



**Responsible officers - Consultation on draft regulations and guidance**

**Consultation Questionnaire**

This questionnaire is designed to supplement the consultation document which sets the context to the questions. It should be completed after reading the draft regulations and draft guidance.

**Regulation 3 sets out the organisations required to nominate or appoint responsible officers.**

The draft regulations seek to designate the widest range of organisations that employ or contract with doctors to ensure that responsible officers are in all settings where that approach is necessary and appropriate. We do not believe it would be either practical or appropriate to designate organisations employing doctors who do not work in clinical settings, and are not involved in direct patient care.

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

Please delete:

**YES**

**Q2 If you answered NO to Q1 which other organisations should be designated?**

Although we agree that all the mainstream organisations that need to have a responsible officer are covered in Regulation 3, those doctors who work for organisations which do not fall within the list of designated bodies, or who are self-employed, must still be able to revalidate or relicence. As currently drafted, the framework causes concerns for forensic physicians, forensic pathologists, medico legal advisers and coroners. We would welcome working with DH and GMC to help progress this work.

**Regulation 5 provides safeguards for circumstances where there may be a conflict of interest.**

In circumstances of personal or professional conflict between the doctor and the responsible officer, it may be difficult to retain an objective judgement. We do not think that it is right to put either the doctor or the responsible officer in a position whereby a conflict of interest could affect an evaluation of fitness to practise. Regulation 5 provides for organisations to nominate or appoint an alternative responsible officer where a genuine conflict of interest exists.

**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.**

Although Regulation 5 provides for another responsible officer to be appointed in the event of a conflict of interest, there is no definition of such a “conflict of interest”. As we suspect that conflicts will arise more often than anticipated, and in a variety of different circumstances, we recommend the guidance should be more robust and detailed as to how conflicts will be identified, minimised and addressed, to ensure fairness and reduce the need for legal challenges.

We note that in paragraph 3.35 of the draft guidance at annex 2, it states that “if a conflict exists between the doctor and the responsible officer...it is important that every attempt is made to resolve the issue using the existing mediation procedures”; however we are not aware that such mediation is consistently available. Therefore we suggest that adequate resources will need to be provided.

In addition, we suggest there must be provision for an appeal process involving an independent arbiter (i.e. outside the Trust) if a dispute cannot be resolved.

**Regulation 6 sets out the requirements for nomination or appointment as a responsible officer.**

The vast majority of respondents to the consultation on the role of the responsible officer were in favour of responsible officers being required to have a licence to practise.

Alternatively, as Medical Directors are likely to be nominated as responsible officers and some do not have a clinical element to their role, it has been suggested that responsible officers should instead have the option of having a licence. The view is that the licensing of doctors with no clinical role could lead to a situation where, for example, a medical manager undertaking no clinical work would be legally entitled to prescribe and issue death certificates.

The GMC and the Department of Health are of the view that medical managers play an important role in ensuring the safety of patients and that they should, and will, be able to provide evidence to demonstrate they are fit to practise. Responsible officers should be medical practitioners licensed as fit to practise medicine and who themselves will be up to date in medical practise in order to be credible with the public and colleagues when carrying out the responsibilities of the role. We have therefore included this requirement in Regulation 6(a).

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

Please delete:

**YES**

**Regulation 7 allows the nomination or appointment of one person as responsible officer for two or more designated bodies.**

It requires both organisations to ensure that the responsible officer meets the requirements, that they will not be overburdened and that there are not likely to be any conflicts of interest in taking on the role. Regulations 12 and 18 enable the transfer of resources to the employer of the responsible officer.

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

We are concerned that Regulation 7 allows a responsible officer to cover two or more designated bodies, as we believe the administrative workload of a responsible officer is likely to be much higher than anticipated, and is potentially onerous and unachievable. As organisations vary enormously in size, we recommend there should be a limit on the overall number of doctors a responsible officer can cover so that s/he can perform their functions effectively. The independence of the responsible officer must not be compromised.

**Regulation 9 gives the functions of a responsible officer in England, Scotland and Wales.**

Please refer to regulation 9 in the accompanying draft regulations for the functions.

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

Please delete:

YES

**Q7 If you think there are other functions that should be specified, please explain what they are.**

**Regulations 10 and 11 set out the connection of doctors with a responsible officer.**

Organisations need to know which doctors they are responsible for and doctors need to know who their responsible officer is.

Regulation 10(1) sets out the connections between doctors and designated organisations where the doctor is employed by, or contracts with, only one organisation i.e. the doctor has a connection with only one designated body.

Regulation 10(2) concerns the situation where a doctor is employed by, or contracts with, more than one organisation. It defines the criteria for deciding which responsible officer a doctor relates to as where the majority of their

clinical practice is undertaken. Variations in the ways some doctors work may lead to cases where it will not be possible to decide a doctor's responsible officer based on the majority of their clinical work. In such cases, we think that if the doctor is employed by an NHS organisation the connection should be with that body. Where it is still not possible to determine the responsible officer a doctor relates to, the final report to decide will be the GMC registered address of the doctor.

**Q8 Do you agree that Regulation 10(1) sets out the appropriate connections for doctors?**

Please delete:

**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?**

Please delete:

**YES**

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

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

No.

**Regulation 11 establishes the connection between a responsible officer and their own responsible officer.**

As Regulation 6 sets out that a responsible officer will be a licensed medical practitioner, we think that they should themselves, therefore, also be linked to a responsible officer who will ensure they are subject to the same evidence-based assessment as those they are responsible for. Regulation 11 sets out the hierarchy in order for this to happen.

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

We anticipate the responsible officer will be subject to a degree of scrutiny and suspicion by many doctors, particularly when the role is first introduced. Therefore it is essential that his/her own professional practice, as well as his work as a responsible officer is subject to rigorous appraisal.

We also suggest that it may not be sufficient for a single responsible officer at strategic level to carry out this appraisal function.

**Regulation 16 lists the additional functions of a responsible officer in England.**

There is a distinction between the tasks to be undertaken, and accountability for them in relation to doctors. In our view, the accountability for ensuring the systems are in place and working satisfactorily in relation to doctors should be with the responsible officer.

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

Please delete:

**NO**

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

We consider many of these additional functions in Regulation 16 to be the responsibility of the Human Resources department. Making these the additional responsibility of the responsible officer is likely not only to add a huge administrative burden, but once again make the actions and decisions of the responsible officer open to challenge.

Regulation 16 (2)(d) states that responsible officers will “manage admission to the performers’ list”. Yet as PCTs already have in place adequate procedures for dealing with admission to performers’ lists, we feel it unfair and unnecessary for responsible officers to have this additional responsibility.

Regulation 16 (4)(d) states that “any person who has raised concerns about a medical practitioner is kept informed of the progress of the investigation”. However although we support their right to be assured that the matter is being dealt with, to have the right to any more information breaches the right to confidentiality of the doctor concerned.

Regulation 16 (4)(g) states that responsible officers will be able to “identify concerns and ensure that appropriate measures are taken to address these”. However we feel this process may overlap with the current disciplinary procedure, “Maintaining High Standards in the Modern NHS”, which specifies procedures that must be followed before suspension can be carried out (referred to as ‘Exclusion’). We believe it would not be reasonable for one responsible officer to make such a recommendation as s/he will have had access to previous information about a doctor’s fitness to practise and this may colour the objectivity of a new assessment .

**Regulations 12 and 18 discuss provision of resources. Regulation 12 applies in England, Scotland and Wales. Regulation 18 applies only in England.**

The response to the consultation on the role of the responsible officer stated that the Department of Health intended to specify explicitly in regulations each of the areas we think should be resourced. Following further consideration, we have now decided that such an approach would not be appropriate. Therefore, Regulations 12 and 18 have set a general duty on designated organisations to provide responsible officers with sufficient funds and other resources necessary to carry out the responsibilities and functions set out in Regulations 9 and 16.

**Regulations 13 and 17 are the duty to have regard to guidance.**

Regulation 13 applies in England, Scotland and Wales. Regulation 17 applies only in England. In both regulations, guidance issued by the Secretary of State has to be taken into account.

**Regulations 14 and 19 create offences**

Both Regulations 14 and 19 create offences where a designated body fails to provide resources for a responsible officer or a responsible officer is prevented from carrying out their statutory duties. In addition Regulation 14

creates an offence where there is a failure to nominate or appoint a responsible officer.

**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.**

We consider it unfair for some doctors, as referred to in Regulations 12 (3) and 18 (3), to be obliged to fund the work of their responsible officer. In particular, there is the potential for self-employed doctors to be penalised by this requirement. In order to ensure equality of access to responsible officers across the diverse activities within the profession, we recommend that these costs should be met from a central fund.

**Draft Guidance**

The draft guidance has been prepared in co-operation with the British Association of Medical Managers (BAMM), the BMA Medical Managers Committee and NHS Employers. In preparing the guidance many medical managers throughout the country have commented and assisted.

You are asked to read the draft guidance and comment on the content, structure, style and layout of the document. Your input will help shape the guidance and ensure it is both relevant and appropriate to the needs of responsible officers, their organisations and the doctors who relate to them.

**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.**

With the regulations as currently drafted, we have serious concerns as to whether the responsible officer role will be achievable and question whether the proposals will achieve the stated objective of improving quality care.

The demands of the role outlined in the proposals require somebody of quite exceptional skills and competences. Although it is assumed that many Medical Directors will become responsible officers, this is a significant extension of their role, not only in terms of responsibility, but also in their powers and workload. There is already a marked variation in the abilities of Medical Directors. The additional duties are likely to be onerous and we anticipate that many senior doctors with the necessary professional standing may be either unwilling or unable to take this on. Therefore we question whether it will be possible find 1000 individuals with the skills and aptitudes to succeed in the role.

We are concerned as to whether the responsible officers will be adequately equipped to carry out their duties. In the impact assessment, it is projected that there will be around 1000 responsible officers and every designated organisation will have only one responsible officer. As these vary enormously in size, the number of doctors relating to a responsible officer may vary from a handful to multiple thousands. We consider the funding requirements envisaged in the impact assessment report are wholly inadequate and caution that the role of responsible officer is doomed to failure unless properly resourced. .

Finally it is not clear from the regulations what will happen if the responsible officer is subject to a complaint to the GMC. At the very least this is likely to undermine credibility, yet given the current timescale for dealing with GMC cases this is likely to have a potentially serious adverse effect on the responsible officer's ability to carry out his/her functions.