

Paper 20

<b>Recommendation</b>  <input type="checkbox"/> <b>DECISION</b> <input checked="" type="checkbox"/> <b>NOTE</b>	<div style="border: 1px solid black; height: 20px; width: 100%;"></div> <p>is asked to <b>note the Medical Engagement Paper and support the recommendations</b></p>
<b>Reporting to:</b>	<b>Trust Board</b>
<b>Date</b>	30 <sup>th</sup> November 2017
<b>Paper Title</b>	Medical Engagement at SaTH
<b>Brief Description</b>	<p>This paper examines the importance of medical engagement, presents to the Trust Board the current position within the Trust, and provides recommendations for further action.</p>
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<b>Recommended / escalated by</b>	
<b>Previously considered by</b>	
<b>Link to strategic objectives</b>	<p>PATIENT AND FAMILY - Deliver a transformed system of care (VMI) and partnership working that consistently delivers operational performance objectives</p> <p>SAFEST AND KINDEST - Develop innovative approaches which deliver the safest and highest quality care in the NHS causing zero harm</p> <p>SAFEST AND KINDEST - Deliver the kindest care in the NHS with an embedded patient partnership approach</p> <p>HEALTHIEST HALF MILLION ON THE PLANET – Build resilience and social capital so our communities live healthier and happier lives and become the healthiest 0.5 million on the planet through distributed models of health</p> <p>INNOVATIVE AND INSPIRATIONAL LEADERSHIP - Through innovative and inspirational leadership achieve financial surplus and a sustainable clinical services strategy focussing on population needs</p> <p>VALUES INTO PRACTICE - Value our workforce to achieve cultural change by putting our values into practice to make our organisation a great place to work with an appropriately skilled fully staffed workforce</p>
<b>Link to Board Assurance Framework</b>	<p>If we do not work with our partners to reduce the number of patients on the Delayed Transfer of Care (DTC) lists, and streamline our internal processes we will not improve our 'simple' discharges (RR 951)</p>

	<p>If there is a lack of system support for winter planning then this would have major impacts on the Trust's ability to deliver safe, effective and efficient care to patients (RR 1134)</p> <p>If we do not have the patients in the right place, by removing medical outliers, patient experience will be affected (RR 1185)</p> <p>If we do not develop real engagement with our staff and our community we will fail to support an improvement in health outcomes and deliver our service vision (RR 1186)</p> <p>If we are unable to implement our clinical service vision in a timely way then we will not deliver the best services to patients (RR 668)</p> <p>If we do not get good levels of staff engagement to get a culture of continuous improvement then staff morale &amp; patient outcomes may not improve (RR 423)</p> <p>Risk to sustainability of clinical services due to shortages of key clinical staff (RR 859)</p>
<p><b>Outline of public/patient involvement</b></p>	<p>Not directly affected.</p>
<p><b>Equality Impact Assessment</b></p>	<ul style="list-style-type: none"> <li><input checked="" type="radio"/> <b>Stage 1 only (no negative impacts identified)</b></li> <li><input type="radio"/> <b>Stage 2 recommended (negative impacts identified)</b> <ul style="list-style-type: none"> <li>* <b>EIA must be attached for Board Approval</b></li> <li><input type="radio"/> negative impacts have been mitigated</li> <li><input type="radio"/> negative impacts balanced against overall positive impacts</li> </ul> </li> </ul>
<p><b>Freedom of Information Act (2000) status</b></p>	<ul style="list-style-type: none"> <li><input checked="" type="radio"/> <b>This document is for full publication</b></li> <li><input type="radio"/> <b>This document includes FOIA exempt information</b></li> <li><input type="radio"/> <b>This whole document is exempt under the FOIA</b></li> </ul>

## Medical Engagement at SaTH

*“There is clear and growing evidence supporting the hypothesis that there is a direct relationship between medical engagement and clinical performance. The evidence of that association underpins our argument that medical engagement should not be an optional extra but rather an integral element of the culture of any health organisation and system.” (Clark & Nath, 2014)*

### Introduction

There is evidence from both the NHS and health systems around the world that the level of medical engagement is a critical factor in the overall performance of a health system or organisation. Recent publications from the King’s Fund and other interested groups have described the association between levels of medical engagement and organisational performance, including the safety of patient care.

This paper summarises the literature around medical engagement, describes work done to date at SaTH and makes recommendations for future work to improve medical engagement in our organisation.

### What is medical engagement?

Surprisingly, though various definitions have been used in the literature, there now is a universally accepted definition of medical engagement in the literature. According to Spurgeon *et al* (2008) medical engagement is defined as:

*“The active and positive contribution of doctors within their normal working roles to maintaining and enhancing the performance of the organisation which itself recognises this commitment in supporting and encouraging high quality care.”*

Clark (2012), summarising the literature on medical engagement, observes that:

- Medical engagement is a priority for Chief Executives wishing to improve performance,
- engagement is a two-way process involving organisations working to engage employees and the latter having a degree of choice as to their response,
- engagement is measurable,
- level of engagement correlate with performance and innovation,
- engagement levels in the UK are relatively low, and this presents a major challenge.

According to Erlandson (2003), *“When administrators talk about physician engagement, they are generally speaking in code for what they would like physicians to do but can't get them to do it. When physicians speak about engagement, they are speaking in code for what they already give that is not appreciated, valued or supported by the administration. Both sides stake out viewpoints, positions and interactions that make real progress, change or collaboration impossible.”*

## Why is medical engagement important?

There is long-standing evidence from across sectors that the level of employee engagement in an organisation directly influences the performance of that organisation. Within healthcare in general, and the NHS in particular, there is emerging evidence for, and interest in, the correlation between staff engagement and organisational performance.

Michael West has examined the results of the NHS staff survey for individual organisations and compared the scores to the organisations' performance. This work has highlighted that the level of staff engagement is linked to a variety of individual and organisational outcome measures – including staff absenteeism and turnover, patient satisfaction and mortality – and safety measures, including infection rates (West and Dawson, 2012).

Although West's work applied to all staff groups, there are particular reasons why medical engagement is important. Doctors make diagnostic and treatment decisions that affect patients' lives and have significant resource requirements. And, given the pace of innovation in Medicine, doctors are used to change, often have well-developed networks internally and in the wider health service, hence making them ideally placed to be key influencers across a health system.

## What can healthcare organisations do to improve levels of medical engagement?

According to Clark (2012) *“The key to creating a culture of medical engagement is encouraging and empowering doctors to take the lead on a wide range of service improvement initiatives and to be much more involved in setting the overall direction for services and across systems.”*

An IHI paper on engaging clinicians with quality improvement (Rheinertsen & Gosfield, 2007) describes the following principles as key to improving levels of medical engagement and therefore improving organisational performance.

1. Discovering common purpose, e.g. reducing hassles and wasted time.
2. Reframing values and beliefs, e.g. making physicians partners, not customers.
3. Segmenting the engagement plan, e.g. identifying and activating champions.
4. Using 'engaging' improvement methods, e.g. making it easy to do what is right
5. Showing courage, e.g. providing back-up all the way to the Board.
6. Adopting an engaging style, e.g. involving physicians very visibly and valuing their time.

Clark (2012) also quotes Gosfield & Rheinertsen's unpublished work on medical engagement at the McLeod Clinic in Canada where significant improvements were achieved by:

1. **Asking doctors to lead** – The mantra is 'physician-led, data-driven, evidence-based', with every major improvement initiative led by a physician and reporting to the board upon completion.
2. **Asking doctors what they want to work on** – McLeod initiates about 12 major clinical effectiveness improvement efforts each year; physicians recommend the list of priorities to the board. 'They are working on things that are meaningful to them, AND to the institution'
3. **Making it easy for doctors to lead and to participate** – McLeod provides good support staff to optimise the time that doctors devote to leading any improvement initiative. The key is that McLeod does not waste doctors' time.

4. **Recognition for doctors who lead** – Physicians who have led or been involved in improvement initiatives are recognised in many ways, including having the opportunity to present their work to the Board for approval and adoption.
5. **Support for medical staff leaders, with courage** – Inevitably, many improvements meet with resistance from physician colleagues or other clinical professionals. McLeod provides strong support to doctors leading improvement initiatives when they are confronted by difficult colleagues or other obstacles.
6. **Opportunities to learn and grow** – McLeod provides support to those physicians keen to learn more from the research and literature on quality, safety and human factors.

A recent report from the King's Fund entitled "Medical Leadership: a journey not an event" (Clark & Nath, 2014) examined four Trusts in the UK noted for their high levels of medical engagement. The Trusts included in the report were University College London Hospital NHS Foundation Trust, Northumbria NHS Healthcare Foundation Trust, Salford Royal NHS Foundation Trust and Southern Health NHS Foundation Trust. The authors commented that culture change takes time and that, in all of the four organisations, it was notable that there was a stable and long-standing leadership team.

Other findings from this study were:

1. **Culture**

There was a health culture of collaboration and mutual respect between doctors and managers in the four Trusts.

2. **Governance**

The formal management and governance structures differed significantly between the organisation. However, common to all was that doctors, supported by managers, led directorates and divisions in all four organisations. The authors estimate that between 15% and 40% of senior doctors in these organisation held formal leadership positions. (In comparison, SaTH has 11% of doctors in formal leadership positions). All the organisations studies had fora where clinicians could discuss clinical services and their improvements without waiting for a crisis to erupt.

3. **Selection of consultants and medical leaders**

All the organisations put significant effort into the selection of new consultants. The stance in these organisations is that being a clinical expert is not sufficient; rather they seek out doctors whose values chime with those of the Trust and who are committed to leadership and improving quality. In Northumbria, for instance, the selection of a new consultant takes place over 48 hours of a selection centre which includes a psychometric testing, a values-based interview, observations in a clinical setting and a formal ward round.

Another key feature is the effort these organisations put in to recruiting doctors to clinical leadership positions. There was evidence of significant time spent assessing leadership competence and selecting candidates using assessment centres. Time was also spent clarifying the roles and expectations of candidates.

#### **4. A consultant's journey and leadership development**

The four organisations had well-developed induction programmes and spent significant effort on developing new consultants in their first few years of employment, using coaching and leadership development programmes. These foundation programmes ensured that all consultants and senior doctors had a baseline level of leadership competence with bespoke leadership development for those doctors selected for formal leadership positions.

#### **5. Education and training**

The leadership and personal development opportunities described above were seen as part of a wider organisational commitment to education and training. Other features were board level directors of education, and opportunities for doctors in training to engage in both leadership activities and quality improvement initiatives.

#### **6. Learning from others**

The four Trusts had actively learned from other organisations around the world including Inter Mountain, Institute for Healthcare Improvement, Geisinger, New York Presbyterian, Jonkoping, GE, Virgin Atlantic and the Virginia Mason Institute. Rather than a one-off, 'sheep-dip' approach, the Trusts had well-developed and long-lasting relationships with these other organisations, with staff frequently travelling to gain more knowledge and experience. As a clear mark of their commitment, these organisations had developed explicit compacts with their medical staff.

This King's Fund report includes two checklists for Trusts wishing to improve levels of medical engagement (see Appendix 1).

### **How well are we doing at SaTH?**

As members of the Senior Medical Leadership team, when determining our assessment of medical engagement in SaTH, we have reviewed the definitions of medical engagement. In doing so, we have considered carefully evidence from engagement work already performed in our Trust and the concerns that have been raised in focus groups of doctors and managers.

The feedback received from these sessions has revealed that many doctors report that they feel like technicians, as they do not feel that they are engaged with or talked to about the changes that are made to their everyday work, such as theatre lists and clinics. They describe concerns about late changes to their allocated work duties on wards, and expectations that they will see patients for Theatre, whom they have not assessed before, and are not advised of these changes with an adequate timeframe.

Doctors state that they do not feel listened to, that they feel that the organisation makes decisions without their involvement and they are then told what to do. A frequently raised concern, that illustrates this, is that the requirement that they provide at least six weeks' notice, in order to take leave or to re-schedule commitments, is not reciprocated. Important meetings sometimes are called with a few days', and even only a few hours' notice, with an expectation that the clinicians will attend. Doctors report that the meetings may then go ahead, without them being present if they are unable to attend, with decisions being made without clinician input.

Doctors also acknowledge that there are opportunities, with sufficient notice given, for them to be involved in developments within the Trust, and to contribute to decision-making. While there are examples of excellent engagement (v.i.), a frequently cited reason for lack of engagement is that of high clinical workload and the need to prioritise service demands.

We also know that, when supported, doctors are highly motivated proponents for change and contribute considerably to service developments in the Trust. We have seen excellent improvements in patient care and in clinical processes when doctors contribute to the Transforming Care work in the Trust. Examples include RPIWs in Respiratory Medicine on both sites, PRH Emergency Department and Out-Patient Clinics.

There also are other noteworthy examples of doctors leading change through engagement, that are developed within specialities, and without the need for TCI / KPO team to be involved, such as improvement in Chronic Renal Disease identification and management, and links with Community care in Diabetes, Cardiac Failure and in Chronic Pulmonary Disease.

We consider that more work is required to understand the factors behind doctors not feeling fully engaged, and that this also could be used to increase the levels of medical engagement. This paper for the Board provides an excellent opportunity to set out the plans for this.

### The Medical Engagement Scale

Improvement in healthcare requires engagement of doctors who are willing to be involved in the improvement work and innovation of services. The Medical Engagement Scale (MES) is a validated measurement method used for informing organisations of the current state of medical engagement.

The scale below is a simple short survey which provides an overall index of medical engagement together with an engagement score on three reliable meta-scales, each of these three meta-scales provides two reliable sub-scales. Attached to this survey is our assessment, based on evidence, of the level of engagement within SaTH.

### Scales and Definitions

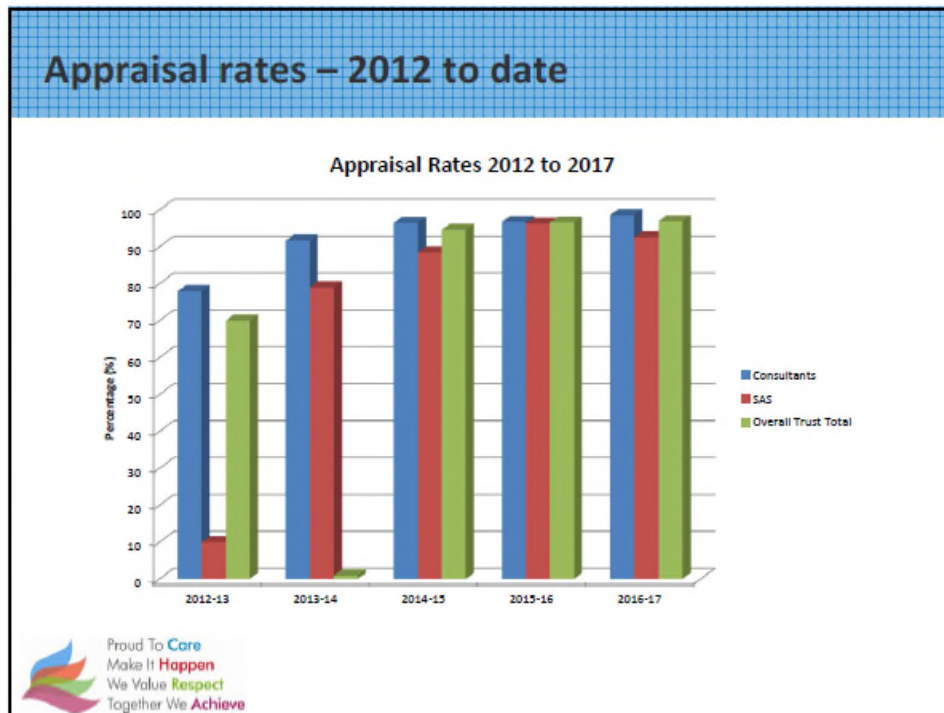
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MES Scale	Scale Definition <i>[The scale is concerned with the extent to which.....]</i>	
Index: Medical Engagement	...doctors adopt a broad organisational perspective with respect to their clinical responsibilities and accountability	✓
Meta Scale 1: Working in an Open Culture	...doctors have opportunities to authentically discuss issues and problems at work with all staff groups in an open and honest way	✗
Meta Scale 2: Having Purpose and Direction	...Medical Staff share a sense of common purpose and agreed direction with others at work particularly with respect to planning, designing and delivering services	✓
Meta Scale 3: Feeling Valued and Empowered	...doctors feel that their contribution is properly appreciated and valued by the organisation and not taken for granted	✗
Sub Scale 1: [O] Climate for Positive Learning	...the working climate for doctors is supportive and in which problems are solved by sharing ideas and joint learning	✗
Sub Scale 2: [I] Good Interpersonal Relationships	...all staff are friendly towards doctors and are sympathetic to their workload and work priorities.	✗
Sub Scale 3: [O] Appraisal and Rewards Effectively Aligned	...doctors consider that their work is aligned to the wider organisational goals and mission	✗
Sub Scale 4: [I] Participation in Decision-Making and Change	...doctors consider that they are able to make a positive impact through decision-making about future developments	✗
Sub Scale 5: [O] Development Orientation	...doctors feel that they are encouraged to develop their skills and progress their career	✗
Sub Scale 6: [I] Work Satisfaction	...doctors feel satisfied with their working conditions and feel a real sense of attachment and reward from belonging to the organisation	✗

## The Staff Survey

When considered in the context of SaTH's medical staff, the Staff Survey shows a mixed set of responses.

Doctors at SaTH have shown excellent engagement in the appraisal and revalidation process, as shown by the measure that they now have an excellent appraisal rate of 97% for 2016-2017, as compared with the average of 87% for other acute Trusts.



However, in contrast, the staff survey demonstrates that 84% of Medical and Dental staff at SaTH report that they are working extra hours, as compared with 71% for other acute Trusts.

As a measure of personal motivation and clinical job satisfaction, 96% of doctors at SaTH agree that their role makes a difference to patients, as compared with 90% for other acute Trusts.

However, only 29% report good communication between senior management and staff, as compared with 33% for other acute Trusts.

The variation of these results suggests that, while doctors show a strong commitment to the Trust and a willingness to engage, there also is evidence of the impact on these of workforce shortfalls, hence the need for better communication as a means of supporting engagement.



## **Feedback from DEEP and meetings of the Trust's Medical Leaders**

Some qualitative assessment of the level of medical engagement within SaTH is possible from **the** informal feedback provided by doctors attending the Medical Directors DEEP (Doctors' Essential Education Programme) and from meetings of the Medical Leaders (Clinical Directors, Care Group Medical Directors, Deputy Medical Directors, Medical Director and Medical Performance Team).

The format for DEEP has been changed, as we felt it was important to give Senior Medical Staff greater opportunity for discussion. When considered with the feedback from focus groups, this has provided further insight into the current frustrations with which doctors are living and working.

Doctor shortages are certainly taking their toll on the workforce, with key points being described as: challenges in caring for their patients in the way that they want to; excessive on-call rotas; having to act down due to shortages in the rotas of more junior doctors. Some doctors report a general feeling of burnout and lowering of resilience, with this affecting all areas of their working life, citing the effect on them of the enormous pressure on the NHS as a whole, and here at SaTH.

In the case of medical leaders, the most frequently noted areas for improvement include: their personal development as leaders, greater recognition of the work required by these leadership roles, and the Trust's recognition of the additional responsibilities that they take on. As a specific example, doctors identify recent changes in pensions and tax regulations that can result in them actually losing money, in tax, as a result of the responsibility payment that they receive as remuneration for this work. The Trust already is responding to these concerns, by encouraging doctors to enrol in the Leadership Academy and Lean for Leaders programmes, by providing increasing support for clinical leaders in the work that they do, and by exploring other forms of recognition, rather than remuneration, for the work that they do.

## **Opportunities for improvement**

Many suggestions for improvements and innovative ways of working have been proposed, such as an increase in the availability of phlebotomists, in particular working on the weekend, in order to assist in the work of junior doctors. Further suggested developments include an increase in the number of Advanced Care Practitioners, and the development of other clinical roles, including even that of medical scribes.

A clearly expressed expectation, that underpins engagement linked to a continuing commitment to improvement, is the need for doctors to experience the results of their ideas being applied and making a difference. One senior doctor said "I've had this idea for two years, and can't understand why I've had to wait so long to see it happen". Doctors cite "bureaucratic processes" and the need for exhaustive business cases, that may then be turned down, as frequent disincentives to their engagement.

One suggestion from our doctors, that may assist in addressing these concerns, is that of greater direct engagement by Board members in their clinical and governance meetings. It is felt that this would increase the awareness of Board members of the problems encountered and the willingness to develop and implement solutions; the expectation is that this would also assist doctors in overcoming obstacles to change and improvement.

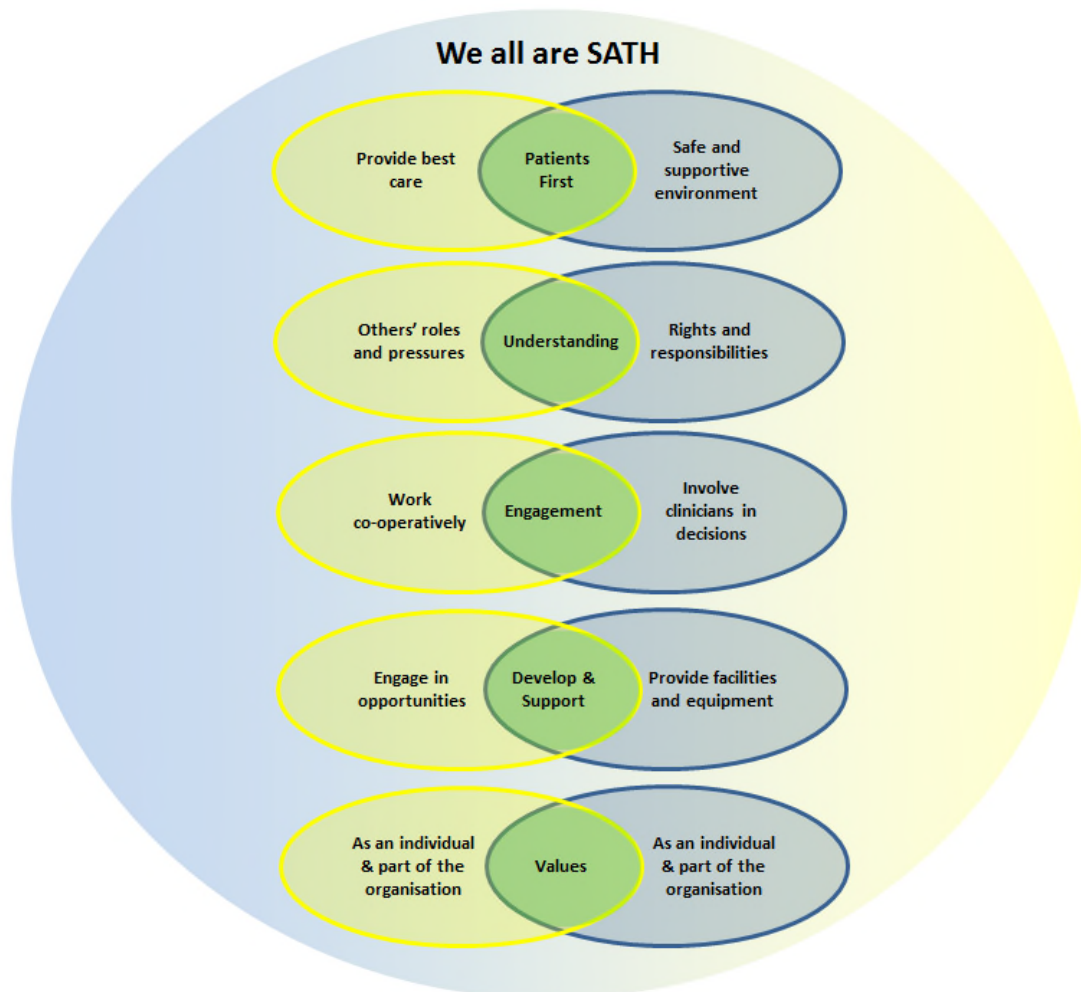
## What have we done, to date, at SaTH?

1. **Job planning** – the Trust has purchased Allocate job planning software to support more detailed job planning and to reduce the burden on Clinical Directors. While improvements have been made over the past three years in the engagement of doctors in job planning, a frustrating barrier has been the mechanism (ie. Word or Excel) that we have used to document and analyse this information. With the support of the new system we shall be able to understand the supply and demand of specialities in far greater detail – which will be of benefit for doctors and the Trust alike – and this will be provided, for the doctors, through a more straight-forward method of documentation
2. **Values-Based and Attitudes Interviews (VBA)** – these provide an important part of ensuring that we create the correct culture and appoint doctors with values and behaviours aligned to those of SaTH. Over the last 2 years all new consultant appointments have involved a VBA interview, in addition to the formal Appointments Advisory Committee. Informal feedback is that recruiting Clinical Directors and other consultants value the additional feedback given by the VBA process.
3. **The Virginia Mason / Transforming Care Programme** – this has provided a structured methodology for doctors to become involved in the transformational work at SaTH. There is much enthusiasm for the work carried out thus far, albeit that the added commitment does mean additional work at often busy times. Doctors involved in this work have identified that a focussed programme of improvement would be immensely beneficial for our patients, our staff and for the Trust..
4. **Working in Partnership Agreement (Compact work)** – while there is concern that a pause on this work has reduced momentum, this process has been well received by the doctors involved, in part because they have felt listened to and engaged within the workshops and master classes. The next steps of this work programme will be to gain agreement – of doctors and the organisation – of the explicit nature of “the gives and the gets”.
5. **Educational support and pastoral care to increase resilience** – there is greater recognition, particularly in these challenging times for the NHS, of the need to improve support for colleagues. At SaTH this has included education, through the Leadership Academy, in the key principles of enhancing resilience, and support – both formal and more collegiate – for colleagues experiencing difficulties.
6. **Clarity of expectations** – much progress has been made to address historic problems with behaviour, practice and performance. There is now a greater understanding of the importance of standards applicable to all, and the expectation that these will be delivered.
7. **Leadership development and training** – in addition to the education opportunities provided at SaTH, over the last five years the Trust has encouraged senior doctors to benefit from multi-professional leadership training at Warwick Business School, from the West Midlands Leadership Consortium, the Generation Q Fellowship provided by the Health Foundation, and educational and quality improvement degrees at selected Universities.

## Work in SaTH towards developing a Compact

A considerable amount of work has been done at SaTH towards the development of a "Doctors' Compact", and a Leadership Compact, including workshops and master-classes with Mary Jane Kornacki and Jack Silversin from Amicus Consulting. Due to other priorities within the Trust, there has been a pause on this work, with the inevitable effect of delaying formal progress to the agreement of a Compact for Doctors.

However, the work done already has provided valuable information on the current level of medical engagement, on the concerns noted above, and on the measures needed to improve engagement.



When we look at the developing 'Working in Partnership Agreement' from a doctor's perspective there is a feeling that the "clinician gives" are not being reciprocated with the "organisational gives". In order to move this work forward, and clearly demonstrate to the doctors that we are working in a more collaborative way, we need to clearly map out what the Trust needs to do to address this.

*"We coach athletes to be their best but we don't coach doctors – everyone needs to be coached to be their very best and we have people's lives in our hands."*

Mr John Abercrombie, Clinical Lead for General Surgery, GIRFT – Implementing Carter, June 2017

## **Recommended actions to improve medical engagement at SaTH**

1. Consider medical engagement as a core aspect of “how we work at SaTH”, hence it being an integral part of a doctor’s working experience.
2. Ensure that there is greater medical involvement in significant decisions within SaTH, so that another part of “how we work at SaTH” involves engagement, inclusiveness and openness.
3. Further develop consultant recruitment processes to include psychometric testing, the involvement of patients, and (simulated) clinical scenarios.
4. Develop new consultant induction and orientation processes, in order to ensure that new consultants meet colleagues in leadership positions both within and outside their immediate clinical area, in order better to understand the workings of the Trust.
5. Support the further development of new clinical roles, in order to support doctors in their clinical work, such as IV technicians, medical scribes, etc.
6. Continue to develop senior doctor job planning in a transparent way to ensure there is greater clarity of expectations within, and amongst different specialities
7. Focus more on clinical leadership: develop further training and education for Clinical Directors and Clinical Leads, in order to develop a pipeline of future leaders.
8. Review the reward package for medical leadership positions at SaTH – recent changes in tax and pension legislation have meant that some of our clinical leaders have incurred significant tax penalties. This has meant that it is currently hard to recruit and retain Clinical Directors.
9. Leverage the work of the Transforming Care Institute to engage doctors more in the many areas of improvement at SaTH.
10. Complete and embed the “doctors’ compact” and the “leadership compact”
11. Commission work to measure levels of engagement at SaTH, potentially using the Medical Engagement Scale (MES).
12. Use the Aston Team Coaching approach to improve engagement in particularly challenging areas.

## **Appendix1: Medical Engagement Checklists**

The following checklists might help organisations, and individuals with medical leadership roles, assess the extent to which medical engagement is being actively sought and developed.

### **For organisations**

- Is there an organisational culture strategy that includes medical engagement as an explicit component? If so, how often is this strategy reviewed?
- To what extent are the board and the executive team (including non-executive directors) fully committed to medical engagement? What activities do you use to evidence that this engagement translates into the way the organisation functions?
- How is medical engagement promoted and brought to life by the chief executive, chair, medical director(s) and director of nursing? To what extent do these individuals communicate with the medical workforce?
- Do the governance arrangements and organisational structure reflect a culture that seeks high levels of medical engagement? How many doctors within the organisation hold formal quality improvement/clinical governance roles?
- What is your organisation's goal for engaging its medical workforce? How does your formal structure reflect this?
- What talent management/succession process do you have in place as an organisation and how does this meet the need to develop your medical leadership pipeline?
- Are junior doctors offered leadership development opportunities, particularly around quality, safety and service improvement? How are doctors empowered to innovate and lead quality improvement initiatives?

### **For medical leaders**

- What activities are in place to attract, recruit, induct and develop medical leaders/consultants? How often are these reviewed?
- To what extent do these processes connect and reflect aims, values and goals at an organisational and divisional level?
- To what extent are doctors involved in strategic planning and prioritising the organisation's decisions? How are doctors involved in the planning and accountability of the services they contribute to?
- How are you developing your organisational capacity and capability for developing and supporting leadership and quality improvement methods?
- How much engagement can you evidence and demonstrate of job-planning, appraisal and revalidation? How do you assure yourself that these processes are fit for purpose?
- What proportion of time are doctors in formal leadership roles accorded specifically for this role and how is their contribution to managing and leading their services and quality improvement projects recorded, measured and valued?
- What processes are in place to ensure that consultants, other senior doctors (eg, staff and associate specialty doctors) and medical leadership appointments are made through a competitive and competency-based process that reflects the organisation's values?

(from Clark & Nath, 2014)

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