Objective setting

A guide to objective setting

Introduction

The document ‘Consultant job planning – standards of best practice’ which is applicable to all consultant medical and dental staff, provides guidance for the introduction of objectives into the consultant job plan. It states that “a consultant job plan should be a prospective agreement that sets out a consultant’s duties, responsibilities and objectives for the coming year”, and “consultant job plans should set out agreed personal objectives and their relationship with the employing organisation’s wider service objectives.”

Schedule 3 of the Terms and Conditions of the 2003 contract goes further in that it provides a contractual framework for the role of objectives in consultant job planning and this is explored later in this section.

It is clear that job planning is now much more than the simple agreement of a timetable; amongst the many criteria to be agreed during the job planning process are a consultant’s objectives and the supporting resources required to deliver them.

This section provides:

- a review of the objective setting section of the terms and conditions
- generic guidance on how to go about setting objectives
- specific advice for the clinical manager and the individual consultant.

The flow diagram below provides a useful aide memoire of the inputs and outputs that need to be considered by both parties, when setting objectives.

![Flow Diagram](Consultant job planning toolkit (January 2005))
Schedule 3 of the Terms and Conditions has the following section on Objectives. This sets out how objectives should be included within the job planning process, some broad details on what areas objectives might relate to, and some clarity as to how objectives should be viewed by the clinical manager and the consultant.

Objectives

3.10 The job plan will include appropriate and identified personal objectives that have been agreed between the consultant and his or her clinical manager and will set out the relationship between these personal objectives and local service objectives. Where a consultant works for more than one NHS employer, the lead employer will take account of any objectives agreed with other employers.

3.11 The nature of a consultant’s personal objectives will depend in part on his or her specialty, but they may include objectives relating to:

- quality;
- activity and efficiency;
- clinical outcomes;
- clinical standards;
- local service objectives;
- management of resources, including efficient use of NHS resources;
- service development;
- multi-disciplinary team working.

3.12 Objectives may refer to protocols, policies, procedures and work patterns to be followed. Where objectives are set in terms of output and outcome measures, these must be reasonable and agreement should be reached.

3.13 The objectives will set out a mutual understanding of what the consultant will be seeking to achieve over the annual period that they cover and how this will contribute to the objectives of the employing organisation. They will:

- be based on past experience and on reasonable expectations of
- what might be achievable over the next period;
- reflect different, developing phases in the consultant’s career;
- be agreed on the understanding that delivery of objectives may be affected by changes in circumstances or factors outside the consultant’s control, which will be considered at the job plan review.

Extract from Terms and Conditions Consultants (England) 2003
What is an objective?

A vital part of the clinical manager’s role is to set sensible, achievable objectives with each of the consultants in their directorate.

An objective is a task, target or development need that the consultant, or the consultant and the person with whom he/she has agreed the objective, wishes to achieve. It should reflect the needs of the consultant, the organisation, health community and health service. In this context, it should arise out of the appraisal process or the job planning process. It should be well thought out, agreed and the resource implications known. The latter could include time, educational pursuit or equipment to name but a few.

Many objectives will be team based rather than focussed at an individual. In these cases, the role played by each individual has to be clear.

Objectives may also have different time scales. At the outset, it is essential to agree the proposed time scale, whether weeks, months or years. At the same time, it is necessary to establish a process for evaluating progress towards achieving the objective.

As objectives may arise from either or both of the job planning meeting or the appraisal process, it is essential to understand the linkages between appraisal and job planning. Almost certainly, these will vary not only between Trusts but also within a Trust. A separate section in this handbook looks at these links.

Clarifying expectations

One of the most common problems that clinical managers face is clarifying with consultant colleagues what performance is expected of them and how it will be reviewed. Lack of clarity can have a detrimental effect on matters such as achieving the anticipated levels of performance, individual or team motivation, the value of the appraisal process, relationships between colleagues and the credibility of the clinical manager in terms of effective leadership.

Clarifying performance expectations can, if handled positively, increase the chances of getting higher performance; provide a greater understanding of the direction of travel and may help motivate individuals and teams, thereby improving relationships.

In other words, there is a lot at stake.

Getting it wrong will actually consume more time and effort than getting it right. It has been shown that the presence of job descriptions and appraisal systems do not make the expected difference to performance clarification. The two things that do make a big difference are thinking beforehand and open discussion.

Thinking

Clinical managers must clarify in their own mind the performance and behaviour that will make a real difference and lead to the setting of real objectives. They require both holistic and descriptive thinking to achieve this.

Thinking holistically means thinking about the whole picture - technical skills, personal skills and inputs and outputs. While, in the final analysis, it is only the outputs that matter, sometimes by paying more attention to the inputs, the outputs will fall into place.

Thinking descriptively helps avoid the trap of discussing performance expectations in terms that are general and subjective. Words like maximum, best, efficient and effective are too vague to clarify performance expectations. The expectations need to be specific and objective – and that is easier than it sounds. They should be measured against three levels of performance – ‘above requirements’, ‘meets requirements’ and ‘below requirements’:
Therefore objectives should be set according to the task, and the performance required for meeting the task, rather than the potential capability of the consultant to perform other tasks.

Having thought through the performance required from consultants, the next stage is to communicate it to them.

Discussion

This concerns the relevant clinical manager and consultant achieving a common understanding of performance expectations. So discussing performance rather than just telling colleagues what is required has several benefits:

- thinking becomes better tuned and enhanced by what is said. Discussion about performance expectations usually makes those expectations more incisive and comprehensive
- people will naturally resist anything they feel is being forced on them, and are more likely to ‘own’ something they have helped create during the discussion
- discussion, listening and agreeing helps build relationships.

The appraisal process should help here as it concerns feedback being given on performance against expectations. One of the ways in which clinical managers can clarify performance expectations further is to agree realistic, achievable objectives.

Agreeing objectives

Agreeing objectives for consultants, either individually or as a team, is a complex, iterative process that may take several cycles to bed in properly. The clinical manager in setting objectives with his/her colleagues has to consider the following:

- aims and objectives of the health community
- the role the organisation will play in achieving these aims and objectives
- the resources available (both people and equipment)
- the skill mix
- the quality achievement (clinical governance status)
- the potential for development - personal and service.

In some situations, the consultant alone will be able to achieve the agreed objective. However, in many situations, whilst the consultant will be responsible for their contribution to the objective, achieving it will require the involvement of other staff – e.g. service related objectives. The process of agreeing the consultant’s objectives should clarify expectations on the part of him/herself, and identify what mechanisms need to be in place to ensure other staff play their part. One way to do this is to ensure that the consultant and team or department objectives are linked.
Whilst the final agreement on the consultant’s objectives is between them and their clinical manager, the involvement of general managers in the process of developing objectives can be helpful. It enables a review of consultant work in relation to the rest of team. This encourages a dialogue between the general manager and consultant about how the consultant could be supported to work most efficiently and effectively. It also enables the consultant to clarify what support will be required to meet objectives.

**Case study:** Having reached agreement with the Local Negotiating Committee, consultants in Hampshire Partnership Trust had a general manager present for the objective setting section of the job planning meeting along with the clinical manager and the consultant.

Consultant feedback was that this approach was helpful. It enabled the consultant to hold the general manager to account for the support required to achieve the objectives, and agreements to be reached to review the roles of staff for whom the general manager had management responsibility.

General managers found it useful to be present, and it facilitated more detailed consideration of service activity and quality than would otherwise have been the case.

There are two potential problems to avoid when agreeing objectives:

1. **Pantomime objectives**
   These are so subjective and general that conversations reviewing performance degenerate into the kind of dialogue heard during a Christmas pantomime. For example, ‘We agreed that you would contribute to team effectiveness’, ‘I have’, ‘Oh no you haven’t’, ‘oh yes I have’…! To overcome this problem it is easy to go to the other extreme and only agree objectives that are easily quantified. That, however, can lead to the second problem.

2. **Incorrectly quantifying objectives**
   This problem is more difficult to spot because the objectives look right. For example, it is easy to create an objective “to reduce the number of patients on a waiting list”. However, as we know, the easiest way to achieve this objective is to give preference to patients with simple clinical conditions. So, although this is a standard hospital objective, it is couched in the wrong language. There should be agreement about targeting those patients with the greatest clinical priority. Measuring the wrong parameters leads to the achievement of the wrong priorities.

The purpose of objectives is to focus consultant’s efforts. Pantomime objectives do not do that and incorrectly quantified objectives might deliver the performance you do not want. So how can you avoid these problems?

**First,** agree a mix of objectives, such as:

1. **Hard objectives**
   These refer to something, usually quantifiable, that must be achieved.
   **Examples:**
   - achieving the 4 hour A & E target
   - to see all out-patients within the 17 week limit
   - cancer service pathology accreditation.

2. **Soft objectives**
   These refer to activities that, whilst important, are difficult or unproductive to quantify. They often describe ‘how’ someone goes about their job and work best when they are descriptive rather than numerical.
   **Examples:**
   - improved quality of service as judged by patients
   - greater involvement of patients in decision making
   - review the working of a multidisciplinary team.

3. **Personal development objectives**
   These relate to a skill or knowledge that, if developed, will improve the inputs and, consequently, the outputs.
   **Examples:**
   - develop a subspecialty skill to meet a required health community demand
   - gain IT database skills or ECDL (European Computer Driving Licence)
   - gain an MBA as a potential medical director.
4. **Team objectives**

These are more useful where the team’s performance is more relevant than an individual’s performance.

**Examples:**
- full accreditation for head & neck cancer team
- increase home diagnosis and follow up of diabetic retinopathy
- reduce hospital admissions by targeting treatment of patients at home e.g. respiratory care team.

5. **Performance standards**

Although not strictly objectives these are appropriate where less-than-acceptable performance would be significant, but where better-than-acceptable performance is either impossible or unnecessary. It relates purely to where performance below the standard is unacceptable.

**Example:**
- if the standard is to see patients within one hour post operatively, then seeing them three hours post operatively would be unacceptable. Whereas seeing them every ten minutes for the first three hours post operatively would be better than acceptable, but unnecessary and an uneconomic use of time.

**Second,** use a framework when discussing and agreeing objectives. The enhanced SMART framework is one of the best:

- **Specific**
- **Measurable (quantified or descriptive)**
- **Achievable and agreed**
- **Relevant**
- **Timed and tracked.**

When discussing performance expectations for the achievement of agreed objectives there are two further things to discuss and agree:

- how the performance will be reviewed
- how the consultant will be helped to achieve good performance.

**Reviewing progress against objectives**

Reviewing progress gives the clinical manager the opportunity to:

- tackle problems while they are still small
- spot learning and development needs that will benefit from immediate attention
- involve other staff in working with the consultant to achieve progress where appropriate
- use feedback to modify behaviour
- capitalise on spontaneous coaching opportunities.

How the clinical manager agrees to monitor performance with the consultant depends on the nature of the objective and the culture of the organisation. Following certain principles can help maximise benefit and help the consultant achieve good performance. It works best when it:

- happens quickly
- is accurate and believed
- is relatively easy to collect and collate
- is ‘owned’ by the people whose performance it is describing
- it is as user-friendly as possible.

Collecting information that is then sent off elsewhere for analysis and which is returned one or two months later hardly meets these criteria, but it is common. Not only does it go against the five principles, but also it prevents local fine-tuning of performance. If consultants can be fully involved in the process, they tend to feel part of it and see the benefit in it for themselves, their team and their patients. This makes it easier for them to achieve their full potential.