to the process and thereby an extension of self-awareness. The use of the term "weaknesses" by these authors and others, has a negative connotation. I would prefer to use the term "learning opportunities", taken from the literature on Neuro-Linguistic Programming (O'Connor and Seymour 1990), which clearly has a more positive perspective, and which will underpin the activity as developmental rather than critical or punitive.

Appraisal systems using 'multiple raters' are on the increase with for example such activity as peer review included for professional staff. The focus this places on development may be seen by managers as elitism or by the professionals as internal autonomy (von Ginlow 1990). It is also likely that professionals with their view of the vocational, public service nature of their work, will be keen to solicit customer feedback as one element of their appraisal. Given the moves to a total quality Health Service that the Patients' Charter advocates, this element of the professionals' appraisal activity seems wholly appropriate.

4. Time and timing

What is clear is that any investment in the staff and the organisation will take time. Peters (1989) confirms this by agreeing appraisal is and should be time-consuming. However, whether this is seen to be an investment or a drain on the organisation will depend upon its effectiveness.

Time and indeed timing will need to be considered for the following purposes;

* Establishing the scheme
* Training the staff in their scheme
* For the appraisal events to take place.

Dimmock (1985) states that unless the time is set aside to consider objectives, design and implications, the "game might not be worth the candle". Philp (1990) considers time with particular regard to the frequency of events, and asserts that most damage has been done by traditional approaches that "concentrate on formalised schemes on a once a year basis". Interestingly the NHS IPR scheme does include a 12-month review section as well as an annual planning cycle. The Oxford Polytechnic, now Oxford Brookes University, also describes, in its introduction to a document on Staff Performance review, "annual target setting and development plan" (Champion 1990). Odiorne (1990) in proposing a quarterly cycle substantially challenges the idea that an

activity as important as appraisal can be left to an annual event. It may be of course the case that annual appraisal fulfils the need, but it seems more likely in the rapidly changing world of the '90s that this will be too long a time interval. Indeed it might be preferable not to prescribe the time span, but allow this to be negotiable between the parties. Eggert (1993) is less flexible in suggesting that appraisal is destined to failure unless the feedback follows as soon as possible after the activity, which might suggest a daily appraisal. This would not only be impractical, but probably excessive; however, Peters (1989) reports specific daily feedback on performance for the Japanese employee. What Eggert (1993) does substantiate, is the need for flexible and spontaneous feedback / appraisal running alongside planned events, which are able to occur when the need arises.

Metcalfe (1985) sees the time spent on training in appraisal as an investment, since it enhances performance and can have vital relationship benefits between staff and management. Travellers' Fare, the catering activity of British Rail are emphatic that the time spent training for appraisal was a major success factor in its PRP system (Wilson and Cole 1990).

5. Record keeping

Regardless of the other details that may affect an appraisal scheme, what will almost uniformly be required is some method of record keeping. This will enable participants to accurately recall events. However, the access and ownership of such records will need clarification. A bureaucratic organisation may desire to hold these centrally and to include counter-signatory, such as the 'grandparent' in the NHS IPR scheme. The 'grandparent' is the 'equity assessor', and is described in the handbook as the job-holder's manager who makes sure that appraisal happens, that it is taken seriously, and that it is based on reasonable judgements (NHSTA 1986). This also means that the document is available outside the appraisee/appraiser relationship, and to a more senior member of the organisation. It may even be that in some organisations these records are kept secret from the individual. This would clearly prevent the sort of relationship within which appraisal could be seen as a developmental activity rather than a management tool. Peters (1989), in asserting the developmental approach to appraisal, contends that formal appraisal records should be straightforward. He suggests a simple written contract to replace the complex set of forms and rigid bureaucracy of many systems.

The use of Personal Profiles established as a part of mainstream education (Garforth and MacIntosh 1986), have now been taken-up by the UKCC in the recommendations

of its professional development project (UKCC 1990). The profile would seem to be an appropriate place for an appraisal to be kept. This would reflect its purpose to facilitate development and not to exert control.

Whatever the system for record keeping, what is clear is that this is an area where agreement is essential.

6. Reliability, relevance and validity

These three major issues will need to be considered here as they must be in any activity where measurement occurs (Open University 1981). To be reliable, measurement will (as Deale (1975) suggests) need to measure whatever is measured in a consistent way. It must not only be accurate but also repeatable by different people. The relevance of the appraisal scheme is identified by its ability to measure those aspects of performance that would contribute to enhancing performance. This activity is more likely to need to move from the relatively straightforward area of quantity, into the more complex one of the quality. To retain validity, Deale (1975) suggests, the appraisal scheme must measure what it intends to, must be related to clear criteria and must be based on a procedure that explores that intention with regard to those criteria. This will be problematic if the focus of the appraisal is developmental and the contents include reflection on contemporary experiences rather than just pre-determined expectations and goals.

There will need to be in place recognition of the fact that some outcomes or goals may be subject to the influence of other factors outside the appraisees' control. Indeed in a profession such as nursing, that is part of a large 'family' of a Health Care Staff, both intra- and inter-professional influences will need to be considered.

Much of the literature on appraisal raises questions that to some extent reflect the difficulty of establishing appropriate criteria, and it is clear from a summary of the literature that an evaluation of appraisal schemes is much needed. As Elliott (1989) suggests, research-based forms of appraisal related to the actual job are badly needed. It is anticipated that the present research will contribute to meeting this need within the field of nursing by assisting in the development and use of a valid, accurate and reliable scheme of appraisal for nurses.

7. Use of the Appraisal

Clearly if the purpose of appraisal is to enhance performance of both the individual and the organisation, the outcomes generated must be put to positive use. One way of

achieving this can be found in the notion of an action plan (NHSTA 1986), in which the information gathered forms the basis of a negotiated plan for the future. Such plans needs to be designed to meet both the organisational needs and the individual needs.

The use of the appraisal to evaluate pay levels (Performance Related Pay, PRP) is far more contentious. Poundsford and Rowland (1991) assert that, in the NHS, the IPR scheme is not good a lever for enhancing performance when focused too much on pay. The management brief of one Regional Health Authority (Yorkshire R.H.A. 1992) suggests that considerable groundwork needs to be done before PRP can be introduced. The IMS Report (IHSM 1992) is clear that the need for an operating scheme of IPR for the country's 600,000 nurses, which reflects the core element of clinical work, is a prerequisite building block to PRP. Dutfield and Eling (1990) raise the notion that if pay is included in appraisal, there is likely to be an emphasis on minor successes, with a parallel playing down of difficulties, that if addressed could truly enhance the individual and the organisation.

One RHA has gone part way to introducing PRP by offering sabbatical leave, travel fellowships and even leisure passes as indirect financial incentives to IPR (IRS/EOC 1992). This in part supports Perry (1986), who asserts that performance pay might be based on too simplistic a theory of motivation for public sector workers. Silverman (1992) goes further and suggests that merit pay may even act as a demotivator. Eric Caines, the one-time Director of Personnel at the NHS Management Executive, in a radio broadcast (1993) was unable to provide the evidence that supports the theory that pay motivates. Rather he argued that the absence of evidence to say it did not, indicated that it did! Chris Haskins in the same programme suggested that PRP was a "second best to good management", and Mark Thompson suggested it "undermined the psychological contract". For professionals, the psychological contract to provide a quality service may be compromised by suggestions that good performance is dependent upon financial reward rather than by way of professional fulfilment. Caution towards linking performance to pay too closely is raised by Lewis (1993:13):

> "... once pay is introduced into the appraisal process then other aspects ...notably the identification of training and development takes a back seat."

It might be concluded from such arguments that PRP as a feature of performance review is not the panacea for productivity within the public sector. Insufficient evidence exists to suggest proceeding with a system of merit pay based on

performance for the 600,000 qualified nurses, especially in the absence of a fully operational performance review scheme, and with so many questions about its success unanswered.

8. Clinical supervision

The exceptional nature of clinical supervision as an evaluation, support and feedback strategy, warrants a degree of exploration. As a staff management approach it has the qualities that might permit it to be used instead of, or perhaps alongside, other appraisal activities. Darley (1995) acknowledges a clear link between appraisal and clinical supervision, but also deprecates the use of appraisal (IPR) as a substitute for clinical supervision. Loganbill, Hardy and Delworth (1982) (quoted in Hawkins and Shohet 1989:41) define supervision as,

> " ...an intensive, interpersonally focused, one to one relationship in which one person is designed to facilitate the development of therapeutic competence in the other person."

The established use of supervision is found in a variety of professional groups including midwives (UKCC 1986) and social workers (Hawkins and Shohet (1989). The advantage to nursing staff of clinical supervision, as explored by Johns (1993) has been reinforced by re-examination of A Strategy for Nursing (DOH 1989). The new edition of the 'Strategy', A Vision for the Future (DOH 1993) clearly advocates clinical supervision as one means to advancing professional performance. Target 10 of the 'Vision' sets out the need for local and national discussions to report on the way forward for this during 1994. It was not until the Autumn of 1995, however, that the UKCC planned a conference to generate their professional guide-lines on clinical supervision.

Supervision is an interaction between a supervisor and supervisee, which aims to assist the latter to become more effective. It recognises that enhancing the individual enhances the organisation, and it is based upon a negotiated contract. In relying on supervisee acknowledgement of needs, it is interested in professional development within the framework of a professional code of conduct. Bishop (1994) identifies three overall aims for supervision: to safeguard standards, to develop professional expertise and to deliver quality care.

The benefits of supervision are, to assist the individual to conceptualise practice, to advance a philosophy of that practice, and to explore issues of concern. It may be

these issues will be explored either coincidentally or apart from any appraisal activity, and may also, according to Hawkins and Shohet (1989), operate at different levels:

Level 1 Trainee Dependence (novice), highly motivated, but in need of assistance to evaluate and reflect on practice.

Level 2 Autonomy/Dependence (explorer), may vary from overwhelmed to over-confident and need assistance in gaining balance.

Level 3 Collegial (competent), aware of the therapeutic nature of their practice, keen to explore wider implications.

Level 4 Appropriate Autonomy (crafts person), aware of the need to confront personal and professional issues. Aware of the broad context.

Management supervision is not singled out by Hawkins and Shohet as a discrete activity, rather "management", "education" and "support" are given as three integrated roles in the model they develop from the work of Kadushin (1976). They do warn of the potential abuse of power within their model of supervision, and it appears that, by their integrated approach, they see no need to distinguish between professional and managerial supervision. It is, however, an approach that focuses upon development rather than control and judgement. The terms "normative" "formative" and "restorative" as used by Procter (undated) are clearly similar. A number of examples of the growing use of supervision in nursing are set out in a booklet produced by the King's Fund Centre (Kohner 1994a), and the subsequent guide-lines published by the Centre (Kohner 1994b) under the title "Clinical Supervision". This avoidance of the adjectives "professional" or "managerial" gives a clear mandate for supervision to focus on nursing practice.

The statutory use of "supervision" is already well established for midwives, and is the subject of a working party of the Association of Radical Midwives. This association wishes to address concerns about the model of supervision, which is not always seen as a support mechanism to enable midwives to practise with confidence. The midwife will be allocated the supervisor, who may have 20 or more midwives to supervise and has the statutory responsibility to ensure public protection. Such supervision is often discharged at a distance, by infrequent meetings, and with little confidence for the midwife that it will be beneficial. This suggests the use of the term "supervision" in midwifery may be substantially different from that being actively promoted elsewhere.

Use of supervision as a development strategy is raised by Ooijen (1994) in a personal commentary. In the face of significant expansion of supervision for all nurses, she

raises concerns about the exact approach to supervision, fearing that it could become a punitive action to control the work-force. McCallion and Baxter (1995:20) have mooted that supervision may be perceived as a management monitoring exercise,

> "...to either check up on them or identify faults that could then be used for disciplinary measures".

This must be acknowledged as a distinct danger, although at present there is a wealth of material published that promotes supervision as a developmental activity.

OPTIMISING SUCCESS

It would seem valuable at this stage to draw a few conclusions from the above observations before proceeding. Three main issues stand out, that require clarification and hopefully consensus to enhance the success potential of any scheme. These are described as principles rather than policies or procedures. They are:

The Purpose It should be clear from the outset why appraisal is being introduced and what it is intended to achieve. No purposes should be covert or indeed introduced later unless consensus on this has been achieved (Stake 1989). The purpose will also need to reflect or even confirm the culture and ethos of the organisation and its staff.

Agreement The number and nature of the issues that impinge on appraisal are so important that they should be discussed and agreed upon at the outset of the introduction of any appraisal scheme. These would include, type of scheme, timing, training, etc.

Commitment Without commitment, no scheme will succeed. Commitment can be demonstrated by staff involvement, together with managerial resources and, perhaps most importantly, managerial involvement.

The above three principles are significantly interrelated. Appraisal is only likely to succeed where they are established in association with each other.

The nature of a scheme of appraisal that reflects these three issues, is taken up by Metcalfe (1985:1017) who, in an article recognising the importance of appraisal in the NHS, is keen to indicate that,

> "...implemented in the wrong way it could 'seriously damage your organisation's health.'"

CONCLUSIONS

In conclusion it seems that appraisal is vital to a large manpower-heavy organisation like the NHS, but that achieving a successful scheme of appraisal has many contentious aspects and potential pitfalls. The greatest of these would be the divide between top management, who might want an assessment-centred scheme that focuses on performance enhancement, and the staff who desire a developmental and motivating scheme (Fletcher 1993). This gulf will not easily be filled, and indeed may be widened by nursing's professional aspirations that challenge a managerial/organisational ethos. The confrontation between a management and a professional culture is also apparent in the difficulties currently being faced in Education and the Police Force as they also attempt to introduce appraisal. The features of professionalism place a charge on the individual to demonstrate accountability within their autonomy against an agreed body of knowledge. The principles of such professionalism must be reflected in the appraisal scheme if it is to operate successfully, which may be why previous attempts have had limited success.

Appraisal operates from both instrumental and experiential approaches to work. The instrumental style is more hierarchical and bureaucratic and lends itself to a more formal appraisal scheme. The experiential style is developed by experiences rather than rules and might use self-development contracts (Handy 1990) to reflect partnership rather than bureaucracy. The NHS and nursing in particular is more experiential in its outlook, particularly in Oxfordshire. This may in part explain the poor uptake of formal appraisal schemes, if they have not been presented in ways that reflect the staff work-culture (professional). However, the arguments in favour of appraisal and the benefit it can have on both personal performance and organisational objectives are strong. What is not clear are the details of the scheme or schemes that are likely to optimise the activity. Although both are clearly significant, it does seem that a) how the scheme is applied and managed may have more impact upon the outcome and effectiveness than b) what the exact process is.

Part of being a professional is the notion of "service" (Vaughan 1989) and certain characteristics are desirable in the individual offering such service. These are set out for each nurse in the Code of Professional Conduct laid down by the governing body of nursing, the UKCC (UKCC 1992), and include such things as continuous professional updating, and a willingness to accept accountability and responsibility for one's own practice. It is part of the intention of this research to clarify the relationship between appraisal, and the ability of the individual nurse to fulfil their

professional obligation and is an issue that will be returned to and addressed in more detail in Chapter 3.

Having clarified the purposes of appraisal and outlined some of the major issues in appraisal schemes, it is necessary to consider the questions that are raised in this chapter. To examine the subject of appraisal more thoroughly, I designed my research so as to explore the following questions:-

What do you understand by the term appraisal?
What is your attitude to appraisal?
What do you as a nurse in practice, and/or as a nurse manager want of an appraisal scheme?
What effects do you perceive appraisal to have?
Are you currently appraised, and if so, in what way?
What issues do you feel are significant for appraisal schemes?
What is the relationship between appraisal and professional fulfilment for nurses?

In the context of interviewing, more questions arose, but the above provided the basis for understanding what nurses themselves thought about the place of appraisal with regard to their professional fulfilment.

CHAPTER 3
THE CONTEXT OF THE STUDY: NURSING IN OXFORDSHIRE

INTRODUCTION

The notion of performance at work and its evaluation by means of appraisal were explored in the two previous chapters, posing a number of questions that were used to focus the research interviews. In this chapter, I extend the discussion to consider the context of this study - namely nurses in the National Health Service (NHS) in the Oxfordshire District Health Authority.

These two organisations are closely connected and were, at the time of the research, both undergoing major organisational change in the light of Government legislation (Working for Patients (Department of Health 1989)). The organisational shift in the NHS is one that has parallels in Higher Education. The beau ideal of the self-governing collegium where professionals practise their craft unfettered other than by internal autonomy, had been replaced by a series of "administrative fashions" (Becher and Kogan 1992). The managerial model, of General Management in the NHS (Griffiths DHSS 1983) and of that of the Jarrett committee on Education (1985) were replaced in the 1990s by 'market' models. As a result, survival of the fittest, competition and economics became the driving forces, much to the chagrin of the respective professionals. In the NHS one of the main thrusts of the change to create a 'market-orientated' service was the devolution of power to the individual Trusts. The focus on Health Care was to reflect the needs of the locality served, giving rise to more localised patterns of care and practices, and more individual managerial strategies. Cohesion of the NHS as a whole is thereby imperiled, and along with it the cohesion of any of the component managerial activities within it, such as appraisal. Powell (1990) examines the concept of "organisational networks", which might be a desirable and effective approach for both Education and Health Care. This style of organisational relationships would permit the business aspects of the market economy to operate, but with collegiality, reciprocity and mutual benefit included as the interpersonal features.

The Oxfordshire Health Authority, once a policy-making body, under the new NHS fulfils a purchasing remit. It negotiates contracts to provide Health Care from clinical provider units (NHS Trusts) according to the needs it identifies in the population. The Trust's nurse managers, the Directors of Nursing/Executive Nurses had previously established the Nursing Policy Group (NPG) which had a policy-making role. This group had for some time exerted authority by way of guide-lines,

such as that on Professional Nursing Practice (Nursing Policy Group 1993) included as Appendix I, rather than by formulating mandatory rulings. April 1994 saw the division of the Oxford Health Authority into seven semi-autonomous NHS Trusts, and with that, the dissolution of the Nursing Policy Group. Initially the professional heads of nursing from six of the Trusts continued to meet on a more informal basis to discuss common interests. These included supervision, reward strategies and nursing performance, but the discussions did not result in agreed District policies or guide-lines being produced.

Nursing in Oxfordshire was recognised for its creative approach to management by Ryan (1989) and for its pioneering clinical practice by writers such as Pearson (1988). It is therefore important to explore the contextual culture in which this arose. The importance of culture to the quality of the service and patient outcomes is clearly stated by McDaniel and Stumpf (1993). Randall et al. (1984) suggest that the appraisal system operated by an organisation can tell a great deal about how the staff are viewed - whether they need controlling or nurturing. Models of appraisal have potential for change, as the ethos of the NHS shifts from a professional, via a management, to a market focus.

To explore the particular culture of nursing in Oxfordshire I used the model of Hawkins and Shohet (1989). They discuss appraisal by way of supervision within caring professions, and I used their approach to organisational analysis. Their model proposes five cultures:

Personal Pathology
Bureaucratic
Watch Your Back
Reactive/Crisis Driven
Learning/Developmental

Each of these cultures produces a different attitude and style of working in the organisation, and therefore in the appraisal and associated personnel strategies.

PERSONAL PATHOLOGY

In the personal pathology perspective, the difficulties within the organisation are said to arise from individual failings. This might suggest appraisal is useful to control workers by punishment and weeding out, or by reward, along the lines of McGregor's theory X.

McGregor (1960) put forward two suppositions about human nature and behaviour at work - theory X and theory Y. Theory X represents the assumptions of "traditional" organisations:

* the average person is lazy and dislikes work
* most people need to be coerced, controlled and threatened with punishment to achieve objectives (of the organisation)
* the average person avoids responsibility and prefers to be directed, and lacks ambition.

Theory Y on the other hand represents the assumptions of current research knowledge, and celebrates the integration of both individual and organisational goals:

* work is a natural aspect of life
* people will exercise self-direction
* given the right conditions, individuals accept and seek responsibility
* the ability of individuals is only partially utilised.

The McGregor X assumptions imply appraisal as a tool to coerce 'poor' staff who are failing the organisation; staff without problems do not need it. Indeed it might suggest if you need appraisal, you must have problems! This is intensified by organisations that focus all their feedback activities on new staff and students, with none for senior staff, and who might therefore measure success by not needing appraisal.

Within Nursing, extensive performance evaluation is expected. It occurs for students, and recent proposals have confirmed the need for preceptorship for newly qualified staff (UKCC 1990). The latter activity is only recommended for the first 4 months following a new registration. Previous legislation (1971 National Staff Committee) concentrates upon setting in place appraisal for the most senior staff. The extent to which these examples are based upon a personal pathology culture is not clear, but their impositionary nature suggests it.

THE BUREAUCRATIC CULTURE

Hawkins and Shohet (1989) draw attention to the work of Menzies (1960) who in describing the nursing service of a large teaching hospital identifies the depersonalised nature of its bureaucracy. She is critical of the breakdown of the work to be done into tasks with little regard for the people involved. This includes clearly laid down rules, regulations and lists of procedures, that act to check that the work has been done, and in a prescribed way. It is also problem-centred, but sees the problems more in terms of mechanical issues.

It is this same work by Menzies that is often mentioned when discussing the organisation of nursing in clinical settings. Nursing has over recent years embraced Primary Nursing (Manthey 1980), which challenges bureaucratic work patterns by enhancing the autonomy of individual practitioners. Oxfordshire embraced the principles of primary nursing readily and was amongst the pioneers of nurses in this country to use it in practice.

It is also within this culture that appraisal may take the role of organisational barometer, with individual performance used to reinforce, or to indicate the need to change, the 'rules'.

'WATCH YOUR BACK' CULTURE

This functions by 'showing up' other departments or individuals who are failing in an arena of competition. Here again the appraisal is seen as an indicator of the level of weakness, and rather than to address issues; it helps ensure that issues are hidden lest they affect competitive ability. It is a culture in which 'keeping your nose clean' leads to promotion. As a result areas of practice where development is required are covered up, to prevent exposing 'failings'. This is particularly so if the appraiser is not from within the same power sub-group. It is also an approach to appraisal that is focused on sharpening the competitive edge rather than on genuinely and broadly ensuring development.

REACTIVE/CRISIS CULTURE

The need for appraisal here is given low priority unless there is a problem affecting performance, when appraisal is used to solve the problem. Once the problem is solved, the appraisal scheme is allowed to fall into disuse. When appraisal does occur, it is frequently hurried and only focused on the immediate problem(s) and rarely concerns itself with developmental needs.

THE LEARNING/DEVELOPMENT CULTURE

In this culture appraisal is most likely to flourish, because growth, development and learning are all central to the organisation. The notion of the "Learning Company" (Pedlar et al 1991) is a clear example of this culture, where the following exist:

* learning is seen as a life-long activity for all staff
* all work situations may potentially create learning opportunities
* problems are learning opportunities
* good practices arise from exploring learning cycles

* feedback exists at all levels and is on-going
* time is an expected dimension of change
* regular review and evaluation are part of the activity of individuals and the whole organisation.

This approach reflects the Theory "Y" of McGregor (1960), and will ensure that the psychological contract (Mullins 1989) is enacted. These two principles will ensure that the well being and performance of the nurses is optimised as well as the activities of the organisation.

Clearly no one organisation is likely to always match all these criteria, nor is it likely that any organisation will match precisely any one of the five cultures. To help clarify thinking with regard to appraisal within the Oxfordshire Health Authority, some reflection on 'its true, perceived and desired organisational culture' seems essential. Crudely, the NHS more often seems to reflect the reactive/crisis culture, and I was surprised, upon joining the Oxfordshire Health Authorities Nursing in 1990, to discover that it promoted a learning culture. Binnie (1988) acknowledged Nursing in Oxfordshire had moved away from a centralised bureaucracy to a new professional style. It is this move that appears to have been the vital factor in enabling the creativity and development for which nursing in Oxfordshire was celebrated. This at a time when nursing in the country was striving towards greater professionalism, with autonomy as one of its central pillars (Vaughan 1989).

The 'post-Salmon' (Ministry of Health 1966) hierarchy and line management were suggested by Runciman (1983) and Redfern (1981) to have led to a dissatisfied and often dysfunctional relationship between ward nurses and their managers. This produced a wholly disempowered nursing work-force, who saw in the new professional autonomy, an opportunity to enhance care together with their own well-being. In Oxfordshire the Nursing hierarchy appreciated this chance early on and had moved towards the organic hierarchy that Ryan (1989) described. This gave rise to an emergent "learning company" (Pedlar et al. 1961), and the notion of a support rather than a power hierarchy. It lead to the production of the guide-lines to replace policies and procedures. Indeed it might be true to suggest that the original Guide-lines on Professional Nursing Practice in Oxfordshire (Pembrey 1989) were a forerunner to the new UKCC code of conduct and Scope of Professional Practice (UKCC 1992) for all nurses. The new devolved authority for all nurses removed many of the rules and regulations. This was the case particularly amongst the component parts of Nursing in Oxfordshire. Evidence of this is the interest shown in Oxfordshire in the work of

Benner (1984) and Schon (1983) and their proposals for critical incident analysis as a means to reflective practice, wherein individuals are encouraged to exercise greater individual accountability.

Nursing in Oxfordshire's support hierarchy was at the time, and to an extent is still today, an unusual nurse management pattern. Nursing Policy Group (NPG) elected in 1993 (at the start of the primary data collection for this research) to preserve this philosophy and the learning culture that existed. Nursing in Oxfordshire had resisted moves to a management model in the late 1980s, and indeed it strengthened its professional status and philosophy. This was at a time when the professional collegium model was being challenged by broader political changes. Only time will tell what influence the market ethos will have upon the nursing profession, its culture and indeed its approach to such activities as appraisal.

In any discussion on contemporary professional nursing it would be remiss not to focus on the work of Benner (1984), who in a study of nurses recommends the use of reflective practice, and of the critical friend, as means of assisting the professional to grow. She identifies five levels of competency in clinical practice: novice, advanced beginner, competent, proficient and expert, indicating the process of becoming a professional. These levels closely mirror the four levels of Hawkins and Shohet that are set out on page 36 above.

This developmental attitude was embodied in statute by the UKCC (1993), the nurses governing body, in its final pronouncement on PREPP (Professional Education and Practice Project). The report contains two key recommendations germane to this research:

* the requirement for all nurses to undertake periodic refreshment to maintain their professional registration
* a preceptorship period for all newly registered nurses, a period identified as a time when the new professional nurse requires support, guidance and feedback to safeguard their practice.

The literature on appraisal suggests that this type of activity (preceptorship) should be available to all staff throughout their career and not only for the first four months. Johns (1990) identifies appraisal as a vital component of professional nursing, and raises the notion that it can assist the autonomous professional nurse to acknowledge and appreciate the boundaries of practice. Pluralistic accountability; to work, colleagues and the profession is extremely onerous, and must be a feature of

professional autonomy. Johns is clear in identifying performance review as a vital element of autonomy, and suggests the use of professional supervision to achieve this.

Pembrey (1992) challenged nurses in a seminar paper which takes up this point and suggests nurses should acknowledge that professional autonomy is not a state of independence or isolation, but one that must pay regard to legitimate knowledge and practice, and therefore must overtly accept the notion of accountability. It might therefore be paradoxical to suggest a need for this study in an organisation such as Oxfordshire where so much autonomous professional practice is celebrated. Pembrey (1992) asserted that nursing was in an adolescent state with regard to the relationship between autonomy and accountability. This study into appraisal sought to explore the extent to which that situation exists in Oxfordshire. The nature of management of Nursing in Oxfordshire, and the advanced status of autonomous professional should be accompanied by developed appraisal schemes. It was my view, from a senior management position in the organisation, that this was not the case. In particular in my role as Head of the Oxfordshire Clinical Education and Practice Group (OXCEPT), which was responsible to the Nursing Policy Group of the Oxfordshire Health Authority, I noticed an increasing number of requests from staff wishing to get involved in appraisal in the early 1990s. They included staff of all grades, who either had or did not have personal experience with appraisal, including IPR. Their questions reinforced the need for this research, particularly to explore whether the need for appraisal is motivated by professional, managerial or market orientated reasons.

In addition the joint assignment of two of the students on an OXCEPT management course clearly identified the demand for appraisal. Their small study of morale, motivation and job satisfaction made a number of references to the inadequate appraisal opportunities that exist for nurses in one of Oxfordshire's Units (Booth and Craig 1993). The main purpose of my research was to explore their findings in the light of the view stated by Quinn (1980:327):

> "In the Hospital Nursing Service there is a system of staff appraisal carried out on a yearly basis...."

This view is not borne out by the information set out in Chapter 2 and is, however, a surprising view, given that the Nursing Staff Appraisal scheme was only introduced in 1971 (National Staff Committee 1971).

I am also inclined to suggest that Oxfordshire reflects the broader professional position indicated by Batehup and Herbert (1991:8):

> "Twenty years on and appraisal is still not widely used for nurses."

This is echoed by Walton (1985) who suggests appraisal has by and large failed to gain universal acceptance. Walton goes on to suggest that Oxfordshire had set up a customised scheme, but in five years as a senior nurse in the District I have not seen evidence of this. Before I came to the District I anticipated that appraisal schemes would be in existence, given the degree of professional awareness and development, the management style and the learning culture that were already in place.

A second purpose of my research was to explore the comments by Fitzgerald (1989:95) who was at the time of writing a senior clinical nurse in Oxfordshire:

> "Most readers will be able to recall instances where the use of appraisal has seemed to be of little value. Indeed, some have suggested that it is time wasting, punitive and sometimes destructive."

CONCLUSION

In many centres, nursing has undergone a major shift from a hierarchical and essentially bureaucratic organisation at national, local and ward level to an emerging new profession with autonomous practitioners as a central feature (Errser 1988). This has come about as devolution of management to wards and departments (Williams and Sears 1991) has accompanied devolution to individual nurses (Heslop and Sparrow 1991), and 'primary nursing', the 'named nurse' or similar moves to patient focused-nursing systems occur. What is central to this is the relationship between autonomy and accountability. Manthey (1991) in addressing the Nursing Times Sisters' Conference drew attention to this as an indivisible issue, as does Alsopp (1991:86), who suggests that an appraisal system is

> "...essential to monitor the professional practise of nursing".

The shift in power is a central feature of Nursing in Oxfordshire as it is in the UKCC Code of Conduct (1992) and the 'new' Health Service (Working for Patients, DOH 1989) for nurses throughout the UK. However, the overwhelming evidence not merely anecdotally, but in the literature in general, and locally in Oxfordshire (Kimblin 1992), suggested that the necessary evaluation of individual performance by

way of appraisal was not in place. An exercise in the Summer 1993, to set the future nursing agenda in the largest of the Trusts, identified the need for a comprehensive appraisal system as a major priority. Whether this was to reflect the professional needs of the nurses or the newly created market needs of Trusts was not stated.

What is beyond doubt is the unlikely success of nationally generated schemes of appraisal (Dimmock 1985) in contrast to those negotiated locally. The responsibility I have, to manage a professional practice development team (OXCEPT) for nurses in Oxfordshire is both a proactive and reactive one. The clear need for appraisal, especially in such a professionally advanced Authority, has been a personal concern and one brought to my attention by colleagues. The result was the establishment of appraisal and supervision workshops as part of the OXCEPT program. The workshops were set up with the expectation that they might help put in place, and/or develop the appraisal strategies that were both desirable professionally and required by the Trusts. It may also be that the effect of putting in place an appraisal scheme might encourage restrictive management regimes to allow professional growth and the subsequent patient care development it can give rise to. This may lead to greater fulfilment for nurses as more of them become fully autonomous and are helped by appraisal to realise their potential and to understand professional accountability. The Summer of 1994 saw a large demand from managers and staff alike for guidance on clinical supervision, either as part of appraisal or instead of it.

Nursing management in Oxfordshire is more akin to McGregor's Y theory of behaviour at work (McGregor 1960) and the staff are seen to be self-directed, motivated, keen to work and to develop themselves. In the light of the perceived learning culture of the organisation, the opportunity to utilise experiences at work in an appraisal scheme were clear. This would not only assist in reaching managerial objectives, but also enrich the practice of individual nurses. Appraisal would not only help provide the safeguards for managers about efficiency and effectiveness at work, it would also considerably contribute to the professional fulfilment for nurses.

This research entered the debate from a firm base of discovery, along the lines suggested at the end of Chapter 2. It was hoped that the work would be able to contribute to the development of nursing and thereby patient care, by way of a case study of one Health Authority's Nursing Staff (Oxfordshire) exploring the issues of appraisal. It was acknowledged that the attempts to introduce an objective setting scheme based on judgement (IPR), had been met with ambivalence by the nurses. Given the focus on development and professional autonomy of Oxfordshire's nurses,

it may be none too surprising that previous schemes had not been fruitful if they were based solely upon judgement and control. This research would also it was hoped offer to the profession at large insight and assistance to address the same issues and, in the knowledge of the culture in which they arose, to reproduce them, if appropriate in their own.

Footnote

From April 1995 OXCEPT was no longer a Nursing Service simply for the whole Health District. It operated on a trading basis within and beyond Oxfordshire. My post as District Education Adviser therefore disappeared and was replaced by that of Head of OXCEPT. During 1994 there were questions about the viability of the meetings of the nursing directors of the Trusts, but in 1995 there were moves to reform them as a Nursing Executives Forum, to explore their perceived common agenda.

CHAPTER 4
EXPLORING AMBIGUITY: THE RESEARCH METHODOLOGY

INTRODUCTION: A SEARCH FOR METHOD

The subject of appraisal and professional fulfilment for nurses has been a subject I have repeatedly thought about as a qualified nurse. Despite this almost continuous concern and interest, I have for many years not found a satisfactory vehicle to explore the matter, until, during preliminary reading on research methodology, I came across the following assertion by Gluckman.

> "Clearly one good case can illuminate the working of a social system in a way that a series of morphological statements cannot achieve." (1961:9)

I was concerned about appraisal, its existence, benefit and impact upon professional fulfilment in nurses. I had brought this interest with me to Oxfordshire, where I had noticed a number of additional dimensions to the debate. The main issues I wished to explore were: appraisal and professional fulfilment in nursing in the context of Oxfordshire's culture.

The particular questions this research addresses left me wanting to explore in the case study a number of issues with regards to appraisal that include the following:

* the nurses' experiences of appraisal
* the extent to which the District guide-lines on appraisal reflect practice
* the nurses' understanding of the term "appraisal"
* the nurses' views of and attitudes towards appraisal
* what the nurses desired from an appraisal scheme and how they would like it to operate
* the relationship between appraisal and good nursing care
* the relationship between appraisal and professional fulfilment, professional growth and professional accountability
* the relationship between appraisal and clinical supervision
* the relationship between appraisal and (personal, professional and organisational) goals.

I elected to use a methodology that would preserve the contextual dimension and look for sense within the context, given the unique features of nursing in Oxfordshire. The work of the 'Chicago School' had established the case study as a research method particularly among sociologists but, as Mitchell (1983) observes, its popularity had gone into decline, surviving mainly in education research. Mitchell in advocating and encouraging a reconsideration of the use of case studies in sociological research, identifies their ability to render more explicitly the details of the subject of the research. This matched my intentions and desires.

I had previously used a qualitative approach to a piece of research (Northcott 1988) but, given my own limited experience and the Health Authority's Ethical Committee's concern about the research proposal, I had wavered. I was unsure I would be able to demonstrate an adequate 'scientific' approach to the research to satisfy their expectations or reach valid conclusions. Doyal, in a seminar (later published in 1993), identified knowledge as a conceptual commitment that allows the social relations to determine what is 'real'. He further suggested that empirical knowledge is illusionary and cited Popper (1972) and Kuhn (1970) to support this view. Cronbach (1982) confirms this stance, and goes on to suggest that in trying to understand the varied contextual experiences we face day to day, we are all social scientists engaged in case studies. This revived my interest in case study as a methodology for the research. I was particularly reassured, while reading Merriam (1988) on case study, to come across the statement:

> "...the case study researcher must have an enormous tolerance for ambiguity." (1988:37)

The anticipation of the ambiguity, serendipidous findings and wide range of research findings that such a study would expose had been partly the cause of my delay in starting the research. I realised that it was these very features that case study was able to accommodate and indeed set out to reveal.

Reading Doyal (1993) confirmed my commitment to qualitative research in both philosophical and practical terms. I was interested in a process not a product. A process whereby meaning was mediated through me. I also had an enthusiasm to function as the primary research instrument. This seemed so paradoxical, given that in the first instance it had been these elements that had in part delayed approval on ethical grounds and had unnerved me.

The five key characteristics of case study research outlined by Stake (1981) provided a powerful argument for the approach. The study was **inductive**, as I was open and keen to explore the topic with my colleagues. There would be a **multiplicity of data** given the size of the organisation. I would be seeking to obtain the **descriptive** experiences of my colleagues, about a **specific** issue. The research would be **heuristic**, setting out to bring new meaning and understanding, and to lead to a rethinking of the phenomena.

My aspirations were to present a documentary in conversation rather than in a technical format. Merriam (1988) identifies case study as being able to generate a final report that is descriptive, interpretive or evaluative, and one that the researcher is part of. This versatility was the final convincing factor, in that it allows for a final outcome that is unpredictable. I was therefore prepared to start the work in the mode suggested by Yin (1984) of "Exploring Ambiguity", and to examine "Appraisal and Professional Fulfilment of Nursing Staff in Oxfordshire".

THE CHOICE OF CASE STUDY: A MEANS TO REVELATION?

The context of the research is bounded naturally by the fact that it focused upon the nursing staff of a single Health Authority which, although large and diffuse, has a number of unifying and relatively unique features. The need for a bounded system outlined by Smith (1978) was placed in some doubt after the research had started, as the Health Authority and its 'control' of nurses was given over to individual NHS Trusts. This aspect was explored in Chapter 3. However, the 5,000 plus nurses in the Authority work in an environment with unusually devolved authority and advanced professionalism, which I believe initially remained intact following the move into NHS Trusts.

The case study approach adopted for this research set out to explore appraisal and professional fulfilment for the nurses in Oxfordshire in an inductive manner. The research started with this broad objective and, as Bogdan and Biklen (1982) suggest, moved to narrower foci as it progressed.

Case study has its roots in the professions and is used by both Medicine and Law to inform practice, but, as already stated, the types of case study are many and varied. Case study within nursing and during my own nurse training was a regular activity, with the case study setting out to provide a description of care in a given situation and by doing so to influence future practice. However, in Education the use of case study to provide more than just description is expanded to provide an evaluation. This

requires careful selection of the sample. Hamel (1993) suggests case studies are able to "locate the global in the local", or in Simon's term (1980) aspire to approximate a "...Science of the Singular". Stake (1981) suggests, case study can be undertaken in a "naturalistic" mode and as such does not claim to provide absolutes, but to furnish descriptions of the situation which aspire to be part of the dynamic world of the professional, or in the words of Adelman, Jenkins and Kemmis (1980), to provide "a step to action". These authors further commend the approach by identifying the greatest strength of a case study its ability to reveal the realities of human life in a given context.

The arguments in support of case studies are also strongly made by Guba and Lincoln (1981) who claim that its "thick description" allows for a broad picture to be painted, from which interested parties can assess the extent to which they agree or disagree. The case study has similarities with the techniques of Glaser and Strauss (1967) wherein theory is grounded in the constructions in which they are set. The case study as House (1980) suggests, "tells the story", as a construal of what the author saw and heard. The case study is embedded in history and a context; it aims to facilitate the reader's own understanding rather than offer generalisations (Walker 1985). As such it accepts the idiosyncrasy of the instance but also the potential for readers to generalise from this. As Stake (1985) puts it, the case study attempts to get to know people and to understand their meanings and thereby lead to a "naturalistic generalisation" by way of its building on the tacit knowledge of the reader. This is to allow for vicarious understanding, by accommodation into existing knowledge for example, the revelations of fellow professionals. In this way it informs practice.

Popkewitz (1984), cited by Guba (1990:61), gives strong support to the approach:

> "case studies have a symbolic potency in establishing the importance of one's immediate encounters and power in defining situations."

The area of study, although clearly bounded by the culture of a single Health Authority is complex, and a research approach able to accommodate a variety of perspectives of the issue was essential. It is clear from the literature that the case study can serve this requirement (Simons 1987, Stake 1985, and Yin 1984). The research also needed to be a democratic activity in which data generated were not only for public consumption, but would also contribute to the 'growth' of the participating colleagues in the study. That is, the research process would assist them to make sense of their experience whilst exploring appraisal and professional

fulfilment. However if the research is to contribute to the body of knowledge, it must be conducted systematically and reflect appropriate rigour.

The notion of research as an act of discovery to contribute to the 'body of knowledge' of new facts or relationships, has often been qualified by the need for this discovery to be by way of a systematic scientific enquiry (Macleod Clark and Hockey 1989). Hockey (1991), Dockrell and Hamilton (1980) and others identify a spectrum of research methods that need to be accommodated within a definition of research. The term 'scientific' however might not always be appropriate to them all. Eisner (1990) for instance is clear that alternative paradigms for research undermine the tacit belief that there is only one dependable way to know. In the collection of works edited by Guba (1990) three paradigmatic persuasions are focused upon, namely, scientific, constructivist and critical theory methodologies and are debated widely. This debate over paradigms is best summed up by Schwandt (1990:275) who in discussing research methodology as a search for the 'Holy Grail', suggests that it has been found "in a beaker of our own making". He defuses the arguments that give a hierarchy to the methods in the spectrum and argues for resistance to the "tyranny of methodological dogma". It is more important to spend time considering the principles that give credence to research and its methodology, whatever the details and status of the process. McGrath (1982) sets out the dilemmas that he suggests need to be considered:

* generalisability of the findings,
* precision and control in measurement,
* and existential realism.

At this point I feel it is worth noting that in the qualitative paradigm of research, accuracy may be a more appropriate term than precision, an issue that is certainly germane to my research. Indeed it was my express intention that control in measurement should be avoided.

The aim of research is according to some researchers to generate hypotheses, to others it is a search for understanding in order to illuminate and describe, what Silverman (1985) calls "interpretivism". It is for this reason that a naturalistic approach, to present a "slice of life" as proposed by Guba and Lincoln (1981) was chosen, using the case study as the approach to examine that 'slice'. The difficulty of identifying the existential realism of that 'slice' is a complex philosophical issue which also requires attention.

From the outset objectivity as commonly used in the physical and natural sciences had been dismissed as a possible goal on the grounds proposed by Flew (1979) of "naive realism". There is no reality external to the mind. Naive by the epistemological assumption that direct and valid knowledge of that reality is possible. Objectivity assumes a direct correlation between being and knowledge and is therefore a naive realism, which is no less a problem to 'scientific' (quantitative) than to 'naturalistic' (qualitative) research. It also justifies the use in part in this research of the somewhat unconventional use of the first person. The reflexivity (Hammersley and Atkinson 1983) of the researcher as an integral part of the social world of the study as explored by Rogers (1983) is acknowledged and will be used to help make sense of and validate the contributions of my colleagues in the research findings. The extent of this collegial involvement in other paradigms may be less acceptable but I have been guided by the view of Walker (1974:83). He draws a parallel between the anthropologist and the educational researcher:

> "The point is not that the field anthropologist is in danger of becoming part of the situation under study, but that he fails unless he does."

The intention of the research was to strive for understanding and to generate findings that are in no way expected to be omnipotent or definitive, but that would be useful to others. The research would generate impartial findings which as Gouldner (1971) suggests are "descriptive", as identified earlier on page 52 (see Stake (1981)). The intention from the outset was to reflect multiple realities, and to seek divergence. This produces research that is strong on realism - that is in search of meaning not of law. In this way it has a generality that will, as House (1980:80) suggests, leave the audience to choose "how to interpret the findings and of how much credibility to assign them."

The data, however, is not presented in a raw state, and the very use of cognitive mapping (Jones 1985) indicates a first-level analysis. The analysis, for which I am entirely responsible, is, nevertheless underpinned by a number of validity checks. The desire to examine the situation in the natural state allows the research to remain true to the phenomenon under study (Matza 1964), rather than risk the distortions of experimentation, especially as the chosen methodology requires immersion into the milieu being examined by myself (Malinowski 1964). The research will, it is hoped, contribute to the body of knowledge of new facts and relationships in a scientific way as defined in naturalistic terms and not according to physical science.

The rejection of an artificial reality created by experimentation in making way for a natural enquiry (Denzin 1971) may be equally prone to naive realism (Hammersley 1992) - a situation so often demonstrated by the relegation of the researcher, in an epistemological sense, from the equation, by the use of 'objective' language. It is for this reason that the linguistic convention of disassociation has not been adopted. The reflexivity that underpins the enterprise here, is acknowledged by the use of the first person. The linguistic device of the third person to convey objectivity is indeed naive (Porter 1993) and has been challenged elsewhere (Reid 1991, Webb 1992, and Swanson-Kauffman 1986). I wish to honestly and openly record my reflexive contribution to the research, with caution from the outset regarding the dangers of reinforcing my own biases and beliefs.

CASE STUDY IN NURSING RESEARCH

Nursing, or "New Nursing" to use Salvage's (1990) term, in its thrust for professionalism recognises the value of research, not only for professional enhancement but also for its potential to improve patient care (Dingwall and McIntosh 1978). However, this has been predominantly quantitative, and the work of Melia (1982) was one of the first examples of qualitative methodology. It follows the examples in sociology that attempt to understand and empathise with behaviour in specific contexts (Mills 1961, Webb 1992), a strategy attributed to the seminal work of Weber (1947), who described it as "verstehen". It was this possibility of getting to the depth of the issues that led me to use the case study as the approach to the research.

In 1984 Hockey, an eminent nurse researcher, devoted considerable time to exploring the question "What is research?" In 1991 (in her second edition) she pondered whether it was reasonable to assume the question was no longer relevant, as all nurses would have a clear idea about the nature of research. She also acknowledges the limited attempts at defining nursing research and offers her own:

> "...research into those aspects of professional activity which are predominantly and appropriately the concern and responsibility of nurses."
>
> (Hockey 1991:5)

Within nursing over the past decade alternative methodologies have, as Porter (1993) suggests, gained credibility in a profession that was predominantly influenced by positivistic approaches. The young academic discipline of nursing, as Webb (1992) writes, attempted to imitate the hypothetico-deductive methods of its 'bed-fellow',

medicine. Indeed in seeking ethical approval for this study, I met disquiet about my proposal with regard to its lack of the science that Chalmers (1982) speaks of. This was a situation made more irritating given the apparent insistence of the committee that research needs to reflect natural/physical science. My intention from the outset had been to avoid that perspective.

Nursing is a practical discipline about action and interaction and as such is a phenomenon that should be researched actively and as a whole. Isolated nursing acts are meaningless and can only be understood within their context. Nursing research should, as Greenwood (1984) suggests, be undertaken in ways that accommodate the social construction of nursing. Given the problem I was focusing upon, the use of a qualitative methodology was not only appropriate but important, for it would be professionally acceptable.

Consideration of the philosophical dimensions underlying the chosen research approach is part of the process by which the study is validated. If the study is to contribute new facts or relationships it must follow the requirement for the systematic 'scientific' enquiry (Macleod Clark and Hockey (1989) as reported on page 54).

THE UNDERLYING ISSUES TO CASE STUDY RESEARCH

Case study serves many issues and is ideal for researching particular situations. Because of this, however, it raises other problems. In any research endeavour the need to ensure the rigour of the methodology is paramount, especially as qualitative research of the type proposed here will generate data from a number of contexts. The means by which the rigour is measured in quantitative research has been applied to the paradigm used here in order to attempt to demonstrate the equal 'science' of the methods. Sandelowski (1986) points out the illogicality of trying to use positivistic rules and procedures to validate research from a different paradigm philosophy, such as a case study which is essentially qualitative.

The requirement in quantitative research for strict replicability is predicated upon the ability to demonstrate validity and reliability. These are highly valued attributes. Within the qualitative paradigm, however, the same approach is not feasible, given that the research is located in a particular context (Kennedy 1979). The following four particular underlying issues were carefully considered before undertaking the present research;

A. Validity
B. Reliability

C. Rigour

D. Generalisability.

A. Validity

Validity requires that the results of the research are valid, based on precision and are faithful to the intentions. There are a number of aspects of validity that are examined in this research to ensure the true value, applicability, consistency and neutrality that Guba and Lincoln (1991) state as necessary components of validity in qualitative research. Deale (1975), following Stufflebeam et al. (1971), breaks down validity into a number of components, namely construct validity, predictive validity and face validity. House's (1980) definition of validity as the "worthiness of being recognised" is clearly a crucial one if this research is to do justice to the respondents and truly help the understanding of the issues. Qualitative research, as House further points out, relies upon impartial methods to generate results that are true, credible and normatively correct. Simons (1987), in a summary of the work by House, clearly states the invalidity of "untrue" research. She also sees a need for research to be believable to the audience it was intended for as well as to others. This would ensure validity to the greatest extent, but it is not the place of the case study to be predictively valid, an issue considered later in this chapter under the heading generalisability.

A further point that House (1980) makes is with regard to impartiality of the researcher, which is of particular relevance to this case study. I accept fully the notion of "moral deficiency" (House 1980) that the 'uninterested' researcher might be at risk of. The respondents in the study are colleagues; they deserve my interest; and, as a fellow nurse, this interest in them and their experiences compounds my endeavours to ensure their views are accurately reported. To achieve this I have used a number of methods in the research. Following the advice of Merriam (1988), I also carefully explored my own bias at an early stage. Such setting out of my world view and assumptions helps confront possible bias.

Kidder (1981) suggests the dimension of internal validity, which concerns itself with the different impact of independent variables, is not of significant concern to qualitative research. Conflict that might arise, given the descriptive and idiosyncratic nature of this research, is anticipated. Care was taken to ensure consistency in the data collection method, in the expectation and anticipation of a variety of answers and the need to present that variety in the findings.

The difficulty of applying conventional approaches to validity is one that a number of qualitative researchers have addressed (Patton 1990, Lincoln and Guba 1985). The qualitative researcher is no less concerned about validity. Therefore, as Lincoln and Guba suggest greater concern is given over to credibility, transferability, dependability and confirmability than to internal and external/ecological validity, reliability and objectivity. Therefore three particular methods were used to address the need for validity:

1. Triangulation

The use of techniques to retrieve data from a variety of sources to focus on a single point are widely reported in social science research (for example, Denzin 1978, Rossman and Wilson 1985, Adelman et al. 1980). The use of many accounts in the case study of the same situation and issues provides a multiplicity of perspectives which will all need to be represented. The very diversity of the correspondents' contribution to the case study approach provides triangulation by way of multiple sources (Silverman 1985). Triangulation by providing the comparison of a number of accounts helps ensure validity and may even expose bias. Triangulation of sources was used extensively in this research, but not triangulation of methods or of theories. The use of multiple theories is, as Lincoln and Guba (1985) state, unacceptable to naturalistic enquiry, and the use of multiple investigators is particularly difficult in an emergent research design and a PhD research study.

2. Auditing

To ensure dependability, Guba and Lincoln (1991) suggest setting up an auditing function. The present research obtained auditing in two ways. This first was through the supervision from the Education Department of the University of Southampton, where the research was scrutinised with particular regard to the methods used. The second was produced locally. The research was subject to the critical review of five professional associates, four of whom work in the Oxfordshire Health District and the fifth in academic consultancy. All five were well placed to advise on the validity of the research.

To increase the validity further, and also the integrity of the research, a system of cross-checking was used to provide validation from the respondents.

3. Personal Cross-Checking

To be wholly credible, the research report must represent the multiple realities of the respondents. The respondents were accordingly offered an opportunity to react to the

results and to the findings. There were several ways the contributions were fed back to the respondents. Firstly the 'transcript maps' for each contribution were sent to the individual concerned along with an invitation to pass judgement, or, as Macdonald and Walker (1974) recommend, to improve their account. Secondly, sessions for geographically and other homogeneous groups were offered to obtain their response to the collected material. This was done, as Lincoln and Guba (1985) suggest, with no obligation to honour individual criticisms, but to enable them to be heard, as they offer a powerful endorsement of the credibility of the results. The respondents were asked on both occasions to consider whether the map clearly represented their views, to provide a supplement if it did not, and to indicate their reaction to the data.

The three strategies mentioned here were deployed primarily to achieve a picture that was "...credible to the constructors of the original realities".

(Lincoln and Guba 1985:296)

This negotiation of drafts is more than a courtesy; it is as Rist claims (cited in Stake (1985)) essential to accuracy and completeness.

B. Reliability

Reliability is not prized for its own sake, but, as Lincoln and Guba (1985) suggest, as a precondition for validity, since an unreliable measure cannot be valid. In traditional 'scientific' research the need for reliability, is to ensure a later investigator following the same procedures would obtain the same results and draw the same conclusions. Kirk and Miller (1986) offer two clear dimensions of reliability, namely diachronic and synchronic. The case study provides for the latter by seeking "...similarity of observations within the same time period" (p 41-42). It does not attempt to achieve the former as it acknowledges that the social world is too dynamic to possess stability across the time dimension. The case study is set in time and it is appreciated that the context will move on and never be repeated. Because of this the use of cross checking, peer-debriefing and triangulation are more important ways of ensuring the rigour of the enterprise than its repeatability.

C. Rigour

Several methods were deployed to ensure the rigour of the findings.

1 Credibility

The use of credibility as a criterion of rigour has been proposed by Lincoln and Guba (1985) and two techniques were used to operationalise this: prolonged engagement

and peer debriefing. The credibility of research in the final analysis is demonstrated by the ability of the participating nurses to recognise their experiences in the descriptions and interpretations of the research. In addition, another researcher should arrive at comparable or even the same conclusions, given the data and contextual considerations. The strategies used in this research to ensure credibility are the following.

2 Prolonged engagement

The need to spend sufficient time engaged in the study ensured full appreciation of the culture in which the study was set and to 'test' the evidence produced. Schwartz and Ogilvy (1979) give considerable weight to spending time exploring the context of the research to ensure that an accurate account is obtained. This also ensures that potential distortions are identified and examined. For many researchers the need to be acclimatised to the field of study, and for the participants to become at ease will also require time (Jackson 1968). Given the circumstances of this research this latter was not a significant issue. The risk of researcher bias is, however, all the more significant given my role within the organisation and my declared concerns about appraisal for nurses.

The element of time spent within the study also enabled, as Eisner (1975) suggests, pervasive issues to emerge - the issues that really count. It also gave me time for checking all the issues that emerged, to ensure that the spurious were discounted and the eccentric but pertinent were retained. In a case study this helps provide ecological validity, which is further enhanced by the use of Peer Debriefing.

3 Peer Debriefing

Peer debriefing did not only help overcome the somewhat lonely business of the naturalistic enquiry; it also provided as Lincoln and Guba (1985) indicate, exposure of the work to peers. The content of each chapter and the entire research was offered to my colleagues working in clinical practice development within Oxfordshire. The group are conversant with the context of the research, and they work with the respondents used in the primary evidence collection. They are therefore ideally placed to underpin the credibility of the study, by providing impartiality. It is by these techniques that the credibility of the research was assured.

D Generalisability

The expectation that the research will be generalisable requires particular attention.

The difficulty of applying research findings widely is given by Marshall and Rossman (1989) as a particular weakness of all qualitative research, and especially of the case study. Generalisability is only of limited concern here, given that primarily the target audience will be within the case - the nursing staff of the one District. For this reason generalisation within the case can be expected to be a valid and reliable activity (Merriam 1988). The size of the case in this research and the range of work situations available create a broad-bounded system, which might accommodate some of the contextual variations that make generalisability a challenge for research using a case study. The issue of application of the research findings within the bounded system and beyond can only be appropriate if the research had that intention in mind from the outset. However, with the provision of a detailed account of the contextual nuances, it is hoped readers will be able to judge for themselves the validity and generalisability of the research (Mitchell 1983).

The term 'particularistic' used by Wilson (1979) and by Merriam (1988) help to define the special features of case study. Hamel et al. (1993), MacDonald and Walker (1975) and Simons (1994) all suggest that the nature of case study allows examination of a specific instance to illuminate a general problem. Indeed Simons suggests: "By studying the uniqueness of the particular, we can come to understand the universal" (Simons 1994).

There are and will be many nurses and nursing organisations similarly placed to the one I examined in Oxfordshire. Whether or not they can or wish to generalise from this research to their own context, must be left to their discretion.

The use of "working hypotheses" (Cronbach 1975) rather than generalisations in the analysis of the research is to allow for greater external validity. This makes the findings available for appropriate consideration by a much larger audience. It is also a potentiality that gains support from Guba and Lincoln's (1981) concept of "fittingness", and their emphasis on the context within which the research took place. Human behaviour is mediated by context, and generalisations of any sort that pretend to be context-free will, according to Guba and Lincoln (1981), have little that is useful to say about that behaviour. Mitchell (1983) gives clarity to this issue by suggesting that the extent to which case study can be used for generalisation depends upon the adequacy of the underlying theory and the corpus of related knowledge as much as upon the particular instance. It is in part to allow this possibility that extensive contextual information is included in the research.

Cronbach (1980) broadens the discussion on this issue by suggesting that the scientific and the qualitative approaches to research both have difficulty with generalisation. The former by virtue of the establishment of the findings within such carefully controlled circumstances, and the latter by virtue of its idiosyncrasies, with neither able to offer anything guaranteed to be relevant outside their respective settings. What Cronbach suggests (1980:231-235) is the concept of "extrapolation". The modest speculation to similar situations that extrapolation offers is the invitation I also wish to extend. However this is not generalisation in the broad sense of the word, and is perhaps illumination rather than the understanding that Simons indicates in the quotation on page 62.

The case study is in harmony with all qualitative methods in that it can describe, understand and explain, and, as Yin (1989) argues, expand and generalise theories by analytical generalisations. It is my contention that, with regard to the question "How do you know you are a good nurse?" and the relationship between appraisal and professional fulfilment, the case study serves that purpose well. What it cannot do, and was not designed to achieve, is to enumerate frequency by statistical generalisation.

Finally, to underpin the whole process of the research, reflexivity was a valuable stance to adopt.

REFLEXIVITY

In my position as an educationalist, manager and clinician, I anticipated that the non-hierarchical nature of nursing in Oxfordshire, together with the method chosen for this study would ameliorate many of the difficulties associated with researcher involvement. The notion of reflexivity as described by Garfinkel (1967) underpins the research, and rather than make futile attempts to eliminate the effects of the researcher, these effects are intentionally included. This was done to try and ascertain how and in what ways such effects affected the research; for this reason, my personal reflections were recorded throughout the research. My own beliefs were, as Gouldner (1971) suggests, considered in the same fashion as those of the respondents. This further challenges the notion that research is an objective (in the sense of physical/natural science) endeavour that the researcher should and can be distanced from. Just as I hoped to respect the contribution of each respondent as valid and valuable, so I applied that approach to my own views. Usher (1992) is clear that I can only hope to know the reality by being part of it and that all social research is founded, as Hammersley and Atkinson (1983) identify, on participant observation.

The research endeavour was firmly established on available evidence, and as such the case study here will be presented as a "slice of life", a slice that by nature is fallible. Qualitative research accepts that no social event is homogeneous, and therefore a positivistic paradigm would not only misrepresent, it would be destined to fail. The bending back that reflexivity offers is in itself a validation, wherein the researcher continually checks both method and data for accuracy.

The problem of theory and its validation is at the core of all research. Much criticism levelled at case study and at the qualitative methods of sociological research, is that its subjectivity and lack of rigour renders it of little value to generate theory (Hamel et al. 1993). The deductive approaches to research provide 'science'

> "...by being able to reconstruct facts, give them meaning within the scope of a theory or theoretical framework, and by using a set of review procedures provide analytical methods". (Godelier 1982:24).

This deductive approach requires a theory to be constructed before it can be validated - a process that not only predetermines the outcome but also fails to allow for the serendipidous revelations that have led to so much reliable theory we now have of the world.

The case study approach does not have as its main aspiration the generation of theory; however, what it can do is demonstrate a theory of the case. By providing the contextual details, and a number of validation checks, the data presented can "locate the global in the local" (Hamel et al 1993:v), and thereby be of value to the profession at large.

THE MAIN DATA COLLECTION TOOL; INTERVIEWING

The use of interviews as a research tool is a method of data collection that has a long and extensive history. Treece and Treece (1986) commend the method by suggesting interviews can give rise to better depth, better exploration of issues, better cover of the issues, a good response rate and flexibility as they need not be predetermined. It is appreciated they are a relatively labour intensive method but as Cormack (1991) notes, this is balanced by the likelihood of "better returns". He further identifies the need for training in the method which is particularly costly if a number of interviewers are deployed. The 20 years experience I have as a nurse and my previous use of interviewing as a research tool (Northcott 1988) gave me confidence in adapting this approach.

The philosophical stance that underpins the research was revisited with regard to interviewing, and an interactionist stance to interviewing was thought to be appropriate. Silverman (1985:157) carefully explores the use of interviews and draws an interesting conclusion:

> "...interview data displays cultural realities which are neither biased nor accurate, but simply 'real'."

The need for the data to be credible is clearly set out by Kenny and Grotelueschen (1980), but they are quick to eliminate the need for scrutinizing data in terms of truthfulness. The use of interviews as the main method of data collection is affirmed by Yin (1989:88) as;

> "...one of the most important sources of case study information is the interview."

The reasoned preference for an interactionist approach given by Denzin (1970) is that interviews give no pretence to universal generalisability - a feature of case study already explored in the chapter. Allowing individuals to give unique ways of defining the world, elimination of a fixed sequence of questions, and permitting respondents to raise issues not in the schedule is, Denzin suggests, important to the veracity of the case study. What the respondents say is seen as equally important to the force of their comments or, as West (1979) calls it, as the "doing".

The forms of interviews set out by Powney and Watts (1987) were considered, and the "informant" style was chosen, over the "respondent", as offering greater opportunity for the interviewee to lead the session and to raise the issues they perceive to be important. The unstructured approach this gives rise to may, however, not generate responses to issues already identified as significant and it is for this reason that a hybrid method of interviewing was preferred. The style of interview suggested by Guba and Lincoln (1981) which accepts the principle that the interviewee is likely to be more knowledgeable than the researcher was firmly accepted. Previously raised issues were also revisited and put to subsequent interviewees. The style, as Burgess (1984) suggests, was that of a conversation - more akin to a "dialogue" than an "interrogation" - which ended not following a predetermined question list or a set time but when the point of diminishing returns was reached, i.e. when no new information was being revealed.

The respondents were chosen for their interest in the subject and likely value rather than at random, to try and ensure saturation of the available information. Many were volunteers as a result of an invitation to take part in the research that was placed in the OXCEPT newsletter. The details of the sample are given at the end of this chapter on page 76.

There is a need to get to the heart of the matter in the case studied, and Guba and Lincoln (1981:166) suggest the unstructured interview can assist to "...ascribe meaning to some event, situation or circumstance."

The use of semi-structured interviews is clearly recommended by a number of authors (Burgess 1984, Simons 1987) for the opportunity they give to address issues as they emerge. This is explored by Dexter (1970); he confirms that in the standardised interview deviation is "statistically handled" but that in the unstructured interview it is taken as a cue to widen the exploration. The engagement between the respondents and researcher is unlikely to be conducted on goodwill alone and I acknowledged the benefit for the respondents of being heard. The validation of views and feelings as being worthy, and the possibility of the researcher being able to influence practice, may give payoff to the respondents. In the context of the research reported here and given my position in the organisation this is a likely and indeed an intended outcome. It is the "step to action" that Adelman, Jenkins and Kemmis (1980) note as a possible advantage of case study.

There are however a number of potential problems that may distort responses, which are identified by Denzin (1970), as follows:

* interviewee and interviewer status
* the difficulty of penetrating private worlds
* establishing rapport.

To address these issues the interviews occurred in comfort and privacy, but did not guarantee absolute confidentiality. The data gathered, although not published verbatim with names, might conceivably be traced to individuals. However, given the size of the study this was not thought to be a grave risk or one likely to compromise any individual. The data obtained would become publicly available, and each colleague was given a copy of my perceived content (map) of their interview. They had the option to withdraw if they wished. The audio-tape recording of the interview was offered to any individual who wished to retract their information. The tapes are still held in confidence by the me.

The use of audio-tape recording is the most common means of recording interviews (Powney and Watts 1987). The interviews were conducted individually for logistical reasons: this also allowed a full opportunity for each respondent to enter into a dialogue with me.

The views of Hammersley and Atkinson (1983) that interviews are a form of social control, wherein the interviewer will always influence the information gained and all the data arrives from artificial settings, are accepted. The particular interview technique used and the cross-checking return of transcript data to respondents were procedures designed to address the control implicit in the method. These measures help ensure the method generates the accurate "slice of life" intended.

The approach to interviewing reflected some of the guide-lines for practice that Powney and Watts (1987) suggest, namely;

* a methodology pilot, to check the efficacy of interviewing as a data collection tool
* preliminary introductions and discussion to precede the recorded interview
* brief notes were taken during the interview, to keep track of significant points raised that required subsequent exploration
* written information about the research was provide and informed consent was obtained from each respondent.

Audio-taped interviews also allowed for postponement of the processing and reporting of the data to ensure undivided attention could be given to the interview dynamics. In practice each tape was 'mapped out' within 3 days of recording. The maps and tapes were also revisited at a later stage to check accuracy of the mapping.

PRESENTATION OF THE DATA

My final consideration in this section is that raised by Nisbet and Watts (1978) with regard to the presentation of the evidence obtained. Nisbet and Watts identify a number of dangers associated with presenting the data obtained from the case study, such as:

Journalism: picking out and emphasising the sensational.
Selective reporting: choosing only evidence that supports the conclusions.
Anecdotal style: letting illustrations and detail take over.
Pomposity: deriving profound theory from banal events.
Blandness: uncritical acceptance of informants response.

These were considered during the evidence gathering and during presentation and analysis. The problem for the audience in distinguishing the evidence from the interpretation I placed upon it was addressed by the provision of 'maps' to each respondent. The interview material, in the form of audio-tapes, had to be transformed into text for presentation. Care was needed to select a way of undertaking this that assured accuracy and avoided the pit-falls mentioned above. Each 'transcription' was prefaced by a written contextual note, and as these would identify the individual they were linked to the data by codes only known to me. These notes contained the following; personal details, location, timing, my perceptions and thoughts on the interview.

The transcription of the tapes I appreciated from the outset would be extremely time-consuming, given my desire to ensure the sample truly reached the point of diminishing returns for each candidate and for the whole case study. Techniques for transcription that were economical yet effective had to be developed. Marshall and Rossman (1989) report the difficulty in transcribing the voluminous data created by qualitative research, and recommend streamlining the transcription, organisation and analysis of the evidence. This combined approach they argue can preserve the meaning of the data and provide a preliminary analysis in a distinctly economical way. However, I chose to take this efficiency one step further, using the technique of "cognitive mapping" as set out by Jones (1985). The evidence was transcribed and analysed directly from the audio-tape into cognitive maps.

COGNITIVE MAPPING

> "Cognitive Mapping is a modelling technique which intends to portray ideas, beliefs, values and attitudes and their relationship to one another in a form which is amenable to study and analysis.
>
> (Eden, Jones and Sims 1983:30)

A cognitive map is the visual representation of the individual's or the group's knowledge base. It is cognitive in the sense that it represents conceptualisations and interpretations and is mapped in order to preserve the interconnections and organisation of the information. In this form, it was able to preserve much of the individual context. In conjunction with the researcher's world, its intersubjective approach advances Marshall and Rossman's (1989) idea one step further, namely to a second level of meaning. It eliminates the costly and somewhat sterile typed verbatim transcriptions, and also allows notation of the qualitative elements of the interview, such as emphasis, tone and even silence. It produces, as Jones (1985)

suggests, a somewhat messy result, but sets out the entire interview on one (sometimes large) sheet of paper. The exact approach I used for mapping is set out in Figure 3 as cognitive mapping guide-lines.

COGNITIVE MAPPING GUIDE-LINES

1. Generate field notes at the end of each interview to report the interview process and have these to hand when mapping.
2. Ensure each interview preceded a period of at least 3 hours to produce the map.
3. Be prepared with a large (at least A3) sheet of paper, Sellotape, correction fluid and a black pen. I always use black and avoid colour to facilitate photocopying.
4. Listen to the audio-tape right through without stopping or writing anything, and re-wind.
5. Start mapping. I prefer to start at the centre of the paper with a focal word. Run, re-wind, run etc. to accurately obtain the data from the tape. Attach extra paper as needed, to accommodate the evidence.
6. Set out and consider the evidence cognitively! Formulate codes, establish connections, and record non-verbal data, to produce a record that reflects the constructions of the respondent. If necessary take breaks to allow material to sink in or to ponder over points.
7. Keep verbatim quotations from the tapes separately, and indicate on the map that they arose.
8. Annotate the map to identify connections as well as respondent and researcher input.
9. Underline to emphasize, and use any personalised method to add evidence, or to ensure clarity of the evidence.
10. Be dynamic, and allow the technique to evolve to optimise the process of coding, categorising, interpreting and transcribing as an all-in-one activity.
11. Send a copy of the map to the respondent and invite them to report on the accuracy, as well as adding or censoring the content.

Figure 3 Guide-lines on Cognitive Mapping

Using this mapping process led in turn to the production of composite cognitive maps, that were used as the research evidence. This, it is acknowledged, is not raw data, as all the maps are configurations of my interpretation. However, they were subject to the scrutiny of the respondents (personal cross-checking) and auditors to

ensure accuracy and although time-consuming to produce, gave rise to intense immersion in the data which, I contend, enriched the research. Despite the apparent fragmentation of evidence that cognitive maps produce, each map ensures that the connections between points are preserved. Links between maps can easily be established. Mapping recurrent themes in similar positions on subsequent maps, greatly assists the analysis of the evidence. This subsequently leads to the presentation of the findings, in two main ways:

* analysis, looking for patterns
* interpretation, looking for meaning in the patterns.

The maps generated in the research helped to formulate the themes of ideas that emerged from the interviews. The creation of this "indigenous typology" (Patton 1987), allows presentation of the data in a way that reflects the naturalistic philosophy of this research.

Much of the success in obtaining evidence for this research arose from the use of cognitive mapping as a strategy for handling research evidence. I undertook the research with full confidence that case study was an appropriate method to explore appraisal for nurses in a given context. In discovering cognitive mapping, I came across an approach to collate and analyse the evidence that significantly helped accommodate the difficulties that a qualitative study creates with regard to the amount of evidence generated. I found little in the literature with regard to cognitive mapping and was interested to note the invitation by Jones (1985) to adapt the technique. The guide-lines on cognitive mapping on page 69 of this thesis are a late draft of my ideas on the technique that have been refined a number of times during the research from the original invitation by Jones. I offer these guide-lines to other researchers as a starting point for their own use of the technique. I confidently recommend the use of cognitive mapping as a valuable research tool for handling a large volume of evidence outside the context of this research.

ETHICAL ISSUES

The concerns of Guba and Lincoln (1981) that case study has unusual ethical dangers, given the ability of the writer to select data to fulfil their own wishes. The need to ensure that ethical safeguards are in place is also an issue that professionals are constantly sensitive to by virtue of their accountability. The proposal to undertake the research was submitted to the Nursing Research Ethical Committee of the Oxfordshire Health Authority and approved in August 1992. Seeking this approval reminded me of the main issue of ethical concern in a qualitative research,

namely respondent protection, by way of anonymity and confidentiality. Preserving the confidentiality and anonymity of the individual's contribution might have been difficult, given the focus of the study on a single organisation. The culture of the organisation in question is developmental and not recriminatory. Given the number of respondents, it was anticipated that this would allay any concerns. The sample came from all parts of the Oxfordshire District and from all the Trusts and Units, making it extremely difficult to identify individuals. The evidence in the report is presented anonymously, and each respondent was offered the opportunity to retract or to add to their mapped transcript. It was also anticipated that the use of cognitive mapping would also help protect the respondents. No transcripts of the interviews were produced; I produced the maps myself; no respondent maps have been published and I hold the tape recordings.

It was pointed out that the nurses were contributing to research that would be published. The evidence from respondents was collected in confidence and would be presented anonymously in the research. It was therefore stressed that, whilst anonymity was guaranteed, absolute confidentiality could not be. This was reinforced immediately prior to the individual interview, and the safeguard of withdrawal was also reiterated. The participants were also offered protection by virtue of the origination and the intention of the research. There were no pressures from sponsors to have the access or control over the data that Walker (1985) warns of. This contributes to a degree of participant protection and an unfettered approach to the research for myself.

The question of researcher involvement has been raised frequently, by authors such as Yin (1989), but given the expectation by Guba and Lincoln (1981) that the case study should "teach", I was not only involved, but I took actions that stemmed from my participation. This included the setting-up of appraisal and supervision workshops that arose following requests from colleagues, who were aware of my research endeavours. The running of such workshops was an integral part of my role within the organisation and one that I felt would enrich the research rather than contaminate it. These were educational activities, designed to offer a range of appraisal methods to a self-selecting audience of colleagues, who by definition were interested in the topic. The facilitation style of the workshops allowed participants to contribute widely to the debate, thereby offering me insight into the appraisal activities they had experienced. The use of such educational research "in action" as opposed to "on action", is given credence by Stenhouse (1975). It might also be

seen as an ethical failing, not to have acted so as to address this potential professional dilemma.

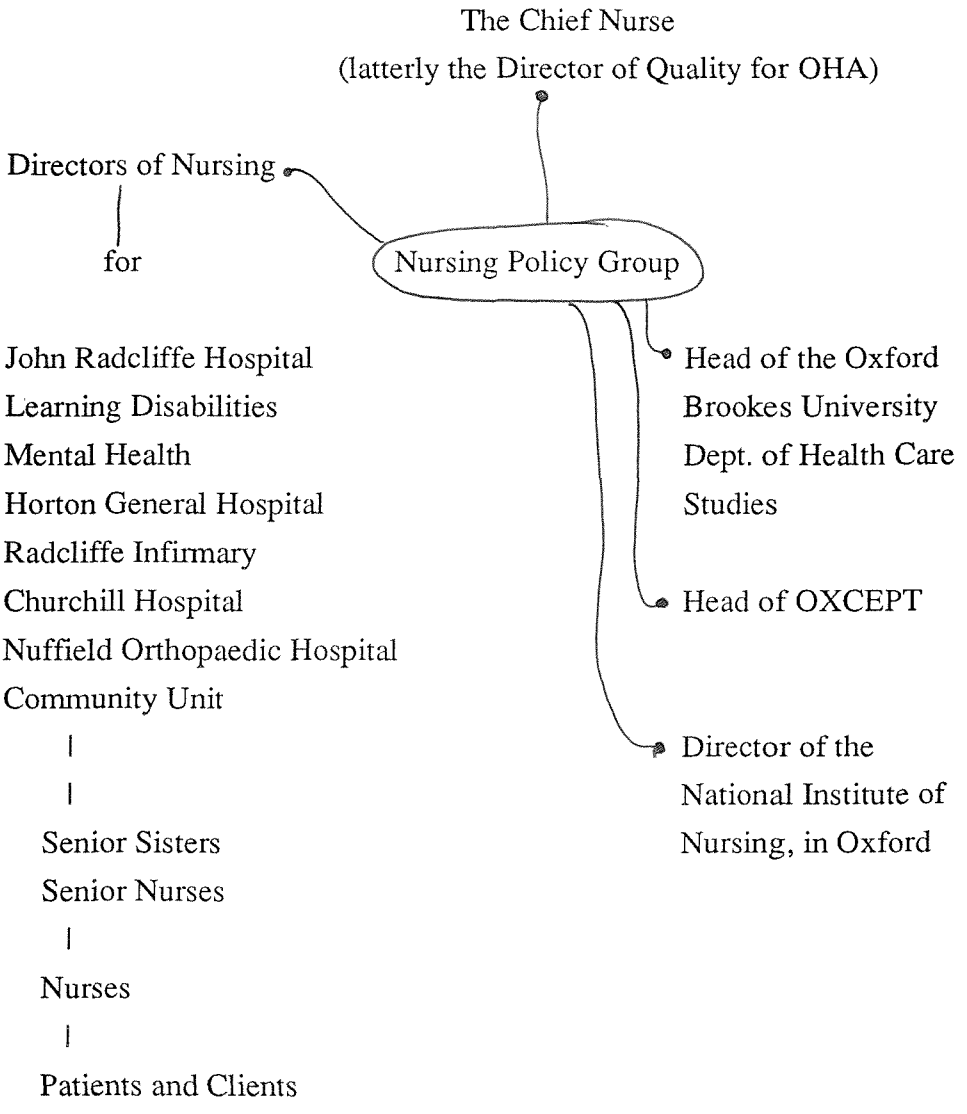
The ethical notion of truth is one that was especially important as Guba and Lincoln (1981) suggest oversimplification, exaggeration and a biased personal account may arise in a case study. Auditing, was used to help reveal this, but this would not detect author processing, as the evidence was not presented 'raw'. This analysis did, however, in part accommodate the ethical concerns of the method, firstly by ensuring respondents' anonymity, and secondly by offering a clear invitation to respondents to withdraw any potentially damaging material from the research report.

DATA COLLECTION SCHEDULE

The emergent design of the case study necessitated a return to the proposal and schedule at intervals for a number of reasons. These include: to make amendments, to ensure the purposes of the research were being obtained, to ensure issues raised were explored. The schedule is therefore set out with dates, to indicate the stages which were part of the prolonged engagement that was outlined in the section on the validity of the research.

The setting for all the evidence collection was the Oxfordshire Health Authority's Nursing staff. There are 5,000+ registered nurses employed within the Authority. The organisation might be represented as in Figure 4.

Figure 4 The Nursing Structure of Oxfordshire District Health Authority May 1993



There were five main contributors to the nursing management group in Oxfordshire, the Nursing Policy Group (NPG). These were:

The Directors of Nursing (Chief or Executive Nurses) for each Unit / NHS Trust

The Chief Nurse (latterly Director of Quality, OHA)

The Head of Health Care Studies, the Oxford Brookes University

The Head of Oxfordshire Clinical Education and Practice Team OXCEPT (the author of the research)

The Director of the National Institute of Nursing, based in Oxford.

To generate the evidence for this research, nurses from across the whole Health District were chosen as follows:

METHODOLOGY PILOT

To provide a pilot of the evidence-gathering method a pilot set of interviews were conducted during July and August 1993, using colleagues who had expressed an interest in the research. These were a convenience sample of ten nurses from within Oxfordshire, who had responded to an advertisement in The OXCEPT News (Summer 1993). This sample provided a broad range from across the specialities and the grades of nurses in Oxfordshire.

MAIN SAMPLE

The methodology pilot sample assured me of the effectiveness and efficiency of the methodology to generate legitimate evidence. I therefore decided to extend the number of respondents in two ways to give the case study breadth.

Selected sample: To ensure the sample within the case study was representative of the population of nurses in Oxfordshire, I invited a further eight individual nurses to broaden the sample. I was cautious not to use the term 'interview', as this had shown itself to have a proleptic effect during previous research I had conducted (Northcott 1988). If the word 'interview' was used, an expectation to answer questions prevailed, whereas if the word was deliberately excluded, a more conversational and interviewee-led session occurred.

Random sample: To provide the triangulation mentioned earlier on page 59, of the information from the volunteers with that of my selected sample, I elected to interview seven more individual nurses chosen at random. To achieve this I asked the personnel department of each of the seven Trusts to provide me with the name of their 58th member of staff on the pay-roll. One of the Trusts did not respond to this request.

The three sampling techniques, volunteers, chosen, and random, fit within the descriptions of samples found in (Merriam 1988), and formed the "purposive sample" she describes. The sample based on probability was "purposeful" (Patton 1980) and included nurses in part for their perceived ability to contribute to the study.

The size of the sample had been a concern to me at the outset as I was unsure how many respondents I should try and interview. However given the stance I adopted

towards generalisation as a naturalistic activity, I felt the sample size should be governed by the notion of diminishing returns. The purpose of the sample was not to satisfy some preset determinant, but to maximize information. It was therefore ended when the evidence stream dried ("informational redundancy", Lincoln and Guba (1985)) and not to reflect statistical confidence.

AUDITING OF THE STUDY EVIDENCE

To ensure the accuracy of the evidence provided by the sample, a number of auditing activities were undertaken. The first by the use of identified Auditors, the second by way of Peer Debriefing, and the third by Group Sessions. This evidence is presented in chapter 5, Map 5.

Auditors Several colleagues were asked to become auditors of the study; one worked as an academic consultant, the other four were professional colleagues. The former gave invaluable assistance in the methodology and presentation of the study. The latter, senior nurses in the District, provided an overview of the organisation and its nursing to validate the nursing perspective presented in the study.

At the end of each year the accumulated work was offered to the four peers to consider. A current draft of the research was sent to them two weeks before a two hour meeting organised to explore their views. The results of these three meetings are presented in the data section of this research.

Peer Debriefing The Clinical Practice Development Team (OXCEPT) were used to provide peer debriefing of the research. Again, at the end of each year's work, a draft of the research was circulated to the seven colleagues in the team with an invitation to offer comments in writing. No indication of expectation with regard to positive or negative comments was given, only an invitation to offer feedback or comments on the draft. The information provided by these three sessions is presented in the data section of this research (Chapter 5, Map 5)

Group Sessions Each interviewee was sent a copy of their own map, as well as the composite map of the evidence. Their responses to these were recorded. I also ran 2 group sessions in the summer of 1994 to which they were invited. At these sessions, the findings of the research to date were presented for comment. The information gathered at these sessions is presented in the data section (Chapter 5, Map 3).

The total sample that generated the evidence for the research was:

Personal interviews	
Methodology pilot	10 nurses
Main study	
Selected	8 nurses
Random	6 nurses
Group sessions	
Peer debriefing activity	3 sessions
Group feedback	2 sessions
Auditing	3 sessions

The interviews (conversations) were conducted as set out in this chapter; they all explored the questions set out at the beginning of the chapter. Other questions were inductively added as the research progressed, along with issues the participants raised.

The full sample of nurses that provided personal evidence could also be represented as follows.

By Qualification	
Registered Children's nurse	1
Registered General nurse	13
Registered Midwife	3
Registered Mental nurse	2
Registered Mental Handicap nurse	4
Registered Health Visitor	1
By position	
Clinical (D & E grades)	7
Clinical / managerial (F grade)	7
Managerial (G,H & I grade)	7
Senior nurses (above grade I)	3
By gender	
Male	2
Female	22
By work location	
Hospital	16
Community	8

This information is provided in order to give details of the sample, not to explain or in any way justify the sample or the findings.

PART 2
CHAPTER 5
EXPERIENCES OF APPRAISAL: 'MAPPING' THE TERRITORY,

5:0 INTRODUCTION

The particular need for a recursive and dynamic approach led, as argued in Chapter 4 to the use of a case study to provide in-depth understanding within a focused area. The use of such concepts as "fittingness" (Guba and Lincoln 1981), "extrapolation" (Cronbach 1975) and "naturalistic generalisation" (Guba and Lincoln 1981) were used to ensure the validity, integrity and utility of the study. The onus in the perspective I have adopted is on the reader to establish for themselves individually the value of the research to other contexts. The data collection was flexible, as described in Chapter 4 and an on-going analysis mediated by cognitive mapping ensured that the purposive sample of 24 nurses generated rigorous evidence about appraisal and professional fulfilment for nurses.

This undertaking quite clearly is one for which a map would prove invaluable. Years of experience and observations as a nurse had led me to believe that an accurate map of the appraisal activity for nurses either did not exist, or was extremely elusive, or that, though many maps existed, none of them were accurate! My own experience of appraisal as a nurse and professional educator revealed a dearth of activity in the area of appraisal, both in Oxfordshire and within the profession at large, but threw no light on why this was the case.

The research process by which new knowledge and understanding is obtained seemed to be the ideal means to set that situation right and construct such a map. I had come across the quotation, "the map is not the territory", by O'Connor and Seymour (1990:24) prior to undertaking my research, and considered it particularly significant as I had elected to use "cognitive mapping" (Jones 1985) as a data-analysis technique.

I was interested to find out what value a map would be if one existed, and whether producing one would be a useful activity to help nurses explore appraisal. A map, after all, is selective, with a particular purpose and with some information deliberately left out to ensure it is usable and not too cluttered. It needs to accurately represent the key features, but also to leave open the opportunity for the 'traveller' to explore for themselves. I undertook the research with that in mind. I would create a map, our map (the participants' and mine), and it would include both the good and the bad features

of the territory. I would be both cartographer and one of the surveyors, with the majority of the survey information arising from the colleagues who assisted me by providing (through interviews) most of the evidence for the research. Given the amount of evidence from the nurses that helped generate the maps, I was confident the research could serve as a guide for others but not spoil for them the pleasure of their own exploration and discovery.

The research methodology was founded on a serendipidous idiosyncratic inductive mode and was, from the outset, a journey to reveal theory, not one to prove it. The case study of nurses from one Health Authority in Oxfordshire provided a snap-shot that allowed me to describe the territory by means of a map. However, I make no claims that this is a definitive map. A map is not the territory, just as this research is not the complete picture. That being the case, readers of this research are invited to explore the territory, but not necessarily reach the same conclusions. However, it is my belief that the maps and evidence presented in the research will provide a number of important sign-posts and recommended routes for colleagues so as to ensure that their explorations of the world of appraisal and its relationship to professional fulfilment for nurses are fruitful.

This chapter of evidence is built upon five maps that I generated during the process of this research and that represent the tape-recorded evidence that I have retained. In parts of this chapter I have included thoughts and ideas that occurred to me as I set out the evidence contained on the maps. These are presented as COMMENTS at the end of some of the themes and sub-themes.

The five maps that emerged were:

Map 1 The macro map, which is a summary of the full map. It contains evidence from the participants, and represents the 24 individual maps that were the result of 'conversations' that were conducted with colleagues. It was used to generate sections 5.1-5.9 in this chapter and is include as Figure 5. It must be stressed that as a summary map, it is unusually tidy, and much smaller than the original, which again I have retained. It comes first in order to reflect the primary importance of the evidence provided by the nurses in the case study.

Map 2 The interview process map contains the responses and feelings that I collected as the process of evidence-gathering proceeded. It is included as Appendix II, and was used to create section 5.10 in this chapter.

Map 3 The group's feedback map arose from two sessions held to allow the 24 respondents to reply to the 'macro map', and is included as Appendix III. It was used to create section 5.11 in this chapter.

Map 4 The diary and reflexive map is of data generated from the reflective and reflexive activities. This is included as Figure 6 and was used to create section 5.12 in this chapter.

Map 5 The peer debriefing map is of data arising from sessions held with peers as a check on rigour and validity. This is included as Appendix IV and was used to create section 5.13 in this chapter.

These five maps provided three sources of evidence that I collected and contributed to, as follows:

Primary evidence that arose by way of maps No.1 and No.3
evidence of the rigour and validity of the research from map No.5
evidence from the reflective maps that I generated as the research was in progress, Nos. 2 and 4.

It must, however, be stressed that for reasons of confidentiality no individual maps are presented either in the text or appendices of this research. They and the audio recordings they originated from are held securely by me.

The process of triangulating the literature on appraisal, the five maps and my own ideas and experiences are distiled here in this evidence chapter of this research, 'Experiences of Appraisal: Mapping the Territory'.

MAP 1 EXPERIENCES OF APPRAISAL

Nine themes emerged from the field work of the research and are displayed on the macro map (Figure 5 between pages 80/81). The process of theme emergence is returned to in section 5.12.5, but was essentially a matter of prominence. Prominence was gained by my immersion in the evidence from all sources and was enhanced by the cognitive approach to mapping. This in conjunction with the reflexivity, reflection and conversations engaged in during the research, facilitated the emergence of themes

FIGURE 5
MACRO MAP - SUMMARY
Aug 1994

APPRAISAL

SUPERVISION 10f
Part of Mid-Justice
- Supportive
- Unsupportive
+ to examine practice + goals
+ Mutual activity
+ clinically focussed
+ avoids rut
+ monthly feedback / support
+ support and challenge
+ reflective
+ not heard of it
+ It's in every 6 weeks
+ Part of I:P
+ mystique associated
+ sets new challenges
+ Professional appraisal
+ explore sensitive issues
+ vital for growth
+ good interview question
+ encourages reflection
+ can't happen until trust / criticism difficult
+ allows dysfunct practice
+ introduces evaluation
+ Political practice
+ help you learn - questi practice
+ monitor competence
+ safeguards autonomy / accountability
+ addresses frustration
+ answers standard / consistency
+ quality assurance
+ Patients are vulnerable
+ helps enthusiasm - potential
+ accomodates change

Professional Impact of Appraisal 10e

Mentorship. Preceptor 10B
+ informal/informal appraisal
+ same idea
+ open minded
+ appraisal
+ similar to IPR
+ same as appraisal
+ fill gaps in training
+ 2 way

Patient Care 10a
+ vital focus
+ improve
+ no effect
+ vital element

PROFESSIONAL

PRP
+ how can you measure what can't see how
+ appraisal plus
+ damage appraisal
+ negative effect
+ goal bonus — team Performance
+ separate — individual
+ frightening
+ off days!
+ risky.
+ damage morale
+ important to link Pay / Perf

Records
+ holding notes
+ learning contract
+ written
+ Profile / Portfolio
+ P.D. plan
+ reflective diary
+ confidential.

How
+ role based evaluation
+ goal setting
+ Constructive feedback
+ learning contract
+ simple format
+ Dialogue
+ informal and formal
+ honest
+ Professional growth / control
+ flexible
+ regular
+ agreed

Desired Scheme 9

What 9a
+ Team
+ Individual / goals
+ Reflections
+ Critical incidents
+ work experiences
+ Conflict
+ clinical Performance

When 9c
+ Biannual
+ regular — monthly annual
+ Daily
+ staff frustrated
+ dynamic
+ mutually agreed

Time 9b
+ ayear to introduce
+ Priority
+ commitment

Who of 9e
+ individual
+ team
+ effect.

By Who 9d
+ Self
+ Peers
+ subordinates
+ others
+ clients

Mode
Should be
- available
- unambiguous
- agreed
- established

Informal
Peer
Day to day help problem
Remain unreviewable

How 6

Numbers 8bi
1.10 +
1.60 +
1.30 +
1.6 +

Relationships 8bii

INDIVIDUALS 8biii
+ relationship
+ open minded
+ respect
+ democratic
+ dialogue
+ Private
+ had to tell boss for it
+ Year like / love
+ planning important
+ interest / genuine
+ extension from scheme
+ regard
+ 2 way exchange
+ honest / open
+ Priority
+ skill based
+ time available / committed
+ realistic
+ skills needed
+ assertive / self aware
+ consensus scheme

ORGANIZATION 8biii
+ Flattened hierachy
+ respect
+ agreed — standards
+ local schemes
+ encourage
+ judgement not control
+ variable
+ avoid burn out
+ clear goals
+ fear of future
+ input to/from
+ seen as input
+ not relevant
+ a chore
+ needs ability
+ time out to establish
+ culture
+ Key to development
+ staff cooled
+ honest / open

Training to 7a
+ 2 days theory / none on Practice
+ standard setting
+ don't know
+ is there any?
+ only to give feedback
+ self taught - reading
+ trial and error
+ jointly at first
+ sitting in
+ not all staff have skills

Training for 7b
+ none
+ role model
+ handout
+ 1312
+ library
+ L.P.
+ management course
+ 1/2 day
+ don't go
+ 3 days / supervision
+ 2 / 4 years ago
+ from to form
+ vital
+ learnt from being
+ mentioned on management course
+ study day

Who 6c
+ Self
+ Peers
+ Patients
+ doctors
+ several
+ external
all 3

Experiences

Current Post 6a
+ cascaded goals
+ not a priority
+ no official scheme
+ optional
+ line management
+ hit and miss
+ none, never
+ informal only
+ inadequate
+ min team feedback
+ makes you confident
+ when there's a problem
+ lip service
+ in your time
+ Positive monitoring
+ none - haven't asked / definite requests
+ hard to ask
+ cascade
+ goal focussed

Historical Timing 6B
+ Biannual
+ Not often enough
+ 6 monthly
+ 1/2 hour every 6 months
+ 15 mins in 3 years
+ two weeks notice all afternoon
+ 5-10 mins
+ all positive
+ good scheme
+ fantastic
+ never
+ Poor
+ infrequent
+ cascade - start never started
+ none since training
+ twice in 3 years
+ self assessment only
+ too rigid
+ Planned annually - don't happen
+ not focussed on practice
+ didn't question practice
+ during training - but a farce
+ Bureaucratic
+ Paper work heavy

Records 5
+ none
+ don't know, not sure
+ Portfolio
+ joint held
+ self held
+ 'boss' held
+ learning contracts (aim)
+ evidence of accountability
+ reflective diary
+ agreed
+ open wall
+ access by consent

Access / confidentiality 5a
+ assumed
+ uncertain
+ not sure whose
+ negotiated
+ used for referees

IPR 6d
+ lost over time
+ talk only
+ never heard of
+ unrealistic goals
+ no joint - not followed up
+ no grandparent
+ no impact on practice
+ looked forward away
+ once in 3 years
+ form focussed
+ too rigid / controlling

Definitions 1
+ Evaluation vs Planning
+ Feedback — know and need to know
+ told - right + wrong
+ Praise — not telling off
+ two way
+ objective setting
+ not sure / confused
+ reflection
+ how you're doing / how you feel
+ informal get together / with more senior
+ hostile term - need new one.

"The phrase appraisal means different things to different people"

Purpose 3
+ monitor
+ sort out problems
+ explore work
+ safeguard accountability / autonomy
+ role clarification
+ links to hire + fire - or not
+ career planning - needs shortcomings
+ help P.R.P
+ feedback Praise motivate, job satisfaction, invest in staff
+ set goals < own organisation — new challenges
+ coming from — going to
+ two way learning
+ encourage reflection
+ Part of quality assurance / standard setting
+ grading — career planning
+ support
+ address conflict
+ control staff
+ change management
+ what you know / need to know
+ sounding board

"I feel lost without it"
"It's not here for me."

Attitudes 2
+ dawning
+ suspicion
+ despair
+ negative — unfortunately
+ threat, scared
+ Painful
+ embarrassing
+ tearful
+ worried, nervous
+ intimidated
+ resistance
+ limited value
+ infrequent
+ Critical
+ Punitive
+ tonight - looked forward to
+ Positive
+ not sure I am
+ invaluable
+ Controlling
+ unnecessary
+ irrelevant
+ too busy for
+ Boosted esteem

Appraisal of 4
+ Self — Person and Performance
+ against objectives
+ Reward philosophy
+ boss set goals / or with / negotiated
+ my goals
+ job description — (3 years old) up to date

NIGEL NORTHCOTT
©

by virtue of the prominence. The themes were created by me. They were subject to ratification by the respondents and auditors who were sent them for comment.

The evidence is presented here using the macro map as a framework, with the indigenous typology that emerged on the map describing and classifying the evidence. Equal weighting is given to all the responses since they are actual perceptions of the individuals. None of the evidence in this research is set out in a particular order. It does not represent the sequence of theme emergence or any prioritisation on my part. The order of theme emergence was unique to each interview, and arose either spontaneously from the respondent or by my invitation. Extensive anonymised quotations, set out in bold text, are used to illustrate the participants views and to preserve individual confidentiality. No attempt has been made to quantify precisely the evidence, other than in general terms such as 'most', 'the majority' etc. to provide some indication of how opinions were divided. This is how it was. No attempt has been made to resolve any contradictions or reduce the diversity. There are occasions when evidence is repeated in more than one theme, as it did not always fit neatly into separate sections. There are also many contradictions within the evidence as a whole, and indeed on occasions the views of respondents were diametrically opposed to each other.

Following a number of the themes, I have included comments that reflect either my own attitudes, or further interpretation of the evidence by me. The nine themes that arose were;

5.1 Experiences of appraisal
5.2 Definition of appraisal
5.3 Purpose of appraisal
5.4 Attitudes to appraisal
5.5 Records keeping
5.6 Training and appraisal
5.7 Interpersonal dynamics
5.8 Professional issues
5.9 Desired scheme

Experiences of Appraisal (5.1) is examined first given its historical nature and Desired Scheme (5.9) concludes the section given its intentional nature. The other seven themes are explored as they are presented on the map (Figure 5) from their

approximate clockwise position. This is done for convenience, and the numbering used corresponds to the original map.

5.1 THEME 1: EXPERIENCES OF APPRAISAL

The first theme that emerged was experiences of appraisal, which is presented as five sub-themes.

5.1.1 What was appraised This was mapped out as the first part of the evidence that was offered; it reported on current and previous experiences of appraisal. The majority of the participants suggested that appraisal was against goals/objectives set for the job. Where the goals had originated was highly variable. Ward, unit, boss, organisation and individually established goals were all mentioned, as were goals negotiated from multiple sources, although at times conflict over these had not been comfortably resolved. It was also stated that at times the goals were not overt: for example, **"Grass roots staff are kept in the dark"** was one reply to a question about the goals of the appraisal that illustrates this.

Alternatively, or on occasions simultaneously, appraisal was based upon the job description, indicated by **"It can't be done without a valid job description"**. There was clear agreement that job descriptions were important in assessing performance, but that they were often inaccurate, out of date or unavailable: **"My current job description is 13 years old!"** was not an unexpected or exceptional comment.

The separation of the individual's performance from that of the team also raised concern. One nurse suggested that self and boss assessment of individual and team effort should be made against agreed goals and the current practice of the nurse. This approach indicated a very comprehensive view of appraisal, but was exceptional in its complexity and perceived value. The use of such a creative approach as this and many of the suggestions about what should be appraised were idealistic proposals rather than reports of the reality. This is returned to later (Theme 5.9).

Next are the individual experiences of appraisal that were reported. These were clearly distinguished into the current post and previous posts, and the rest of this theme is subdivided accordingly. The evidence that readily fitted together, whether it was experience of the previous week or of 20 years ago, related to the time between appraisals and the time set aside for them.

5.1.2 Time Factors The time between appraisals ranged from never, **"I've never had one"** to formally every three months and **"with provision for more upon request"**. The majority opinion was of dissatisfaction with regard to frequency: **"only when there's a problem"**, **"only during training as a nurse"**, **"infrequent"**, and **"planned annually but never happened"**, were clear examples of this. Others reported a 3, 6 or 12 monthly appraisal event but that the events were often late or forgotten, e.g. **"the system is biannual, but I've not had one in 6 years"**. The idea of appraisal as an event that can only happen if there is time, or **"we're too busy to do appraisals"**, was seen as an unsatisfactory excuse by the nurses. In summary, **"not often enough"** was the clear message about the frequency of appraisals.

It emerged too that the time set aside varied immensely, from a whole afternoon to 5 minutes when the sister was free. One participant talked of **"their half hour"** every 6 months, but the majority mentioned 15-30 minute time-slots.

Time was not the only area of concern about individual experiences of appraisal, and additional evidence is presented in the sub-themes of Previous posts (5.1.3) and Current experiences (5.1.4).

Each of these is explored from four perspectives; how? what? who? and the attitudes of the participants to the scheme. A separate section (5.1.5) on the IPR system (that in theory is in place for all nurses) is given at the end of this theme.

5.1.3 Previous posts How appraisal had worked for the participants in their previous posts might well be summed up under two general experiences: it ground to a halt and in principle it was a cascade system, which often didn't get off the ground. The cascade had often started at the top of the organisation, with the Director of Nursing, and was experienced by the individual via a number of nurses in the hierarchy. It was rarely reported to have reached nurses in clinical roles, **"at the workface"**, having petered out before that level in the organisation. For one nurse it was only a self-assessment, but for the majority it was a system initiated and managed by their 'boss'. Too often it was seen as telling off or criticism.

The content was also the subject of concern to the participants, as it seldom related to practice, and for some it was a purely bureaucratic exercise that was **"paper heavy"**, with no practical value or impact. The attitudes of the nurses who could recall appraisal in previous posts often viewed it as, **"inflexible, too rigid and lots of forms"**, and **"I never got anything from it"**. There were several participants who

had used their experience of appraisal to mould the activity in their present post, and indeed a couple who had been part of a scheme that had met their needs and who said it had worked well.

5.1.4 The current experience How their current scheme operated, if there was one, was again highly variable. The use of a cascade, particularly of goals to be met, was mentioned. "**Informal chats**" and "**no official scheme**" were seen as only a small improvement from no scheme at all, and for one nurse this was despite repeated requests. However, the attitude to goals was not always favourable: "**A goal-centred system of appraisal may be limited to those goals**". This clearly highlighted the difficulty of summarising the performance of a nurse into a small number of goals, which, for this nurse, was an annual occurrence.

Praise was given to schemes that were flexible and allowed individuals to negotiate what was relevant to their performance management. More often the goal-based systems were seen to be unrelated to practice: "**Its only setting objectives; it's only a plan that doesn't affect practice**". This approach, it was suggested, ran the risk of leading to complacency. Schemes that were able to identify problems and ensure the training to meet them were applauded, yet some such schemes were felt to be too positive. Appraisal that lacked sufficient critical feedback or that created no new goals would not encourage the nurse to develop their practice.

There was mention of a range of possible contributors to appraisal, including review by peers, external assessors, patients, doctors and a mini-team feedback session. Innovative approaches such as positive monitoring and multiple rating were mentioned. But for the main part "**boss-down appraisal**" was used.

The variation of approaches to appraisal brought an equally wide range of attitudes, from delight, "**It's brilliant!**" to inadequacy: "**We're always waiting for it to start**" and "**directives from 'god'**" are clear examples of the disillusion and antagonism provoked by unhelpful schemes. This was in contrast to the view that a good scheme was able to have a positive affect on both individuals and the whole workplace. However, some of the nurses indicated that lip-service was paid to appraisal as something that had to be done; but there were no sanctions for not bothering. For too many there was little perceived value in appraisal and I would conclude that, with notable exceptions, there was marked apathy and uncertainty towards present appraisal. This is summed up by "**I suppose IPR is an appraisal system?**" This rhetorical question not only gives voice to the desire for an effective system but also

identifies my final sub-theme, IPR, the dedicated appraisal system for the NHS, including nurses.

5.1.5 Individualised Performance Review (IPR) was dismissed out of hand by some participants for its perceived preoccupation with goal-setting, and its lack of impact on practice. Significantly, it had not even been heard of by a number of the respondents.

It was also clear that the IPR scheme had not been applied as set out by the NHS(TA). The equity assessor (the 'grandparent' in the scheme) was not always used and time spans of 2, 3 and more years were mentioned between the 'annual' events. It was also felt to be restrictive and rigid. Two reports were made of local modifications but these were not felt to be successful: the time-spans between contact were again too long or it was not seen as a priority. There were suggestions that it **"fails, because it only looks forward"** with no place for reflection on practice, although this is open to the interpretation of the appraiser. It might, however, be an indication of the training and competence of staff to use IPR rather than an integral design weakness. The training for IPR was reported to be off-the-job, which failed to equip the nurses with the skill or confidence to utilise the scheme. The implementation of IPR was often by a cascade that **"fizzled out before it reached clinical nurses"**. The literature had suggested IPR was not well utilised, but I was surprised at the limited knowledge about the scheme and the degree of apathy from those who had used it, or been exposed to it.

5.2 THEME 2: DEFINITION OF APPRAISAL

The attempts to define appraisal and the allied terms such as performance review, supervision, IPR and performance management, generated much uncertainty and contradiction amongst the participants. This paralleled the confusion or lack of clarity encountered in the literature. **"The term appraisal means different things to different people"** and **"I'm confused about the terms"** are comments from two respondents, indicating the difficulty they have in defining the terms. However, the statement **"no one knows what it is, or how to do it"** suggests that this difficulty may not be restricted to individuals. There were even suggestions that these terms needed to be replaced because of this confusion, along with ensuring that expectation and comprehension were uniform. The calls for a new term were also raised in association with concerns about the process of appraisal: **"...connotations of testing - needs a new term"**. Statements such as **"I suppose IPR is appraisal"**, and

"appraisal is an unknown quantity" illustrate the confusion and difficulty the respondents had with defining the process of appraisal.

The apparent lack of consensus on the meaning from the respondents echoed the situation I had discovered in the literature. This illustrates the problem with all concepts, that of individual interpretation. The effect this lack of consensus has upon the impact of appraisal as a means of enhancing performance is clear. The stated views of participants were that appraisal is to set objectives, to focus on praise, to get feedback, to be told what is wrong - or all of these, or some of them! The importance of praise was commonly mentioned, as opposed to **"being told off"**, which was either not raised at all or challenged as inappropriate. Negative and potentially destructive approaches were seen to be a legitimate part of the activity by only a few respondents. These were always qualified by statements questioning the appropriateness and potentially damaging effect this might have.

The comment **"appraisal is where evaluation meets planning"** offered a useful summary of the views of a number of the respondents. The notion of a process was the vital ingredient for many, of an activity that was intended to determine, with the help of a colleague (most often senior), where the individual was and where they might aim for in their professional career. The idea of an opportunity to explore current work as a starting point for planning professional progression was well stated, as was the desire for this to happen. A two-way process was suggested to allow both parties to benefit, but it was appreciated this would be difficult without a clear purpose and intent in mind.

In conclusion, for many of the 24 nurses in the sample, the term appraisal was one they had heard of, but were unable to define, just as they were unable to discriminate between appraisal and performance review or IPR. The confusion and difficulty I had experienced both personally and from the literature was reinforced by the field work. Many participants either did not offer a definition or were unable to discriminate between the terms, and those who did try to discriminate left me unsure if I was any clearer! Indeed I reconsidered my own views of the terms as a result of the experience of this exploration with fellow nurses. A number of the participants returned to defining terms as the interview proceeded and as their thoughts unravelled. However, when it came to the third theme, the purpose of appraisal, a clearer picture emerged, that at times helped to define appraisal.

5.3 THEME 3: PURPOSE OF APPRAISAL

As with any concept and especially given the emotion of the topic, establishing a universally agreed definition was always going to be difficult. The contextual, cultural and highly personalised influences of the participants were also significant here. Their ability to describe appraisal in terms of its purpose was easier. However, given that their responses reflected their personal experiences, there was unlikely to be one right answer and little chance of consensus. In general terms, the purpose of appraisal might be summed up by, **"I feel lost without it"**. This not only gave an indication of the value and purpose of appraisal, but also indicated the type of feelings that arise for staff who do not get appraisal. **"Stretch, not stress, staff"** and **"development, not control, by management"**, complement the principle of need, by suggesting that the underlying purpose that should govern appraisal was development. The majority of responses gave positive purposes for appraisal, and from the evidence, four kinds of purpose emerged

professional (5.3.1)
sound (5.3.2)
ancillary (5.3.3)
and questionable purposes (5.3.4).

5.3.1 The professional purposes focused upon accountability and autonomy. Comments relating to the vulnerability of patients were given to underline the need for monitoring and feedback on performance as part of the safeguard for an autonomous professional. Indeed this point is addressed again later in this chapter (Theme 5.8 where professionalism is specifically addressed). The setting and maintaining of standards and links to quality assurance were also raised as part of the legitimate professional agenda. It was also in this theme that a spontaneous comment about appraisal by one of the participants confirmed that appraisal was one of the ways to **"...help teach you to be a good nurse"**. If this was what appraisal was doing, I needed to obtain details and to share them with the profession at large, but this was contradicted by the comment **"IPR doesn't improve practice"**. This comment, given in the context of knowing that clinical performance is essential to nursing clearly identifies that IPR was failing in this for some nurses.

5.3.2 The sound purposes were those that the respondents recognised as justifiable and valid. Sound was the term used by one of the respondents to indicate acceptable, good and useful. Sound purposes are presented as sub-themes

Assess training needs (5.3.2.1)
Help planning and set goals (5.3.2.2)

Give feedback and improve performance (5.3.2.3)
Plan promotion and career development (5.3.2.4)

5.3.2.1 The value of assessing training needs was directly mentioned by only a few participants; a large number, however, indicated the usefulness of an opportunity to explore **"where next"**, but only if the **"where from"** was first appreciated. It was also clear from a number of comments that training needs should be generated from the appraisal alongside a clear indication of the organisational needs. For this purpose, a clear job/role description was seen as vital, as was an agreed philosophy of the department and organisation. The phrase **"what you know and what you need to know"** clearly identifies the place of assessing for the training needs. One individual felt that identifying the training needs was not appropriate or satisfactory if there was not the mechanism in place to meet or to respond to those needs.

5.3.2.2 Help planning and goal-setting were linked to identifying and meeting new challenges, whether these arose from the individual, the organisation or both. **"I do think we need planning in our lives"**, **"people need new challenges, new goals"**, and **"where am I now and where am I going - how do I get there?"**, all illustrate the importance the nurses attached to the planning and developmental opportunity of appraisal. Colleagues did specify the need to distinguish between the short and the long term goals, and expressed a strong need to ensure that both individual, organisational and professional goals were addressed.

5.3.2.3 The provision of feedback and improving performance was often raised as a professional purpose, but it was also raised by a large number of participants as an issue in its own right. Comments such as **"they get more out of us, we get more out of them"** and **"others' opinions help you grow"** are a clear indication of the perceived value of appraisal to develop staff. It was, however, also for its absence that feedback was mentioned. **"You wonder how you're doing and no one tells you"**, was a heart-felt plea by a number of participants who felt that **"the sounding board"**, the **"praise"**, **"encouragement"** and **"investment"** that appraisal could offer was missing. The **"support"**, **"appreciation and reflection"** that was central to good appraisal was emphatically stated as essential to improving standards and motivating staff, both by nurses who received it and by those who desired it. The majority of participants concurred with the idea that **"getting no formal thing** (appraisal) **was like working in a tunnel"**. They also reported the opinion that if appraisal was not there to provide feedback this was not only professionally unacceptable but also a source of disappointment and demotivation.

5.3.2.4 The promotional and career planning benefits of appraisal were identified. It was recognised that appraisal was able to both indicate suitability for promotion and to indicate potential career options and opportunities. It was, however, in the area of indicating potential for promotions and perceived value of the individual nurse to the organisation that some of the more questionable purposes of appraisal (explored in 5.3.4) were raised by a few of the sample.

COMMENT The sound purposes reinforced the view that appraisal could and should have a central role in the development and accountability of nurses, or at least it has that potential.

5.3.3 The ancillary benefits, while reflecting the developmental potential, also identified **"appreciation"**, **"mutual learning"** and **"helping with interpersonal issues"** as significant spin-offs from the appraisal process. The help appraisal gave to reflective practice and to the elimination of suspicion, enable it to enhance the internal dynamics of the workplace. It was seen as able to facilitate the philosophy of change that is needed as staff face the challenges of the 'new' NHS, and in particular to ensure that a culture of development was in place to facilitate mediation should conflict arise. Development and motivation were key words for many of the participants, and the purpose of appraisal might well be summed up by two telling quotations: **"We don't feel appreciated by management - part of it is because we aren't appraised - you feel so unmotivated 'cause you think - well what's the point - no one appreciates you - except the patients"**, and **"I don't feel appreciated"**. These were highly emotionally stated and gave clear support to the general view that appraisal had a crucial purpose for both the professionalism and the successful management of staff. It must, however, be operated so as to avoid purposes that are not overtly agreed, or that might damage the central potential of appraisal, namely to ensure development.

5.3.4 The questionable purposes that were identified were only raised by a small number of respondents, but are highly significant issues. **"Hire and fire"** issues such as **"indicating downgrading"** and appraisal as a means of **"controlling staff"**, whilst mentioned, were also seen to contradict the main purpose as seen by the clear majority, which was to help develop the staff. The use of appraisal as one of the indicators for promotion was acknowledged as appropriate, but its use for disciplinary purposes was not seen as acceptable. The staff who suggested it might be **"used against them"**, were all adamant that this somewhat questionable purpose should only operate if it was clearly agreed in advance.

The linkage of appraisal to pay levels was another contentious use, with limited support from the respondents. The concept of performance-related pay, of rewarding good performance, was alluded to, but there was no insight as to how it might link with appraisal without effecting the fundamental purpose of developing the staff. The most detrimental impact of the questionable purposes was most frequently related to the impact they might have upon appraisal as a developmental process.

The next theme that follows the emotive statements given by the respondents under the heading questionable purposes, is that of attitudes to appraisal, which drew a wide spectrum of often contradictory views.

5.4 THEME 4: ATTITUDES TO APPRAISAL

The most telling remarks for me in the research were in response to asking the participants to respond to the question "How do you know you are a good nurse?" This question provided a large amount of evidence in a number of themes, but comments such as **"I've never got anything from it"** (appraisal), **"no one ever told me I wasn't"**, and **"I'd feel quite lost without it"** (appraisal), indicate the range of attitudes to appraisal evoked by this simple question. The responses did not all directly answer the question, but do provide useful insight.

The theme presented a diversity of opinions, and five sub-themes emerged from the evidence

- 5.4.1 Apprehension
- 5.4.2 Hostility
- 5.4.3 Enthusiasm
- 5.4.4 Uncertainty
- 5.4.5 and Disappointment,

5.4.1 Apprehension The apprehension that surrounded appraisal was best summed up by the comment **"I've seen staff in tears about appraisal"**. The impact of this experience not only generated concern about future appraisal for these individuals but also for other staff, as they were aware that colleagues had found the experience so traumatic. This unease was not restricted to the one event, but was likely to lead to avoidance of appraisal from there on. Terms like **"suspicious"**, **"daunting"** and **"nervous"** also portrayed the apprehension for staff, which was heightened if the appraisal was sprung upon the nurse. Indeed a number of the participants mentioned avoidance of appraisal by both themselves and their colleagues for fear of it being **"harsh"**, **"demoralising"** or **"unproductive"**, and not assisting in their

development. The lack of perceived benefit from and relevance of the appraisal created apprehension that the exercise was not only pointless but was, on occasions, unnecessarily uncomfortable. Several respondents who were responsible for appraising reported staff being 'absent' or using avoidance techniques when appraisals were due, which they suggested arose from ("**unfounded**") fear of the event. Such apprehension had proved to be groundless for a couple of participants who admitted to having had such feelings, only for the conduct, intention and benefit of subsequent appraisal to be such that their fears proved to be unwarranted. However, for a large number of the participants, the apprehension had been confirmed, and outright hostility to appraisal was voiced.

5.4.2 Hostility The hostility was interestingly qualified by terms such as "**unfortunately**", and "**I've never got anything from it**". The latter was said in a conversation which in general saw great value in appraisal, and I return to this later in the sub-theme of disappointment (5.4.5).

The hostility was identified by words such as "**negative**", "**despair**", "**punitive**", "**threatening**" and "**tearful**", which as descriptions of appraisal indicated the extent of uneasy feelings that appraisal created. Hostility that was described as embarrassing was qualified by one participant with the word "**unfortunately**", indicating concern that such feelings arose, as they perceived appraisal as a positive opportunity. "**Fear**", "**expectation of criticism**" and "**intimidation**" were all used to describe appraisal and helped to explain the resistance that was expressed. Perhaps what was particularly significant to this research was one specific comment, "**IPR doesn't inform me about my practice**", indicating hostility arising not from its perceived unpleasant nature, but from the failure (in their experience of appraisal) to address the focal activity of nurses, namely practice or patient care.

There was also veiled hostility if not distinct disappointment expressed by the nurse who received the first appraisal in four years on her final day in that post. She suggested that "**It's a very valuable thing**". It seemed the manager felt appraisal was a useful way of summarising the nurse's employment, but did not possess the insight to provide appraisal for other than retrospective purposes. The nurse had valued the feedback, but deeply regretted having to wait so long for it, and that it came at a time when she would be unable to address its contents in that post.

COMMENT The emotion and extent of hostility to appraisal expressed by the nurses in this sub-section (5.4.2) surprised me. When I realised how much disappointment

existed I could not understand why there also appeared to be so much apathy, especially as the enthusiasm for appraisal was often from nurses who had secured it for themselves. I had to concede that the fear and apprehension were so great that appraisal was not an activity that nurses would readily bring upon themselves, even if they expected it to be so significant to their professional career. There appeared to be three distinct aspects: appraisal in theory, the actual practices, and the expectations and desires of the nurses. Much of the hostility appeared to arise from the lack of congruity between these.

5.4.3 Enthusiasm The enthusiasm that was expressed was as powerful as had been the hostility, and the word "**terrific**" was not the only one that surprised me. "**Looking forward to**", "**positive**", "**keen**" and "**invaluable**", all provided evidence of the enthusiasm for and therefore the value placed upon appraisal that exists. I did not identify a sub-theme on value - not that it didn't arise, but when it did it was enthusiasm that seemed to be more central. Comments such as, "**It's invaluable for newly qualified staff**", "**It's a very valuable thing**" and "**I was told how wonderful I was**", all indicate both enthusiasm and value. The theme is ideally summed up by the following quotation, "**having regular time to check out performance will massively improve esteem and the work**". However, one comment drew my attention back to the primary question of the research: "**it helps teach you how to be a good nurse**", but this was not repeated. More often enthusiasm towards appraisal was dampened by the uncertainty that surrounded the practice and personal experience for most of the respondents.

5.4.4 Uncertainty The uncertainty on a number of occasions arose from the content of appraisal, especially as this was often not related to the clinical work of the participants. But there was also uncertainty as to whether appraisal had happened. "**I've never really had one**", was mentioned alongside comments such as "**Maybe with appraisal the whole job wouldn't have been so frustrating**". These raise questions about the value of appraisal. However there was also uncertainty that arose for participants who were not receiving appraisal as to the effect it might have had upon their fulfilment: "**I don't really know where to go from here**", "**Everyone thinks they do the job well**" and most poignantly, "**you go to work day-in day-out - you've no idea how you're doing - no one says to you**". This last comment suggests disappointment that arose from the uncertainty of appraisal practices. What was also sought was confirmation of the respondents view of their own performance. Contradictions to this view were also welcome if offered constructively.

5.4.5 Disappointment was summarised by **"It's not there for me"**, and **"the staff desperately want to know how they're doing"**. Perhaps the most telling comment on this theme was **"I've had two appraisals in 30 years, one was chaos, and I can't remember much about the event, and the second was disrupted by interruptions"**. These examples of quite profound disappointment, are reflected in a number of similar comments. **"It's never a priority, for most people; it's a bit of a chore"**. The disappointment felt was summarised in the quotation: **"Getting no formal feedback was like working in a tunnel"** - a comment that might also question the whole appropriateness of autonomy in nursing as a profession unless appraisal is in place.

5.5 THEME 5: RECORD KEEPING

The record keeping on the whole related to the current experience. Here again the range of responses was great. The use of a professional portfolio was mentioned, which reflects very contemporaneous thinking, but more often records were goal-related. Further examples of dynamic records of performance feedback, such as reflective diaries and personal learning contracts, were also mentioned.

I was concerned that some participants were not aware of any records being kept, and others had not seen them. **"I'm not sure my boss has a record"** exemplified this. The confidentiality of the records was also open to question, with **"not sure"**, **"assumed"** and **"unless negotiated"** indicating a interesting range. Several believed that the appraisal record would be used for creating a reference and most assumed the record was confidential to them and their line manager. Two nurses imagined more senior staff could gain un-agreed access, and one clearly was not at ease with the access to their written record of appraisal: **"I've removed mine from the filing cabinet, it was unfair and I disagreed with it"**. This nurse was particularly concerned that her appraisal records were not confidentially held. Many of the nurses were unsure who might have access, and **"I'd certainly like the records to be confidential; I'm not sure they are"** indicates this point. Frequently the records were reported to be jointly held or if in a portfolio only held by the individual. In this case they were also seen as evidence of professional accountability, but for the most part it wasn't clear to the nurses why records were kept.

On the whole the topic of records was one that brought a number of questions to me from the participants about what was done elsewhere, as well as seeking to clarify the legal requirements. What was evident, especially when the participants speculated on desired schemes, was the need to sort out what records should be kept, who should

have access to them, and the purpose the records of performance should serve. It was also apparent that a number of the participants had not considered this issue at all. When I enquired about training and appraisal (theme 6, below) I unravelled part of the reason for the difficulties with record keeping.

5.6 THEME 6: TRAINING AND APPRAISAL

The preparation of nurses for appraisal emerged as two distinct activities - training for doing appraisals and training for being appraised. Not all the respondents were involved in undertaking appraisal of others and I was therefore not too surprised at the paucity of information that emerged about this. However, in part, difficulty arose because consensus about what constitutes appraisal had not been achieved.

5.6.1 Training for doing appraisals was prefaced by a distinct comment, that was not however underpinned by additional evidence from the sample, but which confirmed a number of views that were clearly related to the necessity of training. The particular comment was **"You need particular skills to make it meaningful"**. This acknowledges the skills required, but, **"I've never really been taught how to do it"** and **"there were no guide-lines"**, suggests that the training to obtain those skills was not happening. **"It's very difficult doing an appraisal when you've never had one"** not only confirms the evidence in Theme 1 (Experiences of Appraisal), it also throws into doubt the likely effectiveness of some of the appraisers. One went so far as to ask if there was training, and a number referred to being **"self-taught"**, which included **"using a book"** and **"trial and error"**. The training that was undertaken was most often from their own appraiser, who 'taught' individuals to appraise their own team, often by a **"sitting-in"** approach, until confident. Attendance at a course was also mentioned, but it was criticised for being too focused upon the theory; no training on the practical skills was reported. The belief that not all staff have the skills to be appraisers was aired, but the importance given to training did not bear this out. The reasons for this seemed to relate more to availability of 'courses' than to enthusiasm to attend them, a view echoed in the training for being appraised.

5.6.2 Training for being appraised was a similarly uncertain process yet was stressed to be vitally important. The variations of attitude and approach ranged from **"I learnt from an excellent team leader when I was an E grade"**, and **" module 1312 made me realise I wasn't well prepared"**, to **"it was difficult at first without any training"**. The majority expressed a view based loosely upon **"learnt from being"** (appraised), with mention of **"lecture practitioners"**, **"management**

courses", "**a handout**", "**books**", together with "**full**" and "**half study days**". The comments also included "**a single day - why? - the purpose? - how to? - IPR's, to set goals**", but this had been two and a half years ago and could not be readily recalled. Attendance at a 3-day workshop on supervision was mentioned as good training for appraisal, and indicated as a more professional alternative to appraisal. However, it was once again the absence or poor quality of preparation that seemed to dominate, despite the well-accepted view "**It's vital to get training for this**".

5.7 THEME 7: INTERPERSONAL DYNAMICS

There were four broad sub-themes of the interpersonal dynamics of appraisal that emerged. They were;

Enhancing features 5.7.1
Inhibiting features 5.7.2
Organisational culture 5.7.3
Interpersonal relationships 5.7.4

5.7.1 Enhancing factors The first of these examines the dynamics between appraised and appraiser that enhance the appraisal process. These were raised in some way by all the respondents, none so clearly as, "**appraisal and the like is dependent upon the right relationship**", and perhaps most significantly, "**staff appreciate having an interest shown in them**". The strength of feeling about such interest and its tone was demonstrated by the use of words such as "**trust**", "**dialogue**", "**privacy**", "**regard**", "**respect**" and "**genuine interest**". These characteristics of the relationship were all reported to be beneficial and helped ensure the effectiveness of appraisal.

There were a number of respondents who offered ways of enhancing appraisal which might counter their own negative and critical experiences, and these are focused upon in Theme 5.9, where such desired schemes are reported. Regardless of its perceived value, it was clearly stated that the presence of an appraisal scheme, and the fact that energy was committed to try and provide feedback, was itself seen as a factor that would help ensure success. Indeed having to request appraisal when no scheme appeared to operate was a reason for its limited success.

There was acceptance that initiating the event was a joint responsibility. The establishment of the process and the organisational culture to set aside time were factors that would demonstrate the commitment of the organisation. It was felt that attitudes towards and even the enthusiasm of staff to initiate appraisal would increase

if the process was a true representation of a support hierarchy. The need to ensure that the rhetoric of a support hierarchy was enacted was crucial, as any perceived shift from this in practice lead to uncertainty and reluctance to partake. The need for appraisers to reflect the stated organisational culture was one of a number of examples where a need for theory and practice to be in harmony was expressed. Others examples included **"confidentiality"**, **"intention"** and **"commitment to the process"**. The tone of the individual appraisal was significantly attributed to the appraisers, and it was clear their individual approach and attitude to appraisal was pivotal to success. The genuine interest of the appraiser in operating the scheme in a collaborative way that concentrated upon a two way dialogue, was seen as crucial. This would ensure goals and objectives were negotiated and realistic, and based upon an honest and agreed evaluation of performance. The use of a democratic approach, in which dialogue was evident, reflected the intention to develop the staff and not the alternative, to control them. The processes of judgement adopted should reflect professional values and not purely those of a bureaucracy.

This sub-theme has been reported elsewhere, in part in the themes on desired schemes (Theme 5.9) and attitudes to appraisal (Theme 5.4), with one overriding notion arising. The respondents wanted appraisal for both personal and professional developmental reasons. They felt the responsibility for establishing a scheme with a culture to enhance and develop staff lay with management. This would tap into the genuine desire of the staff to gain insight into their effectiveness as professionals.

5.7.2 Inhibiting factors In contrast to the clear views of how appraisal could and does work, there was significant evidence that drew attention to the factors that inhibited the activity. Invitation to appraisal by way of the phrase, **"can I have a word with you"** or **"we must do your appraisal"**, conjured up the frequently reported feeling of **"what have I done wrong"**. This expectation and the idea that nurses are **"in-bred not to praise"**, and **"nurses can be horrid to each other"**, establishes an expectation of appraisal that is severely inhibiting. The expectation of attack and criticism was clearly stated by **"if people are going to give you feedback on what you're doing, then they'll pick on the negative things"**. An attitude of negativity it was suggested might establish a degree of self-fulfilling prophecy. Comments such as **"controlling"**, **"summoned"**, **"fear"**, **"uncomfortable"** and **"a chore"** also risk this. **"It felt like a control"** was the tone of appraisal that operated in an organisation that would, **"if I was doing a bad job, tell me"**. This comment not only indicated they only got negative feedback, but that this approach was unacceptable and inhibited the process itself.

There was evidence of specific fears about appraisal being used for hire and fire (Theme 5.3.4.) and as part of performance-related pay and the detrimental effect this might have. It was a strongly voiced opinion that the purpose, intent and culture were vital elements in preventing the negative view of appraisal. The respondents were more vocal about the positive behaviours that enhance appraisal, and comments were frequently made that offered positive approaches to counter negative experiences. The term 'unfortunately' frequently preceded criticisms such as **"hurried"**, **"controlling"** and **"non-existent"**; and the expression **"stressed not stretched"**, offered a concise summary of the negative feelings. The accepted need and indeed enthusiasm for appraisal to stretch the staff, and to serve both the staff and the organisation well, was clearly stated. It was, however, more often that this was suggested to replace a scheme that generated stress by being threatening, inconsistent and focused upon control, than because it was in place.

5.7.3 Organisational Culture The organisational culture was identified by most respondents as a key feature to the likely success of the appraisal scheme. The cultural aspects were considered as organisational, departmental or even of the small team; the principles in the comments were considered to be universally applicable. There were a number of speculative comments that reflected upon the changes the NHS was undergoing, and how Trusts might change the culture and thereby the practices of performance management. These were no better stated than **"the fears of the new NHS Trusts, that they will affect appraisal"**. This comment was offered against the background that any alteration to the principle that appraisal was a developmental activity would be detrimental to all concerned. It was also a sentiment put forward to some extent in reverse, namely that there were fears that some Trusts might not work to ensure that an equitable means of feedback was in place.

The need for a clear philosophy and agreed process for appraisal was firmly established; as was a clear philosophy for the Trust and the department, along with an accurate up-to-date job description. **"The way IPR was sold in the organisation, I didn't bother with it"** - this is more a reflection on the culture of the organisation than a reflection of the scheme. The phrase **"important but not urgent"** again illustrates the impact of the organisational attitude to appraisal, although the resistance was also seen to emerge from the staff. **"Some people don't want to improve"** was not the view of the majority; some who voiced it added the rider **"if the improvement was dictated and not negotiated"**. It was clear that a supportive, encouraging and essentially development culture within the organisation would do much to ensure the success of appraisal and thereby the success of the organisation.

Appraisal as a collaborative venture operating on broad principles could accommodate both **"I developed in spite of the organisation"**, and **"I'm not really sure if I am a good nurse"**. Fundamentally, the view that **"I'm not sure my appraiser is really interested"** was also a reflection on culture that all the respondents were critical of. The desire to be appraised was seen in the same light as a desire to be recognised and to gain insight into performance. These are both dependent upon the organisational culture.

5.7.4 Interpersonal relationships The final sub-theme acknowledges interpersonal relationships, and raised the issue of the logistics of the appraisal. The quotation **"there are too many of us for it to work"** sums up the concern. Ratios of 1:40 and 1:30 could have precipitated the **"my boss is too busy ... too many staff"** attitude, for appraisal to either work or even be introduced. This also was discussed with regard to the earlier comment of **"important but not urgent"** (Theme 5.7.3). Questions were asked about how genuine was the importance if ways were not thought of to overcome the problem of logistics. Respondents recommended a simple change to a cascade within the grades of nurses, rather than the head of department trying to keep control of all the appraisals. It was also reported as a key to success, where moves to such a team-based appraisal meant no member of staff was responsible for the appraisal of more than six colleagues. This also allowed for the operation of a system where appraisers were also appraised.

The need for time to be allocated for appraisal was raised, with particular dissatisfaction expressed at the five-minute appraisal or one snatched during a free moment. Having the appraisal **"sprung upon"** them gave no time for preparation for the event. This placed the appraised in a vulnerable position and did not lend itself to the possibility of a mutually beneficial exchange. However, it was recognised that there is often a need to evaluate a recent significant practice event, and that this could be the trigger for an appraisal event.

It was equally important that privacy should be afforded and this was evident from comments such as **"it was impossible; we were constantly interrupted"**. It was for this reason that it was suggested the appraisal should take place away from the workplace. There was also the contrary view. Appraisal was considered to be a crucial element of appropriate professional practice and should be accommodated within the working day. If appraisal was truly seen as an important part of work, and was recognised as such by the organisation, time should be identified along with a suitable venue and commitment for it to happen.

COMMENT Theme 7 gave rise to the belief that two types of appraisal were desirable: the planned intermittent event to consider a number of work issues and the spontaneous opportunity to obtain feedback on a significant event. Appraisal was seen very much as a desirable part of the professional life of the nurse, with interpersonal and organisational culture being identified as crucial elements of the process. Time, privacy and a genuine intention for a dialogue to bring about the development of the professional were clearly stated as desirable, but often absent, features.

5.8 THEME 8: PROFESSIONAL ISSUES

A number of sub-themes emerged within the broad theme of professional issues, that reinforced the need and perceived value of appraisal. They also included further suggestions on how to enhance the success of schemes. The importance of appraisal to the concept of professionalism was the subject of a number of comments such as **"If we want to be professionals, we've got to have appraisal"** **"A good ward has an appraisal system"**, and **"Professionally we've got a responsibility - haven't we - to continue to develop?"** One of the respondents went as far as to suggest that appraisal had been the means by which they had become **"aware of professional ability by virtue of the feedback"**.

It was felt that evaluation was not a strong feature of nursing practice and, given the **"vulnerability of patients"**, some means of regular feedback upon performance was essential to ensure standards and quality of care. This would tap into the **"enthusiasm to develop"**, **"help address conflict and frustration"**, as well as **"safeguard professional accountability"**. Personal and professional accountability were both reported to be complex concepts, and any process that provided additional information would be welcomed. It was recognised that quality of care and development of competency was a part of practice dependent upon feedback. The expression **"police practice"** was also used to indicate the need to underpin the autonomy of professionals, but in a comment commending development not control as the mode.

However, there was reference to a more controlling approach, which described the need for appraisal because **"everyone thinks they do the job well"**. This was complemented by the comment **"some people don't want to develop"**. The recognition that there is not always the personal realisation that development, accountability and professionalism are relevant to nursing, was raised as a major concern by a small number of the respondents. There was speculation that this could

be due to the alienation of prior experiences, or indeed the absence of appraisal as a developmental activity.

There was broad acceptance in the evidence that professionalism required commitment and a susceptibility to change. However, comments like **"as far as I was aware, I was working to the best of my ability"**, indicate that not all nurses are aware of this. The comments, **"they'd tell me if I wasn't"** and **"no one ever told me I wasn't"**, were not offered to reinforce the lack of perceived need for appraisal, but as evidence of the profound disappointment that uncertainty about performance standards gives.

It was not always that developmental awareness was lacking, nor that managers were not fulfilling a duty to give feedback, for it was suggested that some managers **"find giving praise difficult"**. There was also concern that appraisal **"might reveal sensitive issues"** that are difficult to explore. This would help to explain the paucity of appraisal for some nurses. Respondents were not surprised that some managers avoided the difficulty of tense interpersonal interactions that might arise during appraisals. These points reinforce the importance of the issues raised in Theme 5.7, about interpersonal dynamics. Changes that had occurred in the legitimate behaviour and relationships of professionals were acknowledged as a potential source of this difficulty. The need for trust, regard and altruism was identified for inter-professional behaviour, as it had been for the relationships with clients/patients.

The importance of appraisal to safeguard professional accountability was clearly stated in the light of concerns that some nurses took on work without **"proper training"**. Appraisal was seen as a very important opportunity to reflect upon performance and learn from experience. This was felt to be particularly important as there exists ambiguity about what actually constitutes good nursing, and insight into this can be obtained during appraisal. It was also indicated that getting to an understanding of good nursing was one of the purposes that appraisal could help address. The use of reflection, to help develop self-awareness, and **"appraisal to underpin autonomy"** were beliefs strongly asserted. Questions about, **"How safe are autonomous practitioners without appraisal"** were asked in the light of the possibility that it could help ensure **"they get more out of work, we get more out of them"**. This notion, which sets appraisal up as an organisational investment, was reinforced by the idea **"if we had more time invested in us, we'd perform better"**.

COMMENT "A good ward has an appraisal system" serves to summarise the evidence offered on the professional significance of appraisal. The conclusion that appraisal occurred on a good ward was not explored in terms of cause and effect. It was, however, clear from the evidence that the activity was an important factor in promoting the quality of care as well as enhancing the practice and satisfaction of the nurses.

There were three additional sub-themes that emerged under the umbrella term professionalism. These were:

Performance-related pay, 5.8.1
Supervision, 5.8.2
Mentorship/preceptorship, 5.8.3.

5.8.1. Performance-Related Pay I was surprised that performance-related pay (PRP) was spontaneously raised by a number of the respondents. On a number of occasions I introduced it into the conversation since recent government announcements and media attention had brought the idea into the spotlight. One respondent initiated a concern that, **"it miffs me that good performance isn't rewarded"**. This idea of additional reward by way of a financial bonus, however, received very limited support within the sample. There were concerns about how the performance of nurses would be measured and how an individual's performance would be separated out.

The effect of performance- related pay on appraisal was a grave concern, and it was clear that it **"would significantly alter the relationship"**. The judgement and comparison involved, and the inevitable quotas and limits set for PRP were seen as challenging the principles that nurses had a desire to develop. This was promoted by their professionalism and their psychological contract. The risks involved in an essentially quantitative evaluation to indicate pay levels was made worse by the difficulty of separating any individual's contribution out from the essentially team-working basis of nursing. The whole **"frightening"** idea raised questions about how to measure care and the nature of the nurse/patient relationship. It was felt managers might well have work that could be broken down into elements that might lend themselves to graduated pay scales, but the essentially qualitative nature of nursing care was more problematic. **"I'd love to know how they'd monitor** (clinical) **performance."**

It was evident there were concerns that until appraisal itself had been fully established, its use for PRP was inappropriate, although it was also suggested that

PRP was a way of ensuring that appraisal occurs. It was further noted that a fully operational appraisal system might eliminate the need for PRP to promote effective and efficient working, particularly as **"it's been shown not to work in other industries"**.

5.8.2 Supervision was a concept that had entered mainstream nursing culture during the period of the research, although it had been in existence for certain nurses for a considerable time. It was introduced into the conversations by a number of the respondents and was seen as highly significant by one of them: **"autonomy without supervision is very frightening"**.

The respondents were clear that supervision should be a more frequent activity than appraisal ('annual'), as it was a more likely activity to generate development, by providing support and challenge. It was felt that having a clear focus upon the actual work of the nurse, it would include the clinical practice that had so significantly been absent from so many nurses' appraisal experiences. It was speculated that the introduction of supervision would be affected by the adverse experiences of appraisal, especially if the lessons of the mandatory and bureaucratic schemes had not been heeded. There was also a clear importance attached to the relationship between the parties along the lines explored in Theme 5.7. It was stressed that the relationship in supervision should be able to address the creation of a collaborative agenda in order to meet the needs identified.

Supervision had been in place for a number of the respondents, whether as a mandatory event (midwives), or as part of the agenda of Investors in People (IiP), or because of professional insight (mental health nurses). However, those that had experienced these schemes did not feel they were universally transferable or necessarily worthwhile. The same principles of development and mutual respect were seen to be vital to facilitating supervision, and the same pitfalls that had been identified for appraisal were also considered applicable. Supervision was needed **"often enough to keep track of new challenges"**, and once established, **"staff would miss it when it didn't happen"**. The frequency of supervision that had been experienced ranged from a monthly to an annual event, with the latter connected to the statutory notification of intent to practice for midwives.

5.8.3 Mentorship/preceptorship Mentorship was not raised by all the respondents. Those who mentioned it, make a case similar to that made in respect to supervision, identifying the same elements as desirable in appraisal. This was particularly so, as

the mentor and preceptor roles are fundamentally about development, although the need to provide summative evaluation for a course of study is also often an element of the current mentor role. There was the same uncertainty about a universal definition of the terms, but one respondent saw it plainly as beneficial to practice. **"I've got a lot more out of the time than I would without a mentor"**, and **"It's very useful to have someone who can be objective"**, give testimony to this.

Mentorship/preceptorship were strategies seen to be more appropriate to education and training and for new staff (as indicated by the UKCC), or as an **"informal appraisal"**, than to on-going professional practice and growth. There was clearly a view that the principles that underpin appraisal should be similar to those for mentorship/preceptors. It was also suggested that appraisal and mentorship/preceptorship might benefit from incorporation into the newly introduced practice of supervision.

COMMENT The difficulty experienced with defining these terms, however, turned the evidence full circle, with the need for unambiguous understanding among the staff. The problems that I had encountered in the literature with the terms appraisal, supervision and performance management, were, I suspect, one of the reasons for the patchy experiences reported in this evidence. I had started the research with an aspiration to gain insight into these terms, and although I felt better informed after undertaking this research, I had no clear view. A number of principles had emerged from the respondents' contributions and it was evident to me that these were more important than clear definitions of the key terms.

The criticisms I had encountered from the respondents were, I felt, an expression of frustration and disappointment as well as concern about their accountability as professionals. The respondent feedback evidence (Theme 5.11) provided an opportunity to check this out. It seemed that full professionalism was unattainable unless an effective means of performance evaluation and feedback was in place.

5.9 THEME 9: DESIRED SCHEMES

The invitation to talk with me about appraisal frequently led to speculation by respondents about schemes and approaches that in their opinion would lead to a more fruitful activity. Aspirations and suggestions were offered by all the respondents including those who felt negative about appraisal and those who were engaged enthusiasts for it. It was evident to me that the respondents not only wished for appraisal, but also believed it could work.

No one scheme emerged. Rather a number of schemes did, along with a number of general principles that were seen to be useful.

The strong messages within this theme were that appraisal should occur for those who currently did not get it, and that it should be improved for those critical of their current experience. **"The staff desperately want to know how they're getting on", "We've always said we need a system of appraisal on the ward"** and **"What we've got isn't working"** were quotes from separate respondents, illustrating the strength of their desire.

The evidence supporting the availability of a scheme of appraisal was underpinned by a number of sub-themes about desired schemes, that emerged from the evidence. These were

What? 5.9.1
By whom? 5.9.2
Of whom? 5.9.3
When? 5.9.4
How much time? 5.9.5
Content and how? 5.9.6 and
Record keeping 5.9.7

5.9.1 What? should be appraised, clearly identified the need for a broader view of the individual's performance than they had been used to in the past. In particular the need to ensure that clinical performance was included for practising nurses was emphasized. There was an acceptance of the need to balance the goals of the organisation with those of the individual, but too often the system was seen purely as a cascade of goals down the hierarchy of the organisation. The individual nurse was identified as a member of a team, or of a number of teams. As well as the individual's performance, their effectiveness and impact within the teams needs to be a feature of performance evaluation. **"Critical incidents", "every-day work experiences"** and **"reflection"** were commended as essential sources of material to inform the agenda of appraisal. These sources having the dual advantage of helping to explore the clinical practice of the nurse and at the same time identifying goals that are closely associated with the core skills of the post. This means of setting goals could be combined with the declared goals of the organisation to allow for a collaborative approach to appraisal. This could ensure development as a broad remit of professional accountability.

5.9.2 By whom? This element identified the need for a wider base than had been experienced, and for this to include the evaluative feedback of peers, clients/patients, self and other staff, as well as the manager. This was not necessarily to ensure a degree of triangulation. Often it was suggested as an indication of the complexity of the nurse's role and the need to generate evidence about performance from a number of the people who the nurse works with and for. Self-appraisal, along the lines of the procedures to explore personal practice identified in the paragraph above (5.9.1: What?), was seen to be a crucial, yet often overlooked, aspect of appraisal. It was, however, emphasized that self-appraisal is an activity that does not imply self-reliance, but is one that is greatly enhanced by a 'helper', such as the appraiser. It also was for this reason that a number of the respondents commended the use of a senior colleague for their expertise with regard to clinical practice.

"It's easier to share emotions with a peer" was regarded as particularly true if the peer had greater knowledge and experience. The opportunity to explore practice in this manner, along with being able to generate feedback from another perspective, was clearly seen to be beneficial. The use of the dimensions of self and peer evaluation of performance was seen as highly desirable, and the benefit could be further enhanced by evidence from other sources. The use of feedback from clients/patients was **"a vital component"**, but obtaining this was problematic for a number of respondents who were **"unsure how to get this"**. The input of the boss was not perceived to be an essential part of the process, but this appeared to be more of a criticism of the style of management than of their status or position. The value of feedback from a more experienced colleague who might be the boss was welcomed, if feedback was offered in the positive manner already set out in this research (5.3.2). Appraisal evidence given to facilitate development was welcomed, but if offered as an act of control, it was likely to lead to disaffection. The connection between experiences of appraisal that the respondents reported, the importance of 'what' was appraised, how the appraisal was conducted and their desired scheme, clearly illustrates the value of cognitive mapping. The approach preserved connections within the evidence as well as providing a clear picture of a complex issue.

5.9.3 Of whom? The respondents were also clear that 'of whom' should not be confined to the individual nurse, given the team work that characterises much of nursing practice. The influence and impact of the team on individual performance

was seen to be a significant issue. This would be particularly so if part of the role was to manage others. This managerial responsibility should also be subject to the scrutiny of accountability by way of appraisal.

5.9.4. When? the appraisal occurred was clearly a factor that reflected the importance given to it, particularly by the organisation. The notion that **"if it happened regularly, it would break down suspicion"**, and **"certainly more often than now"** (annual), illustrate the need for appraisal to be given greater priority. The separation of appraisal into informal and formal raised the option for daily informal feedback along with a less frequent formal event. The timing of appraisal events should reflect the needs of the individual and the organisation, and intervals of 2-3 months were suggested. This was in opposition to the commonly stated pattern of 'annual (if at all)'. In a particular criticism of annual appraisal, a respondent suggested **"because things happen so often here, the goals I set, and we set, aren't relevant any more"**. The annual appraisal in an ever-changing NHS of the 1990s was seen to be destined to have a limited value, if any value at all.

COMMENT The comment I made at the end of section 5.7.4 would seem to apply equally to the desired timing of appraisal. There was a confirmed need for both spontaneous appraisals (informal) and a more planned intermittent event (formal), to ensure the effective feedback.

5.9.5 How much time? This element of the appraisal was an issue that generated a great deal of comment, much of which arose from the limitations in the respondents' experiences. Appraisal was an investment in the staff and the view of one of the nurses, expressed earlier, that it appeared to be important but not urgent (Theme 5.7.3), appeared to lead to the interpretation that it is not important. The need for time for the scheme to run in and to become established, and for the training to be provided was an ingredient of appraisal that was too often neglected. It was not seen to be satisfactory that it was left for appraisal to be done in **"goodwill time"**, which suggested a limited level of commitment from the organisation as well as from the individual.

COMMENT Appraisal as a component part of staff development and performance management will enrich the organisation and should be recognised as doing so by being afforded adequate resources.

5.9.6 Content and How? The content of the appraisal, and how it is undertaken was an area where little consensus arose. There were a number of principles that several respondents agreed with, but there emerged no one way to appraise. Included in these principles was the need for role based evaluation, constructive feedback, goal setting (organisational and individual), and a culture that focused actively upon professional growth. Flexibility and an open honest exchange were perceived to be more likely to address the mutually agreed goals. The simple formula **"Where am I now, where am I going and how can I get there?"** summed up the desire for appraisal from one respondent. This simple approach, that was more dependent upon a relationship than on a set of procedures or forms, was one echoed a number of times.

5.9.7 Records The records that are kept of appraisal events needed to be confidential and easy to complete and were best seen as part of a personal development plan placed within individual profiles. A professional portfolio, as required by the UKCC, was suggested a number of times as the most appropriate place for records that were fundamentally about the professional development of the individual. Personal professional portfolios, were seen as an essential part of the life of a professional nurse. They could help maintain a clear career track, as well as providing evidence for APEL (Accreditation of Prior Experiential Learning) for individuals pursuing higher education. It was suggested with accord that the requirement by the UKCC to keep a portfolio was a useful and natural place to preserve the records of the appraisals' developmental evidence.

Learning contracts and reflective diaries along the lines of the students from the Oxford Brookes University were recognised as valuable means of achieving development. Both methods capture the essence of evaluating practice by developing personal performance awareness and directions for growth. They were also accepted as relatively familiar approaches, as many of the respondents had experience with them as mentors to the University nursing students.

There were a number of the respondents who did not subscribe to any particular approach to record keeping, but the whole sample felt confidentiality, unless expressly negotiated, was absolutely essential.

The use of whatever records for the purposes of hire or fire was firmly deprecated, unless the individual consented, for example, to provide evidence of development to substantiate a claim for promotion. There was uniform concern that appraisal records might be covertly or openly used for disciplinary (fire) purposes.

COMMENT. The strongest point that emerged in this theme was the need to overcome the large amount of dissatisfaction with current appraisal practices, by introducing one! It was, for some respondents, not even necessary for the scheme to meet the desirable elements listed in this theme; for many, anything was likely to be better than nothing. The need to include a number of principles to guide schemes, to ensure the appraisal operates to develop staff potential, and to protect against the pitfalls identified, would complement actually being appraised.

5.10 Map 2: THE INTERVIEW PROCESS

The experience of conducting the interviews was in itself a significant learning experience for me, and aspects of that process enriched the research. For that reason I elected to generate a "cognitive map" from the notes I collected at the conclusion of each interview. The map (Appendix II) contains two different sets of numbers. The large numbers highlighted are themes that emerged, whilst the small numbers are references to individuals by codes. This map is a relatively tidy affair, given that it was generated from pages of a note-book, and reports a simple dialogue with myself, and was originally in a prose format. I identified seven themes from the exercise; several of them having a number of sub-themes. These themes were;

5.10.1 How it was for me
5.10.2 Relationships
5.10.3 Surprises
5.10.4 Participant benefit
5.10.5 Audio tape recorded interviews
5.10.6 Quality of the evidence
5.10.7 Responses to the maps

5.10.1 How it was for me The flow of each interview was highly variable, and both those that flowed too easily and those that didn't presented their own difficulties. The 'easy' interviews were difficult to keep up with. Despite keeping hand-written notes, on occasions, too many issues arose at one time and it was difficult to remember them to explore further. This was compounded by questions that I asked, which often raised even more issues. The less fluent interviews were easier to keep up with and to draw points out of, but they sometimes left me feeling that I had led the participant or that something had held them back. However, I also sensed that the less flowing interviews were as the participant had wanted, although at times I felt as if I was conducting a tutorial on appraisal! This notion is returned to in Theme 5.10.4.

The overall impression I had of interviewing was that it was an effective and comfortable evidence-collecting method, and that when it did feel uncomfortable for the participants, it was more to do with their difficulty articulating answers than with the interview process itself. I had sensed a desire to please from some of the participants, indeed several brought notes, but most often I felt the easy conversational style gave a good opportunity for us both to learn from the encounter. It certainly generated a wealth of evidence. I had experienced with some of the early interviews a little unrest on my part when the evidence challenged my 'suspended' expectations. I eventually came to acknowledge that it was the contradictions and variety, as well as the consensus, that gives credibility to the method. The relationships between the participants and myself was for me one of the highlights of the research, and clearly a theme in its own right.

5.10.2 Relationships Given my position in the organisation, I had anticipated I would need to watch out for uneasiness from participants who felt compromised by my seniority. In fact I never sensed this. I am sure several weren't aware of the role I held, and they all appeared to talk freely. I sensed, to a degree, that some of the respondents answers included attempts to assist me in my endeavours. I also recognised that some issues might have been raised in the hope I might be able to help ensure that they were addressed outside the research. The uncertainty and lack of experience that some of the participants had with regard to appraisal, on occasions, made the interview difficult, until I assured them that there were no right answers, and that whatever they had to say was valuable. The variety of interpersonal relationships was wide, but all of them fell into a range to be expected from a sample of this size. The desire to help, confusion about the terms and even embarrassment about experiences had all been anticipated by me. There were however some surprises for me in the content of the conversations.

5.10.3 Surprises The first of these surprises was my reaction to information about a good appraisal scheme. Despite attempts to suspend my own judgements at the outset my reaction left me uneasy. I became acutely aware just how much I wanted the participants to confirm my own horror stories, and when these were contradicted I felt quite taken aback. I was equally surprised at the level of knowledge and appreciation of the dimensions of professionalism shown by some of the participants and the lack of it in others. Concepts like supervision had been in the contemporary professional press for some time, but were only raised spontaneously a couple of times. Performance related pay and ways of meeting professional accountability were again

often only present in the conversation at my prompting. I had expected some confusion over the definitions, but was surprised how extensive this was.

I was surprised at the ease in which the data accumulated. In the early days of the research I had feared that the interviews would not yield sufficient evidence, given the paucity of my own experience and the impact of appraisal suggested in the literature. I was not only impressed by the amount and the variety of evidence, but also the pleasure I experienced collecting it. I wondered very early on in the interviewing whether this pleasure was mutual. I was assured by participants' concluding comments that it was.

5.10.4 Participant benefit I felt the participants not only found the interviews enjoyable, they also derived benefit from them. I sensed a number of agendas for the nurses: for example, to learn about appraisal, to gain approval for their own approach, to clarify their understanding, to air a grievance and to express fears for the future. This list is not complete but does reflect some of the feelings I made at the time of conducting the research. It was, however, during the 18 months after starting to conduct the interviews that I became convinced that the research was mutually beneficial. I had sent out a letter to the full sample of 24 nurses inviting them to one of two group-feedback sessions. I received apologies from 5 of the nurses who had left the district, and a total of 8 nurses attended the sessions reported in 5.11.

I also used the feedback sessions in part to explore the use of tape recorded interviews, as I had been distinctly pleased with them.

5.10.5 Audio tape recorded interviews I had been cautious at the outset of using audio recording, mainly from a technical perspective. I overcame this by seeking advice on the equipment and ensuring I had ready access to hard-ware of the best quality. I also had some concern about the intrusion of the machine, but did not find this was a problem (see Theme 5.11.3). I had chosen an unobtrusive flat microphone with high sensitivity that meant there was no need to talk directly into it; therefore it did not form a barrier to good communications. I also found that letting the tape run from initial contact and not stopping until the participant had left addressed two small concerns. There was the need for a degree of warm-up, but stopping this to start the tape annulled the benefit, and often rich evidence emerged as the participant went to leave the room. It had taken a couple of interviews for me to be confident the recorder was working, but by careful positioning I could see the 'running light' to reassure me.

Only once did I have technical difficulties, but still managed to collect the full conversation. I had the inconvenience of having to turn tapes over a couple of times, but again did not feel this created a barrier. The distraction of the telephone was eliminated, but noise outside the office, and on one occasion an interruption from a personal caller, did affect the flow. This had occurred when I travelled to undertake the recording, and from then on I had stressed the need for a private room, or used my own office.

5.10.6 Quality of the evidence As I collected the 24 individual tapes of evidence I reflected upon the information these were generating. I was unable to identify any clear consensus as I had anticipated. The average length of the recordings was 30 minutes, but both shorter and longer conversations yielded equally valuable evidence. Indeed some of the longer recordings contained a great deal of drifting away from my research interest, and some of the shortest were the most productive, being almost entirely focused. I had concerns about the size of the sample with regards to the volume of evidence it would provide, but was assured by the diminishing returns (anticipated from the methodology literature) during later interviews. I had on several occasions revised my interview schedule. The final number of respondents was less than my early predictions as I had reached a point of saturation earlier than I expected. I was impressed by the range of issues raised, and, having examined the literature in advance of the interviewing, was reassured that the issues were reflected in the participants' experiences. As previously stated (5.10.3), contradictions to my own views unnerved me, but as the collection proceeded I found contradictions to be as exciting as agreements. The evidence that arose from the volunteer and the chosen group of nurses were equally rich, but that from the random group was at times more difficult to facilitate, but in the event it proved equally useful. However, the acid test for me with regards to the evidence was the attitude of the participants to the maps I generated.

5.10.7 Responses to the maps I sent a copy of the specific individual map to each participant within five days of the interview. This was to ensure my processing was always up to date, and to allow the participants a chance to respond with the details of the occasion fresh in their mind. At an early stage I voiced my concern to my supervisor that I had received no response to the maps. I was only partially reassured that this was not unusual and that it might indicate approval. Later I received two written and four oral responses, all of which confirmed the accuracy of their map and the participants' surprise at the amount of evidence generated and set out in their map.

I have since had several conversations with a number of the participants who now talk freely with me about appraisal. They have reasserted their satisfaction with the method used to generate the evidence. Finally, invitations to the respondents to feedback on the research (reported in Theme 5.11) gave me a great deal of confidence about the evidence, given their affirmation of its credibility.

5.11 Map 3 RESPONDENTS' FEEDBACK

The original letter inviting participants to take part in this research also indicated that opportunities would be offered to review the evidence when it had been interpreted by me. The first opportunity to do this was immediately following the individual interviews, when I sent a copy of the individual map to each nurse. The second opportunity was offered in the Autumn of 1994 when I sent a copy of the macro map (Figure 5) to each respondent and invited them to respond directly to me or meet with me to discuss its contents.

Five respondents replied to inform me they were no longer living in Oxfordshire and that meeting would be difficult. They all affirmed that the contents of the map presented an accurate picture for them, and that they were amazed that so much evidence had accrued, but did not offer any new evidence. Eight respondents met with me, either with other respondents or alone, and as a result of those meetings I created Map 3, which represents respondent feedback.

The emergence of themes from this map lacked the depth and distinction of Map 1, which I attributed to the smaller number of respondents and the largely confirmatory evidence offered.

However, the following themes did arise

- 5.11.1 Accuracy
- 5.11.2 New evidence
- 5.11.3 Surprises
- 5.11.4 A way forward

5.11.1 Accuracy The respondents all acknowledged the contents of the map as a highly plausible account of the experiences of appraisal for nurses. The sheer volume of evidence and range of contradictions presented surprised them, but contributed to their acceptance of its credibility. In particular, the range of views presented in Themes 5.2, 5.3 and 5.4 assured them that the representation in the maps had taken into account the wide range of views that nurses would have. The use of often

diametrically opposed views was seen to be another indication to them that I had made a fair presentation.

The most important responses in this section of evidence were those indicating that the respondents felt the evidence reflected the current position for nurses with regard to appraisal, and indeed the views they had presented. **"I could tell I'd said some of it"**, along with repetition of much of the evidence, left me confident I had set out an accurate case record.

5.11.2 Additional Evidence The respondents not only affirmed the map's content from their own perspective, but also reassured me that they could appreciate the likely accuracy of the evidence offered by others. There were also a number of additional pieces of evidence offered, either to complement colleagues or to contribute new thoughts. Comments such as; **"Appraisal should have structure"**, **"be informally formal"**, **"needs a multiple perspective"**, **" be more than annual"** and **"should reflect practice"**, all reinforced the evidence offered in theme 5.9.

The need for training to include role-play was stressed, as was the risk that without training difficulties were almost inevitable. Appraisal could be **"unnecessarily intrusive"**, **"be brain-washing"** or **"badly managed therapy"** unless clear training on techniques and principles was provided. The assumption that appraisal was a natural skill was re-stated as erroneous and it was emphasized that the concerns raised in 5.6.2 about the lack of training to appraise others was a major concern. It was emphasized by a number of the respondents that it was training for **"doing appraisal"** that was more important than understanding the exact method. Skills such as counselling, goal negotiation and facilitating developmental (learning) contracts were all identified as possible aspects of training events.

The purpose of appraisal to develop the professional was revisited and confirmed, as was the importance of an up-to-date job description upon which to frame the appraisal. It was emphasized that for many nurses the job description was often out of date and rarely featured as part of the appraisal. It was also suggested that appraisal might be a useful means to help generate an accurate job description. The purpose of appraisal as a developmental strategy was re-iterated. It was suggested this approach would lead to greater success than had previously been experienced, and would be a powerful means towards ensuring professional fulfilment.

The **"fizzled out cascades"**, **"omission of clinical grades"**, and **"mythical"** existence of appraisal, were all confirmation that the evidence of unacceptable appraisal activity explored in Theme 5.1 was accurate. Indeed two quotes from this group of nurses reinforced this view: **"I felt really angry I've never had a good IPR"**, and **"you'd die and no one would recognise what you've done"**.

5.11.3 Surprises There were a number of surprises for me in the evidence offered in the feedback sessions; similarly there were surprises for the respondents. The volume of evidence presented in each individual map and particularly the compilation map, amazed many of the nurses, as it did me! The extent and range of critical comments in Theme 5.4 (Attitudes to Appraisal) and the degree of disappointment had both been surprising. However, these surprises were not challenged as inaccurate. The fact that only one respondent openly recognised a comment they felt they had made was in itself interesting. Even more of a surprise was that the other participants were unable to recognise their contributions directly. However, they all felt the map set out a highly credible picture of the situation as they saw it, which both reassured and indeed pleased me. Despite adopting a reflexive stance, it was not until I received the assurance from the respondents that I felt fully confident about the quality of the evidence I had set out.

I was surprised about the expectations the participants had for training, both for and to appraise, especially from those participants who had not considered how training/education could or might enhance the process of appraisal.

It was a cause for concern, as much as a surprise, that so much of the evidence was critical of existing appraisal activity for the nurses, and that this was accepted as a highly likely situation by the nurses. Indeed the comment, **"until you'd interviewed me, and until I'd seen all this** (the maps) **I'd not realised how important it** (appraisal) was".

I had not expected issues such as Performance Related Pay, clinical supervision and the clearly stated links between appraisal and accountablity to be raised so frequently or with such vigour. However, the most surprising aspect was the importance that the nurses attached to appraisal to inform them on their practice. The nurses' uncertainty about their ability (to be a good nurse), was rarely remedied by their appraisal, either because appraisal did not occur or it was not featured within it.

Finally there were views that I had experienced while undertaking the research that were also raised by the respondents. **"It was fun taking part"** and **"I enjoyed taking part"**. I was particularly pleased that the respondents had enjoyed collaborating with me. I had not expected this sentiment to be presented so strongly and spontaneously by the respondents. I had been concerned that the use of an audio-recorder might have been intrusive and cause discomfort for the respondents. None of the sample reported any difficulty with this, and certainly I had not felt or noticed it to be obtrusive.

5.11.4 A way forward It was clear the respondents were enthusiastic about moving forward to establishing a comprehensive appraisal system for all nurses, but felt the solution was not via one prescriptive way. This very much echoed the evidence so far presented in Theme 5.9 (Desired Scheme), and was emphasised in the light of the substantial need that existed. The importance and value of appraisal, especially for nurses engaged in clinical practice was strongly reiterated. It was, however, suggested that any moves to re-introduce appraisal should acknowledge potential antagonism based upon experience to date, as well as, the enthusiasm that the nurses have for feedback.

The changing frame of reference for nurses, as the new NHS Trusts emerge, raised questions about the purpose that appraisal might be expected to play. These questions should be viewed against the clearly stated opinions that appraisal should predominantly be a developmental tool. The fears of appraisal as a bureaucratic tool to control the nursing work-force I suspect arose at the time of evidence-gathering as the nursing media actively cautioned against Performance Related Pay and the adoption of more macho styles of management by new NHS Trusts.

The need for guide-lines, training and a clear framework for implementing a scheme of appraisal were stressed along with the desire for a more comprehensive approach to performance management. The combination of clinical supervision with an annual appraisal was suggested as a possible approach that would also focus upon the clinical component of nursing. This approach could provide formative and reflective feedback arising from supervision, with a summative goal-setting activity operating at less frequent intervals, and the two systems interacting.

5.12 Map 4 THE AUTHOR'S CONTRIBUTION (DIARY AND REFLEXIVE ACCOUNT)

The process of conducting research according to a paradigm in which I was intentionally including my own contribution, required reflection and reflexivity to

ensure rigour. I had for this reason chosen to collect information in a 'research diary' about the interview experiences and the ideas that emerged from feedback, conversations and any other sources. This evidence is set out on map 4, (Figure 6, between pages 116/117), and from this, six Themes emerged that recount my experience of the research.

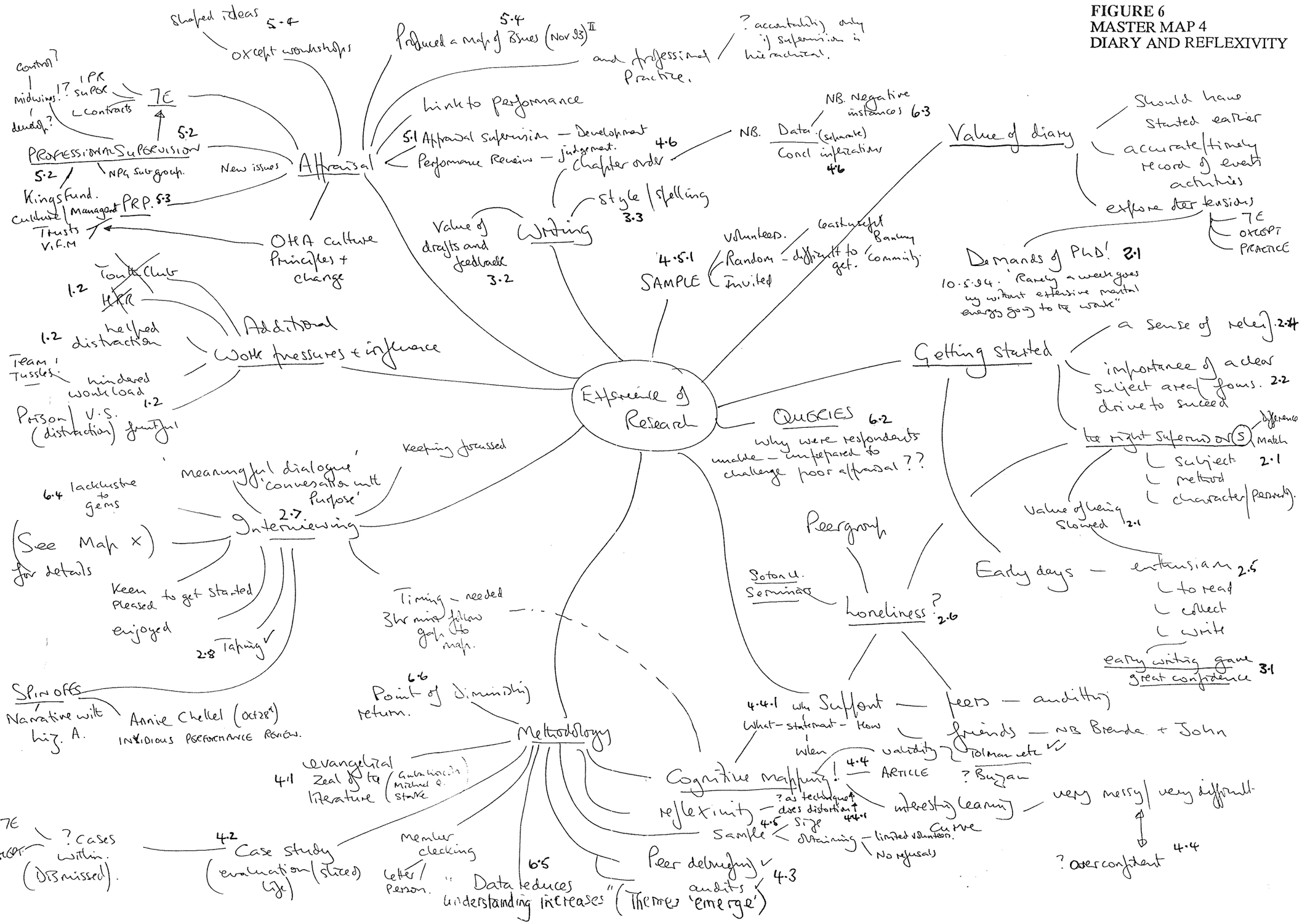
5.12.1 The value of reflection and reflexivity
5.12.2 The process of research
5.12.3 Writing
5.12.4 Methodology
5.12.5 Participant knowledge, the evidence
5.12.6 Personal knowledge

5.12.1 The value of reflection and reflexivity I had not considered the need to start keeping a formal diary until early into the second year of the study, and in hindsight this was late. Now I would consider it to be essential to start this concurrently with starting the research, if not before that. The reflection and reflexivity allowed me to analyse both the processes and products continuously and adjust my actions accordingly. This dynamic approach was in part necessary in a field of research where the process of change was probably at an all-time high-speed, but also where the choice of methodology was an emergent design.

The approach also helped my time-management and planning skills, as my diary entries alerted me to my progress and, significantly, to the effect of other life pressures on the research. I had elected to undertake the research part-time (spare-time), and was only prepared and able to use a limited amount of scheduled work-time for it. The use of a diary stands out for me as a strategy to strongly commend to both researchers and practitioners alike. The awareness it gave me of other pressures allowed me to reduce some of these to ensure my research progress was steady. Remarkably, I remained on schedule with the research whilst undertaking a wholesale reconfiguration of my world of work, in part by being aware of the need to dynamically adjust the personal demands on my time.

I also benefited from the casual jottings in the diary that kept ideas on my agenda. On occasions, I returned from work, from running, from the theatre or wherever with ideas in my head that I recorded in the diary. Many of these ideas significantly informed the research.

FIGURE 6
MASTER MAP 4
DIARY AND REFLEXIVITY



5.12.2 The process of research The stimulus to undertake this research was my increasing desire to say something about appraisal for nurses and its impact upon professional fulfilment. I commenced the research some 20 years after first sensing that the 'problem' existed and attribute my success in completing this research to the duration of my concern. The process of research is not always easy to sustain, but the desire to continue persisted throughout, thanks also to assistance I received. The earliest assistance I needed was to clarify the research problem. In my haste and enthusiasm I had a good general idea but had not refined this or set a clear agenda. I had experienced a great sense of relief from starting the work, but had to learn how to balance the various pressures upon me, not only those from the research but those from work and life in general. I was surprised by the amount of time working on, or just thinking about, the research took. The practical work of exploring the literature and collecting the evidence proved to be highlights of the process. A particular delight was the audio-taped interviewing, especially as this proved to be such a successful and fruitful activity, as reported on map 5 (section 5.13).

The supervision and peer auditing were invaluable aids to the research. The former offering advice, guidance, criticism, encouragement and in particular pacing. I had originally been over-enthusiastic, and the slowing influence of supervision had been essential. The peers had given me day-to-day support, and in particular the assurance that I was generating an accurate picture and making appropriate interpretations. Together they had helped prevent the loneliness of the research process, as had my colleagues who showed interest and encouragement.

In part I put my overall progress down to the encouragement I had to start writing some of the early material within the first year. I therefore had concrete results, albeit in draft form, within months of starting work. This acted as a significant motivator, and, with the advantage of a word-processor, could be and were re-edited many times.

5.12.3 Writing I began getting ideas on paper during the first year of the research, and had written the background and issues on appraisal by the end of that year. I have to concede the element of the research that I had feared most was the writing up, but with the help from my supervisors and peers it proved to be extremely enjoyable. The help to shape the text cannot be praised enough, and was pivotal to the final success. The linguistic conventions of academic writing had concerned me. I felt the 'objectivity' of the third person compromised my beliefs about the world and that it was not suitable for my some-what conversational style of writing and indeed evidence-gathering. I had therefore been delighted to discover these conventions were

not as rigid as I had imagined, especially given my chosen methodological paradigm. The arrival of a spellcheck facility helped disguise my failings here, and also provided the spin-off benefit of allowing me to learn to use a word-processor while writing up the research. I also acknowledge the benefit that validating my linguistic style has been in helping me appreciate some of the methodological nuances.

5.12.4 Methodology I had used a case study approach for a previous piece of research (Northcott 1988), and was confident of and at ease with the qualitative approach to research, whilst acknowledging the need to read more widely, as this research necessitated new depths and greater breadth of knowledge. The number of 'new' and exciting authors in the field of qualitative research that the process exposed me to was indeed a bonus. My understanding of the veracity of 'science' and the significance of personal constructs of knowledge were also strengthened by this research.

The acknowledgement of the contextual nature of all human behaviour not only reflected my profound acceptance of the individualisation of nursing care that emerged in the 1980s, it also confirmed my choice of a methodology that celebrated the same principles. The use of generalisation in a naturalistic manner provided a refreshing way of ensuring the research contributed to the body of knowledge without compromising the individual contributions or denying the contextual influences. I was concerned at the need to aggregate evidence, to condense it into the form presented here. However, by the careful use of personal cross-checking and auditing used (see page 59), I remained confident the individual contributions were not absorbed and lost, but that they all helped to build the theory that the research generated, and to ensure that the insights were well grounded. The use of checking and auditing also served to address the dangers of research becoming a lonely endeavour. The contact with both respondents and auditors helped provide assurance with regards to the accuracy and rigour of the research, and also to allow me to share and celebrate the findings as they were revealed.

I cannot deny some reservations about qualitative approaches to research. At times I found myself straying towards a positivistic stance. For example, I had in the early stages of generating an interview schedule looked for ways of ensuring the sample met traditional conventions of representation and randomness. It was, however, the notions of "informational redundancy" (Lincoln and Guba 1985) and "slice of life" (Guba and Lincoln 1981) that re-guided me to my decision to take a purposive sample and the need to emphasize internal rather than external validity.

I also found the revelation of profound contradictions within the accumulating data, in particular direct challenges to my own beliefs, difficult to accept. However I soon came to cherish such differences as much as the congruences, and to accept them all as equally valid examples of individual experience that were real and therefore relevant. I was equally concerned at the beginning of the evidence gathering about how to ensure the large amount of often contradictory evidence could be assimilated. I was aware of the need to concentrate the large amount of oral evidence into a written format and was concerned that in doing so I might lose the sense of variety and diversity, and so become utterly bogged down with the volume of data. I was therefore particularly excited to discover the technique of cognitive mapping and to adapt it to this research. The setting out of evidence in a pictorial form suited my style of thinking, and eventually proved to be a useful technique to share with a number of colleagues, all of whom were trying to discover a suitable means of transforming qualitative interview data into written evidence. This was a particular delight to me, as an educationalist, to come upon an approach that I could not only utilise, but that I could also pass on to others. I also found my views and approaches to performance management and its teaching were moulded by the experiential learning of the research as a personal process.

The reflective and reflexive approaches had a number of transferable benefits, including addressing the conflicts that arose. The swings of confidence and enthusiasm to continue the research were explored by a process of reflection. The acceptance of learning as a lifelong activity and the notion that mistakes should be seen as learning opportunities, were most encouraging principles. The concerns about possible distortion and the danger of over-confidence were also managed by the same self-critical processes, as well as by the methods of checking rigour as the research proceeded.

Finally I wish to report a reaffirmed interest in and enthusiasm for qualitative research. In my acceptance and celebration of the individual contributions of evidence, I came to appreciate not a 'better than' but a 'different from' distinction. This became as true for my methodological beliefs as it was for my knowledge of appraisal. I had not only learnt there was no Holy Grail of research; there was equally not one for appraisal.

5.12.5 Participant knowledge, the evidence The importance of accepting dissension without judgement or comparison was an essential step in the evidence collection. I had both subconsciously and at times consciously hoped for a degree of consensus,

and in particular a consensus that agreed with my views. I soon found my enthusiasm for evidence-gathering was in fact enhanced by contradiction and disagreement from the accumulating evidence. The excitement grew steadily over the first half of the evidence-gathering period, but as the decline in novel responses and contributions began to occur, I noticed my own enthusiasm to collect evidence tending to ease back.

I enjoyed the evidence-gathering, so did the respondents, but the arrival of significantly diminishing returns allowed me to reach a stage at which analysis of evidence should legitimately replace its collection. This allowed me to move on, in order to do credit to the respondents who offered the evidence, to analyse it and to use it to generate theory. My preliminary investigations of the literature had identified confusion and a wide variety of views and issues that surround the topic of appraisal. The respondents did not disappoint me. The accounts of the respondents experiences were indeed a rich vein of evidence. The depth of feeling, hostility and disappointment about their experiences with appraisal surprised me, as had the persistent desire for a scheme to be established. I also had not expected the link between appraisal (performance feedback) and professional fulfilment to have been so clearly stated, especially in the face of such personal tales of appraisal disappointment. The actual words "I don't know if I am a good nurse", were used by several of the respondents to reflect the very concern that had initiated my research in the first place.

Finally I was intrigued to observe the phenomena of decreased volume of evidence bringing about increased understanding. I was very aware that as I moved raw evidence into individual maps, and individual maps into macro maps, that I was gaining greater insight into the subject and in particular into the beliefs and experiences of the colleagues that I talked with. This in turn was providing me with increasing confidence and understanding of the process of appraisal and its impact upon professional fulfilment. This also assured me that the themes I had identified were accurate and would help create a clear case record.

5.12.6 Personal knowledge The personal benefit I gained from undertaking this research is, I hope, enhanced by the contribution it can make to the profession at large. Cautioned by the notion of "the arrogance of certainty", that Richard Pring (1994) drew attention to in the 1994 BERA conference, I am delighted to be able to share my journey with the profession at large. The insight provided by the conversations within the case study left me assured about some of the principles of appraisal that might enhance professional nursing. Research, the revelation of

knowledge by a systematic enquiry, had been achieved in two main ways for me: firstly by the increased understanding about the subject of appraisal, and secondly about the process of revelation.

I had not anticipated the range of personal knowledge the endeavour would reveal for me. Cognitive mapping, personal cross-checking, clinical supervision and "naturalistic" research all represent issues I discovered while undertaking the research. I had also been able to contribute to professional debates on subjects such as performance related pay, role-based development, and clinical supervision, all as a result of this research.

5.13 MAP 5 PEER DEBRIEFING

The positions I held during the time the research was conducted within the Oxfordshire Health District, provided me with access to a number of colleagues I could call upon as peers to help the process of establishing the rigour of the research. I needed critical friends who could provide me with their own candid views and challenge the representation I was making. I chose peers from both senior clinical posts and from within the network of clinical practice development nurses. In total I met with nine peers over the course of the first two years to try and ensure the account I was producing was credible, and validly represented the phenomena being studied. I also anticipated they would be able to comment upon the portrayal of the organisation, which would be crucial to validate the organisational culture and to ensure that a wider readership would be able to extrapolate from the findings.

The process provided valuable insight into the conduct and progress of the research as well as valuable encouragement to proceed. The research was in part an integral part of a busy post within a large Health Care District, and as such the loneliness of research that is frequently reported was not a problem. I had many peers who enquired about the progress. But I also needed specific feedback about how I was doing, especially as I speculated that nurses needed the same feedback with regard to their practice.

I did not pursue the peer debriefing to the same limits of redundancy as I had during the main evidence gathering. I was cautious that the exercise was to underpin the research and help provide rigour, and not to over-ride the evidence from the respondents. I was aware that excessive use of peers could result in perhaps a censorship or distortion of the evidence from the respondents. I therefore conducted

the final year of the work without their input, but did submit early drafts of the final work to three peers for their comment.

Three themes emerged from the peer auditing map (Appendix IV), and these were:

5.13.1 The research process

5.13.2 Presentation of the research

5.13.3 Appraisal and professional fulfilment for nurses.

5.13.1 The research process The following three sub-themes emerged here:

5.13.1.1 Reflection and reflexivity

5.13.1.2 Case study

5.13.1.3 Research rigour

5.13.1.1 Reflection and reflexivity These two deeply personal processes that I used to help frame the research problem and to constantly review the research were challenged by the peers. They suggested that as well as safeguarding and legitimating the research, they could also used as a smoke-screen to reassure readers of the research and to provide a rationalisation for me. Questions were asked about the bias and self-fulfilment within the research. **"Can you actually suspend your own beliefs?"** or at least isolate them to prevent them unduly influencing the evidence reporting and interpretation?

"Was the whole research a confidence trick?" This question about whether I could use respondents to tell a story whose plot and indeed ending I had already written, was unexpected but not inconceivable. This view was the most significant of all the comments from the peers, and one that I examined most carefully. I suspected that sub-consciously there might be an element of truth in it. I reported in 5.12.4 the difficult feelings I experienced when evidence contradicted my own beliefs. The reflections upon these feelings and this powerful example of peer feedback were constant companions throughout the latter stages of the research, as I even more diligently strove to tell the story of the respondents.

The comments about potential bias were offered alongside others that suggested the research read a bit like an exorcism. Was I setting aside my disillusion with appraisal for nurses? I felt I was, and at times I felt somewhat isolated in my views; but as the evidence accumulated, I felt that the views of the respondents helped generate inter-subjective views that would offer valuable naturalistic generalisations for the profession at large.

These comments that so starkly challenged my integrity and purpose were exactly what I had hoped for. I had not anticipated the subject, but the frankness assured me that the critical friends I had chosen would indeed help underpin the rigour of the research. I had already considered many of their concerns and reported them in section 5.12.4. In writing this part of the evidence last, I was also able to consider the whole of the evidence in the light of the comments.

The peers did, however, also suggest that the research was setting out an accurate portrayal of the situation, which in part we attributed to the processes of reflection and reflexivity. The constant looking back, analysing and thinking all helped to ensure a rigorous approach.

5.13.1.2 Case study In the early drafts of the research, the peers reported confusion and uncertainty about the term 'case study' as used by me. They requested a clear definition of the term, as well as a more coherent chapter setting out the methodology and methods. The rationale for the choice was also of interest to them: **"Was it the best methodology, or one that would get past the ethics committee?"** This could not have been further from the truth, given the initial difficulty I had experienced assuring the ethical committee of the rigour of a case study.

These questions led me to reconsider my choice of method, and to return to the literature to seek clarification. This in turn led to a re-writing of the chapter in a more convincing manner. I had developed a profound conviction in favour of case study as a form of naturalistic enquiry, and the reminder from my peers to ensure that this message was unambiguous was much appreciated. I found my fervour for case study almost evangelical and my interest in all forms of research invigorated. The use of a naturalistic evaluation helped address the challenges to integrity reported in the previous section (5.10.1.1), and in part explain why guide-lines, possibilities and probabilities are used in the recommendations in the place of statements of greater prescription.

5.13.1.3 Rigour In questioning the methodological considerations, and in particular the use of reflection and reflexivity, the peers sought assurance about the rigour of the research. The requirement to justify what I had undertaken and how I had undertaken it provided an invaluable source of reassurance to me about the results. The peers specifically enquired about the process of cognitive mapping. The technique was new to all of them, although the notion of setting out information figuratively was not.

They expressed concerns about the effect of my position and status within the organisation, and about the style of the interviewing. The use of third-party checking of the maps and recordings was suggested as a check on the validity. I chose to rely upon the personal cross-checking ("member checking", Lincoln and Guba 1985) that I used, in part because I felt the respondent could better appreciate the context of their own interview and therefore its accuracy. This approach also provided an opportunity for them to add or take back from the evidence, and most significantly it protected their confidentiality. I had from the outset considered the impact of my status upon the research, and was again invited by the peers to consider **"why did they tell you?"** Was I being told information by respondents with the expectation, if not the expressed desire, that I would do something about it? I was influential and could perhaps intervene to address their concerns. This of course might well be a legitimate reason to cooperate with any research. These concerns reminded me of the need to stress the confidentiality and anonymity of the evidence, and of the importance of accurately reporting the evidence. It also cautioned me to ensure I was not generating unrealistic expectations for the respondents that I might be unable to deliver.

The peers reported that the evidence provided a credible account of the case studied, and reflected many of their own experiences and expectations. This assured me that the methodology, methods and evidence did justice to the subject and to the respondents.

5.13.2 Presentation of the research The peers all commented upon the presentation of the research. They found the style easy to read and commended the linguistic approach of the first person. They felt this reflected ownership and the inter-subjective nature of evidence generated in conversations. It also allowed for the research to have the feel of stories of the life experiences of the nurses involved. The "slice(s) of life" that was identified in the methodology was very much present for them. It was also a slice that told a story that they considered had generated theory to inform practice. The ideas and themes that emerged in the evidence lead appropriately to the guide-lines and recommendations. However, they cautioned me that the style might not represent the expectations of examiners, or the conventions of academia. They said the use of quotations to illuminate the evidence helped provide credibility, and also made for interesting reading.

In early drafts, they had requested a lot more unpacking of terms, to ensure understanding, but also appreciated that a number of these were features of the research. They felt the section on contextual issues was crucial to the account, given

the some-what eccentric nature of the Oxford District. The history and culture of nursing in Oxfordshire needed to be clearly set-out to ensure any extrapolation was appropriate.

The term 'professional fulfilment' was pivotal to the whole research, and therefore it should be prominent throughout and intensely analysed. The questions **"Does everyone have intrinsic desire for feedback?"** and **"Do staff really want honest feedback"** required careful consideration. I had championed an ideology of self-actualisation, and perhaps assumed that performance was a continuum that all nurses strive to move along. The peers questioned this quite bluntly.

The challenges and the difficulties I had encountered from the outset in trying to find universal definitions for terms such as 'appraisal' and 'performance management', were the very motivations for the research. I wanted to know more about the position of nurses with regard to appraisal and in particular to professional fulfilment.

5.13.3 Appraisal and Professional Fulfilment The peers provided valuable insight into the process of the research, and, although I had not anticipated it, also into the product. Primarily the evidence arose from the respondents, but I also gained insight from the auditing activities, as well as from my own reflections. The two quotations given in the previous section along with **"What are the advantages of not knowing how you are getting on?"**, were a profound focus for consideration. However, one quotation remained with me throughout, despite having considered it early on in the research: **"How come we have progressed so far without appraisal?"** The grid set out as Figure 1, in Chapter 1 on page 6, was crystalised at one of the peer debriefing meetings and had been confirmed during the meetings and interviews with respondents. The possibility that poor practice could continue with good appraisal was suggested by the peers as quoted above. This situation was confirmed by evidence from a respondent; **"...some people don't want to improve"** (5.1.7.3).

The peers were keen to point out that developments in nursing in Oxfordshire appeared, from their experience and from the evidence, in part to have occurred in the absence of good appraisal. They reported that IPR had not got off the ground in the District, indeed there were suggestions that it actually disempowered staff. This was seen to be as a result of the predominance of top-down goals that were cascaded to staff, operating much like a control measure. The use of appraisal (IPR) to

establish negotiated goals that would enhance individual performance and help assure professional fulfilment, had not been widely practiced.

There was acceptance that appraisal must include an element of judgement, with the qualification that it should be modulated by agreed professional standards, rather than as a normative comparison or attempt to standardise staff. The peers also raised an interesting paradox, that nurses might tolerate an oppressive and controlling appraisal as an easier option than setting their own goals. Such an approach would provide the nurse with a good reason for not achieving the goals. This again could suggest that nurses might not strive to fulfil their potential, but choose to be told how and what skills to develop. The concept of learned-helplessness was raised by them as a possible explanation for the apparent apathy reported earlier.

The cynicism raised in this theme was no surprise to me. It generated a number of issues that I explored with the respondents during the feedback sessions.

Prior to the peer debriefing I had gained the distinct impression from respondent feedback, that despite unhappy and unsuccessful experiences with appraisal, the demand for it remained and to some extent was increased. It was clear that appraisal should be in part a means to enhancing practice, and the term 'fulfilment' was used to illustrate one of the purposes they saw for appraisal that was often overlooked. I fed this back to the peers, who again questioned whether this was as a result of intrinsic desires or as a response to the increasing competitiveness of the 'new' NHS. They had perceived Oxford's nurses as competitive, and felt that moves to introduce an appraisal system that tapped potential would be popular. The peers, however, were not as clear as the respondents that nurses were intrinsically keen to gain feedback and thereby develop their potential.

COMMENT In part, my use of peer debriefing/auditing had arisen as a result of the interest and encouragement offered to me by a number of colleagues. Their enthusiasm to help and to share in my journey had in the early stages led to a number of informal discussions. These helped me unravel issues, clarify direction and keep going. It was, however, only after I read Lincoln and Guba (1985) that I formalised the process. Along with supervision, I found the peer debriefing lived up to all expectations; it was sobering at times, it helped ensure honesty, and it was cathartic (Lincoln and Guba 1985). I was less concerned from the outset with the loneliness of research that is predicted, but all the same found the critical friendships that developed invaluable for more than off-setting the loneliness. I felt I had indeed

chosen well, for I got devil's advocacy and direct challenge as well as encouragement and affirmation. Finally, the process assured me of the utility as well as the credibility of the research.

PART 3

The two preceding parts of this research examined in part 1, the context, the research question, and the research methodology, and, in part 2, the evidence gathered. This final part extends the analysis and interpretation and draws together the research as a whole. This part is divided into two chapters as follows;

* Chapter 6: Further Analysis and Interpretation

* Chapter 7: Reflections and Guide-lines

CHAPTER 6
FURTHER ANALYSIS AND INTERPRETATION

INTRODUCTION

Having so firmly adopted and used the technique of cognitive mapping to set out the evidence for the research, it is perhaps not surprising that I chose to set out graphically the issues of appraisal in this chapter. The final map I generated, was in January 1995 and it was used to inform this chapter. It is included as Appendix V and is typically messy and not particularly easy to work from. This led me to distil it into the 'tidy' version of the map that is included here as Figure 7. From this tidy second map, the 11 issues that constitute this chapter were identified. The final map was created by immersion and triangulation of the evidence from the following;

my own experiences and diary, reflexivity and reflections
the experiences and feedback from the respondents
the literature examined
the process of auditing
the process of supervision
the peer debriefing.

These were analysed together, by discussion, re-reading and drafting text, in order to look for patterns and to give meaning to those patterns.

This is not the first map of the issues of appraisal that I produced. As early as 1992 I generated a map from the literature and from my own experience to help me to appreciate the territory I might need to cover in the research. One of the early maps is included as Appendix VI. This early map I set down as a base-line from which to start the research in October 1992. The inclusion of the evidence from the additional sources as indicated above led to the replacement of this simple map by the final map in the Spring of 1995. It is this final map, together with the processes of creating it, that informs the discussions in this chapter and underpins the recommendations in Chapter 7.

The seven key issues of appraisal that I anticipated would be central to the research were set out in 1992. These were

Appraisal
Schemes/Methods (twice)
Culture: development and control
Influences

Records
Who? (who is? and who by?)
Purposes.

I included schemes/methods twice, as I appreciated that development or control as the fundamental intention warranted a clear distinction.

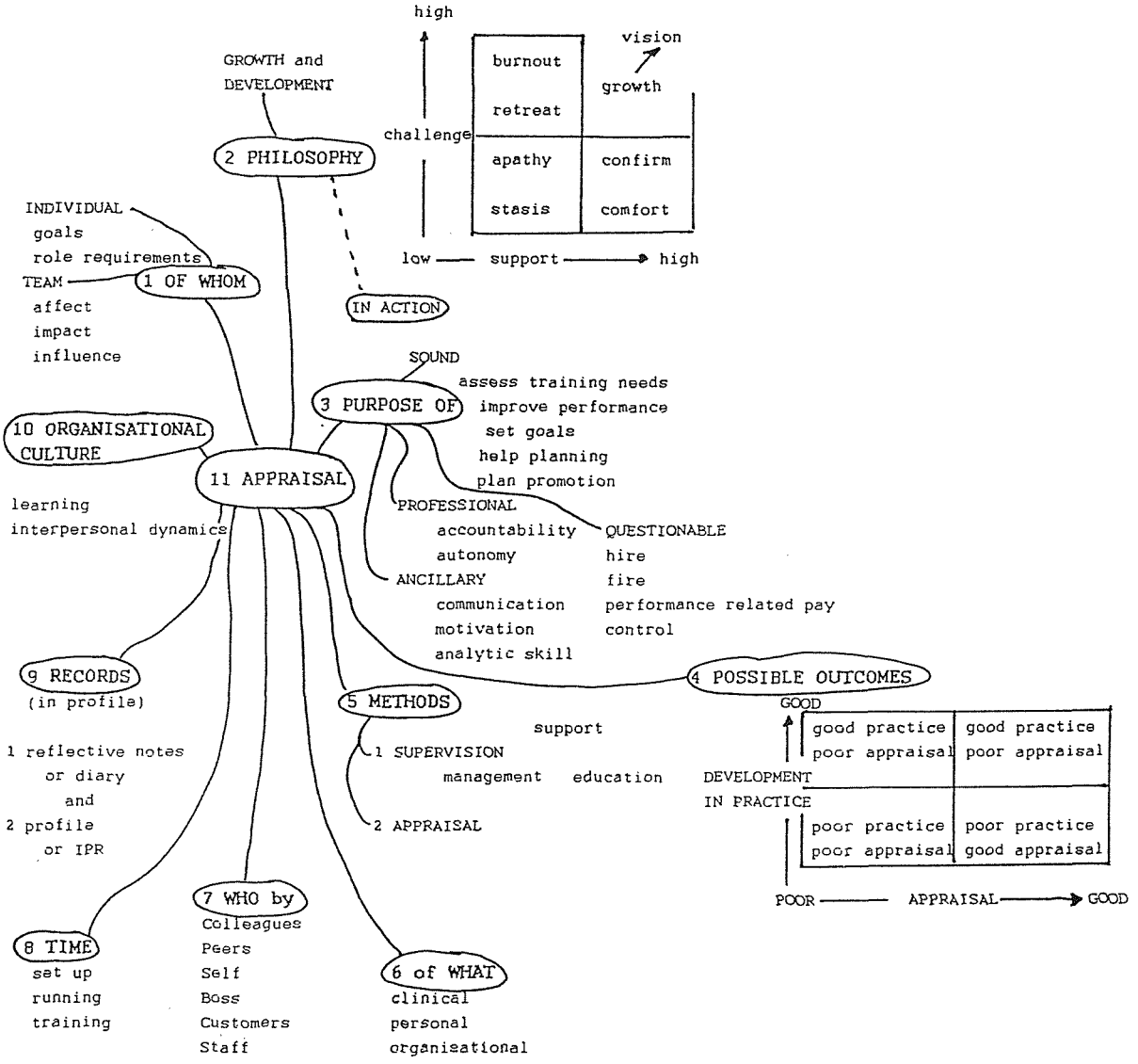
The final map (Appendix V) indicates that eleven issues eventually emerged. I divided 'Culture' into 'Philosophy' and 'Culture', although this was not intended to deny the inter-relation between them. 'Time' was included as a separate issue as a result of the awareness that the primary evidence-gathering gave me. The inclusion of 'Outcomes' arose as the evidence-gathering was audited, and I became acutely aware that this was a problematic and important area.

The maps were invaluable in guiding me to appreciate the territory I needed to cover in a rigorous exploration and analysis of appraisal; they indicated the whole picture. They also provided me with a comprehensive summary of each stage of development of the research.

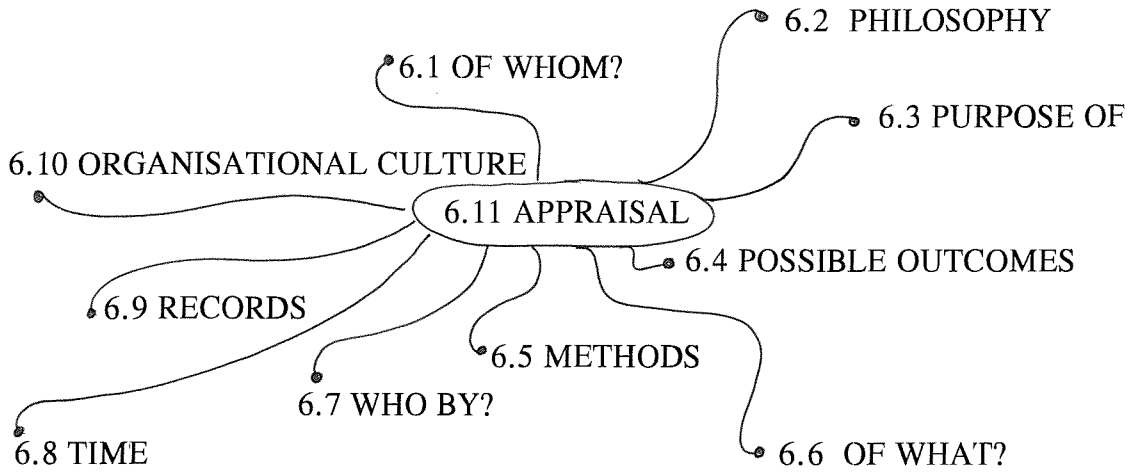
From the outset it is important to stress that ambiguity, contradictions and diversity of views were revealed. The final map presents a somewhat generalised or idealistic position. The map therefore does not represent a consensus of the whole evidence, but rather the most frequently occurring positions. Where significant deviations from this general position exist, these are outlined either on the map itself or within this chapter.

The summarised layout in Figure 7, between pages 130/131, offers an easily accessible focus; the connections and interconnections that are present on the originals have been omitted. This makes clear that eleven key issues of appraisal emerged as explained above and are the sub-headings of this chapter.

FIGURE 7
SUMMARY OF KEY ISSUES



These are numbered in the same way as on the map and are as follows:



The numbering of the key issues is not sequential nor significant, but simply follows the way I displayed the issues on early maps. This reflects my belief that they are equally significant and any form of ranking or ordering would create a false impression. Appraisal is the focal point of the map. Although at first I considered it as the point from which all the other terms arose, with hindsight I came to realise it was also the end-point. This was mainly because so much of my understanding of the concept has arisen from exploring and appreciating the other ten issues. It is for this reason that I address the term appraisal as the primary focus at the end of this chapter (6.11). It helps to summarise the chapter and draw the thinking back to the question "How do you know you are a good nurse?".

The content of Chapter 6 is very much an intersubjective view that represents an amalgamated analysis of: i. the contributions from the interview respondents, ii. the literature and iii. my own consideration of the subject. These are predominantly presented together, with the source only indicated where this is of particular significance. Where direct quotations from the respondents are used, these are, as before, in bold typeface.

6.1 OF WHOM?

Appraisal is both of something and of someone. In a profession such as nursing, where responsibility is a key concept, quality of performance should be the subject of concern for each individual. A great deal of the developmental thrust in nursing in the past decade has been towards humanistic thinking, which celebrates the unique individual with worthwhile intentions. This requires an approach to appraisal that recognises holism, and sees the person and their performance as inseparable (Elliot 1989). An approach to appraisal that acknowledges this belief, is also more

likely to be accepted and to be fruitful. It will also help reinforce an holistic approach to nursing practice. There is a fundamental dilemma here that is too often overlooked: an holistic approach to patient care is in part dependent upon the same approach being used for appraisal. The experiential contradiction created if these two are incongruous may help to in part explain the erratic development both have had in modern nursing. The contradiction may further be compounded if either appraisal or nursing philosophy are also victims of a theory/practice gap. Gray and Pratt (1991) argue for a mutual synergy with regard to nursing theory and practice; I contend such a link is equally important to the practices of appraisal. The importance of appraisal being appraisal of the individual in their role was emphasized during the evidence-gathering for this research.

The research, however, also indicated that conducting appraisal as an integrated personal activity may be very threatening, as opposed to an approach that separated performance from the person. It is this aspect of appraisal that reinforces the need for a sensitive developmental approach if success is to be optimised. Lack of such an approach, might explain the hostility and emotive comments about appraisal reported in this research in section 5.4.2. The need for integration, along with recognition that nurses have an intrinsic desire to be a good nurse, is likely to ensure appraisal is a success. By the same token, if the appraisal lacks sensitivity and disregards the relationship between practice and person, it should be no surprise that apathy, disinterest or indeed antagonism arise. It will also be essential that within the appraisal there is an exploration of the concepts 'good nurse' and 'success' to ensure the expectations of all those involved are based upon common understanding.

The research also revealed a number of influences on performance that need to be accommodated in an appraisal scheme. A large amount of a nurse's time is spent working in isolation, although much of their performance may be subject to the influences of other Health Care Professionals. They may be a constituent part of a team, as in team nursing or in Primary Health Care Teams, but they may still largely practise alone. It is therefore important that appraisal reflects the influence of and impact upon other staff who might affect performance. Working in a multi-professional health care industry is likely to have an effect upon the achievements of any individual. Members of both the inter- and intra-professional teams might impede, or indeed enhance, performance, as might ancillary and managerial staff. Consideration of the performance of other team members is particularly important when team-work is a strong feature, or when there is a leadership component to the nurse's role. It was felt that in part the evaluation of the leader's performance should

reflect the performance of their team and its individual members. This point is returned to in issue 6.6 which looks specifically at what is appraised, and the impact of the performance of the nurse as a team member.

A question raised by one of the respondents was the belief or rationalisation, that failings in performance might be a result of shortcomings in the leader. This can lead to a complex appraisal difficulty if the manager of the nurse is also their leader and is the member of staff responsible for providing the appraisal. This situation is returned to and considered in more detail in issue 6.7, which considers who should conduct the appraisal.

The implementation of appraisal as a mutual process was identified as one of the ways to overcome the tension that may arise in hierarchical appraisal. It accepts from the outset that both parties are responsible for the performance outcomes, and both stand to gain from the appraisal. It also implies that the appraisal process should be two-way. It would also reflect the Oxford District Guide-lines from the Nursing Policy Group (1993) (Appendix I), that clearly promote a dual responsibility for appraisal.

In addition to influences from the professional staff, the nurses identified influences upon performance that might emanate from patients, both directly, or more often, indirectly. From the outset, it is important to clarify how the effect of these factors will be accommodated into the appraisal process.

The variety and complexity of professional nursing illustrates the need to ensure that single episodes of performance or interactions do not dominate the appraisal. In all work snapshots of performance are unlikely to provide an accurate picture. This is especially so in a profession where many interactions are unique.

It is impossible to conceive that a scheme of appraisal could be generated to incorporate accurately all the influences upon the individual. This is perhaps all the more reason to be sensitive to them, whatever approach is being used. It was emphasized that appraisal should be of the individual, with their performance and personal attributes being considered together, but with acknowledgement that a number of influences may affect performance.

6.2 PHILOSOPHY

In many of the aspects of this research the philosophical principles that underpin appraisal were raised. These ranged broadly from control to development. It was evident that appraisal operates right across this range. The two extremes, and the spectrum of approaches that exist between them, in part explains the difficulty that is experienced in defining and subsequently establishing appraisal schemes. The early maps of the issues of appraisal were dominated by the two opposing dimensions of appraisal, namely, development or control. This is clearly shown on the October 1992 map (Appendix VI) and was to an extent the reason why I considered culture, methods, psychology and philosophy under the two headings, as shown in figure 8.

	DEVELOPMENT	CONTROL
CULTURE	Learning	Crisis/reaction
		Person pathology
		Watch your back
		Bureaucratic
METHODS	Critical incidents	BARS
	Learning contracts	Peer ranking
	Supervision	Organisational data
	Negotiated goals	Cascaded goals
		IPR
		Management by objectives
PSYCHOLOGY	"McGregor theory Y"	"McGregor theory X" (McGregor 1960)
PHILOSOPHY	Professional ethos	Management ethos

Figure. 8 Development and Control as the two dimensions of appraisal; from the October 1992 map of issues (Appendix VII)

As the research progressed, I came to accept the two dimensions of control and development as the two ends of the spectrum, and accepted the need to address culture, methods and philosophy as separate issues. In considering the philosophy of appraisal, the grid shown as "philosophy in action" within Figure 7 is the one included on page 17 (as Figure 2) of this research.

It is set out below.

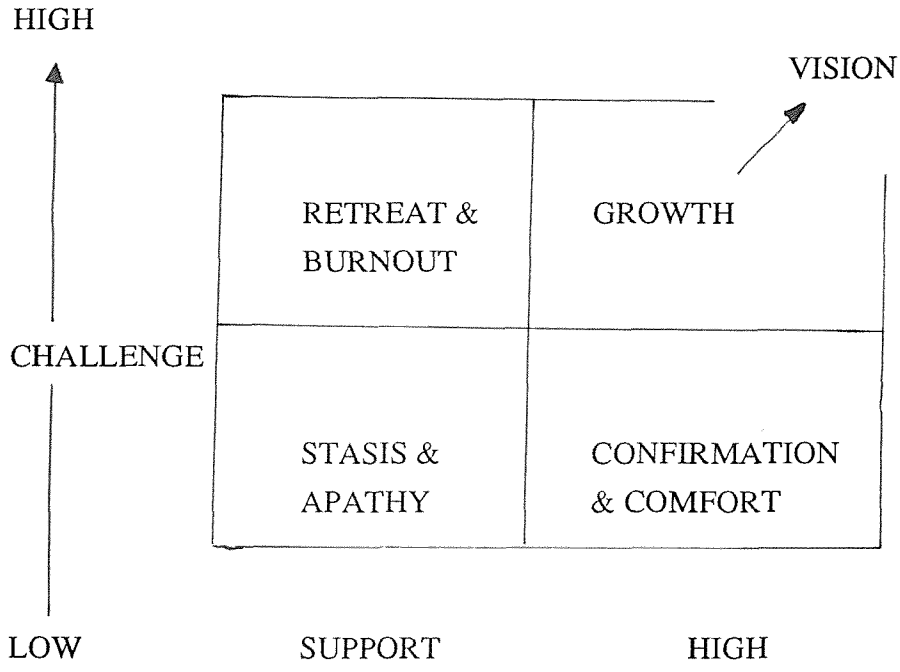


Figure 2 The Challenge and Support dimension and affect (after Daloz 1987)

The grid is derived from the work of Daloz (1987). It provides a useful conceptualisation of the respondents' views of the impact of support and challenge on performance. Careful balance of the independent variables of challenge and support was acknowledged as the key to success, if indeed development is the intention of appraisal. If it is not, the move towards a humanistic basis of nursing practice mentioned in the previous section (6.1) is likely to be compromised. This might again explain why appraisal has only been of limited success. In a profession focused on humanistic care the need for an appraisal scheme that was similarly orientated was clearly revealed in the research findings.

Appraisal as a controlling activity which sets out to challenge the staff to meet goals from normative or bureaucratic origins, without necessarily ensuring that adequate support is in place, was deprecated. This approach had been experienced by a number of the respondents and was reported as totally unsatisfactory. It had been one of the difficulties encountered with appraisal that I had stated previously (Northcott 1993).

Similarly, challenge (without the complementary support for a professional nurse who accepts the need to develop) could result in the phenomenon of burn-out that is

commonly reported in the nursing literature (Whitehead 1989). The majority of the respondents reported that the infrequency and the low quality of their appraisals together with increasing work pressures had led them to experiencing feelings of burn-out themselves or had witnessed it in colleagues. They expressed profound disappointment at the apparent disregard for staff that low support, by way of poor appraisal, indicated.

Traditional forms of appraisal, where there is an almost hegemonic approach of cascading objectives, were seen as a clear example of an approach to appraisal that is intended to control nurses. It was accepted by the respondents that the objectives of the organisation should contribute to the agenda for developing the staff. However, it was clear from the respondents that such objectives should be negotiated. They should not be set for or by the nurse, and certainly they should not be **"presented as directives"**.

Complete absence of appraisal would be likely to give rise to the situation set out in the bottom left corner of the grid. The lack of new challenges, created in negotiation with the appraiser, risks leaving the nurse either apathetic or apprehensive about developing their practice. However, the assertive and self-confident nurse may use self-appraisal to overcome this problem. In issue 6.4, this is further commented upon as it was not always reported that poor appraisal led to poor performance. Indeed absence of appraisal had given rise to and could give rise to profound development in practice. This however, would require significant self-awareness, reflection and insight.

The fourth option in the bottom right-hand corner is clearly one that might lead to a failure of the organisation to optimise potential as well as possibly creating dissatisfaction for the professional. The high level of support confirms current performance, but does not encourage exploration of new areas of practice to stimulate growth and development.

Mullins' (1989) notion of the psychological contract and the moral commitment of professionals (Eraut 1994) were confirmed as important. The reciprocal obligations and expectations of the psychological contract for the nurses included the provision of feedback by way of developmental appraisal. This, in collaboration with the nurse's desires and intentions, would lead to good nursing. Unless the growth options on the grid are operatedf professional fulfilment may be compromised. The principles of growth and development are set out in the UKCC Code of

Conduct and reflect the aspirations of a professional psychological contract. The desire to develop professionally would be well served by the challenge and support of a developmental approach to appraisal. This would lead to professional growth and the vision to see creatively beyond established practice.

The use of control as the overriding philosophy for appraisal might ensure the goals of the organisation are set for the staff, but ensuring their enactment would be problematic and likely to compromise the professional aspirations of nurses. This approach and effect were reported to be in operation for some of the nurses using Individualised Performance Review (IPR). Goals had been set often on an annual cycle and in a prescriptive way. Individuals on the whole paid little attention to these goals until the next annual event drew near. Whether this was because the goals were unacceptable, because the time span was too great or the overriding principle/philosophy was unacceptable, was not established in my research. It is conceivable that all three may be significant, either together or separately, and with similar detrimental effects. Evidence also indicated that IPR did not always get down as far as clinical staff for whom setting top-down objectives might be more difficult. When it did, it had a tendency to generate disinterest and anxiety, given the nature of the goals.

The higher grades of nurses who engage in IPR often have the goals set as the major levers for their performance related pay (PRP). This coercion to bring about success might legitimately be seen as a means to control rather than to develop, and might account for their acceptance of IPR. Conversely, the fact that PRP has got down to few clinical staff may account for their limited uptake and involvement in IPR. From the research, I gained the clear impression that the three interlinked concepts of IPR, PRP and control were of limited value to nursing as a profession. These are also three concepts that are unlikely to significantly influence practice, did little to enhance the status and well-being of the nurses, and reflected the principles of McGregor (1960) theory X. This again gives rise to the contradiction of the humanistic beliefs that currently predominate in nursing practice. However, the shifts in the NHS to a market model may lead to these macho approaches being used, which might stifle professional growth and fulfilment. This may of course be one of the secondary objectives of an economically driven health industry, given the autonomous nature of professional practice.

Use of a negotiated development strategy that reflects the professional philosophy of nursing is more likely to succeed and will not need to depend upon the coercion of

performance-related pay. Development approaches to appraisal ensure that the needs of the organisation are met, but not by imposition. Explorations, with the staff, of the organisational aspirations in conjunction with a focus on the desire of the nurse to develop, is much more likely to succeed, especially if support and challenge are provided in a clearly collegial manner.

Ownership, derived from negotiating the goals, was clearly an approach with greater potential for success, and one that epitomises the learning culture (see issue 6.10, and the Learning Company (Pedlar et al 1991)), where growth and development are seen as the responsibility of the whole organisation. This reflection of the McGregor (1960) theory Y position is also in harmony with the current ethos of the profession. It supports the moves to a network model of organisation, which would bring greater mutual success and fulfilment to all staff.

6.3 PURPOSE OF

The philosophy that underpins appraisal will significantly influence the purposes, and vice versa to some extent. Figure 7 identifies four sub-themes that emerged, namely

a. questionable purposes
b. sound purposes
c. professional purposes
d. ancillary benefits.

These sub-themes gave me the overwhelming impression that appraisal was best considered and operated as a developmental strategy. Evidence from the research and the literature, as set out in Chapter 2, both indicate that the central purpose of appraisal should be to facilitate growth and the development of potential. It was particularly interesting to note that this was still strongly stated and expected by the research sample, who generally expressed very mixed personal feelings and experiences of appraisal. Indeed it seems that the awareness of the developmental potential of appraisal was, in part, the reason for the disappointment of many nurses (see section 5.4.5 of the evidence of this research).

a. Questionable purposes of appraisal were those that seemed to operate from a philosophical base more aligned to control. These purposes were recognised in my research and in the literature and were invariably mentioned by respondents as what appraisal should not be. Appraisal that was used to inform the need to fire or to 'weed out' staff was seen as the greatest threat to both the integrity of the scheme and its likely success. Covert or overt use of appraisal as a possible trigger for disciplinary

action was guaranteed to alienate staff. It was thought it would also create a working environment that was contrary to the philosophical alignment of nursing as a dynamic/developmental profession. Energy to ensure development, could also be lost if staff purely focused upon aspects of their work that prevented disciplinary action. This point is clearly stated on page 22 of this study where the work of Yankelovich and Associates (1983) is reported. This work suggests that "50% do not put in effort to their job above what is required to hold onto it". It might be deduced that this might either be as a result of no appraisal, or of the use of appraisal as control, or of the absence of appraisal as a developmental action.

Respondents suggested that if goals are only set annually this can operate to stifle real development. Once the set goals are met, the enthusiasm to develop can be lost, or indeed further development is held back, to be used at a future goal-setting event perhaps a year or more later. This could be overcome by more frequent meetings, or by placing greater emphasis upon the individual to identify goals and to encourage greater self-reliance.

Appraisal as the means to control unsafe practice was also vociferously challenged. Feedback on such aspects of practice should immediately follow the event in order to be effective and fair to the nurse, as well as the patients. It is partly for this reason, and in the light of the dynamic nature of contemporary nursing practice, that feedback on performance should be provided routinely and not simply be triggered by errant practice. Appraisal as a means for checking unsafe practice accounted, in part, for the negative views of its benefit and for the anxiety reported. **"It's a punitive activity, only used when there was a mistake!"**, or **"to help remedy shortcomings"**, illustrate this well.

Jootun (1995) suggested that appraisal was more often an annual (if you are lucky) event. This time scale would be totally inadequate to ensure development and could indicate appraisal as operating in anticipation of inadequate performance or as the result of actual failure to perform. This practice was reported by respondents in this research, and was seen to be a significant factor in alienating nurses from appraisal. These points were among a number that also influenced the section on method(s) that is presented in this chapter (6.5).

All employing authorities have agreed disciplinary procedures that should be used to explore unsafe or unacceptable practice. This would allow appraisal to

operate as the developmental strategy that the findings from this research advocate. It might also be that fully operational developmental approaches to appraisal could contribute to a Trust or organisation being able to mothball its disciplinary procedure.

Appraisal for the purpose of 'hire' generated less feelings of concern, but once again it was believed to be a use that could significantly contaminate the central purpose of development. Appraisal evidence used by individual nurses to enhance their professional development would clearly be an appropriate and legitimate use. Indeed they might choose to offer their appraisal in support of career enhancement. The use of appraisal by a manager to inform a reference, or to assist in decisions about career aspirations created a degree of concern. This was particularly so if the use was covert or without prior agreement. This could best be overcome by the incorporation of appraisal within a personal professional profile. The requirements within the UKCC PREP report (UKCC 1995) for nurses to produce a profile would provide a place for appraisal evidence to be stored (see records, issue 6.9). It would also allow prospective employers to ask nurses to offer evidence themselves from their profile to support their employment aspirations, prospects and applications. It was accepted by the respondents that appraisal will indirectly inform a reference, but its use as a primary or covert purpose raised concern.

Performance-related pay (PRP) has recently gained greater impetus with government policy suggesting that public sector pay increases should be linked to increased productivity and be negotiated locally. It would appear that linking PRP and appraisal would at present have a number of fundamental difficulties, not least of all because a system of appraisal is not in place for all nurses! This was confirmed in Oxfordshire by Fox (1995), who reported that not all of the Trusts he surveyed had appraisal for staff in the more junior grades.

The need within PRP for a clear set of criteria upon which to base the reward also creates difficulty. The criteria for what constitutes a good nurse are not universally agreed, given the complexity of the role, and, in part, because of the individualistic nature of patient care. The dynamic nature of professional nursing practice would make attempts to specify good practice, that are set in time and place, extremely difficult, if not impossible.

If PRP was associated with specified goals, then, once these had been met, further development would become less attractive, suggesting that PRP might even inhibit the development of good or indeed excellent practice. This of course is assuming that

pay does promote good practice, in a profession where the psychological contract has such a strong impact. Thompson (1993), speaking generally about PRP, is clear that it is a practice that undermines the psychological contract.

It was made clear by the nurses in this research that the requirement to develop and provide good care was uppermost in their thinking. Appraisal was seen as desirable to provide confirmation of good practice, but the use of PRP, linked or not to appraisal, was not valued, indeed quite the opposite. The notion that good practice could only be 'bought' was perceived as offensive to professionals whose primary intent as nurses was to strive to deliver optimum standards of care. It would also appear that at present the two systems, namely appraisal and PRP, lack the development, acceptance and sophistication to operate independently, let alone in conjunction with each other.

It was also apparent from the research that being an appraiser was much more difficult if the role involved hire, fire and PRP. The act of judgement on professional practice or to help develop colleagues was seen to be desirable and attractive. Judgement to enact the three controlling purposes (hire, fire and PRP) would place the caring nurse as an appraiser in an alien and difficult role.

The effect of hire, fire and PRP as purposes of appraisal were all seen as illustrations of control and therefore neither desirable nor appropriate for any profession, including nursing. Control was identified in the research as a purpose in its own right, and was equally dismissed. The terms "**painful**", "**threatening**", "**embarrassing**" and indeed "**controlling**" were all used to indicate appraisal as an activity far from developmental in intention. These feelings were most frequently used to illustrate the participants' previous experiences of appraisal, and were the opposite of the schemes that the nurses projected as desirable. Expressions of hostility towards appraisal were often countered by suggestions about how it could be done. These requests were always for a system of appraisal that was developmental, in contrast to the descriptions of control and apathy that had been experienced.

It was clear from the research that for both ethical, philosophical and practical reasons, control was inappropriate. The paternalistic and directive approach it uses were identified as the antithesis of the prevailing culture of humanistic professional care - - the basis of modern nursing. It was an approach that was it was felt could act to suppress the development of good nursing by its example and inhibit the developmental potential of appraisal.

A small number of the respondents felt reward and performance should be in some way connected, but how to ensure that this was fair was a concern. The majority of schemes of PRP are based upon quotas of reward and upon predetermined percentages of improvement. Developmental appraisal has infinite potential that no organisation in the public sector, with a limited budget, could possibly accommodate. This was reason enough for a number of the nurses to reject the concept completely.

Despite the questionable purposes, appraisal was strongly requested by the nurses in this research, but with the emphasis on development. The purposes that could achieve this are explored under the three further sub-headings: sound, professional and ancillary.

b. Sound purposes The sound reasons very much echoed the positive reasons offered in the literature and suggested appraisal could produce a number of beneficial influences. Improvement in performance was a likely consequence of appraisal for a number of reasons. The increase in motivation and enthusiasm of the staff would benefit them as individuals as well as enhance the organisation. This enhancement and fulfilment provided for the individual professionals together with their organisation was considered to be likely only if the intention and design of the appraisal was developmental. It was considered very unlikely that the controlling influence of a meritocracy, or a punishment/control approach, would have the same positive influence on practice.

Improving performance is a clearly stated requirement of the Code of Conduct for Nurses and of the principles of the profession, and this was echoed by the nurses in the research. There was clear agreement that growth as a result of challenge and support was very much the aspiration of an appraisal scheme for nurses. It was also the source of professional fulfilment as confirmation of good practice could be provided along with encouragement to enhance practice. Recognition of the individual nurse and the attention appraisal led to would increase both motivation and performance.

Bringing about improvement requires feedback that is not threatening, especially as nursing practice is such a personal endeavour. Feedback and assessment were also vital to the respondents in order to ensure planning and to inform the strategic and operational actions of the nurse. It was evident from the research that appraisal offers an opportunity for both short-term and long-term planning. Nurses were made aware of the need to ensure additional clinical and educational experiences were obtained.

They felt that together with the appraiser these could be arranged. It was anticipated that planning together would ensure collaboration and coordination of the efforts of all individuals, as well as ensuring the necessary resources were in place to bring goals into fruition. However, it was also evident from the respondents that appraisal undertaken badly could inhibit nurses who were performing well.

Development and growth are an investment strategy for any organisation, and appraisal is a vital opportunity to help establish appropriate education and training activities. The appropriate use of resources is clearly important to a NHS Trust and appraisal can be a powerful strategy to help establish the training and educational agenda. Care is essential to avoid the frustration that staff will experience if needs are identified and not met. To effect this, it might be best if a degree of cascade for appraisal was in place, i.e. the line manager acting as one of the appraisers. The manager can therefore take on the responsibility to respond to the training and education needs raised. To this end appraisal has the added advantage of drawing to the attention of management the developmental needs of the staff in the organisation. Appraisal that is operated sensitively may also be able to reveal any functional difficulties in the organisation that management should address. It would, however, be essential that the manager should have direct knowledge of the nurse's performance and the context they worked within. There is a risk with an appraisal scheme that it might raise expectations of the staff regarding their own and the organisation's potential that cannot be reasonably fulfilled. Active involvement by the manager in sustaining the scheme, or indeed as an appraiser, will help ensure these concerns are acknowledged.

Positive reasons which the research drew attention to, include the likelihood that developed staff would strive for new challenges. In a profession with a large mobile population, this may lead to losses to the organisation but gains to the profession. It may therefore be one of the paradoxical benefits of developmental appraisal that it may increase staff turnover, unless promotion or recognition can be provided internally. This is an area where appraisal may create frustration and even resentment if hopes are generated but are not acknowledged by the organisation. This difficulty, raised the question of the place of merit-pay. It was suggested that if such a reward system was a criterion based, quota free system and truly rewarded good performance, it might help retain good nurses. Such a system should not be solely linked to a possible percentage increase in salary, as this may not be particularly effective. Reward by means of more annual leave, study leave, support to study or gain-sharing, may be far more appealing to the nurse with a profound

sense of the psychological contract and team-working. It was, however, acknowledged by the respondents that the most significant reward was the recognition and genuine interest that a developmental appraisal offered, and the impact on practice that this could have.

In my post as an education, practice and development manager/facilitator in Oxfordshire, I am surprised how rarely development activities are requested or undertaken as a result of appraisal. Respondents confirmed that this is not because appraisal is not orientated in that way, but because developmental appraisal is not occurring. On the occasions I have been aware that appraisal has precipitated involvement in a study event, appraisal had helped to direct the nurse to an appropriate activity and had left them feeling appreciated and valued.

c. Professional purposes It was evident from the respondents that they appreciated the potential appraisal has in a profession where autonomous practice is so much a feature. The major changes in recent years away from a strong nursing hierarchy and towards the 'new' professional, primary nursing and nurse practitioners, illustrates this change. It was even suggested that autonomy should be questioned wherever appraisal was not in place. The development of the scope of practice of the nurse accelerated in the mid-1990s. This was as a result of a number of factors including technological changes, reduction in junior doctors' hours, increasing patient dependency and improving health service efficiency. A number of the respondents were adamant that as the extent and complexity of nursing practice developed, the need for accurate feedback on performance was all the more important. Rather than focusing on training events for specific procedures, they felt comprehensive and integrated appraisal and clinical supervision could be central processes to the developing role of the nurse. The feedback and support they offered would allow for appropriate development of nursing practice and the fulfilment of individuals.

Recognition of the need for feedback and independent evaluation of each practitioner was one of the reasons behind the introduction of mandatory supervision for midwives (pointed out by Flint, 1993). The model appears not to be reflected in practice, with midwifery-supervision having inconsistent uptake. This would not seem to be because the principle of professional feedback is questioned, but rather because the quality and availability of midwifery-supervision has been highly variable and is more often viewed with apathy, or perceived as control by midwives (UKCC 1986).

Midwives have a long history of practitioner status, and it is in part the moves towards similar autonomous practice for all nurses that reinforces the need for their practice to be evaluated in some constructive way. The increase in the number of nurses providing care based upon unique therapeutic interventions is (in a profession where much of the practice is based upon experience and intuition) expanding. This situation requires the feedback, planning and discussion that appraisal can offer to underpin the individual nurse's autonomy, and to help generate nursing theory. The ambiguous nature of good nursing that was identified during this research, may be established inductively by means of the dialogue, evaluation and development within appraisal.

Competent performance, as one of the hallmarks of professional practice, was accepted as not constant but a continuing process that can lead to mastery. The view of competent performance as one of the dynamic features of professional practice is described by Hawkins and Shohet (1989) and Benner (1984), and is set out here on page 36. This continuing development, along with practices such as reflection, learning cycles and contracted learning, are strategies that enhance performance and should be features of appraisal. Progression and professional growth can be facilitated and monitored by an approach to appraisal that acknowledges this. The confirmation of good nursing facilitates personal and professional growth and promotes fulfilment for the individual nurse. Reflection and the use of experience as a focus for learning were specifically identified by the respondents as legitimate appraisal activities that were essential in the rapidly changing world of nursing.

Accountability is a multifaceted aspect of health care, and it was clear the identification of good nursing should be characterised by more than just the accountability of the nurse to their manager! Accountability is also patient-orientated and a personal responsibility. This aspect is returned to in Issue 6.7 which examines ideas about who should provide the appraisal.

The manner in which drug administration errors are dealt with was offered by one of the nurses in the research as an illustration of the danger of not using a developmental approach to provide feedback on performance. Using such an occurrence as a learning opportunity ensures the acknowledgement of the error as well as leading to improved performance. A more punitive approach, based upon authority and control, appears to work if measured by the number of cases of drug administration errors. However, this approach may only lead to a reduction in the number of reported incidents. The

developmental approach, it was suggested by the respondents, would help lead to a reduction in the actual number of drug administration errors.

It would be wrong in this section to imply that a uniform attitude by the research participants to appraisal as a professional developmental activity existed or was desired. The idea of appraisal to 'police' practice was raised and linked with the suggestion that some staff deliberately avoided appraisal because of this aspect. Whether this was to avoid the revelation and examination of poor performance, or was a reaction to previous experiences and the expectation of a control/punitive approach, was not established. There was consensus about the inextricable link between the value of appraisal and professionalism in an occupation that is ever changing and where the customers (patients) are often vulnerable. This was endorsed by the clear benefit to the respondents who had a positive experiences of appraisal: they reported improvement in both their nursing practice and their self-esteem.

In summary, I was surprised that appraisal was so firmly linked to professional fulfilment by so many of the nurses. They clearly shared the frustrations I had felt at the lack of feedback on my performance, especially on the practice component. A number of the nurses I met in this research used the opportunity to explore with me ways of how to obtain quality feedback on their own performance, or to introduce appraisal to their work-place. This was so, despite their own previous poor experiences of appraisal.

d. Ancillary benefits The ancillary benefits that a scheme of appraisal could offer, were, for example, the use of reflective practice for nurses as a direct means of developing professionally, and its use to develop the analytical skills that reviewing practice can help facilitate. Nursing practice, and in particular decision-making, requires the nurse to consider carefully a number of factors in a given situation. Such analytical skills can be enhanced by their use in appraisal to lead to professional growth and beyond this to professional vision.

Necessity within appraisal for the nurse to spend time in private with their 'manager' exploring performance provides an opportunity for discussion and undisturbed time to share each other's thinking. This has the additional benefit of improving communication if conducted developmentally and it allows for the nurse to feel valued and thereby motivated. Trust and better knowledge of each other are also enhanced and will lead to more productive working. The developed communications

are based upon exploring and analysing professional performance. They provide an ideal focus from which both parties can learn and develop.

The full benefit that appraisal might offer was unknown to a number of the nurses in the research either because they had never been part of a truly developmental scheme, or because their experience was one of control or apathy. The same frustrations and disappointments that I had faced, which are set out in the early chapters, existed for many of the nurses I met. The nurses also did not know if they were a good nurse, although they were keen to find this out and, in part, anticipated that the research would draw attention to this and help to make amends. They desired the developmental opportunity they felt appraisal could offer, for both personal and (as importantly) professional reasons, for themselves and for the nursing profession at large.

6.4 POSSIBLE OUTCOMES

I commenced this research with the assumption that appraisal was a beneficial activity, and that good appraisal would equate to good practice, and vice versa. I had already sensed a degree of paradox about this correlation, and during a peer auditing session for this research a direct challenge was made to the connection by one of the group. This research confirmed that paradox, and as a result I speculated on page 6, that four possible options concurrently existed within nursing. These are reproduced here, and are as included on the map of key issues (Figure 7).

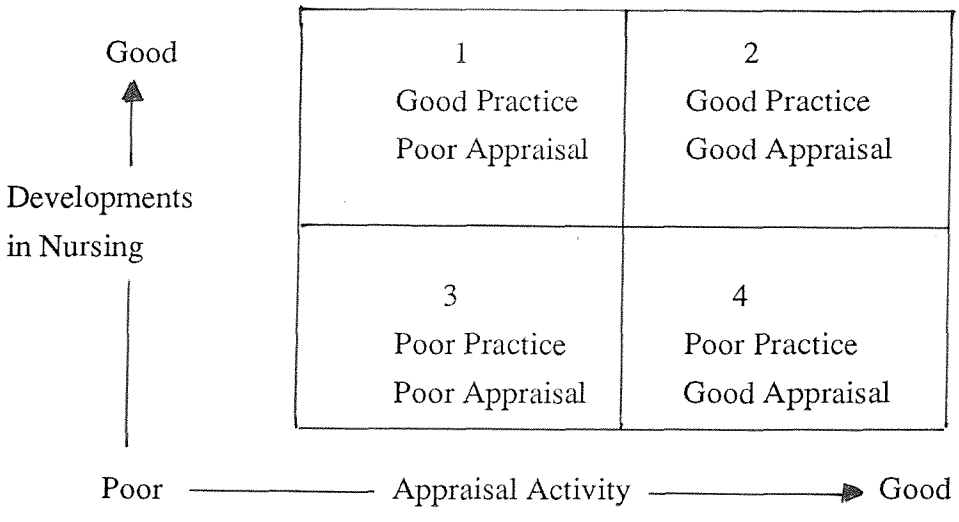


Figure 1 Nursing Development/Appraisal Correlation Grid

I am aware that the grid is an oversimplification of the situation, but it sets out the four poles of a complex interaction. The obvious nature of the 'South West' (3) -

'North East' (2) axis is radically challenged by the opposing axis. Poor practice is no more a guaranteed result of poor appraisal than is the reverse. The grid taught me, by display, the risks of making assumptions, and also the benefit of the peer auditing that was used as a rigour check (section 5.13) of this research.

All the four grid options are, I believe, significant and likely to occur. Similarly, I believe that just as the bottom left (3) is the worst scenario, so the top right (2) should be the aspiration of everyone involved in nursing. Poor appraisal might be expected to result in poor practice, but, as was reiterated in the research, absence of appraisal or poor appraisal can also be accompanied by good practice. Whether in fact this practice could be improved by good appraisal was not explored here, but it is highly logical to expect all practice could be further enhanced.

Why poor practice might result from good appraisal draws attention to the particular conception of good. It might mean good in the bureaucratic sense, that is, the appraisal was done according to policy or done on time, rather than good as in its effect on performance.

The findings from this research make the case for good appraisal that equates to practice/performance success and is designed around and focused on development. Good appraisal is based upon clearly agreed criteria for the process and performance. This interpretation of good appraisal would have the desired effect on professional practice, and might eliminate the South-East (4) corner of the grid.

The use of controlling or directive approaches, or contamination by PRP, may be good as judged by its own definition. However, it cannot guarantee desired results if those results are improved/developed practice.

Finally, it must be acknowledged that in any social encounter there are no certainties or absolutes, but it is worth trying to optimise success! The link between good appraisal and good practice was evident within this research, and if professionally the latter is the goal, then appraisal must be undertaken in a way that is believed to be good for all concerned.

6.5 METHODS

I had originally anticipated that this research would lead to the emergence of a new method(s) of appraisal, to overcome the deficiencies identified in existing approaches. This did not occur and I realised it was not the methods of appraisal that were at fault,

but more often the purposes, process and application. I reconsidered my expressed antagonism towards existing appraisal and performance management approaches, and reached the conclusion they were predominantly based upon the way the 'appraisal' was conducted. I was convinced that despite the apparent poor appraisal activity that had been experienced, there was clearly the view that appraisal is potentially a vital component of professional development and fulfilment of nurses, especially clinical nurses. It offers a degree of safeguard with regard to accountability, provides feedback and assurance about the goodness of practice, and is a desired yet often missing feature of nursing.

The importance of the process of appraisal is very much the focus of this whole chapter, and in particular this section, which considers method(s) of appraisal. Methods used for appraisal had been central to my thinking from very early in the research, as identified in the map from 1992 (Appendix VI). A number of the methods for rating performance are identified in Chapter 2, together with the exploration of supervision. These methods, were developed from the published material and the evidence collected from the nurses in Oxfordshire and presented me with a wide choice.

There were five pairs of terms that I gave careful attention to in order that the appraisal methods(s) recommended would accommodate the evidence that emerged. These are as follows;

formative	-	summative
informal	-	formal
planned	-	episodic/spontaneous
norm-referenced	-	criterion-referenced
organisational goals	-	individual goals

What was not clear was which one of each pair was the most appropriate. I came to the conclusion that they all had a place depending upon the purposes of appraisal. If appraisal was intended to be a developmental activity it needed to be both a formative and summative event. It had to provide developmental feedback and consider performance against certain criteria. It had to have status as a legitimate and important aspect of work, and therefore be formal, but as one of the respondents suggested be **"informally formal"** - a formal process that was conducted in an informal manner, to reflect development as opposed to control. Appraisal needs to be planned to reflect its importance and benefit. There is also a distinct need for either partner to initiate

feedback opportunity at unscheduled times. This is in order to reflect the dynamic nature of nursing. Appraisal should be referenced by clear criteria that indicate good practice, but in a profession these may legitimately be the norms of the profession. Goals of both the formative and summative aspects of appraisal would enable the activity to help plan future work as well as to evaluate present and past performance. Individual and organisational goals should be considered together to provide a comprehensive appraisal system.

Following extensive reflection and consideration of the evidence, I was left convinced that what was needed, in an appraisal scheme for nurses, was a method or methods that could incorporate the five pairs of terms. In particular it was impressed upon me by the respondents that a process of appraisal alongside a practice such as clinical supervision could ensure a developmental and dynamic approach that would reflect nurses' professional aspirations.

6.6 OF WHAT?

Central to the process of appraisal is which aspects of work to appraise. The focus on predetermined goals and objectives is frequently what is appraised and this was accepted as appropriate. Use of an activity that encourages nurses to plan and to establish goals to work towards can allow both the organisation and the individual to create legitimate targets of performance.

Including negotiation in the goal-setting activity is vital if the intention is development, and only if control is one of the intentions of the appraisal should the goals be prescribed. Imposition of "boss-set goals" was a clear example of goals that were not the subject of negotiation, and, rather than lead to development, these gave rise to antagonism and apprehension for the nurse. Cascading goals down the organisation created feelings that were more akin to a task orientation to work. Contemporary approaches towards holism in nursing practice have striven to eliminate this stance. Goal setting should be undertaken to accommodate a number of aspects of working practice that include organisational goals, team/departmental goals as well as the aspirations of the individual. For a number of the nurses this would be difficult, given that organisational and team goals were not available, and indeed in some cases no philosophy of practice existed to guide the individual nurse. The presence of a job description enabled the nurses to articulate goals against a set of organisation parameters, but this was not uniformly available and for one nurse the job description was "at least 17 years old".

The requirement to set individual goals in the absence of organisational goals, or a philosophy of practice, or an active job description was reported by more than one of the respondents. This caused particular difficulties when subsequent evaluation of the goals indicated they were unacceptable. Whilst not wishing to invite a prescriptive approach to goal-setting, it was evident from the research that too often base-line information was not available from which the nurses could negotiate their individual goals. The use of prescribed goals, may, however, stifle innovative practice and devalue routine work, and even inhibit performance. If the achievement of goals is too firmly applied, nurses might be either unable or unwilling to introduce new goals during a planning cycle. This is especially likely if PRP is available only to previously planned goals. This raises the possibility of new ideas being suppressed or held back until a subsequent planning event.

What was perceived to be an even more important concern, particularly to the respondents, was any allusion to the clinical aspect of their work in their experiences of appraisal. The major component of nursing, and the focal point for the majority of nurses, is clinical care. It was the experience of the respondents that by virtue of being routine it was unlikely to feature in their appraisal. This absence was deprecated by most of the nurses interviewed. The recent introduction of clinical supervision was seen to be a potential means to address this. Supervision running parallel to appraisal would ensure that the real work of the nurse was considered. Reflection and critical incident analysis were recommended to provide supervision with techniques that examine practice in a way that could help generate appraisal goals.

It was suggested in a number of the interviews that the poor uptake and poor availability of appraisal for nurses was a direct result of the absence of patient-care orientation in the process. Emphasis upon the importance of feedback relating to the clinical aspect of nursing was the point at which this research had started. It was evident that the majority of the sample did not know if they were a good nurse. Like me, they were unhappy that this situation existed.

There was also concern that if PRP is too closely linked to appraisal, then the focus may well shift towards aspects of performance that are most easily measured. This could lead to data such as attendance and punctuality being used to evaluate performance at the cost of actual nursing practice.

The overall feelings about what should be appraised, focused upon the negotiation of goals in a dynamic way that included both long-term and current nursing practice issues.

6.7 WHO BY?

Who provided the appraisal when it did occur was in the main the line manager, although a number of other patterns were identified. The use of self-assessment was reported, but for a number of the respondents this felt more like abrogation than collaboration. It was even suggested that without an up-to-date job description, the manager needed the nurses to make a first draft of their goals, to inform the manager of the details of the current nature of the post. Nurse managers attempting to appraise as many as thirty members of staff had used self-appraisal: this was in part to save time but also because they had difficulty keeping track of so many staff. This approach, whilst better than nothing, does little to provide support or provide additional views of performance.

There were reports of multiple rating being used but these were limited to self, boss and equity assessor. The equity assessor (the grandparent) approach that is proposed in the IPR scheme was in use, but questions were asked about the relevance and value of the third party. This was most often mentioned because the equity assessor was rarely a member of staff the nurses had day-to-day contact with, or one whom they regarded as credible. The 'grandparent' in IPR was not always in place, or had not been heard of, despite its clear inclusion in the documentation.

Multiple rating using a number of different people strongly emerged in the research as a feature that would enhance appraisal. Provision of a number of perspectives on performance would reflect the composite nature of nursing and give a much more accurate idea of good nursing.

There were a number of sources that could be used to inform the appraisal, as follows

Self-appraisal has the distinct advantage of engendering more commitment to the process and reducing possible defensiveness. It must, however, be undertaken in the light of the difficulties that individuals may have in rating their own performance. Encouraging nurses to be mindful of their work would allow practice to be modulated by the self-aware nurse using reflection-in-action (Schon 1987). Self-appraisal would also be essential as line managers are rarely present for significant lengths of time to observe the nurse at work. Exclusive use of self-appraisal in nursing would be

problematic if the goal was to develop practice, as standards are the dynamic responsibility of the body of nursing, not of the individual.

Peer/collegial appraisal Feedback from peers was widely reported by the respondents as beneficial, but invariably as an informal activity that many did not see as a part of appraisal. Nurses had reported that the absence of hierarchical appraisal had led them to using a single peer of their choosing to provide performance feedback. When this was more formalised it was recognised as a valuable and legitimate contribution to appraisal, suggesting its use should be promoted more widely. The logistics and expense of involving a large number of peers or colleagues in the appraisal process can in part be ameliorated if peer supervision is utilised as a parallel aspect of appraisal. This mutually beneficial process helps provide peer feedback which can uniquely provide insight into the effectiveness of the nurse within a team-work setting.

Despite the value the respondents felt about performance appraisal from colleagues from other professions, this type of evidence was seen as difficult to obtain, unless the supervision operated in multi-professional teams. It may however be that moves towards multi-disciplinary care planning will be the forerunner of greater inter-professional appraisal of performance.

Superior appraisal The most common approach to appraisal is from or with the next senior member of staff or line manager. This method does run the risk of being seen as a top-down, authoritarian method, but, by identifying it as a mutual developmental process or as one of a number of approaches to appraisal, this effect can be reduced. Again the assumptions about the intentions and desire of the staff to work that McGregor (1960) postulated are significant here, as is the stance taken with regard to leadership. The leadership of directing, supporting, coaching and delegation that Hersey and Blanchard (1988) promote clearly utilises appraisal as development. This "model II" approach (Argyris and Schon 1982) calls for:

open communication and constructive challenge to practice
emancipation of individuals
common goals
shared control within a support hierarchy
interdependence

This provides a situation within which appraisal would operate as a mutually developmental process to meet the widest of needs.

The number of staff any one boss is responsible for appraising needs to realistic, and certainly less than ten. This was one reason given by respondents for the perceived lack of success of appraisal for nurses and of the supervision of midwives, where one supervisor may have twenty or more midwives that she is responsible for.

Much of this research focuses on the two poles of appraisal, viz, development and control and it is this dimension that will most influence the success of appraisal. The success, enthusiasm and benefit of appraisal arising from more senior staff will hinge on the underlying philosophy, the approach and the interpersonal relationships that exist. These are considered in issue 6.10 on organisational culture.

Customer appraisal One of the more innovative approaches to appraisal that arose in the research was feedback from the patients and clients that nurses work with. How this **"vital component"** could be obtained was a concern to a number of the nurses. It was felt unrealistic for this to be sought directly, because of the ethical dimension and subjectivity, but the spontaneous evaluations by way of letters and personal testimonies, which could be important sources of evidence, should be included.

Each of these approaches can help to provide a broad picture of the individual's contribution to work. Clearly, attempts to triangulate the picture by some form of multiple rating will be more accurate. It will also help address any bias that exists or may be rationalised as the reason for an unsatisfactory appraisal. All the approaches identified here are liable to the vagaries of subjectivity. The creation of a truly objective system of appraisal is unlikely to be achieved, but multiple rating is one way of triangulating the evidence to gain a more accurate picture of performance.

Operating appraisal in conjunction with clinical supervision as advocated in issue 6.5, together with the use of a number of sources of evidence will lead to an appreciable increase in the amount of time and energy that appraisal occupies. However, if development is the focus of the appraisal strategy, then the time that is invested in this process is likely to be regained fully by increased productivity and motivation.

6.8 TIME

The respondents had re-iterated the sentiments of Tom Peters (1987) where he states: "Appraisal is very time-consuming". In the early maps that I produced, I had not

considered time to be a major issue. I had considered that the time spent on appraisal would be seen as an investment, given its potential benefits to the staff and the organisation. This view was echoed by the respondents, but they indicated that immediate demands upon time often displaced appraisal. Many of the nurses felt the present work-pressures made planning difficult and this was a significant factor in their dissatisfactions with appraisal. Pressure on time had lead to an number of the nurses providing or attending appraisal activities in their own time. It was even reported that this was a more satisfactory arrangement. Whether this was because it was more private, less hurried, less likely to be postponed or more likely to happen was not explored. It did, however, indicate the commitment towards appraisal that the individual nurses have, that they would give up their spare time to ensure that it occurred.

Time for appraisal clearly emerged as a significant issue, for three reasons:

a. To establish the scheme
b. To provide training
c. For the scheme to operate

a. To establish the scheme

The need for planning and local agreement about the scheme emerged in both the literature and from the respondents. Introduction of the NHS Individualised Performance Review (IPR) scheme 'failed' due to lack of ownership by the nurses. Those who had used it reported local modifications and long delays in its implementation (if it was implemented at all). Equally frowned upon were lengthy negotiations to ensure every detail of a scheme had been considered. The respondents indicated that what was needed were simple guide-lines that allowed for interpretation by those directly concerned. It was also felt that if such a scheme was introduced it would be more likely to operate than current practice was, given their busy work schedule.

The need for patience was also identified, although a number of the respondents felt they had already waited too long. It was accepted that introducing an appraisal scheme would take time, but introducing a more clinically related and flexible approach might expedite this.

b. Training to provide appraisal

It was recognised that training to conduct appraisal was necessary, but that "training by doing" had been as effective as other methods. It was evident from the nurses that

much of the time spent in off-the-job training had not been particularly valuable. It was suggested that a more appropriate scheme in the form of guide-lines could be introduced by a local cascade rather than by spending time on a course or study day. Certainly the idea of spending time away from work learning about appraisal was thought to be extravagant.

Paradoxically, one nurse had spent two days on a workshop about appraisal, but in the following two years never received an appraisal. The bottle-neck that waiting to go on the course creates was given as another reason for poor appraisal activity.

Given that the evaluation of care is an integral part of nursing practice, and that the desire to develop naturally exists, it was felt that clear flexible guide-lines would be a successful and less time-consuming way to introduce appraisal. The overall view was that the time should be spent on the actual appraisal interaction and not on the bureaucracy around it. A cascade 'on the job' scheme, that involved discussion and negotiation, was seen to serve this view well.

c. For the scheme to operate

Whatever scheme of appraisal is established it would need time to operate. All too often this is not acknowledged; indeed, there was some expectation that it should be undertaken outside work hours. The majority view was that if the time spent on appraisal was more productive, i.e. spent on actually appraising, then it would be more likely to be accommodated. It was, however, essential that manpower planning recognised the need for time to invest in the staff in this way, although it was anticipated the time spent would in the long term be recouped. The respondents were clear that appraisal time should be allocated and recorded on duty rotas. This was to ensure that it occurred and to signify its importance.

Time was given as a problem by a number of the nurses, especially where the ratio of appraised to appraiser was high. Incidents of ratios of 30 to 1 and 40 to 1, were reported which led to concern about the time this required of the appraiser and of the quality of the appraisals. Ratios of 5 or 6 to 1 were advocated as this would allow the activity to be in proportion to other aspects of work, to occur more frequently, and to be of greater quality.

The time needed for individual episodes of appraisal was explored. 45-60 minutes was identified as about right. Snatched 10 minutes in the middle of a busy day were deprecated, as were annual sessions of 2 hours or more that some nurses had

experienced. Hurried and infrequent appraisals were reported to be more likely to be setting or giving goals rather than negotiating them. The need for identified time was reiterated, if the intention of the appraisal was to develop staff. This requires regular contact and time to explore work. There was acceptance from the respondents that an annual appraisal event was too infrequent to meet the needs for nurses. More frequent contact in order to generate, to monitor and to evaluate development was essential, and should be considered as an investment rather than a drain on resources.

In conclusion, it was clear that time is a crucial element in appraisal. If appraisal is undertaken successfully it is well spent, given the impact and benefit appraisal can have; it is an investment. It was emphasised by the respondents that if the senior nurse in the department considered appraisal as important, time would be allocated for it even in the busiest wards and departments.

6.9 RECORDS

It was evident that a number of the issues already discussed in this chapter would influence, or at least be guided, by the nature of the records that might be kept on appraisal. The use of appraisal as a developmental activity necessitated a record-keeping system that clearly reflected this intention. Evidence provided by the nurses revealed that a variety of record keeping methods were in place, including confirmation that for some that no records were kept. Of particular concern was the purpose and confidentiality of any records, particularly when access to the records was uncertain. It was reported that large variety of types of information were kept in the records, some of which were not accessible to the nurse.

It was acknowledged, however, that the line manager would need to be conversant with the contents of the appraisal, and in particular any goals it contained. The value of negotiated goals was recognised as an important means of enabling the manager to assist the nurse to develop, by ensuring that appropriate resources were allocated.

Inclusion of appraisal information in personnel files kept by management (or the use of extensive forms for appraisal), as had been experienced in Individualised Performance Review (IPR), was seen as unnecessarily bureaucratic. Such practices also create the impression that an intention to use appraisal as a control exists. It was thought that the creation of an annual appraisal and goal-setting record in the personnel file of the nurses was of limited value as well as creating the distinct impression that the purpose was more aligned with control. To operate

developmentally requires records that are freely accessible to the nurse, if not held by the nurse, to allow appraisal to function as a dynamic process.

Confidentiality of appraisal documents was raised by a number of the nurses who felt uncertainty about who did, and should have access to them. The respondents felt that information from clinical practice (such as supervision notes, reflective diary entries and critical incidences) were all valuable to the appraisal record, but should only be available to a restricted audience. This would not only protect the nurse from inappropriate disclosure but, most importantly, the patients who may be identifiable within reflections arising from clinical practice. A nurse-held record would accommodate this and patient-related information would be protected.

It was recognised that the manager might wish to have a record of the appraisal but it was felt this should be a record of the event rather than for the evidence of performance. This could be met by the nurse's own personal notes, which should also contain information about the content. This should be kept confidentially unless consent was given to use the notes more widely. The possession of these would allow the appraiser to discharge their role of monitoring the appraisal, and to keep abreast of the issues which were current for that nurse.

One of the suggested kinds of nurse-held records was the creation of personal development contracts (PDC) between the nurse and the appraiser. These should be the property of the nurse, but they would have the advantage of reflecting the mutual responsibility for development. Unlike the annual goal-setting documentation, PDCs can be added to as the need arises. They can also be concluded between annual reviews if appropriate.

What emerged in this issue was the need to move away from record-keeping as a bureaucratic activity, towards record- keeping to underpin the practice of appraisal as a developmental activity - an activity that nurses would wish to actively engage in. Certainly in Oxfordshire, the use of learning contracts is so well established in under- and post-graduate nurse training that their use for nurses' appraisal is quite logical and would be readily acceptable.

6.10 ORGANISATIONAL CULTURE

It was evident from the interviews conducted that appraisal was able to contribute a great deal to the work of nurses, and that culture was a crucial element in ensuring

this. This was both an organisational and local/interpersonal issue; it will be considered accordingly.

ORGANISATIONAL CULTURE

The effect "the way things are done round here" (McLean and Marshall 1988), was felt to have a powerful impact on appraisal. The two main philosophical thrusts of development or control were also regarded as dimensions of culture. It was acknowledged that aspects such as flattened hierarchies indicated the culture but were peripheral to the central notion of whether a learning culture existed.

The exact term culture was not used, but concepts such as **"support"**, **"encouragement"**, **"friendly"**, and **"staff development centred"** were used to indicate the culture that was felt could enhance appraisal and performance. Coercion and the possible macho management of new Trusts was identified as an unacceptable and inappropriate background to developmental appraisal.

It was particularly interesting to note the apparent disempowerment to challenge the lack of appraisal or the use of controlling approaches from some of the nurses interviewed. This might suggest that if the beliefs about the culture or the approach to appraisal are that it is intended to control, then it is not something to encourage or to invite upon yourself. This apparent apathy towards appraisal might reflect a lack of confidence that it could help improve practice or professional well being. Given the experiences of the nurses that were reported, I was not in the least surprised that disinterest and apathy towards appraisal existed. The cultural expectations of an annual prescription of goals was certainly enough to convince one of the nurses that appraisal was not something associated with professional growth. In contrast to this, there were nurses interviewed whose enthusiasm for appraisal indicated appreciation of it as an aspect of a work that helped them feel valued.

The culture of the particular organisation the nurses worked in and the whole NHS was discussed with regard to appraisal, often with a degree of uncertainty and suspicion. Fears were voiced that moves from a professional focus via general management to a market orientated organisation were raised on a number of occasions. However, more significant to many of the nurses was the local culture of the ward or department they worked in.

LOCAL / INTERPERSONAL CULTURE

It was apparent that, almost regardless of the scheme of appraisal that was operating, the local culture was an issue that had the most significant impact upon appraisal. Relationships between the staff involved was a crucial feature in terms of the attitudes towards appraisal, as well as the likelihood of success. The interpersonal culture was thought to be capable of ameliorating many of the difficulties that might have existed with regard to the seniority or status of the appraiser, to the scheme in operation and to the organisational culture.

The recognition and value of the support and challenge that appraisal could provide was modulated by the manner in which it was conducted. This included such issues as time, with lack of it provided by the appraiser as an indication of disinterest in the activity and in the individual. Recognition, and the interest shown by appraisal represented a significant element of the psychological contract that is important to nurses. It was abundantly clear that genuine regard by the appraiser in showing respect for the individual nurse and an intention to conduct an honest two-way exchange were vital elements of appraisal. Need for privacy was one of the key features of an activity that was expected to be an exchange between colleagues where the intention was to develop practice.

Inclusion of control, or the association of appraisal with the hire and fire issues (explored in section 5.3.4 and in issue 6.3 of this study) was deprecated. While there was acceptance that the appraiser might help establish and prioritise personal goals, they should not lay them down. The term "being appraised" indicated an approach that was top down and not conducive to developing the nurse. Indeed it was an approach that was likely to precipitate avoidance and resistance. Such an approach also influenced subsequent interest in appraisal, with a number of the respondents citing previous controlling experiences of appraisal as leading to disaffection and limited interest.

6.11 APPRAISAL

The final issue is the one upon which the whole research hinges and from which the other issues emerged. It is therefore used to summarize the Chapter and to bring the preceding 10 issues together.

"The term appraisal means different things to different people," was offered by one of the respondents. It serves as a useful summary of the revelations I encountered in trying to find a definition and understanding of appraisal. Anticipation of gaining

insight and a clear definition of the term, as well as definitions for a number of related terms from this research, was soon set aside. I was better informed, but at times my confusion was increased rather than ameliorated! Consensus is still a long way off. Many of the respondents in the research suggested notions of "**where evaluation** (of the nurses' performance) **meets planning**" as a means of summarising if not defining appraisal for them.

The euphemisms 'development interview', 'performance review' (Individual Performance Review / IPR), 'career planning' and 'review', all indicate the difficulty experienced by Institutions in deciding what appraisal is, and what is intended, expected and required of it. The suggestion that, with so many contradictions and such a poorly understood term, a new term was needed, appealed to me. It is however likely that any new term might inherit the confusion, and indeed might even increase it! A new term also does little to address the anomalies that are the cause of the confusion, especially as so many are associated with the appraisal process.

Difficulties in defining appraisal are compounded by the practices, which at times are contrary to the stated intentions as well as the expectations and desires of individuals. This was particularly apparent from the poor experiences of appraisal reported by a number of the respondents. They used terms like "**painful**" and "**embarrassing**" to describe their appraisal, yet remained enthusiastic about its potential and felt disappointed that it did not happen for them in the way they expected and wanted it to.

It was confirmed in the research that appraisal should be undertaken as an important, formal and significant part of work and its management. It should be considered as an investment in both the well-being and performance of staff. This requires time but can generate direct and indirect benefits to the service. The culture and atmosphere in which it takes place needs to be informal to help emphasize a developmental rather than a controlling intention. It was acknowledged that one of the processes and purposes of appraisal was judgement but that this should operate as a manifestation of professionalism not bureaucracy.

The concept of feedback was central to a number of the respondents; terms like "**praise**", "**evaluation**", and "**finding out how you are doing**" indicate this. It was important that the feedback should discuss performance to date, as well as leading to speculation and planning about the future: "**to stretch, but not stress**" the staff. The feedback or appraisal evidence should comprise the views from a number of sources.

It should not be based upon a single opinion as was too often the case. This is especially so if that single opinion is from that of a colleague who may not always be seen as credible or fair.

It was particularly evident from this research what appraisal is not. The two approaches of cascading objectives and being "ticked off" were experiences that had alienated nurses by experience or anticipation. The impact of negative and punitive approaches were not thought to produce the net result of improving performance. The etymological origins of appraisal (meaning to prize, from prisier, French) are compromised if the activity becomes purely a cascade of objectives and/or a telling off. The cascading of objectives down an organisation only shifts responsibility and does nothing to develop potential, nor does it offer encouragement to the staff.

Attempting to ensure that organisational goals are addressed might of course require the goals to be further delegated; this would need to be negotiated and discussed. This will ensure that the appraisal is truly a development activity which, in part, is a an opportunity for the nurse to appreciate their role and function in the organisation. It also needs to be undertaken in conjunction with the perceived individual and professional goals.

The common assumption and practice of appraisal as a downward or unidirectional activity was one that indicated control as the central intention. It is vital that if evaluation is to contribute to planning there must be a means by which the appraisal operates as a two-way dynamic process. The appraiser will need to acknowledge their role in providing the resources and facilitation for the individual goals, and to ensure individual and organisational development.

An appraisal is a process not a product (see 6.10), and for this reason the application of the scheme will be the most influential aspect of the activity. It is perhaps the fact that the word appraisal is a noun that leads to a good deal of the difficulty. Appraising might be a more helpful term as it clearly indicates a process.

In conclusion I was left, at the end of the evidence gathering and of the analysis, feeling quite intrigued about how the situations revealed had arisen. I had encountered a large amount of dissatisfaction, disappointment and uneasiness about the practices and experiences of appraisal. The degree of optimism for appraisal from nurses with poor as well as apathetic experiences I had not unexpected. It would seem that the psychological contract has a strong influence on the practice of nurses and that

tapping into this by means of developmental appraisal would have a profound impact and was clearly demanded.

The supportive and developmental ethos of clinical supervision had arisen firmly in the minds of many of the nurses as a means to replace appraisal with a truly professional means of providing confidence about being a good nurse. However, they had fears that supervision could fall victim to the same apathy and controlling influences of appraisal and thereby fail. Supervision is not intended to generate evaluation of performance from a range of perspectives, but it does have the common goal with appraisal of developing the professional nurse. This is returned to in Chapter 7 where the reflections that arise from this research indicate the need for supervision and appraisal to operate concurrently and interactively.

CHAPTER 7
REFLECTIONS and GUIDE-LINES

INTRODUCTION

This research set out to examine the experiences and perceived benefit to nurses of appraisal. The clear message that emerged from the majority of the nurses in this case study was that their experiences were similar to mine: i.e. they were not happy or satisfied with appraisal and felt much could be done to enhance it for nurses. Many of their appraisal experiences were flawed and had not been useful to help them develop professionally, despite their expectations that they would and should. Despite this the nurses remained confident that appraisal could assist in the development of quality practice and play a significant role with regard to their professional fulfilment. Indeed a small number of the nurses in the case study had experienced this and reported marked enthusiasm for appraisal.

This chapter is organised around eight reflections. These arise from an inter-subjective view; the evidence generated by the case study that is extensively set out in Chapter 5, my own experiences and from the literature. They focus on how the process of appraisal could operate as a means to develop nursing practice and ensure professional fulfilment. The reflections are presented in a summary form to support the discussion of the major issues facing nursing with regard to its use of appraisal. These are then followed by a set of guide-lines on appraisal. These non-prescriptive guide-lines include a sample personal development contract (focused on learning) and an annual performance review evidence sheet. The guide-lines were generated from this research and are presented in a format that enables them to contribute to research as well as to stand alone. The guide-lines are printed in a different type-face to allow for them to be printed onto six sides of paper for convenient copying. However I wish to emphasize that as guide-lines the intention is that they should inform approaches to appraisal but not dictate them.

I wish to emphasize that my own views with regard to appraisal have been significantly modified as a result of undertaking the research. Meeting with fellow nurses to explore appraisal lead me to realise that the principle of appraisal was quite sound, but that it is the process of appraising that requires a great deal of attention to optimise its effect. The intention of this research was to contribute to the body of

knowledge about appraisal for nurses. The reflections are therefore presented as issues to be considered by all nurses and especially those involved in the planning and implementation of appraisal and are grounded in the in-depth analysis of one case study.

An integral link between appraisal and clinical supervision was established during the research. This link was primarily by virtue of the developmental potential the nurses identified in the two activities. Clinical supervision lacks the bureaucratic label and history of appraisal and was promoted by some of the nurses in the case study as a possible replacement for appraisal. This might be possible in the long term, but at present neither appraisal nor clinical supervision is established in a comprehensive or satisfactory manner throughout the profession.

The context of this case study has been carefully set out in the earlier chapters and any generalisations to be drawn from this research should acknowledge this context.

Each of the eight reflections is presented in bold text and is followed by a discussion. The chapter ends with the guide-lines that were developed from the research.

Appraisal informs and helps guide the professional fulfilment of nurses.

The formal contract of employment that a nurse holds is only one of the obligations to practice and perform well. The psychological contract of mutual expectation between a nurse and their employer was recognised in the case study as a large and important component of the nurse's work. The commitment to care, to be a good nurse, comprises a large element of the psychological contract for the nurses. Appraisal was acknowledged as one of the ways that the nurse's formal contract can be developed, by providing feedback and evaluation of performance, but the exact way this is done should reflect the psychological contract. The feedback on performance from appraisal was seen as essential to the process by which a nurse is able to explore potential and gain professional fulfilment. To deny this is to fail to tap potential and risks creating a demoralised and undervalued nursing work-force.

Appraisal was clearly recognised as a potential means to help overcome the doubts and concerns about the quality of care delivered that individual practitioners can only partially obtain for themselves. It will provide satisfaction, reassurance and personal reward that will motivate the nurse into continuing professional

development towards fulfilment. The recognition and assistance to develop can provide confirmation of good practice and help the nurse to explore new areas of work. The attainment of personal, professional and organisational goals, that are part of developing potential, were also identified as important to enhance the professional fulfilment for nurses.

Appraisal as a purposeful strategy to examine practice was seen as central to establishing professional dialogue as part of working life. This will contribute to the provision of an appreciation and understanding of performance and set in place debate and discussion in which further issues can be explored.

The assertion that good appraisal could ensure good performance was made by the nurses in this research with acknowledgment that good performance may also arise when appraisal is bad. However, it was recognised in this research that performance in the latter case could be further enhanced by good appraisal. From the evidence, it appears that much of the celebrated innovatory nursing in Oxfordshire probably arose in the absence of appraisal. While the research did not reveal the conditions that led to the acknowledged developmental practice, it was confirmed that feedback on performance (appraisal) was one of the ways to enhance or indeed further enhance the performance of all nurses.

Nurses in the study strongly believed that appraisal can play a significant role in developing and guiding professional fulfilment. It was also evident from this case study that this potential of appraisal has not always been reached. Why this situation exists is addressed in part in the other reflections on this research.

The central focus of appraisal should be development.

The moral commitment and psychological contract that are central to nursing contain within them the importance of care: to be a good nurse in the widest sense of the word. It is for this reason that appraisal should operate as a developmental activity to affirm the natural intention of nurses to strive to improve and to extend their skills. The requirement to consider professional performance as a process of continuing development is enshrined in the nurse's professional code of conduct and is echoed in much of the contemporary literature. Areas for development should be negotiated within a supportive professional dialogue that recognises the natural need and desire of each nurse to develop. Acknowledgement of the need to improve requires the acceptance that current practice requires development. This

acknowledgement may be difficult and compromising for the nurse. The disequilibrium between current and potential performance should be handled in an environment where the challenge to develop is met with support and not one where punishment or 'exposure as a failure' prevail.

It was evident from this research, that the use of appraisal to control nurses was a strong reason for the degree of alienation that was reported. Control as the overt or covert intention of appraisal is unlikely to be wholly successful and is likely to inhibit the developmental growth of nurses. The fundamental contradiction of the two purposes, i.e. control and development, indicates that they are mutually exclusive. They must be separated in the organisation's performance management strategies. The need to control and manage inadequate or inappropriate performance was seen as a legitimate but distinctly separate activity from appraisal. It was acknowledged that any need to control unsafe practice should be managed by the organisation's disciplinary procedures and not by appraisal.

The use of appraisal as a comparitive/normative exercise was rejected by the nurses in favour of an approach that strives for professional development. The use of ranking within appraisal was rejected as unhelpful and potentially divisive, as well as extremely difficult to apply fairly. The use of appraisal as a means to inform on the remuneration of nurses (performance related pay) was recognised. However, this link was made with strong reservations if not outright rejection given the perceived difficulties that exist, that are examined in this research.

Developmental approaches to appraisal could more readily reflect the world of work and generate goals from work experiences. The sterile cascading of objectives down the organisation was reported to feel more like attempts to control the nurses. Negotiation of mutually agreed objectives would ensure mutual benefit to the individual, the organisation, and the profession, whereas the setting of objectives by the manager could feel more like management of change without appropriate support.

Use of control as a function of appraisal has been dismissed throughout this research as the antithesis of a legitimate and successful approach to appraisal. It is clear from the evidence that the use of coercion and control are unlikely to bring about the desired improvement in performance and may even serve to inhibit it. The atmosphere of fear and mistrust that a culture of control creates could lead to inhibited goal-setting, in order to reduce the risk of failure. It can also lead to the setting of simplistic goals that neither stretch the nurse nor significantly influence

practice. Control was also reported to have a detrimental effect on morale in addition to its direct impact on performance.

'New' nursing has at its centre the empowerment of patients and indeed nurses, and this approach should underpin appraisal in order to avoid an experiential dilemma. In its rejection of control as the force behind appraisal and its overwhelming support for a developmental approach, this conclusion about appraisal has an everyday effect. It should influence all aspects of the appraisal process and thereby all aspects of nursing practice.

Preparation for undertaking appraisal requires particular education and training.

It was evident from the research that current training and education activities have not always effectively contributed to the introduction of appraisal schemes. Indeed they may even have inhibited their use. The establishment of elaborate and complex education and training events was felt to be time-consuming, and bottle-necks arose as nurses waited to attend these events. This had generated delays in the introduction of appraisal to all nurses, as training cascades often failed to reach clinical staff.

Misgivings and difficulties with appraisal reported in this research indicate the need for education and training to establish a scheme that will reflect the type of appraisal to be used. A prescriptive approach was seen to risk compromising the central intention of appraisal, namely to develop nurses. For this reason it was felt that guide-lines should be created. These would be an appropriate basis for any education and training with regard to appraisal. They should permit negotiation and agreement by the individual groups of staff. The use of guide-lines was seen to reduce the risk of a prescriptive approach to appraisal as they allow the details of the process to meet the particular needs of each individual. The prescriptive system of the NHS Individual Performance Review scheme (IPR) was reported to have had only a limited uptake. It was evident from this case study that IPR has not been widely successful in terms of uptake or impact and, in part, this had arisen from its lengthy training and somewhat prescriptive approach.

The use of a precise scheme of appraisal necessitates more intensive and extensive education and training to ensure its accurate use. This is expensive in terms of the time required to train all the staff and this in turn it was suggested, explained the

concentration of appraisal on senior nurses, who were first onto the training programme. The cascade of the scheme to other staff in the hierarchy was so long after the launch that it more often fizzled out. The energy to cascade the system or the commitment to provide the training had stopped well before it reached many of the nurses in the case study. Nurses in junior grades were seen to be least able to articulate feedback on their performance and being heavily engaged in clinical practice are well placed to influence direct patient-care They constitute the bulk of the nursing work-force and, with a set of clear guide-lines, it was felt they could be speedily engaged in effective appraisal.

Local interpretation of guide-lines would allow for a locally based cascade of training which could adapt the scheme to the needs of the staff. It was evident from the research that learning by doing had been a successful way of implementing appraisal and, if underpinned by clear guide-lines and support from colleagues, could be the basis for an effective scheme.

It was felt that training in negotiation, counselling and interpersonal skills, along with general managerial training, would enhance the appraisal activity. The need to be trained in these process skills was given preference over training about the appraisal product; this could be included as part of a general on-going education programme for all nurses.

Appraisal is an investment in the nursing staff.

The nurses in the study emphasised the need for full recognition of the developmental potential of appraisal. The acknowledgement and demonstration of appraisal as an investment strategy they stressed would require a commitment of time and other resources that would reap great benefit to the organisation.

The nurses recognised that the provision of support and challenge to nurses would require time to be set aside for both the appraiser and the appraised. The use of a local cascade that incorporates appraisal in teams could help reduce the burdensome use of time by the sister/charge nurse of a ward with 25 nurses to appraise. This had explained the failure of appraisal for a number of the nurses. Previous attempts at introducing appraisal had often been where the responsibility rested upon one nurse in the clinical setting; in these situations, time was reported to be the reason why the scheme failed to reach all staff. The use of team leaders, where they existed, had engaged nurses who were in more direct daily contact with the nurses and in

ratios of 1:5 or so, and, the implementation of appraisal had therefore been more successful. This size of ratio would also help to ensure that the on-going support and assistance from appraisers would be more likely to occur.

Identification of the time for appraisal activities on the duty rotas had helped ensure that it was acknowledged as a legitimate feature of work. A suitable location for the meetings between the nurses was given high priority, to allow for the privacy that a sensitive dialogue about work and its development might demand. It was acknowledged that establishing the quality of relationship that would enhance appraisal for nurses may take time and patience, especially where, previous experiences of appraisal had been unfruitful. To help appraisal address the needs of the individual, the profession and the organisation, it was stressed that the (annual) review of performance should be supported by more regular opportunities to consider practice and its development. A single annual appraisal event in a health care business that is changing so rapidly was clearly seen as inadequate as an investment strategy to enable the nurses to contribute effectively or develop appropriately.

Provision of the education and training events that are identified directly or indirectly within the appraisal will indicate genuine organisational recognition of the activity. Negotiation of goals, without ensuring that the resources to meet them are in place, could create mistrust of the integrity of the scheme.

It was indicated that the returns from this investment might include improved performance and motivation of the staff, as well as improvements in staff retention, quality of care and productivity. However, these may be long-term, and therefore patience would be required as such improvements may not be obvious in the early days of the appraisal activity.

Appraisal as an investment strategy should start soon after the nurse takes up their post and not await the passing of a significant time period as a number of the nurses had experienced. It was felt that newly appointed nurses might have even greater anxieties and concerns about their performance: appraisal as a developmental activity was seen as one way of overcoming this. Newly appointed senior nurses frequently created delays to appraisal, especially if policy dictated that they should lead the appraisal cascade and wait a year after coming into post to be appraised themselves.

Appraisal is a significant strategy in personnel management.

The value and importance of appraisal as a personnel management strategy to enrich and enhance the performance and well-being of nursing staff was felt to be underdeveloped. Appraisal was acknowledged as an important strategy in the development and enrichment of nurses, despite the anxiety that it had generated for them in the past. Performance development was recognised as a life-long process by nurses in the study. It was acknowledged that some degree of monitoring ("policing") of nursing practice is required to underpin accountability, but not in order to punish shortcomings. It was emphasised that any such monitoring should be intended to develop and not to control nurses.

Performance underachievement was recognised as a situation that requires the mutual attention of the nurse and their manager to bring about development. The responsibility for ensuring the presence of appraisal requires managers (including team leaders), to take the lead in promoting appraisal given that fear, disaffection and apathy may exist. The availability of accurate job descriptions against which performance could be appraised was of particular importance to the nurses, many of whom felt the job descriptions they had were out of date.

The value to the organisation of the enhancement of performance would be compounded by the increased morale and motivation of the nurses. Recognition that appraisal could enhance performance was considered in the light of its impact upon the recruitment and retention of nurses. An effective and operating appraisal scheme was identified as one factor that would influence job choice by prospective staff. It would subsequently become a major factor in the decision to stay in post. The feelings of being taken for granted and of not being given encouragement had been significant factors in the growth of job dissatisfaction. The absence of regular systematic praise and feedback could not be compensated for by occasional comments about good performance, or by appraisal that is triggered by failings in performance.

Operating appraisal as a developmental rather than a controlling strategy is central to its success and value. It can significantly contribute to performance quality, job satisfaction and service development, and is a pivotal aspect of the management function. Reported difficulties and uneasiness with current appraisal for many nurses will require a concerted effort to overcome. A clear alignment of appraisal to

development could expedite (re)-introduction, and put in place a personnel system of major organisational significance.

Suspicion and indifference are features of the current culture of appraisal.

Experiences of appraisal have generated an appraisal culture in nursing that leaves it hampered by suspicion and apathy. For many of the nurses in the case study the District Policy (Appendix 1) that indicates regular review and development is, and had been, empty rhetoric. A considerable degree of indifference exists among many of the nurses who are responsible for conducting as well as for receiving appraisal. This arises for a number of reasons that include nurses previous poor experiences, uncertainty about the value of appraisal and the failure of management to recognise the long-term investment that it offers. Nurses who celebrated appraisal were those for whom it was a developmental activity or those who have appraisal linked to their performance-related pay.

Previous experiences of appraisal as a controlling activity created the suspicion that it could only operate in that manner, resulting in low enthusiasm and little commitment to it. This was the case despite appreciation of the potential of appraisal to enhance performance, underpin accountability and create well-being. Conversely, where the experiences of appraisal were positive the enthusiasm and support for it was profound.

The culture of unease about appraisal has been fuelled by the recent changes in the NHS that created Trusts. There are concerns that these changes might herald a more 'macho' approach to management in order to operate in the new market economy. The use of appraisal to control the work-force in order to foster competition is an aspect of the new NHS that the nurses feared and the use of appraisal was one that developmental appraisal could falter within. Such a controlling approach, however, could be counter-productive and lead to further disaffection and resistance. Appraisal as a developmental activity will help create a mutually collaborative culture which could optimise market endeavours as well as the professional fulfilment of the nursing staff.

The need to re-launch appraisal or even to use a different term (such as appraising) to describe it were suggested as possible ways of rejuvenating the activity. However, a change in name only would be unlikely to create greater long-term involvement and interest in appraisal and might even result in increased suspicion.

The changes that are required to reduce the indifference and suspicion relate to the underlying principles and practices of appraisal. These would need to be re-examined and addressed in a re-launch.

Concerns were evident with regard to the introduction of clinical supervision in that it might suffer a similar fate to appraisal, i.e. that it may not become established. Clinical supervision has the advantage that it does not have the history that has affected appraisal, but it was suggested that it could become another means to control the profession. Enthusiasm within the profession for clinical supervision should be capitalised upon and nurtured, and used to demonstrate the developmental intention of an organisation. The introduction of clinical supervision could help in the (re-)establishment of appraisal, in part by helping to reduce the suspicion and indifference.

The evidence and records of appraisal will significantly influence effectiveness.

To overcome the concerns about confidentiality and access to appraisal evidence the research confirmed that records should be held by the individual nurse and seen as their property. This would reinforce the primary intention of appraisal as a developmental activity and precludes the use of these records for other purposes, other than with the nurse's consent. The evidence could contribute to the departmental evaluation, or be used as evidence in support of career enhancement, but only if the nurse advances them.

This approach accommodates the recent proposals from the UKCC that require individual nurses to create a personal professional profile. The profile should contain evidence of competence and of development; this is the ideal location to store appraisal evidence. Adoption of nurse-held records also overcomes the bureaucratic problems of how long to keep the records, who should have legitimate access to them, and whose responsibility they are. Profiles may need to be submitted to the profession (UKCC) to be scrutinised in order to monitor development. This places the emphasis upon the nurse to ensure that appraisal and evaluation of performance occur. However, nurses who currently shy away from appraisal should not be induced into undertaking it merely to produce records. Records are a by-product of developmental appraisal.

The evidence of appraisal could be drawn from a number of sources (including patients) and logistically the individual nurse is best placed to collect it. Multiple

sources of evidence were seen by the nurses in this study to offer a stronger basis upon which to make judgements and help the nurse gain an accurate impression of performance.

The need for records of the appraisal events should not be confused with the evidence on performance. Such records may need to be kept by the nurse manager to confirm the process is operating, but they do not need to include detailed evidence of the developmental goals. A record of which goals are being worked towards, together with a brief record of achievement could be kept, but these should be freely accessible to the individual nurse and kept confidentially unless consent is obtained for their use elsewhere.

Appraisal should reflect the ethos of holism.

Appraisal had limited impact for nurses in this study. This was in part as a result of the failure to acknowledge the importance of holism that encompasses nursing practice. Appraisal schemes were operated without taking account of the contradiction they presented to the caring nurse if an apathetic, hasty and punitive approach to appraisal was used. This presents a picture that is the antithesis of the quality care the profession strives for. Appraisal needs to operate in a culture where critique is valued and to be established within a relationship where challenges to practice are met by the genuine intention to provide support. This will provide a culture for appraisal in which individuals are valued and collaboration and mutual respect predominate. This will advance good nursing care and development in accordance with the psychological and negotiated contracts as well as the desires of the nurses.

What follows are a set of guide-lines that incorporate the above reflections into a practical guide for action.

GUIDE-LINES for APPRAISAL for NURSES

These guide-lines present a flexible approach to appraisal for nurses, that will require local agreement about the details. They are intended for all grades of Nurse (nurses, midwives and health visitors), including those who will be appraised as well as those responsible for establishing and conducting appraisals. Appraisal is the process of planning that results from the evaluation of performance. It evaluates the personal, organisational and professional contribution of an individual and creates appropriate action plans to ensure development. The guide-lines recommend that from the outset, appraisal for nurses should operate in conjunction with activities such as clinical supervision.

THE BENEFITS

The organisation, the profession and the individual nurse will benefit from appraisal operated as a developmental activity, in a number of ways:

* Improved patient care Appraisal should provide regular performance feedback to confirm good practice outcomes. Using evidence from a number of sources, it will enable the nurse to gain a realistic picture of their performance. The **negotiation** of goals will enable the nurse to plan development to address needs.

* The development of potential and improved use of resources Appraisal can assist the nurse to recognise the importance of continuing professional development and to accept the notion of life-long learning. The development of potential will lead to professional fulfilment for the nurse and optimise their contribution to the organisation.

* Improved morale The recognition of the contribution made by the nurse will assist in recruitment and retention of staff and enhance performance by improving morale.

THE PRINCIPLES

The primary principle that should underpin appraisal is development, both of nurses and of nursing. This principle should be evident in every aspect of the activity.

* Appraisal should operate interactively with clinical supervision.

* It should draw evidence from a number of sources, to reflect the range of work of the individual.

* It should be undertaken within a professional relationship of mutual respect.

* The responsibility for appraisal should be held jointly by the nurse and their manager.

THE PURPOSES

Appraisal has a number of purposes and functions, including some that contradict the principle of development.

Professional purposes

Appraisal is important to the development of the 'good nurse' who 'cares'. It can achieve this development in a number of ways, by:

* supporting and challenging autonomous practice
* ensuring accountability
* developing the psychological contract to care.

Sound purposes

There are a number of purposes that will reflect the needs of the nurses and the organisation:

* providing feedback on performance
* assessing education and training needs
* improving performance
* negotiating goals
* facilitating organisational and personal growth
* planning service development.

Ancillary benefits

A number of benefits may arise that have broader organisational impact.

* improving interpersonal communications
* developing analytical skills
* increasing trust, regard and enhancing interpersonal relationships.

Questionable purposes

There are a number of purposes that might have the effect of inhibiting appraisal, and may reduce its benefits.

* to control performance or to rank/compare staff
* to help decisions about reward strategies
* to determine employment and promotion
* to trigger disciplinary action.

The use of these purposes may account for reluctance in nurses to use appraisal and can conflict with the central purpose of development. Individual nurses might wish to use appraisal information in support of promotional claims or to confer reward, but these should be agreed or initiated by the nurse. Failure to perform satisfactorily should be dealt with by the separate process of disciplinary action, not by appraisal.

PROCESS OF APPRAISAL

a. RELATIONSHIP WITH SUPERVISION AND PROFESSIONAL DEVELOPMENT

The introduction of Clinical Supervision[1] and the requirements for professional development outlined in the PREP recommendations from the UKCC[2], reinforce the importance of developing skills and competence. Supervision can help generate goals and provides the opportunity to regularly

review their development. Clinical supervision and appraisal should therefore be operated interactively.

b. ANNUAL PERFORMANCE REVIEW AND GOAL SETTING

The provision of an annual performance review and goal setting will allow the nurse to gain feedback on their performance and plan for the following year. This meeting should be with a more senior colleague and proceed as follows:

* The review should focus on the individual and commence within the first month of coming into post, with an introduction to the process and preliminary goal negotiation.
* the evaluation of performance should include evidence gathered from a **number** of sources to create an annual summary. An example of an annual summary document is given at the end of these guide-lines.
* gathering of the appraisal evidence should be the responsibility of the individual nurse.
* The more senior colleague who assists in the appraisal activity should only be responsible for as many other nurses as their workload permits. It is suggested this might be no more than six. They should be conversant with the organisational goals and have the authority to negotiate goals and develop the nurse's job description. They **may** also be the nurse providing supervision.
* No goals should be cascaded down the organisation; goals should be negotiated with each individual nurse.
* The job description and supervision activity should dynamically interact to create goals and vice versa.
* Goals should be generated as a result of current practice as well as from the annual review.

c. RECORD KEEPING

The evidence of performance, records of negotiated goals and evaluation of progress to meet them should be the responsibility of the individual nurse. They should be kept within the nurses's own personal professional profile. The use of learning contracts to frame goals may help, and a simple example is include in these guide-lines.

Records of appraisal **events** should be kept by the line manager in order to monitor the process.

d. INDIVIDUALISED PERFORMANCE REVIEW (IPR)

These guide-lines are designed to apply equally to existing schemes of appraisal, such as IPR, as well as informing the provision of appraisal for all nurses.

OPTIMISING APPRAISAL FOR NURSES

Ensuring that the following factors operate is central to the success and full benefit of appraisal for nurses:

* It should be recognised that apathy and apprehension exist for many nurses with regard to appraisal.
* The purpose, design and process of appraisal should be the development of nurses, the profession and the organisation.
* Appraisal should operate interactively with clinical supervision.
* Appraisal should be conducted in an atmosphere of mutual respect and interest.
* Evidence of performance should be collected from a number of sources.
* Appraisal evidence should focus on reflection on practice and be facilitated by support and challenge to create development.
* Records of evidence gathered and planned goals should be held by the individual nurse in their professional profile.
* A nurse should be identified to coordinate the appraisal activity in each setting.
* Annual reviews and personal goals should contribute to, and reflect organisational goals. Job descriptions should accurately reflect the role and be concurrently reviewed and updated.
* Appraisal activity should be audited and evaluated to ensure its benefit to all nurses.
* Time should be identified for appraisal activity to be undertaken, with appointments planned in advance.
* Regular review and on-going support will ensure negotiated goals are met.

REFERENCES

1. Kohner N (1994). Clinical Supervision, an Executive Summary. London: Kings Fund Centre.
2. UKCC (1994). What PREP will mean for you? UKCC Register 15, p4-5

ACKNOWLEDGEMENT

These guide-lines were generated from research that looked at "Appraisal and Professional Fulfilment for Nurses" in the Oxfordshire Health District. The case study set out to explore the nurses experiences and attitudes towards appraisal. It revealed that many nurses were uncertain about the answer, and dissatisfied with their experiences of appraisal. These guide-lines reflect their views about 'good appraisal' as an activity that should enhance the organisational, professional and personal potential of nurses.

Nigel Northcott, Oxfordshire Clinical Education and Practice Team (OXCEPT), Academic Suite, Littlemore Hospital, Oxford. OX4 4XN. 01865 221578, or 13 Riverview, Sandford on Thames, OXON, OX4 4YF.

PERSONAL DEVELOPMENT CONTRACT

Date..... Contract number ....

Name i.....Helper ii.....Line Manager iii.....

IDENTIFIED NEED / GOAL.

OUTCOMES TO MEET NEED.

RESOURCES NEEDED.

TIMETABLE.

PROGRESS, REVIEWS AND EVALUATION.

Agreement signature i.....ii.....iii.....

Achievement signatures i.....ii.....iii.....

Date.....

Note. This sample of a learning contract recognises that the helper(s) may be different from the line manager and that agreement includes the provision of support and assistance.

ANNUAL PERFORMANCE REVIEW EVIDENCE

Name.....Date.....Location.....

PERSONAL REVIEW

PEER REVIEW

MANAGER REVIEW

CUSTOMER REVIEW

COLLEAGUE REVIEW

STAFF REVIEW

Signatures Nurse.....Date
Nurse manager.....Date

The information in each section may be provided by inviting the appropriate person to write directly onto the review, or by the nurse completing a summary. The review may be used directly or indirectly to complete a departmental annual review. The customer review might be third-party information, spontaneous feedback or indeed solicited evaluation. The staff review section should only be completed by staff with line management responsibility.

APPENDIX I

GUIDELINES ON PROFESSIONAL NURSING PRACTICE IN OXFORDSHIRE

PROFESSIONAL PRACTICE

Introduction

These guidelines are agreed by the Directors of Nursing Service in Oxfordshire and therefore apply to all nurses, midwives and health visitors.

Welcome to Oxfordshire and we hope that you will be happy and enjoy nursing here. We are keen to achieve very high standards of nursing. We believe that patients/clients are best served by nurses who clearly understand the nature of professional nursing practice. In turn, we believe nurses should be helped and supported in developing their professional practice.

We acknowledge that each patient/client should have a named registered nurse and that each nurse should be individually responsible and accountable for their practice. The way in which this principle is achieved will vary in different teams. We encourage work organisations which allow nurses to be responsible for individual patients/clients, whatever the duration of their need.

Nursing in Oxfordshire tries to avoid restrictive procedure lists of what nurses may or may not do, and to encourage teams and their managers to agree among themselves and with their medical and other colleagues what new work the nursing team should take on and what new skills need to be developed.

The guidance at all times is:

- Individual nurses are responsible and accountable for their own decisions and actions.
- They must be able to defend those decisions and actions as being in the best interest of patients and clients.
- They must only undertake work for which they are trained and competent to perform.

NEW NURSING WORK

The above guidance also applies to new nursing work. A nurse must know and abide by UKCC, Oxfordshire Health Authority Individual 'TRUST' and local policies for new work and be clear that this is undertaken in the best interests of patients/clients.

- Responsibility and accountability for the new work must be clearly defined and accepted.
- Nurses must refuse to undertake work for which they are not trained or competent to perform.
- Training and assessment of competence must be undertaken.

Guidance can be obtained from your own nurse manager or Clinical Practice/Professional Development Nurse.

LIABILITY

The legal position is, and always has been, that each individual is responsible for their own actions. It is noted in HC(76)26 that in any action for damages a nurse may be held legally liable if it can be shown that either they have failed to exercise the skills properly expected, or that they have undertaken tasks that they are not competent to perform. In approving policies that involve new nursing work the Trusts within the Oxfordshire Health Authority would accept liability for the nurse's actions.

NURSING MANAGEMENT AND SUPPORT

Each Trust within the Oxfordshire Health Authority will have a nursing executive and a unique management pattern. Each nurse should acquaint themselves with that individual Trust's management structure.

OPPORTUNITIES FOR LEARNING AND INCREASING PROFESSIONAL COMPETENCE

Oxfordshire is committed to investing in its qualified nurses and there are many opportunities for learning and development. Maintaining and developing professional competence is seen as the responsibility of each qualified nurse.

Central to this activity are Lecturer Practitioners who are employed to integrate theory and practice, to enhance patient/client care.

It is the District policy that each nurse should have a regular opportunity to formally review their progress and plan their development with their nursing manager. The responsibility for arrangements lies equally between the individual nurse and the line manager.

The School of Health Care Studies (Post Registration) offer post basic courses approved by the English National Board and Oxford Brookes University which cover clinical and community interest. They also offer the Diploma in Nursing and post registration Degrees in Health Care Studies. Details of all these courses is available from Jill Brookes, Ext 21550.

The Clinical Education & Practice Team (OXCEPT) provides a range of professional activities open to all Oxfordshire Health Authority nurses. A newsletter detailing events is published each term and circulated to all clinical areas, details from Joy Carter, Ext 21578.

The National Institute for Nursing based in the Radcliffe Infirmary provides a centre for practice development and research. Details of activities can be obtained from Jane Rose, Administrator, on extension 24833.

NURSE PREPARATION IN OXFORDSHIRE

A 4-year degree programme in all branches of Nursing and Midwifery is offered by the Oxford Brookes University, School of Health Care Studies for all nursing and midwifery students in Oxfordshire. This is clinically facilitated by the lecturer practitioners.

Practice Sub-Group, Nursing Policy Group
April 1993 profguid
Revised August 1993

APPENDIX II
INTERVIEW PROCESS M2

APPENDIX III
GROUPS FEEDBACK
MAP 3

QUOTE!

Until you interviewed me, and until I'd seen all this ... I really had it realised seen how important it was...
I felt ~~very~~ really angry I've never had a good IPR or ... you feel almost that you're fodder
You'd die there and no one would recognise what you've done

3:4

It's so stretched at work it's difficult to keep buoyant.

MAPPED DATA

NOT SURPRISED
lack of job description
expectation of success
benefit etc
Not met by reality.

SURPRISE
5.11.3
* degree of disappointment. at the number and extent of negatives.
* number of benefits identified. that mitigate and fear was present
* had it considered being trained to be appraised was useful
* how much data has been produced (how broad)

Respondent value — I enjoyed taking part in taking part

Generated according to their experience

Sept. Oct.

concern that culture might be hostile
ration difficulties

ACCURACY
5.11.1
- importance of culture
I could tell I'd said some of it.
Not surprised at the range of comments — NB Des/Att. Appraisal
agreement with range — No consensus
Could the sentence be what respondents feel they should have said.
The wide variety of views is to be effected (some) — different experiences
You can pick out things you might have said
the content is credible

anonymity
I could still recognise myself directly

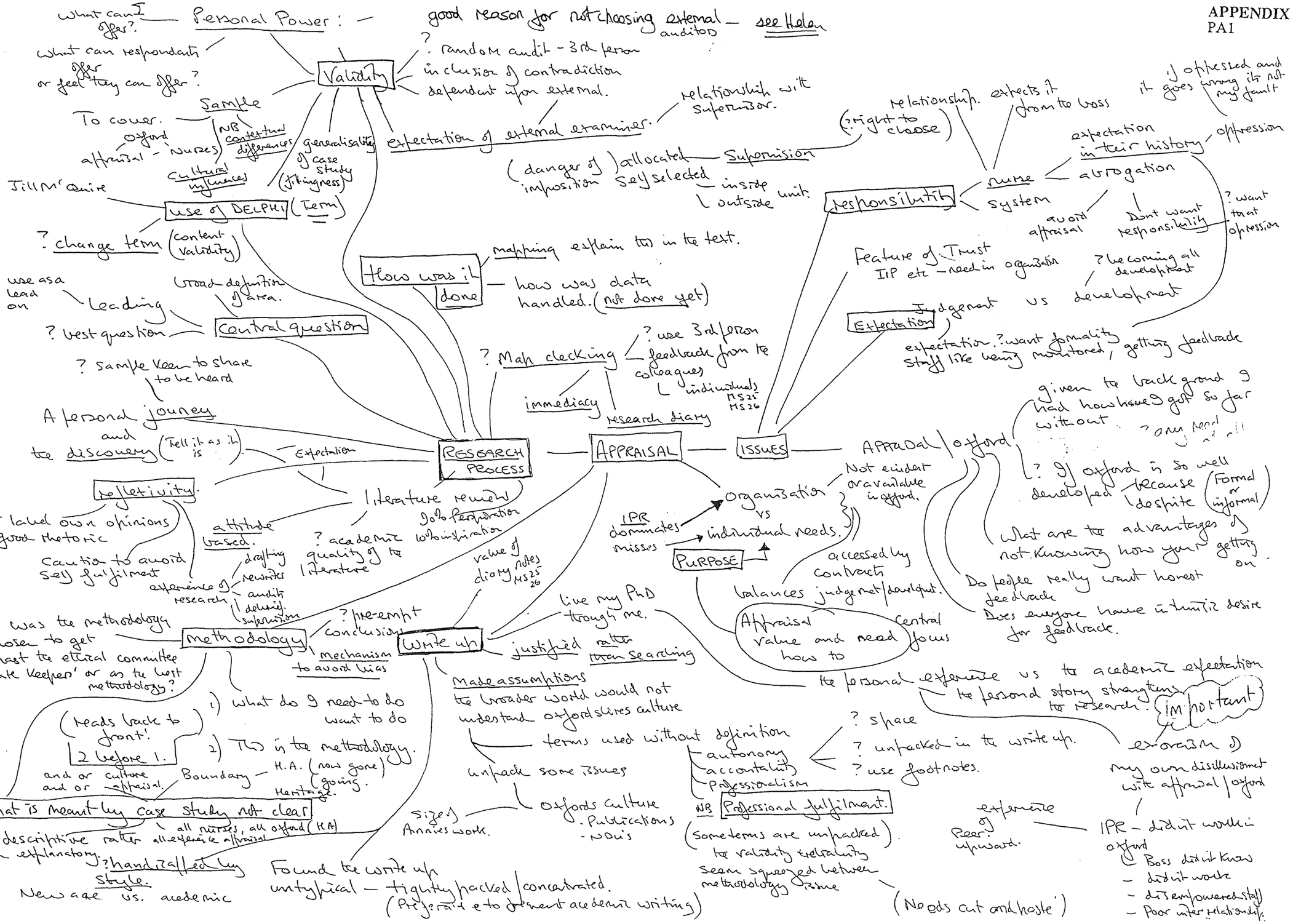
APPRAISAL
Good features
+ Practice focus
+ multiple raters
+ much more than annual
Different to IPR

QUESTIONS
How did you get those headings
asked about quantitative evidence — how many people said certain things
grandparent in IPR?
Did appraisers & appraisees have different views.
What is perceptions.

TRAINING
Role Play Training & cascade — managed very badly
— damaging experience for Participant

NEW EVIDENCE
Confusion re information for Midwives
Appraisal should have structure
Be informally formal
assumed people would be able to appraise
experience would alter evidence
expectation of appraisal not being met.
appraisal could be used as a form of brainwashing
mythical
Risk of intrusion — badly managed 'therapy'
job description vital — or appraisal can help create J.D.
records — in portfolio — appraiser holding notes to assure continuity.
Control — Positive (Professional)
Negative (Bureaucratic)

WAY FORWARD
? New Term supervision to overcome expectation
NB Culture of NEW TRUSTS.
Separate appraisal (summary)
Supervision (formative)
antagonism enthusiasm
Try it out
guidelines not prescription
acknowledge
must address practice (fundamentals of care)
Hit and miss
supposed cascade in place in today
recomend framework
recomend HOW TO as well.
Clinical nurses missed!
Cascades (risks)


Personal Power: —
what can I offer?
what can respondents offer or feel they can offer?
Validity
good reason for not choosing external auditor — see Helen
? random audit - 3rd person
inclusion of contradiction
dependant upon external.
Sample
To cover.
Oxford Appraisal - Nurses
NB contextual differences
Cultural influences
generalisability of case study (Stringency)
expectation of external examiner.
relationship with supervisor.
(danger of) allocated — Supervision
(? right to choose) Self selected — inside / outside unit
relationship. expects it from to boss
it gives / offended and wrong its not my fault
expectation in their history
oppression
abrogation
Responsibility
nurse
system
avoid appraisal
Don't want responsibility
? want to at oppression
Jill Mr Quire
use of DELPHI (Term)
? change term (content validity)
how was it done
mapping explain this in the text.
how was data handled. (not done yet)
use as a lead on
Leading
? best question
Broad definition of area.
Central question
Feature of Trust IIP etc - need in organisation
? becoming all development
Judgement vs development
Expectation
expectation. ? want formality staff like being monitored / getting feedback
? sample keen to share to be heard
A personal journey and the discovery (Tell it as it is)
? Mah checking
? use 3rd person feedback from to colleagues / individuals MS25 MS26
immediacy
research diary
RESEARCH PROCESS
APPRAISAL
ISSUES
Appraisal / Oxford
given to background I had how have I got so far without
? If Oxford is so well developed because / despite (Formal or informal)
What are the advantages of not knowing how you're getting on
Do people really want honest feedback
Does everyone have in their desire for feedback.
Reflexivity.
× label own opinions
× good rhetoric
Caution to avoid self fulfilment
attitude based.
literature review
? academic quality of the literature
No participation
No indication
drafting
rewrites
audit
delivery
supervision
experience of research
value of diary notes MS25 26
Organisation vs individual needs.
Not evident or available in Oxford.
IPR dominates misses
PURPOSE
accessed by contracts
balances judgement/development.
Appraisal value and need how to
central focus
Methodology
? pre-empt conclusion
mechanism to avoid bias
Write up
live my PhD through me.
justified rather than searching
Was the methodology chosen to get past the ethical committee gate keepers' or as the best methodology?
Made assumptions the broader world would not understand oxfordshires culture
terms used without definition
autonomy
accountability
professionalism
? space
? unpacked in the write up.
? use footnotes.
unpack some issues
Oxfords culture
- Publications
- NDU's
Sizer Annies work.
NB Professional fulfilment.
(Some terms are unpacked)
the validity reliability seem squeezed between methodology issue
(Needs cut and paste)
the personal experience vs the academic expectation
the personal story strengthens the research. IMportant
exorcism of my own disillusionment with appraisal / oxford
experience of Peer / upward.
IPR - did it work in oxford
Boss did it know
- did it work
- disempowered staff
- Poor interrelationship
1) what do I need to do want to do
2) This is the methodology.
(reads back to front)
2 before 1.
Boundary — H.A. (now gone) (going.) Heritage.
and or culture and or appraisal.
What is meant by case study not clear
all nurses, all oxford (HA)
descriptive rather than explanatory.
? hand crafted by style.
New age vs. academic
Found the write up untypical — tightly packed / concentrated.
(Prejorative to dominant academic writing)

APPRAISAL — WHERE EVALUATION MEETS PLANNING

APPENDIX V
FINAL MAP JAN 1995
FURTHER ANALYSIS AND INTERPRETATION

The way we do things around here
Deal T Kennedy K Corporate cultures: the Rites + Rituals of Corp Life
Penguin.

Not control

High

Vision

Challenge

Facilitation
Privacy
Time
Enthusiasm
Respect
Gender
Genuine Control

INTERPERSONAL DYNAMICS

10 ORGANISATION CULTURE

Learning opportunities

LEARNING

SUBSIDIARITY

Climate
Client Interest
support + bars
striving to improve

INDIVIDUAL
- Goals
- Role requirements

1 WHO of

MUTUAL PROCESS

TEAM
- EFFECT
- IMPACT
- INFLUENCE

GROWTH
DEVELOPMENT
Professional Judgment

PHILOSOPHY 2

IN ACTION

Dalog

BURNOUT
RETREAT
GROWTH

Apathy
Stasis
Confirm
Comfort

how

Support

- give feedback/motivation
- assess training needs
- improve performance
- set goals
- help planning
- plan promotion
- reward

high Valued appreciated

Psychological contract (Mullins)

moral commitment to serve esteem
obligation to self monitor
at hand knowledge/Prac
contribute wider
(Erault 236)

Performance Reward criteria

Good

Develop ment in practice

Poor

Good Practice / Poor Appraisal	Good Practice / Good Appraisal
Poor Practice	Poor Practice
Poor Appraisal	Good Appraisal

Appraisal

Good

4 POSSIBLE OUTCOME

PERFORMANCE APPRAISAL MANAGEMENT

3 PURPOSE

Stretch not stress

SOUND

PROFESSIONAL
- accountability
- autonomy
- communication
- motivation
- analytic skills

ANCILLARY

QUESTIONABLE
- hire
- fire
- P.R.P.
- control

HOW DO YOU KNOW YOU'RE A GOOD / BEA BETTER NURSE ?

LEARNING CONTRACTS

5 RECORDS

OWNERSHIP

UKCC PREP

PROFILE

Goals
Reflective Practice
Critical incidents

Bars
org Data
etc

methods

7 SYSTEM

Supervision

JORMATIVE + SUMMATIVE

Support
Management — Education

REFLECTION ON PRACTICE

APPRAISAL (DYNAMIC)

EVALUATION / REVIEW

(JORMATIVE)

Future Past Present

Informal / spontaneous

Planned — episodic (IRR)
SUMMATIVE annual
(goal setting)
not just HR!
(Limitations)

8 TIME

To set up / agree

TO DO — Training
TO BE — Running

INVESTMENT

by WHO

- colleagues / Peers
- Self
- Boss
- customer
- staff

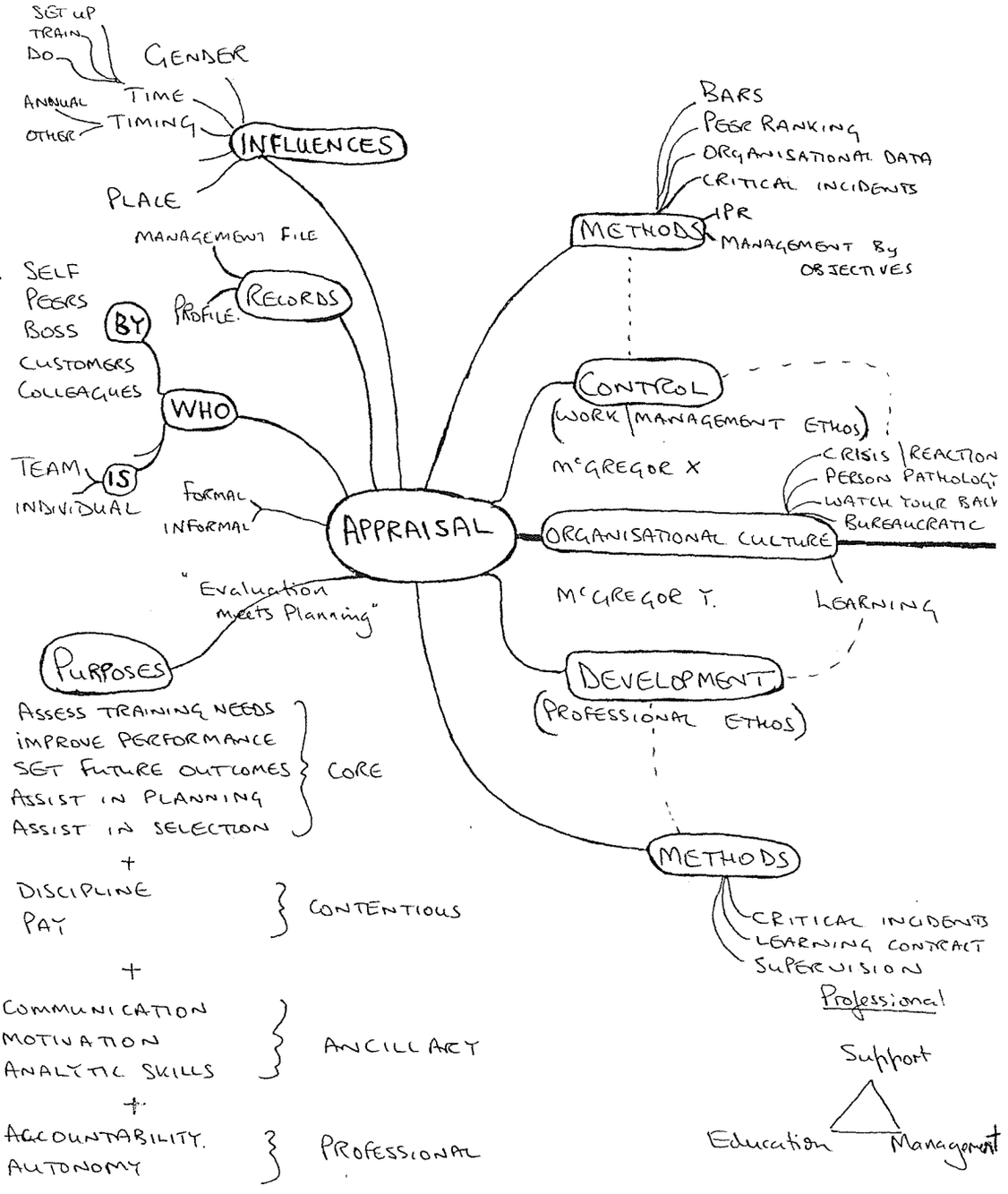
Multiple raters.

of WHAT 6

Clinical - Practice
Personal
organisational

Job description

APPENDIX VI
SOME OF THE ISSUES
OCT 1992



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