25th July 2012

Department of Health consultation on Responsible Officers in the New Health Architecture

1. I write with regard to the Department of Health consultation on Responsible Officers in the New Health Architecture.

2. The Royal College of General Practitioners is the largest membership organisation in the United Kingdom solely for GPs. Founded in 1952, it has over 44,000 members who are committed to improving patient care, developing their own skills and promoting general practice as a discipline. We are an independent professional body with enormous expertise in patient–centred generalist clinical care. Through our General Practice Foundation, established by the RCGP in 2009, we maintain close links with other professionals working in General Practice, such as practice managers, nurses and physician assistants.

3. The College welcomes the opportunity to respond to this consultation.

4. We have provided answers to the individual questions below:

Q2.1 Do you agree that the NHS Commissioning Board (NHS CB) should be designated in the Regulations and required to nominate or appoint responsible officers for primary medical care doctors?

Yes – This is the most logical approach. CCGs are too small and may be likely to be too fluid to take on this responsibility, as well as having greater possibilities for
conflicts of interest. NHS CB regional offices should have the best available balance of scale and regional focus.

Q2.2 Do you agree that the NHS CB should be given the flexibility to appoint the number of responsible officers it considers appropriate? If not, please explain your alternative.

Yes – though, given that, as stated in the consultation itself, the Department of Health recognises that a single RO would be too remote from local information and unable to take on the workload, surely it would be sensible to specify a minimum number of ROs, or a maximum number of doctors that they may be responsible for.

Q2.3 Do you agree that the NHS CB should be designated in the Regulations and required to nominate or appoint responsible officers for this very small group of secondary care locum doctors?

We have no view on this.

Q2.4 Do you agree that the NHS CB should be the designated body for the responsible officer’s responsible officer in the new architecture?

Yes, but there will need to be clear governance to avoid conflicts if interest – one provision might be that the RO’s RO should not be their line manager or in a position of seniority within the same local office of the NHS CB.

Q2.5 Do you agree that the national mandate is the most appropriate method of addressing potential conflicts of interest between responsible officers in the NHS CB?

Yes, this seems appropriate.

Q2.6 Do you agree that Local Education and Training Boards (LETBs) be designated in the Regulations and required to nominate or appoint a responsible officer for postgraduate trainees? If not, please explain your alternative.

Yes, we accept this may be the most appropriate option. However, as with other aspects of the role of LETBs, we have some doubts about their ability to discharge
these duties with regards to postgraduate trainees in primary care, and would suggest that this be kept under review.

Q3.1 Do you agree that a requirement to check the language competence of doctors working in England should be set out in the Responsible Officers Regulations?

Yes – this will avoid confusion. The RCGP is a strong supporter of proposals to ensure the language competence of doctors, and feels this is a positive step in that direction.

Q3.2 Do you agree that the Regulations should not expressly provide how language competence should be ascertained, but that guidance should be jointly produced by the General Medical Council (GMC) and NHS CB?

Yes – it makes sense to establish the principle in the Regulations, and for general standards to be developed, but to allow for the methodology to evolve with time.

Q3.3 a) Do you view it helpful for the GMC to annotate their register to confirm suitability for the Doctor’s first post in England and language competence for that post: and would this approach have sufficient merit to outweigh any practical difficulties if its application were in England only, but not in Northern Ireland, Scotland or Wales?

Once there is a single Performers List for England, the possibility of a doctor failing a language test in one part of England and then re-applying in another should be removed. The annotation could therefore be part of the Performers List. This would not exclude a doctor failing a language test in England and re-applying in another devolved administration area; however, with good liaison between the countries this risk could be managed. The GMC Register is not the best place to conduct NHS business and it would be preferable to find NHS solutions to this problem.

b) Do you view that this may impact on different groups in different ways, for example groups not already on the register?

We have no view to state on this.
Q3.4 Do you agree that responsible officers in the UK should be required to notify the GMC where they have significant concerns on the language competence of an individual?

Yes – if the GMC has licensed that doctor, then the GMC should be informed.

Q3.5 In terms of costs: What is the current approach to the payment for language tests in your organisation; and do you agree that for the majority of organisations there will be little increased cost relating to the strengthened responsible officer’s role?

The cost of this should fall to the applicant doctors.

5. As stated at Q2.1 above, we agree that ROs should be placed in the NHS CB. That said, it will be important for the ROs to have clear lines of communication with the CCGs within their patch, since it is the CCGs who will have the crucial place in determining the future role of primary care.

6. If the role of the RO is changing (both in terms of location and language checking etc), it will be important that they are trained up and subject to evaluation; most will have grown into the role having moved across from PCTs, and the current cohort may or may not be fit for the future – but there needs to be a proper appointment process to make sure.

7. The RO structure for primary care is based on the premise that the majority of GPs are independent and self-employed. As we see primary care in places starting to be provided by corporate organisations with their own medical directors, then those organisations may want to have a much greater influence on appointment, revalidation, appraisal and on-going training.

8. Given all these kind of changes, it might make sense for these proposals to be subject to review in a few years time.

9. We gratefully acknowledge the contributions of College leads on revalidation and commissioning in formulating this response.

Yours sincerely

Professor Amanda Howe MA Med MD FRCGP
Honorary Secretary of Council