Small Designated Body Conference (North region) Notes
"Enabling organisations to collaborate between themselves"

25th February 2015 9.30am – 4pm

Venue - The Place Piccadilly Manchester

Attendees	
Essam Adbulhakim – Synexus Limited Janet Bott – David Lewis Rajendra Chaudhary – Doctors & Dentists Protection Union Charles de Wet – Boehringer Ingelheim Lyd Fiona Douglas – Synexus Limited Sabri El-Sherif – Alexandra Private Hospital Mark Findley – City Health Care Partnership CIC Gary Francis – Barnsley Hospice David Garwood – Lincolnshire & District Medical Services Craig Gradden – Liverpool Community Health Ben Green – Institute of Medicine John Holden – MDDUS Fiona Hughes – Retroscreen Virology Limited Tok Hussain – Healthworks Ltd Debra King – Wirral University Teaching Hospital	Sheila Johnson – Springhill Hospice Carl Jones – Transform Medical Group Nazar Kazzazi – Make Yourself Amazing Alan Malin – St George Healthcare Group Julian Mark – Yorkshire Ambulance Service Christine Mozzamdar – The Hospital Group Chris Pick – Springhill Hospice Colin Pollock – GMC David Polson – Manchester Fertility Vanessa Rhodes – The University of Chester Rachel Sheils – Overgate Hospice Fiona Thomson – Templars Medical Agency Robert Turner – Alpha Hospitals Limited Steve Wilkinson – Danshell Healthcare Trish Reid – Bridgewater Paul Twomey, Janet Bell, Kerry Gardner – NHS England
PT welcomed everyone to the meeting, this is the 3rd event organised by NHS England specifically for small designated bodies (DBs). Across the north there is a variation of organisations, some larger and some having only a few doctors.	
Fitness for purpose – capacity and resilience to deliver revalidation (Debra King) **Group work** • Governance - What does this look like in relation to revalidation? • QA of appraisal • Responding to concerns	
Feedback from group 1 - Governance - What does this look like in relation to revalidation? Looks different for many organisations because they are different types, all are driven by policies,	

DBs have their own issues, sometimes if the organisation has no clinicians except for RO sometimes the policies are not used on a daily basis which brings with it some challenges.

It's key to make sure recruitment is right, different DBs have various systems in place, and some systems may be of interest to other DBs. There are very few requests for information relating to doctors working in organisations which don't have a prescribed connection to that specific DB. There are doctors the DB holds information on but the DB is never asked for this information.

Action plan

- Create a contact list – provides a forum to ask general questions – this can be circulated to all – may encourage smaller discussions and meetings.
- Use group initially to look at performance data and before the end of the day will come up with 1 or 2 areas to be circulated to the group and try and generate some response.
- Recruitment – discuss best practice via the email group.

Feedback from group 2 – Quality Assurance of appraisal

- Benchmarking – need to agree what the standards are and needs to be communicated to relevant cohort of doctors. If come from large specialty, it's easier to work out what things should look like, need to work out benchmarking for rare species i.e. smaller numbers.
- Network – to support quality assurance.
- Standardised documentation is important – MAG is quite universal now, need good quality ideas and examples for both common and rare species. Need to make sure you have good examples. This helps ensure consistency. Also ties into scope of work. How do you manage the competitive nature of what we do? How do you make sure the standardised bits get managed separate to the competitive bits? Need to have shared standards.
- Manage commercial challenge – can look at other examples.
- Federation – faculty.

Action plan

- **Build relationships.**
- **Share resources; don't reinvent the wheel.**
- **Networking - building on established structures.**
- **NHS England to share the peer review document with the group.**

Feedback from group 3 – responding to concerns (RTC)

There were diverse representatives within this group.

- Dealing with RTC – policy framework is important, appraisal policy and whether its incorporated or not a RTC element, also making reference to MHPS, emphasis on sharing policies with the doctors, RO's,
- Involvement of HR teams and discussion about the use of external teams as opposed to using internal HR teams to preserve confidentially.
- Clarity is needed within the policy of what items apply to which doctors.
- Discussion about the role of the RO internally versus externally and difference between managing conduct and capability.
- Grading of concerns, frequency and severity and what triggers you would specify within the organisation, to discuss with GMC or NCAS.

Action plan

- **Policies need to reference other organisational policies e.g. occupational health, remediation, and appraisal and need to reference how the doctor would be supported.**
- **Foster relationships with GMC and NCAS reps.**
- **Small organisations to get together to form a bank of external trained investigators. Q - How do you QA the investigators? A - Pass investigation to another RO to review.**
- **Form networks for discussion of these things - hospices meet quarterly, appraisal and revalidation is a standing agenda item.**

GMC support (Colin Pollock & Michael Anderson)

http://www.england.nhs.uk/revalidation/wp-content/uploads/sites/10/2014/03/map-annex-e.pdf

NHS England escalation process.

Small Designated Body Outsourcing and conflicts of interest (Debra King)

Group work

- Outsourcing the RO role
- Outsourcing the HR function
- RO for multiple organisations
- Develop strategic plan to focus on supporting quality of service linked to RO function

Group 1 – outsourcing RO role

How would you do this?

- Not necessarily a whole package to outsource may have devolved packages, recruitment, case investigation, etc. Where there is an outsourced RO it is the person who makes the final decision on recommendation.
- Good will versus SLA – without an SLA at any point that function could disappear, therefore have a letter to say what would be provided by either party.
- Types of RO – active RO and looking at governance, some don't communicate as much as they should.
- Cost – sometimes not paying for the RO, some charge £1,000 per doctor per year, private organisation there is little incentive for anyone to provide the RO role with good will.
- Risks – a small organisation with a small number of doctors having an external RO may allow the RO to see enough of the work to improve the quality compared to someone working in isolation.
- Distance between RO and doctors, distance between RO and governance structures.
- Need bilaterally dynamic approach.
- How does the DB get QA of the roles carried out by an external RO?

Action plan

- Need engaged managed networks.
- In future there may be a role for someone to be an RO and nothing else.

Group 2 – outsourcing the HR role

- HR function – pre-employment, in employment, occupational health. Need to define which bits can be outsourced e.g. reference checking, performance management. Costs associated with the outsourcing, costs vary, how do you put a figure on this? For smaller organisations it is a potential large cost. Huge benefits to having internal HR function but the feeling is that sitting alongside the organisation and governance / internal risks and keeping a watchful eye on the process is important.
- Is there any benefit in HR function providing support to small DB's? Could offer a service to e.g. hospices, could transfer it across, and could see benefits in working in this way as a larger HR function as long as the capacity is there.
- Collaboration – in HR we share best practice across the networks.
- Better and beneficial to have HR within the organisation rather than outsourcing.

Group 3 – RO for multiple organisations - How do you understand and influence governance

in organisation you are not based in fully employed by? What are risks?

- Clear SLA needs to be in place – RO needs to be confident that they will be allowed to attend board meetings or access information to carry out their role effectively. RO should be a member of the board, the RO guidance recommends this, this isn't mandatory it's guidance only.
- Multi-site operations – if RO for one organisation it is easier to have unified policies, if RO for multiple organisations it's more difficult to do, stuck with the organisations policies.
- Adequate resource is required to do the role.
- Support from the board for the recommendations made as an RO is required.
- AOA – as RO needs to know what is in that and who is completing it / submitting it. Should form part of the SLA.
- Relationship with higher level RO is required – in order to discuss diversity of work.

Action plan

- **Template SLA for RO's working in multiple organisations – template to be distributed.**
- **External RO network could be created as a sub group of small DB network.**

Group 4 – Develop strategic plan focused on supporting quality of service linked to RO function - How would you do this? What are risks?

Conflicts of interest - Consider conflicts possible in groups 1-4.

- A sound RO process is required – have a means of reporting, know who is within the RO structure, have a means of supporting them, log their details and profiles, etc. Supporting them via the appropriate training e.g. appraiser training and providing them with opportunities to ensure appraisal process is completed on time.
- Look at how the RO function supports the organisation in general, important that organisation recognises and agrees the role is an organisational role not just that one person's responsibility.
- One specific DB explained their current process - every 2 months, feed into quality meetings, dashboard process feeds in, this is for all of doctors including locums, trainees and GP's, have a medics dashboard and looking at various areas to add in – this reports into the clinical review group. Any issues are then reported through to the board.

Conflict of interest where there are only 3 doctors in a small organisation, this is common of

hospices; governance process needs to be integrated into each of these.

If you are an RO with shares within the small DB, this is seen as a conflict, one organisation has an RO who completes a financial disclosure form, therefore out in the open and transparent, could then include this within their appraisal. There is no guidance on this from NHS England or GMC but it's mainly about being transparent.

Finance and time costs – What is minimum capacity to deliver RO function? (Paul Twomey)

Information sharing / communication (Debra King)

Framework for Quality Assurance (FQA)(Paul Twomey)

MAPS (Paul Twomey)

What is PDP for Small DBs?(Debra King)

Round up & close

Summary of actions

Common theme throughout is the need for a network:

- **an email group**
- **meeting face to face**
- **external RO sub-group**
- **e.g. some hospices currently meet quarterly and appraisal and revalidation is a standing agenda item**
- **get together to form a bank of external trained investigators – in order to QA the investigators, pass investigation to another RO to review**

Governance

- **Recruitment – discuss best practice via the email group**
- **Performance data – to be discussed via the email group**

Quality Assurance

- **Share resources; don't reinvent the wheel, already a lot of things happening e.g. for NHS England specifically share the EXCELLENCE2 tool, peer review document and the FQA documents**

RtC

- **Policies need to reference other organisational policies e.g. occupational health, remediation, and appraisal**
- **Policies need to reference how the doctor would be supported**
- **Foster relationships with GMC and NCAS reps**

RO for multiple organisations

- **Template SLA for RO's working in multiple organisations – template to be distributed.**

Feedback on the event

- 100% of attendees rated the event either good or excellent.

Comments received include:

- Looking forward for next meetings
- Very helpful and informative. Good networking opportunity
- Very helpful and informative
- Excellent meeting, useful information, great action plans
- A lot to think about - thank you
- Really good informative day
- I am a Medical Director in my first consultant job in a small BD with external RO - so a little bit cut off. This event has shown me many loopholes in my systems and also shown me lots of ways to close those loopholes. Fantastic - thank you so much