NHS England

All RO Network – National Event 4th June 2014

Putting the jig-saw pieces together the essential art for Responsible Officer of triangulation information block to information flow and best practice

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Topic of discussion: Communication across the system (i.e. gap of communication between NHS and Independent sector RO including Locum agencies) in order to carry out whole practice appraisal – Flow of information between the independent sector and the NHS is a real concern *in both directions*

Lack of communication between NHS and independent sector ROs leads into following situation and due to insufficient information about doctors full scope of work, it proves difficult to carryout appraisal, covering total scope of Practice. This may lead to the RO not being aware of issues which are causing concerns in other organisations such as

- Low level concerns but not enough to refer to GMC (good communication channel will help both ROs to have full insight of low level concerns about the doctor, facilitate clear and common understanding about any restrictions that doctor would have)
- Should the Doctor resign whilst investigation on-going at local level (organisation to inform the doctor's potential/future employer/RO about the investigation and actions intended– ***which is not currently happening****)*
- Issues with appraisal

Frequently doctors and RO not aware of each other (i.e. RO not aware that doctor is connected to them and doctor not aware who is their RO) – this will exaggerate any difficulty in communication

Triangulation of information for doctor from locum agency is extremely challenging as their employment/contract follows hierarchy of subcontracting and flow of information is broken in most of the cases. It is sometimes difficult to track information about their RO as there are often changes in the agency – but outs etc and individual Doctors often work for a number of agencies

Should an RO not respond to an inquiry raised by another RO, an escalation process should be developed and then followed. In such a case the RO requesting information could/should approach ELA or tier 2 RO. These individuals can then be used to 'persuade' the recalcitrant to provide information – and if still creating difficulties take further action. It was suggested that this would be an issu or poor practice for an RO and the Tier 2 RO would triangulate the event – and if repeated across the system may need to call the refusenik RO to account (?non-engagement for poor performance)

Suggestion to streamline communication between ROs:

1. Organising RO networking meeting every quarter and encourage universal attendance to develop the links needed
2. At these events the expectation of sharing information should be promulgated along with recognition of the benefits of this.

Recommendation to GMC:

1. It was agreed in the meeting to recommend that the GMC provide a function on the GMC connect, accessible to the Ros only, enabling them to see doctor's history of RO, organisation and issues before allowing the doctor to connect. It was also suggested to add previous RO name onto GMC search engine when searching for particular doctor by their GMC number.

However, the GMC representative who was at the meeting advised that this information is already available upon accepting doctor's connection. (I am not sure if this was actually supposed to be publicised as knowledge and the formal recommendation needs to be made – might be worth checking with Kirstyn first please)

2. GMC to provide access to information about every doctor and their RO (current and previous) to all ROs via GMC connect account

It was also noted that the system is gradually developing a database of 'scope of practice' for all Doctors which will legitimise this process to a much greater extent. It remains a risk that individuals will not declare all the sites in which they work – which in it's own right becomes a probity issue for said individual