

Peer Coaching in Remediation

Conclusions of an exploratory workshop run by the Academy of Medical Royal Colleges and the Faculty of Medical Leadership and Management

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Foreword

Imagine that you are a Responsible Officer and that a career-grade doctor for whom you are responsible is in difficulty. Complaints from patients and concerns raised by colleagues suggest that aspects of the doctor's specialist knowledge or skills have "gone off the boil". Your investigations suggest that, whilst the concerns are not serious enough to warrant a referral to the regulator, there is a need for this doctor to refresh his / her specialist skills under the supervision of a colleague in the same specialty for a period before resuming full independent practice. Let us assume that the doctor has insight and is keen to address the deficiencies in their knowledge and skills, but your organisation does not have peers with the necessary skills to undertake the supervisory role.

Unfortunately, there is no "off the peg" solution for this situation because it accounts for a small proportion of cases where remediation of a doctor's practice is required. There are considerable practical and contractual obstacles in arranging for a suitable peer to work alongside the doctor, whether in your organisation or in another organisation. It is likely to be expensive and success cannot be guaranteed.

However, the alternatives are not attractive either. If you opt simply to restrict the doctor's practice, their skills will be under-utilised, with an adverse impact on the clinical service. If you allow the doctor to carry on working in the hope that things will improve, the safety of patients may be put at risk and the doctor may ultimately end up with the regulator.

Who should undertake the "peer coaching" role in this situation? How should they be trained for this role and by whom? Who should indemnify the supervision? Who pays?

The purpose of this workshop was to look for a better answer than "somebody else" to these (and other) very difficult questions that the scenario above poses.

Mr Richard Smith
AoMRC Remediation Implementation Working Group Chair

Introduction

The implementation of revalidation has ignited a debate around the remediation of doctors who are not performing as expected. Peer coaching has been proposed as one potentially useful mechanism for supporting doctors through remediation, but feedback suggests that knowledge, skills and experience in its use, vary widely across the profession. In fact, there has not even been general agreement on the definition of Peer Coaching.

The Faculty of Medical Leadership and Management, together with the Academy of Medical Royal Colleges, has run a workshop aimed at sharing experience on peer coaching in remediation and taking stock of what work needs to be done to help colleges support their members in this way.

The workshop enjoyed senior representation from patients, the Academy, the Colleges and Faculties, NCAS, the defence unions and the regulators. The aim was to identify areas of agreement and key questions that remain to be answered. This report represents the conclusions reached and identifies further work that is required. An outline of the workshop sessions and discussions is provided at Appendix A and B. Other than from plenary speakers, none of the comments made during the workshop have been attributed to individuals.

What do we mean by peer coaching?

“Peer Coaching” has been used in a number of industries. The following definition has been used in education:

“A confidential process through which two or more professional colleagues work together to reflect on current practices, expand, refine and build skills, share ideas, teach one another, conduct classroom research or solve problems in the work place.”¹

In the context of the remediation of doctors, activities labelled as peer coaching have sometimes included more summative components. For example, one participant defined peer coaching as an activity encompassing the following:

- Supervised practice to acquire or re-acquire specific skills
- Most commonly (through not exclusively) focuses on procedural skills
- A relationship of mutual respect and trust
- The coach maintains an appropriate degree of detachment and objectivity
- Reports on progress against agreed objectives

Other participants reported using peer coaching in the clinical setting, but without any summative component. There was considerable debate about whether summative activities could be included under the title of peer coaching.

¹ How to Plan and Implement a Peer Coaching Program, Pam Robbins.

<http://www.ascd.org/publications/books/61191149/chapters/A-Definition-of-Peer-Coaching.aspx>

The difference between these definitions can be considered across three main axes:

- Degree of independence of the coach from the doctor's employer/regulator (reporting requirements)
- Degree of observation of the doctor's clinical practice
- Formative versus summative nature of the relationship

Areas for further research

Answers to the remaining questions in this report are to some extent dependent on where the definition lies along these three axes. If a national approach is to be taken to peer coaching in remediation, then it will be important to decide whether peer coaching is an appropriate name for the activity, clarify the definition or to clearly define different activities along these axes and what they should be called.

When would peer coaching be appropriate?

There was consensus that peer coaching could be useful in cases where there is a clearly defined deficit in knowledge, skills, or behaviour, that was judged to be remediable and where the practitioner recognised the need for such remediation. So far, peer coaching has most often followed an NCAS assessment and has become more formalised since the foundation of NCAA/NCAS, but there was a suggestion that it needs to be more closely linked with appraisal.

There was a clear view that patient safety should be the paramount consideration:

"If this doctor is unsafe, then I don't want them treating patients and I don't want you spending three months talking about it."

It was also agreed that the expense of peer coaching meant that it would be appropriate in a relatively small number of cases and should be embarked upon only after a robust assessment. It was noted that prevention was likely to be cheaper and more successful than remediation and that more attention should be focused on this area.

Areas for further research

If a national, regional or specialty based approach to peer coaching is considered, then it will be necessary to undertake a robust assessment of demand and to analyse trends following the implementation of revalidation.

To ensure that doctors who could benefit from peer coaching can receive it and that resources are not wasted on cases that are likely to be unsuccessful, employer organisations would benefit from guidance on when to offer peer coaching.

Who should provide peer coaching?

The group discussed what sort of clinicians should provide peer coaching and how they should be organised as a group.

It has been assumed that, by definition, peer coaching should be offered by clinicians in the same specialty and at a similar level of seniority as the recipient. However, the group allowed for some flexibility around these requirements if the recipient was in agreement.

The group felt that clinicians with experience of offering clinical and educational supervision to trainees would provide a suitable pool of candidates from which to select the first wave of peer coaches. Much of their experience and training would be relevant.

It was felt that a network of peer coaches should be organised by a national body. There was no clear agreement on which body this should be:

- Individual Colleges and Faculties
- One lead College or Faculty
- The AoMRC
- Defence Unions
- Other national organisations

There was consensus that local organisations would not have sufficient demand for peer coaches to support their own networks.

It was pointed out that many elements of peer coaching may be offered by other types of coaches, including non-clinicians. This supports the need for a robust assessment of the doctor before embarking on peer coaching.

Areas for further research

If an organised approach to providing and supporting peer coaching is to be taken, then further consultation with potential host organisations would be needed to assess their appetite. These organisations may include Colleges and Faculties, AoMRC, defence unions and other national organisations.

How should peer coaches be trained?

The group agreed that the success of peer coaching depended on the quality of the training provided. They also agreed that the activity carries significant risk for the peer coach and that training was an important mitigation factor.

The training required will depend on the precise definition of peer coaching employed, however, key knowledge, skills and behaviours have been identified:

Knowledge:

- Of the risks involved for the peer coach
- Of coaching models
- Of a broad range of support sources for sign posting
- Of assessment tools that could be requested
- Of equality and diversity issues
- Of GMC Good Medical Practice

Skills:

- Recognising the need for escalation
- Setting goals, contracts, and boundaries
- Assessing engagement
- Managing conflict and emotion
- Having difficult conversations
- Reflection
- Assessing the role of team/group dynamics
- Documentation
- Giving feedback

Behaviours:

- Joining calibration groups
- Submitting to quality assurance
- Attending supervision
- Continuing professional development

There was disagreement around who would be best placed to provide this training. Options included:

- Colleges and Faculties
- AoMRC
- Other training organisations

It was recognised that the above elements of training are broad and might be best provided on a modular basis, potentially by different organisations.

The need for experience and continuing professional development was highlighted. It was suggested that training might provide a gateway to peer coaching. Regulating the number of peer coaches trained might then ensure a sufficient volume of work for existing coaches. This might be achieved through the establishment of a self-regulating group that could meet refresh their skills regularly.

Areas for further research

If a coherent training programme is to be developed, one organisation would need to be commissioned to develop and deliver training. Experienced educationalists would be required to work with a range of stakeholders to identify the precise content and delivery mechanisms that would be most suitable.

How should we quality assure peer coaching?

Participants felt that the first step in quality assuring peer coaching was to agree the definition and set standards. AoMRC was identified as an organisation that could potentially achieve this. It was felt that peer coaches could be accredited and that their practice could be assessed through supervision, feedback from the recipient and feedback from their RO.

Areas for further research

If there is to be an organised expansion of peer coaching, then it would be helpful for a national body to produce a set of standards.

The same organisation should also produce appraisal guidance to allow peer coaches to be robustly appraised and revalidated on this aspect of their practice.

Contractual issues and insurance

There remains significant uncertainty around the legal implications of peer coaching. The group agreed that this was a significant area of risk for the peer coach, the doctor, the employing organisation and any coordinating body. Differing approaches have been taken in previous cases, but the group could not be assured that any of the approaches suggested, offered satisfactory protection for each party. Uncertainty around the definition of peer coaching further confuses the situation.

Areas for further research

Reliable legal and HR opinions should be sought and this should be discussed with a range of stakeholders, including the regulators. The implications of these opinions should be made accessible to all of the parties who may consider becoming involved in peer coaching.

Model agreements should be prepared and made available.

Who should pay for peer coaching?

Most episodes of peer coaching undertaken so far have been funded by the recipient's employing organisation. Recognising the expense of peer coaching, the group felt that any expansion of the scheme would require a review of who paid. The group had a range of views on who that should be:

- The doctor receiving it
- The employing organisation
- The NHS through a central fund
- The Colleges
- An insurance scheme

This was influenced by the employment status of the doctor:

- NHS Trust
- NHS GP
- Independent sector

The doctor's specialty was also a consideration. Providers may be prepared to invest more in remediating doctors in shortage specialties.

On the one hand, it was argued that government had already made a significant investment in a doctor's education and training and that remediation should therefore be the doctor's responsibility. On the other hand it was argued that the

NHS had a responsibility to look after its employees and should therefore do everything it could to help doctors in need of remediation.

Training peer coaches would also be expensive and participants suggested a similar list of funding sources for this as for peer coaching itself.

Areas for further research

Further work is required to estimate how much a period of peer coaching is likely to cost, how much it is likely to cost to train a peer coach and the annual cost of keeping them up-to-date.

Before any expansion of peer coaching, consensus would need to be reached on who would pay for the training of peer coaches and who would pay for the coaching sessions.

Does peer coaching work and is it cost effective?

There have been anecdotal examples of successful and unsuccessful attempts at peer coaching. The group cited key predictors of success related to the person and the approach to peer coaching. These included:

- Insight
- Engagement with the process
- Remediability of the underlying problem
- Clear goals

Despite these anecdotal reports, there appears to have been no robust studies of the effectiveness of peer coaching in medical remediation. Given the lack of evidence on cost, it is impossible to say whether peer coaching is cost effective.

Areas for further research

If an organised expansion of peer coaching is considered and the definition of peer coaching has been agreed, then research into effectiveness and cost effectiveness would be recommended. This research might consider the impact of peer coaching on factors such as:

- Return to full/partial practice
- Reduction of sickness absence
- Impact on appraisal and revalidation outcomes
- Impact on process measures
- Impact on team dynamics
- Impact on staff satisfaction
- Impact on patient outcomes
- Impact on PROMs

These findings should be combined with those of the costing research proposed above, to determine the value of peer coaching.

Conclusion

The use of peer coaching as a formal component of remediation appears to be a relatively recent phenomenon, since the formation of NCAA/NCAS. There are anecdotes of its successful and unsuccessful use. However, there is still no universally agreed definition of exactly what counts as peer coaching in this context, nor has there been any robust research into the effectiveness or cost effectiveness of peer coaching in remediation. The workshop held by the Faculty of Medical Leadership and Management and the Academy of Medical Royal Colleges represents a first step towards resolving these issues. It has identified the key questions that remain to be answered before the value of peer coaching can be fully assessed. The research suggested could be conducted in parts or commissioned as one integrated study.

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Dr Emma Sedgwick, Sedgwick Coaching

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Appendix A – Chronological Description of the Workshop

Second Floor Gallery, Royal College of Anaesthetists
19th June 2014, 0900 – 1645

0930 – 1000 Introduction

Mr Richard Smith, AoMRC

Mr Smith introduced the workshop and the topic of peer coaching. He outlined the context in which peer coaching is often used, following a judgement that an issue can be remediated. He outlined the case study of a successful peer coaching relationship and identified elements that extended the traditional model of peer coaching. These included reporting to the doctor's trust, on his competency and observing the doctor's clinical practice.

1000 – 1045 Remedial Coaching

Dr Emma Sedgwick, Sedgwick Coaching

Dr Sedgwick outlined her previous work as a Psychiatrist and as an executive coach. She elicited views from delegates on their experiences of coaching. These were positive and these included helping to reflect on one's own life, realising natural strengths and latent skills, and understanding where they could bring value.

Dr Sedgwick addressed the issue of differing definitions of peer coaching and touched on the importance for a coach of understanding what it is that they are actually delivering. Is it coaching, therapy or clinical supervision? The importance of being clear about boundaries.

She also reflected on her experience that referrals have been increasing in recent years. These have been from a range of sources. Of 19 cases, twelve have had NCAS involvement, two have had college involvement, two have resulted from comments on 360-degree feedback in Trusts.

Dr Sedgwick explained that her coaching relationships last around eight months, during which she may or may not observe the doctor in clinical or team settings. She does not assess their clinical competence, but she generally provides an interim and final report to the doctor's Trust. It is important to note that these reports can sometimes end up being used as part of GMC or other proceedings.

1100 – 1145 Focus Group 1

1145 – 1245 Contractual, Indemnity and other issues to be aware of

Mr Richard Smith, AoMRC

Dr Ash Samanta, NCAS
Dr Robin Cordell, Faculty of Medical Leadership and Management
Professor Hugo Mascie-Taylor, Monitor

Panel members gave a brief outline of the key issues that doctors giving and receiving peer coaching, employers, colleges, and others needed to be aware of. These included indemnity, reputational issue, media involvement, understanding what is remediable, occupational health, non-NHS doctors, contracts, training, standards, quality assurance, and funding. These issues were then explored in the question and answer session.

1315 – 1400 Focus Group 2

1415 – 1615 Forum Theatre

Mr Joel Greig, Practive

Joel facilitated two Practive actors in a forum theatre session. This is a technique that allows the audience to reflect, analyse and explore in detail, the behaviours, strategies and mindset that they could use to get a positive outcome if they were a peer coach. Two scenarios were acted out:

- The audience were given a scenario and took part in an initial discussion. Actors then enacted a pre-scripted scenario.
- Joel asked the audience for their feedback to help the “protagonist”.
- The comments were taken into account and the scenario was re-enacted taking these into consideration.
- Joel engaged the audience throughout, by asking what skills were effective, what needs to be improved, and what issues arose.
- The audience were able to pause and replay the scenario to improve it as it played out.

Although the purpose of the workshop was not to train peer coaches, participants reported that this was a useful exercise in understanding what might actually be involved.

1615 – 1645 Feedback, Discussion, Closing Remarks

Mr Richard Smith, AoMRC

Appendix B: Outcomes from the Focus Groups

The focus group sessions covered the following topics:

1. What do we mean by peer coaching and what does success look like?

Dr Ash Samanta, NCAS

Groups felt that for peer coaching to be successful, there needed to be a clear definition of what was expected from each party, along with clearly set timelines. There was also a general feeling that

There was no consensus on a definition of peer coaching, but three main points emerged from the discussion:

- Peer coaching would seem to be a combination of peer supervision, along with mentorship and coaching
- Peer coaching would be particularly helpful if there were specialty specific issues that needed to be resolved
- Peer coaching should be undertaken by someone who is not close to the practitioner (i.e. an immediate colleague).

Participants felt that "general coaching" could be undertaken effectively by a non-medical coach

Again, regarding what success might look like, themes emerged:

- Returning the practitioner to the workplace to undertake safe and productive work
- Providing the practitioner with some form of collegiate support for a period of time following completion of peer coaching
- Periodic assurance through evidence of good practice with mentorship and feedback on a fairly frequent basis in the immediate post coaching period, but tapering thereafter
- A long term programme for review of maintenance of the benefits from peer coaching linked to appraisal

2. Content of training for peer coaches

Dr Tom Foley, FMLM

This focus group identified necessary content under three headings:

- Knowledge
 - Risks to all involved
 - Coaching models
 - Broad sources of support for signposting
 - Assessment tools that could be used
- Skills
 - Setting goals/contracts/boundaries
 - Assessing engagement
 - Managing conflict and emotion
 - Having difficult conversations
 - Reflection
 - Assessing the impact of team dynamics
 - Documentation
 - Giving feedback
- Behaviours
 - Minimising feelings of humiliation
 - Calibrate coaching outputs
 - Submit to quality assurance
 - Participation in supervision

3. Quality assurance processes for peer coaching

Dr Robin Cordell, FMLM

Participants raised the following key questions:

- What do we mean by quality?
 - Quality of output
 - Quality of process
- What does a good outcome look like?
- How can we be sure that the coaching we are providing is of the right standard?
- How can we ensure that this is interactive rather than an assessment?
- How can we manage expectations on all sides?
- How should training and accreditation of the peer coaches be organised?
- Who should set the standards?