RADAM

(readable appraisal discussion assessment method)

Introduction
This is a revised ADAM document that is aiming to be both readable and useful to appraisers.
Colleagues in Wales had previously identified that **we cover eight areas in the appraisal discussion.**
This project identified what appraisers do during the appraisal discussion and then **allocated appraiser behaviours into one of three categories: excellent, competent and needs further development.**
We hope this simple format helps appraisers access the information and to use it as a resource for their appraisal work by considering an area of the appraisal discussion and comparing what they do to RADAM and then making changes if this is needed.

Area one: Preparation and Planning

Excellent	Competent	Needs further development
Appraiser fluent with content of doctor evidence including: . detailed knowledge . understanding of issues . leading to flexibility in discussion The appraiser feeds back on the disruption caused by repeated or significant interruptions	The environment appears suitable to the doctor and appraiser: . private room . seating arrangements suitable Appraiser appears to have detailed notes, e.g. draft appraisal summary Appraiser refers to the notes Appraiser has planned which areas to discuss Appraiser has evidence of prepared questions Appraiser familiar with the doctors evidence The appraiser recognises and deals with interruptions	The environment appears unsuitable . not private room . seating arrangements unsuitable Appraiser appears to have no notes Appraiser has no evidence of prepared questions Appraiser is not familiar with the doctors evidence Appraiser focused interruptions

Area two: Engage and explain (includes signposting)

Excellent	Competent	Needs further development
Purpose: . acknowledge achievements . recognise barriers . generate PDP Agenda (Doctors evidence entries): . important to doctor . important to appraiser . relevant to responsibilities . focus on patient care	Introductions made Informal discussion (icebreaker) Signposting: . purpose described . agenda described . timeframe described . process described including discussing last year's PDP	No introductions No, or too much informal discussion Little/no description of purpose Little/no description of agenda Little/no description of the process

. revalidation requirement . third party requirement Process: . discuss Dr evidence entries/constraints/reflections . areas for development(action point) Discussion includes: . doctors attitude to appraisal . doctors work role – and link to appraisal . appraisers role to facilitate/challenge/pass information when appropriate		Little/no evidence of signposting

Area three: Last year's PDP

Excellent	Competent	Needs further development
Last year's PDP: . exploring outcomes of achieved PDP items . evidence of challenge of non-achieved items . consideration of constraints . reiteration of importance and relevance of PDP relating to revalidation	Last year's PDP items discussed: Achievement identified Acknowledgement of achievement Items not achieved identified Reasons for non-achievement identified Discussion regarding continued relevance of non-achieved PDP items, leading to identification of further action points	Last year's PDP: . last PDP not discussed . achievements not identified . items not achieved ignored

Area four: Discussing the Drs appraisal evidence and agreeing action points

Excellent	Competent	Needs further development
Appraiser encourages doctor self-evaluation Appraiser challenges to uncover doctor: . effect on professional activity . relevance to patient care . reasoning . interest . motivation . preferred learning style . developmental inertia Action points justified – through relevance to doctor's role and discussion of possible: . change in professional activity . improvements in patient care	Items chosen because: . doctor choice . doctor responsibilities . appraiser choice through negotiation . focus on patient care . revalidation requirement . third party requirement Appraiser briefly summarises doctors evidence leading to new discussion Appraiser is facilitative Appraiser probes, gathering more information using:	Items for discussion picked at random The doctor appears to repeat areas described/ reflected on in F3 (through lack of appraiser summarisation) By not probing or challenging the appraiser adds no value to the material discussed Appraiser: . tests knowledge . acts as a teacher . is directive

. motivation . interest . revalidation . learning styles	. checking to confirm understanding . summarisation to confirm understanding Appraiser encourages the doctor to identify learning points Action points identified from a 'next steps' discussion Action points agreed Appraiser acts as resource for information about appraisal and revalidation	Appraiser fails to identify learning points Action points are not considered

Area five: Constraints

Excellent	Competent	Needs further development
Wider value of constraints discussed with respect to delivery of local services and education New constraints are identified and labelled as such in the discussion. Constraints are identified and appraiser challenges to seek potential or real solutions Action points from discussion of constraints are: . identified . considered . agreed	Constraints are identified from the discussion of the doctors: . role and responsibilities . F3 entries including: . probity and health . reflections . constraints entries . last year's PDP Analysis of constraints through a brief discussion Absence of constraints discussed	Constraints are: . not identified . not discussed 'Nothing can be done' collusion

Area six: Agreeing the PDP

Excellent	Competent	Needs further development
Living PDP is considered Living PDP items are justified through brief discussion PDP items are prioritised by: . doctor interest . doctor professional responsibility . learning to improve patient care . doctor professional requirement (e.g. revalidation) . to show progression from last PDP Appraiser encourages ownership of PDP through: . doctor identifying learning outcomes . doctor description of documentation to validate	Signposting 'PDP time' Dedicated time to plan the PDP Considers action points from: . doctor evidence entries . constraints . probity and health . last year's PDP Action Points are prioritised to PDP entries Appraiser negotiates the PDP to make it: . specific . achievable . aim to improve patient care	No signposting of PDP time No dedicated PDP time Action points: . not reviewed . not prioritised PDP is mainly constructed by appraiser No consideration of: . specificity . achievability

learning
. doctor agreeing a timeframe

Area seven: Next steps and closing the discussion

Excellent	Competent	Needs further development
Appraiser closes after checking 'anything else' before moving on	Next steps discussed: . appraisal summary completion, timeframe . email contact . doctor to review appraisal summary . doctor to agree the appraisal summary or request amendments . appraiser suggests choosing next appraiser Appraiser signposts the end of the discussion and closes the discussion	No clear end to the discussion Omits next steps

Area eight: Encouraging ownership of the appraisal summary

Excellent	Competent	Needs further development
The appraiser recognises and explores the reasons for doctor emotional responses The appraiser encourages doctor reflection through eliciting: . ideas . concerns . expectations . effect on doctor's team . feelings of doctor's team . effect on patient care The appraiser is able to use facilitation and information giving when appropriate Appraiser maintains a focused appraisal, without closing down the discussion, whilst maintaining flexibility	Appraiser recognises and manages issues of confidentiality The appraiser shows interest and the doctor is engaged, rapport is established: . eye contact . verbal encouragement . non-verbal facilitation . recognition of emotion . use of facilitative language . shared humour The appraiser: . acknowledges doctor achievement . shares experiences to facilitate . gives peer-based feedback . is mainly facilitative . shares information (e.g. process, revalidation)	Confidentiality is breached by the appraiser The appraiser: . appears disinterested leading to doctor disengagement . ignores doctor achievement . does not give advice when needed The appraiser appears to: . teach . show off . self-deprecate . humiliate The appraiser dominates and does not encourage doctor contribution: . appraiser imposes their choice of doctor evidence entries . verbal cues ignored . non-verbal cues ignored The appraisers diction or inappropriate use of language causes misunderstandings