Report on the South Region Event for Responsible Officers and HR Leads
Tackling concerns: from avoidance to action

Berkshire Conference Centre – Madejski Stadium, Reading, Berkshire, RG2 0FL
Thursday 29 January 2015

Introduction

The Conference was open to Responsible Officers and all members of the teams who support and work with the RO function. HR Directors and Managers were particularly welcomed in light of the topics and discussions during the day. There were a range of workshops on offer which were repeated enabling attendance at four (two in the morning and two in the afternoon) and there were opportunities for networking for appraisal/revalidation managers/administrators and appraisal leads. The programme for the day is attached **(Appendix A).**

171 delegates attended along with speakers, workshop presenters, GMC Employer Liaison Advisors, lay representatives and the NHS England (South) Revalidation team, totalling 197 **(Appendix B)**. This report provides details of the presentations and workshops and the feedback collected from the evaluation forms submitted by delegates **(Appendix C)**.

During the closing session there was a mention of independent verification visits and feedback from a lay representative and designated bodies who had been involved in a visit **(Appendix D).**

Welcome

The Conference was opened by Mr Nigel Acheson, Regional Medical Director, NHS England (South)

Presentations:

Medical Leadership Revalidation and 'Good to Great'

Mr Peter Lees, Chief Executive and Medical Director, Faculty of Medical Leadership & Management

(slides – **Appendix E**)

Lessons from a case study: How does the Baby P story teach us about staff engagement, avoiding conflict, reducing risks and saving money

Dr Kim Holt, Consultant Paediatrician and Co-Chair of Patients First

(slides – **Appendix F**)

Workshops

Delegates had the opportunity to attend the following selection of workshops during the day:

Workshop 1: Recruitment and induction – appointing the right doctors for your organisation, led by Kathy Gillman, Assistant Director of Human Resources, Buckinghamshire Healthcare, Carolyn Apps, HR Business Partner, East Kent Hospitals University NHS FT and Dr Andrew Dayani, RO and Medical Director, Somerset Partnership NHS FT

Three different approaches to recruiting doctors were shared, developed as a result of concerns with doctors on attitudinal and behavioural grounds, and a clear understanding of the patient and cost benefit of recruiting doctors with team working, empathy and good communication skills.

The approaches included:

- Development of a competency framework, redesign of interview content, training of interviewers, assessment centre with psychometric testing retaining the Advisory Appointment Committee. Outcomes include reduction in complaints about consultants, behaviours and attitudes matching trust values, resulting in improvements in patient experience and care.

- Values based recruitment with a compulsory pre interview visit to the hospital where specific competencies assessed by potential colleagues such as team working and leadership ability, an individual or group presentation assessing communication skills and an observed scenario assessing negotiation skills and patient focus.

- Recruitment including a scenario based assessment in two forms, a written scenario which is discussed and a telephone scenario which assesses verbal skills, listening, empathy, assessment of nuance and clinical language. The panel includes other professions and patients.

Workshop 2: Enabling staff to raise concerns about a doctor – a case study, led by Dr Alison Milroy, Assistant Director (Revalidation) Kent & Medway Area Team (slides – **Appendix G**)

Key messages from this workshop included:

- The need to ensure that all staff working with doctors know when, how and to whom to raise concerns if they have any concerns about a doctor.

- Sometimes doctors who are held in high esteem may not be worthy of the trust placed in them and staff should not be afraid to voice their concerns.

- The impact of the culture of an organisation on the ability of staff to raise concerns.

- The need for chaperones to have training in order to carry out the role effectively.

- The problem of a flat hierarchy and no clear leadership.

- The case study highlighted the numerous opportunities for missing detecting this doctor's behaviour.

Workshop 3: Managing the employment of locums and short-term doctors effectively; from the organisation, the agency and the doctor's perspective, led by Marjorie Rogan, Project Manager Quality Improvement and Patient Experience, NHS England (South) and Fahed Youssef, Locum Agency RO (slides – **Appendix H**)

Discussion points during presentation:

- Robust RO management of locums imperative.
- Shared view of mandatory information – a 'passport' for locums to ensure consistency of information re revalidation is available.
- Need to know the numbers of short term locums working.
- Adopt a similar mapping process to the one used for trainee doctors.
- Provide locums with fixed time to completed revalidation requirements.
- Ensure all information exchanges can be by electronic, user friendly formats.
- A Named person at "employer" site should be responsible for ensuring feedback is provided to the locum agency on performance -could be shift leader.
- Incentivise by offer .
- Locums should approach revalidation in the same way as all other doctors - they shouldn't be treated differently

Workshop notes:

Transient short term locums – little confidence in their revalidation progress. Scope of Practice is worrying.

Locum GPs within community health, is this work included in their whole scope of practice?

Shortly to retire locums – need to ensure their appraisal and revalidation is robust and full scope of practice understood.

Worry – those doctors undertaking private practice only – need confidence processes are robust.

Further training required for locums on the revalidation process – still some confusion.

Need better feedback from placements – who ever signs off the timesheet is responsible for providing feedback on short term locums.

Contracting organisations need to ensure appropriate feedback is sent to agency – not only when there is a problem.

Are we confident locums attached to agencies not on the framework (sub contracted agencies) have a robust appraisal/revalidation process?

Develop an app to allow consultant to provide better feedback.

Broad agreement for 'doctor passport' but would have to be electronic to be accepted.

Work to be done on understanding the number and position of the short term locums moving from one organisation to another.

Workshop 4: Tackling disruptive and dysfunctional behaviour in clinical teams, led by Dr Jenny King, Practice Leader and Director, Edgecumbe Health (slides – **Appendix I**)

Workshop 5: Networking opportunity for revalidation managers / administrators

- Attendees shared their approaches to doctor engagement, including 6 monthly lunchtime events given by the RO for any doctors, but particularly aimed at new entrants and doctors from other countries, and the offer of one to one explanations by members of revalidation teams. Having a clear escalation policy which is known about and understood also helps engagement.

- Other topics covered were the sharing of information for new appointments, with different processes in use, such as the reconciliation of ESR monthly reports with GMC Lists, doctors being required to fill in the form with details of their last RO, before payroll are authorised to pay them.

- Managing deferrals were discussed, and the group were alerted to a new tab facility on GMC Connect to see previous deferral history and previous ROs with contact details.

- The group discussed what information and processes are being used to support the ROs judgement. Examples of where a decision making group to support and advise the RO on revalidation recommendations, particularly in complex cases, were shared.

- As deaneries are increasingly being asked for MPIT forms for all applicants for NHS trust roles this presents a huge volume of work. Health Education England Thames Valley will return MPIT forms where a job offer is made, rather than at pre interview stage.

- There was discussion about how best to support doctors in short term contracts so they have some form of review to take to their next appraisal. Some offer an annual review by a trained appraiser for short term contacts, others have a mini review undertaken within the division where the employee works.

Workshop 6: Investigating concerns – making the process work effectively, led by Anne Rothery, NCAS Advisor, Dr Liz Thomas, Assistant Director, Revalidation, NHS England (Devon, Cornwall & Isles of Scilly) and Janet King, HR Director, Frimley Health (slides – **Appendix J**)

Anne Rothery offered some observations based on her experience with NCAS:

- There is immense value in getting the pre assessment right.

- If the facts are known there is no need to do a formal investigation.

- When managing capability, prioritise local resolution.

- Inform the practitioner at the very start and keep them up to date to maintain trust.

- Appoint the right case manager and investigator – avoid conflict of interest or appearance of bias.

- Document everything professionally including phone calls.

- Confidentiality – ensure those who need to be involved have the necessary information, but only those who need to know.

Janet King gave her perspective as an HR director on Protected Conversations which have been recognised in law since July 2013 (presentation attached), which can be a way of negotiating a settlement with an employee without recourse to a tribunal.

There was plenary discussion on the following points:

- Consent and confidentiality can hold up an investigation – the underlying principle is that patient safety can override individual rights.

- A doctor under GMC investigation with a restriction applied through an IOP panel will routinely have an IOP review hearing at least every 6 months although it may be sooner. In the event that the doctor obtains additional information that could be relevant to their IOP restrictions, they can make a request to bring the date forward for their next IOP review hearing.

- Is a power differential needed in an investigation – No, but the investigator needs to be trained and empowered. There can be advantages in having a non -medical/ less senior doctor investigator as their time can be allocated more easily and they can bring their own skills egg HR expertise/ specialty knowledge.

- How detached should the Medical Director/RO be in the pre formal process – a judgement should be made early on as to how serious the concern is, and the level of involvement of the MD/RO determined as a result.

- Is team dysfunction included in an investigation – it is difficult to measure team dysfunction, but often this can result in organisational issues which are a factor in cases.

- Sourcing case investigators for cases in small designated bodies eg Hospices - the nearest NHS Trust can often provide case investigators, however a formal, detailed contract which includes indemnity provision is essential.

- How does the ability to "agree" references in a protected conversation sit with RO responsibilities? Any reference must be consistent with the responsible officers' duty to take any necessary steps to protect patients.

Workshop 7: Doctors working across sectors – how can effective information sharing take place across the NHS and independent sector, led by Anne Younger, Senior Revalidation Manager, NHS England (South) and Marjorie Rogan, Project Manager Quality Improvement and Patient Experience, NHS England (South) (slides – **Appendix K**)

- Regulations state that there is a requirement for sharing information.

- Opportunity to include the requirement for doctors to share information such as all the current cycle appraisals and previous RO details in contracts.

- Feedback that organisations are using a variety of methods to seek information to confirm fitness to practice and that the MPIT form is seen as cumbersome and off-putting, when actually the request is very simple – are there concerns and if so what?

- Appraisers can assure the RO that information is shared by ensuring whole scope of practice is not only declared but referenced proportionately in the appraisal information used.

- Where organisations do not respond to requests for information options are to advise the NHS England regional revalidation team who can take this up across regions, and/or your GMC ELA.

- Develop guidance on thresholds to share – particularly where low level concerns are present.

- Always know who the RO is and notify them – ensure the pre-employment checks establish this.

- Check whole scope of practice; rely on employers as well as doctors – cross check to assure probity.

- The GMC have just made ROs and their contact details available on GMC Connect through the History tab when in the "All Doctors" screen, and intend eventually to make this available on the public website. In the meantime the Regional revalidation team England england.revalidation-south@nhs.net can meet individual requests for contact details.

Workshop 8: The leadership challenge: an approach to the consultant who is not stepping up from 'technician' to 'leader', led by Dr Judy Curson, Deputy Director – Workforce, Public Health England

The issues are not unique to medics: also applies to lawyers, engineers etc.

Issues identified by the groups:

- Recruitment does not explore those values and skills that will be tested to the max. Tendency to recruit 'mini me'.

- Organisations are not clear about their expectations of consultants as leaders; we don't train for leading or support them to lead. Small organisations often lack role models or senior consultants to offer support or mentoring.

- 'Doctors leave training with no construct of leadership and then join organisations that have no constructs of leadership'.

- What does the organisation want from its leaders? Does it know? (is it just people to kick?)

- Job plans do not give enough time to develop other aspects of the role – focus on direct clinical delivery. They are bogged down by management 'stuff' rather than leading.

- In some specialties ‘medical leadership’ is discouraged because of the focus on the multi-disciplinary team. This can result in disengagement of consultants. They don’t know how to be engaged as followers.

- Postgraduate doctors in training are ‘infantilised’. We don’t listen to them. Short rotations don’t facilitate them embedding in organisations or ‘finding out ‘how things are done around here’. Training in silos does not expose them to the skills needed to develop complex services. We train them to be technicians and then appoint them to roles as leaders. The transition to consultant is a bigger step now – and a surprise. They have theoretical training in leadership now but it is not translated into skills.

- Once appointed to consultant posts we allow them to ‘marinade’ in the organisation too long before developing them – sapping their energy/enthusiasm/courage/resilience.

Strategies suggested for prevention – organisation wide

- Systemic approach to leadership.

- Recruitment process – to assess the ability to take on leadership roles – at medical student stage onwards – people who adaptable to circumstances and environment.

- One Trust has assessment centres for consultants – uses psychometric tests, actors, interview and presentation; specifically interviews against Trust values.

- The values and behaviours of the organisation need to be lived by senior staff, not just listed on a poster. Organisations need to inculcate the desired culture early.

- New consultant leadership programme needed – structured involvement in Trust management and how to make things happen.

- Developing understanding that leadership doesn’t necessarily mean being in charge or having authority – allowing people ‘not’ to be leaders.

- Appraisers need to help develop good PDPs not ‘personal stand still plans’ – must be more challenging. Appraisal linked to organisation’s values.

- Train for leadership for sustainable change, systems leadership. Graded exposure to leadership challenges. We must train people to lead services within the current pressures on the NHS, developing skills not just knowledge. Fellowships have been successful – one year supported programme to develop leadership skills.

Ideas for Remediation – helping individuals

- Why are they struggling? Address organisational factors and then support individuals.

- Be clear about expectations.

- Make sure they have time for this.

- Expose individuals to different teams; show them something different eg a service where they can’t make a technical contribution.

- Mentoring/coaching – a safe space to develop self-awareness, build a development plan and support.
- Appraisers can help align individuals – internal and external can be useful.
- Team building exercises and feedback.

Workshop 9: Supporting doctors to get back on track, led by Michael Finnigan, CEO i2i and Charlie Vivian, Consultant Occupational Physician, Matthew Stephenson, Consultant Psychiatrist & coach and Maggie Woods, Associate GP Dean, Health Education Thames Valley

The workshop offered suggestions for supporting doctors through coaching and a new support programme that has been used in other fields but not yet with doctors.

Following the meeting for ROs and HR Leads on Thursday 29 January, delegates may be interested to know that Dr Charlie Vivian and Michael Finnigan are keen to set up a pilot programme, as proof of concept of their programme helping doctors to get back on track. If you have one or more doctors who you would like to attend this pilot, please email Charlie Vivian (charlie.vivian@icarushealth.co.uk). For more details about the the programme in other fields please see the i2i website, www.i2i-121.com

Workshop 10: Networking option – Appraisal Leads

Discussions included:

- The usefulness of MSF and what would be useful to know rather than some of the questions currently asked as they do not always reflect the relationship with the doctor being reviewed; how to deal with doctors for whom their self assessment is incongruent with assessment from others.
- Outcomes of PDPs and the lack of content from the MSF, which needs to be considered as part of the full scope of practice. PDPs will improve over time?
- Honorary Contracts and prescribed connections cause some problems for doctors who are not directly employed by a DB. Use of the GMC algorithm can be helpful.
- The use of 'Passports' for medical appraisals for Locum Doctors so that they can offer assurance to agencies/DBs of their appraisal and revalidation status.
- The potential for GMC Connect to hold annual appraisal data for each doctor so that DBs can see this readily.
- Large variation across organisations in the number of appraisals carried out by appraisers, some appraisers only doing 3 appraisals, and others more than 20.
- Quality of appraisal discussed and agreement that this needs benchmarking. Some designated bodies hold meetings where a lay NED chair discusses with manager, lead appraiser and every appraisal is viewed. Sometimes the summary and other times the whole document.
- Some doctors receive a letter from RO discussing learning and PDP.
- Mandatory training checked in some designated bodies.

- Use the Excellence tool to QA, easy to find by googling and has been validated.
- One designated body has used an exercise where the appraiser and appraise both QA the appraisal together using the excellence tool.
- Most designated bodies provide a report from the Clinical Director for the appraisal.
- Primary care rely on the self-declaration which can be a problem if the GP 'forgets' to present his concerns.
- Can be useful to appraise outside organisation in another designated body.
- Appraiser training discussed, one designated body used MIAD – v expensive but v good.
- Some designated bodies have monthly meetings, others 3 monthly. Expect appraisers to attend at least 50%.
- Discussion on how good ideas are escalated in the organisation from appraisal.
- Wider scope of practice - most designated bodies seek report.
- Discussion re use of appraisal as performance tool, used a lot in primary care.
- Confidentiality of discussion, varies, some are happy that info is shared and others not so happy as the doctor has enlisted lawyer/BMA who insist discussion confidential.
- Patient Satisfaction Survey and where this applies. e.g. cremation referees and pathologist– not so easy but should seek feedback from those appropriate to provide it.
- Some Section 12 doctors also decline the PSQ but agreement that it is appropriate to try and seek feedback and can also ask relatives/carers.
- As much as possible try and encourage PSQ in some form. e.g. one designated body gets feedback from the relatives of ITU patients.