NHS Resolution 8th Floor
10 South Colonnade
Canary Wharf
London
E14 4PU
Telephone: 020 7811 2700

August 2024
FOI 6613

Thank you for your emails received between 4th-18th June 2024 in which you asked questions with regard to Behavioural Assessments provided by Practitioner Performance Advice. This response is being sent solely with regard to your queries which fall under the Freedom of Information Act 2000 (FOI Act).

The other matters you have raised in respect of the management of your case are being handled separately by NHS Resolution's Assessment & Remediation team.

In your email dated 4th June, you asked the following:

- *As I understand from NHS Resolution website, this has been completed as an unblined subjective cohort study of only 141 subjects. Did the results of the cohort study demonstrate any statistically significant P values in the doctors who where identified by NHSE as requiring assessment? If so may I please request a copy of the statistical analysis.*

In your email dated 7th June, you asked the following:

- *I would like to better understand how it is NHS resolution imply findings on their website.*

- *I would be grateful to receive a copy of all of the evidence used by the external organisations in their evaluation to support the conclusions on NHS resolution website.*

In your email dated 18th June you asked the following:

- *I would be really grateful to see the evidence that the third party use to make their conclusions.*

- *I am [hence] wondering how the third party and NHS come to make the conclusions they do on their website?*

- *You state that the analysis revealed significant differences across most domains of both tests compared to the control group. Please provide me with the evidence used to lead to these: "significant differences".*

- *I would also be grateful to be forwarded the thematic analysis which was performed on the random sample of 30 reports.*

- *I would also value the methods used within this including the coding, categorizing, identification of patterns and themes and what patterns and themes are identified, how they are measured and the evidence used to determine the correlations you previously highlight as significant differences.*

Our response

To help respond to your request, it might be helpful to first direct you to our website which outlines the purpose of Practitioner Performance Advice ('the Advice service') and the services we deliver. As an advisory body our role is to help healthcare employers/contracting bodies and practitioners where concerns have been raised about individual practitioners' performance, and work with those involved to resolve these issues. You can find more information about us here.

We understand that your queries are in relation to the analysis that informed the *Insight* publication on our website, Behavioural Assessments: findings from an in-depth qualitative and quantitative analysis. To respond to your requests, we have provided the analysis that informed the *Insight* publication. The work was carried out by Edgecumbe and Work Psychology Group, who are experts in Behavioural Assessment. We have also provided an additional document which provides a more detailed account of the statistical methods used. This latter document, outlining the statistical methods, was provided to the Advice service in July 2024 and created to address your queries. Disclosure of this to you falls beyond our responsibilities under the FOI Act.

The analysis and methods documents address your requests for information which are summarised below:

- Detail of the information which informed the *Insight publication*
- The statistical analysis

- Significant P values between the two groups in the analysis
- The method and results of the qualitative analysis.

Some of the information you have requested cannot be disclosed due to exemptions which are detailed below; these relate to the following part of your request:

- *I would be grateful to receive a copy of all of the evidence used by the external organisations in their evaluation to support the conclusions on NHS resolution website.*

We have applied redactions to direct quotations from participants on the grounds that this information was provided in confidence and could potentially lead to the identification of one or more of the individuals whose data was used to inform the study. Names of individuals have also been redacted. The following exemptions available under the FOI Act apply to the redacted information:

- Section 40 – Personal Data Exemption
- Section 41 – Information provided in confidence.

Please refer to our refusal notice below for further explanation of the exemptions applied.

Refusal Notice

<u>Section 40(2) – Personal Data Exemption</u>

We have redacted information that could lead to the identification of individuals, as we believe that disclosure of this information is exempt under Section 40(2) by virtue of section 40(3A)(a) of the FOI Act, where disclosure to a member of the public would contravene one or more of the data protection principles. The data protection principles are set out in Article 5 of the General Data Protection Regulation. We take the view that it would not be fair nor lawful to disclose such information, and any disclosure would therefore contravene the first data protection principle.

The individuals were not told (and have therefore not consented to) their personal information would be shared in this way (i.e. that the information has the potential to lead to their identification), and we do not believe they would have a reasonable expectation that their personal data would be released in this way. As a disclosure under the FOI Act is essentially a disclosure to the ‘world’, NHS Resolution believes it has a responsibility to protect those individuals’ identities, as disclosure could potentially cause damage and/or distress to those involved.

The exemption under section 40(2) is an absolute exemption, and in this instance, NHS Resolution is not required to undertake a public interest assessment. However, in light of our application of the exemption contained under section 41 to withhold confidential information, we have further detailed our consideration for the public's interest in disclosure detailed under 'Breach of Confidence Test' further below. This is because the law of confidence recognises that a breach of confidence may not be actionable when there is an overriding public interest in disclosure.

Section 41 – Information provided in confidence

Section 41(1) of the FOI Act sets out an exemption where the information requested was provided to the public authority in confidence. There are two components to the exemption:

i) If held, the information must have been obtained by the public authority from another person. A person may be an individual, a company, a local authority or any other legal entity. It is not restricted to information provided verbally or in writing. The exemption does not cover information which the public authority has generated itself, although it may cover documents (or parts of documents) generated by the public authority if these contain confidential information provided by a third party. It is the information itself, and not the document or other form in which it is recorded, which needs to be considered.
ii) Disclosure of the information would give rise to an actionable breach of confidence. In other words, if the public authority disclosed the information the provider or a third party could take the authority to court.

Breach of Confidence Test

To determine whether a breach of confidence would occur if the information were to be disclosed, it is necessary to conduct a Breach of Confidence Test.

A breach of confidence will become actionable if:

- The information has the necessary quality of confidence, if it is not otherwise accessible, nor trivial;
- The information was given in circumstances under an obligation of confidence; and
- There was an unauthorised use of the information to the detriment of the confider.

The Information provided to NHS Resolution, and subject to this exemption, has been imparted on the understanding that it would be used for the purpose for which it

was supplied, namely, to undertake an analysis of behavioural assessments. There is an expectation that the withheld information would be treated confidentially. All requests made under the FOI Act are applicant blind, so a public authority will always view any disclosure as one into the public domain. A release under the FOIA is therefore considered to be a release to the public at large.

Section 41 is an absolute, class-based exemption meaning that, if there is harm in release, that there is no statutory public interest balancing exercise required. However, the law of confidence has an “in-built” public interest defence. We have taken this into account and determined that it does not outweigh the harm that would occur from disclosure.

This concludes our response to your request.

If you are not satisfied with the service that you have received in response to your information request, it is open to you to make a complaint and request a formal review of our decisions. If you choose to do this, you should write to Tinku Mitra, Deputy Director of Corporate and Information Governance, Data Protection Officer for NHS Resolution, within 28 days of your receipt of this reply. Reviews of decisions made in relation to information requests are carried out by a person who was not involved in the original decision-making about the request.

If you are not content with the outcome of your complaint, you may apply directly to the Information Commissioner for a review of the decision. Generally, the Information Commissioner will not make a decision unless you have exhausted the local complaints procedure. The address of the Information Commissioner’s Office is:

Wycliffe House
Water Lane
Wilmslow
Cheshire
SK9 5AF

https://ico.org.uk/

Summary of analysis methods

Below is a brief description of the analytical methods that were used for the quantitative and qualitative analysis outlined in the accompanying document, 'PPA Data Analysis: quantitative and qualitative'. This summary of analysis methods was produced by Edgecumbe and shared with Practitioner Performance Advice in July 2024.

Summary of Analysis Methods

Key Question:

How does the profile of the PPA group compare to a non-PPA control group of consultant doctors?

Quantitative Analysis:

- **Analysis of NEO and HDS Results:**
    - The study analysed the psychometric profiles of doctors using the NEO Personality Inventory (NEO) and the Hogan Development Survey (HDS).

Experimental Group (PPA Doctors):

- **Sample Size and Demographics:**
    - **N = 141** (110 males, 31 females; age range data only).
    - This group comprises doctors referred to the PPA.

Control Group (Consultant Doctors):

- **Sample Size and Demographics:**
    - **N = 357** (216 males, 141 females; average age 41.32).
    - The control group consists of consultant doctors who had applied for consultant roles.

Comparison with Previous Research:

- Unlike the 2012 research, which compared the personality profiles of doctors referred to PPA with a UK working population norm group (N=656), the 2020

analysis compares the PPA group to a non-PPA control group of consultant doctors.

Data Standardisation and Visualisation:

- **Conversion to T Scores:**
    - Raw NEO data were converted to T Scores based on the working population norm. T Scores are a type of standardised score that allows for comparison across different tests and populations. They are scaled to have a mean of 50 and a standard deviation of 10.
    - This means that a T Score of 50 represents the average score, while a T Score of 60 would be one standard deviation above the mean, and a T Score of 40 would be one standard deviation below the mean.

- **HDS Data Visualisation:**
    - HDS results are typically categorised into three risk levels: high risk, moderate risk, and low risk.
        - High Risk: Indicates significant tendencies that might derail success under stress or pressure (a score above 90%ile).
        - Moderate Risk: Reflects moderate tendencies that could occasionally hinder performance (a score above 70%ile).
        - Low Risk: Suggests minimal tendencies that are unlikely to interfere with performance (anything below 70%ile).
    - Visualising these risk levels allows for a clear comparison of the average risk scores between the PPA and control groups, helping to identify potential derailers under pressure.

Statistical Testing:

- **T-Tests:**
    - T-tests were performed to determine if there were statistically significant differences in the psychometric profiles of PPA doctors versus the control group.
    - A T-test is a statistical test used to compare the means of two groups. It helps determine if the differences observed between the groups are statistically significant or if they could have occurred by random chance.

- There are different types of T-tests, but here we used an ‘Independent Samples T-Test’: Used when comparing the means of two independent groups (e.g., PPA doctors vs. consultant doctors)
- P-Value: The p-value is a probability measure that helps determine the significance of the results. It indicates the likelihood that the observed differences between groups occurred by chance.
- A P-value less than 0.05 is typically considered statistically significant, meaning there is less than a 5% chance that the observed differences are due to random variation.
- If the P-value is low (below the 0.05 threshold), it suggests that the differences between the groups are likely not due to chance and may be attributed to the specific factors being studied

Data Visualisation:

- **Box Plots:**
  - PPA doctor psychometric data were visualised using box plots compared to the control group.

Demographic Summary:

- A summary of the sample demographics was provided, capturing:
  - **Gender**
  - **Type of Doctor:** GP or hospital doctor
  - **Age Range**
  - **Ethnicity**
  - **Place of Qualification:** UK, outside EEA, and other EEA

Qualitative Thematic Analysis:

- **Braun and Clarke Thematic Analysis:**
  - The Braun and Clarke method of thematic analysis was employed, which is widely regarded as best practice for its systematic and rigorous approach to identifying, analysing, and reporting patterns (themes) within data.
  - The process involves six phases:
    1. **Familiarisation with the data:** Transcribing data, reading and re-reading the data, noting down initial ideas.

2. **Generating initial codes:** Coding interesting features of the data systematically across the entire data set, collating data relevant to each code.
3. **Searching for themes:** Collating codes into potential themes, gathering all data relevant to each potential theme.
4. **Reviewing themes:** Checking if the themes work in relation to the coded extracts and the entire data set, generating a thematic map of the analysis.
5. **Defining and naming themes:** Ongoing analysis to refine the specifics of each theme and the overall story the analysis tells, generating clear definitions and names for each theme.
6. **Producing the report:** The final opportunity for analysis, selection of vivid, compelling extract examples, final analysis of selected extracts, relating the analysis back to the research question and literature, producing a scholarly report of the analysis.

- The NEO facets and HDS scales were mapped to the themes produced to indicate the potential personality differences between the control and experimental groups within those themes.

Reference for Braun and Clarke Method:

- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101. doi:10.1191/1478088706qp063oa

NHS Resolution

PPA Data Analysis: quantitative and qualitative

Edgecumbe and Work Psychology

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Contents

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Overview

- Aim: to answer the research question: *"What are the factors common in practitioners referred to the PPA?"*
- Quantitative analysis: NEO and HDS results
  - Experimental group PPA doctors
    - N= 141: 110 males and 31 females (only have age range)
  - Control group consultants applying for NHS substantive roles
    - N= 357: 216 males and 141 females, average age 41.32
  - A priori power analysis was conducted to determine the necessary sample size for this analysis and confirmed that these two samples were appropriate to determine a medium effect size.
- Qualitative analysis: of a random sample of 30 PPA behavioural assessment reports
  - Randomly allocated to the 2 researchers (Edgecumbe & WP)
  - Thematic analysis

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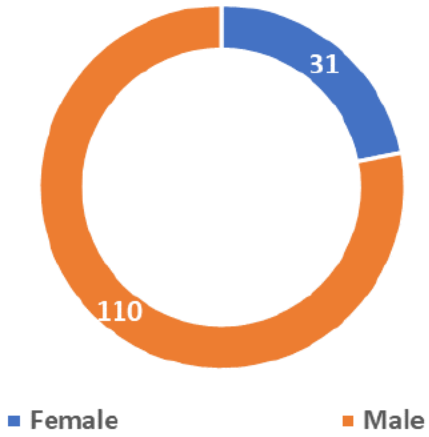
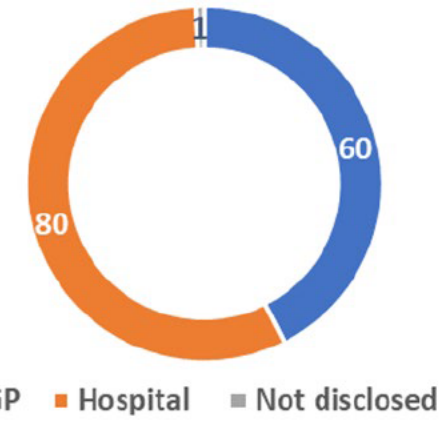
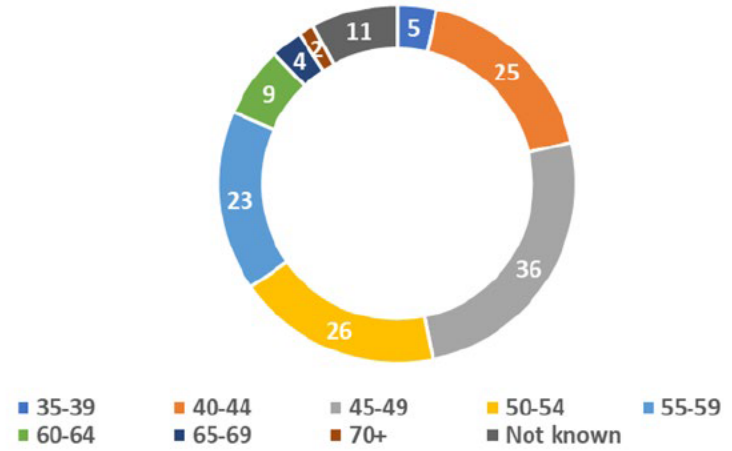
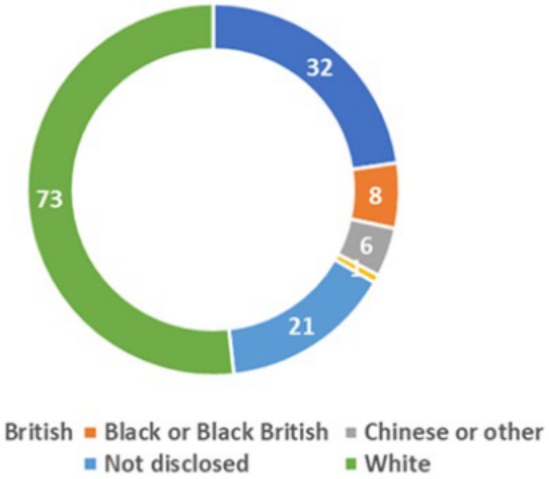
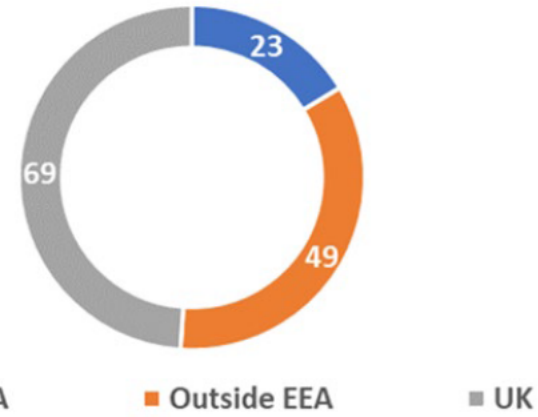
Summary of the PPA Sample











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Quantitative Analysis

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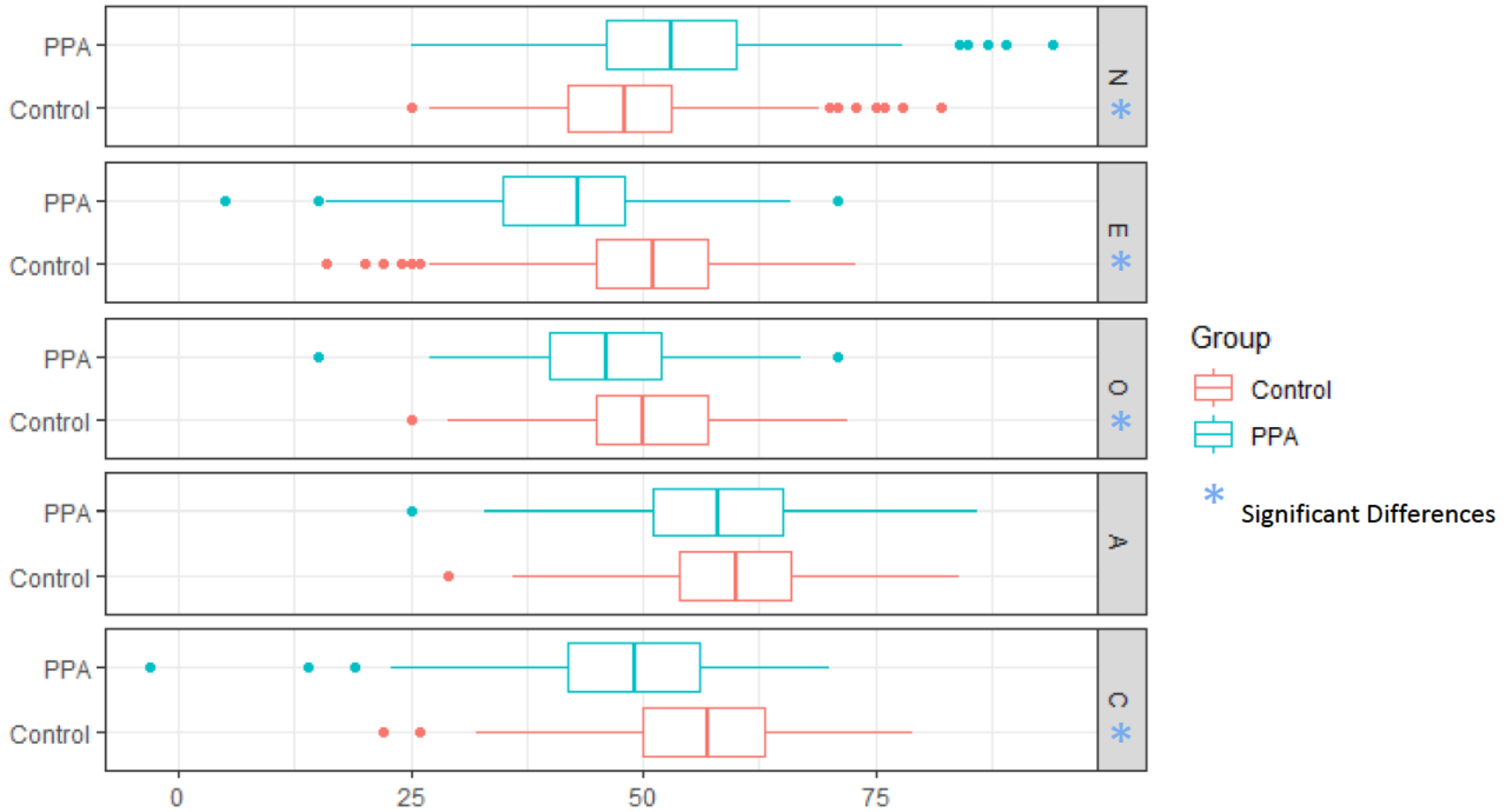
Interpreting the quantitative results

- Research by Edgecumbe in 2012 explored the personality profiles of doctors referred to PPA compared to a *UK working population norm group (N=656)*.
- Key question of interest with this 2020 analysis is how does the profile of PPA group compare to a ***non-PPA control group of consultant doctors***?

- Considerations when interpreting findings:
  - No firm conclusions should be drawn about a population of doctors based on psychometric test scores alone
  - Use in conjunction with other evidence and other sources (e.g. qualitative analysis);
  - Try not to over-interpret significant differences in personality measures – it does not provide indication of causality
  - Cross sectional analysis - a point in time

PPA and Control Group Data: NEO Domains



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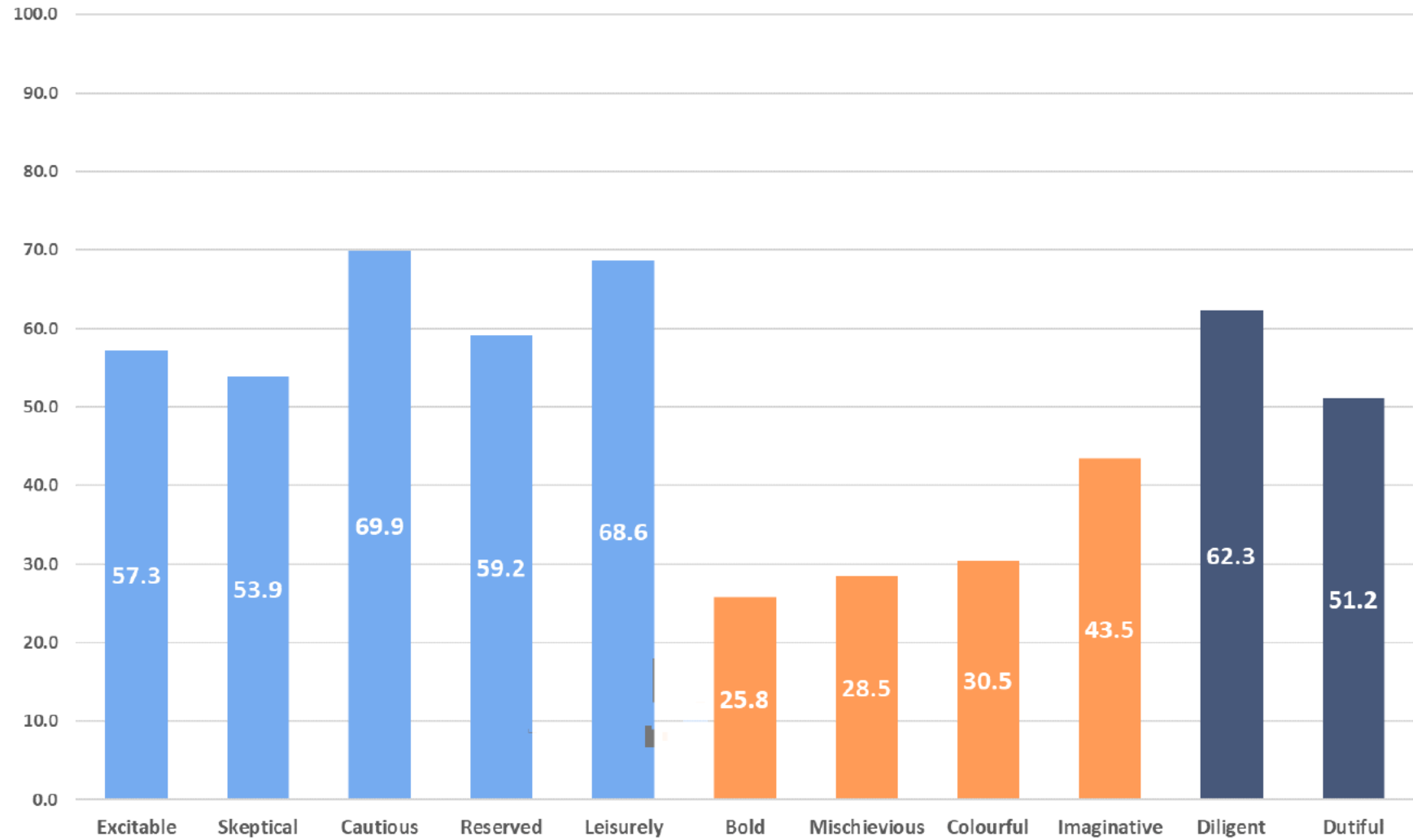
HDS Scale Averages: PPA practitioners

High Risk (90-100%)

Moderate Risk (70-89%)

Low Risk (0-69%)



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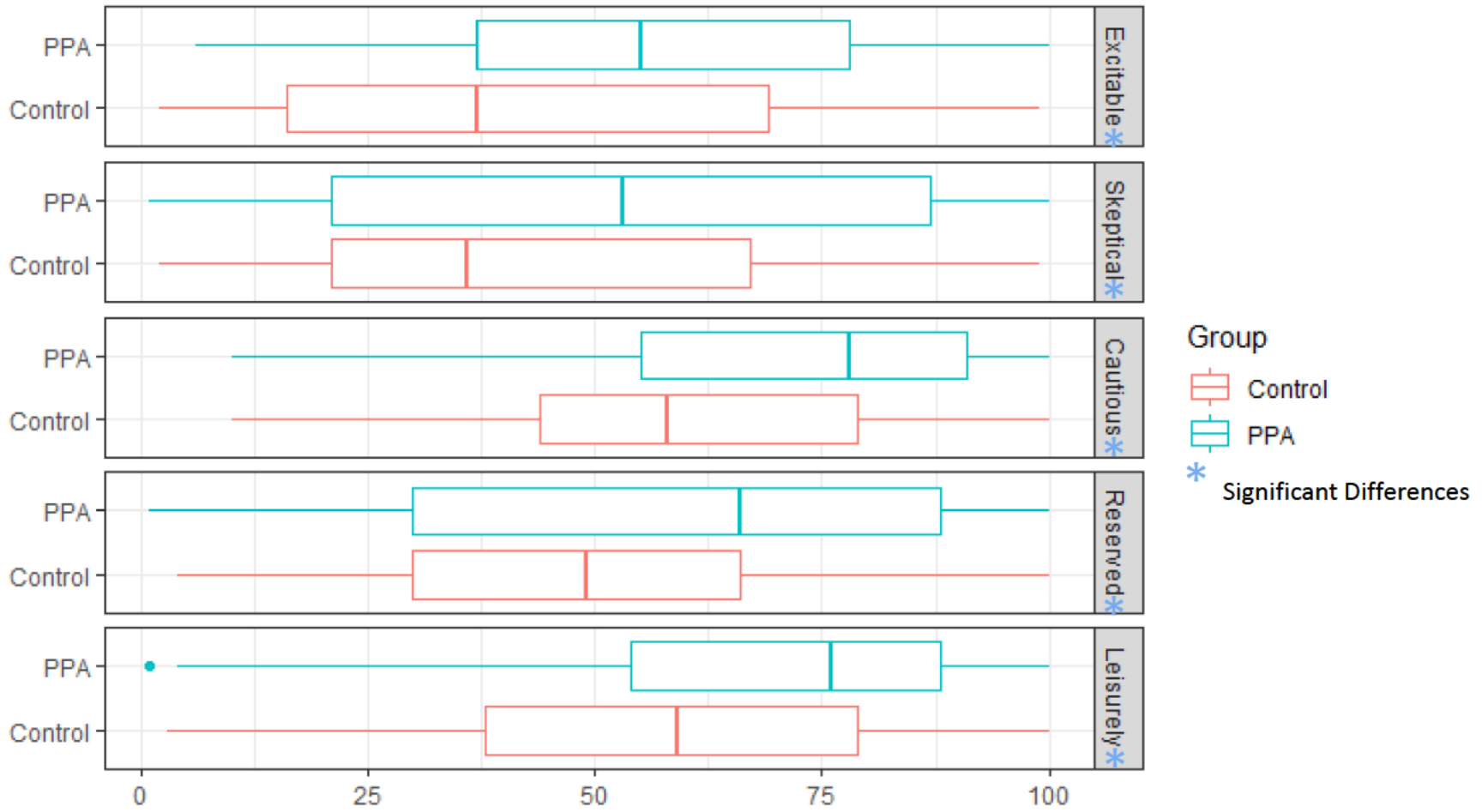
PPA and Control Group Data: HDS Scales Moving Away



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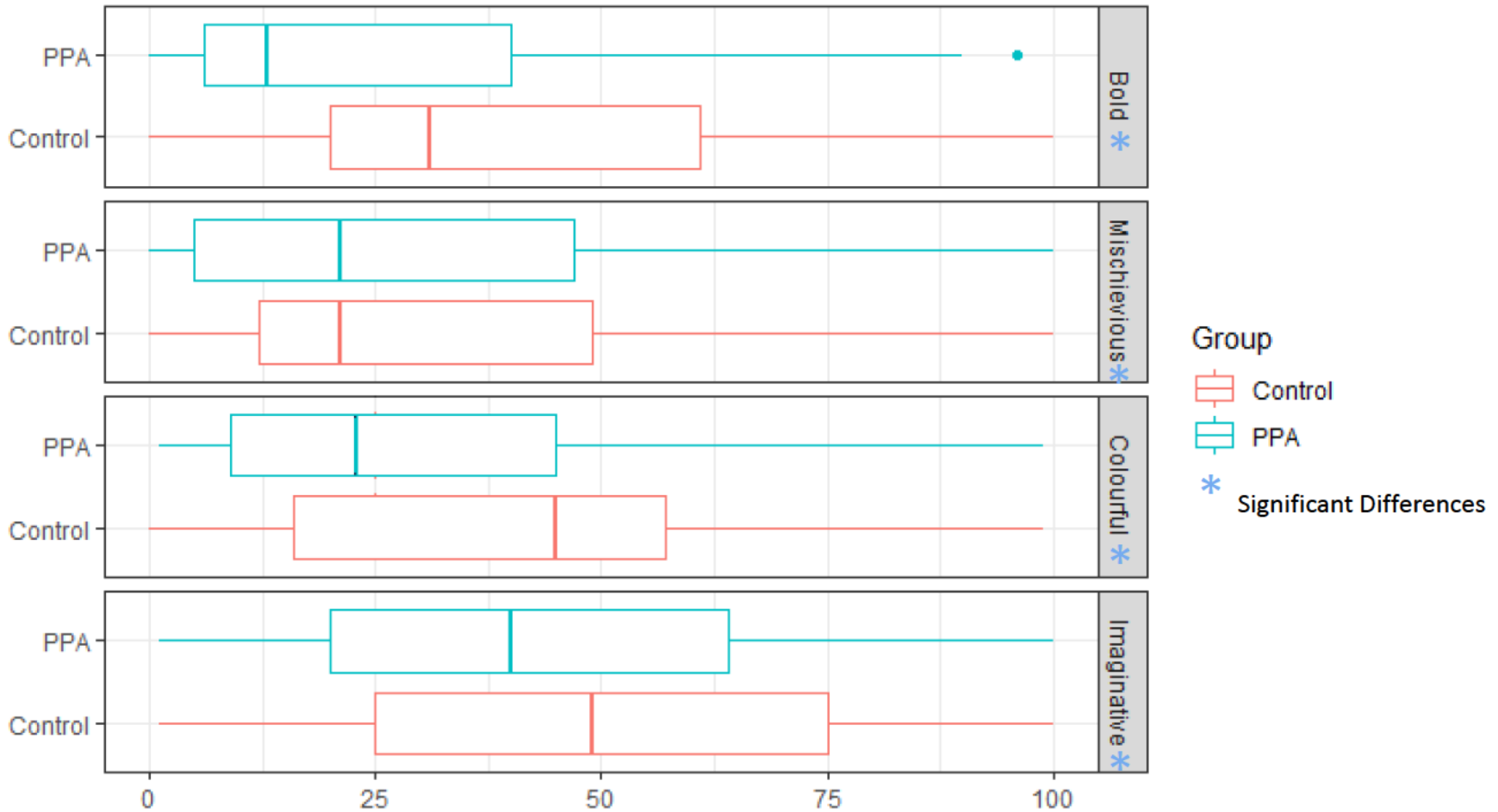
PPA and Control Group Data: HDS Scales Moving Against



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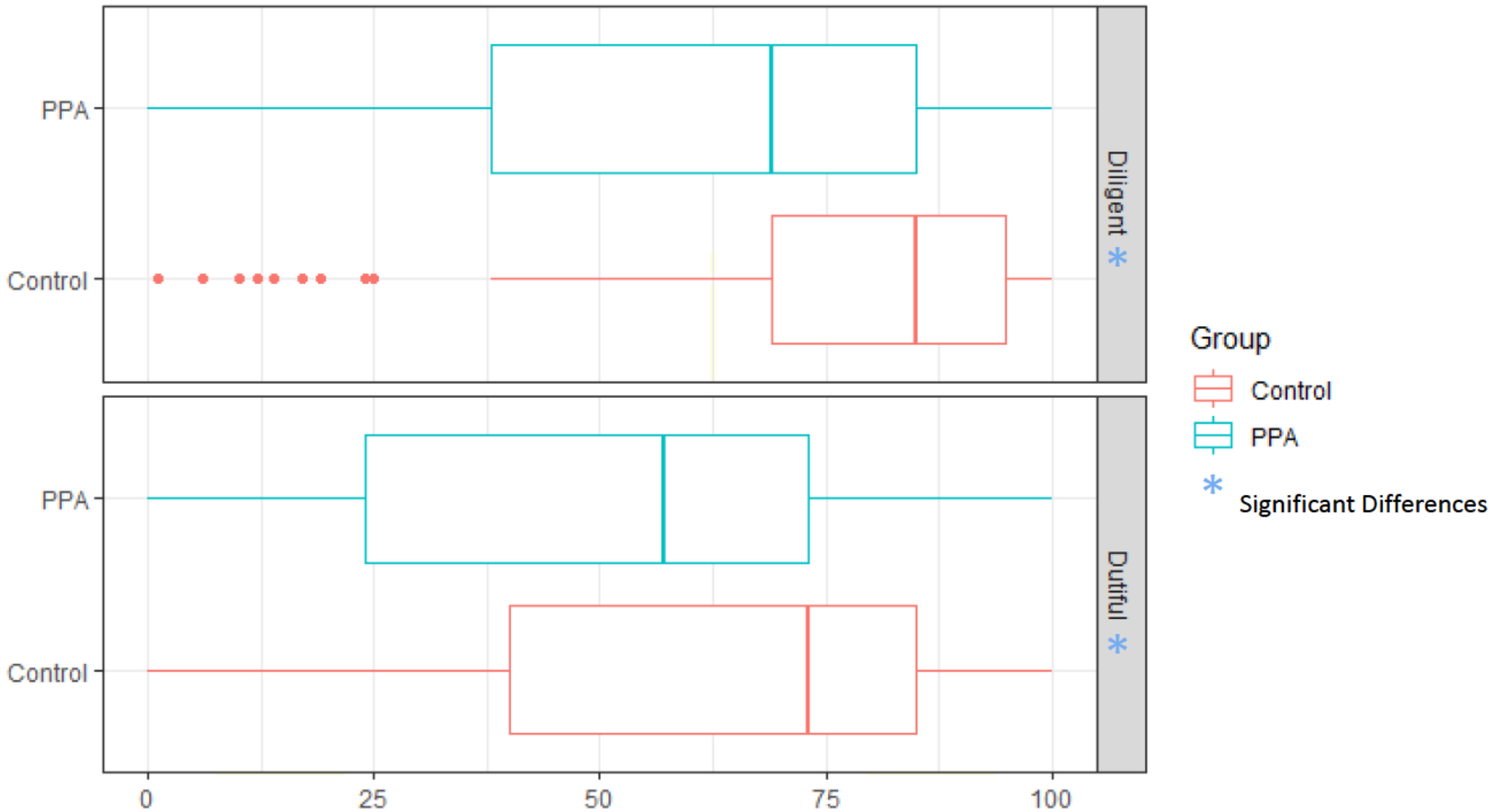
PPA and Control Group Data: HDS Scales Moving Towards



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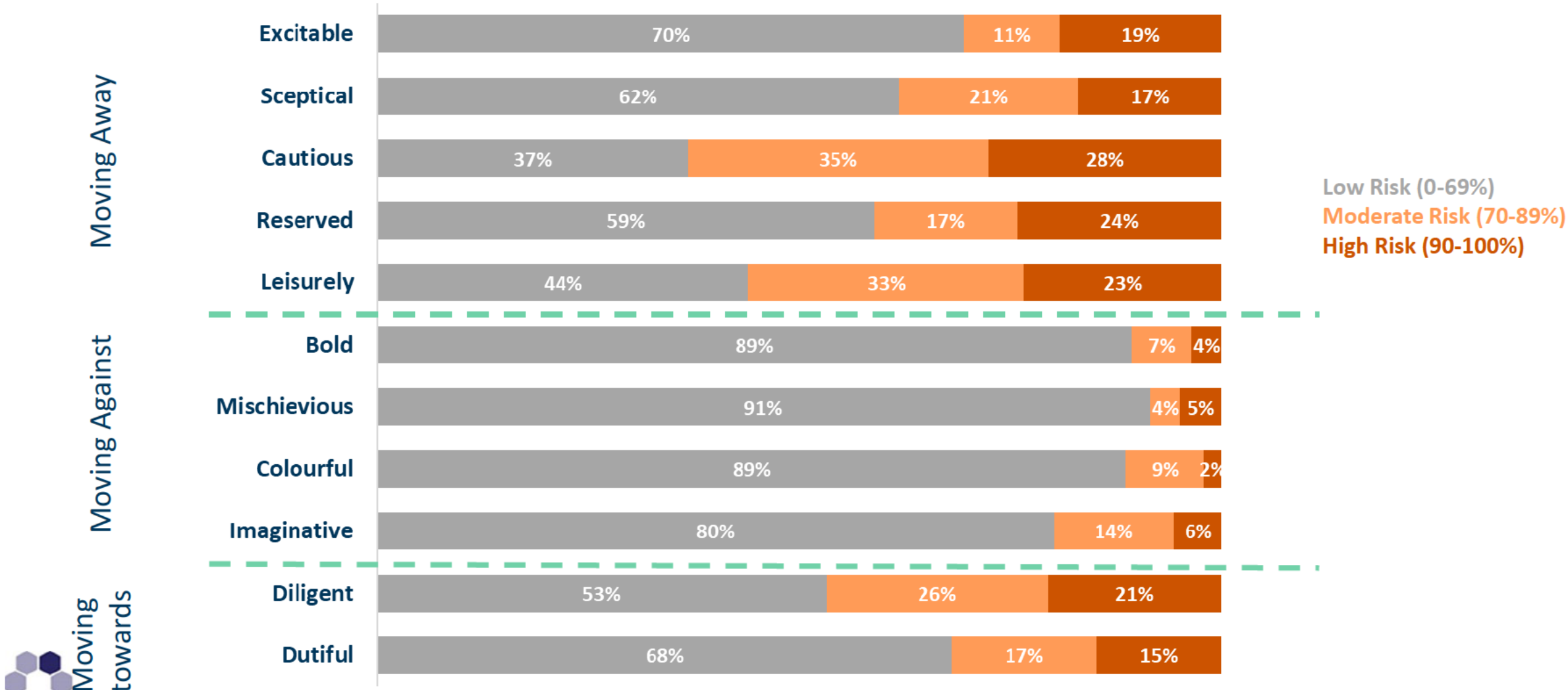
HDS Frequency Distribution

Proportion of PPA doctors within each risk bracket for each HDS Scale compared to the norm group



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Validating quantitative and qualitative findings

NEO Facet	Themes	PPA Average	Control Average	Diff btwn PPA and Control	P Value	Significant
N1: Anxiety	3a, 10	51.82	49.27	2.55	0.026	Y
N2: Frustration	6, 7, 8	53.19	47.08	6.11	0.000	Y
N3: Despondency	3a, 4d	54.84	49.39	5.44	0.000	Y
N4: Self-Consciousness	1, 2, 4a, 4b, 4c, 4d, 5, 6, 7	55.15	51.07	4.08	0.000	Y
N5: Impulsivity	2, 4b, 6, 8	47.76	45.78	1.98	0.049	Y
N6: Vulnerability	3a, 4d, 5, 7, 8	54.58	48.69	5.90	0.000	Y
E1: Warmth	4d, 5, 7, 8	48.45	53.94	-5.49	0.000	Y
E2: Gregariousness	4d, 5, 9	46.94	51.38	-4.44	0.000	Y
E3: Assertiveness	6, 7, 8	40.99	48.12	-7.14	0.000	Y
E4: Pace of Living	10	40.41	47.53	-7.12	0.000	Y
E5: Excitement Seeking	10	42.39	48.85	-6.46	0.000	Y
E6: Optimism	4d, 8, 10	44.94	51.52	-6.58	0.000	Y
O1: Imagination	11	47.31	47.95	-0.64	0.521	N
O2: Aesthetics		51.01	52.46	-1.45	0.102	N
O3: Feelings	1, 2, 4a, 4c, 5, 6, 9	45.67	50.45	-4.78	0.000	Y
O4: Actions	10, 11	41.94	48.45	-6.51	0.000	Y
O5: Ideas	11	50.35	53.80	-3.45	0.000	Y
O6: Values	11	44.82	48.34	-3.52	0.000	Y
A1: Trust	4b, 4c, 5, 6	49.70	53.24	-3.53	0.001	Y
A2: Straightforwardness	4c, 6, 7, 8	59.69	58.66	1.03	0.223	N
A3: Altruism	2, 3b, 9	53.15	57.93	-4.78	0.000	Y
A4: Compliance	2, 6, 7	53.40	55.86	-2.45	0.009	Y
A5: Modesty	1, 4a, 4b, 4c, 6, 7	57.16	54.57	2.59	0.012	Y
A6: Compassion	1, 2, 4a, 5, 6, 7, 9	58.70	58.71	-0.01	0.991	N
C1: Competence	1, 2, 4a, 4b, 4c, 6, 11	45.28	54.39	-9.11	0.000	Y
C2: Order	2, 10	51.00	54.54	-3.54	0.001	Y
C3: Dutifullness	2, 3b, 3c, 4c, 9	52.06	56.22	-4.15	0.000	Y
C4: Achievement Striving	3b, 3c, 11	44.87	55.86	-10.99	0.000	Y
C5: Self-Discipline	3c, 4b, 9, 10	45.03	52.59	-7.56	0.000	Y
C6: Deliberation	2, 10	52.41	55.04	-2.63	0.007	Y

Themes
1: Lack of self awareness and insight
2: Disregard for clinical guidelines
3a: Personal issues/ emotional demands
3b: Workloads
3c: High standards
4a: Lack of self awareness
4b: Self-control/ denyng vulnerablities
4c: Denying responsbility
4d: Reserved/ withdrawn
5: Independent
6: Straighforward and direct communication
7: Conflict Avoidant
8: Frustration/ Irritability
9: Patient Focussed
10: Preference for structure, routine and control
11: Openness to development and learning

Validating quantitative and qualitative findings

HDS Facet	Themes	PPA Average	Control Average	Diff btwn PPA and Control	P Value	Significant
Excitable	3a, 4b, 6, 8	57.26	45.11	12.15	0.000	Y
Skeptical	4b, 4c, 4d, 5	53.87	46.08	7.80	0.012	Y
Cautious	2, 4b, 4c, 4d, 5, 7, 10	69.87	55.58	14.29	0.000	Y
Reserved	1, 4d, 5, 7, 9	59.16	50.50	8.67	0.004	Y
Leisurely	3b, 4c, 7, 8	68.59	58.51	10.08	0.000	Y
Bold	1, 2, 4a, 7	25.77	40.65	-14.88	0.000	Y
Mischievious	2, 5, 10	28.55	32.84	-4.29	0.114	N
Colourful	5, 6	30.48	41.18	-10.71	0.000	Y
Imaginative	11	43.49	49.49	-6.00	0.037	Y
Diligent	2, 3b, 3c, 9, 10	62.33	73.51	-11.17	0.000	Y
Dutiful	2, 3b, 3c, 4b, 4c, 4d, 5, 7, 9, 11	51.16	63.59	-12.43	0.000	Y

Themes
1: Lack of self awareness and insight
2: Disregard for clinical guidelines
3a: Personal issues/ emotional demands
3b: Workloads
3c: High standards
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10: Preference for structure, routine and control
11: Openness to development and learning

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Qualitative Analysis

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Qualitative Themes

RESILIENCE

- Demands
- Lack of support
- Frustration/ irritability

INTERPERSONAL

- Independent
- Straightforward
- Conflict avoidant

OPERATIONAL

- Patient focused
- Preference for control
- Disregard for guidelines

LACK OF SELF AWARENESS AND INSIGHT

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Lack of self-awareness and insight

[redacted]

- Practitioners overtly described developing themselves, but evidence focused around developing clinical and technical skills and knowledge, and not personal growth and skills.
- Further, their narrative indicated a lack of self-awareness around the limits of their knowledge and competence, the impact of their behaviour on others, and areas for personal development. Many practitioners failed to show that they seek or accept feedback, attribute blame externally, and had not sought to deal with concerns prior to the referral.
- The PPA doctors are significantly more **Self-Conscious (N4)** and **Modest (A5)** and significantly less **Open to Feelings (O3)** and **Self-Confident (C1).**
- Under pressure, the PPA doctors are also significantly less **Bold** and more **Reserved** than the control group.

Resilience: Demands

[redacted]

- Many practitioners experienced considerable demands in the period preceding the incidents that led to their referrals. These appear to have taken their time, energy and focus away from aspects of their work, potentially contributing to said incidents. These demands include individuals'/ their families' medical or mental health issues, heavy workloads and high standards.
- The PPA doctors are significantly more **Vulnerable to Pressure (N6),** more **Anxious (N1)** and more **despondent (N3)** when faced with setbacks.
- Under pressure, the PPA group are also more likely to display dramatic emotional peaks regarding people and projects **(Excitable)**

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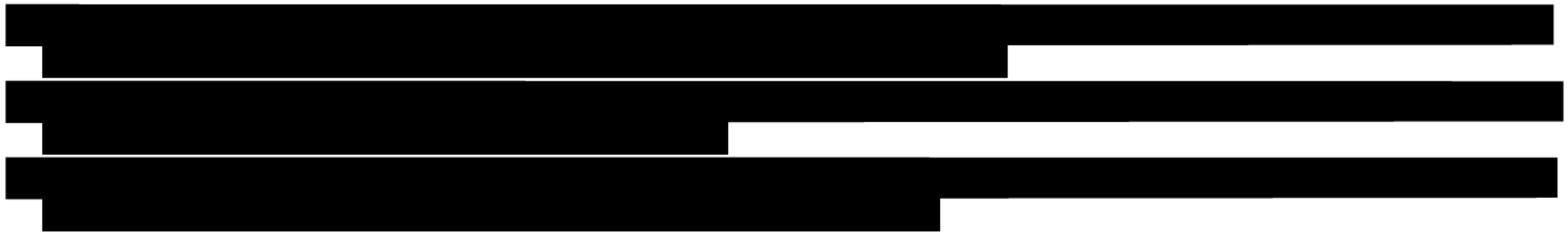
Resilience: Lack of support



- Many practitioners lack the support (social, mental health, workloads etc) required to cope with the demands because they:
  - Lack the self-awareness to realise they need support.
  - Deny personal vulnerabilities and exercise self-control around their behaviour to manage others' perceptions of them.
  - Do not recognise that it is their personal responsibility to seek support when they did it.
  - Withdraw from others, in turn reducing the likelihood others will recognise their need for support and offer it.
- The PPA group are more **Self-Conscious (N4)** and **Modest (A5)** but less **Open to Feelings (O3)** and **Self Confident (C1)** than the control group.
- Under pressure, the PPA group are also significantly lower on the **Bold** HDS scale.

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Resilience: Irritable

[redacted]

- Some practitioners appear to be more prone to becoming privately but easily irritated and frustrated by others. Under pressure, some practitioners appear to lack sufficient self-regulation and coping strategies, resulting in outbursts and being perceived as angry or irritable.
- The PPA doctors are significantly more likely to feel **frustrated (N2)** and react **impulsively (N5).** They are also less **warm (E1)** and **positive (E6)** than the control group.
- Under pressure, the PPA doctors are more **Excitable** and **Leisurely** than the control group.

Interpersonal: Independent

[redacted]

- Many practitioners appear to be introverted, transactional, and functionally focused, displaying a limited interest in connecting socially with others outside of the necessary formal interactions/ communication required to 'get the job done'. In some this may be exacerbated by a lack of trust in others' intentions / motives.
- The PPA doctors are overall less **Extraverted (E)** than the control group. They are less **Warm (E1), Sociable (E2), Open to feelings (O3)** and **Trusting (A1)**
- Under pressure, the PPA group are more **Cautious** and **Reserved** while also less **Colourful** and **Dutiful** than the control group.

Interpersonal: Straightforward

[redacted]

- Most practitioners communicate in a frank and direct manner. Whilst beneficial for clarity, many described being perceived as lacking in diplomacy, blunt, rude, inconsiderate and insensitive. For some practitioners, this may relate to their cultural and family backgrounds, or ease with English as their second language.
- The PPA group are more likely to get **Frustrated (N2),** more **Self-Conscious (N4)** and **Impulsive (N5).**

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Interpersonal: Conflict avoidant

[redacted]

- In contrast to the previous theme, many practitioners seem to be highly motivated to maintain harmonious relationships with others and display low levels of assertiveness. These practitioners were more likely to avoid conflict, dislike providing negative feedback, and struggle to convey their messages clearly.
- The PPA group are more **Self-conscious (N4)** and **Vulnerable to Stress (N6)** than the control group. They are also less **Assertive (E3)** and more **Modest (A5)**.
- Under pressure, the PPA group are also significantly more **Cautious**, **Reserved** and less **Bold** than the control group.

Operational: Disregard for guidelines

[redacted]

- Practitioners reported frustrations regarding the impact of administrative and/ or clinical guidelines on their work and decision making, noting that they often disagree with them and find them to be unnecessary bureaucracies. Some even noted that they are more likely to bend these to suit theirs/ their patients' needs a result.
- This approach was most common in highly self-confident practitioners who displayed low levels of self-awareness regarding the limits of their competence. It also originated from practitioners who felt guidelines impeded compassionate responses to patients and described situations relating to moral injury or distress.
- The PPA doctors are significantly more **Impulsive (N5)** than the control group. They are also less **Compliant (A4), Altruistic (A3), Ordered (C2)** and **Dutiful (C3).**
- Under pressure, the PPA group are also significantly less **Dutiful** and **Diligent** than the control group on these HDS scales.

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Operational: Patient focused

[redacted]

- The majority of practitioners are highly patient-centric, compassionate and motivated to put their best interests first. In some instances, this appeared to cloud judgement and detrimentally impact their ability to balance empathy with objectivity in decision making, setting boundaries, and with interactions with patients and colleagues.
- The PPA group are similarly **Compassionate (A6)** to the control group.

Operational: Preference for control

- Many practitioners displayed a preference to control the environments they work in, favouring those which are familiar and present low levels of ambiguity and risk. They described building build routine, stability and predictability into their lives and noted how they can be inflexible or reluctant to delegate under pressure.
- The PPA doctors are significantly more **anxious (N1)** than the control group. They are also less **excitement seeking (E5), open to actions (O4)** and prefer a slower **pace of work (E4).**
- Under pressure, they are significantly more **Cautious** than the control group.

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Learning for PPA: Impact of the referral/ process on practitioners

Constructive

- Referral/ process often well received – many approach proactively and constructively, aiming to clear their names and return to practice.
- Many expressed intent to minimize the opportunity for, and the impact of, the characteristics that caused adverse consequences for themselves and others following the referral.
- The referral/ process appears to prompt retrospective demonstrations of capacity for insight, development, and change in practitioners.
    - Many engage in self-reflection, CPD activities and personal development to address concerns raised by referral/ process.

Detrimental

- Many describe referral/ process inducing feelings of remorse, regret and shame which detrimentally impact their wellbeing and capacity to practice effectively.
- Other impacts of referral/ process on practice included:
    - increased self-consciousness and reduced self-confidence in ability to practice/ make independent decisions
    - over-cautiousness, including over-reliance on others for support and gaining consensus
    - scepticism, paranoia and withdrawal from others to avoid scrutiny

Thank you

[redacted]

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Appendix

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Quantitative data

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Section 1
Personality

NEO-PI-R

NEO Personality Inventory Revised

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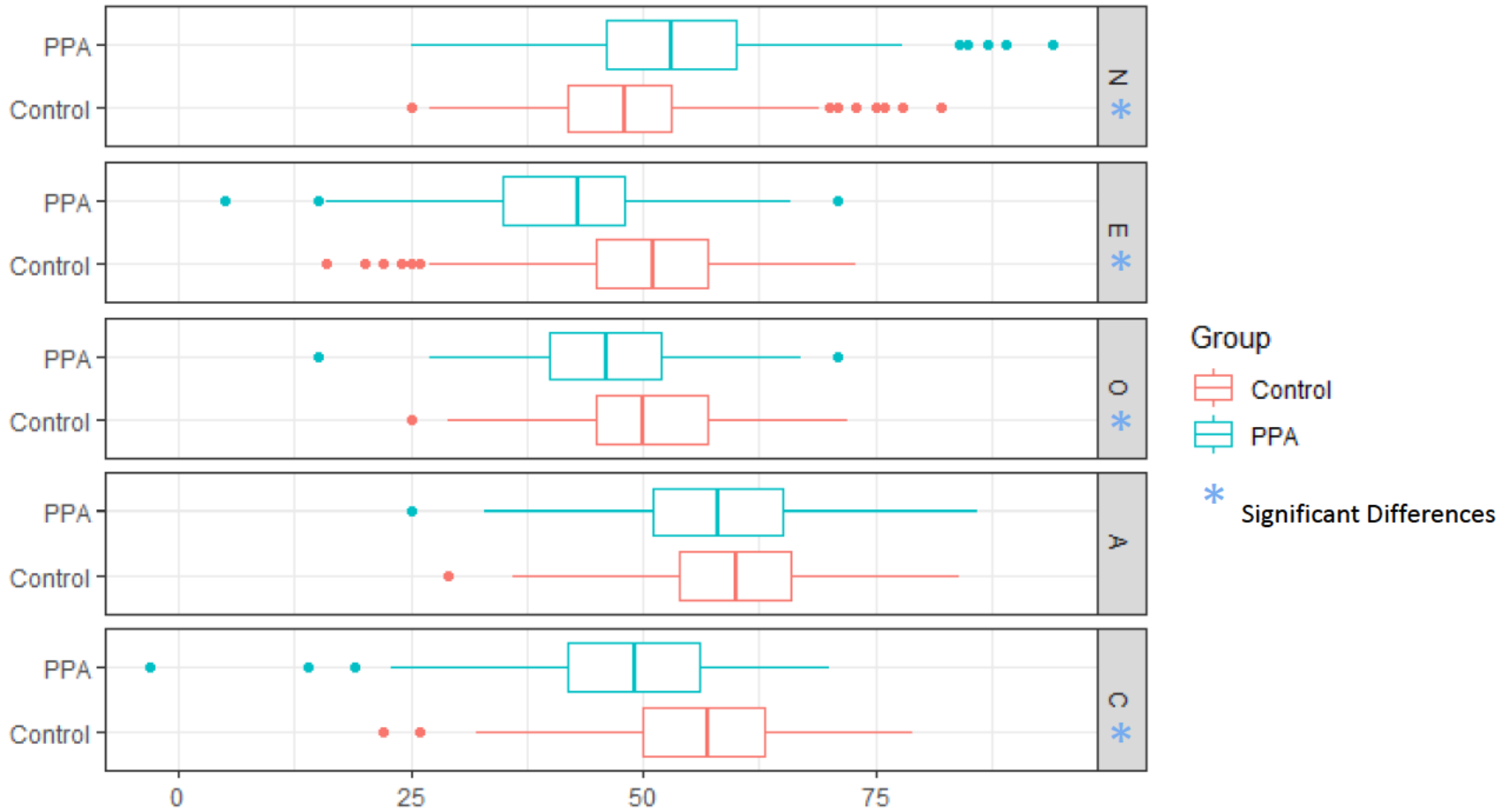
NEO-PI-R

- Five factor model of personality
  1. Neuroticism
  2. Extraversion
  3. Openness
  4. Agreeableness
  5. Conscientiousness
- Each factor divided into 6 facets/traits
- 240 items
- Norm group
  - British working population
  - Cohort of 357 medical consultants applying for consultant positions

PPA and Control Group Data: NEO Domains



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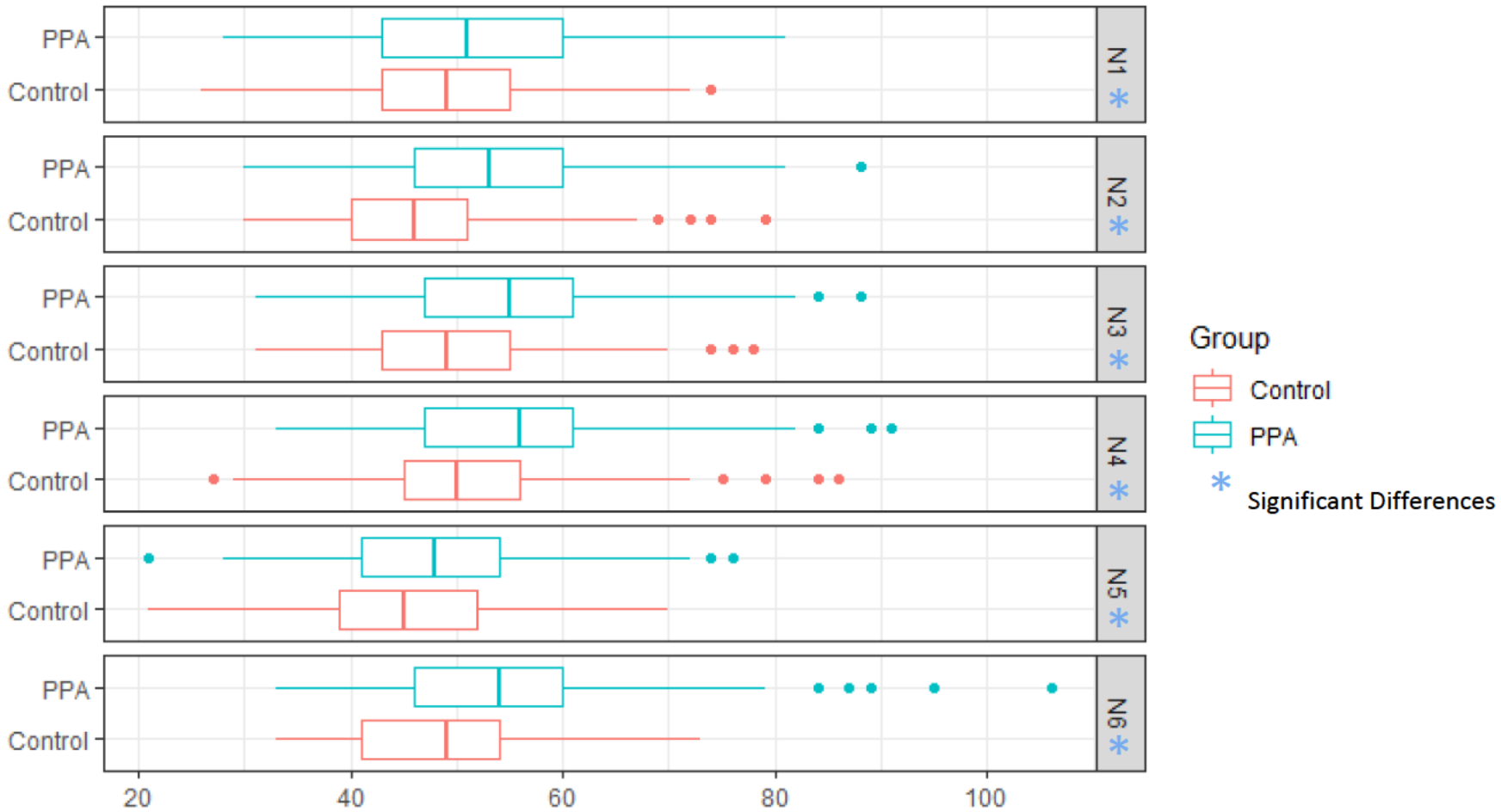
PPA and Control Group Data: Neuroticism



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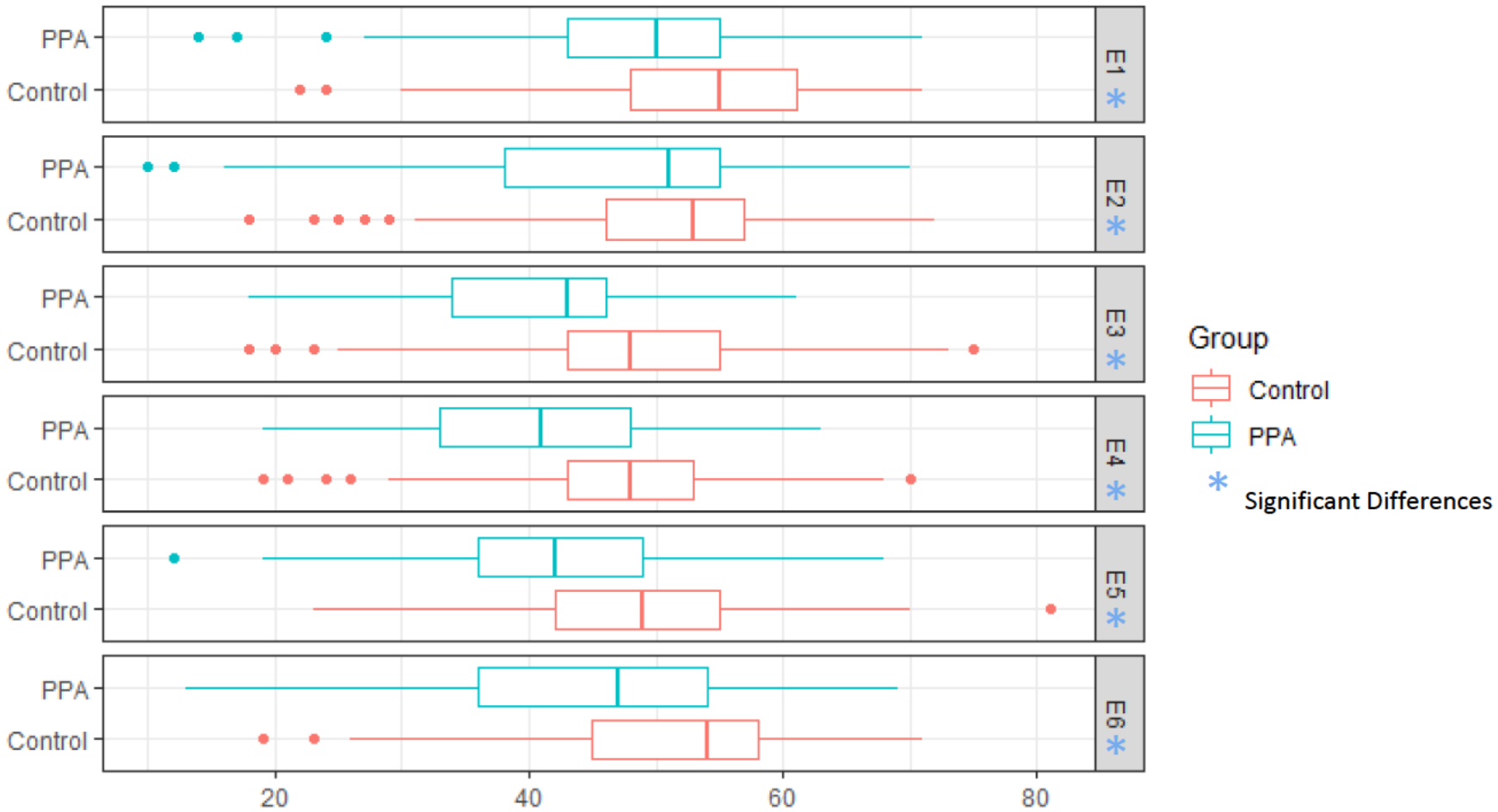
PPA and Control Group Data: Extraversion



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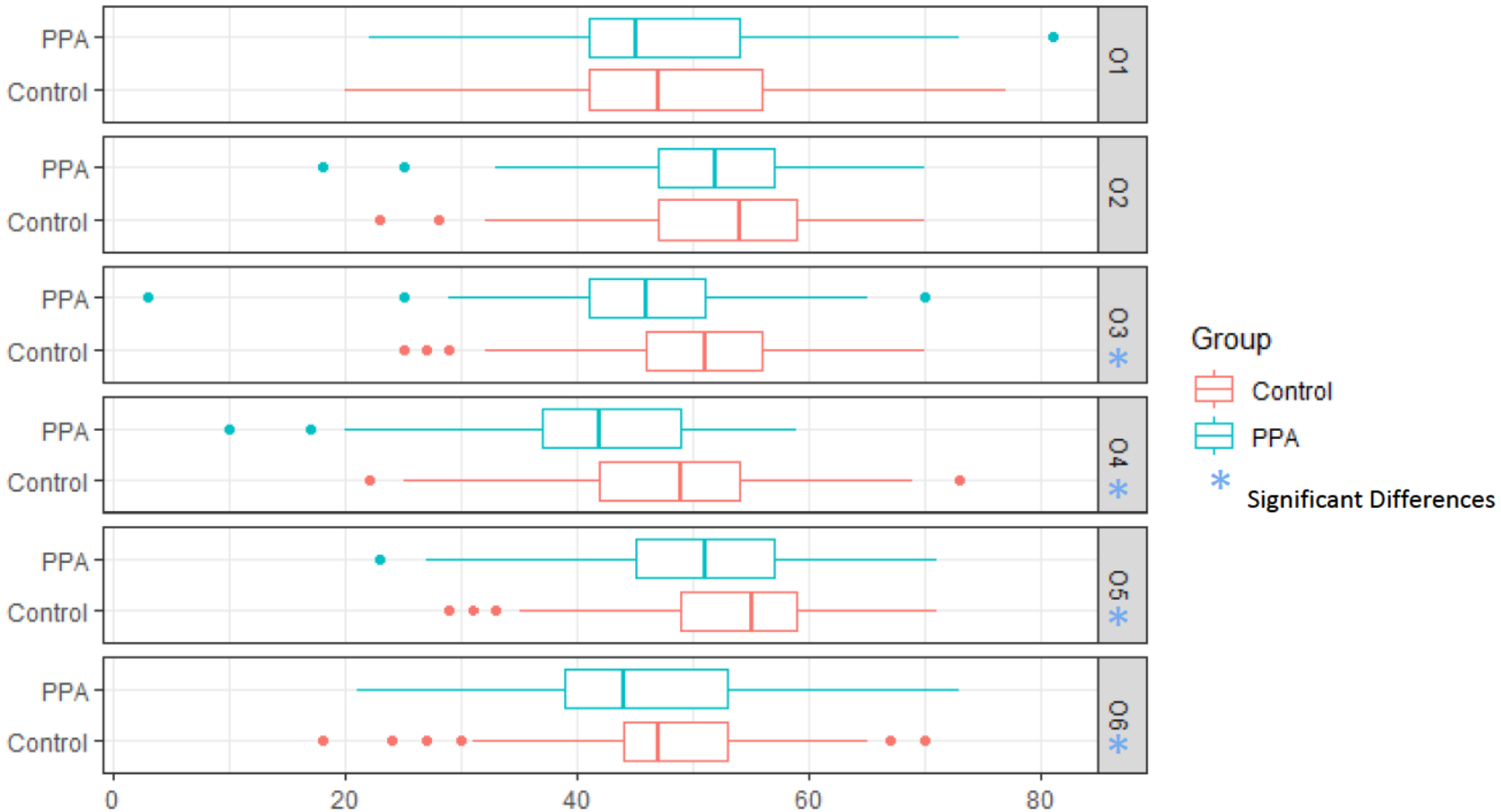
PPA and Control Group Data: Openness



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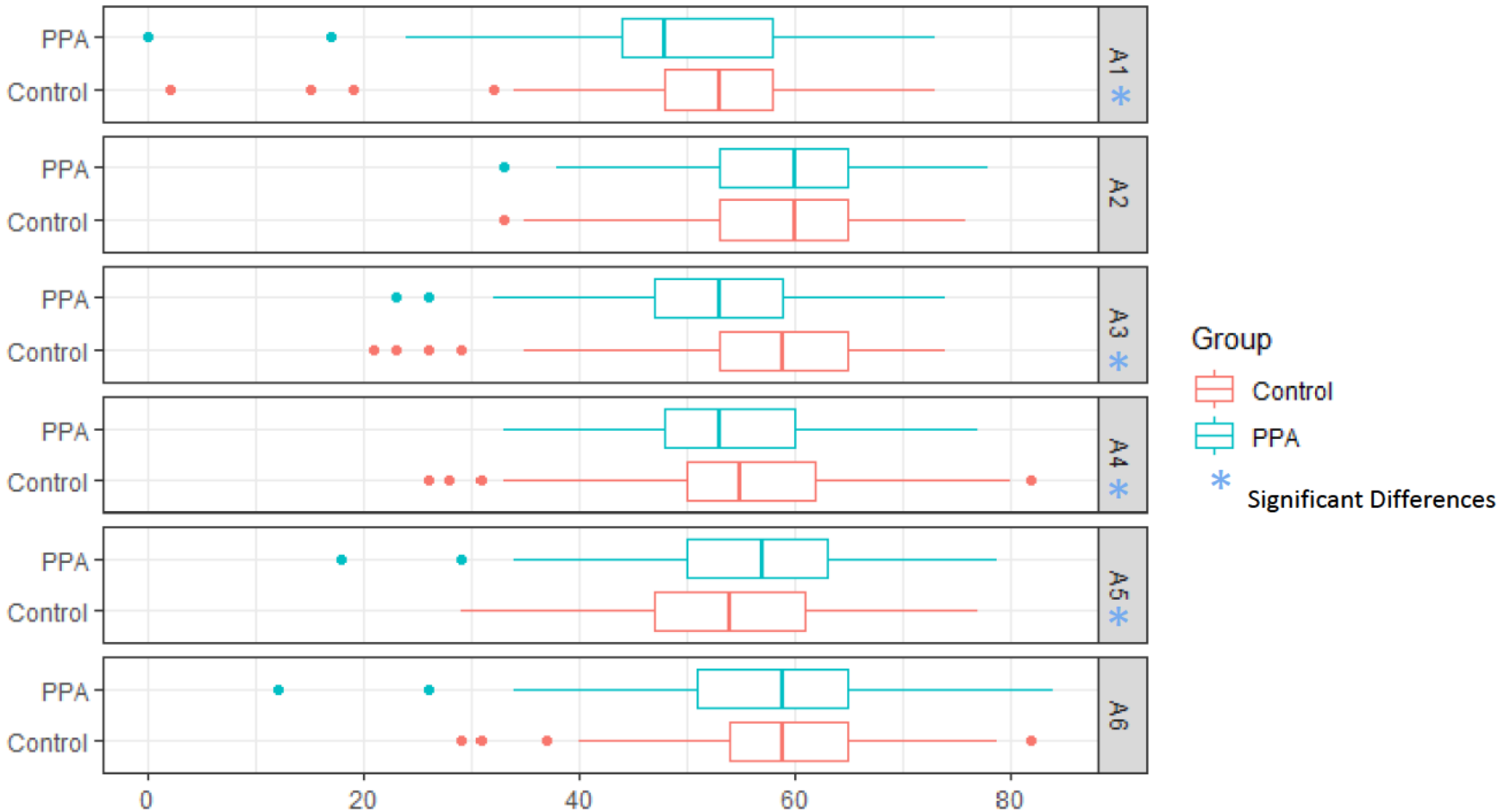
PPA and Control Group Data: Agreeableness



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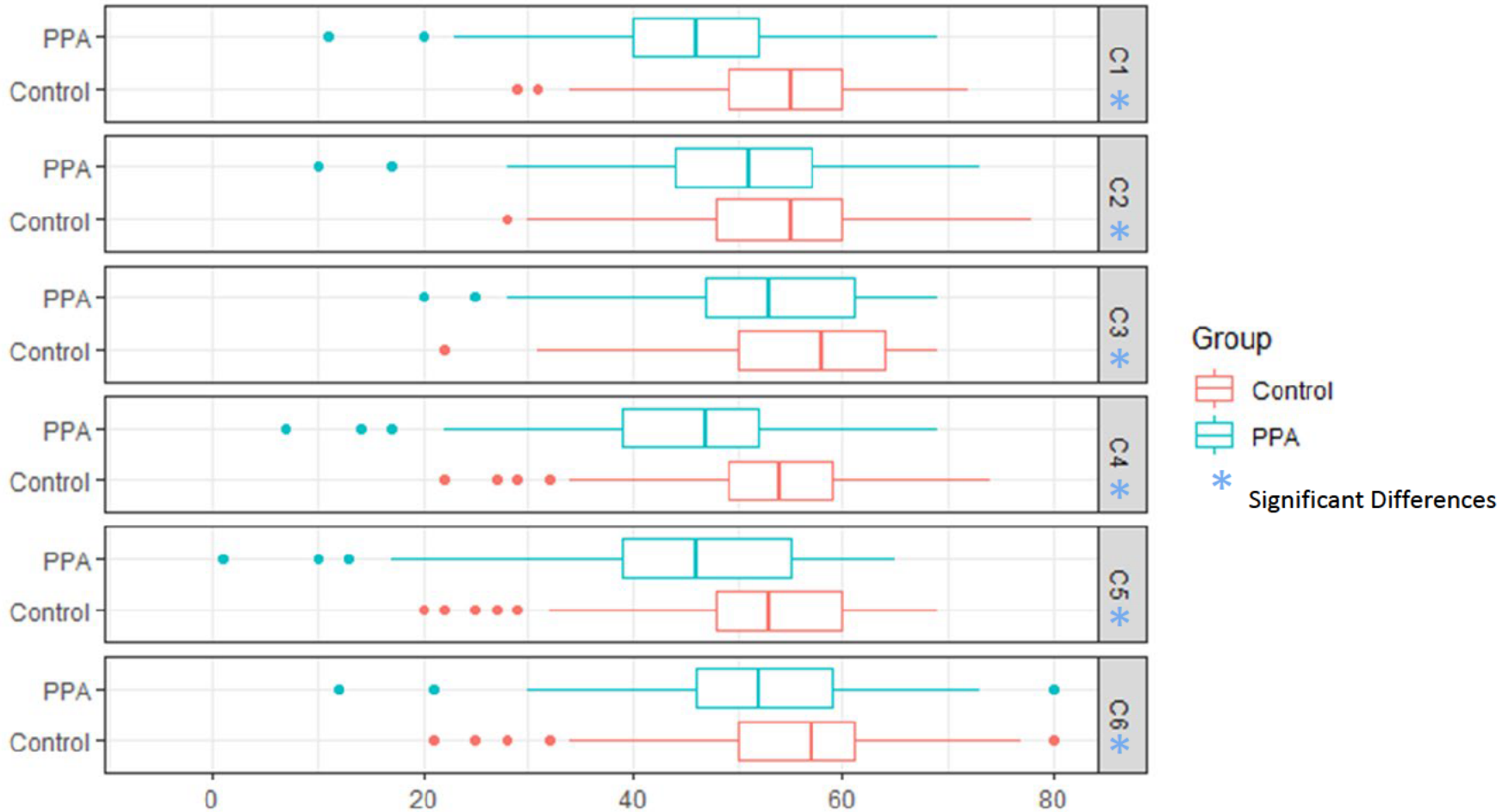
PPA and Control Group Data: Conscientiousness



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Section 2
Behaviour under pressure

Hogan Developmental Survey (HDS)

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Hogan Development Survey (HDS)

- describes the “dark side” of personality – qualities that emerge in times of increased pressure and strain and can disrupt relationships, damage reputations, and derail peoples’ chances of success
- 154 items – 20 minutes to complete online
- 11 main scales with 3 sub-scales each
- Norm group
  - 100,000+ working adults
  - 357 medical consultants applying for consultant positions

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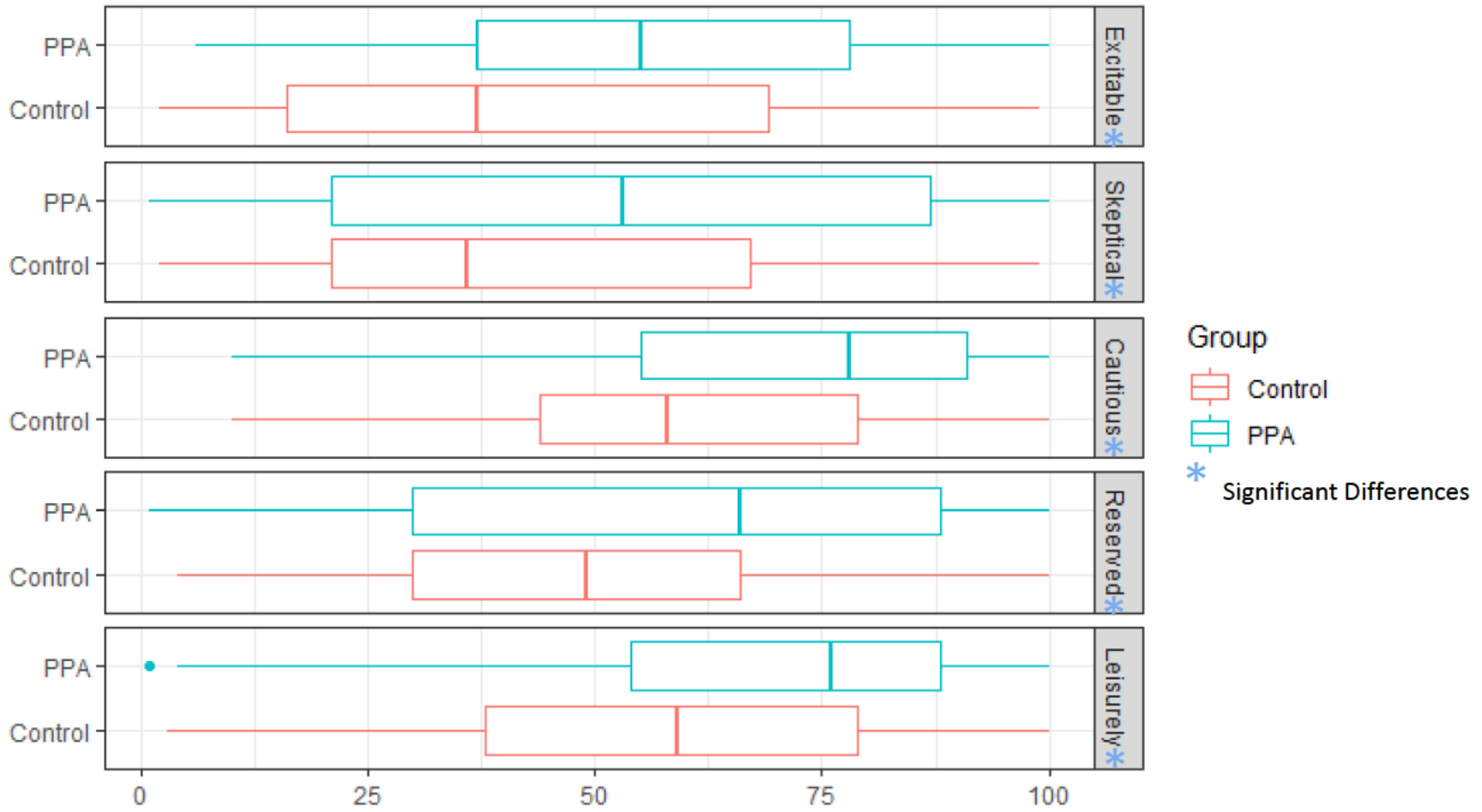
HDS Scales

Scale		Description
Moving away from others	Excitable	Acting with passion and energy – becoming **moody, irritable** and hard to please under pressure.
	Sceptical	Bright and perceptive – becoming **cynical, mistrustful**, doubting others' true intentions under pressure.
	Cautious	Conservative – becoming **reluctant to act and take risks** under pressure.
	Reserved	Independent – becoming **aloof, detached** and unapproachable under pressure.
	Leisurely	Co-operative on the outside – becoming **stubborn, resentful** and passively resistant under pressure.
Moving against others	Bold	Confident and assertive – becoming **overly self-confident** and self-promoting under pressure.
	Mischievous	Charming – becoming **manipulative and testing the limits** under pressure.
	Colourful	Fun and flamboyant – becoming **attention-seeking and dramatic** under pressure.
	Imaginative	Innovative – under pressure **ideas may not land well** with others and may seem unusual and eccentric.
Moving towards others	Diligent	Detail-orientated and hard-working – becoming **perfectionistic and demanding** under pressure.
	Dutiful	Conforming – becoming **eager to please and submissive** under pressure.

PPA and Control Group Data: HDS Scales Moving Away



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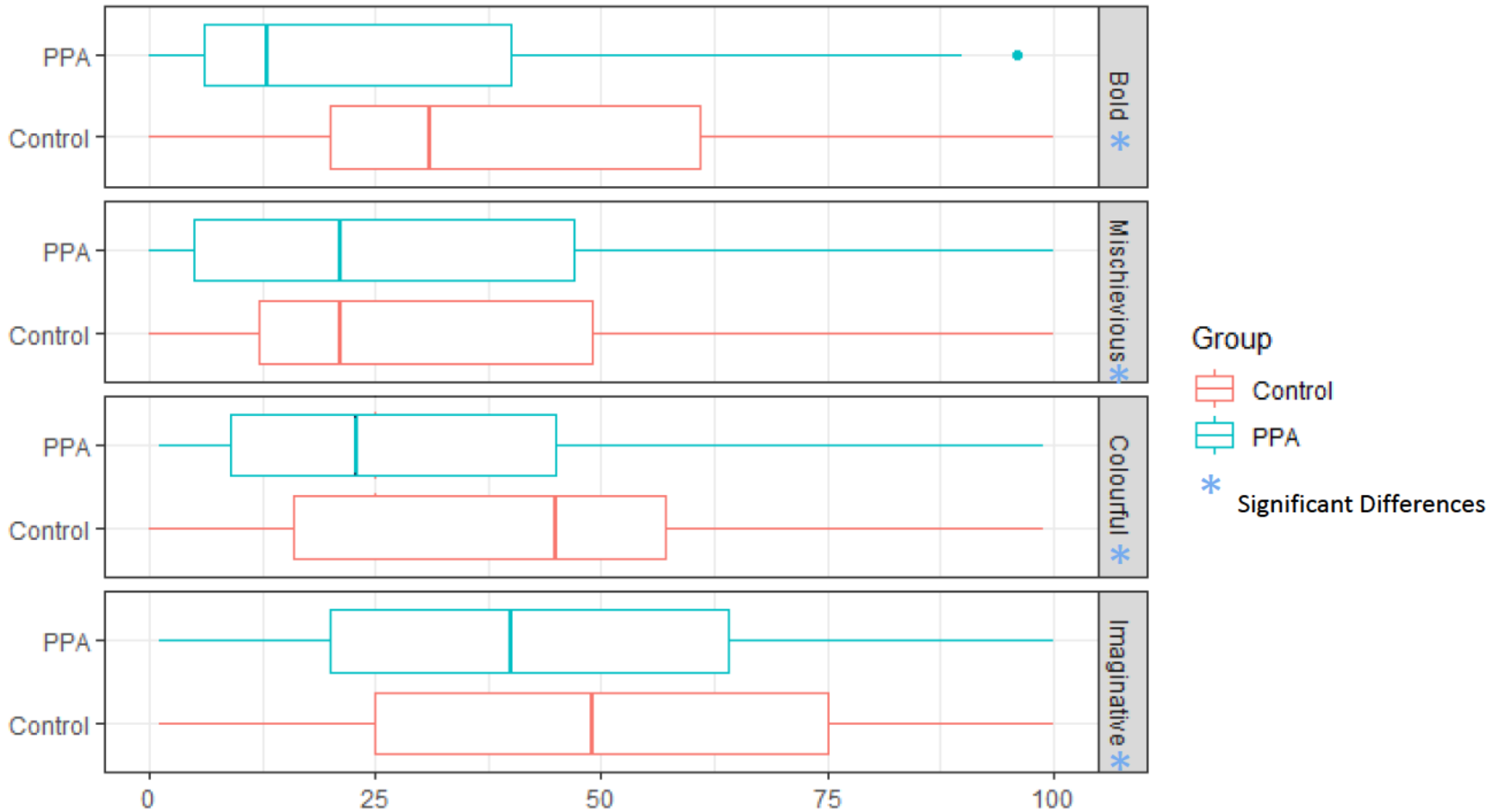
PPA and Control Group Data: HDS Scales Moving Against



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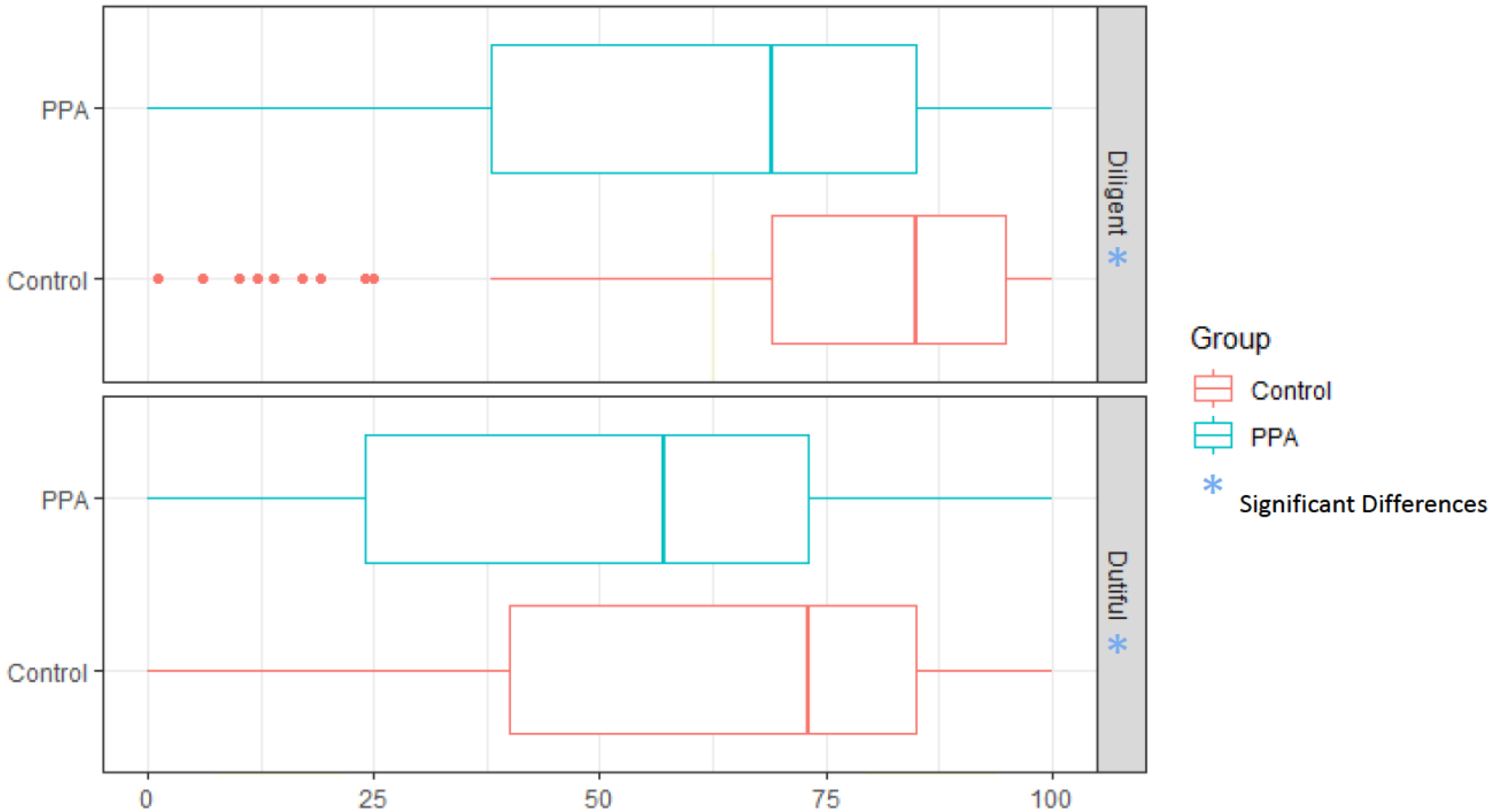
PPA and Control Group Data: HDS Scales Moving Towards



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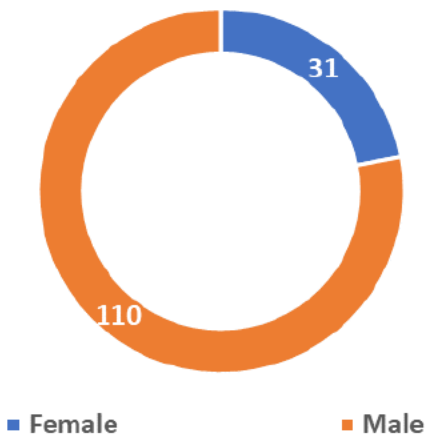
PPA Data - Demographic Specific Results

Gender



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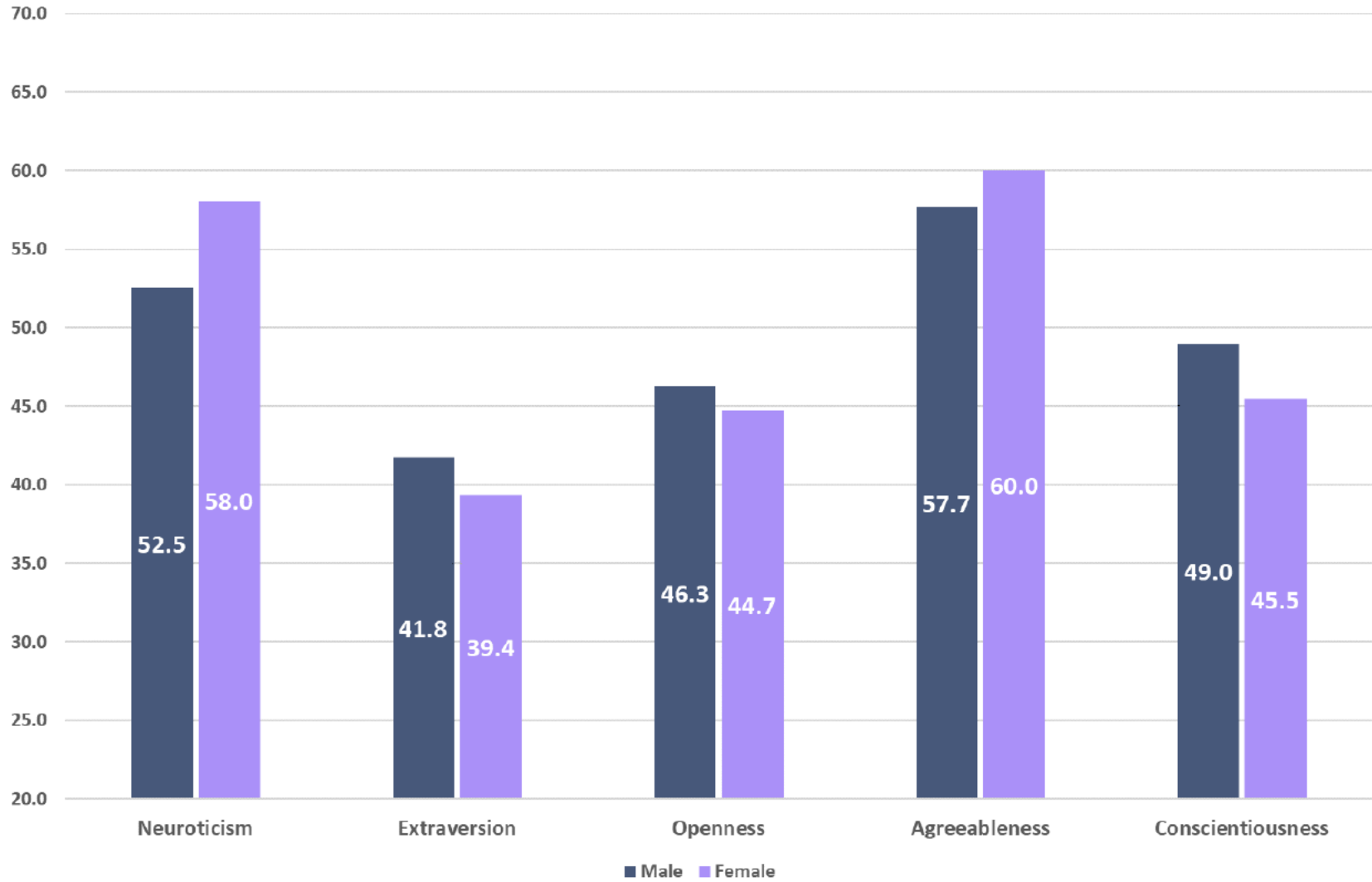
NEO Domain Averages - Gender



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HDS Scale Averages – Gender

HDS Scales		Gender	
		Male *(110)*	Female *(31)*
Moving Away	Excitable	57.9	55.0
	Skeptical	55.4	48.5
	Cautious	68.5	74.7
	Reserved	60.2	55.5
	Leisurely	70.6	61.5
Moving Against	Bold	29.0	14.5
	Mischievious	31.5	18.0
	Colourful	32.9	21.8
	Imaginative	45.9	34.9
Moving Towards	Diligent	64.2	55.7
	Dutiful	48.2	61.8

Moderate Risk **High Risk**

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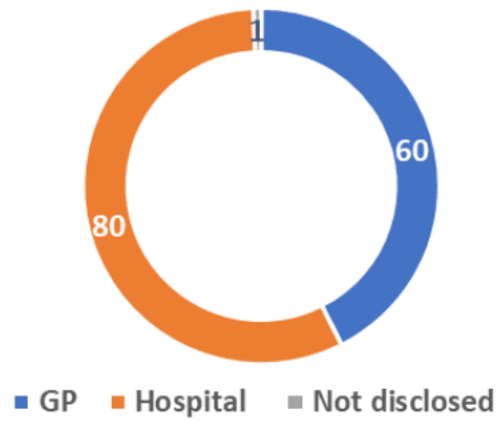
PPA Data - Demographic Specific Results

Type of doctor



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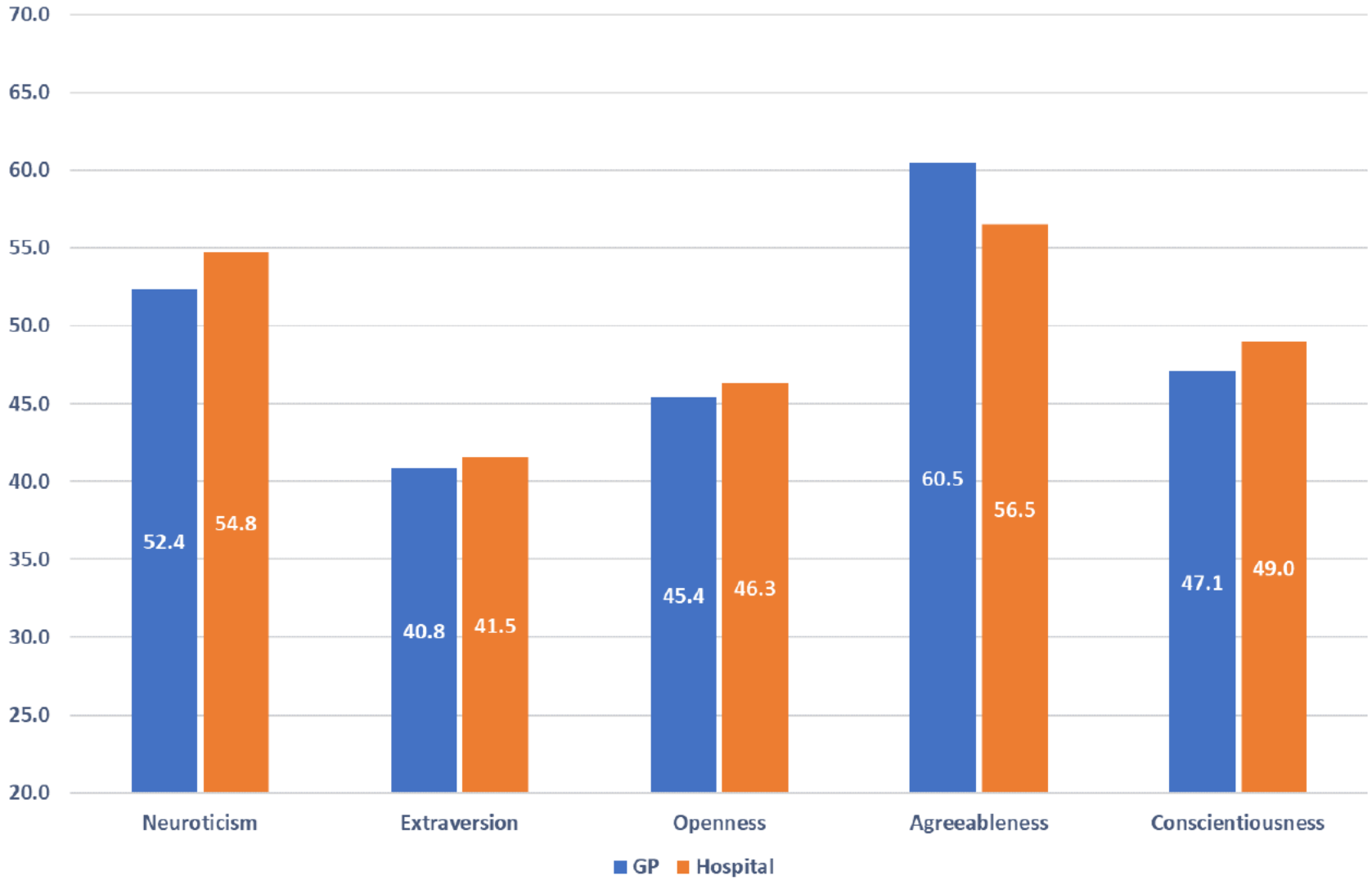
NEO Domain Averages: Type of Doctor



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HDS Scale Averages – Type of Doctor

HDS Scales		Type of Doctor	
		GP *(60)*	Hospital *(81)*
Moving Away	Excitable	54.7	59.2
	Skeptical	54.0	53.8
	Cautious	72.5	67.9
	Reserved	58.5	59.7
	Leisurely	71.9	66.1
Moving Against	Bold	22.6	28.1
	Mischievious	30.3	27.2
	Colourful	28.8	31.7
	Imaginative	40.6	45.6
Moving Towards	Diligent	61.7	62.8
	Dutiful	49.0	52.7

Moderate Risk High Risk

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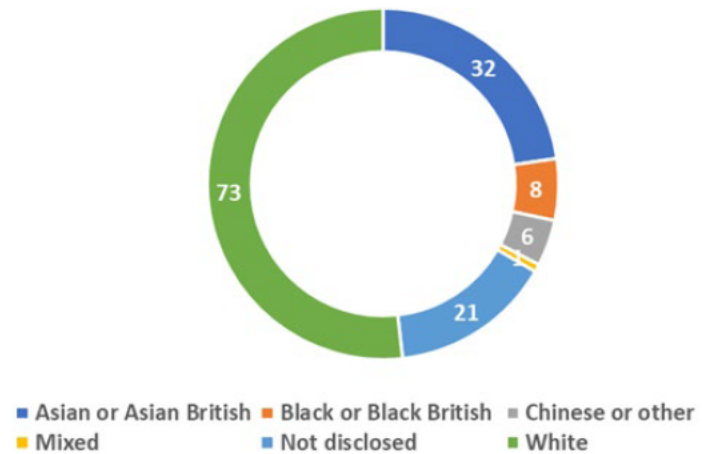
PPA Data - Demographic Specific Results

Ethnic Group



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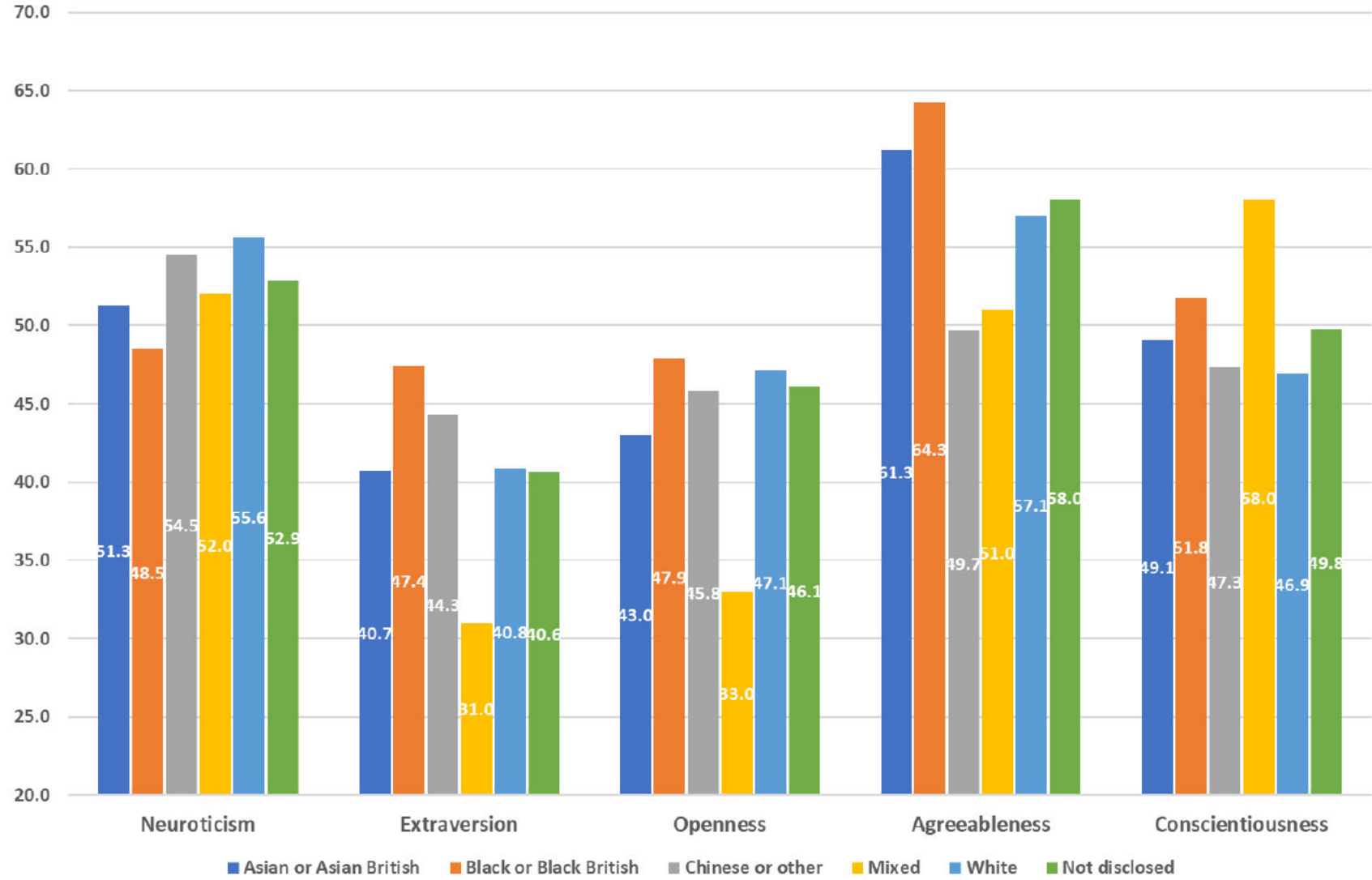
NEO Domain Averages – Ethnicity



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HDS Scale Averages – Ethnicity

HDS Scales		Ethnic Group					
		Asian or Asian British *(32)*	Black or Black British *(8)*	Chinese or other *(6)*	Mixed *(1)*	White *(73)*	Not disclosed *(21)*
Moving Away	Excitable	51.4	41.8	48.7	55.0	61.0	61.6
	Skeptical	43.9	59.8	71.7	96.0	54.5	57.3
	Cautious	76.4	57.4	74.3	86.0	69.3	64.6
	Reserved	51.3	46.6	78.2	97.0	63.4	54.1
	Leisurely	71.7	68.1	76.7	79.0	69.4	58.4
Moving Against	Bold	29.6	38.6	54.2	70.0	20.7	22.3
	Mischievious	20.4	25.3	43.7	12.0	30.7	31.1
	Colourful	26.4	24.6	43.7	34.0	33.1	25.8
	Imaginative	39.8	41.0	50.2	20.0	45.5	42.5
Moving Towards	Diligent	62.3	63.9	76.2	95.0	59.1	67.7
	Dutiful	61.7	47.9	57.5	73.0	45.5	53.1

Moderate Risk **High Risk**

Moderate/ High Risk

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Thinking differently

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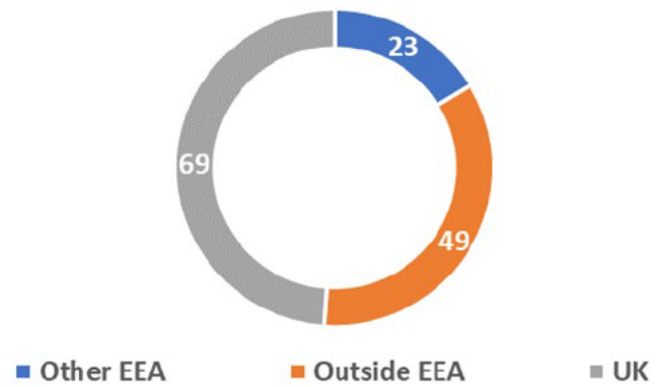
PPA - Demographic Specific Results

Place of Qualification



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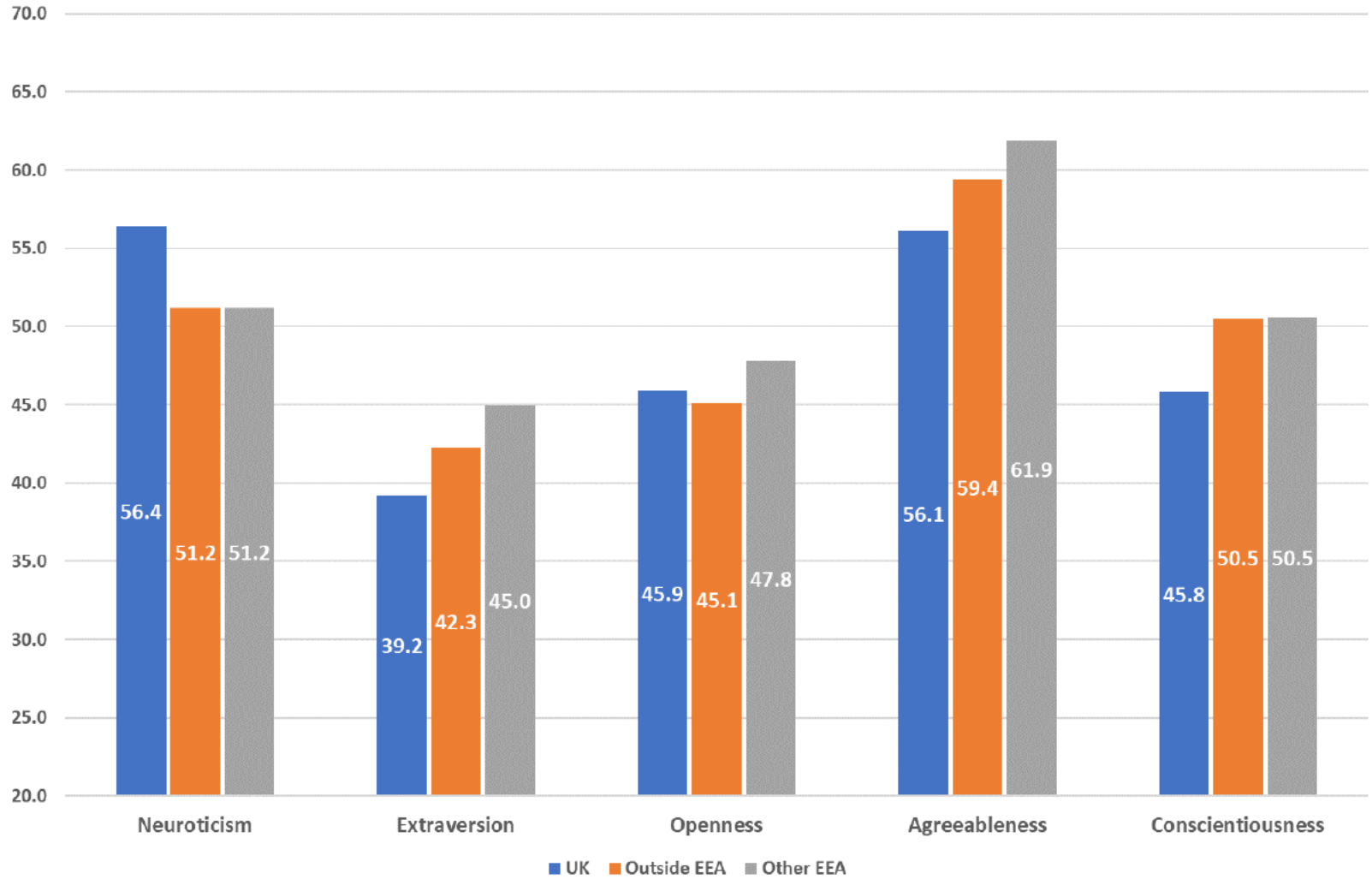
NEO Domain Averages – Place of Qualification



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HDS Scale Averages – Place of Qualification

HDS Scales		Place of Qualification		
		UK (*69*)	Outside EEA (*49*)	Other EEA (*23*)
Moving Away	Excitable	64.3	52.2	47.0
	Skeptical	58.0	51.0	47.5
	Cautious	71.0	68.5	69.5
	Reserved	61.2	55.7	60.4
	Leisurely	71.5	67.2	62.9
Moving Against	Bold	19.2	35.1	25.5
	Mischievious	31.3	26.2	25.0
	Colourful	33.2	28.4	26.7
	Imaginative	47.4	40.4	38.3
Moving Towards	Diligent	59.9	66.6	60.4
	Dutiful	44.9	57.3	56.7

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Thinking differently

Moderate Risk High Risk

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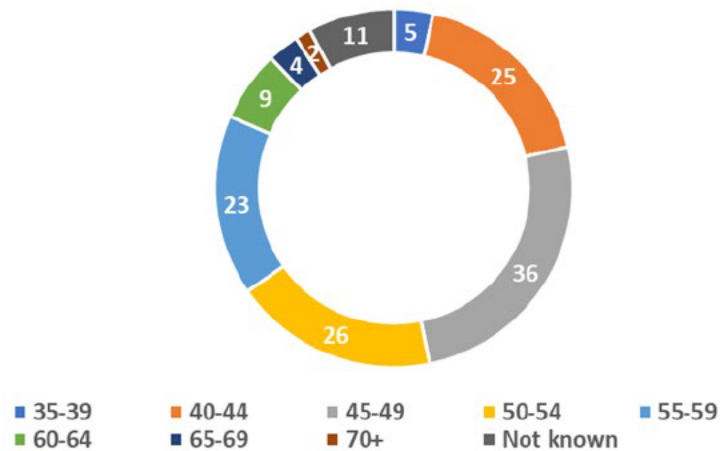
PPA Data - Demographic Specific Results

Age Range



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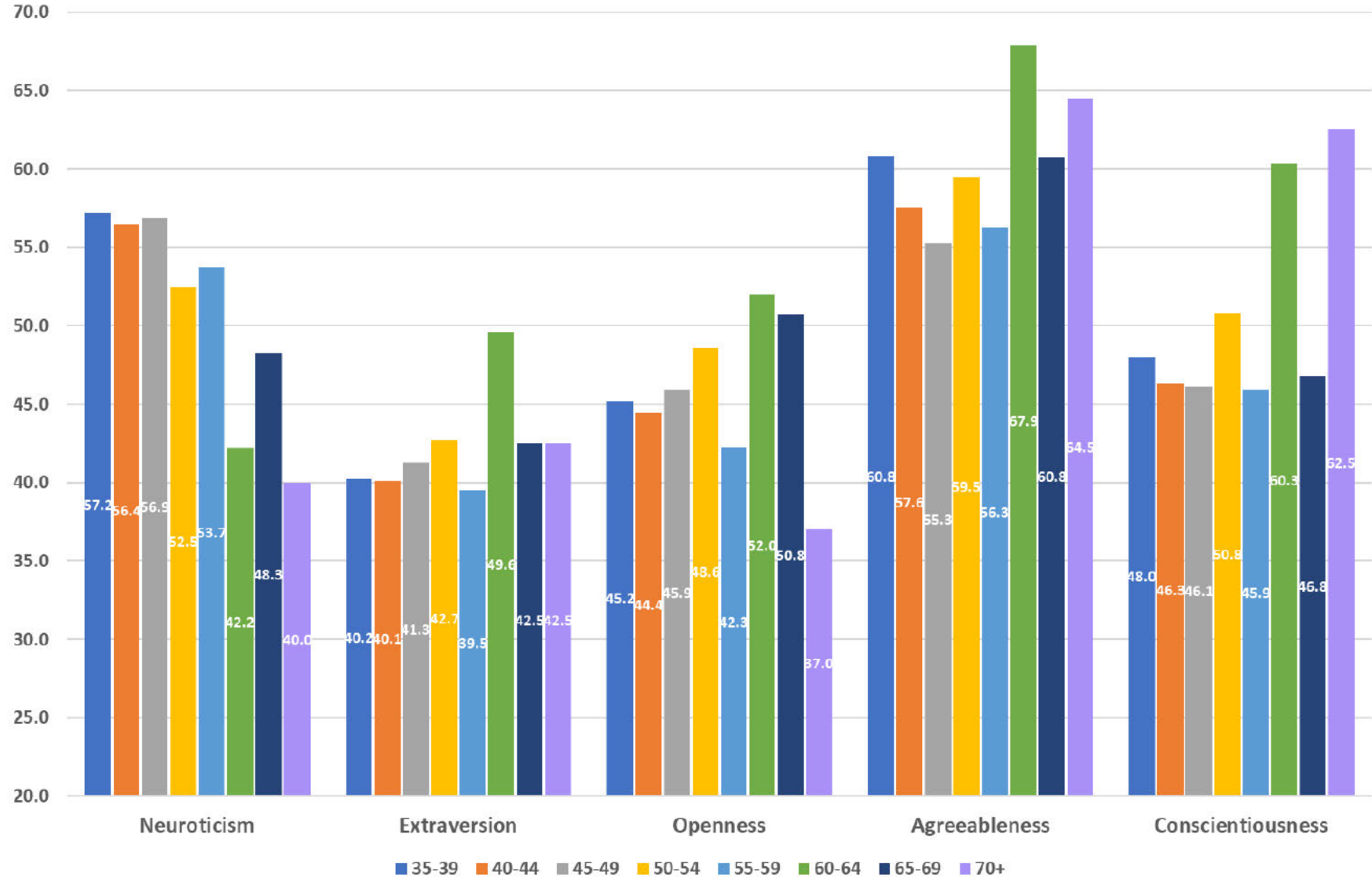
NEO Domain Averages – Age Range



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HDS Scale Averages – Age Range

HDS Scales		Age Range							
		35-39 (*5*)	40-44 (*25*)	45-49 (*36*)	50-54 (*26*)	55-59 (*23*)	60-64 (*9*)	65-69 (*4*)	70+ (*2*)
Moving Away	Excitable	59.4	63.3	55.9	61.7	58.8	40.7	40.3	46.0
	Skeptical	57.6	57.4	54.1	56.5	56.4	32.8	36.8	66.0
	Cautious	60.6	73.3	69.9	70.5	75.8	51.7	58.0	65.0
	Reserved	54.4	55.8	59.4	65.5	65.5	36.3	30.8	54.5
	Leisurely	53.8	76.0	65.5	67.3	74.4	59.1	57.5	71.0
Moving Against	Bold	7.4	32.5	19.3	30.4	28.0	24.3	16.8	58.0
	Mischievious	17.4	27.8	27.2	35.2	31.9	18.2	27.0	49.0
	Colourful	31.8	37.6	25.5	32.7	28.4	36.8	34.0	30.0
	Imaginative	65.0	48.3	43.7	42.6	38.7	35.2	33.8	56.0
Moving Towards	Diligent	56.6	58.4	63.0	66.5	57.9	79.1	54.0	97.5
	Dutiful	60.6	60.2	56.0	45.5	50.5	41.3	25.5	57.0

Moderate Risk **High Risk**

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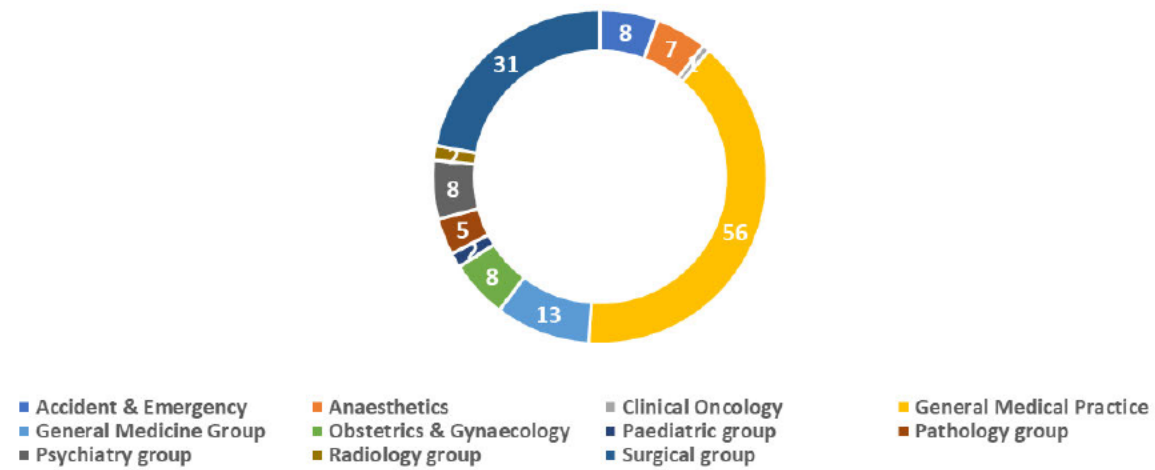
PPA Data - Demographic Specific Results

Specialty



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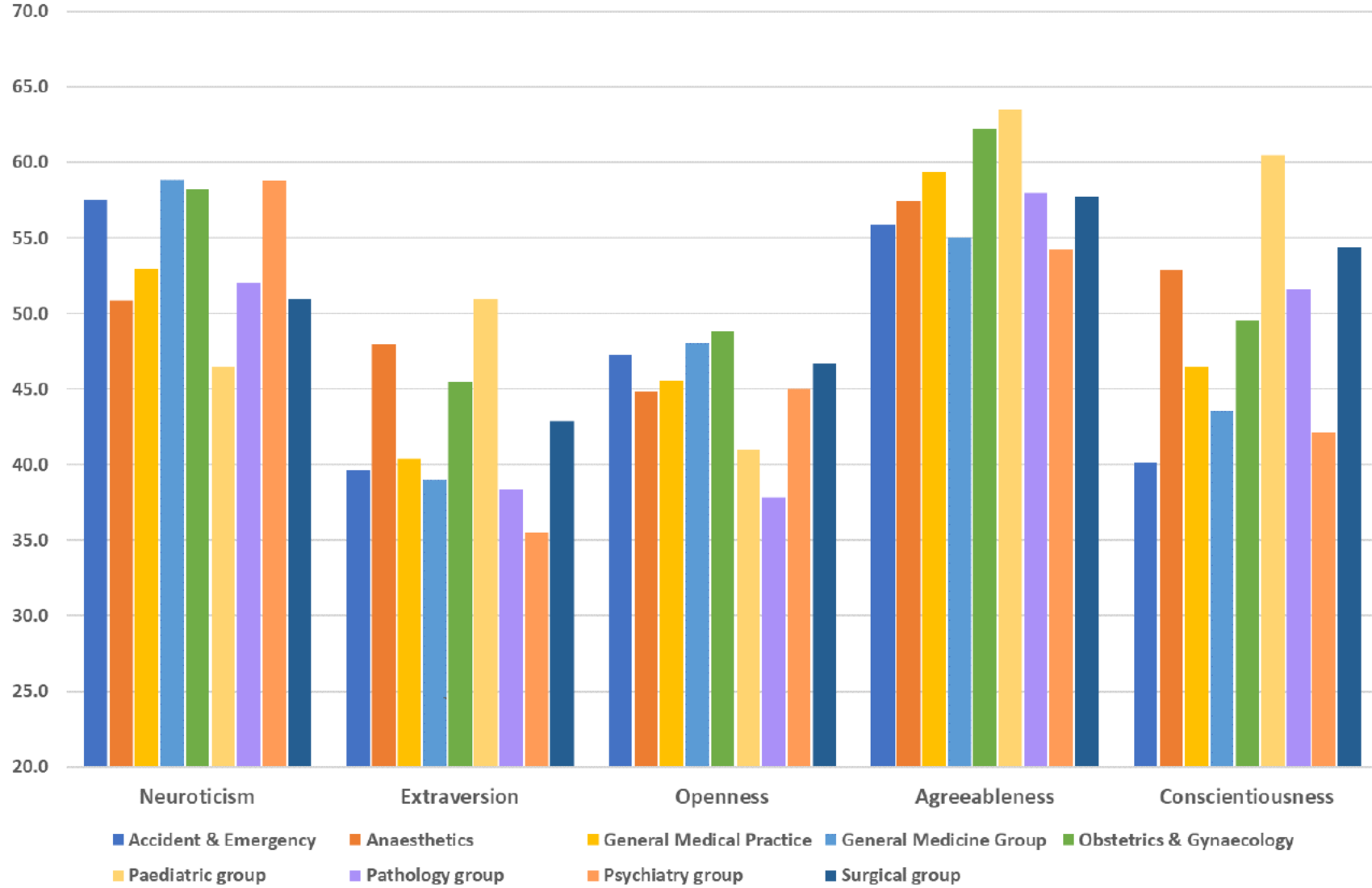
NEO Domain Averages – Specialty



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HDS Scale Averages – Speciality

HDS Scales		Speciality								
		Accident & Emergency *(8)*	Anaesthetics *(7)*	General Medical Practice *(59)*	General Medicine Group *(13)*	Obstetrics & Gynaecology *(8)*	Paediatric group *(2)*	Pathology group *(5)*	Psychiatry group *(8)*	Surgical group *(31)*
Moving Away	Excitable	69.8	52.3	53.8	59.5	57.0	27.5	65.4	60.1	60.6
	Skeptical	61.0	69.1	51.9	61.3	52.0	40.5	59.8	44.8	52.0
	Cautious	73.6	51.4	72.6	78.2	64.6	67.0	79.8	74.9	63.0
	Reserved	60.8	52.4	58.7	54.1	48.6	80.0	50.0	68.4	63.8
	Leisurely	61.0	61.4	70.5	78.4	65.0	52.5	66.4	64.9	67.7
Moving Against	Bold	26.0	39.0	23.4	21.6	26.1	32.5	39.0	23.6	26.9
	Mischievious	27.0	38.1	30.0	30.0	38.1	31.5	6.2	19.8	26.6
	Colourful	39.1	28.0	29.7	26.8	35.5	24.5	14.8	30.1	33.5
	Imaginative	47.0	30.4	40.2	61.5	36.6	32.5	21.4	37.1	51.9
Moving Towards	Diligent	36.4	59.6	60.9	49.9	70.9	60.5	79.6	57.8	73.9
	Dutiful	62.0	57.6	48.1	61.6	49.4	62.0	67.8	44.3	47.3

Moderate Risk **High Risk**

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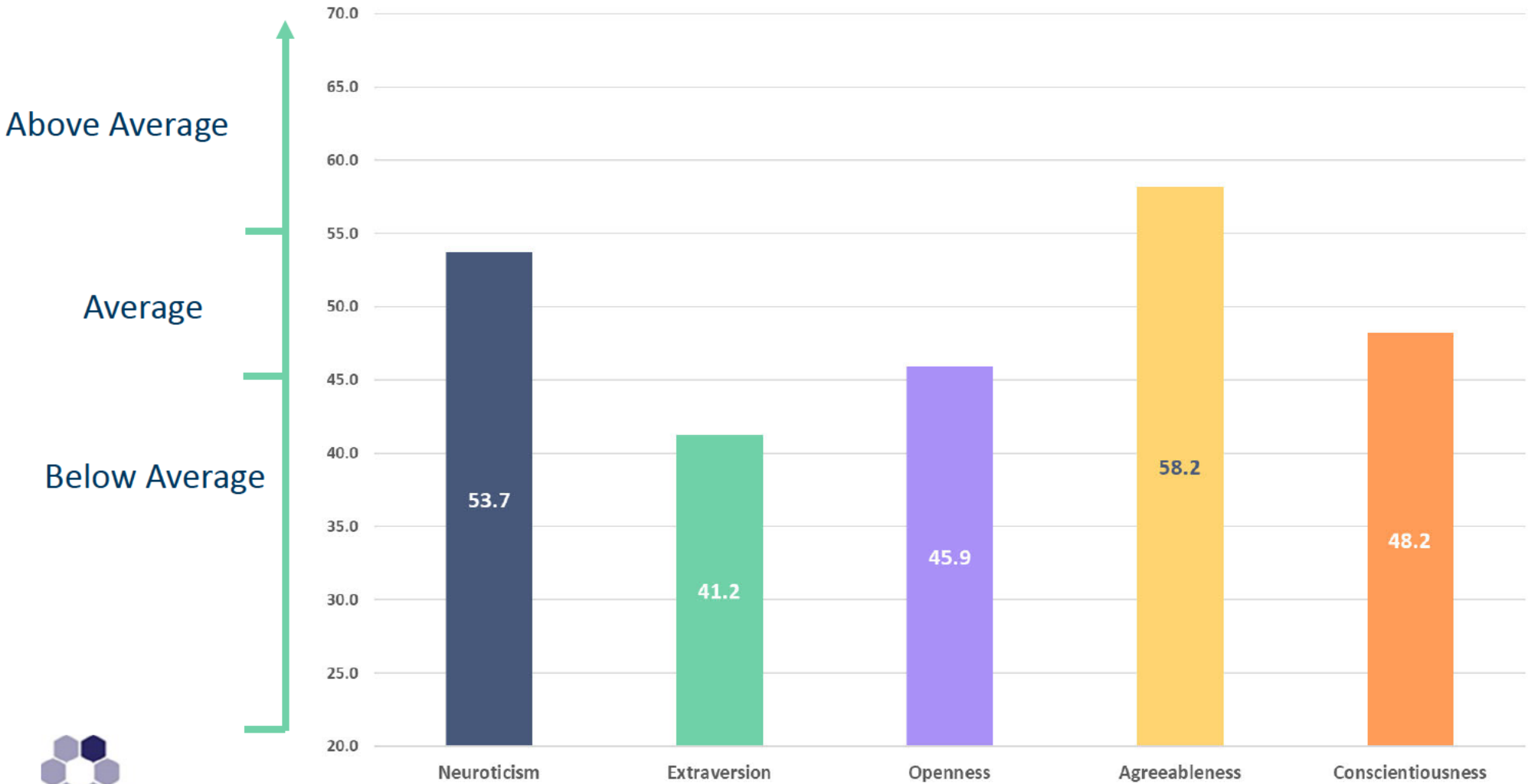
NEO Domain Averages

PPA doctors average compared to the working population norm



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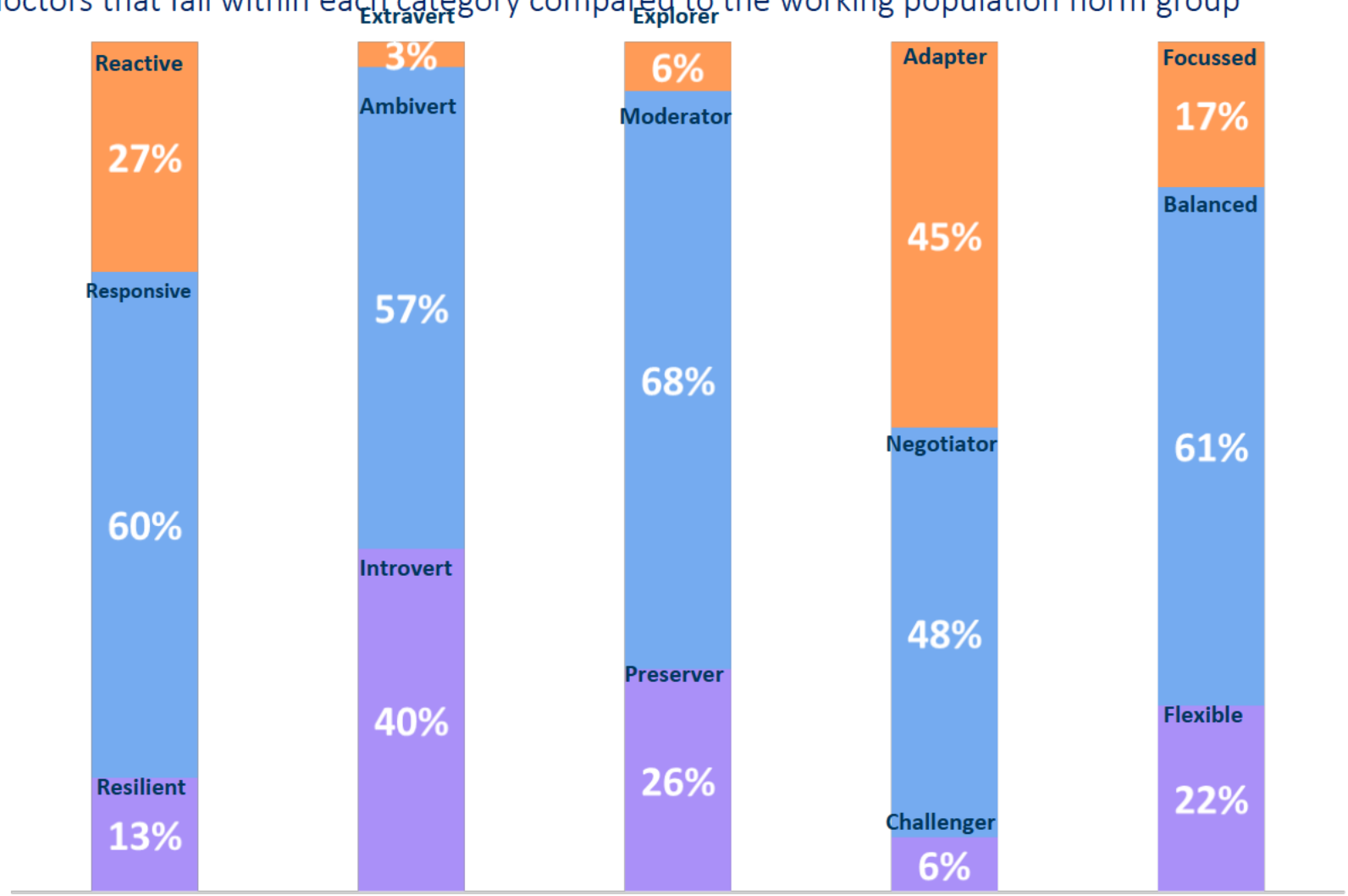
Diversity of Characteristics

Proportion of PPA doctors that fall within each category compared to the working population norm group



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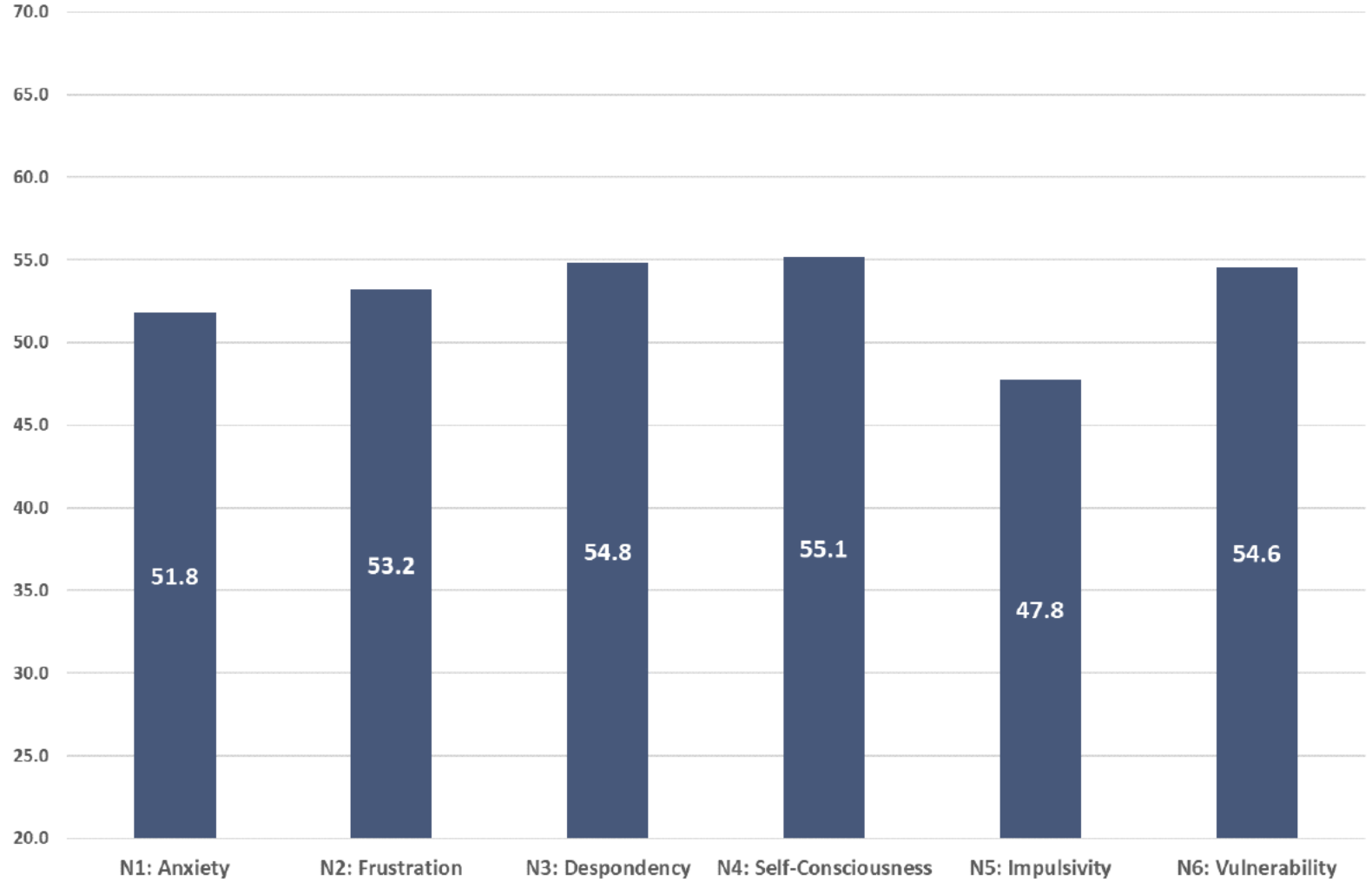
Neuroticism Facet Averages

PPA doctors compared to the working population norm

Above Average

Average

Below Average



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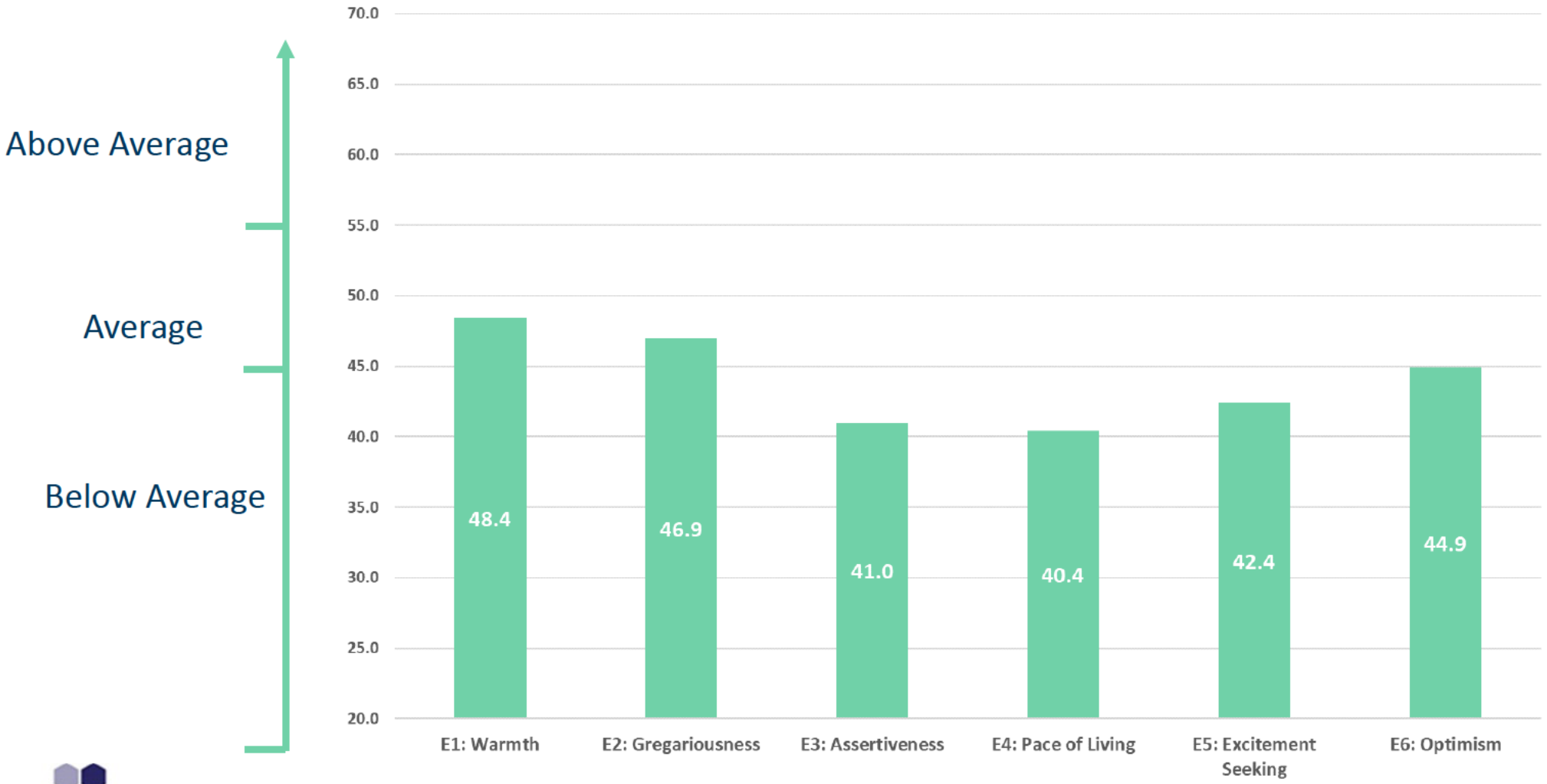
Extraversion Facet Averages

PPA doctors compared to the working population norm



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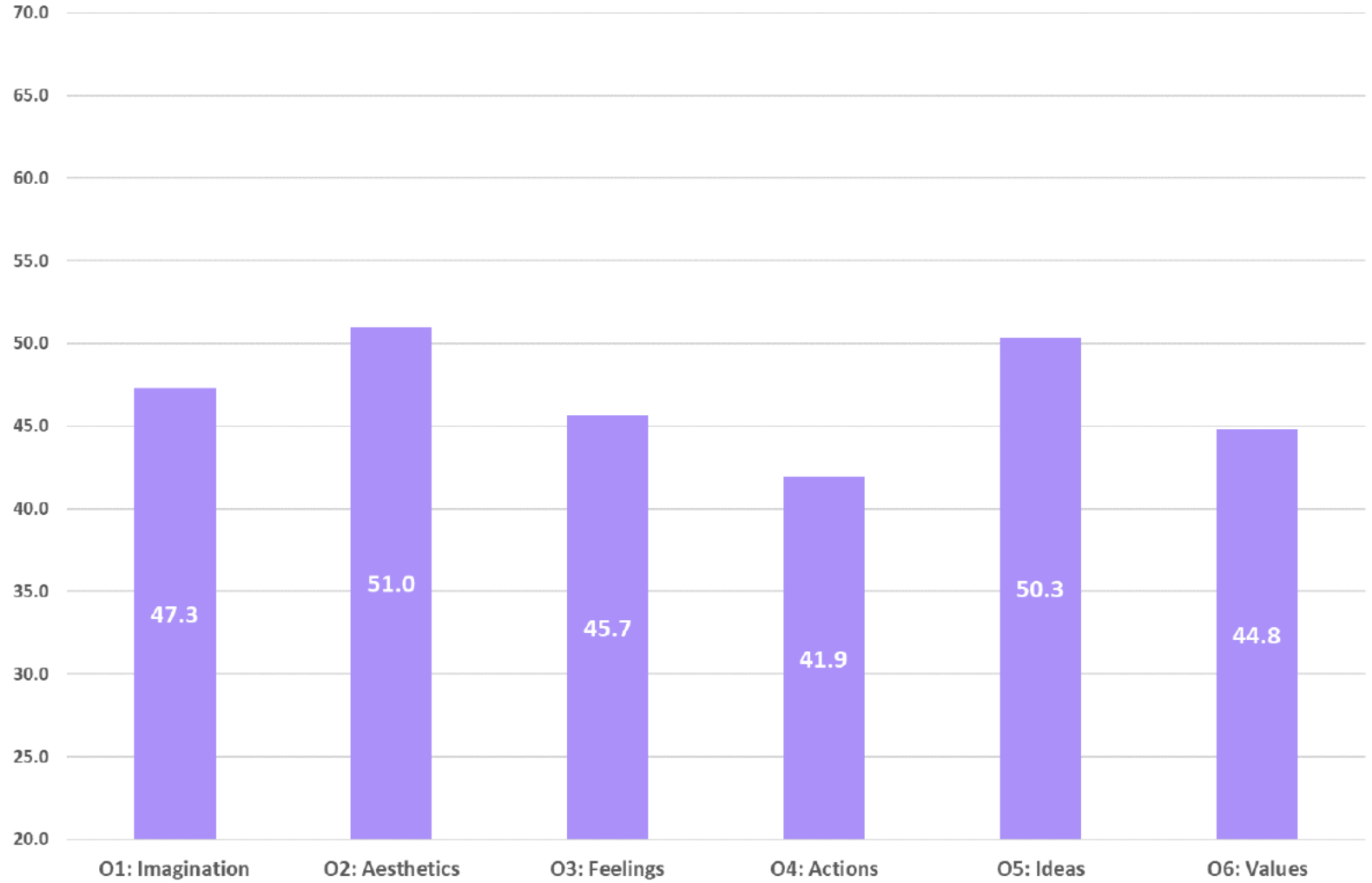
Openness Facet Averages

PPA doctors compared to the working population norm

Above Average

Average

Below Average



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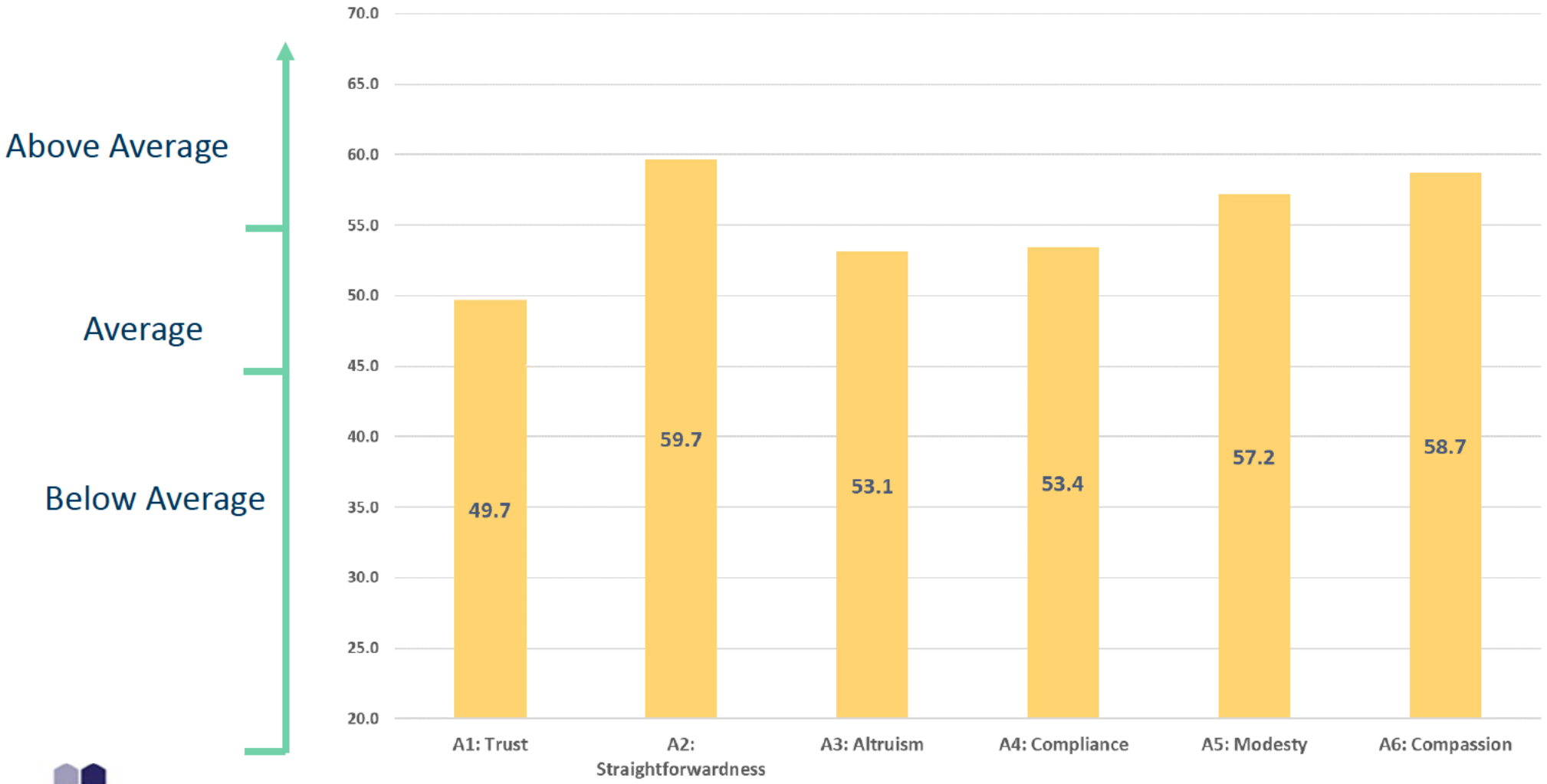
Agreeableness Facet Averages

PPA doctors compared to the working population norm



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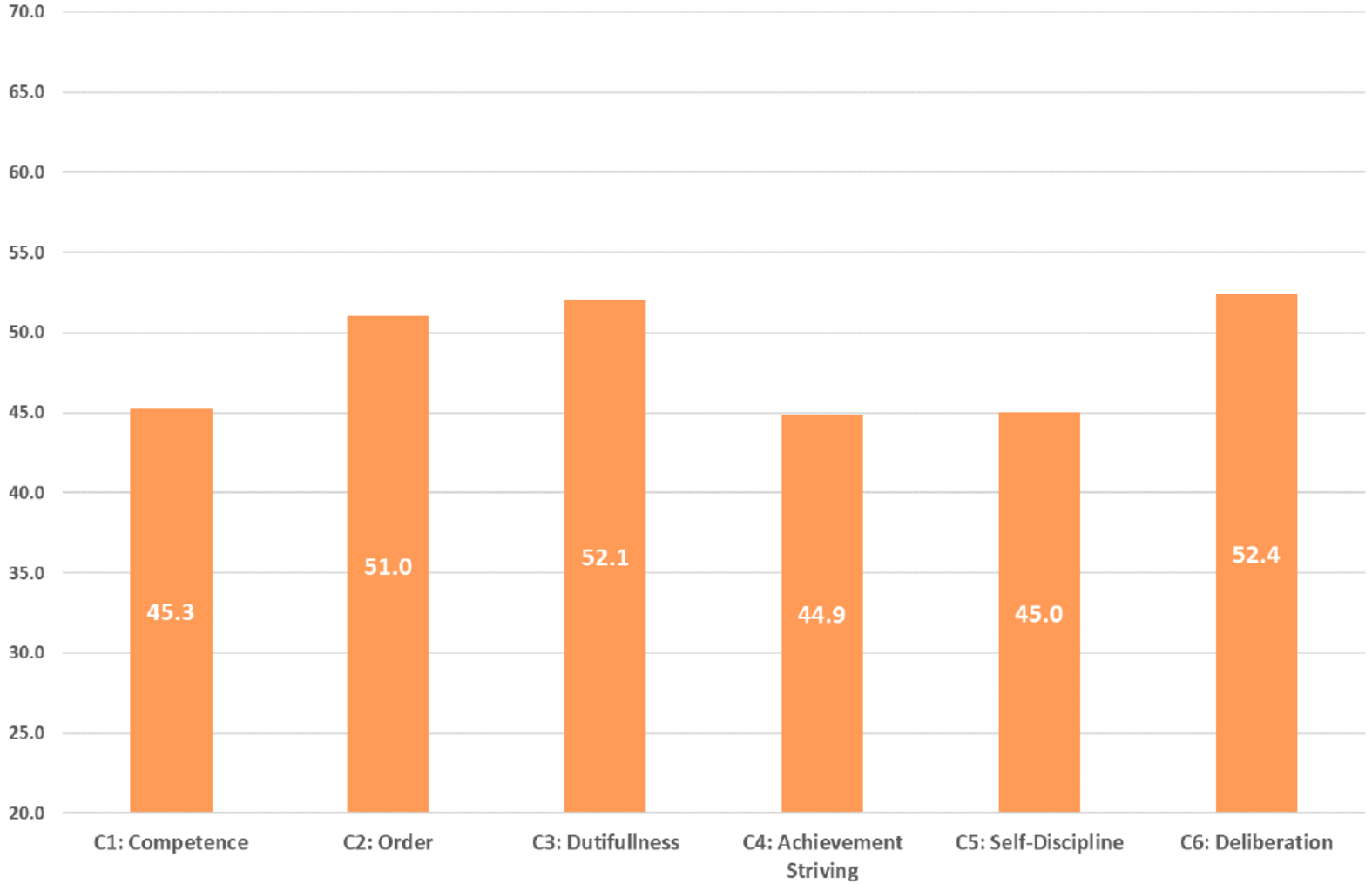
Conscientiousness Facet Averages

PPA doctors compared to the working population norm

Above Average

Average

Below Average



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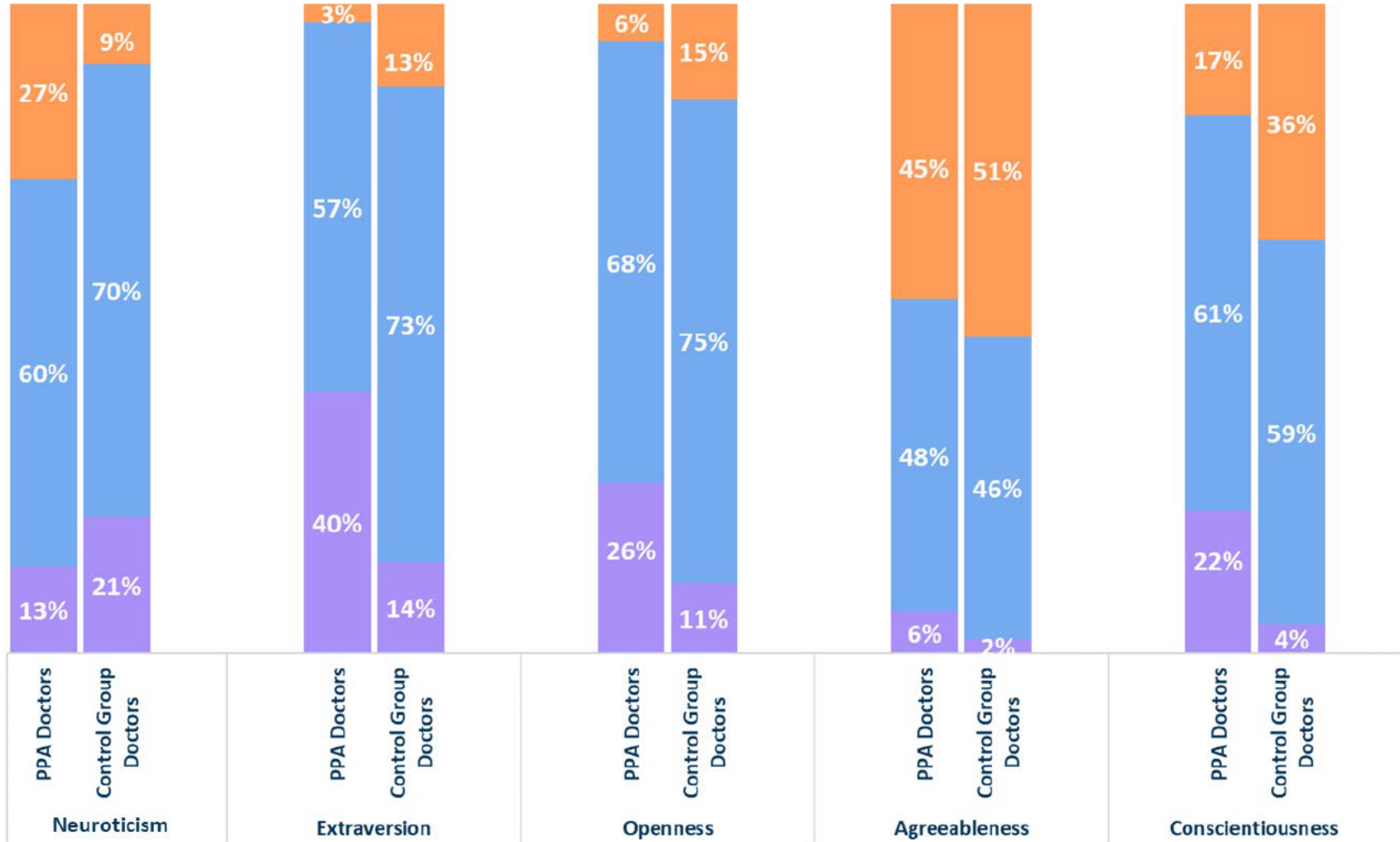
NEO Frequencies compared to control group



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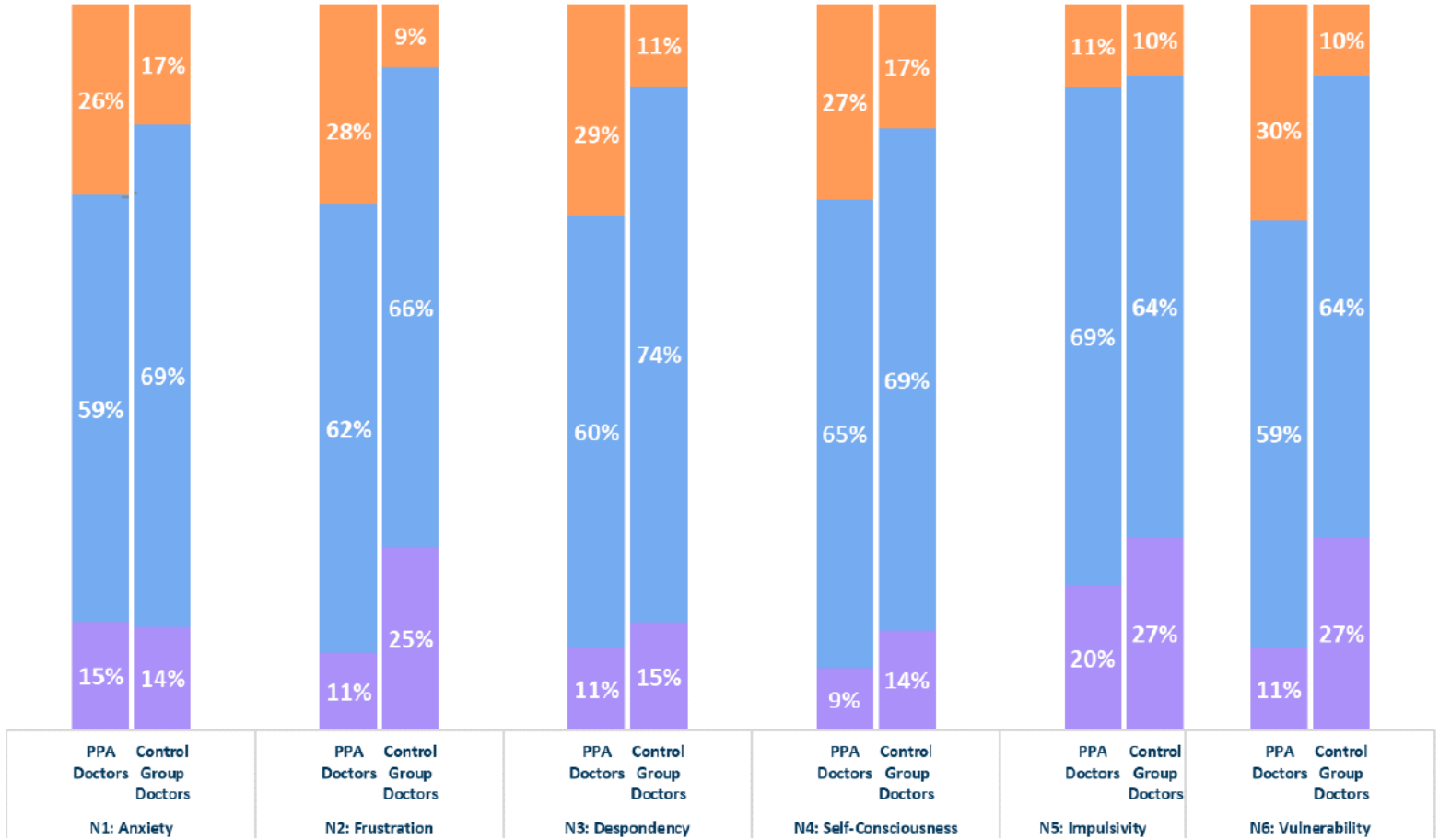
Below Average Average Above Average

EDGECUMBE

Neuroticism Frequencies compared to a control group



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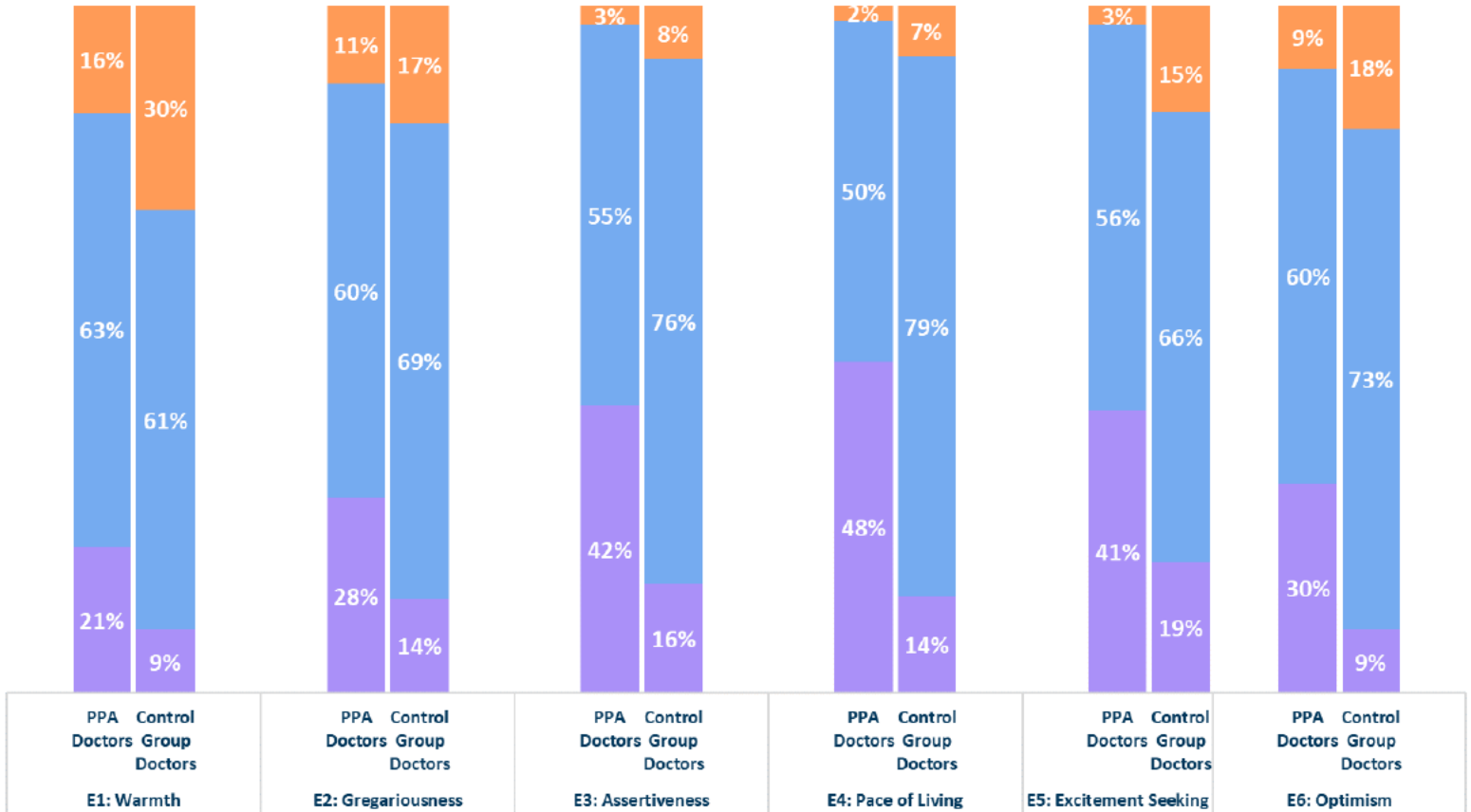
Extraversion Frequencies compared to a control group



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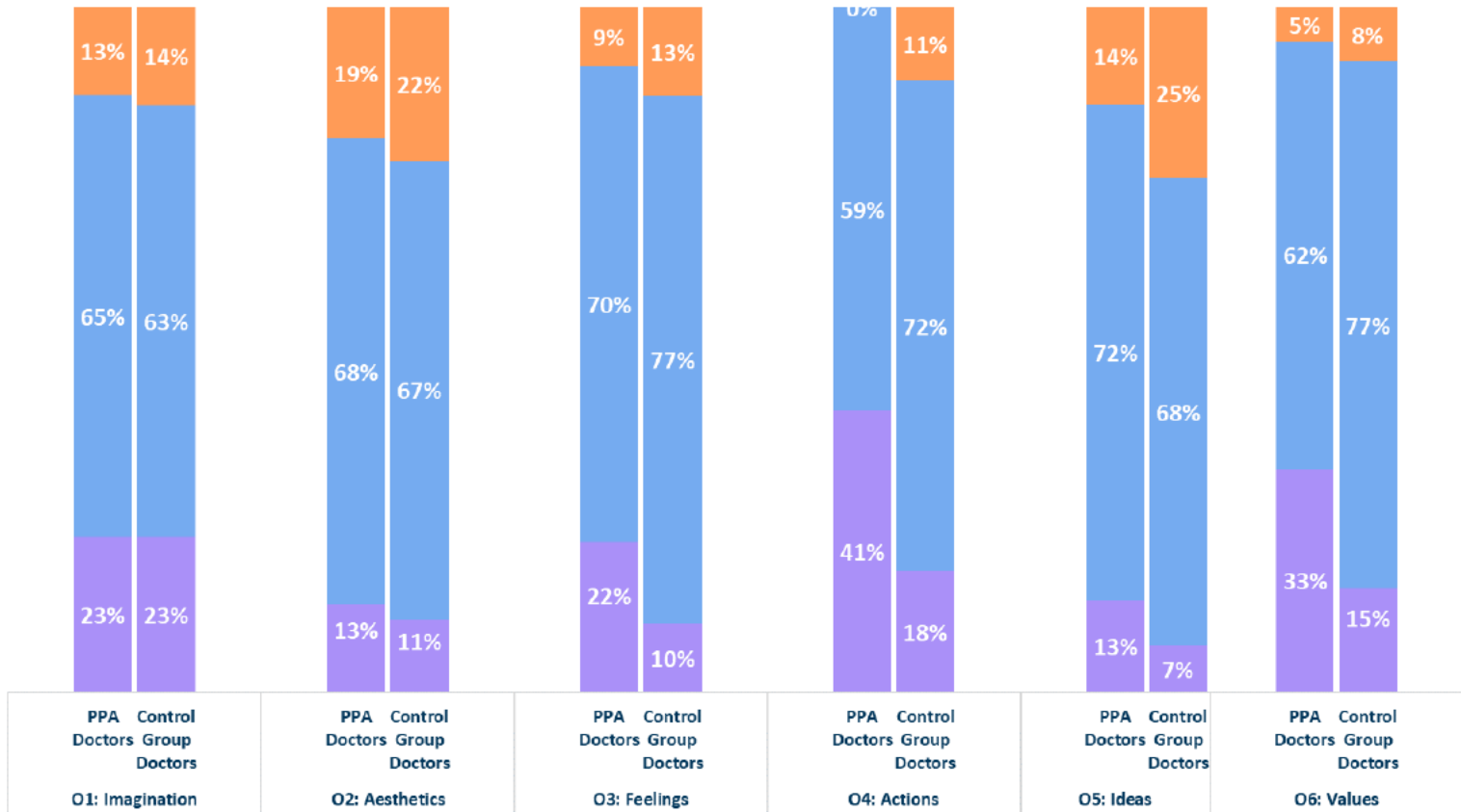
Openness Frequencies compared to a control group



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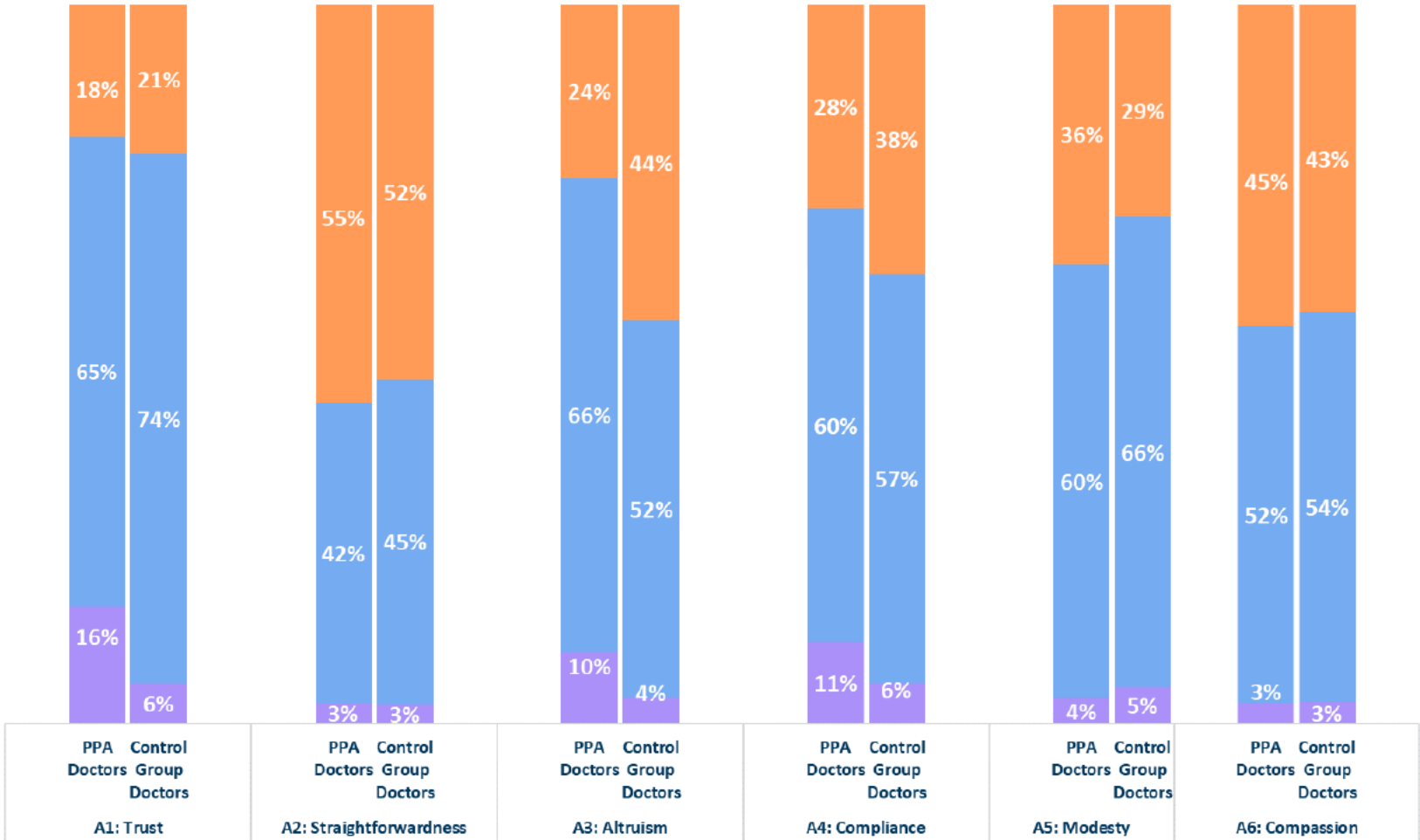
Agreeableness Frequencies compared to a control group



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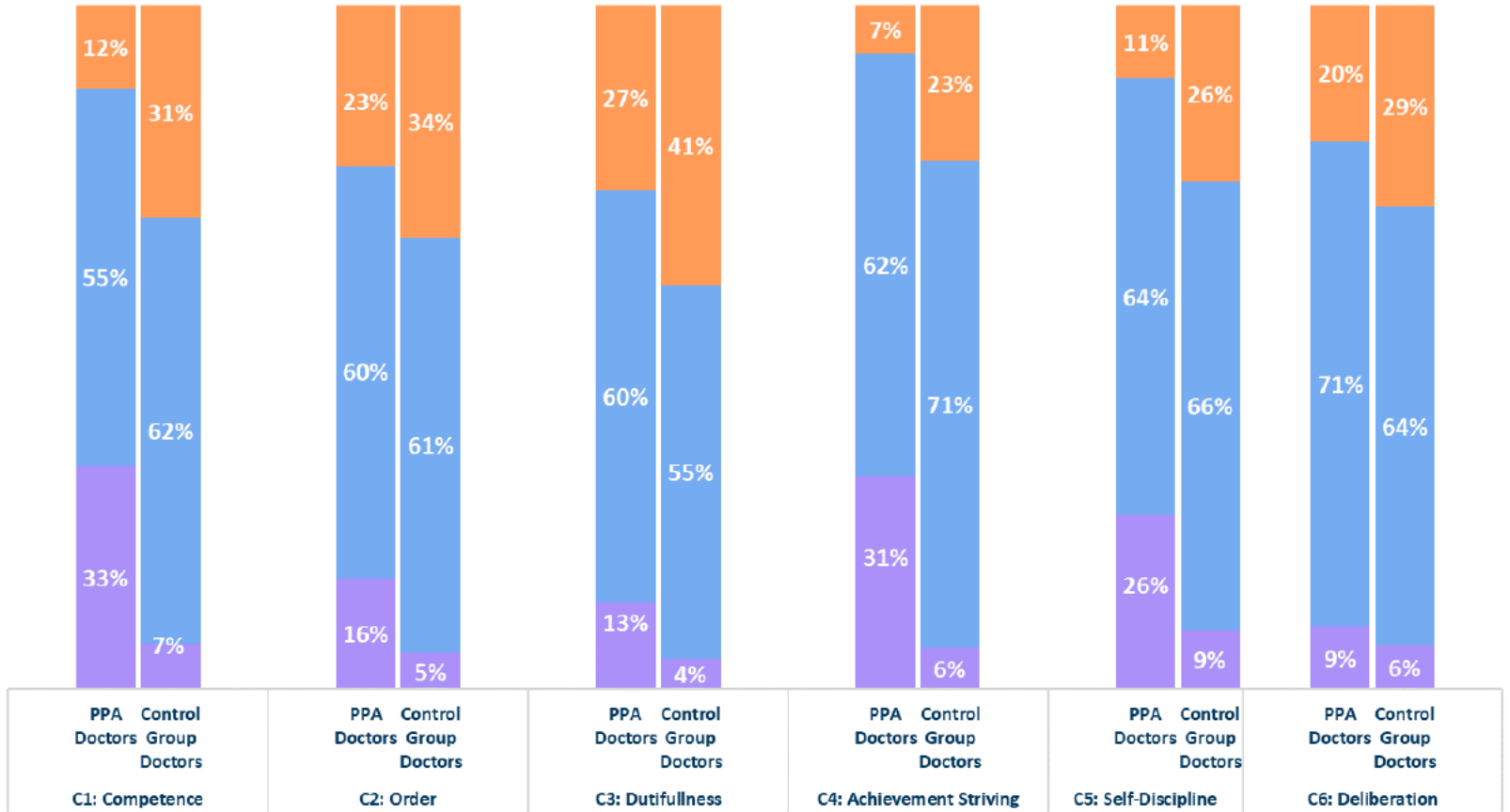
Below Average Average Above Average

EDGECUMBE

Conscientiousness Frequencies compared to a control group



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Section 2
Behaviour under pressure

Hogan Developmental Survey (HDS)

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Hogan Development Survey (HDS)

- describes the “dark side” of personality – qualities that emerge in times of increased pressure and strain and can disrupt relationships, damage reputations, and derail peoples’ chances of success
- 154 items – 20 minutes to complete online
- 11 main scales with 3 sub-scales each
- Norm group
  - 100,000+ working adults
  - 357 medical consultants applying for consultant positions

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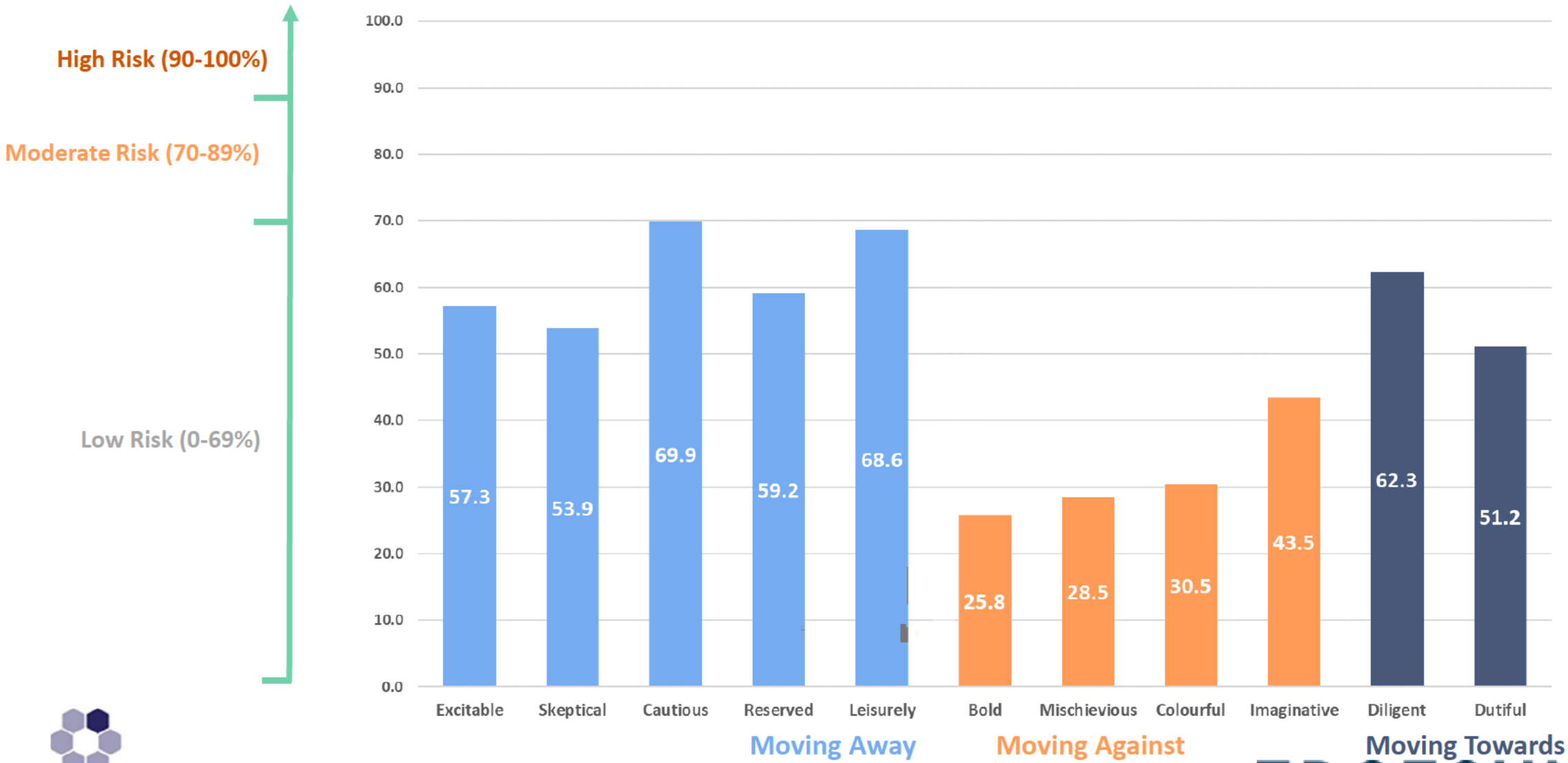
HDS Scales

Scale		Description
Moving away from others	Excitable	Acting with passion and energy – becoming **moody, irritable** and hard to please under pressure.
	Sceptical	Bright and perceptive – becoming **cynical, mistrustful**, doubting others' true intentions under pressure.
	Cautious	Conservative – becoming **reluctant to act and take risks** under pressure.
	Reserved	Independent – becoming **aloof, detached** and unapproachable under pressure.
	Leisurely	Co-operative on the outside – becoming **stubborn, resentful** and passively resistant under pressure.
Moving against others	Bold	Confident and assertive – becoming **overly self-confident** and self-promoting under pressure.
	Mischievous	Charming – becoming **manipulative and testing the limits** under pressure.
	Colourful	Fun and flamboyant – becoming **attention-seeking and dramatic** under pressure.
	Imaginative	Innovative – under pressure **ideas may not land well** with others and may seem unusual and eccentric.
Moving towards others	Diligent	Detail-orientated and hard-working – becoming **perfectionistic and demanding** under pressure.
	Dutiful	Conforming – becoming **eager to please and submissive** under pressure.

HDS Scale Averages: PPA practitioners



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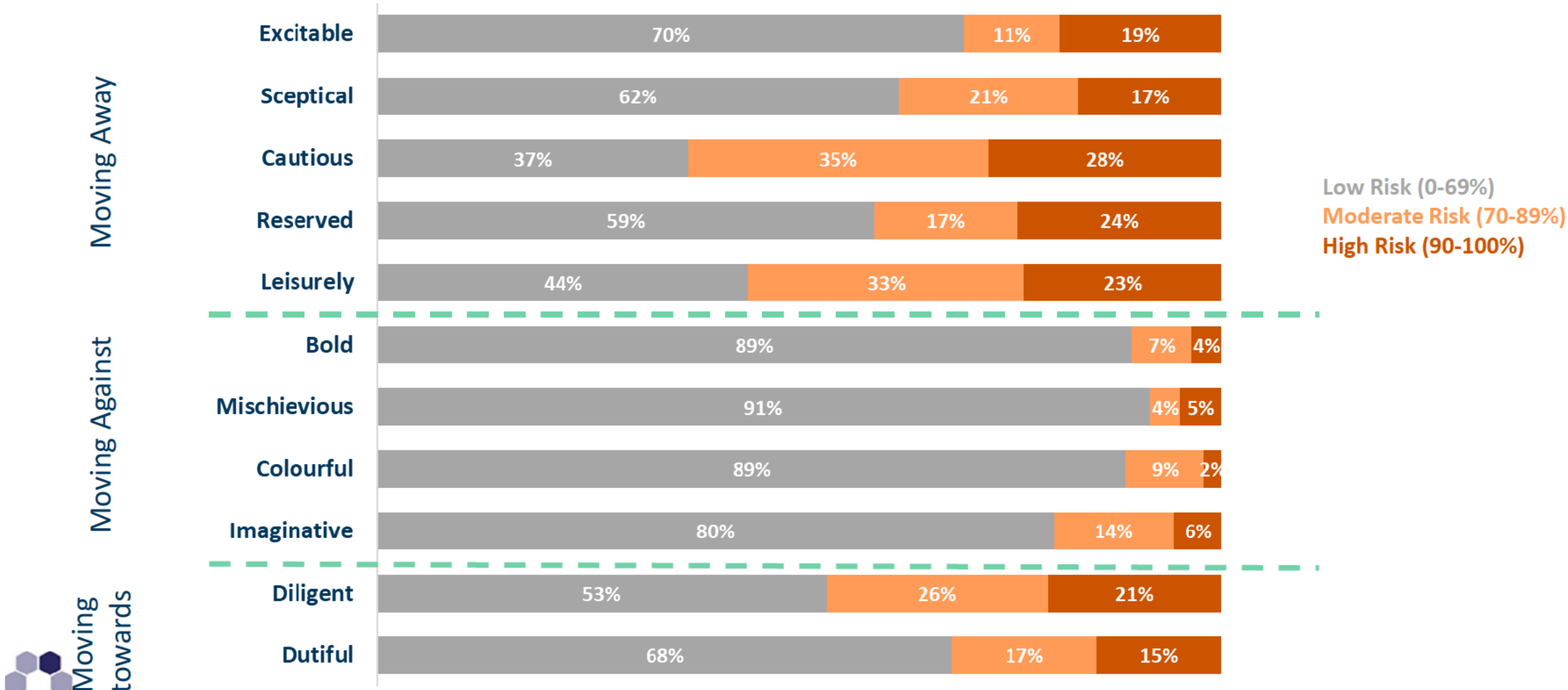
HDS Frequency Distribution

Proportion of PPA doctors within each risk bracket for each HDS Scale compared to the norm group



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HDS Frequency Comparison: The proportion of PPA doctors and Control group doctors that fall within each risk bracket for each HDS Scale

HDS Scales		Low Risk		Moderate Risk		High Risk	
		Control	PPA	Control	PPA	Control	PPA
Moving away from others	Excitable	82%	70%	11%	11%	8%	19%
	Sceptical	79%	62%	18%	21%	3%	17%
	Cautious	59%	37%	30%	35%	11%	28%
	Reserved	79%	59%	12%	17%	8%	24%
	Leisurely	70%	44%	22%	33%	8%	23%
Moving against others	Bold	76%	89%	15%	7%	9%	4%
	Mischievious	89%	91%	8%	4%	3%	5%
	Colourful	87%	89%	10%	9%	3%	2%
	Imaginative	74%	80%	17%	14%	8%	6%
Moving towards others	Diligent	44%	53%	24%	26%	32%	21%
	Dutiful	48%	68%	33%	17%	19%	15%

Links to existing research on doctors in training

Table 1 Problems and symptoms of poor performance identified in previous research

(1) Clinical performance and knowledge	(2) Interpersonal behaviour	(3) Conduct	(4) Other factors
Poor assessment and diagnosis[5] Inappropriate investigations[5] Failure to respond to urgent situations[5] Problems with practical procedures[5] Managing competing priorities[5]	Poor communication with patients or colleagues[5] Low conscientiousness or high neuroticism[6] Interpersonal conflict[5] Rigidity[2]	Failure to follow protocols/ guidelines[5] Motivation and interest in work[6,7] Distraction by non-work stressors[3,7] Poor self-insight and lack of reflection[2] Too little or too much self-criticism[8]	Poor note-keeping (e.g. illegible)[5] Physical and mental health issues[2] Harmful or self-defeating behaviour, e.g. alcohol[2]

Patterson F, Knight A, Stewart F, MacLeod S. (2013) How best to assist struggling trainees? Developing an evidence-based framework to guide support interventions. *Education in Primary Care*. 24: 330–9.

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What can we learn about early identification and interventions?

- Similar themes for doctors in difficulty earlier in career pathway
- How are these identified (early prevention)
- What are the successful interventions?
- Any links to current PPA research on concerns raised by healthcare organisations about practitioners?

Table 2 Framework of problems, causes and solutions to difficulty in GP specialty training

Types of problems and causes	Support from trainers	Support from coaching
Clinical skills and knowledge		
Lack of clinical knowledge: insufficient revision, taking exams early, lack of reflection and insight into own knowledge	Discuss issues and identify knowledge gaps, use free AKT quizzes in tutorial sessions, encourage wider reading, arrange mentoring from previous trainees, arrange more teaching	Explore learning styles, revision and time management techniques, and encourage trainee to focus on reflection and owning their development
Performance in an exam or assessment		
Difficulties at examination: time pressure, feeling thrown by wrong answers, undiagnosed dyslexia, distrust of CSA	Develop exam techniques through practising short consultations and watching videoed consultations; revision tips and practice papers	Teach relaxation techniques, resilience and structuring consultation
Anxiety and stress: pressure of taking or failing the exam, juggling training, work and personal commitments, stress from personal life, and problems in relationship with trainer	Refer to Occupational Health Psychologist if longer-term issues	Encourage trainees and focus on the positives, e.g. patient feedback, relaxation techniques
Physical and psychological ill health	Refer to Occupational Health to identify any impact on training	
Effectiveness of consultation		
Communication deficiencies: restricted vocabulary, poor word knowledge and comprehension, inappropriate turns of phrase, abruptness, tone of voice, pacing, body language, learning bad habits from friends or cohort	Check for formulaic responses, arrange a mixed study group (IMG and UK) or sessions with successful trainees, encourage trainee to converse with practice staff	Feedback on style, role playing and phrases to use
Disorganisation: lack of structure and poor time management in consultations and lack of revision	Trainer or coach: show how to structure a consultation (using models), personal organisation, practice ten-minute consultations	
Problems with empathy, sensitivity and patient-centredness	Trainer or coach: encourage feeling emotions and develop techniques for establishing rapport, active listening, asking questions and checking understanding	

Patterson F, Knight A, Stewart F, MacLeod S. (2013) How best to assist struggling trainees? Developing an evidence-based framework to guide support interventions. *Education in Primary Care*. 24: 330–9.

Lack of self-awareness and insight

Summary:

- Observers attribute anger and blaming others as signifying lack of self-awareness and insight on the part of the PPA doctor; however, the PPA doctors report shame, lack of confidence and a tendency to discount feelings, suggesting that they may have awareness of their failings, but struggle to accept them and exhibit defensive behaviours as a consequence.

Resilience

Summary:

- Compared to the control group, PPA doctors are more likely to experience their work as demanding (this may reflect objectively high demands and / or PPA doctors' greater propensity to report vulnerability to pressure) and to feel anxious about and ill-prepared to deal with the pressures. They often fail to secure the support they need, in part due to tendencies to feel shame and self-doubt and to withdraw from others. This imbalance between demands and resources to meet those demands results in anger and / or despondency, and in some cases burnout.

Interpersonal

Summary:

- The PPA doctors are significantly less likely to invest energy in relationships at work. Vulnerable to stress and quickly irritated, the PPA group are significantly less receptive to the feelings and emotions of others, so that the may come across as blunt, rude, insensitive or cold. The PPA doctors' self-consciousness and lower assertiveness may lead to conflict avoidance, so that they seem unassuming and unwilling to provide critical opinion.

Operational:

Summary:

- PPA doctors experience higher levels of anxiety and this is manifest in heightened needs for control and stability. They show typical levels of compassion, yet they tend to be less dutiful, methodical and confident of their abilities. They are more likely to report dislike of guidelines and a willingness to act outside them, especially where they believe doing so is in the patient's best interests. However, they may lack the ability to discern and define appropriate boundaries and use the patient as a way of bypassing new, unfamiliar ways of working or the opinions of others to remain in control. The lower levels of self-confidence and higher levels of caution and anxiety may have led to the PPA doctors reporting an openness to development in order to regain control and avoid the feelings of frustration, judgement and despondency experienced following their referral in the future.