Procedures, Perils & Prospects of a clinical director

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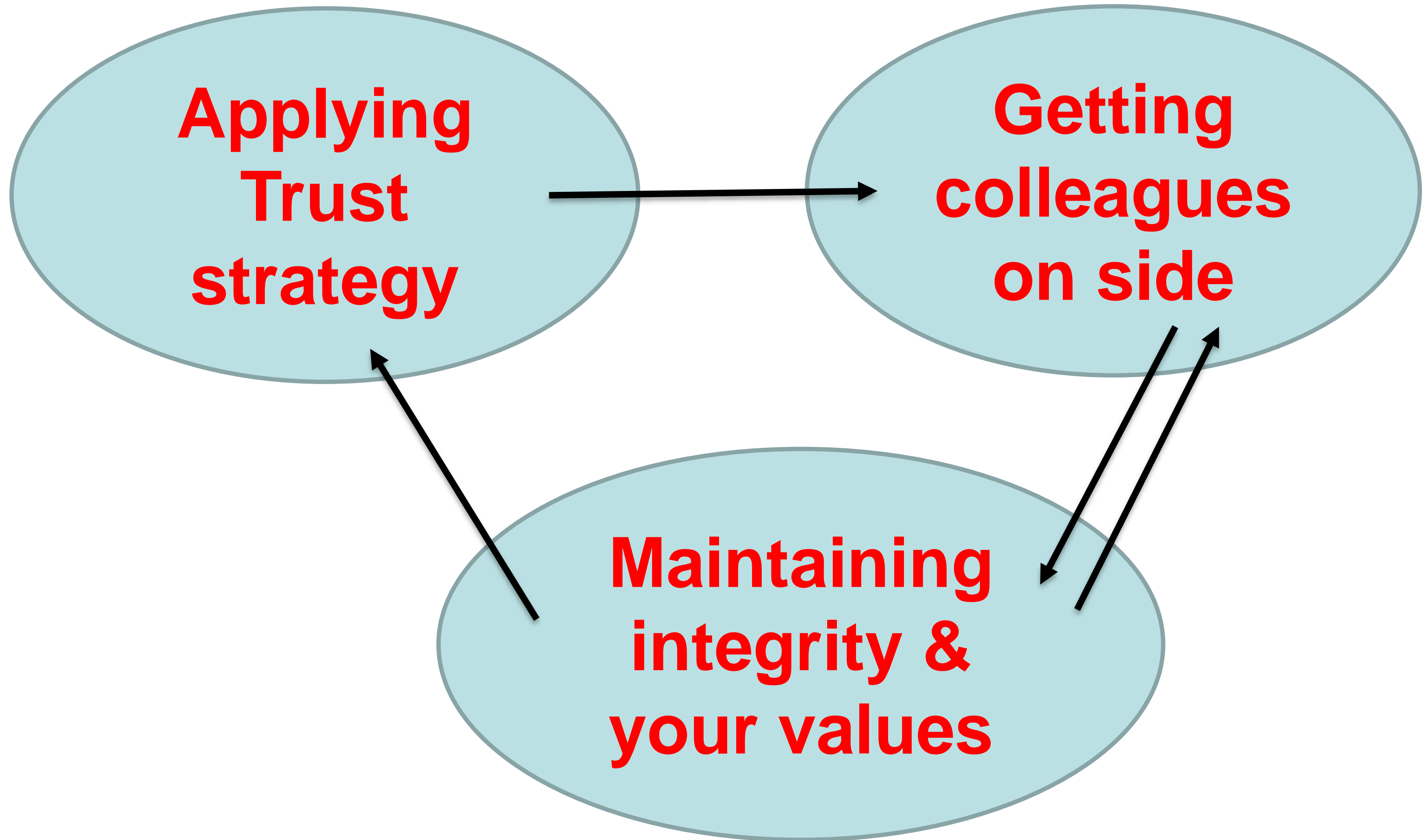
Objectives of talk

1. aptitude screening options
2. job planning procedure
3. applying smart ways of working
4 conduct, performance & whistleblowing issues
5. maintaining integrity and confidence
6. avoiding moral injury & burnout

mind map of a CD

Erin Marie Olszewski

Objective(s) of an effective CD



aptitude screening

1. Screening tests
- - Eysenck Personality Inventory
- - Myers Briggs personality traits
- - Northumbria aptitude screen

2. Use of anonymous 360 feedback
- - avoid selection bias
- - get line manager or senior nurse to select
- - get admin to assist patients to fill in after appt.

3. Interpreting results
- - your place in narcissistic spectrum
- - psychopathic spectrum
- - defensiveness spectrum

job planning

Job planning - ‘bread & butter’ job of CD

- - balancing Trust needs and wishes of consultant
- - clarity & transparency on needs essential
- - common issues waiting lists, day on-call system
- - private practice work (what can help Trust)
- - ideally, part of Team Job Plan (sub-specialisms)
- - your role as an ‘honest broker’ (Matthew 10.16)

Coaching style of consultation

- There are established training packages (inc. NHSI)
- - this could be a pre Job Planning meeting
- - leave your ego at the door; be curious
- - ignore your values, expectations, assumptions
- - at times use 'Socratic questioning' (why & how)

- Leads to
- - questioning pre established / self imposed restrictions
- - an action plan of what to look into (homework)
- - ideally with time scale, and a set review date
- - building respect & trust as a leader (future MD job?)

applying ‘smart working’

2 examples

- Triage portals & pathways @ adult A&E*
- - based on Camp Bastion experience
- - critical care (CC), frail elderly, mental health, GP overflow
- - triage (nurse led) can commence with paramedics
- - Specialist Nurse led +/- junior Drs, protocol ,templates

- Non-Technical skills in Ward Rounds / MDT’s (WANTSS)
- - training developed by RCSEd (Flin & Youngson)
- - based on observation of ward round practice, outcomes
- - Situational awareness, decisions under pressure,
- - communication, teamwork, leadership

SBARD format for flow thro assessment, documentation, handovers & letters

- SBARD stands for
- S = Situation (salient bio, presenting issue)
- B = Background (PMH, Drugs list, Collateral Hx, Social Hx)
- A = Assessment (Examination, Investigations)
- R = Anticipated risks, severity, potential mitigation
- D = Decision (Working Dx, Communication, Rx, F/U)

- Applied in Psychiatry (Psych Liaison, Crisis Teams)
- - using a linked template (avoids missing key information)
- - also used in Obs & Gyne, Paeds, Care of Elderly
- - commenced by paramedics & nurses @ initial assmt.
- - edited as more information available (Bayesian synthesis)

difficult conversations

Case study (for breakout session)

- 54 year old consultant of asian origin
- - normally a ‘safe pair of hands’
- - last 4-6 months more antagonistic, easily frustrated
- - s;peech irregular, slurred
- - also, writing less clear (rewriting drug cards)
- - found sleeping in the office in the afternoons

- Questions
- - what could be going on?
- - how would you approach this situation?
- - how would you approach him?

Conduct & Performance

- Conduct concerns usually expressed by other staff (MDT)
- - could be anonymous, with no prior direct communication
- - episode(s) suggesting frustration, disinhibition, bigotry
- - could include contacts with patients & carers
- - social media inputs seen by others (ex. Covid vaccines)

- Performance issues
- - more likely to be based on fact (but, not necessarily)
- - often emerging trends rather than individual episodes
- - compared to colleague activity & expected outcomes
- - prescribing and other technical issues

- On occasion, combined conduct & performance
- - ex. alcohol & substance abuse, burnout, depression

Managing the discussion

- Clear summary of concern(s) helpful
- - initial ‘open dialogue’ discussion
- - person’s immediate response not taken as ‘evidence’
- - thereafter, could involve a combined HR meeting
- - decision on action plan (incl. suspension, ‘light duties’)

- Aware of other parties getting involved
- - Medical defence, BMA, Trust LNC Lead, family members
- - ensure a ‘friend’ can accompany person @ HR meeting
- - ideally recorded or minutes taken by secretary
- - ‘leave your ego at the door’ & remain professional

- Action might be an outcome audit, 360, m.h. referral*
- - also, suspension, documented warning, GMC referral*

Whistleblowing

- Can be overt (i.e. an IR1 entry)
- - or contact with 'Trust whistleblowing champion' (WBC)
- - possible person has already contacted the CQC
- - approach needs to be different (potentially a victim)
- - also potentially vexatious or a secondary gain motive
- - could lead to an audit, SUI investigation

- Need to clarify and document concerns
- - need to elicit details, data, contemporaneous records
- - reassure person action will be taken
- - ensure early follow up (mitigate anxiety, guilt)
- - let your line manager know (department MD)
- - sp. if impending CQC visit (not enough time to sort out)

crisis? what crisis?
THE BAY HOTEL
WY 805
Utting '12

leading colleagues over a crisis

- Ex. a data hack, lockdown, MRSA / Clos. outbreak
- - meet colleagues ASAP (to clarify what has occurred)
- - agree temporary work patterns, risk mitigation
- - review concordance on agreed plan
- - meet regularly (weekly) to get back to usual practice

- However, ‘never let a crisis go to waste’ (Machiavelli)
- - good opportunity to introduce new ways of working
- - hopefully you have worked up ideas before crisis
- - ideally, discussed them with colleagues pre-crisis
- - get group buy in (rather than seen as enforced)

acute workforce crisis

- Omicron wave in Paediatric A&E, Junior Dr strike
- - need immediate contact with leadership team, HR
- - also, other relevant parties (estates, communications)
- - inform colleagues thereafter (avoid rumours)
- - agree temporary redeployment (job, site), risk mitigation

- Acute staff shortages
- - first 2 weeks, colleagues are expected to cross cover
- - thereafter, renumeration needs to be negotiated
- - either individually (extra PA's, BMA rates)
- - or, a C grade award for each consultant in department*

avoiding burnout & moral injury

maintaining your integrity & values

- Main problem is following ‘the party line’
- - potential professional jealousy (+ isolation)
- - ‘caught between a ‘rock and a hard place’
- - excessive paper admin / e mail workload
- - having to rigidly follow Trust orders / policies

- Main cause of Moral Injury is
- - breaking with ‘primum non nochare’
- - as applied to patients& colleagues
- - when unable to confront bullying
- - being unable to confront line management

How can above be mitigated?

- Personal Opinion
- - having a senior ‘protector’ essential*
- - a robust unshakable faith, stoicism helpful
- - alongside a pre-negotiated end date (< 2 years)
- - maintaining hobbies, family life, sense of humour

- Avoid ‘wall to wall’ meetings*
- - a walk in grounds between (or 3 min. HITT)*
- - ‘managing by walking around’ (Peters)
- - dropping in on colleagues on a Friday afternoon
- - keep boundaries (management socials, alcohol)

concluding remarks

In conclusion

- A CD posting can be a mixed blessing
- - it is what you make of it (and learn from it)
- - can be a step up to a divisional medical director
- - can undermine trust of colleagues (‘moved to dark side’)
- - personal cost need to be calculated beforehand
- - having a mentor (and confiding with one’s spouse)

- Try and get some on the job training
- - Coaching, Non Tech Skills, Motivational interviewing
- - watch trends in health delivery (incl. AI, Hubs, Integration)
- - learn to cope with ‘projective identification’
- - learn to spot sociopathic or narcissistic traits
- - in others and in your mental makeup (pre-screening)*

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