Professor Steve Field, FRCGP, Chairman of Council

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Department of Health consultation: Draft regulations and guidance on the role of the responsible officer

1. The College welcomes the opportunity to comment on this consultation on draft regulations and guidance on the role of the responsible officer. The College responded to the Department of Health’s consultation on the role of the responsible officer in July 2008, and continues to take an active interest in this area.

2. The Royal College of General Practitioners is the largest membership organisation in the United Kingdom solely for GPs. It aims to encourage and maintain the highest standards of general medical practice and to act as the ‘voice’ of GPs on issues concerned with education, training, research, and clinical standards. Founded in 1952, the RCGP has over 38,000 members who are committed to improving patient care, developing their own skills and promoting general practice as a discipline.

General comments:

3. The Responsible Officer (RO) will be appointed by and be accountable to the NHS Trust. Consequently, there may be a potential conflict of interest between public protection and the need of the Trust to provide services, rendering the RO vulnerable to accusations of bias or prejudice, especially if they have long-standing relationships, both positive and negative, with doctors within the Trust. For this reason, we wish to reiterate our recommendation, as stated in the Guide to Revalidation for General Practitioners, that the RO in a primary care organisation needs to be advised by a trained RCGP Assessor and a trained Lay Assessor in making revalidation recommendations to the GMC. It is absolutely essential that arrangements work in the best interests of patient safety and ensure the highest level of public confidence in the system.

4. Several GPs have sought reassurance that the RO will be accountable, and further clarity in this area would be welcomed.

5. Our view is that an RO in a Primary Care Organisation should normally be a GP. If that is not the case, the RO should take advice from a deputy who is a GP.

6. The British Association of Medical Managers (BAMM) RCGP medical director group will support the development of ROs in primary care. We wish to acknowledge the support and leadership of Dr Jenny Simpson, Chair or BAMM.

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7. We note that there is no longer mention of the need for the RO’s recommendations to be made through the Trust Board, which we believe would raise the risk of Board interference in the recommendations. We would welcome confirmation as to whether this is simply an error of omission, or whether it signifies a change in policy. The College believes that the RO should make their recommendations directly to the GMC.

8. We would suggest that a national training structure is established for ROs to ensure consistency and high standards. The role of the RO should be considered as a new professional role and will require specialist expertise and developmental infrastructure.

9. The RCGP is currently developing proposals for the revalidation of doctors in training. These doctors are employed and on Performance Lists, so it is important that they are included in the process. One commentator has suggested that Deans could act as responsible officers for trainees, but it is not clear whether this view is widely held.

10. We are aware that there are certain groups of GPs, including those who do not have a stable base of employment, who would welcome assurance that they will be revalidated in an appropriate and achievable way. These GPs are probably harder to oversee so it is important that it is established how they will interact with the RO.

11. We believe that PCTs should take responsibility for doctors who have been removed from their lists for performance issues as well as those who are returning to practise following GMC suspension on the condition that they are rehabilitated. In these circumstances, it would be advisable to ask the appropriate authority to allocate a responsible officer, and ideally nominate a host PCT responsible officer to take on this responsibility, as they would probably work with the local deanery to provide supervised training. Mike O’Brien, Minister of State for Health Services, has asked Professor Steve Field, RCGP Chairman, to lead on a project with Dr David Colin-Thomé, National Clinical Director for Primary Care, to strengthen the Performers List following the recent death in Cambridgeshire PCT.

12. Consideration should be given to the workload that ROs will take on, particularly as they are already likely to have a large management and leadership portfolio. A Wales-based commentator has suggested that Welsh organisations would need at least two ROs, one for secondary care and one for primary care. It is argued that this would be preferable to delegating the responsibility for primary and secondary care to one person as the burden of responsibility would be too great. It is suggested that the same may apply in large Trusts and Health Boards elsewhere.

13. Relevant organisations must ensure that any doctor who may be intent on criminal action cannot conceal information from the RO. Recording all complaints will go some way towards achieving this, but the quality and effectiveness of data protection processes should be considered paramount. The holding of such information will help serve to protect the public, but it might also have the potential to damage individual careers and the profession in general if it is not managed and used appropriately.

Answers to specific questions in the consultation document:

Q1) Do you agree that Regulation 3 designates all those organisations that need to have a responsible officer?

14. Yes

Q2) If you answered NO to Q1 which other organisations should be designated?
15. N/A

Q3) Do you think Regulation 5 provides sufficient safeguards in the event of a conflict of interest arising? If not, please explain what further measures should be considered.

16. As previously stated, the RO should be advised by a trained RCGP Assessor and a trained Lay Assessor in making revalidation recommendations to the GMC. However, it is arguable that the regulations should specify a process that would occur if it was felt that a conflict of interest was impairing a fair process. One option would be an appeal process to the GMC or a higher NHS authority. It should be agreed that patient safety overrides loyalty or responsibility to an organisation. More guidance on this area would be welcomed – but a decision will need to made on whether this would take the form of an Approved Code of Practice or Guidance notes. Commentators have sought clarification as to whether ROs would be excluded from dealing with relatives and business partners.

17. There may be some unease about independent commercial organisations appointing their own RO; this does not seem to be addressed by this Regulation.

18. It is important that organisations are not able to exert influence over the RO’s recommendations to achieve specific aims. For example, an organisation might try to vary the standard by which a recommendation is made in times of organisational difficulty in terms of recruitment. Whilst not envisaged as such, medical directors could use the recommendation process as a hierarchical tool to enforce compliance, silence or particular forms of practice. If some level of independence between the RO and the organisation is not maintained, interpersonal relationships could allow a powerful or deceitful individual to continue in practice when they are not fit to do so. These are, of course, worse case scenarios, but some would argue that they are not entirely unrealistic.

Q4) Do you agree that Regulation 6 should require responsible officers to have a licence to practise?

19. As we have stated, we believe that an RO in a Primary Care Organisation should normally be a GP. If that is not the case, the RO should take advice from a deputy who is a GP. However, due to the demands of medical management, ROs may find it difficult to carry out a significant amount of clinical practice in addition to the RO role. However, we agree that ROs should be, at a minimum, licensed.

Q5) In circumstances where the responsible officer acts for another body, are additional criteria to those in Regulation 7 needed?

20. In Wales, as one commentator has suggested, the government should have the authority to appoint ROs if organisations fail to do so. However, they argue that the government should not have the power to appoint Medical Directors, though it may have involvement in such a process.

Q6) Are the functions set out in Regulation 9, relating to the evaluation of a doctor’s fitness to practise, appropriate?

21. Yes

Q7) If you think there are other functions that should be specified, please explain what they are.
Q8) Do you agree that Regulation 10(1) sets out the appropriate connections for doctors?

22. Yes

Q9) Do you think Regulation 10(2) enables doctors in designated organisations to be linked to an appropriate responsible officer regardless of their working pattern?

23. Yes

Q10) If the answer to either Q8 or Q9 is NO please explain.

24. N/A

Q11) In particular, do you think there are any other alternatives to using the doctor’s registered address as a final report to decide?

25. No comment

Q12) Please comment on the appropriateness of the system set out in Regulation 11 to manage the conduct and performance of responsible officers.

26. One commentator considered this to be reasonable. However, the option of ROs being responsible to SHA (or CMO Department) ROs could be explored.

Q13) Do you agree that the additional functions of a responsible officer set out in Regulation 16 are appropriate?

27. Yes, though we should be mindful of the burden of responsibility that ROs will take on, which must be manageable. The College plans to support ROs in primary care through the RCGP assessor and the RCGP BAMM network of medical directors.

Q14) If you think there are other functions that should be specified please explain what they are.

28. ROs should check the accuracy of qualifications.

Q15) Please comment on the extent to which regulations 12-14 and 17-19 achieve the policy objectives set out in the previous consultation paper on the role of the responsible officer.

29. No comment

Q16) Please comment on the content, structure, layout and ‘useability’ of the draft guidance. Comments on the guidance can be submitted either as track changes or clearly annotated with paragraph numbers.

30. This is very clear and easy to understand, particularly from a lay perspective.

31. I gratefully acknowledge the contributions of Professor Mike Pringle, Mrs Ailsa Donnelly, Dr Andrew Spooner, Professor Amanda Howe, Dr Martin Wilkinson, Professor Steve Field and Dr Paul Myres towards the above comments. While contributing to this response, it cannot be assumed that those named all necessarily agree with all of the above comments.

Yours sincerely
Professor Steve Field
Chairman of Council