Public Concern at Work
Suite 301
16 Baldwins Gardens
London EC1N 7RJ
Telephone 020 7404 6609
Fax 020 7404 6576
whistle@pcaw.co.uk
www.whistleblowing.org.uk

Public Concern at work

SENT BY EMAIL AND POST

michael.wright@dh.gsi.gov.uk
responsibleofficer@dh.gsi.gov.uk

Michael Wright
Department of Health
Quality Strategy Branch
Room 423, Wellington House
133-155 Waterloo Road
London SE1 8UG

28 October 2008

Dear Mr. Wright,

CONSULTATION ON RESPONSIBLE OFFICERS AND THEIR DUTIES RELATING TO THE MEDICAL PROFESSION

Public Concern at Work (PCaW) is the UK's leading authority on public interest whistleblowing. Promoting individual responsibility and organisational accountability is at the heart of our work. By way of background we attach (at Annex A) a brief description of the charity and our work with the NHS. In addition, PCaW was invited to provide extensive evidence to the Shipman Inquiry and to contribute to the Ayling and Neale Inquiries.

We welcome the Government's commitment to promoting strong local clinical governance arrangements to protect patients and promote quality health care. In each of the two extreme cases of doctors' malpractice mentioned in the consultation, the official inquiries revealed how the harm could or should have been prevented, or - as in the case of serial killer Harold Shipman - been contained. The facts showed, *inter alia*, that opportunities to sound the alarm were missed, that early warning signs were not picked up, that recruitment and monitoring systems were not robust enough, and that communication had failed or had not been transparent enough. It is right to identify where the problems lie in such cases and it is right to try to address these. We would caution however, against assuming that creating the role of a responsible officer for every doctor in the UK will in fact better protect patients. That said, we hope that our comments and suggestions are helpful in ensuring that responsible officers are as an effective and integral aspect of local health governance as possible.

We limit our observations to three aspects of the role and make a final suggestion as to how to ensure compliance. First, we consider that most, if not all, of the proposed functions of the responsible officer fall properly within the remit of the Medical Director and where such a post exists we see no need to create a new or separate

function. Secondly, in our view, the proposal that the responsible officer is "personally responsible" to report / make recommendations to the General Medical Council (GMC) is particularly problematic. The reason for this is two-fold: the first is a concern that it unwittingly creates a new duty and the possible chilling effect this will have on staff raising early concerns about a doctor's practice, and secondly, the lack of separation of powers between investigation, reporting and enforcement creates conflict in the role of responsible officer. An unintended consequence of this may be to undermine the governance responsibility and function of the Boards of healthcare organisations. We conclude with three suggestions to address these concerns including vesting the responsibilities envisaged for the responsible officer in the Medical Director or equivalent roles; removing the personal duty - or any perception of one - on responsible officers to report to the GMC and give them clear guidance as to their responsibilities; and finally, proposing possible sanctions to deal with health care organisations failing or unwilling to take a lead in clinical governance.

The Role of Medical Director

The clinical governance functions set out in the consultation paper are, for the most part, responsibilities that fall or should fall to already established Medical Directors. Where Medical Directors are in place, it makes little sense to create an additional post of responsible officer and duplicate or confuse the clear line of accountability. The Medical Director is in charge of clinical governance at board level, giving strong leadership from the top of the organisation. Such leadership is, in our view, very important. In cases where there is no Medical Director, the responsibilities should be given to an equivalent medical or clinical lead reporting directly to the Board.

Are responsible officers under a duty?

The consultation document identifies a responsible officer as a senior doctor within a healthcare organisation with specific and personal responsibility for those aspects of the medical revalidation and to the conduct of performance. The document later states the responsible officer is personally responsible for the oversight of investigatory processes into concerns that are raised about a doctors' conduct and performance and whether to refer the case to the GMC along with personal recommendations as to what action might be taken. It is unclear whether the Government wishes to impose a duty on the responsible officer to report to the GMC but in our view, as it is currently set out, this is likely how the responsibility will be understood.

Experience on our helpline (advising thousands of NHS staff over many years) is that, except in the most serious cases, individuals are understandably hesitant to raise a concern about the conduct and performance of a specific doctor if they think it will too quickly call into question that doctor's fitness to practice. Where staff believe a responsible officer is under a duty to report to the GMC, there is the risk of a chilling effect - i.e. that staff will be less likely to raise and communicate concerns early to a responsible officer. In light of this, we recommend that any suggestion of a duty to report directly to the GMC be removed. In our view, it is more important that patient safety concerns are raised and properly investigated at a local level, wherever possible. A duty, or perceived duty, to report to the GMC is likely to hinder the responsible officer in promoting and being part of an effective early warning system.

That said, we agree that the responsible officer should be under a duty to cooperate with the GMC and we suggest, if it does not exist already, that such a duty be extended to all health care.

Local Accountability

It is important that the Boards of healthcare organisations are encouraged to take full responsibility for clinical governance and that the role of the responsible officer is not a means to by-pass this. The consultation document envisages the responsible officer as the local monitor and regulator of doctors. Though we have limited our observations to those aspects of the role which we believe will conflict with the goal of promoting local accountability, we flag here a concern about the internal emphasis on professional regulation of doctors. If the emphasis is too strong or focused in one person, there is a risk that it will stifle the will and ability of the organisation (the Board) to take full responsibility for its clinical governance arrangements. It is possible that the Board will end up relying on the responsible officer to deliver accountability and by so doing, pass over their own governance responsibilities. Whilst we hope that this does not occur, evidence from other sectors indicates that having an external regulating function sitting within an organisation is not as effective a local accountability mechanism as one might suppose (see for instance the role of compliance officer in the financial sector; or the role of Meat Hygiene Service inspectors in abattoirs). For these reasons we strongly urge, that as suggested in paragraph 4.7, the Department gives clear guidance that "the responsible officer should not take decisions on their own but after an appropriate process involving a properly constituted subcommittee of the organisation's board".

In short, the possible functions listed at question 5.2 have the effect of placing the responsible officer in the roles of investigator, prosecutor and judge. We understand that decisions as to fitness to practice remain with the GMC. However, in practical terms, if the responsible officer is meant - or is perceived - to act as local investigator, prosecutor and judge, there is a risk that he or she will be seen as the local face of the GMC and be a means of by-passing local accountability. We would argue that there needs to be a separation of powers so as to ensure that firstly, individuals feel able to raise concerns with the responsible officer and secondly, the board remains accountable.

Recommendations and suggestions

In light of the practical difficulties we have identified above, we make the following recommendations and suggest some alternatives.

1. It should be specified that the duties of a responsible officer will vest in the medical director, or where such a role does not exist, in the medical or clinical lead of the organisation reporting directly to the Board. *This recognises and builds on local accountability and avoids conflict and duplication of roles.*

2. It should be clarified that the there is no personal duty on responsible officers to report to the GMC. *This will ensure a separation of powers between the*

responsible officer and the GMC, and avoid any real or perceived conflicts in the duties of the responsible officer.

The guidance could make it clear that responsible officers are meant to review all cases where an individual doctor's practice or conduct has been found to fall below acceptable standards and to make recommendations to the Board of the employing organisation as to:

a. what action the organisation should take;
b. whether NCAS or other external support should be requested;
c. and, notwithstanding the above, whether the case should be referred directly to the GMC affiliate.

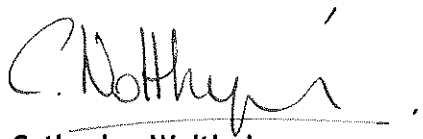
In order to ensure better and more transparent communication of risks, the Department may wish to consider whether employers of doctors should report regularly to the GMC the numbers, types and the action taken in such cases. The GMC affiliate will have the power to see the details of any individual case and to take up their own investigation at any time.

3. Finally, the consultation asked what action might be taken where an NHS trust, for instance, fails to appoint a responsible officer or provide the necessary resources to fulfill the role. We suggest the Government consider the approach of the Combined Code on Corporate Governance with respect to whistleblowing arrangements (see ICAEW Guidance for Audit Committees - http://www.icaew.com/index.cfm/route/118068/icaew_ga/pdf).

   Health care organisations could have a duty to state in their annual reports whether a responsible officer has been appointed and the resources available, and if not, why not. If the reasons for not having a responsible officer are deemed unsatisfactory, a number of possible consequences could follow. These could include a drop in star or risk rating by the Healthcare Commission or the Monitor, or the possibility for the GMC to place a GMC affiliate directly within the organisation with the costs carried by that organisation.

Finally, please know that we would be happy to offer any further assistance to the Department in their consideration of how the role of responsible officer can further enhance robust internal whistleblowing arrangements. This could include a specific section on whistleblowing in any guidance issued by the Department of Health.

Yours sincerely,



Catherine Wolthuizen
Director

ANNEX A

BACKGROUND: Public Concern at Work, whistleblowing and the NHS

PCaW was established as an independent charity in 1993 to address public interest whistleblowing. We do this through four key activities:

- providing free confidential advice to individuals concerned about wrongdoing and who do not know whether or how to raise their concerns;
- public education;
- professional, practical support for organisations; and
- informing public policy.

Over the years we have advised thousands of healthcare staff, including doctors, who have had concerns about serious patient safety issues or risks and have been unsure whether or how best to raise their concern. We have provided consultancy, training and advice to senior managers and directors in Trusts and PCTs in all parts of the UK, have spoken to numerous professional networks and forums, and have provided information and support to health care regulatory bodies, the GMC and the NCAS amongst others. In addition to this work, PCaW was invited to provide extensive evidence to the Shipman Inquiry and to contribute to the Ayling and Neale Inquiries.

In April of this year, Public Concern at Work won the competitive tender to continue providing independent and confidential whistleblowing advice to NHS staff and "others" for three years, to 2011. "Others" includes providing basic advice to NHS organisations as well as the Department of Health and regulatory bodies on whistleblowing best practice and related policy and practical issues.