



Royal College of  
Obstetricians &  
Gynaecologists

# Becoming Tomorrow's Specialist

Lifelong professional development for  
specialists in women's health

Working Party Report  
September 2014







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## RCOG President's foreword

Over the past three years this College has produced two seminal strategic reports in *High Quality Women's Health Care* and *Tomorrow's Specialist*. The *Becoming Tomorrow's Specialist* report not only provides a framework for professional development for newly appointed specialists within obstetrics and gynaecology, but also for all specialists at whatever stage they may be in their career. We all recognise that jobs change over time and that flexibility and the desire and ability to adapt to changing demands will be of paramount importance for the specialist of the future whether in academia or NHS practice. The report was initially born out of a wish to provide guidance and also support in the immediate post CCT phase of work. However, it quickly became apparent that it was as relevant for the established specialist as it was for the new specialist.

There is an emphasis in many chapters about working within teams and providing a platform for individuals to become incorporated into departments and to enable a smooth integration within units. This seamless transition will be fundamental to ensuring departments in future are more cohesive. The principles established at the outset of one's career will form the building blocks for subsequent progress over the next 30 to 40 years.

Implementation of the recommendations is fundamental if this report is to be of value to each and every one of us. I anticipate that the colour coded recommendations will assist individuals in planning and setting their personal development goals. Implementation groups will need to be formed quickly to enable the College to drive forward the principles of change, particularly with a review of our CPD. There is also a responsibility on management and clinical directors to embed this framework in all that we do, to ensure we provide the best possible care for our patients. One cannot overemphasise the importance of individual responsibility of the specialist to develop appropriately.

There are many references and resources that are available for professional development and this will develop as the College aims to have a specific area on the RCOG website to signpost and support clinicians.

Finally and cognisant of the considerable financial constraints within the NHS I recognise that specialists' job plans are under pressure with a particular focus upon reducing SPA time. Professional development will remain essential but planning over time is likely to become ever more relevant as individuals will not be able to do everything all at once. By giving them a framework to work within, resources to guide them, I feel we shall be heading in the right direction as a specialty.



A handwritten signature in black ink that reads "David Richmond". The signature is written in a cursive style.

Dr David Richmond MD FRCOG  
President

## Abbreviations

AoMRC	Academy of Medical Royal Colleges
ATSM	Advanced Training Skills Modules
CCT	Certificate of Completion of Training
CPD	continuing professional development
CRM	crew resource management
CTG	cardiotocography
GMC	General Medical Council
LETB	local education and training board
NHS	National Health Service
PALS	Patient Advice and Liaison Service
PDP	personalised development plan
PROMPT	practical obstetric multi-professional training
RCM	Royal College of Midwives
RCGP	Royal College of General Practitioners
RCOG	Royal College of Obstetricians and Gynaecologists
SPA	supporting professional activities

## Recommendation colour coding

RCOG
NHS/hospitals
Individuals
Other e.g. AoMRC
Entire profession



# I Introduction

Over the past few years the Royal College of Obstetricians and Gynaecologists (RCOG) has approved a series of reports: *High Quality Women's Health Care: A Proposal for Change*<sup>1</sup> and *Tomorrow's Specialist*.<sup>2</sup> These reports have set the College on a path designed to radically change and improve the way women's health care is provided in the UK. In recognition of the importance of the workforce implications of changing professional practice, *Tomorrow's Specialist* describes the way forward to ensure that women's health care providers are receiving the very best training for the roles that will be required in the future.

The drivers for change have been clearly outlined in *Tomorrow's Specialist*. The focus for obstetrics and gynaecology will always be on improving the quality of women's health care. To do this effectively within a rapidly changing health system requires highly skilled, adaptable doctors. These professionals must be able to work in multidisciplinary teams and provide a range of leadership skills. They must have many professional attributes and be fully committed to lifelong learning, closer team working and working across different environments. Only with such a workforce will the aspirations of *High Quality Women's Health Care* become a reality.

The specialist of tomorrow will increasingly work within multidisciplinary teams with close links to primary care. All specialists will also see their services integrated within networks designed to ensure that the very best of women's health care is available to all, irrespective of location, in the most cost effective system possible. All specialists need to develop the clinical and non-clinical skills to work effectively within this model of care.

Specialists in the early years of their post-Certificate of Completion of Training (CCT) careers are likely to be at the mid-point of their professional lives. These specialists increasingly find themselves appointed to permanent posts with specific roles within the full range of obstetrics and gynaecology. Currently many specialists are able to develop their job plans over a period of time to fulfil professional ambition while ensuring the delivery of an effective local service. There is now more mobility within the workforce and an increasing recognition of the importance of portfolio careers. The challenge is to ensure that the service provides opportunities for career progression and specialist satisfaction within a modern, effective NHS.

The NHS is now facing up to the challenges resulting from the [inquiry into Mid Staffordshire NHS Foundation Trust by Sir Robert Francis QC](#)<sup>3</sup> and the subsequent [Berwick report](#)<sup>4</sup> which describes the lessons to be learned and the changes required by the NHS in order to set things right.

The RCOG published its *Manifesto for Change*<sup>5</sup> in response to the findings and recommendations of the Francis report. The Francis and Berwick recommendations have serious implications for all who provide women's health care. Therefore we should be developing the following five themes described in the *Manifesto for Change*:

1. Always put the patient first
2. Zero harm and patient safety
3. Creating outstanding leadership and working together as teams of professionals
4. Regulation, inspection and accountability
5. Metrics and outcomes.

These principles underpin and are embedded in the framework of this working party.

There will be inevitable changes to the way we work such that we clearly demonstrate that the patient is at the centre of all that we do. This will result in specialists assuming responsibility for quality, safety and improvements to care that clearly demonstrate higher standards in carefully defined outcome measures.

The continued development of outcome measures for both individuals and organisations will result in specialists increasingly being compared with their peers, both as individuals and as part of a team. As a profession we should not feel threatened by this, but rather embrace it. This is illustrated by the [RCOG Clinical Indicators Project](#),<sup>6</sup> a programme of work that aims to develop clinically relevant performance indicators for obstetric and gynaecological care using currently available data. While this work and other similar projects will no doubt provide opportunities to improve women's health care, specialists need the skills to ensure metrics are additionally used for personal information and development.

The report *Shape of Training: Securing the Future of Excellent Patient Care*,<sup>7</sup> following the review led by Professor David Greenaway, looks at ways to ensure doctors are trained to the highest standards and able to meet the changing needs of patients. It states that patients and the public need more doctors who are capable of providing general care in broad specialties across a range of different settings, driven by a growing number of people with multiple comorbidities, an ageing population, health inequalities and increasing patient expectations. The report also highlights the need for flexible working, sustainable careers with opportunities for doctors to change roles and specialties throughout their careers and doctors who are trained in more specialised areas.

This new report from the RCOG builds upon many of the recommendations of *Tomorrow's Specialist*. The need for the specialty to ensure 24 hour, 7 days a week cover in our hospitals supports the proposal of more generalised care but we also need specialists working within networks to deal with the more complicated cases. This report also calls for a more flexible development structure which will meet the needs of the workforce who increasingly need to work differently, including part-time working. Greater flexibility will also allow doctors to pursue academic research more easily. This is essential to medical innovation and providing high quality care.

The changes to specialist practice and scrutiny described above are likely to pose significant challenges for all those involved in women's health care. It is likely that those embarking upon a specialist career will feel the challenges most acutely and yet, conversely, they will potentially have the most to gain. We need to create an environment in which specialists in the early years of their careers can thrive in a non-blame culture that rewards achievement.

The Council of the RCOG has approved a working party to build upon the reports outlined above in order to assess the impact upon those involved in the early years of specialist practice, and to devise systems to ensure we give these doctors what Berwick describes as 'career-long help to learn, master and apply modern methods for quality control, quality improvement and quality planning'. We all have an obligation to assure their growth and support.

**Note**

In order to ensure that the Working Party produced a report that would provide the necessary tools for the continuing development of specialists throughout their careers, a quantitative survey was undertaken in an attempt to map those who attained their CCTs from 2002 to 2013 against the posts they are in now. This gave us a snapshot of the progression of specialists from completion of training to obtaining a permanent post. The results of this survey demonstrated that we needed a more detailed qualitative survey, to find out the length of time it took people to find a permanent job after qualifying, what core emergency skills they thought were essential to keep patients safe and whether or not they felt that the training programme had given them sufficient managerial tools. They were also asked about what training they would like to see in any revised continuing professional development (CPD) programme to assist them in their professional development. The unattributed quotes that are used throughout this report are taken directly from the responses to the qualitative survey that was carried out in the summer of 2013.

## 2 Developing and demonstrating safe practice

### 2.1 Introduction

Patient safety and high quality care are at the centre of modern healthcare service provision. The ethos of patient safety should be ingrained within the development of every doctor from qualifying. However, on obtaining CCT the emphasis and responsibility on the specialist fundamentally changes. Education about key elements of safe practice starts within the medical school environment, with further refinement and contextualisation according to the practices and principles of the specialty, whether that be during specialist or subspecialist obstetric and gynaecological practice.

Following inclusion in the specialist register of the General Medical Council (GMC), the principles of lifelong learning particularly apply to remaining up to date and current in the theory and practice of safe care, with ongoing introduction, development, refinement and application of new processes throughout a specialist career.

Responsibility for the incorporation of patient safety into curricula inevitably lies with the bodies responsible for the provision of education throughout a specialist's career. This includes medical schools which are charged with educating students on the foundations of safe practice, followed by the deaneries and medical royal colleges for ongoing education. The place of the NHS is to provide a supportive environment to allow staff not just to be trained but also to provide facilities to improve patient safety. In short, the establishment and maintenance of a culture which is supportive of maintenance of the skills required for optimal safety in patient care.

In this chapter broad recommendations will be made to embed a robust patient safety culture from the viewpoint of the career development of the individual after inclusion in the specialist register, and the inclusion of safety within specialist teams within the host institution.

### 2.2 Context

In its document *Leadership and Management for All Doctors*<sup>8</sup> the GMC is clear that it places the care and safety of patients as the primary duty of all doctors, achieved through the encouragement of collaborative working and engagement to improve safety and quality. The GMC also states that doctors should 'raise and act on concerns about patient safety'.

Following the Francis report the focus on improving patient safety and the safety culture within the NHS has never been greater. The complexity of the NHS as an organisation, as highlighted in the report, was one of the many reasons behind the deficiencies in the organisation and delivery of care in Mid Staffordshire NHS Foundation Trust, which led to several catastrophic events. However, had there been a culture of safety to support front line staff at the point of delivery of care it is unlikely that the situation would have deteriorated as it did.

Since the publication of the Francis report and the very public analysis of its contents it has become evident that aside from the major changes required in the structure of the NHS to deliver a top-down improvement in patient safety there were also deficiencies

in front line care. Several factors, including a lack of measurement of outcomes and the existence of poorly functioning teams, were major contributors to the poor outcomes that came to light.

The recent *Shape of Training* report clearly states its purpose as ensuring that the training of doctors aims to 'meet patient and service needs, and provide safe and high quality care'. In addition, it recommends that 'all doctors develop generic capabilities in key areas including patient safety'. In recommending that local education and training boards (LETBs) and deaneries 'legally award [a] Certificate of Specialist Training which recognises that doctors are able to make safe judgements and to practise safely in clinical teams' it is clear that patient safety has become the driving force behind much of the complexity of medical education.

In the document *Women's Views about Safety in Maternity Care*<sup>9</sup> it was clear that women value safe, high quality care in maternity. Among the 31 women interviewed there were several who felt that safe care is the bare minimum care but high quality care was considered as something above this and comprised, for example, the best possible care available and improved facilities. Patients also valued good team working and communication among staff.

## 2.3 Patient safety at the start of a specialist career

The Berwick report states:

*Every person working in NHS-funded care has a duty to identify and help to reduce risks to the safety of patients, and to acquire the skills necessary to do so in relation to their own job, team and adjacent teams.*

*Good Medical Practice*<sup>10</sup> states clearly that doctors in practice must:

- 'Contribute to and comply with systems to protect patients'  
e.g. audit, reviews, confidential enquiries, adverse event reporting, drug reaction reporting and responding to public health organisations.
- 'Respond to risks to safety'  
e.g. promote a safety culture, take action if equipment, environment, systems or others put patient safety at risk. Offer help in community emergencies or to vulnerable people whose welfare is at risk.
- 'Protect patients and colleagues from any risks posed by your health'  
e.g. consult a suitable colleague and follow their advice if you suspect you have a condition that could place patients at risk, be registered with a GP and maintain appropriate immunisations.

These elements should be covered in detail within both the undergraduate and postgraduate curricula. However, the process of taking part in a training programme does not guarantee that the trainee has a firm grounding in the theory and practice of modern health care and patient safety methodology. While the educational system and employing authority will have systems in place to support doctors as trainees, upon attainment of CCT, trained specialists should be encouraged to develop a reflective approach to lifelong learning and ask themselves these fundamental questions:

- Am I staying up to date in areas of patient safety?
- Am I being supported by my employer and College?
- How do I demonstrate safe practice?
- Am I able to influence positively the safety of the environment in which I work?

These questions should be answered by the individual upon entry into a specialist role as part of the induction process and subsequently through appraisal within the first year of employment as a specialist and beyond. Areas for improvement should be addressed by directing new specialists towards tools to allow them to enhance their knowledge of patient safety, and the College has a responsibility to develop those tools.

This range of tools could include a combination of:

- attendance at a course or a series of courses within a patient safety module
- use of eLearning modules specifically on patient safety
- commencing a log of reflective practice, to include evidence of regular reflection around debriefing patients after incidents, near misses and adverse events
- making safety a specific feedback metric within the team feedback/360 degree assessments.

Presentation of such evidence of meeting specialty-specific milestones will be part of annual appraisal.

Most major reports into patient safety emphasise the importance of leadership and training for the leaders of the future. Patient safety should become part of this process.

The [Keogh report](#)<sup>11</sup> stated:

*Junior doctors in specialist training will not just be seen as the clinical leaders of tomorrow, but clinical leaders of today. The NHS will join the best organisations in the world by harnessing the energy and creativity of its 50,000 young doctors.*

The early phase of a specialist career does not require leadership in patient safety training but the newly appointed specialist should be aware that trainees and other members of the multidisciplinary team will learn from them and thus should demonstrate safe practice in day to day care. This should happen from the start of a specialist career.

## Recommendations

1. Patient safety must be a key part of the early development of a newly appointed specialist.
2. The RCOG must develop a patient safety module to be incorporated into the educational package for the new specialist.
3. All specialists must record personal outcome metrics and maintain a log of reflective practice specific to patient safety.
4. Hospitals must develop systems to underpin and support the specialist for collection of data.

## 2.4 Continuing patient safety

The NHS is an organisation which, as part of its responsibility to deliver high quality safe care to its patients, also has to ensure that it fosters an environment that supports its staff to stay up to date and current in knowledge relevant to their specialist area. Recent reports, such as those below, have reinforced the importance of supporting lifelong learning for patient safety.

From the Berwick report:

- *fostering whole-heartedly the growth and development of all staff, including their ability and support to improve the processes in which they work*
- *embracing transparency unequivocally and everywhere, in the service of accountability, trust, and the growth of knowledge.*

From the Keogh report:

*The entire NHS should commit to lifelong learning about patient safety and quality of care through customised training for the entire workforce on such topics as safety science, quality improvement methods, approaches to compassionate care and teamwork.*

At present specialists collect information pertaining to their performance as individuals through their appraisals and revalidation. This process includes the following components:

- collection of evidence of continued education
- patient feedback
- colleague feedback
- reflective practice
- complaints and compliments
- engagement with the system (indirectly assessed through a local network of trained appraisers).

Opportunities to demonstrate knowledge and practice of care in a safe manner should be developed within the current career structure. Existing data should be used, such as the risk adjusted outcomes data currently being developed by the RCOG and the approaches recommended by the Berwick report, as quoted here:

*Patient safety cannot be improved without active interrogation of information that is generated primarily for learning, not punishment, and is for use primarily at the front line. Information should include: the perspective of patients and their families; measures of harm; measures of the reliability of critical safety processes; information on practices that encourage the monitoring of safety on a day to day basis; on the capacity to anticipate safety problems; and on the capacity to respond and learn from safety information.*

This requires a strong emphasis on establishing an open and transparent culture of portfolios of individualised outcome measures. It is also important to listen to all sources that can rapidly bring to attention available information on patterns of care which could not only highlight safety concerns but could also reward best practice.

In addition, the following more refined measures could be used to demonstrate safe practice although it is recognised that these will require significant additional investment:

- seeking patient opinion
- developing competencies in core skills
- record keeping assessments
- peer review by colleagues/trainees/team members
- chief executive officer/medical director/clinical director statements.

All of these measures of patient safety are useful snapshot measures to assess the performance of a doctor at a particular point in his or her career.

Within a supportive work environment and a well-planned career development structure most of those metrics could be used to develop a portfolio of evidence to demonstrate the following:

- demonstration of attainment of core competencies and integration with
  - efficacy outcomes
  - adverse events
- stepped approach to improving self perception of safe practice
  - knowing one's limits
  - Insight
- reflective practice
  - near misses
  - complaints/competence
  - examples of safe practice
- examples of change management for safety.

To achieve such plans, a specialist curriculum of continuing education into patient safety should be developed nationally. The foundations of this will inform the development of a Personal Development Plan (PDP) on an individual basis, initially utilising information from the appraisal process.

Transparency, candour and openness are vital in safe care. These issues, too, were widely covered in the Francis report and more recently in the Keogh report, as quoted here:

*Sometimes staff did not feel empowered to take action when they had identified an issue and in a few cases, staff felt uncomfortable raising issues with senior management.*

To partly address this, especially within the early years of a specialist's career, a network of support and guidance should be employed. While many will see this support network as a tool for career guidance and clinical education it should also be made clear that this is additionally a tool for education into the basics of patient safety and fostering an environment of openness and transparency. Appropriate support will help new specialists to address issues which could potentially affect patient safety, such as concerns about team members, teams, employers or the working environment.

## Recommendations

5. Opportunities to demonstrate knowledge and practice of care in a safe manner should be developed within the current career structure.
6. More refined measures to demonstrate safe practice (e.g. peer review by colleagues, seeking patient opinion, record keeping assessments) need to be developed and will require additional resources.
7. A greater emphasis on patient safety should be incorporated into the appraisal system and captured within revalidation. (See Appendices 2a and 2b.)
8. Continued education into patient safety should be further developed by the RCOG, underpinned by evidence from individual specialist portfolios.
9. Specialists must develop their own portfolio of evidence demonstrating safe practice.



## 2.5 Further skills in patient safety – leadership, teams and the NHS as a whole

The Berwick report encouraged NHS leaders to place safety as their highest priority:

*All leaders concerned with NHS healthcare – political, regulatory, governance, executive, clinical and advocacy – should place quality of care in general, and patient safety in particular, at the top of their priorities for investment, inquiry, improvement, regular reporting, encouragement and support.*

Good leadership is required for a team to function effectively and in a safe manner. The features of a good leader include good communication, thorough knowledge of team personalities and, importantly, up to date knowledge of how the team performs. Team members are motivated and enthused by good leaders with high standards and knowledge of patient safety. Such leaders should be identified as patient safety champions and they should be mobilised and their skills used to educate others. The importance of leadership is discussed further in Chapter 7 on Developing as a Specialist.

Whether the team is big or small, the key way of monitoring its safety is for members of the team to monitor outcomes and work patterns. Innovative measures should be developed to provide close monitoring of patient safety within the team.

Examples include:

- specific patient feedback from team activities with questions to patients concerning how safe they felt and what could be done to improve their experiences
- team outcomes – using similar tools to those for individuals (as described above)
- peer review – possibly through Royal College assessment
- lessons learned from complaints and compliments
- early identification and support of poorly performing team members
- evidence of communication skills training
- incident reporting and defined learning from root cause analysis
- enhanced/team function 360 degree feedback
- regular team satisfaction surveys.

The Berwick, Keogh and Francis reports make many recommendations to the NHS to improve practices and processes of safety within established systems. These reports also highlight problems where disparate elements of NHS teams were not communicating as they should.

The Berwick report states that the professional regulators and educators should:

*assure the capacity and involvement of professionals as participants, teammates, and leaders in the continual improvement of the systems of care in which they work.*

and

*embrace complete transparency.*

Berwick also recommends that NHS England:

*should organise a national system of NHS Improvement Fellowships, to recognise the talent of staff with improvement capability and enable this to be available to other organisations.*

These recommendations emphasise the need to develop an open culture that supports continued learning and improvement in safety along with identification of those with the necessary skills. Within our specialty we lead the way in team working and have already embedded multidisciplinary working at the core of all we do. For the NHS to do this it should not only actively recruit and develop such people but should make appropriate funds available to reimburse those NHS institutions from where those staff come to allow appropriate secondments as well as ensuring ongoing job security.

Many of the specialist activities of the NHS rely on input from the royal colleges and specialist societies. The Academy of Medical Royal Colleges (AoMRC) should be given the remit to bring together the appropriate key staff across the specialties to ensure that work is not duplicated and to ensure that a unified message is spread to organisations and clinicians alike.

Appropriate delegation from the AoMRC to individual colleges for very specific areas (such as safety in maternity care to the RCOG), will be required to ensure appropriate depth in standards of patient safety. It is also important to recognise that across the totality of clinical medicine, most messages pertaining to the development, encouragement and delivery of a strong culture of patient safety transcend the divisions of specialist medical care.

## Recommendations

10. NHS Employers should support the development of experts in this field and recognise the support of host trusts or formally offer secondment opportunities.
11. The RCOG, AoMRC and the NHS should identify leaders and champions in patient safety within the specialty to identify and communicate key messages to teams and specialists.
12. The RCOG should devise tools that facilitate enhanced assessment of team functions and the safety of care within clinical teams.

## 3 Core clinical skills

### 3.1 Introduction

At the junction of postgraduate specialist training and entry in the GMC specialist register, all specialists should stand at the same level as evidenced by the award of the CCT. Currently, the required core clinical skills for the new specialist will be fundamentally the same regardless of their initial appointment because most specialists will move to a substantive consultant appointment either immediately or, from another post such as a locum post or clinical fellow, within a short period of time.

This chapter will focus on the maintenance and development of the core clinical skills required of a specialist working in acute obstetrics and gynaecology, emphasising the need for ongoing learning, ensuring these skills are up to date, thereby ensuring a workforce is adaptable as well as being safe. Obstetrics and gynaecology is a unique specialty, combining two areas of clinical work into one. The diversity of the clinical work poses some issues for the development of a common set of clinical skills.

While the training curriculum pre-CCT defines the skill set required for specialist certification, it cannot be expected that newly qualified specialists will have extensive experience of every clinical situation they may face. Professional development is a continuous process throughout one's career. There may be a deficiency of skills to manage extreme or unusual clinical situations at an independent level (e.g. caesarean hysterectomy).

There should be systems and processes in place in every obstetrics and gynaecology unit to ensure that all specialists, whatever their experience, are supported to provide safe and high quality patient care through good governance, senior clinical support and realistic departmental job planning. There needs to be adequate time within supporting professional activities (SPA) to achieve this.

### 3.2 Variations in posts

**Table 3.1** Variation of jobs within obstetrics and gynaecology

Type of post	Daytime duties	Nighttime duties	Example of special interest
<b>Obstetric</b>	Obstetrics only	Obstetrics only	Fetal medicine lead
<b>Gynaecology</b>	Gynaecology only	Gynaecology only	Gynae-oncology lead
<b>Combined obstetric</b>	Daytime labour ward session, antenatal clinic, scanning or debrief sessions, alternate week gynae list	Obstetrics and gynaecology	Medical disorders in pregnancy
<b>Combined gynaecology</b>	Specialised gynae clinics, gynae operating	Obstetrics and gynaecology	Colposcopy lead, urogynaecology lead
<b>Balanced</b>	Daytime labour ward session, antenatal clinic and gynae special interest session	Obstetrics and gynaecology	Early pregnancy assessment unit lead, ambulatory gynae lead
<b>Resident</b>	Special interest sessions	Obstetrics or gynaecology	Labour ward lead

Specialists will fulfil a variety of different roles within a consultant post that is best exemplified by a varied balance of elective and emergency commitments. This diversity of exposure within the specialty makes it difficult to recommend a common set of skills that are applicable to everyone. For example, some specialists may work solely in emergency and elective obstetrics without any gynaecology component in their job plan. These doctors would need to remain proficient in intrapartum care and also maintain specialised antenatal diagnostic skills. Similarly, some specialists may work solely in gynaecology and would need to maintain their ambulatory and operative gynaecological skills but may not need to maintain their obstetric competencies.

Specialists will have individualised job plans and will need to maintain and develop core clinical skills appropriate to their job plan. The specialist and their appraiser will need to work together to ensure that the programme of continuing professional development (CPD) and the PDP are congruent with the clinical duties and job plan.

With the increased service demand for out of hours obstetric cover there has been an expansion of posts that have a significant amount of resident on-call duties. These jobs vary considerably in their specification with some specialists 'acting' as a specialist registrar on-call with a senior specialist on-call from home. Some may have a trainee working alongside as well. There are several configurations of patterns of on-call but essentially these specialists spend a large proportion of their job providing acute out of hours care only.

Issues for patient safety largely centre around out of hours care with the focus being on a core set of skills principally to give safe cover 24 hours a day and 7 days a week. This has led to the creation of many new posts that are resident on-call. There is wide recognition that out of hours obstetric care is more onerous for the specialist, in terms of workload, and that emergencies happen more frequently at night on the labour ward than in gynaecology. The design of out of hours workforce configuration is beyond the scope of this working party but there needs to be recognition that the specialty is seeing the emergence of a new type of post. The development of specialists in such posts will need to be evaluated and job satisfaction must not be overlooked.

There is anecdotal evidence from around the UK that many units are addressing 24/7 cover of the labour ward by specialists. This may be by simple expansion of numbers but there are also many examples of innovative working. There are also units (Manchester and Plymouth) that have expanded specialist posts in order to provide 24/7 cover. This requires considerable resources. The RCOG must act as the focal point for the sharing of such potential solutions. One avenue might be through a clinical directors' forum, and through the RCOG itself looking at the advantages and disadvantages of various solutions.

### 3.3 De-skilling

The prevention of de-skilling of a specialist is an important issue to consider. Mandatory obstetric training addresses the issues of infrequent emergencies. Combined with drill scenarios, this goes some way to fostering good team working and bringing skills up to date. However, a clinician starts to lose clinical skills if exposure is not at a certain level. An example of this is cardiotocography (CTG) interpretation, which can in some way be addressed by online modules, but it is the confidence of vaginal assessment, the trial of vaginal delivery in theatre and difficult full dilatation caesarean section that can start to

become a real difficulty when confidence is lost. Confidence on the labour ward, once lost, is very difficult to regain. Similarly, a lack of insight and over-confidence in one's clinical ability may be an issue.

The same is true for posts that lack a significant volume of major gynaecological surgery. Posts that have infrequent major operating will have the same effect. To compound this, annual leave, study leave, audit days and cancelled lists due to lack of bed availability can leave a surgeon with a reduced volume of major surgery. It is also recognised that there is a reduced volume of major operating in modern gynaecology, principally owing to advances in the treatment of menorrhagia. It is therefore necessary to consider what methods could be employed to prevent such loss of confidence.

All specialists have time in their job plans for SPA. While this has reduced considerably as a percentage of the total job component for a specialist, this time is not often used for clinical updating. Consideration should be given to allowing specialists to spend time during daylight hours on the labour ward with the specific remit of gaining experience in certain identified areas of clinical work, which are underrepresented in the main part of their job. This model could be applied to gynaecology as well, with attendance at surgery with another colleague supporting, for example abdominal hysterectomy or laparoscopic surgery.

Other solutions may focus on specific on-call pairing so that two specialists complement each other. The issues of annual leave and the fixed nature of being on-call with the same person have to be considered. Staffing constraints within units may prevent two specialists from being on-call at any one time. It is clear that there is not one solution applicable to every unit. Some units have worked around solutions, particularly in cases of massive obstetric haemorrhage. A gynaecologist (typically an oncologist or urogynaecologist) may be asked to assist when not on-call. An on-call rota covering several hospitals may also be appropriate if geography allows. Merger of smaller units with larger ones may also allow splitting of rotas into obstetrics and gynaecology.

The RCOG should develop educational resources that are tailored towards updating the obstetrician who has less exposure to gynaecology and the gynaecologist who does less obstetrics. These should focus on clinical aspects of care more than theory. There are many resources already available for education but the RCOG must work towards putting key components together as modules in order to create a well balanced exposure as a specialist develops. This should be linked to job planning and CPD.

Within the appraisal process there should be specific questions asked about clinical areas in which the specialist feels they would benefit from learning, and these must be incorporated into a PDP and more crucially, supported by the hospital.

### **3.4 Maintenance and enhancement of core clinical skills**

*At the moment there is a requirement to be involved in simulation but that is open to a very loose interpretation. Simulation training needs to be formalised such that clinical skills can be assessed safely during training, so that we can practise on plastic, not on real patients.*

The maintenance of core clinical skills for patient assessment, investigation and treatment is fundamental to the principles of *Good Medical Practice*. While maintenance of core practical skills is essential, specific requirements will vary on an individual basis according to the job plan details and departmental structure.

*Good Medical Practice* is clear that specialists must participate in activities regularly to maintain and develop competence and performance. This is particularly relevant for specialists providing an imbalance of emergency care services compared with their elective care sessions in the initial years after CCT.

### 3.4.1 Simulation

Simulation in clinical practice is increasing and is well utilised in some units. Many use simulated obstetrics emergency updates to facilitate communication, team working and leadership as well as situational awareness and appropriate decision making. Simulation methods or clinical scenarios are valuable both in the development of non-technical skills and for the maintenance of practical skills which are necessary in infrequent emergency situations. Many of these simulation techniques are incorporated into skills drills within mandatory training and already form a valuable part of obstetric training. More developed packages have taken these basic skills on further into a more formalised programmes, e.g. Practical Obstetric Multi-Professional Training (PROMPT).

More sophisticated simulation equipment (e.g. 3D laparoscopy, ultrasound imaging) is rapidly developing and can be a useful tool to supplement evidence of ongoing competence for surgical procedures such as laparoscopic ovarian cystectomy, laparoscopic management of ectopic pregnancy, ultrasound and amniocentesis. New techniques can be learned as well as getting practice in less exposed areas (e.g. laparoscopic suturing/dissection) Simulation techniques could be promoted within the buddying system as another method to augment clinical and practical skills. Such equipment, however, is expensive at present and resources are needed to expand such training.

The RCOG has appointed a simulation lead in order to set up a network of leaders across the UK so that these expensive resources can be used more cost effectively. This role is to advise on the strengths and weakness of simulation. It is not responsible for delivery but the RCOG has set up a simulation network to complement the role. This network of individuals has an interest in simulation and functions at deanery level. The groups are largely voluntary as they are individuals with an interest but they are not necessarily funded by their trusts or deaneries (it varies across the UK). They are for the most part involved in pre -CCT training, but may also be involved with trained staff skills and drills training.

A network of simulation centres could be developed. The value of these tools will need evaluation ultimately. However, learning a new skill-set or consolidating an existing one on a machine before moving to a patient does not replace clinical exposure but merely complements it. Tutorials are already available to teach specific elements of clinical work which can be logged, and feedback given on areas of excellence as well as areas that still require further development.

Departments should have strategies in place to ensure that newly appointed specialists maintain their competence and maintain skills, specifically in core emergency technical procedures.

### 3.4.2 Career breaks

There may be several reasons for specialists to take a career break of variable duration. Maternity, parental leave and sick leave may impact considerably on exposure to clinical work and that may ultimately affect performance. In some circumstances, specialists will need to re-learn core skills after a prolonged period away from work. If the absence has

been for a short time, they may only need a brief refresher period. Specialists who have not maintained their core clinical skills must be actively supported on their return to work and an assessment of competency considered if areas of concern are expressed. Most units have departmental policies for 'return to work' but it is the responsibility of the profession as a whole to ensure that these returning specialists are properly supported. (See Appendices 3a, 3b, 3c and 3d.)

It can be expected that the newly appointed specialist will encounter clinical situations that require decision making or practical skills beyond their experience. It is expected that specialists will have the confidence and insight, as well as clear departmental guidance and support, to access more experienced colleagues to advise or assist in such situations to ensure safe high quality patient care. (See also Chapter 6 on Buddyding, coaching and mentoring).

### 3.5 Development of new core clinical skills

*Most trainees can carry out the technical skill from a relatively early point in their training, but unless we assess their ability to manage their team then patients will not be getting the care they need.*

Alongside consolidation and enhancement of core clinical skills, specialists will need to continue to develop new skills in line with technological advances and changes in patients' expectations. Such developments will become part of core skills in the future and must therefore be part of an established approach to specialists' continued development and learning.

Techniques that are new to practice or to the department must be offered to patients within established departmental clinical governance parameters. This is, however, different from a specialist agreeing through departmental job planning that they need to learn new skills outside their existing job plan that do not relate to the delivery of core clinical services. If, on the other hand, a new clinical technique was developed and embedded into clinical practice (e.g. a new fetal monitoring technique) all specialists involved in core acute care would need to demonstrate learning in this area.

A model to be encouraged would see newly appointed specialists working within clinical teams with some common clinical commitments shared with specialist colleagues, to facilitate individual professional development. Such a model has the additional benefit of supporting departmental succession planning and cross-cover of unexpected absences. Joint operating lists are commonplace in some larger units providing a high-support learning environment for the development of advanced surgical skills or innovative techniques. The development of non-technical skills such as advanced decision making and complex practical problem solving should also be supported by senior clinicians with joint clinical working. This will facilitate the continuing professional and personal development of the newly appointed specialist and beyond.

Some specialist societies already provide detailed guidance for the recommended clinical standards within their subspecialty. These include a required skill-set, a minimum time commitment and numbers of procedures performed. These subspecialty guidelines have been developed with the intention of reducing patient morbidity and mortality and raising standards in terms of procedure-related complications. With the development of clinical networks and more specialisation within centres of clinical excellence, adherence to the recommendations of specialist societies will become increasingly

important for individual revalidation and departmental accreditation. With movement towards centralisation of specialist services and the development of service networks, opportunities for professional development and formal links between specialists in different departments with different skill-sets will be strengthened. The RCOG should work more closely with the specialist societies to develop core clinical skills further.

### General recommendations

13. Hospitals must ensure that specialists are supported in time (SPA) and resources to maintain and develop their core clinical skills.
14. The RCOG must work towards putting key components of core clinical skills together as educational packages.
15. It is the responsibility of the profession as a whole to ensure that specialists returning to work after a prolonged absence are properly supported.
16. Clinical appraisal and job planning should be directly linked to develop uniform objectives for the maintenance and development of core clinical skills.
17. The RCOG must work more closely with the specialist societies to enhance core clinical skills.



## 4 Continuing professional development

### 4.1 Introduction

*Team leadership, complaints management, risk management and clinical governance skills should not be a one session tick box exercise (like attending a course), but should rather be skills that are actually learned with the guidance of an experienced consultant.*

The RCOG CPD programme is well established and has been widely adopted by practising specialists both in the UK and overseas. The programme is well regarded by other institutions and has been subject to regular review and updating over many years in both format and content. Therefore any proposed recommendations regarding changes to the programme for specialists should be based on best practice and also be supported by evidence. Best practice should also reflect the future direction of the specialty as outlined in recent key policy documents, as discussed elsewhere in this report.

The [2010 AoMRC /GMC report](#)<sup>12</sup> commissioned to review the effectiveness of CPD concluded that effective CPD involves both *learning* and being *fit to practise*, incorporating both the 'why' and the 'how' of learning into practice. The report also suggests that effectiveness is facilitated when professionals are able to determine their own learning needs through reflection within the totality of their practice. This means being able to go beyond what is quantifiable. The overwhelming feedback from the medical profession is that existing consultants learn best from experience. This emphasis on the importance of experiential learning is also a key theme in the recent *Shape of Training* report. Any changes in CPD for newly appointed specialists and beyond must aspire to both capture and capitalise on this fundamental tenet. The discussion and recommendations that follow are therefore based on a distillation of the ideas and actions contained in this evidence as well as a review of the CPD programmes of a number of other royal colleges.

### 4.2 CPD structure

*There is currently little structure to the programme apart from a requirement that a minimum number of credits must be achieved across four CPD categories. (Tomorrow's Specialist point 245)*

The current CPD programme lacks meaningful structure and relevance in relation to services delivered by specialists to their patients. It is all too easy to accumulate credits in areas not relevant to an individual's practice. The only requirement is to accumulate a certain number of points across four broad categories with a minimum accumulation of 50 per year (250 per five-year cycle, as recommended by the AoMRC). There is a desire among Fellows and Members of the RCOG that CPD should gain more personal relevance and capture their actual learning and development rather than the current 'points mean prizes' mentality. There is a strong feeling that this would also be of benefit to patients. There is limited opportunity in the current CPD programme for individuals to demonstrate acquisition of, or development of, new skills. However, with the changing shape of training and practice there needs to be a greater emphasis on maintaining generic skills throughout the CPD programme.

### 4.3 CPD integration with medical appraisal and revalidation

The aim of CPD should be to enhance professional practice rather than impede its development by mandating learning activity that is not relevant to an individual. Key to this is the development of a meaningful and personalised PDP that is agreed at appointment and reviewed through annual appraisal. Currently, many new specialists do not produce a meaningful PDP until they undertake their first appraisal, which in some cases is likely to be many months after appointment. This initial process should be a key part of the induction of any new specialist. Helpful advice and support in developing PDPs is already available and could be quickly modified and adopted (e.g. the Royal College of General Practitioners (RCGP) model).

Recognition within CPD should be given for specific learning experiences such as reflection on feedback from patients, reviews of difficult and challenging clinical cases, as well as learning experiences surrounding an individual's quality outcome measures. This evidence should be available for external scrutiny. The process of review should be driven by appraisal and revalidation. The role of the RCOG should be to provide guidance on content and high quality CPD materials and to set appropriate standards in the form of a well-developed framework. The RCOG's role should not be to monitor CPD programme activity. This is a key component of the appraisal and revalidation processes.

To complement a new CPD structure the RCOG needs to review how the collection of CPD data is obtained. The review needs to embrace modern technology. Too much time is currently spent uploading relevant CPD data long after the event has taken place, and with the advent and popularity of smart phone technology software applications (Apps) need to be developed to enable the rapid capture of data and encrypted transfer to the CPD database. In addition, these databases need to be able to interface with those required for appraisal and revalidation to avoid duplication of data collection. At the very least, they should be exportable in a format that can be easily used for revalidation. The differentiation between local, national and international CPD is now outdated because of the globalisation of IT networks, and should be discontinued.

#### Recommendations

18. The RCOG must review the current categories for CPD in order to integrate and strengthen medical appraisal and revalidation.
19. A personalised development plan incorporating a full review of CPD needs to be agreed within six weeks of appointment.
20. There must be a greater emphasis within CPD recognition for reflection.
21. The RCOG needs to provide the technological support to enable the specialist to seamlessly capture, record and present their CPD activity.

### 4.4 CPD: meeting both individual and service needs

*I think the current CPD programme is too non-prescriptive. As a new consultant, it would have been helpful to have some direction and an idea of what CPD to focus on.*

CPD needs to be tailored to the individual and there should be advice about which elements of CPD are appropriate to that individual. An individual's CPD should reflect their career aspirations as well as their job plan and the needs of the service. Specialists may wish to enhance their careers by furthering their specialist interests leading to a

'credential' in that area (once a credentialling scheme is formalised), and CPD will need to support this process. Flexibility in delivery is key to reflect the needs of individuals with different learning styles.

### Recommendations

22. CPD must be tailored to the individual job plan and the needs of the service.

23. CPD structure needs to have enough flexibility to enhance career development.

24. The RCOG Advanced Training Skills Modules (ATSM) Committee should continue its work and develop further modules, which are appropriate for lifelong learning.

## 4.5 CPD and personal development

CPD needs to enhance non-clinical skills development. This is particularly true for newly appointed specialists where the development of non-clinical skills such as team working, and other knowledge and attributes are often overlooked in any formal programme but are fundamental to success.

The acquisition of professional skills and attributes is just as important as clinical competencies. These should include teamwork, leadership and management, research, education, patient advocacy, continuous quality improvement and patient safety.

CPD assessment needs to be more patient focused. There needs to be greater evidence of learning through experience and reflection. Experiential learning and its impact on future practice should be captured as it is crucial to the development of high quality specialist practice. Demonstration of impact on practice should also be captured and encouraged through all CPD activity not just experiential learning as described in the RCGP model of CPD.

## 4.6 CPD: employer responsibilities

*It would be beneficial to us all if hospital managers were to teach new consultants about financial management and accountability, and the interface between physicians and the management.*

Successful CPD requires investment from employing organisations. Successful organisations invest in their staff, supporting continuing education and training throughout their career. The current medical career structure is somewhat anomalous because much of the formal support framework is removed following specialist appointment. There is a greater need for the development of the job planning and appraisal process to support tailored CPD allowing the career aspirations of the individual and the needs of the patients and local services to be met. Employers should recognise that newly appointed specialists will be going through a transitional period of their career and that well-supported CPD will ultimately benefit patient care.

### General recommendations

25. Maintenance of core skills within CPD should be a top priority for all specialists.

26. The RCOG should establish an implementation group to develop post CCT CPD guidance.

27. Employers should ensure there is adequate time within a job plan to allow a specialist to develop.

## 5 Team working

### 5.1 Introduction

*A team of experts is not an expert team.*

*Without mandating human factor training and assessment thereof we miss being able to assess the person's ability to lead and manage a team, and without this we cannot hope to train effective leaders and teachers of the future.*

Almost every document published by the RCOG and other organisations involved in women's health care over the past ten years has reinforced the need for effective multidisciplinary team working as part of the drive towards a high quality service for patients. It is now recognised that a clinician functioning in isolation is undesirable. Such a clinician is described by some as 'a lone ranger' – an individual who works long and hard to provide the care needed, but one whose dependence on solitary resources and perspective may put the patient at risk.<sup>13</sup>

The modern NHS, through evolution and learning from incidents and institutional failings, has learned that safe and effective care is best delivered by well-motivated and well-led teams that include clinicians, managers and support workers. However, the qualities and knowledge required to work within such teams have only recently been seen as essential prerequisites for the introduction of such working within obstetrics and gynaecology.

### 5.2 What is team working?

Most people are familiar with the concept of team working and recognise that teams in all spheres of life, whether they be in sport, industry or medicine, come in a variety of forms. Yet a review of team working within health care reveals that the definition of a team can vary from the very simplistic definition of 'an activity of people working cooperatively to achieve shared goals'<sup>14</sup> to the more complicated 'group of individuals who work together to produce products or deliver services for which they are mutually accountable'.

Team members share goals and are mutually held accountable for meeting them. They are interdependent in their accomplishment and affect results through their interactions with one another. Because the team is held collectively accountable, the work of integrating with one another is included among the responsibilities of each member'.<sup>15</sup> Team-based health care is the provision of health services to individuals, families and/or their communities by at least two health providers who work collaboratively with patients and their caregivers to the extent preferred by each patient to accomplish shared goals within and across settings to achieve coordinated, high quality care.

Team working skills are crucial and all doctors will find themselves with a variety of team roles within hospitals and institutions throughout their careers. The skills that will be needed for effective team working include those skills listed in Box 1. These skills are frequently described as non-technical skills.<sup>16</sup> Many newly appointed specialists quite wrongly assume that these skills will develop naturally and that it is a normal part of gaining experience. While this is true to an extent, many non-technical skills need to be developed more formally if individuals are to optimise their professional development.

**Box 1** The building blocks of team working (non-technical skills)

- Leadership
- Followership
- Communication skills
- People management skills
- Team building, talent management and inclusiveness
- Cultural and diversity awareness
- Resource management
- Records management

The GMC refers to working within teams in Domain 3 of *Good Medical Practice* (GMP) and it expects most, if not all, doctors to work in clinical teams. Therefore it gives guidance on what doctors must consider when being part of a team at every level:

***Work collaboratively with colleagues to maintain or improve patient care***

*35. You must work collaboratively with colleagues, respecting their skills and contributions.*

*36. You must treat colleagues fairly and with respect.*

*37. You must be aware of how your behaviour may influence others within and outside the team.*

A number of different skills will be needed to work not only within a particular team, but also when working across different teams. As a member of a team, the individual should understand the role and contribution of other team members, and how this can impact on the care of the patient. Doctors who have recently gained their CCTs should be equipped with an understanding of team dynamics to ensure their teams function well, but also to enable them to identify how team function can be improved, developed or formed if needed. Many newly appointed specialists come into a post with a specific role to develop, identified by the hospital. Quite frequently that role may not have existed before, for example, many recently approved jobs for acute gynaecology or early pregnancy.

### 5.3 Team recognition

Most specialists in obstetrics and gynaecology work in teams; it is almost inevitable. Mostly, they move seamlessly from one team to another depending upon the clinical commitment. One day they are in the 'operating theatre team' and the next, they are in the 'labour ward team'. Trainees will recognise the 'on-call team' and the demands of effective handover. These transient teams are an important element of working and professionals need to bring all the skills required to these teams for effective, safer patient care. It is wrong to consider that such transient teams can tolerate poor team players more easily. However, becoming a member of a transient or permanent team or even a frequently changing team may be challenging to some individuals.

A move from the 'lone ranger' style of working may challenge one's professional identity, question one's likely role within a team and challenge individuals' ideas and values about related health professionals. Teams must be built on mutual trust and respect, not competition or rivalry, and this is never more important than in the relationship between obstetricians and midwives on the delivery suite.

It may be that new CCT holders have worked in many teams in their training and so may be more adaptable than the older, more established specialist.

## 5.4 Promoting team working

*I think patient safety must become the top agenda item, but concentrating on those things we can change like team working, clear communication, regular senior review of patients and multidisciplinary working between specialties.*

In 21st century medicine, no single type of healthcare professional, including doctors, is able to provide the full spectrum of diagnostic or treatment options. For example, there is no longer an expectation that one professional will know everything that could possibly be required by any pregnant woman. The evidence base is now too great for any one person to be up to date with its entirety. The only way of ensuring that the very best care is provided to each and every patient is by providing care in multidisciplinary teams that are underpinned by evidence-based practice. Therefore, team working should enable doctors and other healthcare professionals to provide better care than that which can be achieved by a series of individuals working alone.

There is evidence that teamwork offers the benefit of enhanced professional satisfaction and can assist in the development and promotion of inter-professional communication. It may also encourage innovation and quality improvement strategies.<sup>17</sup> Team working may promote the patient safety agenda within organisations as shown by a study which demonstrated that positive team behaviours resulted in improved management in simulated obstetric emergencies.<sup>18</sup> Meaningful team working will promote the introduction of versions of Crew Resource Management (CRM), which has so successfully reduced incidents and fatal outcomes within the aviation industry. Within obstetrics and gynaecology this should enable the continued introduction of simulation and drills for all women's healthcare professionals e.g. PROMPT. The specialty needs to think beyond skills drills and put more emphasis on how to transfer the lessons learnt from leading units, to departments that are not so advanced. It also needs to consider gynaecology pathways as a priority.

The RCOG and the Royal College of Midwives (RCM) are currently promoting a culture of zero tolerance of undermining in the workplace (Appendix 5a). Team working has a significant role to play in conflict resolution and reducing undermining by promoting respect, support and understanding for all team members. Team working should also enable individuals to develop the skills to challenge others in a non-threatening manner, improve behaviour in the workplace, improve reflective practice and enhance meaningful 360 degree appraisal. New specialists have an important role in changing the culture and ensuring they act as role models.

## 5.5 The way forward

*I think far more emphasis needs to be put on team leadership, people management, risk management and clinical governance because this is a large part of my role now!*

True interdisciplinary team working is already becoming a recognised feature of women's health care in the UK but it needs to become universally embedded. There must be more meaningful integration across primary and secondary care and transparent linkage between teams in hospitals and across hospital networks. For this to occur, all those working within obstetrics and gynaecology need the appropriate non-technical skills and

attitudes that will only come from exposure to such team working. Established specialists need to recognise the need to get out of 'silo working practices' and this needs to be encouraged by management.

There must be systems in place to allow doctors in the early years after CCT to challenge poor team working or lack of team working as easily as they would challenge poor patient care. Best practice in team working, as with other areas of practice, must be taught effectively from the start of their training. There is a need for stronger linkage between medical staff and midwives, particularly at a training level, and all healthcare professionals must see themselves as only a part, albeit a very important part, of the process that impacts on the patient journey.

### General recommendations

28. The concept of team working should be embedded within core skills for all specialists.
29. Identification of which teams a newly appointed specialist will be joining and developing must form part of an induction and appraisal process.
30. The appraisal process should value multisource feedback as a reflection of team working skills.
31. Trusts and ultimately the department a specialist is joining must be responsible for effective integration of new specialists into existing teams.
32. The RCOG should promote team working as an important part of specialists' professional development.
33. Hospitals must try to overcome the organisational obstacles to encourage improved team working between midwifery, nurses and specialists.

## 6 Buddying, coaching and mentoring

### 6.1 Introduction

*I had an informal arrangement with a senior consultant colleague who acted as a mentor which was very useful.*

The Specialist Career Development Working Party's qualitative survey identified an overwhelming perceived need among newly appointed specialists for some special support. This feeling is also well understood by more senior specialists who can remember the transition from being a trainee to a specialist when there was, at least in theory, always someone to ask for advice. New specialists find themselves in the situation when they are now that 'someone'.

The need for such support will vary from individual to individual. Those working in a supportive team may feel less need to look outside that team for support, although even in well-supported teams there is still an advantage to be gained by having someone outside that team to provide advice or discuss situations.

It is first worth exploring the different areas of support that are available and, more importantly deliverable, before attempting to decide how to move forward as a profession. There are essentially three types of support:

1. Buddying
2. Coaching
3. Mentoring.

Each of these varies in how hierarchical and formal the relationships are and how long the relationships last. It is important for both the new specialist and the person providing the support to be clear about what is being undertaken at the outset, otherwise it is easy for both parties to become disenchanted.

### 6.2 Buddying

*... a year in which you need friends rather than mentors*

For many, the need is simply for someone to provide advice about a specific or day-to-day clinical management problem or dealing with an awkward colleague. In these circumstances, having a clinical buddy is probably the most appropriate solution.

The main feature of buddying is its informality and having the feeling of a mutual brainstorming approach. The buddy is usually from the same hospital and quite often a few years senior. This type of informal support tends to evolve out of fortuitous meetings of minds as a doctor progresses through training, and is widespread throughout the medical profession, but the very informality and opportunistic nature of it limits its availability. Sometimes the individuals who need the support most are those who find such relationships difficult to instigate, or even do not have the insight to seek such relationships. Therefore self-directed buddying alone is not sufficient.

There is a hierarchical structure to the relationship as the buddy tends to be in a position of giving advice, but this hierarchy is not as vertical as in a coaching relationship. The buddy is usually someone known, and in particular chosen, by the person needing



the support because they are someone that person trusts. Not only is the relationship itself informal, but it is also informal in its timing – meetings are often by chance, arranged over a cup of coffee and lasting for a short period of time. The duration of the relationship can be weeks, months or years. Buddies are also invaluable in an increasingly reflective mutual learning environment, providing support and advice should problems be identified through risk management systems.

Buddies often act as role models and while they can be useful in assisting with specific problems they are also helpful in enhancing understanding 'softer knowledge' such as professionalism, ethics, values and the art of medicine.<sup>19</sup> It is also recognised they provide emotional support and encouragement.<sup>20</sup> There are many advantages to this type of support. It takes little time to set up as both parties may well be known to one another, and working in the same institution means that arranging meetings is easy; the meetings are generally short and focused and so take little time for either party (of major importance in a target driven service); and it deals with a specific problem effectively as it is drawing on the skills of someone who has fairly recently been coping with the same issues.

### 6.3 Coaching

*... the most difficult adjustment was the role of Maternity Clinical Governance and [the] Clinical Negligence Scheme for Trusts ( CNST) where there was very little handover and a big pressure from the management to achieve level three within two years of my appointment*

There are many experiences in professional life that will be challenging. Specific situations might include being asked to chair a committee or having to cope with a difficult colleague where the issue may be more deep-seated. Finding a coach can be invaluable for such specific instances. The learner comes to the expert to acquire a specific defined skill in the manner of an apprentice. This is a formal time-limited relationship with the person being coached being encouraged to set goals for themselves, with reflection along the way in order to identify when the coach's task is completed.

The process of coaching implies more than simply passing on information or advice about how to perform a task. It can also help to identify internal and external factors that might prevent someone from fulfilling that task. Internal blockages might include fear of failure or lack of confidence while external blockages might relate to the culture of the organisation or attitude of staff or management.

While coaching is usually sought by the individual as part of a personal learning plan, less commonly it is mandated by an appraisal process or by an investigation into a serious clinical incident. This type of relationship is beyond the scope of this chapter but time should be allocated in a job-plan for both coach and learner.

### 6.4 Mentoring

*... an insight into the difficulties of working with the NHS and, in particular, the trust. Essentially someone to discuss career development ...*

Mentoring is a more structured and more formal approach to providing support than buddying, but, like buddying, it includes providing guidance and support.

Mentoring has been described as a dyadic (two-way), face-to-face, long-term relationship between a 'supervisory adult' and a 'novice student' that fosters the mentee's

professional, academic or personal development.<sup>21</sup> However, there are almost as many different definitions of mentoring as there are mentors. In fact, the [Coaching & Mentoring Network lists 13 different definitions of mentoring or being a mentor.](#)<sup>22</sup> All of these definitions include elements of long-term relationship, senior/junior, advice and development. Seniority within the relationship is only by virtue of having had mentorship training. The 'advice' element of the partnership is less tangible than the word suggests: the job of the mentor is to help the mentee to find their own right way to deal with the issues they bring to the discussion, without solving the problem for them.

Mentoring is usually, but not necessarily, carried out by an individual in the same discipline. A mentor should not have a close working relationship with the person being mentored. The mentor may not even work in the same hospital. The relationship should be a developmental one – not usually dealing with a specific issue but more the general development of the mentee as a new specialist and beyond. As such, it tends to be more open-ended than coaching, continuing for as long as both sides feel that the relationship is helpful.

In addition to identifying the skills required of the mentor, it is important that the person being mentored approaches the process in the right way. The qualities required of the mentee include availability, honesty, trustworthiness, a positive approach to failure and being accountable, responsible and willing to be stretched.<sup>23</sup>

The most important thing for both mentor and mentee is to allocate appropriate time and give the necessary priority to the process. Without this commitment on both sides neither mentor nor mentee will achieve their aims. Hospital management needs to recognise the formality of a mentoring process as well as its benefits.

Problems with mentoring have also been reported. A review of the literature<sup>24</sup> found that 2.5% of the studies reported exclusively negative outcomes. However, almost half of those being mentored reported support, empathy, encouragement, counselling and friendship through the process. The main problems noted by mentees were lack of time and professional expertise/personality mismatch.

Many do not recognise the difference between coaching and mentoring (see Appendix 6a on Purposeful conversations) and the terms are often used interchangeably. However, whether they are considered the same or that the one is a subgroup of the other, it is essential that the reason for the external support and guidance is identified and that the right approach is chosen for the context.

Finding further reading, see *The Good Mentoring Toolkit for Healthcare*.<sup>25</sup>

## 6.5 Finding support

There are many places where the newly appointed specialist can go to in order to find support. The most obvious place is either the hospital itself or the deanery as a further source of education and development advice. Most deaneries have mentorship schemes for trainees but there is a wide variation across the country as to availability post-CCT. Such mentors, if available, are usually trained through their deaneries and most will participate in ongoing networking support meetings with their fellow mentors. Such participation is expected in order to remain a qualified mentor. There is usually guidance on the website as to what is expected from both participants, and encouragement for the partnership to set ground rules during the first meeting, but agreement on the nature and duration of the relationship is left very much to the participants. There are

advantages to this system: it is entirely voluntary which is one of the key aspects of mentorship that the [Department of Health](#)<sup>26</sup> recommends and there is freedom for the partnership to set its own rules, which is very empowering.

Variations do exist, however. Some of the mentorship schemes available through the deaneries have more of an emphasis on leadership rather than mentorship, as does the East Midlands Leadership Network (see Appendix 6b). Many hospitals have also developed their own internal mentoring scheme for new specialists and other staff. Good quality schemes usually rely on external training of mentors, which is funded by the employing organisation. Often these organisations offer a mentor routinely on appointment in order to encourage participation. In these circumstances, new specialists who do not wish to participate have to make a decision to opt out.

Individual hospitals can access help in setting up local mentorship schemes, for example, the 'Master Class in Mentoring' scheme which will train mentors, advise on setting up a matching process and evaluate mentors' progress. However, these schemes exist as commercial ventures for their founders and as such there is considerable expenditure involved in accessing them.

There are many other mentorship programmes available through organisations remote from the NHS, throughout the business, government and academic worlds. However, there is a lot of emphasis on achievement of leadership potential with programmes outside the NHS, and indeed the term 'mentorship' is used almost interchangeably with 'leadership development', which changes the nature of the relationship and blurs the goals for both.

It is clear that mentoring is not for all and there are issues to consider around the intensity of the process. There is a considerable effort needed by the mentor not only to be trained but also maintain those skills, as well as the time taken in participating in the process itself. This effort should be reflected in the mentors' PDPs and appraisals, with clear recognition for the workload that is involved, being reflected within their own CPD activities.

## 6.6 What makes a good mentorship scheme?

*Mentoring would be good but only if both parties are really committed to it.*

*A mentor needs to be someone you can trust, who is clinically competent and who has integrity.*

Taking up a mentorship role should be voluntary for both parties. The mentee should initiate the request for mentorship; if there is coercion then the relationship is less likely to be fruitful. There may be times, however, when an external adviser may recommend mentoring particularly when there is lack of insight of an individual. The mentee should be clear why they are seeking mentorship in order to inform a clear discussion with the mentor as to the purpose of the relationship. There should be a choice of mentor in order to promote trust.

There is no doubt that there are proven benefits to mentorship, especially for individuals newly promoted into senior positions such as a first specialist role. The reality is that in a world where clinician time away from direct patient care is increasingly limited and scrutinised, any activity related to an individual's job needs to be accounted for. It is difficult to access funding for setting up, administering and participating in

mentorship schemes, especially if the mentor–mentee relationship is across different sites or even different organisations. Clinical directors should recognise the benefits of mentoring within their unit and if necessary do their utmost to support this within their financial constraints.

### General recommendations

34. All specialists must have access to some external personalised support in the form of buddying, mentoring or coaching.
35. All specialists must reflect on the type of personal support they need and this should be highlighted specifically in their appraisal.
36. Both the specialist and the person providing support should be clear what form of support is required (buddying, coaching or mentoring) and be cognisant of the time commitment involved.
37. All mentors should have specific training.
38. The support given by a mentor should be recognised within CPD.
39. Hospitals should ensure adequate time is provided in job plans for the process of professional support.
40. Hospitals should consider setting up schemes with neighbouring hospitals to allow for reciprocal mentoring.
41. The RCOG should consider developing a mentorship programme and making it widely available.

## 7 Developing as a specialist

### 7.1 Introduction

This chapter will analyse some of the challenges the new specialist has to face, and outline some of the solutions they can consider as they begin a stage of their career that could see them remaining in one institution for 20 years or more. The acquisition of the right balance of skills and knowledge prior to the award of CCT will help new specialists find ways of developing individually, as well as developing their careers outside their main clinical domain. The principles and supportive framework will continue throughout one's career.

### 7.2 Induction

Every hospital should have a process or policy in place with details of the responsibilities of the employer for the induction of all new employees into a department (see Appendices 7a and 7b). There are, however, some specific requirements of the new specialist, which the RCOG should promote.

Induction should be an ongoing process in order to integrate new specialists into their teams, departments and units. It should not take place over one day or one week. Clinical directors should ensure that an induction programme includes all aspects of clinical care, with time and effort given to this process to ensure a new specialist integrates smoothly. Utilising SPA time in the first few weeks and months so as not to compromise clinical sessions should be seen as part of normal professional development. This is a very effective use of SPA time.

Working as a specialist is different from being a trainee and it is crucial that new specialists familiarise themselves with not only their own department but also the wider hospital environment. For example, meeting the interventional radiologists face to face during an induction programme, rather than for the first time in the early hours of the morning when dealing with a massive obstetric haemorrhage, is certain to be beneficial.

#### Recommendations

42. The RCOG should define the minimum standards for clinical integration of a specialist into a department.

43. Induction should be a continual process utilising SPA time initially in the first few months.

### 7.3 Leadership

*As a new consultant, it would have been helpful to have some direction in what leadership and management skills I needed to focus on during my training rather than just having to 'pick it up' on the job.*

Being a specialist involves developing skills beyond one's own core clinical abilities. Leadership, management skills and the ability to develop others are examples of this.

Leadership comes in many forms, but by virtue of the title ‘specialist’ many within the clinical team will look up to that individual as a leader from the first day of their appointment. Within a department specialists will, at times, lead a team, which may or may not be multidisciplinary, and at other times they may be a member of a team led by another who may not be a doctor. The ability to seamlessly shift between these different roles in the average working day is a challenging process for any specialist.

The emphasis on leadership in medicine has never been more apparent. Various reports have all identified leadership as a strong tool for enhancing the patient experience and, more importantly, patient safety. It is important to state that one can be a good and effective leader and still be part of a well-functioning team.

Several styles of leadership have been identified:<sup>27</sup>

- directive (coercive) – results in immediate compliance
- visionary (authoritative) – provides long-term direction for employees
- affiliative – creates harmony among employees and with their leaders
- participative – builds commitment among employees and facilitates generating new ideas
- pacesetter – accomplishes tasks to high standards of excellence
- coaching – focuses on the long-term development of employees.

Each of these styles has its place but one may be more appropriate than another in certain situations. For example, directive leadership may be needed in an emergency, but a trainee in difficulty may require a coaching form of leadership. It is important at least to have an awareness of these styles and learn to develop those that may not come naturally. The end goal, however, is to create a working environment in which employees can produce high quality safe care for patients. All specialists will have some skills in leadership but those individuals who are outstanding should be identified, encouraged and nurtured.

There is wide variation in the content of management courses which are often tailored to the generic needs of a new doctor in any specialty rather than a new specialist in obstetrics and gynaecology. In addition, there is a significant difference between teaching management and leadership skills from a theoretical point of view, and giving practical pointers to new obstetrics and gynaecology specialists to help them cope with the daily pressures of their new role.

To address this, a bespoke course in management and leadership relevant to obstetrics and gynaecology should be developed for all specialists and managers (see Appendix 7o). This should be developed by the RCOG in collaboration with other organisations experienced in delivering such training.

A potential way forward may involve specialists making contact with managers in their hospital and buddying with a manager to attend the course. This may equip the buddied pair with the tools to bring about effective positive change for their patients and services and allow that pair to develop their ideas away from the work environment. This may promote an enhanced relationship between management and clinicians which in poorly performing units is often cited as a recurring issue.

In 2009, the [Scottish Government released an NHS improvement leadership strategy](#).<sup>28</sup> It describes some of the qualities that healthcare professionals can develop to improve their leadership potential. These skills are summarised in Figure 1.



**Figure 1** Skills required for developing your leadership potential (taken from [NHS Scotland<sup>28</sup>](#))

Since 2009, the same group has developed a simple tool that can help new specialists as leaders in a department. This tool is called the VOICES framework (see Appendix 7c). It offers simple tools to support individuals in developing their personal skills. Insight into areas in which the new specialist is both weak and strong is important as this is a significant step towards becoming a good leader.

During the training years leadership can be experienced at many levels, from everyday management of the delivery suite to taking the lead in a major gynaecological operation as a senior trainee. These leadership opportunities are often not fully recognised by trainees. However, on commencing a senior role new specialists often become very aware of the need for both leadership and management skills in many aspects of their role.

As a specialist there will be occasions when individuals will require leadership skills as well as occasions when they will be followers within a broader team (see Chapter 5 on Team Working).

Skills that require development in the early years are:

- the ability to develop others
- change management
- service development including writing business cases
- organisational skills including how to work with a secretary/PA
- understanding the requirements for appraisal and revalidation
- specific IT skills including electronic patient records/radiology viewers
- team working
- conflict resolution
- complaints handling
- difficult conversations and undermining

- dealing with serious incidents, debriefing
- financial competency
- understanding the wider NHS.

## Recommendations

44. The RCOG should develop, in partnership with an appropriate organisation, management and leadership resources for all specialists.

45. All specialists should identify which leadership skills they possess naturally and try to develop skills in other areas.

46. The RCOG should identify individuals who have outstanding leadership skills whatever the stage of their careers, with a view to enhancing and developing these individuals.

## 7.4 Dealing with complaints

*Complaint management would be very useful. I'm still not sure how I should write a response to a complaint.*

Becoming a specialist will introduce the individual to the hierarchy of responsibility that specialist status brings. In obstetrics and gynaecology while there is an increasingly specialist-based service there will be many decisions made on the care of patients by colleagues and juniors for which the patient, at least, will frequently still hold the named specialist accountable. The recent 'name over the bed'<sup>29</sup> concept promoted by the Government attempts to identify a sole person who is responsible for a patient's care and as such the individual responsible will be at the forefront of any possible complaints process.

It will be the first time for many specialists that they will have had to deal with complaints directly, both in writing responses to letters of complaint and meeting angry or distressed complainants. All specialists need resources for emotional support when dealing with a personal complaint and the skills to be able to professionally deal with such an issue.

There was an 8% rise in complaints to the [NHS Ombudsman in 2011](#).<sup>30</sup> There were just over 150,000 complaints in the year and this figure is rising each year. It is therefore essential that all specialists, experienced and inexperienced, understand how best to deal with a complaint.

The Ombudsman's report acknowledges that the NHS handles most complaints well. However, it also states that complaints about the way in which a complaint is handled are increasing (see Appendices 7d and 7e). It goes on to say that each complaint that is not addressed properly is a missed opportunity to continue to improve and identify problems and reinforce the trust we put in the NHS to get our care and treatment right.

There are a few common themes that contribute to the poor handling of complaints:

- lack of true candour when dealing with complainants
- equivocal language and sitting on the fence over decisions that were made during the care complained about
- getting key facts wrong



- using technical language without explanation
- false apologies, for example 'I'm sorry you feel the care you received was not good enough'.

New specialists should not handle complaints on their own but should involve key members in their organisation as appropriate. These will include the clinical director, the hospital complaints department and the Patient Advice and Liaison Service (PALS). Discussion with other colleagues and advice on how to respond appropriately is vital and the department or hospital should also offer support as necessary.

Specialists may also find themselves facing either litigation or a coroner's court for the first time. Each hospital/department should have procedures in place to help and support staff at these times. It is not just the individual responsibility of the clinician.

### Recommendations

47. It is essential that all specialists, experienced and inexperienced, understand how best to deal with a complaint.

48. The RCOG should work with NHS agencies to develop national strategies to reduce complaints and ultimately litigation in obstetrics and gynaecology

49. Hospital departments must be more proactive and have procedures in place to ensure all specialists are trained in dealing with complaints, litigation and, if necessary, court appearances.

## 7.5 Difficult conversations and undermining

Some colleagues may be difficult to work with and equally some specialists may feel that they are being undermined by their colleagues both within the department and within the broader organisation, and access to RCOG workplace-based behaviours champions should be available for all.

All specialists will need a number of skills to address these issues. They may already have some of those skills and some may need to be developed. These may include:

- advanced communication skills training enabling the individual to put ideas forward constructively and concisely
- handling difficult conversations with colleagues
- assertiveness skills
- managing interactions at a senior level with colleagues from other departments
- avenues to take if being undermined or overlooked in a department
- tackling discrimination.

(See Appendices 7f, 7g and 7h.)

## Recommendations

50. The RCOG should ensure that intermediate and advanced communication skills workshops are available for all specialists.

51. All specialists must show evidence of competent communication and risk management skills in each revalidation cycle.

52. Communication skills and risk management training should be incorporated in CPD.

53. All specialists should have equal access to bullying and undermining solutions.

## 7.6 Job planning

*I had heard of job planning before starting but had not fully appreciated its importance.*

It is in the area of job plans that most specialists turn to the RCOG for advice. Although the RCOG has expertise and can give advice, it cannot act as trades union for the individual. Specialists must know whom to approach for professional and sometimes legal advice, with respect to difficulties around the intricacies of employment law. Each new job description will contain an initial job plan for the post for which the specialist is applying. Foundation Trusts are not required to have job plans approved by the RCOG, but many do. Therefore many job plans, but certainly not all, will have been through a standardised approval process.

Each job plan review should be undertaken by the clinical director or equivalent and should be agreed with the specialist. If the specialist and clinical director cannot agree, they should approach the medical director to arbitrate.

See Appendix 7i.)

## 7.7 Developing your service

In an increasingly finance driven NHS, the need to prove the financial case to support a clinical development is growing in importance. All specialists may therefore need support to write and develop a good business case in order to move their service forwards (see Appendix 7j). Different organisations will have their own template to complete, and should provide managerial support to complete it. However, the main elements of a good business case are:

- clinical case for change
- clinical options, including do nothing or change nothing depending on the model
- objective quality impact assessment of the options proposed
- financial impact of all the options that have been proposed
- preferred option, and why.

Frequently other colleagues will be able to support, as should the hospital's management and finance departments. Moving a business case forward is more likely to be successful when written in conjunction with other supportive colleagues.

## 7.8 Understanding NHS structure and management

*I hadn't realised how protected I was from NHS management as a trainee. It is something I just assumed happened behind closed doors. When I became a consultant those doors were opened but I had no idea what was expected of me. I wish I had a better understanding of the management structure and had been involved before I became a consultant.*

The NHS is accountable to parliament and structures will often change as governments change. The fundamental principle for two decades, however, has been that funding streams will follow the patient. It is important that the specialist of the future understands how the NHS functions so as to provide the highest quality care they can within the financial constraints placed upon them.

NHS managers come from many backgrounds. Some may have been successful clinicians, while others may have limited clinical knowledge but excel in other areas. Understanding their background and what they are striving to achieve is vital to allow a good working relationship for the benefit of patients. The new specialist will frequently have had little interaction with managers prior to becoming a specialist and should seek the counsel of colleagues, if needed, to engage with the broader team within the department. More effective engagement with managers, both clinical and non-clinical could be explored.

(See Appendices 7k, 7l and 7m.)

### Recommendations

54. The RCOG should maintain a list of resources to support specialists in accessing high quality management training.

55. All specialists should be aware of current issues around job planning and other relevant contractual issues.

56. The RCOG should develop training in key areas around job planning, business development and the structure of the NHS.

## 7.9 Educational roles

Almost all new specialists will have an educational element to their working week, from supervising trainees through undergraduate teaching to supporting non-medical colleagues such as nurses and midwives. The GMC is establishing a process to recognise a number of educational roles. Within postgraduate education this will include named clinical supervisors and named educational supervisors, and within undergraduate education this includes local lead coordinators and those that oversee students' educational progress. As part of the recognition process, trainers will need to demonstrate that they are appropriately trained and most LETBs/deaneries and universities offer training which is available to senior trainees and specialists, to enable them to provide high quality training and supervision for their trainees and students.

Throughout their training new specialists will have come into contact with educators in various roles. This will give the new specialist a valuable insight into the requirements of the current trainee, and many will wish to pursue a career in medical education as an educational supervisor, college tutor, clinical lecturer or undergraduate teacher (medical students and student midwives). They are likely to have a less clear understanding

of regional or national roles. RCOG proposes to launch the new RCOG Faculty of Educators, which describes four tiers in the development of a specialist career in education. As part of this, RCOG educational courses should describe the training that may be required for various roles and the opportunities for progression from one tier to the next. Specialised courses may need to be developed for regional and national roles.

### Recommendations

57. The RCOG should provide new specialists with signposts to available training in medical education through the proposed RCOG Faculty of Educators tier system.

58. The RCOG should develop O&G-specific training courses for regional and national roles to support specialists' development. (See Appendix 7n.)

## 7.10 Professional development

*I would be happy if my appraiser could give me some advice/support/wisdom on an annual basis.*

Support mechanisms and mentoring for new specialists should include consideration of the broader elements of their career. Many specialists may spend up to 20 years in their posts, and while their clinical work may develop it is likely to remain broadly similar throughout that time.

Specialists should give consideration to what other roles they may take up during their careers in order to ensure they have the appropriate training to deliver these roles well. New specialists should consider their career portfolio over the coming 2, 5, 10 or even 20 years. The New Specialists Course will include signposting to other roles within obstetrics and gynaecology that specialists can work towards while maintaining the obstetrician and gynaecologist specialist role.

All doctors will have an annual appraisal, through which both plans for the coming year and longer term can be discussed and developed, for benefit of not only the individual, but also the organisation and the wider NHS. Specialists will need training to understand their part in the appraisal system if they are to get maximum benefit from it.

### Recommendations

59. All specialists must access appraiser training within the first year of the award of the CCT.

60. The RCOG should maintain an accessible list of resources to point specialists to the appropriate training to deliver additional roles to a level of high quality.

### General recommendations

61. The RCOG should produce a recommended list of the minimum requirement for an induction pack that each department should have for new specialists and give an example of a framework for this for hospitals/departments/units.

62. The RCOG should consider a modular format for the New Specialists Course, which could be run as a rolling programme so individuals could access the areas they feel most need for.

63. The RCOG should consider partnering with another recognised organisation to deliver a high quality leadership course for new specialists. (See Appendix 7o.)

64. The RCOG could consider working with a linked university to obtain recognition for the New Specialists Course modules to count towards a postgraduate degree/certificate/diploma in medical management or medical education.

## Summary of recommendations

### Chapter 2: Developing and demonstrating safe practice

#### 2.3 Patient safety at the start of a specialist career

1. Patient safety must be a key part of the early development of a newly appointed specialist.
2. The RCOG must develop a patient safety module to be incorporated into the educational package for the new specialist.
3. All specialists must record personal outcome metrics and maintain a log of reflective practice specific to patient safety.
4. Hospitals must develop systems to underpin and support the specialist for collection of data.

#### 2.4 Continuing patient safety

5. Opportunities to demonstrate knowledge and practice of care in a safe manner should be developed within the current career structure.
6. More refined measures to demonstrate safe practice (e.g. peer review by colleagues, seeking patient opinion, record keeping assessments) need to be developed and will require additional resources.
7. A greater emphasis on patient safety should be incorporated into the appraisal system and captured within revalidation. (See Appendices 2a and 2b.)
8. Continued education into patient safety should be further developed by the RCOG, underpinned by evidence from individual specialist portfolios.
9. Specialists must develop their own portfolio of evidence demonstrating safe practice.

#### 2.5 Further skills in patient safety

10. NHS Employers should support the development of experts in this field and recognise the support of host trusts or formally offer secondment opportunities.
11. The RCOG, AoMRC and the NHS should identify leaders and champions in patient safety within the specialty to identify and communicate key messages to teams and specialists.
12. The RCOG should devise tools that facilitate enhanced assessment of team functions and the safety of care within clinical teams.

## Chapter 3: Core clinical skills

13. Hospitals must ensure that specialists are supported in time (SPA) and resources to maintain and develop their core clinical skills.
14. The RCOG must work towards putting key components of core clinical skills together as educational packages.
15. It is the responsibility of the profession as a whole to ensure that specialists returning to work after a prolonged absence are properly supported.
16. Clinical appraisal and job planning should be directly linked to develop uniform objectives for the maintenance and development of core clinical skills.
17. The RCOG must work more closely with the specialist societies to enhance core clinical skills.

## Chapter 4: Continuing professional development

### 4.3 CPD integration with medical appraisal and revalidation

18. The RCOG must review the current categories for CPD in order to integrate and strengthen medical appraisal and revalidation.
19. A personalised development plan incorporating a full review of CPD needs to be agreed within six weeks of appointment.
20. There must be a greater emphasis within CPD recognition for reflection.
21. The RCOG needs to provide the technological support to enable the specialist to seamlessly capture, record and present their CPD activity.

### 4.4 CPD: meeting both individual and service needs

22. CPD must be tailored to the individual job plan and the needs of the service.
23. CPD structure needs to have enough flexibility to enhance career development.
24. The RCOG Advanced Training Skills Modules (ATSM) Committee should continue its work and develop further modules, which are appropriate for lifelong learning.

### General recommendations

25. Maintenance of core skills within CPD should be a top priority for all specialists.
26. The RCOG should establish an implementation group to develop post CCT CPD guidance.
27. Employers should ensure there is adequate time within a job plan to allow a specialist to develop.

## Chapter 5: Team working

28. The concept of team working should be embedded within core skills for all specialists.
29. Identification of which teams a newly appointed specialist will be joining and developing must form part of an induction and appraisal process.
30. The appraisal process should value multisource feedback as a reflection of team working skills.
31. Trusts and ultimately the department a specialist is joining must be responsible for effective integration of new specialists into existing teams.
32. The RCOG should promote team working as an important part of specialists' professional development.
33. Hospitals must try to overcome the organisational obstacles to encourage improved team working between midwifery, nurses and specialists.

## Chapter 6: Buddying, coaching and mentoring

34. All specialists must have access to some external personalised support in the form of buddying, mentoring or coaching.
35. All specialists must reflect on the type of personal support they need and this should be highlighted specifically in their appraisal.
36. Both the specialist and the person providing support should be clear what form of support is required (buddying, coaching or mentoring) and be cognisant of the time commitment involved.
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## Chapter 7: Developing as a specialist

### 7.2 Induction

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43. Induction should be a continual process utilising SPA time initially in the first few months.



### 7.3 Leadership

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46. The RCOG should identify individuals who have outstanding leadership skills whatever the stage of their careers, with a view to enhancing and developing these individuals.

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### General recommendations

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63. The RCOG should consider partnering with another recognised organisation to deliver a high quality leadership course for new specialists. (See Appendix 7o.)

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Appendix 2a

# **NHS Revalidation Support Team Medical Appraisal Guide**



Revalidation Support Team

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## **Medical Appraisal Guide**

A guide to medical appraisal  
for revalidation in England

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## Introduction

Revalidation of doctors is a key component of a range of measures designed to improve the quality of care for patients; it is the process by which the General Medical Council (GMC) confirms the continuation of a doctor's licence to practise in the UK. The purpose of revalidation is to assure patients and the public, employers and other healthcare professionals that licensed doctors are up to date and fit to practise.

Through a formal link with their organisation, determined usually by employment or contracting arrangements, doctors relate to a senior doctor in the organisation, the responsible officer. The responsible officer makes a recommendation about the doctor's fitness to practise to the GMC. The recommendation will be based on the outcome of the doctor's annual appraisals over the course of five years, combined with information drawn from the organisational clinical governance systems. Following the responsible officer's recommendation, the GMC decides whether to renew the doctor's licence.

The responsible officer is accountable for the quality assurance of the appraisal and clinical governance systems in their organisation. Improvement to these systems will support doctors in developing their practice more effectively, adding to the safety and quality of health care. This also enables early identification of doctors whose practice needs attention, allowing for more effective intervention.

All doctors who wish to retain their GMC licence to practise need to participate in revalidation.

This publication has been prepared by the NHS Revalidation Support Team (RST). The RST works in partnership with the Department of Health (England), the GMC and other organisations to deliver an effective system of revalidation for doctors in England.

All RST publications are created in collaboration with partners and stakeholders.

The *Medical Appraisal Guide* was tested as part of an extensive programme of testing and piloting with over 4,000 doctors, from which the quotes in this document have been derived.

## Purpose and context

The Medical Appraisal Guide (MAG) describes how medical appraisal can be carried out effectively. It is designed to help:

- doctors understand what they need to do to prepare for and participate in appraisal
- appraisers and designated bodies ensure that appraisal is carried out consistently and to a high standard.

The General Medical Council has set out its generic requirements for medical practice and appraisal in three main documents:

- *Good Medical Practice* (GMC, 2013)<sup>1</sup>
- *Good Medical Practice Framework for Appraisal and Revalidation* (GMC, 2013)
- *Supporting Information for Appraisal and Revalidation* (GMC, 2012).

These are supported by guidance from the medical royal colleges and faculties, which give the specialty context for the supporting information required for appraisal.

Doctors should also have regard for any guidance that the employing or contracting organisation may provide concerning local policies.

## Primary audience

This document should be read by:

- doctors
- appraisers
- officers in designated bodies and in organisations providing appraisal services.

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<sup>1</sup> This document was prepared with reference to the 2011 consultation draft of *Good Medical Practice*. A new edition was published on 25 March 2013.



## What is medical appraisal?

Medical appraisal is a process of facilitated self-review supported by information gathered from the full scope of a doctor's work.

Medical appraisal can be used for four purposes:

1. To enable doctors to discuss their practice and performance with their appraiser in order to demonstrate that they continue to meet the principles and values set out in *Good Medical Practice* and thus to inform the responsible officer's revalidation recommendation to the GMC.
2. To enable doctors to enhance the quality of their professional work by planning their professional development.
3. To enable doctors to consider their own needs in planning their professional development.

and may also be used

4. To enable doctors to ensure that they are working productively and in line with the priorities and requirements of the organisation they practise in.

There is a potential conflict of interest when this last purpose, which is normally part of the job planning process, is combined with the revalidation and developmental elements of appraisal. For this reason organisations should (and most do) separate the two processes of appraisal and job planning, though the outputs from each will inform the other.

*“Appraisal allows me to stand back from my work and think about how I can improve what I am doing...”*

*Consultant physician*

The *Medical Appraisal Guide* is intended to complement and build on existing processes for appraisal. It is not intended to replace effective existing processes, where these are in place, and recognises that different groups of doctors require different processes to reflect their own circumstances. The appraisal of clinical academics, for example, should continue to follow the Follett principles.

Effective medical appraisal and subsequent revalidation will both satisfy the requirements of *Good Medical Practice* and support the doctor's professional development.

Doctors in training will revalidate through the Annual Review of Competence Progression (ARCP) and do not need to participate in the appraisal process as described in this document.

### **Medical appraisal in the context of revalidation**

Revalidation is the process by which licensed doctors demonstrate that they remain up to date and fit to practise. Revalidation is based both on local clinical governance and appraisal processes.

*“It is important that doctors understand that they [are] required to participate in this process...”*

*Responsible officer*

The GMC has defined the principles and values on which doctors, as professionals, should base their practice in *Good Medical Practice*.

Effective medical appraisal and subsequent revalidation will satisfy the requirements of *Good Medical Practice* and support the doctor's professional development. This process is supervised by the responsible officer.

Where indicated, the responsible officer will inform the GMC of any concerns about a doctor's fitness to practise, or a doctor's refusal to engage in the processes that inform the revalidation process.

It is important that these issues are addressed as they arise and not solely when the revalidation recommendation is due.



Revalidation Support Team

## Essential components of the appraisal process

Medical appraisal is undertaken annually at a meeting between a doctor and a colleague who is trained as an appraiser.

The appraiser is a trained and skilled individual whose skills and competencies are described in the document *Quality Assurance of Medical Appraisers* (RST, 2013).

The doctor is required to collect supporting information that is relevant to their scope and nature of work.

There are three stages in the medical appraisal process, as shown in Figure 1:

1. Inputs to appraisal
2. The confidential appraisal discussion
3. Outputs of appraisal.

Each of these components is described in this document. Some individual doctors, groups of doctors or organisations may require more detail on a particular aspect of the process.

This guide is therefore supplemented by a number of briefings which clarify particular aspects of the appraisal process and how they relate to particular groups of doctors. The following RST briefings are available on the RST website: [colleague and patient feedback](#), [locum doctors](#), [locum agencies](#).

If more detailed guidance is needed, individuals should contact their responsible officer. It may also be appropriate to discuss specialty issues with the appropriate college or faculty.

Figure 1



## Stage 1: Inputs to appraisal

### Doctors contact details

The doctor's contact details should be provided to ensure that the appraiser can contact the doctor. The date of the appraisal and the designated body with whom the doctor has a prescribed connection should also be recorded.

### Scope and nature of work

The doctor should record the scope and nature of the work that they carry out as a doctor to ensure that the appraiser and the responsible officer understand the doctor's work and practice. This should include all roles and positions in which the doctor has clinical responsibilities and any other roles for which a licence to practise is required.

This should include work for voluntary organisations and work in private or independent practice and should include managerial, educational, research and academic roles.

### Supporting information

The supporting information should relate to the doctor's complete scope and nature of work.

The GMC document, *Supporting Information for Appraisal and Revalidation* describes the six types of supporting information that a doctor will be expected to provide and discuss at appraisal at least once in each five-year cycle. These are:

1. Continuing professional development
2. Quality improvement activity
3. Significant events
4. Feedback from colleagues
5. Feedback from patients
6. Review of complaints and compliments.

*“Until now my appraisal has only concerned my job as a GP. I will now have to include my other roles and I think this will make it a more meaningful and useful process...”*

*General practitioner*

This enables the doctor to demonstrate their practice in the four domains of the *Good Medical Practice Framework for Appraisal and Revalidation*. These four domains are:

*“I was worried about collecting the information but when I read the GMC guidance and realised that I could tailor it to my working life I found the appraisal useful. It was my reflection on the information that was the most important thing however...”*

*GP locum*

1. Knowledge, skills and performance
2. Safety and quality
3. Communication, partnership and teamwork
4. Maintaining trust.

The supporting information is important in itself, but it is also the doctor's reflection on the information and the record of that reflection that informs the appraisal discussion. This allows the appraiser and the doctor to discuss the doctor's practice and performance.

The medical royal colleges and faculties have produced specialty guidance frameworks that offer additional guidance and detail to assist the doctor in preparing for appraisal and demonstrating that they are up to date and fit to practise.

Employing or contracting organisations may expect particular information to be included in the appraisal portfolio or for the individual to demonstrate completion of a relevant element of mandatory or recommended training. It is important to remember that this information may not be required for revalidation.

Appraisal is **not** the forum for the organisation to address specific clinical governance or performance issues.

On occasion, the responsible officer may wish to ensure that certain key items of supporting information are included in the doctor's portfolio and discussed at appraisal so that specific development needs are identified and addressed.

In some settings it is reasonable that this information is sent to the doctor and the appraiser (with the doctor's knowledge).

*“By encouraging our doctors to record the information they need for revalidation in the same place as their record of mandatory training we expect this to be simpler for doctors...”*

*Medical staffing officer,  
acute trust*

This should be undertaken securely and in accordance with information management guidance. An alternative approach is for the responsible officer to stipulate to the doctor that specific information should be included and to check subsequently in the appraisal summary that the discussion has taken place.

The supporting information is produced on an annual basis, building into a comprehensive portfolio over time. It may be appropriate that in a particular year a doctor will focus more on a particular aspect of supporting information. The scope and nature of work should be fully reflected in the supporting information. Whilst accepting that it may not be appropriate to address each and every aspect of the scope of work every year, reflection on any significant events or complaints should normally be included.

The preparation of the supporting information is important but it is the reflection on the information that will lead to identification of areas for development and improvement.

It is not always necessary for the doctor to record reflection on each and every item of supporting information. It may be more appropriate for the doctor to record reflection on a summary, or category, of the information. The appraisal process should ensure that suitable reflection occurs.

*“The personal development plan is the lynchpin of the doctor’s development. However it must remain flexible and reflect the fact that things change in real life...”*

*GP appraiser*

### **Review of last year’s personal development plan (PDP)**

The doctor should provide commentary on the previous year’s personal development plan (PDP) and may also wish to comment on other issues arising from the previous year’s appraisal discussion.

It would normally be expected that the objectives laid out in the personal development plan are completed by the time agreed but it should be remembered that circumstances and priorities may have changed (for example, a doctor’s job may have changed).

It may also be that some objectives take longer than a year to achieve and it may therefore be inappropriate for the plan to be completed, although this should normally be recognised and agreed at the time the plan is written.

The appraisal portfolio should include the personal development plan and summaries of appraisal discussion for each year in the current revalidation cycle.

### **Achievements, challenges and aspirations**

The appraisal should provide an opportunity for a general commentary on the doctor's achievements, challenges and aspirations.

This important part of the confidential appraisal discussion offers the doctor an annual opportunity to review practice, chart progress and plan for development, and ensures that the appraisal is a useful process for all doctors. This may not be a requirement for revalidation but it is a vital part of the appraisal process and should be prepared for and addressed appropriately.

### **Pre-appraisal preparation and reflection**

The doctor should prepare for the appraisal by demonstrating that they have considered how they are continuing to meet the principles and values set out in the four domains of the *Good Medical Practice Framework for Appraisal and Revalidation*.

This reflection should help the doctor and the appraiser prepare for the appraisal and should also help the appraiser summarise the appraisal discussion. The doctor should reflect on their practice and their approach to medicine and consider what the supporting information demonstrates about their practice.

### **Appraiser's review of the appraisal portfolio**

The appraisal portfolio should normally include:

- supporting information (including a summary of all supporting information in the current revalidation cycle)
- a description of the doctor's scope and nature of work (including any significant changes or circumstances)
- previous personal development plans and summaries of the appraisal discussion for each year in the current revalidation cycle
- a commentary on achievements, challenges and aspirations.

The portfolio should demonstrate that the doctor fulfils the requirements of the *Good Medical Practice Framework for Appraisal and Revalidation*.

If the appraiser is not satisfied that the portfolio is adequate to inform the confidential appraisal discussion then this should be discussed with the doctor. The doctor should be given the opportunity to revise or supplement the portfolio.

In rare circumstances the portfolio may be insufficient to inform a discussion and the appraisal should be postponed.

The appraiser may, however, wish to proceed with the appraisal discussion in order to understand the issues that prevent the doctor from preparing a suitable portfolio. If in doubt, the appraiser or the doctor may wish to discuss this with the appraisal lead, responsible officer or nominated deputy.

### **Declarations before the appraisal discussion**

Doctors should make a declaration that is visible to the appraiser that demonstrates:

1. acceptance of the professional obligations placed on doctors in *Good Medical Practice* in relation to probity and confidentiality
2. acceptance of the professional obligations placed on doctors in *Good Medical Practice* in relation to personal health
3. personal accountability for accuracy of the supporting information and other material in the appraisal portfolio.

Organisations have an obligation to assist doctors in collecting supporting information for appraisal. A doctor cannot be held responsible for genuine errors in information that has been supplied to them.



## Stage 2: The confidential appraisal discussion

*“My job is to help the doctor think and to hold up a mirror so that they can see themselves more clearly...”*

*Consultant paediatrician  
appraiser*

The confidential appraisal discussion remains at the heart of every effective appraisal process. The appraiser is in a unique position to support, guide and challenge the doctor constructively, having reviewed the supporting information and commentary provided.

It is the appraiser who uses his or her experience and training to facilitate the appraisal discussion in order to achieve the appropriate balance between the four appraisal purposes described on page 6.

The appraisal discussion is confidential and the privacy that this allows is needed to consider some of the more difficult areas that may be raised.

Confidentiality is not absolute, however, and, much like in a doctor-patient consultation, there may be occasions in an appraisal when the appraiser is obliged to share information gained in the appraisal discussion.

This would clearly be the case should patient safety issues be identified. The appraiser should always act in a professional manner and follow published local procedures where they exist.

When in doubt the appraiser or the doctor may wish to discuss this with the appraisal lead, responsible officer or nominated deputy.

*“I hope doctors and appraisers will see me as a place to get support. I need to understand problems doctors are facing if I am to support them effectively...”*

*Responsible officer*

### **Stage 3: Outputs from appraisal**

The doctor and the appraiser should agree how the appraisal should be summarised and how the doctor is going to undertake further professional development.

#### **The doctor's personal development plan (PDP)**

The doctor and the appraiser should agree a new personal development plan at the end of the appraisal.

The plan is an itemised list of personal objectives for the coming year (or, where appropriate, for a longer period). There should be an indication of the period of time in which items should be completed and how completion should be recognised.

The personal development plan represents the main developmental output for the doctor. It may be appropriate to combine this plan with any objectives arising from job planning and from other roles so that the doctor has a single development plan. The doctor should be clear, however, which elements are required for revalidation and which are required for other purposes.

#### **The summary of the appraisal discussion**

The doctor and the appraiser should agree the content of a written summary of the appraisal discussion.

This written summary should cover, as a minimum, an overview of the supporting information and the doctor's accompanying commentary, including the extent to which the supporting information relates to all aspects of the doctor's scope and nature of work. It should also include the key elements of the appraisal discussion itself.

The summary should be structured in line with the four domains of the *Good Medical Practice Framework for Appraisal and Revalidation*.

It may also be helpful for the appraiser to record a brief agreed summary of important issues for the doctor in that year, to ensure continuity from one appraiser to the next.



## The appraiser's statements

The appraiser makes a series of statements to the responsible officer that will, in turn, inform the responsible officer's revalidation recommendation to the GMC. The appraiser should discuss these with the doctor.

It may be that there is a clear and understandable reason that an appraiser is unable to make a positive statement. For example, a doctor may not have made significant progress with the previous year's personal development plan because of a period of prolonged sickness.

If an appraiser is unable to confirm one, or more than one, statement, this does not mean that the doctor will not be recommended for revalidation, it simply draws an issue to the attention of the responsible officer.

The doctor and the appraiser should each have the opportunity to give comments on the statements to assist the responsible officer in understanding the reasons for the statements that have been made.

The appraiser may also wish to record at this point other issues that the responsible officer should be aware of that may be relevant to the revalidation recommendation.

It would be inappropriate for the appraiser to report issues without the doctor's knowledge.

The appraiser's statements should confirm that:

1. An appraisal has taken place that reflects the whole of a doctor's scope of work and addresses the principles and values set out in *Good Medical Practice*.
2. Appropriate supporting information has been presented in accordance with the *Good Medical Practice Framework for Appraisal and Revalidation* and this reflects the nature and scope of the doctor's work.
3. A review that demonstrates appropriate progress against last year's personal development plan has taken place.

*"I make a professional judgement, but I am not a judge. My statements are there to help the responsible officer make a fair recommendation to the GMC and to support the doctor, not punish the doctor..."*

*Consultant surgeon appraiser*

4. An agreement has been reached with the doctor about a new personal development plan and any associated actions for the coming year.

The appraiser must remain aware when conducting an appraisal of their duty as a doctor as laid out in *Good Medical Practice*. The appraisal summary should include a confirmation from the appraiser that they are aware of those duties.

*"I understand that I must protect patients from risk of harm posed by another colleague's conduct, performance or health. The safety of patients must come first at all times. If I have concerns that a colleague may not be fit to practise, I am aware that I must take appropriate steps without delay, so that the concerns are investigated and patients protected where necessary."*

This provides the context for a further statement that:

5. No information has been presented or discussed in the appraisal that raises a concern about the doctor's fitness to practise.

The appraiser and the doctor should both confirm that they agree with the outputs of appraisal and that a record will be provided to the responsible officer.

If agreement cannot be reached the responsible officer should be informed. In this instance, the appraiser should still submit the outputs of the appraisal, but the responsible officer should take steps to understand the reasons for the disagreement.

## Conclusion

Medical appraisal has evolved to become part of the framework of support and supervision of doctors in many parts of the health sector. In revalidation, appraisal now becomes a universal process, based on the GMC's *Good Medical Practice*.

In setting out the essential components of medical appraisal, the *Medical Appraisal Guide* lays the foundations for the delivery of a consistent process across England.

Effective medical appraisal will inform a doctor's professional development needs and aspirations. It will also allow appraisers and responsible officers to have confidence that doctors remain up to date and fit to practise according to the values and principles of *Good Medical Practice*. Along with clinical governance processes and the management structures within organisations, this will allow responsible officers to make informed revalidation recommendations to the GMC.

This in turn will allow revalidation to serve its primary purposes of promoting improvements in patient safety and in the continuing support and improvement of doctors' practice.

## Appendix 1 Useful documents

### GMC guidance

*Good Medical Practice* (GMC, 2013)

[www.gmc-uk.org/guidance/good\\_medical\\_practice.asp](http://www.gmc-uk.org/guidance/good_medical_practice.asp)<sup>2</sup>

*Good Medical Practice Framework for Appraisal and Revalidation* (GMC, 2013)

[www.gmc-uk.org/doctors/revalidation/revalidation\\_gmp\\_framework.asp](http://www.gmc-uk.org/doctors/revalidation/revalidation_gmp_framework.asp)

*Supporting Information for Appraisal and Revalidation* (GMC, 2012)

[www.gmc-uk.org/doctors/revalidation/revalidation\\_information.asp](http://www.gmc-uk.org/doctors/revalidation/revalidation_information.asp)

### Specialty guidance from the medical royal colleges and faculties

Final specialty guidance on supporting information:

[www.aomrc.org.uk/revalidation/role-of-medical-royal-colleges-faculties/item/specialty-frameworks-and-speciality-guidance](http://www.aomrc.org.uk/revalidation/role-of-medical-royal-colleges-faculties/item/specialty-frameworks-and-speciality-guidance)

*CPD Guidance Framework for Appraisers and Appraisees* (AoMRC, 2013)

[http://aomrc.org.uk/publications/reports-a-guidance/doc\\_details/9555-cpd-guidance-framework-for-appraisers-and-appraisees.html](http://aomrc.org.uk/publications/reports-a-guidance/doc_details/9555-cpd-guidance-framework-for-appraisers-and-appraisees.html)

### Skills and competencies of appraisers

*Quality Assurance of Medical Appraisers* (NHS Revalidation Support Team, 2013)

[www.revalidationsupport.nhs.uk/about\\_the\\_rst/rst\\_projects/Implementation-Support/guidance-and-tools/quality-assurance-of-medical-appraisers](http://www.revalidationsupport.nhs.uk/about_the_rst/rst_projects/Implementation-Support/guidance-and-tools/quality-assurance-of-medical-appraisers)

### The Follett principles

*A Review of Appraisal, Disciplinary and Reporting Arrangements for Senior NHS and University Staff with Academic and Clinical Duties* (Department for Education and Skills, 2001)

[www.academicmedicine.ac.uk/uploads/folletreview.pdf](http://www.academicmedicine.ac.uk/uploads/folletreview.pdf)

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<sup>2</sup> All web references accessed 28 March 2013.

Appendix 2b

**Good Medical Practice Framework for Appraisal and Revalidation**



The *Good medical practice* framework for appraisal and revalidation

General  
Medical  
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Regulating doctors  
Ensuring good medical practice

## **The *Good medical practice* framework sets out the broad areas which should be covered in medical appraisal and on which recommendations to revalidate doctors will be based.**

Current systems of appraisal reflect the diversity of practice settings and employers of doctors. A single format of appraisal will not be suitable for all doctors in all settings but it is possible to identify a number of key principles that are relevant to the whole profession.

The framework is based on *Good medical practice*, our core ethical guidance for doctors, which sets out the principles and values on which good practice is founded. *Good medical practice* is used to inform the education, training and practice of all doctors in the UK.

The framework will form the basis of a standard approach for all appraisals, in which licensed doctors must take part in order to revalidate. Revalidation is the process by which all licensed doctors must demonstrate every five years that they are up to date and fit to practise.

During their appraisals, doctors will discuss their practice and performance with their appraiser and use supporting information to demonstrate that they are continuing to meet the principles and values set out in *Good medical practice*.

### **How doctors should use the framework**

You should use the framework to:

- reflect on your practice and your approach to medicine
- reflect on the supporting information you have gathered and what that information demonstrates about your practice
- identify areas of practice where you could make improvements or undertake further development
- demonstrate that you are up to date and fit to practise.





## About the framework

The framework consists of four domains which cover the spectrum of medical practice. They are:

1. Knowledge, skills and performance
2. Safety and quality
3. Communication, partnership and teamwork
4. Maintaining trust

Each domain is described by three attributes. The attributes define the scope and purpose of each domain. These attributes relate to practices or principles of the profession as a whole.

The principles and values have been pared down from the full advice in *Good medical practice*. They are examples of the types of professional behaviours expected of all doctors.

Some examples from our explanatory guidance *Leadership and management for all doctors* and *Good practice in research* have also been included to provide examples for doctors working in non-clinical roles. Paragraph reference numbers have been provided so that they can be read in their original context.

## Supporting information and appraisal

You will need to maintain a portfolio of supporting information to demonstrate that you are continuing to meet the attributes set out in the framework. Separate guidance, *Supporting information for appraisal and revalidation*, provides more information for you about this.

When you are preparing for your appraisal and collecting supporting information, you should review your practice and consider how the supporting information can demonstrate that you are continuing to meet the principles and values set out in *Good medical practice*.

It is not necessary to structure the appraisal formally around the framework, or to map supporting information directly against each attribute. However, some doctors may prefer to do this and some appraisers may find it useful to structure the appraisal interview in this way.

Collating and discussing the set of supporting information at appraisal over the course of the revalidation cycle will ensure that you have demonstrated your practice against all 12 attributes. In most cases, your appraiser will be interested in what you did with the information and your reflections on that information, not simply that you collected it and maintained it in a portfolio. Your appraiser will want to know what you think the supporting information says about your practice and how you intend to develop or modify your practice as a result of that reflection.



## Good medical practice framework

Numbers following the principles and values in this framework refer to paragraph numbers in GMP, except where preceded by LMAD which refers to our booklet *Leadership and management for all doctors*; or Research which refers to *Good practice in research*.

### Domain 1 – Knowledge, skills and performance

Attributes	Examples of principles and values from <i>Good medical practice</i>
1.1 Maintain your professional performance	<ul style="list-style-type: none"> <li>• Maintain knowledge of the law and other regulation relevant to your work (12)</li> <li>• Keep knowledge and skills about your current work up to date (12)</li> <li>• Participate in professional development and educational activities (9–10)</li> <li>• Take part in and respond constructively to the outcome of systematic quality improvement activities (eg audit), appraisals and performance reviews (13)</li> </ul>
1.2 Apply knowledge and experience to practice	<ul style="list-style-type: none"> <li>• Recognise and work within the limits of your competence (14)</li> <li>• Research 6 and endnote 12</li> <li>• If you are a teacher/trainer, apply the skills, attitudes and practice of a competent teacher/trainer (39)</li> <li>• If you are a manager, work effectively as a manager (LMAD)</li> <li>• Support patients in caring for themselves (51)</li> <li>• If you are in a clinical role:                             <ul style="list-style-type: none"> <li>- Adequately assess the patient’s conditions (15a)</li> <li>- Provide or arrange advice, investigations or treatment where necessary (15b)</li> <li>- Prescribe drugs or treatment, including repeat prescriptions, safely and appropriately (16a)</li> <li>- Provide effective treatments based on the best available evidence (16b)</li> <li>- Take steps to alleviate pain and distress whether or not a cure may be possible (16c)</li> <li>- Consult colleagues, or refer patients to colleagues, when this is in the patient’s best interests (14, 16d, 35)</li> </ul> </li> </ul>
1.3 Ensure that all documentation (including clinical records) formally recording your work is clear, accurate and legible	<ul style="list-style-type: none"> <li>• Make and/or review records at the same time as the events are documented or as soon as possible afterwards (19)</li> <li>• Ensure that any documentation that records your findings, decisions, information given to patients, drugs prescribed and other information or treatment is up to date and accurate (19, 21)</li> <li>• Implement and comply with systems to protect patient confidentiality (20)</li> </ul>



Domain 2 – Safety and quality

Attributes	Examples of principles and values from <i>Good medical practice</i>
2.1 Contribute to and comply with systems to protect patients	<ul style="list-style-type: none"> <li>• Take part in systems of quality assurance and quality improvement (22)</li> <li>• Comply with risk management and clinical governance procedures</li> <li>• Cooperate with legitimate requests for information from organisations monitoring public health (23d)</li> <li>• Provide information for confidential inquiries, significant event reporting (23a, 23b)</li> <li>• Make sure that all staff for whose performance you are responsible, including locums and students, are properly supervised (40)</li> <li>• Report suspected adverse reactions (23c)</li> <li>• Ensure arrangements are made for the continuing care of the patient where necessary (44)</li> <li>• Ensure systems are in place for colleagues to raise concerns about risks to patients (25)</li> </ul>
2.2 Respond to risks to safety	<ul style="list-style-type: none"> <li>• Report risks in the healthcare environment to your employing or contracting bodies (25b)</li> <li>• Safeguard and protect the health and well-being of vulnerable people, including children and the elderly and those with learning disabilities (27)</li> <li>• Take action where there is evidence that a colleague's conduct, performance or health may be putting patients at risk (25c)</li> <li>• Respond promptly to risks posed by patients</li> <li>• Follow infection control procedures and regulations</li> </ul>
2.3 Protect patients and colleagues from any risk posed by your health	<ul style="list-style-type: none"> <li>• Make arrangements for accessing independent medical advice when necessary (30)</li> <li>• Be immunised against common serious communicable diseases where vaccines are available (29)</li> </ul>



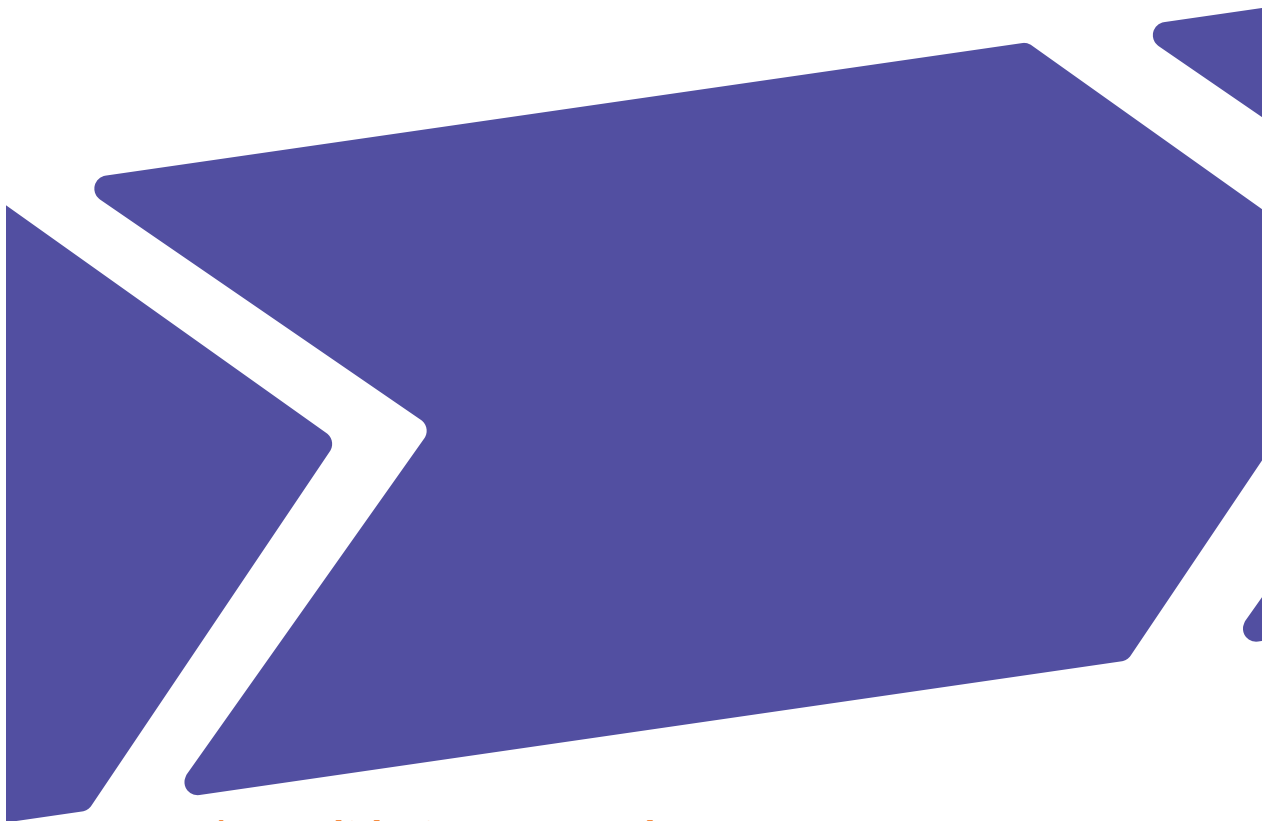
Domain 3 - Communication, partnership and teamwork

Attributes	Examples of principles and values from <i>Good medical practice</i>
3.1 Communicate effectively	<ul style="list-style-type: none"> <li>• Listen to patients and respect their views about their health (31)</li> <li>• Give patients the information they need in order to make decisions about their care in a way they can understand (32)</li> <li>• Respond to patients' questions (31)</li> <li>• Keep patients informed about the progress of their care (32, 49b)</li> <li>• Explain to patients when something has gone wrong (55)</li> <li>• Treat those close to the patient considerately (33)</li> <li>• Communicate effectively with colleagues within and outside the team (34)</li> <li>• Encourage colleagues to contribute to discussions and to communicate effectively with each other (LMAD)</li> <li>• Pass on information to colleagues involved in, or taking over, your patients' care (44, 45)</li> </ul>
3.2 Work constructively with colleagues and delegate effectively	<ul style="list-style-type: none"> <li>• Treat colleagues fairly and with respect (36)</li> <li>• Support colleagues who have problems with their performance, conduct or health (43)</li> <li>• Act as a positive role model for colleagues (LMAD 2f, 23, 63)</li> <li>• Ensure colleagues to whom you delegate have appropriate qualifications and experience (45)</li> <li>• Provide effective leadership as appropriate to their role (LMAD)</li> </ul>
3.3 Establish and maintain partnerships with patients	<ul style="list-style-type: none"> <li>• Encourage patients to take an interest in their health and to take action to improve and maintain it (51)</li> <li>• Be satisfied that you have consent or other valid authority before you undertake any examination or investigation, provide treatment or involve patients in teaching or research (17)</li> </ul>



Domain 4 - Maintaining trust

Attributes	Examples of principles and values from <i>Good medical practice</i>
4.1 Show respect for patients	<ul style="list-style-type: none"> <li>• Implement and comply with systems to protect patient confidentiality (69, 20)</li> <li>• Be polite, considerate and honest and respect patients' dignity and privacy (46, 47)</li> <li>• Treat each patient fairly and as an individual (47, 48)</li> <li>• If you undertake research, respect the rights of patients participating in the research (Research 15-20, 28-30, 31-32)</li> </ul>
4.2 Treat patients and colleagues fairly and without discrimination	<ul style="list-style-type: none"> <li>• Be honest and objective when appraising or assessing colleagues and when writing references (41)</li> <li>• Respond promptly and fully to complaints (61)</li> <li>• Provide care on the basis of the patient's needs and the likely effect of treatment (56-60)</li> </ul>
4.3 Act with honesty and integrity	<ul style="list-style-type: none"> <li>• Ensure you have adequate indemnity or insurance cover for your practice (63)</li> <li>• Be honest in financial and commercial dealings (77-80)</li> <li>• Ensure any published information about your services is factual and verifiable (70)</li> <li>• Be honest in any formal statement or report, whether written or oral, making clear the limits of your knowledge or competence (66, 71)</li> <li>• Inform patients about any fees and charges before starting treatment (77)</li> <li>• If you undertake research, obtain appropriate ethical approval (Research 7) and honestly report results (67)</li> </ul>



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## Appendix 3a

# Return to Work – Pre Absence Form

### Pre Absence Form

If possible this form should be completed by the specialist and their Clinical Director, before the doctor is due to go on absence.

The return to work scheme is compulsory for absences of 3 months or more, but can be opted into for absences less than 3 months if the specialist or Clinical Director feel it is necessary.

<b>Name of specialist:</b>		<b>GMC Number:</b>	
<b>Position:</b>		<b>Clinical Director:</b>	

<b>Current place of work:</b>		<b>Anticipated date of absence:</b>	
		<b>Estimated date of return:</b>	

<b>Reason for Absence:</b>	
----------------------------	--

<b>Summary of discussion between specialist and Clinical Director:</b>		
Discussion parameters:		
<ul style="list-style-type: none"> <li>• Keeping up to date</li> <li>• Use of Keeping In Touch days</li> <li>• Particular concerns</li> </ul>		
<b>Are you happy for the Clinical Director or Trust to contact you while you are absent?</b>	<b>Yes</b>	<b>No</b>
<b>If Yes then what are your preferred contact details:</b>		
<b>Address:</b>		
<b>Email Address:</b>		<b>Phone Number:</b>

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## Appendix 3b

# Return to Work – Pre Return Form

### Return to Work Form

<b>Name of specialist:</b>		<b>GMC Number:</b>	
<b>Position:</b>		<b>Clinical Director:</b>	

#### 1. Initial Review - compulsory

The Initial Review between specialist and Clinical Director should take place between 4 to 8 weeks prior to the estimated return to work date to allow time for the specialist to be incorporated into the rota.

<b>Date Initial Review:</b>	
-----------------------------	--

<b>Place of work at absence:</b>		<b>Date of absence:</b>	
<b>Place of work on return:</b>		<b>Anticipated date of return:</b>	

<b>Reason for Absence:</b>	
----------------------------	--

<b>Intention to return to work Full Time or LTFT?</b>	<b>Full Time</b>	<b>LTFT</b>
<b>Comments:</b>		

<b>Forthcoming roles/responsibilities:</b>	
--	--

<p><b>Summary of discussion between specialist and Clinical Director:</b></p> <p>Discussion parameters:</p> <ul style="list-style-type: none"> <li>• Anything done to keep up to date during absence</li> <li>• Any work done during absence: on calls, KIT days, CPD etc.</li> <li>• Any particular concerns over returning</li> </ul>



## Return to Work Form

<b>Overview of plan for supported return to work period*:</b>	
<b>Recommended evidence to be provided in this period:</b> This must include mandatory training certificates in relevant areas of obstetrics and gynaecology practice	
<ul style="list-style-type: none"> <li>•</li> <li>•</li> <li>•</li> <li>•</li> <li>•</li> <li>•</li> </ul>	

<b>Provisional Date of Return Review Meeting:</b>	
---	--

\*If in exceptional circumstances the decision has been made by both the specialist and the Clinical Director that the supported return to work period is unnecessary, then please provide documentary evidence below that the specialist has maintained active clinical practice during the absence. Then complete Section 3: Return to Work Sign-Off.

<b>Evidence of how active clinical practice has been maintained during absence:</b>

## Return to Work Form

### 2. Return Review – compulsory after supported return to work period

<b>Date of Return Review:</b>	
-------------------------------	--

<p><b>Summary of discussion between specialist and Clinical Director:</b>                  Discussion parameters:</p> <ul style="list-style-type: none"> <li>• Summary of supported practice and log of activity</li> <li>• Overall progress</li> <li>• Outstanding concerns</li> </ul>
<b>What additional learning needs have been identified:</b>

<b>Is an extension to the supported return to work period necessary:</b>	<b>Yes</b>	<b>No</b>
<b>Please comment:</b>		

If Yes, an extension to the supported period is required, please complete Section 4: Plan of Extended Supported Period.

If No, an extension to the supported period is not required, please complete Section 3: Return to Work Sign Off.

## Return to Work Form

### 3. Return to Work Sign Off

**Specialist Statement:**

I feel confident in all respects to recommence usual duties on:			
Signed:			
Printed Name:		Date:	

**Clinical Director Statement:**

I concur that this specialist has demonstrated to me that they are able to return to their usual duties.			
Signed:			
Printed Name:		Date:	

## Return to Work Form

### 4. Plan of Extended Supported Period – if required

Date of Review:	
-----------------	--

<b>Overview of plan for extended supported return to work period:</b>
<b>Required assessments or evidence required in this period:</b> This must include mandatory training certificates in relevant areas of obstetrics and gynaecology practice
<ul style="list-style-type: none"><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li><li>•</li></ul>

Provisional Date of next Review Meeting:	
--	--

## Return to Work Form

### 5. Review of Extended Supported Period

<b>Date of next Review Meeting:</b>	
-------------------------------------	--

<p><b>Summary of discussion between specialist and Clinical Director:</b>                  Discussion parameters:</p> <ul style="list-style-type: none"> <li>• Summary of supported practice and log of activities</li> <li>• Overall progress</li> <li>• Outstanding concerns</li> </ul>

<b>What additional learning needs have been identified:</b>

<b>Is a further extension to this supported return to work period necessary:</b>	<b>Yes</b>	<b>No</b>

<b>Please comment:</b>

If Yes, an extension to the supported period is required, please complete another Section 4: Plan of Extended Supported Period on a separate Return to Work Form.

If No, an extension to the supported period is not required, then please go back and complete Section 3: Return to Work Sign Off.

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## Appendix 3c

# Flowchart for Return to Work



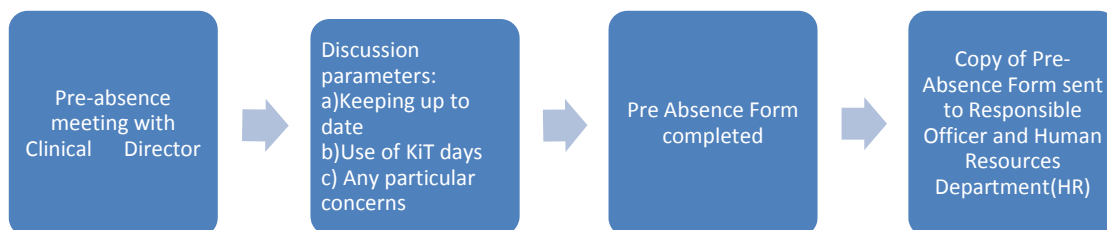
## Return to Work Scheme

The Academy of Medical Royal Colleges recommends an assessment of doctors on return to practice after absences of more than three months. The Return to Work Scheme applies to all specialists after absences of 3 months or more, but can be opted into for absences of less than three months.

Any specialists that have been absent due to ill health or a conduct or capability investigation may participate in the scheme.

### PRIOR TO ABSENCE

If the absence is unexpected then this discussion can be held at a different time.

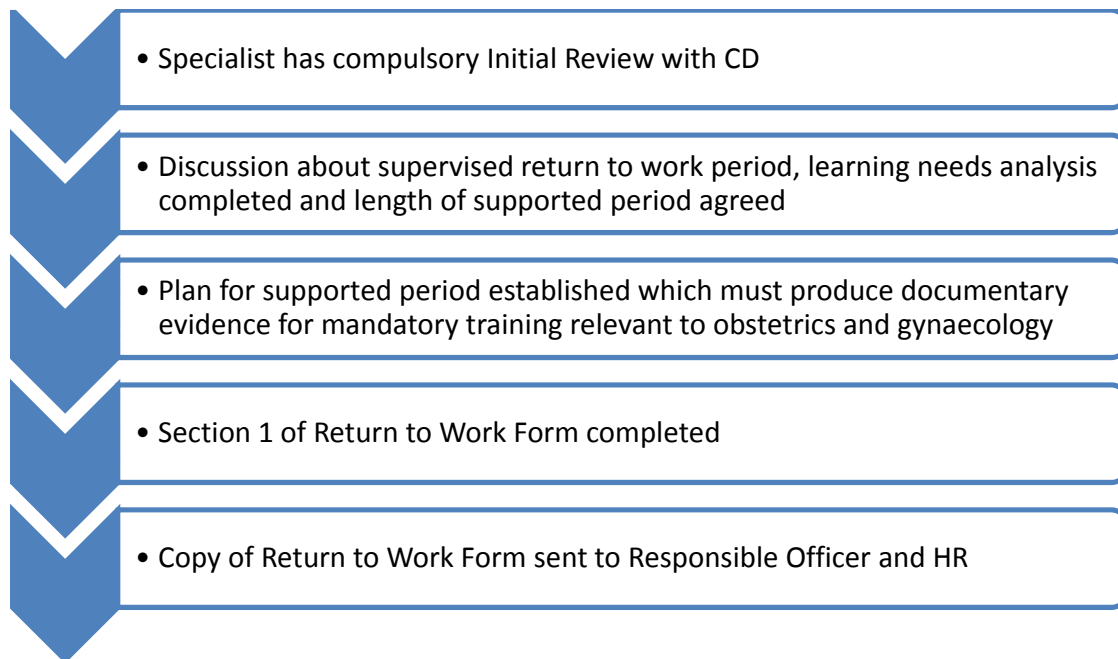


### DURING ABSENCE

- If the specialist and hospital agree the specialist can use 'Keeping in Touch (KiT) days (optional).
- If possible the Clinical Director(CD) sends materials relevant to practice in obstetrics and gynaecology to the specialist at their request.

### PRIOR TO RETURN

Ideally the Initial Review should take place 4 to 10 weeks prior to the estimated return date to allow time for the specialist to be incorporated into the rota. It is expected that this will be a face-to-face meeting.



Please Note: It is expected that in the majority of cases a supported period is required. However, for shorter absences when the specialist has maintained active clinical practice the supported return period may not be necessary. Good evidence of this practice must be documented on the Return to Work Form and the lack of supported period agreed with the Responsible Officer.

## **SUPPORTED RETURN PERIOD**

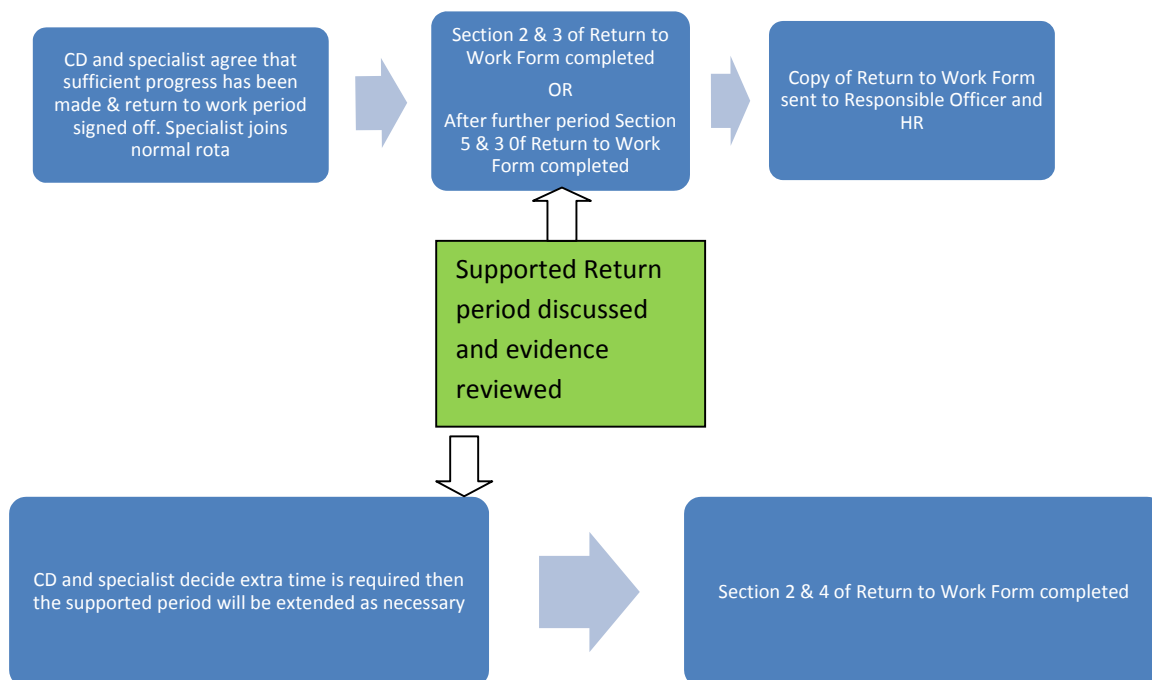
- The length of the supported period can be varied depending on the specific needs of the specialist. It would be expected that a longer absence will require a longer supported period on return.
- This period must be fully supported including on-calls or out-of-hours. When appropriate the support must be direct and not via telephone.



## REVIEW OF RETURN PERIOD

At the end of the supported period there will be a compulsory Return Review of the specialist with the Clinical Director.

### SATISFACTORY PROGRESS



### UNSATISFACTORY PROGRESS



## Appendix 3d

# AoMRC Guidance on Return to Work

ACADEMY OF  
MEDICAL ROYAL  
COLLEGES

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# RETURN TO PRACTICE GUIDANCE

APRIL 2012



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## PREFACE

Through its role in developing revalidation for doctors, the Academy of Medical Royal Colleges developed considerable concern and perceived a lack of guidance regarding doctors' return to practice after a period of absence. In light of this a working group was established to produce a report, both in order to highlight the importance of a good procedure for doctors returning to practice and to provide practical advice. The recommended guidance is based on the considerable experience of the working group involved and a review of the limited evidence available.

**Patient safety is the guiding principle of this report and must be put first, above all other considerations.**

### Who is the guidance for?

- All doctors returning to the same area of clinical practice as previously practiced following an absence for any reason (including those returning to their usual practice after working in a different area of clinical practice). It is the duty of all doctors to ensure that they are safe to return to practice.
- All doctors who are absent for three months or longer and including in all cases where the licence to practice has been surrendered and is then restored by the GMC.

This guidance can be used in all circumstances as part of the process of return to practice. In cases where there are unresolved issues that need to be addressed separately, these should be dealt with via the normal processes. However, this guidance can still be used in addition to that process. Examples of three such situations are:

- Health issues (which should be addressed through occupational health processes)
- Conduct issues (which should be addressed through (HR) management processes)
- Capability issues (which should be addressed through remediation processes).

It should be noted that the guidance focuses on re-entry of doctors to practice. It is not designed as a guide to obtaining re-employment.

I would like to thank the members of the Return to Practice working group who gave their time and expertise to this work. I would also like to thank all those who provided evidence for our research. In particular, my thanks to Kate Tansley, whose energy and intelligence greatly facilitated the production of this report.



**Professor Hugo Mascie-Taylor**  
Chairman, AoMRC Return to Practice Working Group

# 1 WHO SHOULD USE THIS GUIDANCE?

## **Doctors**

It is the professional duty of the doctor to ensure that they are safe to return to practice. Doctors must identify and address issues arising from absence and help set in place the necessary processes to support them to update their skills and knowledge.

## **Designated bodies/those who employ or contract doctors (including GP partners)**

Organisations need to prepare for absences and returns, identify issues, agree the processes - and help put appropriate, targeted and proportionate support and training in place. Employers should facilitate return to work of employees. This might often be within the remit of the clinical manager.

**Regulators including the General Medical Council (GMC) and Responsible Officers** Regulators and Responsible Officers need to ensure that there is proper evaluation and support of doctors to ensure their safe return to the workplace – as part of clinical governance.

## **Doctors' appraisers**

Appraisers need to identify issues affecting the returning doctor and ensure that the correct process is being followed.

## **Locums, their employers and contracting agencies**

Employers and contracting agencies should clarify locums' employment records – these recommendations apply to doctors returning after an absence of three months or more from regular practice (or potentially less than three months if they have not been in regular practice).

## **Those holding performers' lists (currently Primary Care Trusts)**

These organisations may need to consider a mechanism to ensure that doctors absent from practice for three months or more can return to practice safely.

## **Deaneries and/or those delivering/designing training for doctors, and trainee doctors**

Deaneries should plan and ensure a safe and effective return to learning, and also to practice.

## **Organisations offering Continual Professional Development (CPD) and support to doctors, including Medical Royal Colleges**

These organisations may offer updates to clinical skills (Appendix 1).

## 2 HOW SHOULD THIS GUIDANCE BE USED?

Designated bodies and their Responsible Officers, doctors, employers, contractors and regulators all have responsibility to ensure an appropriate process is in place and is followed for a doctor's return to practice to ensure patient safety. The use of this guidance will facilitate this.

This guidance covers doctors who have been absent for three months or more. The checklists (Sections 6 & 7) should be used pre and post absence to conduct an individual evaluation of the doctor returning to practice. The guidance also gives recommendations for a return to practice action plan and organisational policy to ensure an effective return to practice in the interests of patient safety and suggests the need for an organisational policy. The checklists and action plan give an opportunity to identify issues, potential training and support required by the returning doctor. It does not assume that the returning doctor is not fit to practice. The doctor may need advice and guidance from colleagues and managers before answering these questions.

Each doctor will have different needs when returning to practice reflecting their experiences and circumstances, not simply time out of practice. Designated bodies and their Responsible Officers should use the checklists as part of the appraisal process when doctors are to return to practice. They will need to take account of the doctor's revalidation dates and their need to gather supporting information, participate in Continued Professional Development (CPD) etc.

The evidence gathered by the Return to Practice Working Group identified two key factors: time out of practice and increasing age (the evidence is available from the Academy). Taking this evidence into account, the longer the period out of practice, the more robust the process of return to practice should be. However, all return to practice assessments should be robust, appropriate and commensurate with the period of absence as well as other factors identified through the checklists.

- Shorter absences: An absence of less than three months, in the view of the Return to Practice working group, appears less likely to cause significant problems, but may still affect confidence and skills levels. The majority of doctors in these cases should be able to return to work safely and successfully, they may sometimes require support. Should further research evidence on length of absence emerge at a later date, this 'cut off' of three months may need to be reviewed.
- Longer absences: An absence of three months or more appears more likely to significantly affect skills and knowledge. Therefore an assessment is recommended and the approach should be commensurately robust the longer the period of absence to ensure patient safety.

It is important that doctors and employers prepare for any predictable absences from practice. Early notification of absence to the employer will be beneficial to both the doctor and employer, enabling better planning of any support needed. The notification of absence is the doctor's responsibility, but it is the responsibility of a good organisation to work with the doctor to identify issues or support needed. Those who do not have an organisation may be able to obtain help from one of the organisations listed Appendix 1. Where doctors do not have

employers, they still have a responsibility to manage their own return to practice and ensure that they have the necessary support.

The doctor should take an active part in setting up the action plan. This should be done either previous to return or immediately on return. Those carrying out the evaluation may need to judge what insight the doctor has into their needs in creating the plan.

Precisely who undertakes the evaluation is a matter for employers and regulators, but that individual needs to be well defined and appropriate to the organisation e.g. Medical Director, Responsible Officer, Clinical Director or Lead Clinician. Notes should be made and records should be kept. The doctor (and their employer, partner or contracting agency) should review the answers to the previous checklist (if available) to note any changes from expectations and progress during the period of absence.

If evidence arises at any point that patient safety is being compromised, the necessary processes must be put into place, the appropriate authorities must be informed and action taken. The name of whoever is empowered by the organisation to agree that any potential patient safety concerns have been met (and thus the doctor can return to independent practice) should be identified to the doctor.

The final decision regarding returning to practice rests with the relevant body (for example, the employer/designated body, the practice or the regulator). For trainee doctors, plans for a return to learning as well as return to practice, should be made. If an issue arises which creates difficulties in agreement between doctors and employers, normal methods of dispute resolution should be undertaken.

### 3 SUMMARY OF EVIDENCE ON RETURN TO PRACTICE

As part of this report, an extensive search for evidence was conducted. The collated evidence is available from the Academy. In summary, whilst there is little shortage of opinion in this area, there is little clear evidence. However, the best published evidence available is from United States<sup>1</sup> regarding a re-entry programme run for doctors who had been absent from practice for 18 months or more. It states that:

*'The majority (67%) were found to have educational needs requiring moderate to considerable re-education or training ... many re-entering physicians may not be ready to jump back into practice.'*

The re-entry programme study found two key factors affecting a doctor's performance when returning to practice:

- The more years the doctor was out of practice, the more likely they were to have poor performance ratings.
- Older physicians were more likely to have higher ratings of poorer performance.

#### **Other information gathered includes:**

The Federation of State Medical Boards of the USA stated that *'currently many state boards have requirements for physicians seeking to re-enter practice after some time away, such as passage of an examination, demonstration of prescribed number of continuing medical education hours, and others. Thirty eight of seventy member boards in the either have a policy on 'physician re-entry' or they are developing one/plan to develop one.*

A number of other professions in the UK have return to practice processes, varying in the degree to which they are compulsory. For example nurses have university led, regulator approved return to practice courses.

A number of organisations in the UK and abroad offer retraining schemes e.g. The Committee of General Practice Education Directors (COGPED) or have retraining requirements (e.g. some USA state medical boards) for doctors who have been out of practice for two years or more. However, formal retraining schemes do not exist in many specialties in the UK and formal retraining may often not be appropriate for doctors returning to practice after a shorter period of absence, even though doctors should be evaluated after an absence of three months or more.

1. Elizabeth S. Grace MD, Elizabeth J. Korinek MPH, Lindsay B. Weitzel PhD, Dennis K. Wentz MD., Physicians reentering clinical practice: Characteristics and clinical abilities†, 22 SEP 2010



## 4 RETURN TO PRACTICE ACTION PLAN

### In formulating a return to practice action plan, the following should be identified:

- The doctor's learning needs based upon the answers to the checklists
- How the doctor has learned successfully in the past
- How and when it will be assessed whether the learning needs have been met
- Which new learning is necessary to help improve patient care
- How this learning will fit in to the doctor's job plan
- How to fund the learning.

### Possible actions to assist the doctor in safely returning to practice:

- The doctor should list any plans for education on return to practice or any CPD that can be undertaken whilst away, or immediately on return, such as specialty specific updates. The doctor should plan to keep a record of any work or CPD that is undertaken during an absence
- Ensuring that first patient list(s) is/are straightforward and that additional support is available. The longer the doctor has been absent, the longer this support may be necessary
- Ensuring that enough time is allowed when first returning to work for discussions with colleagues and managers to respond and assist where necessary. Again, more time would usually be needed for those doctors who have been absent longer.

### Other important methods to consider using:

- Arranging for periods of observation of the doctor (either by the doctor, the organisation/employer or both)
- Supernumerary arrangements for a period of time if needed
- Professional development (e.g. Essential Knowledge Update, or refresher courses where they exist)
- Setting up formal or informal mentoring arrangements
- Flexible hours or other flexible arrangements that may be necessary.

### Arrangements for ensuring and clarifying the success of the return to practice process:

- Those responsible (e.g. Medical Director, clinical manager, appraiser, Responsible Officer, etc) should be given updates of the plans for return to practice, and of their safe completion. The employer and the Responsible Officer should plan to review progress after a reasonably short period of time, e.g. six months, or more frequently if other causes for concern are identified
- A date for a formal appraisal should be arranged on or soon after absence, and when the appraisal takes place, evidence of completion of the return to practice action plan should be given. The appraisal should determine whether the questions raised in the checklists have been addressed

- Where doctors do not have employers, they still have the responsibility to manage their own return to practice and ensure that they have the necessary support, and that arrangements are made to support their safe return. They may need to inform their Responsible Officer. Organisations who can provide advice to doctors who are returning to practice are listed Appendix 1.

**In drawing up this plan, targets should be realistic and dates should be set for its review.**

## 5 SETTING UP AN ORGANISATIONAL POLICY ON RETURN TO PRACTICE

For the purpose of patient safety, a clear and supportive process for the return to practice of medicine should be in place in all organisations employing or contracting doctors. Doctors themselves also have a professional responsibility to ensure that they are safe to return to practice and follow the guidance set out in this report. All organisations and groups named within this report are responsible for ensuring that they are aware of and use this guidance.

**An organisational policy for return to practice should include:**

- Preparation by doctors and those working with them before any absence from work (where possible) to ensure that there is a supportive plan for the doctor's return – using the checklists and recommendations given in this report.
- An initial evaluation of the individual doctor's needs just before or on return to work, using the suggested checklist and recommendations in this report.
- Following this evaluation, a proportionate response to the doctor's needs should be devised which would have different levels of formality depending on the level of the needs. Employers should consider how the process they agree with returning doctors fits with processes for other health professionals working for them.
- There should be timelines agreed for the completion of any support or training and the evaluations that are necessary.

## 6 PLANNING AN ABSENCE FROM PRACTICE – RECOMMENDED QUESTIONS AND ACTIONS

The following checklist of questions is recommended to be used pre-absence in order to help with identification of issues and facilitate support planning.

1. How long is the doctor expected to be absent? (Is there any likelihood of an extension to this?)
2. Are there any training programmes or installation of new equipment due to take place in the doctor's workplace in the period of absence? If so, how should the doctor become familiar with this on their return?
3. How long has the doctor been in their current role? Is this relevant in determining their needs?
4. Will the doctor be able to participate in any 'Keep in Touch' days or other means of keeping in touch with the workplace? If so, how will this be organised?
5. Does the doctor have any additional educational goals, during their absence?
6. What sort of CPD, training or support will be needed on the doctor's return to practice?
7. Are there any funding issues related to question 6 which need to be considered?
8. Will the doctor be able to retain their licence to practise and to fulfil the requirements for revalidation?
9. Are there any issues relating to the doctor's next appraisal which need to be considered? If so, the Responsible Officer/representative may need to be informed.
10. If the doctor is a trainee, how do they plan to return to learning?
<b>Signatures</b> <b>Doctor</b> _____ <b>Date</b> _____ <b>On behalf of the organisation</b> _____ <b>Date</b> _____

## 7 A DOCTORS RETURN TO PRACTICE – RECOMMENDED QUESTIONS AND ACTIONS

The following checklist of questions is recommended to be used post-absence in order to help with identification of issues and facilitate support planning.

1. Was a pre-departure checklist completed? (If so, this should be reviewed.)
2. How long has the doctor been away?
3. Has the absence extended beyond that which was originally expected? If so, what impact has this had? (If it was an unplanned absence, the reasons may be important.)
4. How long had the doctor been practising in the role they are returning to prior to their absence?
5. What responsibilities does the doctor have in the post to which they are returning? In particular are there any new responsibilities?
6. How does the doctor feel about their confidence and skills levels?
7. What support would the doctor find most useful in returning to practice?
8. Has the doctor had any relevant contact with work and/or practice, during absence e.g. 'keep in touch' days?
9. Have there been any changes since the doctor was last in post? For example: <ul style="list-style-type: none"> <li>• The need for training such as for new equipment, medication, changes to infection control, health and safety, quality assurance, other new procedures, NICE guidance, or anything that the doctor needs to learn</li> <li>• Changes to common conditions or current patient population information</li> <li>• Significant developments or new practices within their specialty</li> <li>• Changes in management or role expectations. What time will the doctor have for patient care?</li> <li>• Are there any teaching, research, management or leadership roles required?</li> <li>• Changes in the law that affect doctors' practice and developments in guidance on professional standards and ethics.</li> </ul>

10. Has the absence had any impact on the doctor's licence to practise and revalidation? What help might they need to fulfil the requirements for revalidation?
11. Have any new issues (negative or positive) arisen for the doctor since the doctor was last in post which may affect the doctor's confidence or abilities?
12. Has the doctor been able to keep up to date with their continuing professional development whilst they have been away?
13. If the doctor is a trainee, what are the plans for a return to learning?
14. Is the doctor having a staged return to work on the advice of Occupational Health?
15. Are there any issues relating to the doctor's next appraisal and preparation for this, which need to be considered? Is the revalidation date affected? (If either/both applies, the Responsible Officer/ representative should be informed)
16. Are there other factors affecting the return to practice or does the doctor have issues to raise?
17. Is a period of observation of other doctors' practice is required and/or does the doctor need to be observed before beginning to practise independently again?
18. Will the doctor need training, special support or mentoring on return to practice? If so, are there any funding issues related to this which need to be considered?
<b>Signatures</b> <b>Doctor</b> _____ <b>Date</b> _____ <b>On behalf of the organisation</b> _____ <b>Date</b> _____

## APPENDIX 1

### ORGANISATIONS WHO CAN ADVISE DOCTORS RETURNING TO PRACTICE

<b>British Medical Association</b>	<a href="http://www.bma.org.uk">www.bma.org.uk</a>
<b>General Medical Council</b>	<a href="http://www.gmc-uk.org">www.gmc-uk.org</a>
<b>Royal College of Anaesthetists</b>	<a href="http://www.rcoa.ac.uk">www.rcoa.ac.uk</a>
<b>College of Emergency Medicine</b>	<a href="http://www.collemergencymed.ac.uk">www.collemergencymed.ac.uk</a>
<b>Royal College of General Practitioners</b>	<a href="http://www.rcgp.org.uk">www.rcgp.org.uk</a>
<b>Royal College of Obstetricians and Gynaecologists</b>	<a href="http://www.rcog.org.uk">www.rcog.org.uk</a>
<b>Faculty of Occupational Medicine</b>	<a href="http://www.fom.ac.uk">www.fom.ac.uk</a>
<b>Royal College of Ophthalmologists</b>	<a href="http://www.rcophth.ac.uk">www.rcophth.ac.uk</a>
<b>Royal College of Paediatrics and Child Health</b>	<a href="http://www.rcpch.ac.uk">www.rcpch.ac.uk</a>
<b>Royal College of Pathologists</b>	<a href="http://www.rcpath.org">www.rcpath.org</a>
<b>Faculty of Pharmaceutical Medicine</b>	<a href="http://www.fpm.org.uk">www.fpm.org.uk</a>
<b>Royal College of Physicians of Edinburgh</b>	<a href="http://www.rcpe.ac.uk">www.rcpe.ac.uk</a>
<b>Royal College of Physicians London</b>	<a href="http://www.rcplondon.ac.uk">www.rcplondon.ac.uk</a>
<b>Royal College of Physicians and Surgeons of Glasgow</b>	<a href="http://www.rcpsg.ac.uk">www.rcpsg.ac.uk</a>
<b>Royal College of Psychiatrists</b>	<a href="http://www.rcpsych.ac.uk">www.rcpsych.ac.uk</a>
<b>Faculty of Public Health</b>	<a href="http://www.fph.org.uk">www.fph.org.uk</a>
<b>Royal College of Radiologists</b>	<a href="http://www.rcr.ac.uk">www.rcr.ac.uk</a>
<b>Royal College of Surgeons of Edinburgh</b>	<a href="http://www.rcsed.ac.uk">www.rcsed.ac.uk</a>
<b>Royal College of Surgeons of England</b>	<a href="http://www.rcseng.ac.uk">www.rcseng.ac.uk</a>
<b>Local deaneries</b>	<a href="http://www.copmed.org.uk/contacts">www.copmed.org.uk/contacts</a>
<b>Medical Women's Federation</b>	<a href="http://www.medicalwomensfederation.org.uk">www.medicalwomensfederation.org.uk</a>
<b>National Clinical Assessment Service</b>	<a href="http://www.ncas.npsa.nhs.uk">www.ncas.npsa.nhs.uk</a>
<b>NHS Careers</b>	<a href="http://www.nhscareers.nhs.uk">www.nhscareers.nhs.uk</a>
<b>NHS Employers</b>	<a href="http://www.nhsemployers.org">www.nhsemployers.org</a>
<b>Association of Anaesthetists of Great Britain and Ireland</b>	<a href="http://www.aagbi.org">www.aagbi.org</a>
<b>Academy of Medical Royal Colleges</b>	<a href="http://www.aomrc.org.uk">www.aomrc.org.uk</a>
<b>NHS Confederation</b>	<a href="http://www.nhsconfed.org">www.nhsconfed.org</a>
<b>Physician Re-entry Website (USA)</b>	<a href="http://www.physicianreentry.org">www.physicianreentry.org</a>

## APPENDIX 2

# MEMBERSHIP OF THE RETURN TO PRACTICE WORKING GROUP

**Professor Hugo Mascie-Taylor, Chairman**  
Medical Director of the NHS Confederation

**Dr Iain Barclay**  
Medical Protection Society

**Ms Maree Bennett**  
Department of Health England

**Miss Su Anna Boddy**  
Royal College of Surgeons of England

**Mrs Charnjit Dhillon**  
Director of Standards,  
Royal College of Obstetricians and Gynaecologists

**Dr Carolyn Evans**  
Flexible Training Adviser,  
Royal College of Anaesthetists

**Professor Peter Furness**  
President, Royal College of Pathologists

**Mr Steve Griffin**  
NHS Employers

**Professor Jacky Hayden**  
North Western Deanery

**Ms Una Lane**  
General Medical Council

**Miss Lorna Marson,**  
Transplant surgeon at Edinburgh Royal infirmary  
and Chairman of the Women in Surgery Advisory  
Board for the Royal College of Surgeons of Edinburgh

**Ms Claire McLaughlan**  
Senior Adviser (Remediation, Reskilling  
and Rehabilitation) Advice and Support,  
National Clinical Assessment Service

**Mr Bill McMillan**  
NHS Employers

**Mr Sol Mead**  
Academy of Medical Royal Colleges Patient Liaison  
Group Chairman

**Miss Susan Mollan**  
Royal College of Ophthalmologists  
**Professor Mike Pringle**  
Royal College of General Practitioners

**Dr Ian Starke**  
Revalidation Lead for the Royal College of Physicians  
of London and Director of CPD for Federation of  
Physicians

**Miss Kate Tansley**  
Revalidation Project Manager,  
Academy of Medical Royal Colleges

**Dr Jean Watt**  
Royal College of Paediatrics and Child Health





**Academy of Medical Royal Colleges**  
10 Dallington Street  
London  
EC1V 0DB

**Registered Charity**  
Number 1056565

## Appendix 5a

# RCOG and RCM Joint Presidential Statement on Undermining



Royal College of  
Obstetricians &  
Gynaecologists



The Royal College of  
Midwives



### STATEMENT FROM THE ROYAL COLLEGE OF OBSTETRICIANS & GYNAECOLOGISTS AND THE ROYAL COLLEGE OF MIDWIVES

The RCM and the RCOG are the standard setters for their professions. By working together to reduce undermining and bullying behaviours, we will improve the working environment for our professional teams and deliver better care to women and families. The RCM and the RCOG together categorically condemn undermining and bullying behaviour under any circumstance.

Together we will promote a positive working environment for all, where individuals and teams treat each other with compassion, dignity and respect, where critical feedback and whistle-blowing are encouraged, and women are central to the care we provide. A culture in which unsafe care is reported by any member of staff, independent of their seniority, will be nurtured and supported.

RCM and RCOG will develop and implement strategies, building on existing good practice and working with other stakeholder organisations, to ameliorate undermining behaviours and bullying behaviour.

We will publish an action plan for our professions to implement UK-wide that will be sent to all UK medical directors with this statement for wide dissemination.

	
<b>Dr Tony Falconer FRCOG</b>	<b>Professor Cathy Warwick</b>
<b>President, Royal College of Obstetricians and Gynaecologists</b>	<b>Chief Executive, Royal College of Midwives</b>

#### Supporting information

- Undermining and bullying behaviour has long been recognised as a problem for Obstetric and Gynaecology (O&G) trainee doctors, as evidenced by repeated national General Medical Council trainee surveys<sup>1</sup>. O&G trainees report more undermining behaviour than any other medical speciality.

<sup>1</sup> [http://www.gmc-uk.org/National\\_training\\_survey\\_key\\_findings\\_report\\_2013.pdf](http://www.gmc-uk.org/National_training_survey_key_findings_report_2013.pdf) 52299037.pdf



2. Although the GMC Trainee Surveys indicate that the vast amount of undermining reported by trainees is carried out by consultants, midwives are the next biggest group - 23% of undermining behaviour reported by trainees was carried out by midwives in 2009, 15% in 2010 and 16% in 2011. The questions were changed in 2012 to ask where undermining behaviour had occurred – the highest percentage of reported occurrences was in the Labour Ward (10.1% = 193 trainees) though these will have involved both consultants and midwives.
3. The 2012 NHS England Staff Survey also reveals that midwives also experience more harassment or abuse from their managers/team leaders or other colleague than nurses and midwives combined (31% compared to 27%)<sup>2</sup>. Undermining behaviour can negatively affect patient outcomes and this was a major factor in the problems experienced at Mid Staffordshire Hospital<sup>3</sup> in nursing.
4. In 2012 RCOG decided to take specific action to reduce the undermining experienced by O&G trainees, and explored the possibility with the Royal College of Midwives (RCM) of a joint workshop, building on the previous joint RCOG/RCM work in 2008<sup>4</sup> ([The Clinical Learning Environment](#)).
5. This joint statement arises from a joint workshop held early in 2013 and heralds the launch of our joint RCOG/RCM action plan to address the issue of undermining and bullying behaviours in obstetrics and gynaecology.

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<sup>2</sup> <http://www.nhsstaffsurveys.com/Page/1006/Latest-Results/2012-Results/>

<sup>3</sup> <http://www.midstaffspublicinquiry.com/report>

<sup>4</sup> <http://www.rcog.org.uk/womens-health/clinical-guidance/clinical-learning-environment-and-recruitment-report-joint-working-p>

## Appendix 6a

# Purposeful Conversations

### 'Purposeful Conversations' FAQs

#### What does 'purposeful conversation' actually mean?

'Purposeful conversation' is our University Hospital Southampton (UHS) term to describe the conversation or discussion (outside line management) between two parties where one party seeks another's (trained) perspective on their issue(s). This could be a single event or short term, which are both coaching, and longer term, which is mentoring. We hope that this neutral term will make it easier for individuals to find the support they seek - we know that, in the past, having to decide between mentoring & coaching has prevented some from then accessing either.

#### Is 'purposeful conversations' just another term for ranting?

'Sounding off' to a trusted friend or colleague about something at work that's bugging us and knowing we will get a sympathetic ear can be extremely therapeutic – or not, particularly when it becomes a habit. Whereas having a purposeful conversation, or a series of them, can help us to reflect on our thoughts and feelings and crystallise them into meaningful action. Purposeful conversations do what their title suggest; stated aims and objectives form a vital part of the dialogue, there is focus on developing skills and knowledge, and each one should end with an agreed action plan.

#### Why would I want to have one of these conversations?

The input of others, perhaps because they have experienced the situation we are facing and/or have the necessary skills to help us work through our concerns, can often be invaluable. We all encounter situations at work, from time to time, such as:

- a change in job or area of responsibility
- new in post
- a difficult working relationship
- a potential promotion with career implications
- finding an area of work, or just the volume of it, challenging
- reviewing a recent learning experience

where the opportunity to talk it through with a colleague is a helpful part of resolving the issue. Other reasons might be, perhaps:

- "I'm not seeing the wood for the trees - I know so much about it, my expertise has narrowed my field of vision"
- "I'd like to develop the ability to step back and look afresh"
- "I'm stuck, don't know what to do"
- "I'd just value an objective view, another's perspective"
- "Someone's suggested it"
- "I feel helpless, I'm struggling"

### **Isn't this what my line manager is for?**

A purposeful conversation with a third party is, ideally, in addition to an effective working relationship with your line manager. Looking at your issue with objectivity, via a different 'lens' - someone not directly involved - can bring you fresh insight. Besides, your working relationship with your manager may be the issue you wish to explore!

### **Who does them?**

UHS has an increasing number of coaches and more than 60 mentors, all trained, both sexes, from different disciplines and of varying seniority – all sharing the common factor of wanting to help others in a purposeful way.

### **Is it confidential?**

Apart from the usual caveats on issues of, for example, misconduct or criminality (!) your discussion remains confidential as far as the coach or mentor is concerned. You, of course, may share what you choose, since it is about you. Your mentor/coach is able to confirm whether they have seen you, though not the detail of the discussion.

### **What does the coach or mentor get out of it?**

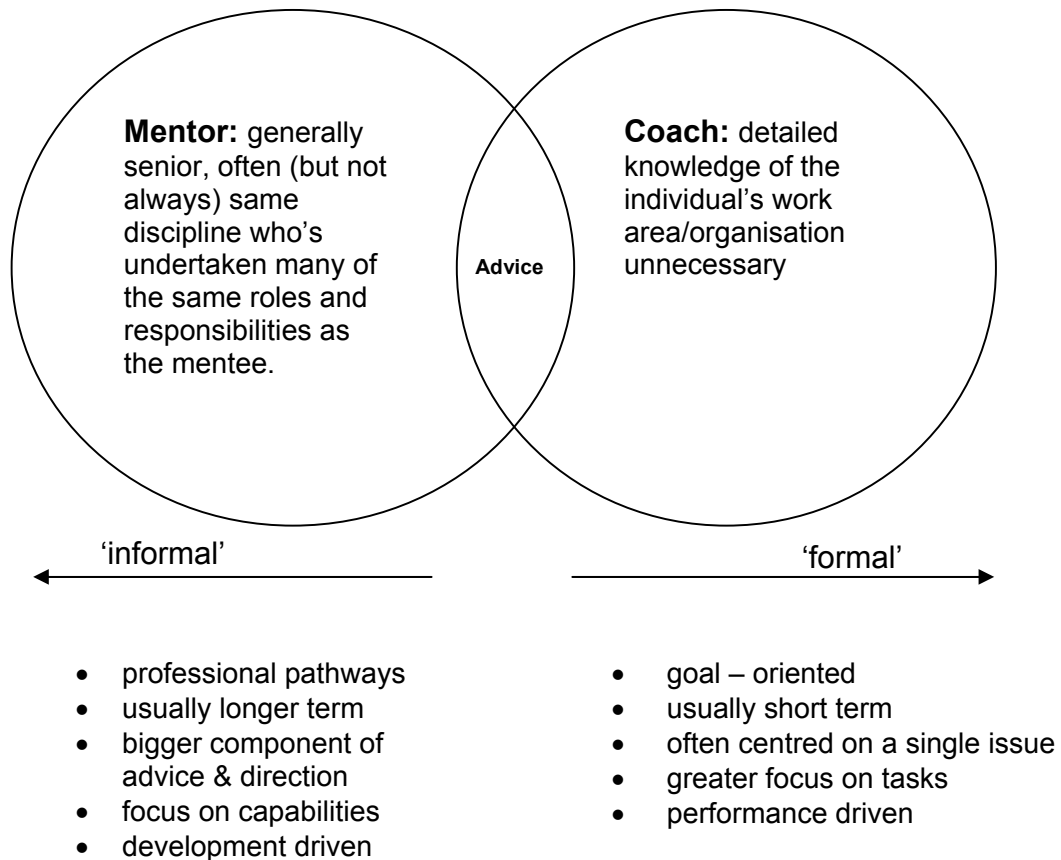
- Helping others in a purposeful way
- Developing their listening and questioning skills
- Learning from the mentee/coachee

### **What are the similarities between coaching & mentoring?**

Features common to both mentoring & coaching:

- developing the mentee's/coachee's personal effectiveness
- mutual trust and respect
- confidential setting
- 1 to 1 with coach/mentor
- 60 – 90' meetings
- agreed 'contract' between both participants
- clear action(s) from each session
- balance of challenge and support
- focus on helping the coachee/mentee to develop their own solutions wherever possible

## So should I get a mentor or a coach?



### Key message:

**if you think a purposeful conversation will help you, choose coaching or mentoring and give it a try, rather than nothing at all!**

## Appendix 6b

# East Midlands Leadership Network – Mentor Database

<https://www.eastmidlandsdeanery.nhs.uk/emln/>

The screenshot displays the NHS East Midlands Leadership Network Mentor Database website. The browser address bar shows the URL <https://www.eastmidlandsdeanery.nhs.uk/emln/>. The page header includes the NHS logo and the title "East Midlands Leadership Network Mentor Database".

**Navigation Menu:**

- HOME
- FIND A MENTOR
- REGISTER AS A MENTOR
- MORE INFORMATION ON MENTORING

**Welcome**

Mentoring is a powerful and flexible means of development that offers participants the opportunity to benefit from focused discussions and mutual learning.

Mentoring provides one-to-one, medium to long term support aimed at maximising an individuals potential and realising ambition. This database is designed to help you find a mentor, or to register yourself as a mentor for others.

**Buttons:**

- SEARCH FOR A MENTOR
- SHOW ALL MENTORS
- REGISTER AS A MENTOR

**Quick search**

Enter one or more keywords to match against mentors' stated interests and experience:

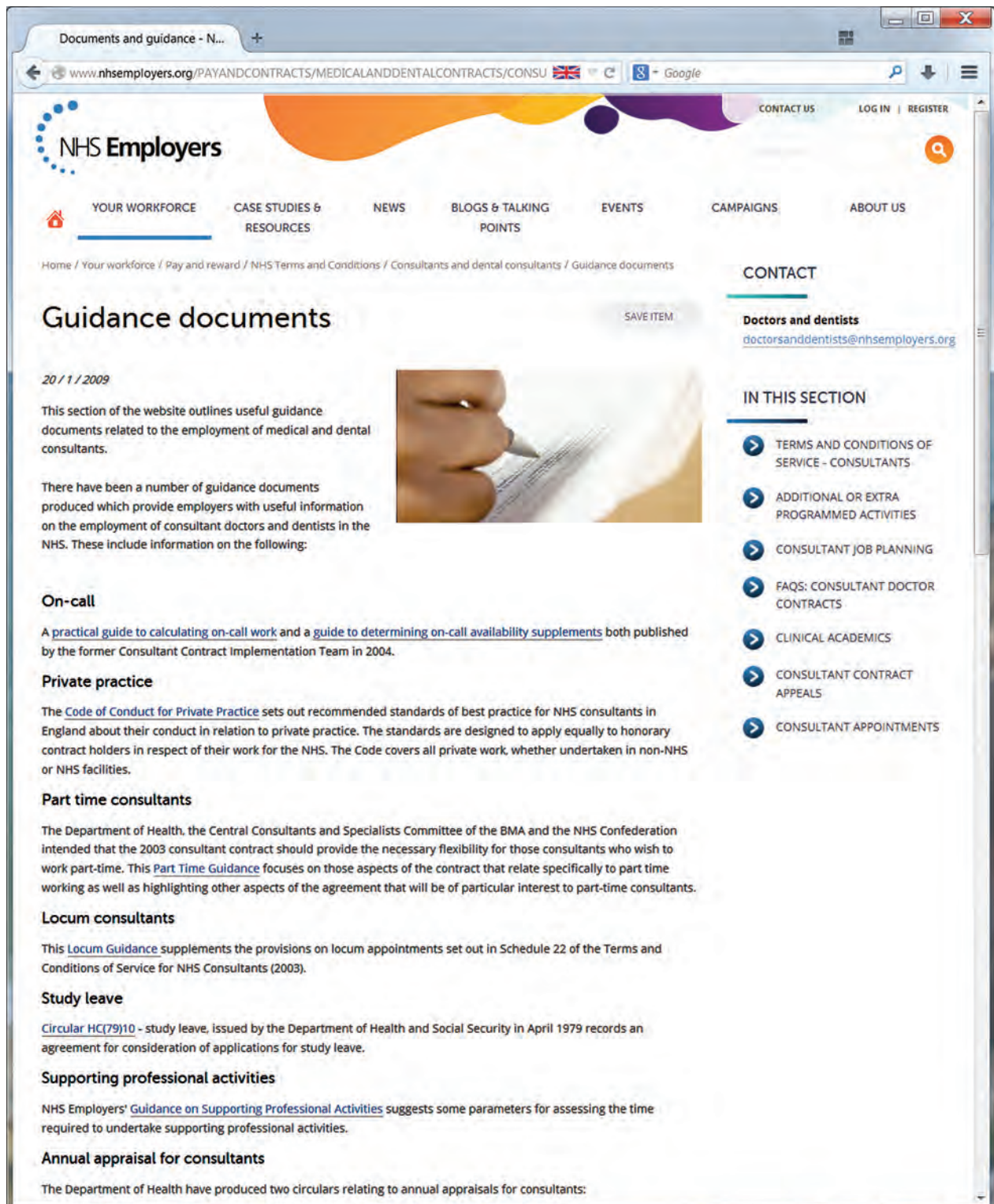
To specify outcomes, resources, timescales, geographical areas and mentoring methods, please use the [Advanced Search](#).

[More Information about mentoring...](#)

## Appendix 7a

# Responsibilities of the Employer for Induction of All New Employees

<http://www.nhsemployers.org/PAYANDCONTRACTS/MEDICALANDDENTALCONTRACTS/CONSULTANTSANDDENTALCONSULTANTS/GUIDANCE/Pages/Consultants-Guidance.aspx>



The screenshot shows a web browser window displaying the NHS Employers website. The page title is "Guidance documents" and it is dated "20 / 1 / 2009". The main content area contains several sections of text and links, including "On-call", "Private practice", "Part time consultants", "Locum consultants", "Study leave", "Supporting professional activities", and "Annual appraisal for consultants". A sidebar on the right contains a "CONTACT" section with the email address "doctorsanddentists@nhsemployers.org" and an "IN THIS SECTION" list with links to various topics like "TERMS AND CONDITIONS OF SERVICE - CONSULTANTS" and "CONSULTANT APPOINTMENTS".

**Guidance documents** SAVE ITEM

20 / 1 / 2009

This section of the website outlines useful guidance documents related to the employment of medical and dental consultants.

There have been a number of guidance documents produced which provide employers with useful information on the employment of consultant doctors and dentists in the NHS. These include information on the following:

**On-call**

A [practical guide to calculating on-call work](#) and a [guide to determining on-call availability supplements](#) both published by the former Consultant Contract Implementation Team in 2004.

**Private practice**

The [Code of Conduct for Private Practice](#) sets out recommended standards of best practice for NHS consultants in England about their conduct in relation to private practice. The standards are designed to apply equally to honorary contract holders in respect of their work for the NHS. The Code covers all private work, whether undertaken in non-NHS or NHS facilities.

**Part time consultants**

The Department of Health, the Central Consultants and Specialists Committee of the BMA and the NHS Confederation intended that the 2003 consultant contract should provide the necessary flexibility for those consultants who wish to work part-time. This [Part Time Guidance](#) focuses on those aspects of the contract that relate specifically to part time working as well as highlighting other aspects of the agreement that will be of particular interest to part-time consultants.

**Locum consultants**

This [Locum Guidance](#) supplements the provisions on locum appointments set out in Schedule 22 of the Terms and Conditions of Service for NHS Consultants (2003).

**Study leave**

[Circular HC\(79\)10](#) - study leave, issued by the Department of Health and Social Security in April 1979 records an agreement for consideration of applications for study leave.

**Supporting professional activities**

NHS Employers' [Guidance on Supporting Professional Activities](#) suggests some parameters for assessing the time required to undertake supporting professional activities.

**Annual appraisal for consultants**

The Department of Health have produced two circulars relating to annual appraisals for consultants:

**CONTACT**

**Doctors and dentists**  
[doctorsanddentists@nhsemployers.org](mailto:doctorsanddentists@nhsemployers.org)

**IN THIS SECTION**

- TERMS AND CONDITIONS OF SERVICE - CONSULTANTS
- ADDITIONAL OR EXTRA PROGRAMMED ACTIVITIES
- CONSULTANT JOB PLANNING
- FAQS: CONSULTANT DOCTOR CONTRACTS
- CLINICAL ACADEMICS
- CONSULTANT CONTRACT APPEALS
- CONSULTANT APPOINTMENTS



## Appendix 7b

# Minimum Standards for Induction

- Initial appraisal to define needs and objectives for the first year in post
- Clear plan for the first job plan review
- Equality and diversity training
- Patient safety awareness
- Local NHSLA procedures
- Local clinical governance and risk management procedures (including involving colleagues and other staff)
- Introduction to key stakeholders within the Trust (medical and non medical)
- Framework of key stakeholders in local health economy
- Access to clinical supervisor training
- Local mentoring opportunities
- Local complaints procedures.

This list is not exclusive and is designed to complement rather than replace local generic induction procedures.

May be a continuum over several months.

## Appendix 7c

### VOICES Framework

- V** be Visible in your department (personal management)
- O** be Open and transparent (personal governance)
- I** consider all Improvement Ideas from all staff
- C** demonstrate Care and Compassion to all patients and your staff
- E** Ensure focus on patient experience
- S** Sensitively and Skilfully challenge inappropriate behaviour, e.g. bullying.

The new specialist should consider their own leadership style and reflect on the qualities in the VOICES model.

The University of Kent has a free 50-question task that helps individuals determine their style of leadership. The test takes about 7-minutes and has good explanation as to what an individual's leadership style can bring to an organisation. The test is available at: <http://www.kent.ac.uk/careers/sk/leadership.htm>

## Appendix 7d

# Parliamentary and Health Service Ombudsman: Handling Complaints – Listening and Learning

Familiarise yourself with the recommendations from the Parliamentary and Health Service Ombudsman: <http://www.ombudsman.org.uk/listening-and-learning-2012/home>

The screenshot shows the website interface for the Parliamentary and Health Service Ombudsman. At the top, there is a navigation bar with the logo and name of the Ombudsman. Below this, a secondary navigation bar contains links for 'Home', 'Overview', 'What our casework tells us', 'Getting it right', and 'From our case files'. The main content area is titled 'Listening and Learning: The Ombudsman's review of complaint handling by the NHS in England 2011-12'. It features a large central image of a woman in a white coat, likely a healthcare professional, interacting with a patient. To the left of this image are several text boxes: 'Complaints about the NHS in 2011-12', 'Poor complaint handling: lessons from our case files', 'Complaints about GPs', and 'Getting it right: our work in the new NHS'. To the right of the image is a text box stating: 'The NHS received 150,859 complaints in 2011-12; a rise of 1.3% on the year before.1'. Below the main content area, there are three more content boxes: 'Foreword', 'Good practice in complaint handling', and 'Statistics'. The footer contains links for 'Contact us', 'Help in other languages', 'Cookies and our Privacy Policy', and 'Site map', along with social media icons for LinkedIn, YouTube, Facebook, and Twitter.

## Appendix 7e

# Parliamentary and Health Service Ombudsman: Handling Complaints – Getting It Right

Familiarise yourself with the complaints report: <http://www.ombudsman.org.uk/listening-and-learning-2012/getting-it-right/getting-it-right-our-work-in-the-new-nhs>

The screenshot shows a web browser window displaying the Parliamentary and Health Service Ombudsman website. The page title is "Listening and Learning: The Ombudsman's review of complaint handling by the NHS in England 2011-12". The main navigation menu includes "Home", "Overview", "What our casework tells us", "Getting it right" (highlighted in orange), and "From our case files". The current page is "Getting it right: our work in the new NHS".

The page content includes:

- Getting it right: our work in the new NHS**  
Complaints to us about the NHS are increasing. The evidence from our case files suggests that much more needs to be done if good complaint handling is to become standard across the new health landscape. The need to listen and learn from complaints has never been greater.
- Good practice in complaint handling**
- Complaint handling in the new NHS**
- Understanding what it means to be an NHS provider**
- Getting it right: our work in the new NHS**

As NHS structures and systems are overhauled, the final report of the Mid Staffordshire NHS Foundation Trust Public Inquiry is expected in January 2013. The Inquiry, into devastating fallings in care at Staffordshire Hospital, examines the broader NHS monitoring system: the commissioning, supervisory and regulatory organisations. Its goal is to find out why problems at the Staffordshire Hospital were not identified and acted upon sooner.

Last year, the then Ombudsman, Ann Abraham, gave evidence to the public inquiry. Explaining that we are not a regulator or an early warning system, she emphasised the importance of acting on intelligence gained from complaints. She said:

*"Patients and their families need to be empowered and encouraged and enabled to have their say. When they do speak up, they need to be listened to and what they say needs to be acted on. And that won't happen if NHS boards don't demand regular information about complaints, and their outcomes, and ask to be told what trusts are doing differently as a result of learning from complaints."*

As the Health Service Ombudsman, we listen to the experiences of individual patients and make judgments on their complaints. Often the people who contact us feel that what happened to them has not been listened to and their voice has not been heard. The information and data we hold can help to ensure that the experiences of individual patients are heard and acted upon more readily in future.

We want to share the information we hold more widely, with providers and commissioners, regulators, MPs and Parliament and patients. By doing so, we can help others evaluate services and inform commissioning decisions; provide data about service quality and choice to the health sector regulators; and provide insight to regulators and to Parliament on system-wide failures within the NHS. We will continue to alert the professional regulators to patient safety

Buttons for "Foreword" and "Download the Report" are visible on the right side of the page.

## Appendix 7f

# Difficult Conversations

<http://www.royalmarsden.nhs.uk/education/school/courses/pages/connected.aspx>

The screenshot shows a web browser window displaying the NHS website. The page title is 'Connected - National Advanced Communication Skills (ACST)'. The navigation menu includes 'Home', 'Diagnosis & treatment', 'Consultants, teams & wards', 'Research & clinical trials', 'Cancer information', 'Private Care', and 'Education'. The main content area features a sidebar with a list of courses, including 'Acute Cancer Care', 'Acute Oncology: Clinical Problems and their Management', and 'Connected - National Advanced Communication Skills (ACST)'. The main content area displays the course details, including a table with columns for 'Who is it for', 'Duration', 'Dates', and 'Costs'. The course is validated by the Faculty of Health, Social Care and Education at Kingston University and St George's, University of London. The course summary states that the importance of good communication in cancer care has been highlighted in successive reports, and this course has been established by the National Cancer Action Team (NCAT) to enhance senior healthcare professionals' abilities to deal with challenging communication situations. The course, which is facilitated by nationally accredited trainers, includes discussion of the research evidence surrounding communication in cancer care, interactive exercises and role-play in small groups with actors. Participants will practise skills and receive positive and constructive feedback in a safe and supportive environment. The agenda for the course is set by the participants in response to their personally identified learning needs. Participants are expected to take part in all aspects of the course and must attend both days to receive their certificate from NCAT. The learning outcomes are listed as follows: Increase awareness of own communication skills; Explore strategies to improve quality of clinical communication; Increase ability to deliver information effectively and explore decision-making; Increase confidence in responding to difficult communication situations; Enhance inter-professional communication. For full details of the course please see the Connected website at [www.connectedonlinebookings.co.uk](http://www.connectedonlinebookings.co.uk). The entry requirements state that applicants should be senior healthcare professionals (band 6 and above) who are working with people affected by cancer.

Connected - National Advanced Communication Skills (ACST)

Validated by the Faculty of Health, Social Care and Education at Kingston University and St George's, University of London.

<b>Who is it for</b>	Senior healthcare professionals (band 6 and above)
<b>Duration</b>	2 days
<b>Dates</b>	5 and 6 June 2014 14 and 15 July 2014 6 and 7 November 2014 24 and 25 February 2015 23 and 24 April 2015 4 and 5 June 2015 13 and 14 July 2015
<b>Costs</b>	£925 for academic years 2013/14 and 2014/15 (overseas student prices will vary)

**Course summary**

The importance of good communication in cancer care has been highlighted in successive reports, and this course has been established by the National Cancer Action Team (NCAT) to enhance senior healthcare professionals' abilities to deal with challenging communication situations.

The course, which is facilitated by nationally accredited trainers, includes discussion of the research evidence surrounding communication in cancer care, interactive exercises and role-play in small groups with actors. Participants will practise skills and receive positive and constructive feedback in a safe and supportive environment.

The agenda for the course is set by the participants in response to their personally identified learning needs. Participants are expected to take part in all aspects of the course and must attend both days to receive their certificate from NCAT.

**Learning outcomes**

- Increase awareness of own communication skills
- Explore strategies to improve quality of clinical communication
- Increase ability to deliver information effectively and explore decision-making
- Increase confidence in responding to difficult communication situations
- Enhance inter-professional communication

For full details of the course please see the Connected website at [www.connectedonlinebookings.co.uk](http://www.connectedonlinebookings.co.uk).

**Entry requirements**

Applicants should be senior healthcare professionals (band 6 and above) who are working with people affected by cancer.

# Appendix 7g

## The Maguire Communication Skills Course

<http://www.christie.nhs.uk/school-of-oncology/maguire-communication-skills.aspx>

The screenshot shows a web browser window displaying the website for the Maguire Communication Skills course. The browser's address bar shows the URL: [www.christie.nhs.uk/school-of-oncology/maguire-communication-skills.aspx](http://www.christie.nhs.uk/school-of-oncology/maguire-communication-skills.aspx). The website header includes the Christie School of Oncology logo and a search bar. The main navigation menu includes: About The Christie, The Foundation Trust, Research Division, School of Oncology (selected), The Christie Clinic, and The Christie charity.

The main content area is titled "Maguire Communication Skills" and includes the following text: "The Maguire Communication Skills Training Unit has 30 years of expertise in communication skills research and training. Our team of expert facilitators delivers a wide range of training suitable for all levels of staff, individuals or organisations." It lists two training prospectuses: "Maguire Communication Skills - Training Prospectus 13/14" and "Maguire Communication Skills - Training Prospectus 2015".

Below this, it states: "The Maguire unit is dedicated to promoting sensitive and effective communication, encompassing compassion, acknowledgement, respect, empathy, and dignity for patients and customers and which empowers the patient to make a fully informed choice based on their needs and preferences." It then lists the unit's support for quality measures in health and social care by:
 

- Enabling Trusts and Healthcare professionals to provide evidence for peer review, CQC Quality Standards and Patient Experience Survey
- Providing training mapped to NICE Guidance & KSF Levels

The "Commissioning training" section explains that individuals can access the programme of courses running in Manchester, which can be funded individually or as "commission bespoke training" to meet specific needs. It notes that communication skills training has been shown to improve compliance, quality of life, patient experience and satisfaction, reduce stress, reduce medico-legal risk, decrease complaints, reduce costs, improve time management, improve job satisfaction and decrease professional stress.

The "Funded training for Voluntary & Community Sector/Charitable Organisations" section states that the Society for the Investigation of Human Values granted funding to the Maguire unit to deliver training within voluntary organisations.

The "Future events" sidebar lists the following scheduled events:
 

- Professional Development for Administrators: 8th Jun 2014
- The Christie FRCS Exit Exam Course in General Surgery: 25th - 27th Jul
- De-mystifying the Science for Cancer Nurses: 9th Sept 2014
- Haematology Study Day: 11th Sept 2014
- Upper GI Study Day: 15th Sept 2014
- ACP: Clinical Practice Cardiovascular Masterclass: 16th Sept 2014
- The Christie Robotic Pelvic Oncology Symposium: 17th Sept 2014
- Still confused about feeding tubes?: 18th Sept 2014
- The Edinburgh MRCS Preparation Course: 20th - 21st Sept 2014
- Targeted Treatments for Haematological Cancers: 2nd Oct 2014
- Lymphoma Study Day: 7th Oct 2014
- Manchester Melanoma Surgery Meeting: 9th Oct 2014
- Acute Oncology: Scenario Based Learning: 15th Oct 2014
- Understanding our Connective Tissue System: 17th Oct 2014
- Professional Development for Support Staff: 22nd Oct 2014
- An Introduction to Cancer: 12th - 13th Nov 2014
- Gynaecology Study Day: 17th Nov 2014
- Targeted Treatments for Lung Cancer: 18th Nov 2014
- Leadership (Intermediate): 26th Nov 2014
- Management of Breakthrough Cancer Pain: 26th Nov 2014
- Targeted Treatments for Solid Tumours: 10th Dec 2014

## Appendix 7h

# Joint RCOG–RCM Undermining Toolkit

Please see the joint RCOG–RCM Undermining Toolkit which will be launched in the Autumn of 2014 on the RCOG website.

## Appendix 7i

# A Guide to Consultant Job Planning

<http://www.nhsemployers.org/Aboutus/Publications/Pages/AGuideToConsultantJobPlanning.aspx>



A guide to  
consultant job  
planning

July 2011 Version 1



# Appendix 7j

## Developing Your Service – Sample Business Case Templates

<http://www.nhshealthatwork.co.uk/business-plan-resources.asp>

The screenshot shows a web browser window displaying the NHS Health at Work Network website. The page title is "Business planning resources - NHS...". The URL in the address bar is "www.nhshealthatwork.co.uk/business-plan-resources.asp". The page features a navigation menu with links for Home, Member's login, Support for Business, and Contact us. The main content area is titled "Business planning resources" and includes sections for "Business Planning Resources:", "Making the business case template", "Business plan template", "Example business plans", "Key questions when planning", "Financial template 1", "Financial template 2", and "Online costing tool (STEM)". A sidebar on the left contains a "Feedback +" button and a list of navigation links. A right sidebar contains sections for "For NHS Managers" and "Support for Businesses". The page also features an illustration of a person climbing a mountain with an OHS flag and another illustration of a person in a wheelchair being assisted by a healthcare professional.

**Business planning resources - NHS...**

www.nhshealthatwork.co.uk/business-plan-resources.asp

Home Member's login Support for Business Contact us

Leading your OH service  
We are dedicated to maintaining a healthy, motivated workforce

NHS Health at Work Network

About us Government Policy Accreditation Clinical Excellence Leading your OH service News

**Feedback +**

Leading your OH service

- Business planning
- Business planning resources
- STEM - cost your services
- Workforce
- Future configuration of NHS services
- Occupational Health in practice
- Clinical skills training
- Marketing occupational health externally
- Commissioning OH services

You are here: Leading your OH service / Business planning resources

### Business planning resources

**Business Planning Resources:**

**Making the business case template**

Use to help you make the business case to senior management for more flexibility, autonomy and reinvestment in your service.

**Business plan template**

A template to help you strategically plan your department and its services.

**Example business plans**

NHS OH services share their business plans.

- Doncaster and Bassetlaw Hospitals NHS Foundation Trust Business Plan

**Key questions when planning**

A useful tool to follow at the planning stage.

**Financial template 1**

A scenario planner.

**Financial template 2**

A budgeting tool enabling you to forecast income and expenditure.

**Online costing tool (STEM)**

STEM is a new and unique tool that is available free to full NHS Health at Work members. It enables OH managers to effectively establish the real cost of delivering complex services. NHS occupational health teams who are not members can purchase the system. Find out more [here](#)

If you require further assistance or have any questions, we have expert advice available. Contact [Andrew Gilbey](#).

**For NHS Managers**

Find out how Occupational Health can:

- Improve the health of your staff AND patients
- save the NHS money

**View**

**Support for Businesses**

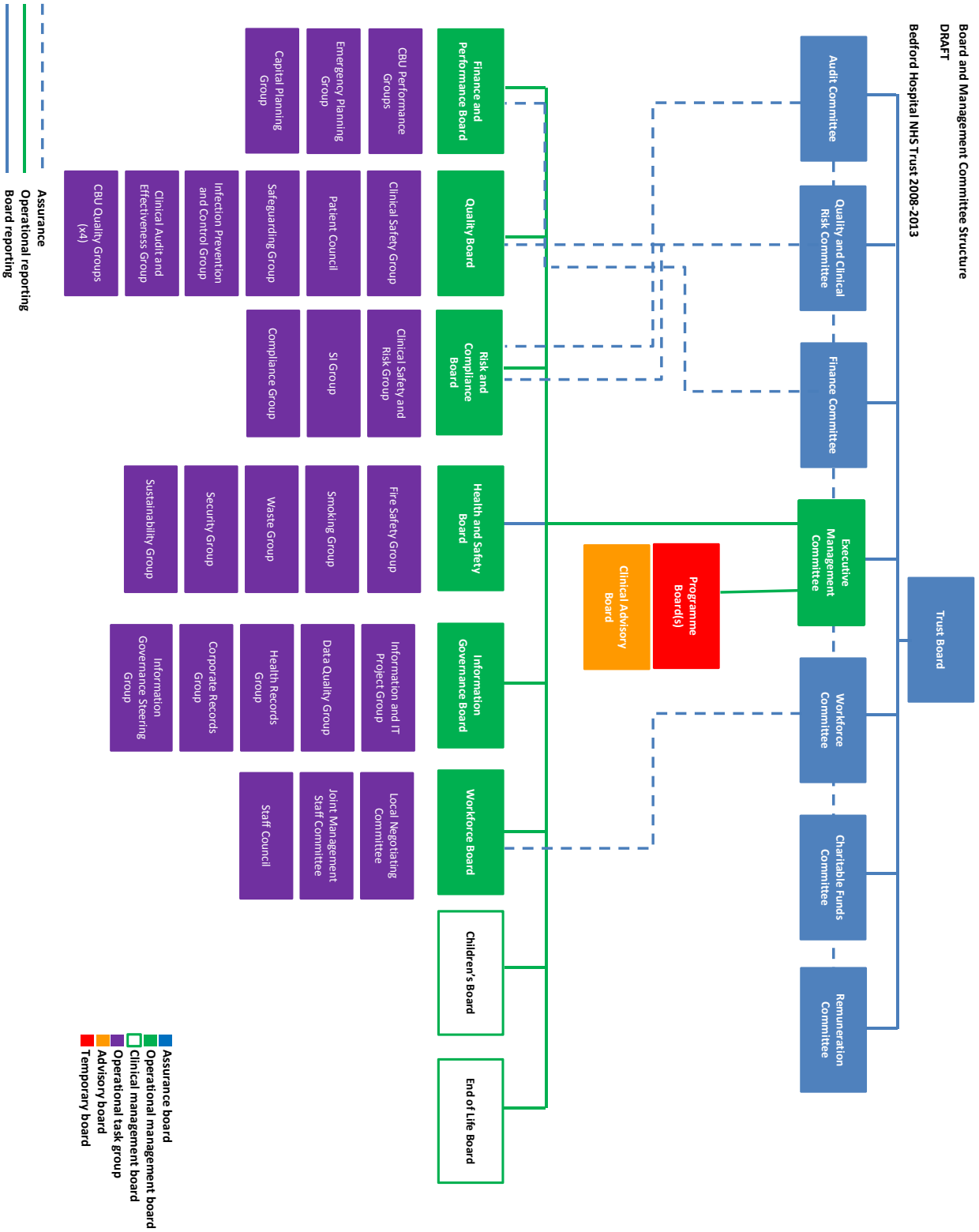
Good health is good for business:

- What is occupational health?
- How it can help your business
- Access to free advice line
- Find your local NHS Occupational Health Provider

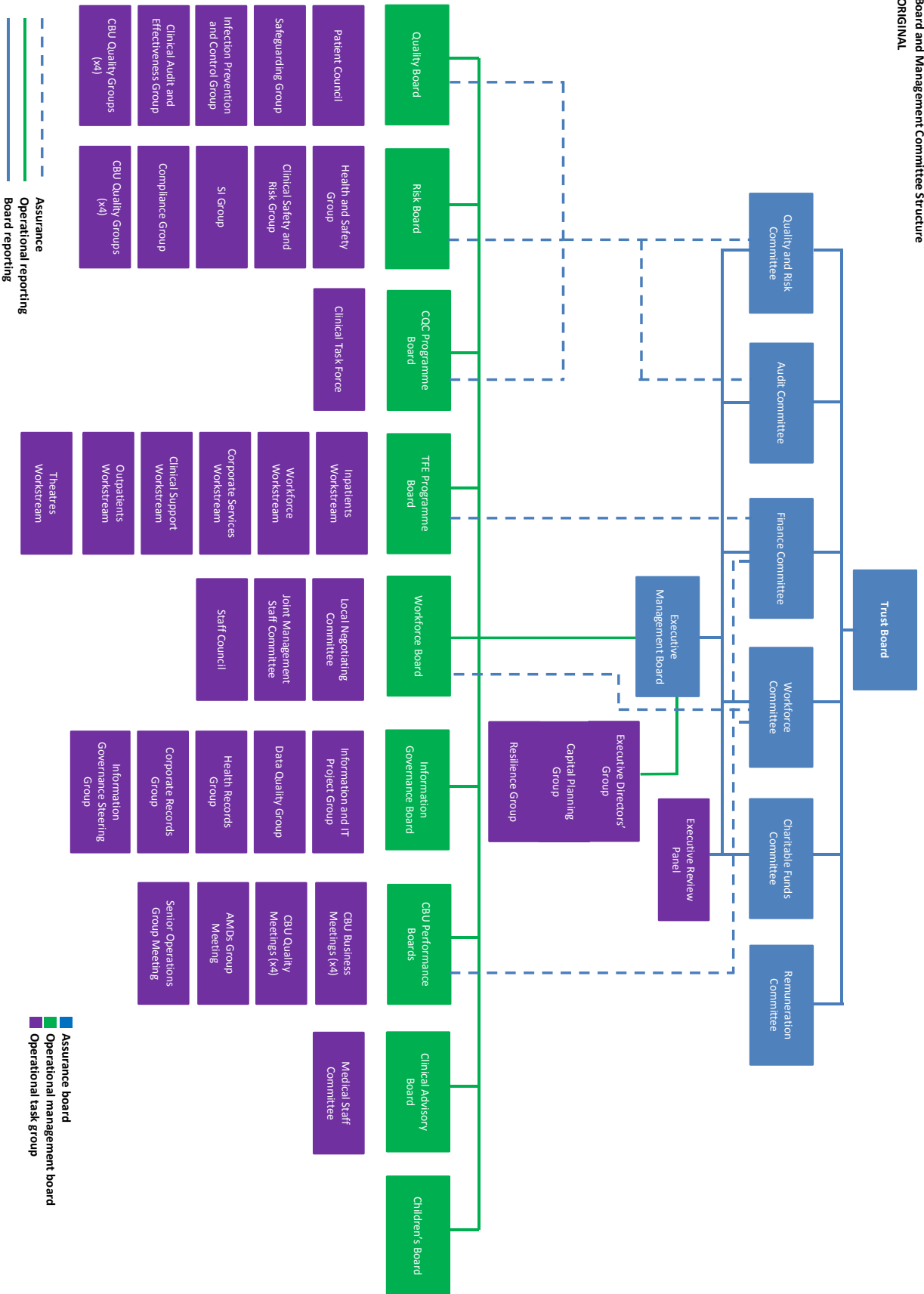
**View**

Comments? Questions? Feedback? Please **Contact us**

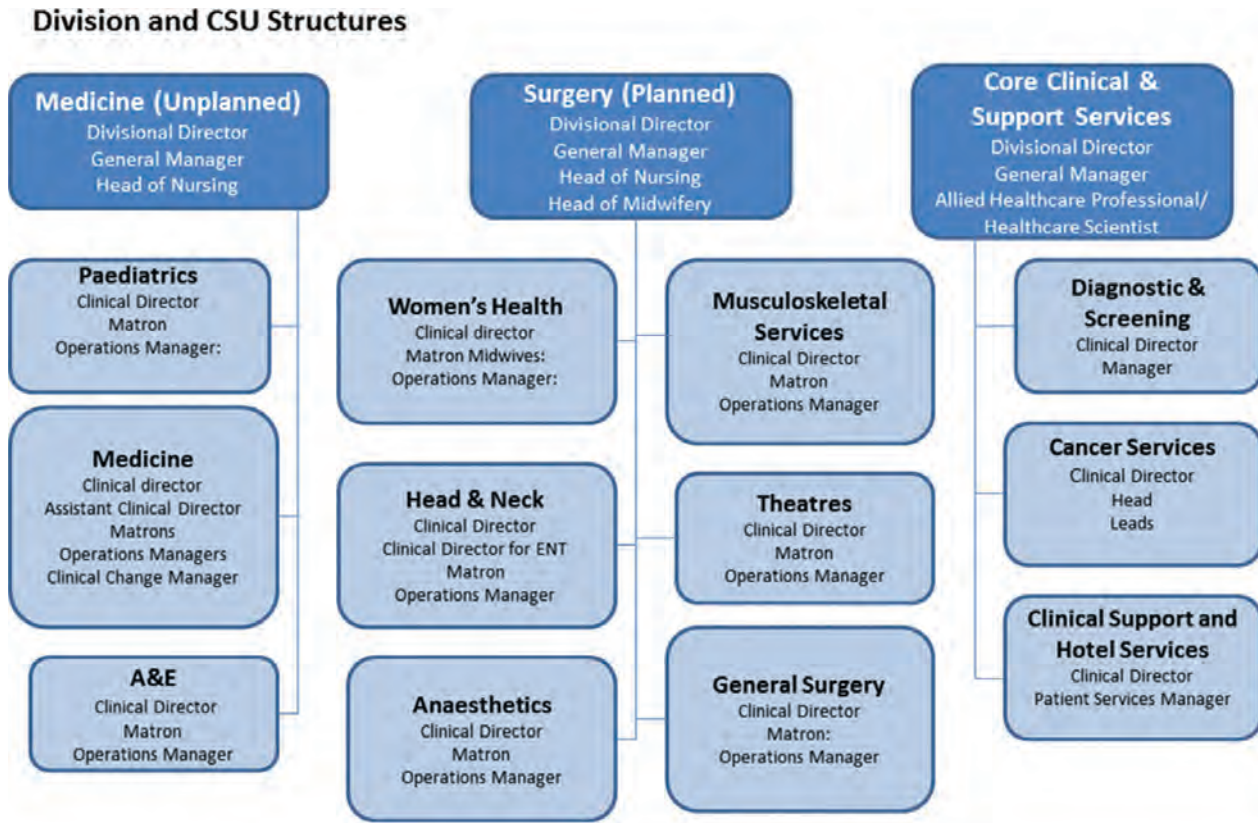
# Appendix 7k Board and Management Committee Structure



**Board and Management Committee Structure**  
ORIGINAL



## Appendix 71 Division and CSU Structures



Example organisational structures, Bedford Hospital NHS Trust 2008-13

## Appendix 7m

# Medical Management Structure for Business Units

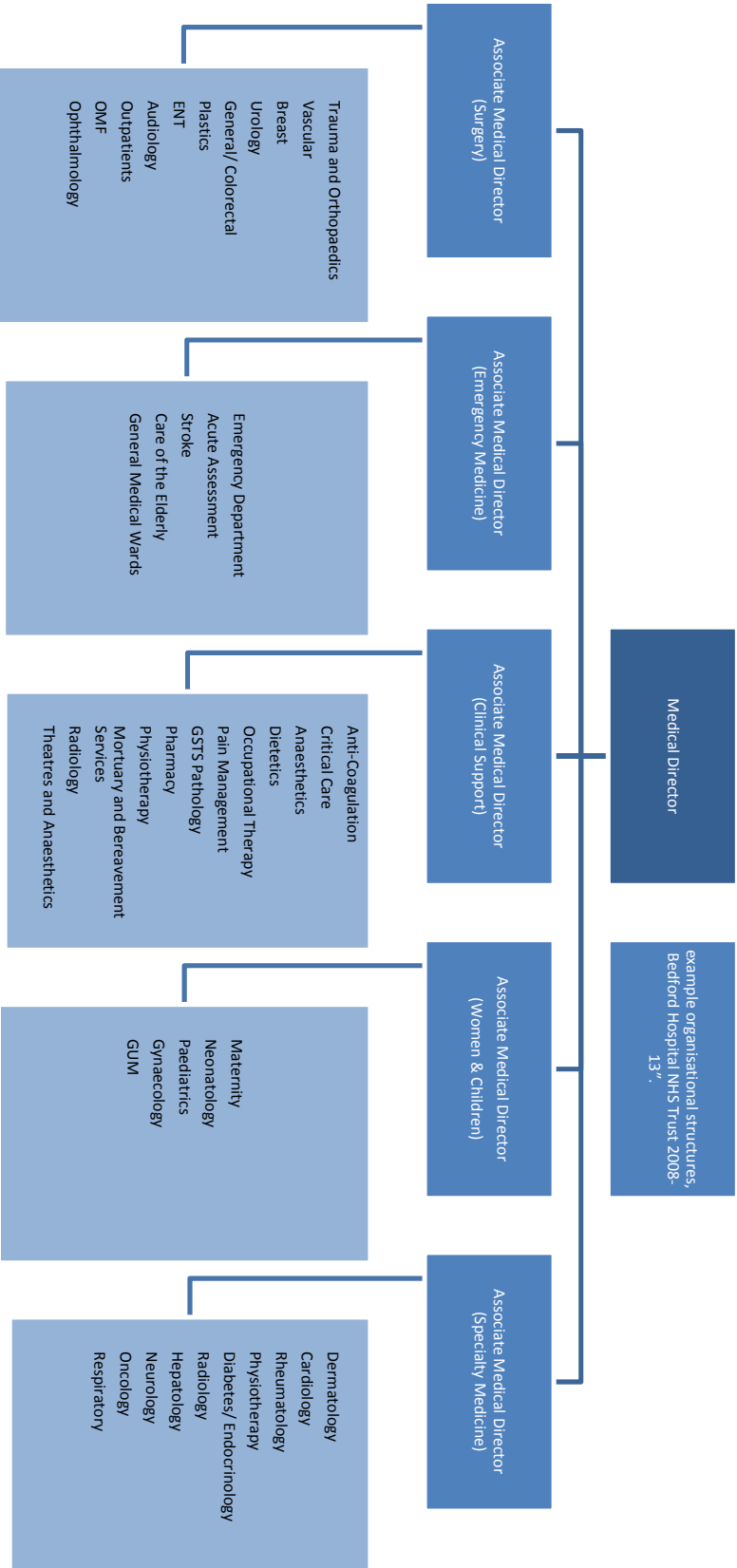
### Medical Management Structure for Business Units

Legend to be applied:-

Dark blue – Executive Director

Mid blue – Business Unit

Pale blue – Specialty Service



example organisational structures, Bedford Hospital NHS Trust 2008-13

## Appendix 7n

# Educational Roles

You can also apply to become a member or fellow of the Academy of Medical Educators. The Academy recognises contribution to 5 domains in medical education or significant contribution in one domain. Membership to this organisation is done through a selection process and once accepted the postnominals 'Macad', 'Med' or 'FacadMED' can be used.

For more information please go to: <http://www.medicaeducators.org/index.cfm/membership/apply-for-membership/>

The screenshot shows a web browser window displaying the 'Apply for Membership' page of the Academy of Medical Educators (AoME). The page features the AoME logo and a navigation menu with items like Home, President's welcome, About AoME, Profession, Education, Membership, Events, News, AoME Resources, and Links. A search bar is located in the top right corner. The main content area is titled 'MEMBERSHIP' and includes a sidebar with links to Accredited Courses, Corporate Partnership, Apply for Membership (highlighted), Why Join the Academy?, Subscription rates, Membership Grades, Recognising Teaching Excellence Workshops, Members' networks and forums, and Members Area. The main text under 'Apply for Membership' provides instructions for applying for Associate Membership and Membership, each with a link to download the application form. Below this, the 'FELLOWSHIP' section explains the two paths for Fellowship: Form A (Achievement in all Five Domains) and Form B (Substantial Achievement in a Single Domain), both with links to download application forms. A recommendation is made to download a handbook for applicants or attend workshops. The page is dated 'Last updated 8 October 2013'. The footer contains a Twitter icon, copyright information for 2014, company and charity registration numbers, and the U6 logo.

## Appendix 7o

# The New Specialist Course

Suggested modules:

- Leadership styles and techniques
- Leadership development
- Buddying with a non-clinical colleague
- Appraisee training (could be delivered locally as part of a generic course)
- Understanding team working
- Promoting patient safety
- Avoiding bullying and undermining
- Job planning
- Business planning
- Educational opportunities
- Understanding CPD and revalidation
- Understanding links between human factors, CRM and team working.

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Mr I Currie FRCOG Chair of the Working Party, Vice President UK Affairs (Buckinghamshire)

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Mr N J Davies FRCOG Chair, Curriculum Committee (Wales)

Professor A S Garden FRCOG Academic representative (Lancaster)

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Mr E J Neale FRCOG Responsible Officer and former Medical Director (Bedford)

Mr T G Overton FRCOG Specialist Societies representative (Bristol)

Mr J J S Waugh MRCOG Editor-in-Chief TOG/Revalidation Committee member (Newcastle)