

# The Role of the Responsible Officer in the Independent Sector

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Designated bodies (DB) within the Independent Health Sector (IHS) vary from a single specialist clinic through to a group of hospitals throughout the UK, providing a full range of services from outpatient care through to Level 3 intensive care. Within this article, I will concentrate on the key differences and challenges that face the IHS Responsible officer (RO) with reference to the independent acute hospital setting.



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The medical profession (Responsible Officers) regulation 2010 sets out the role and responsibilities of the RO: these regulations cover the practice of doctors across all healthcare settings<sup>1</sup>. The requirement to provide quality assured appraisals with appropriate reflection of practice and identification of a personal development plan (PDP) annually over a 5-year cycle in order to enable a revalidation recommendation, is a core component of the role of an RO, whether working within the NHS or within the IHS<sup>2</sup>. The IHS RO must also ensure that all doctors' practice is safe and appropriate to scope when these doctors are working within the independent designated body, despite the fact that the majority of doctors with practicing privileges do not have a prescribed connection (PC) to the independent hospital DB.

The first challenge is that each IHS DB may have hospitals and clinics across the UK and the RO will therefore have responsibility for a range of doctors across different geographical locations. Whilst the majority will have a prescribed connection elsewhere, which is predominately in the NHS, the day-to-day oversight of practice in the IHS DB falls to the RO working alongside the senior management team for that hospital or clinic.

The key differences in the structure of IHS care provision are as follows:

1. Most doctors working as consultants within the IHS designated body:
  - a. Have practicing privileges rather than being employed.
  - b. Will have a prescribed connection to an NHS Trust and therefore their DB and RO will not be the IHS RO.

- c. Will have practicing privileges at more than one IHS provider.
  - d. May work within a limited liability partnership or working within his or her own company or be self-employed.
2. Most doctors are:
    - a. Consultants
    - b. On the specialist register
    - c. Do not have a team of junior doctors working with them.
    - d. Some of the doctors have qualified in Europe and may work both in Europe and the UK.
  3. A number of doctors will work solely in the IHS and these doctors will have a prescribed connection to an IHS DB and to the RO of that DB. The structure and oversight of these doctors by the RO is similar to that in the NHS. There is a lead appraiser, trained appraisers and an annual appraisal. There is quality assurance of the appraisals, provision of 360 feedback and provision of data to fully populate the appraisal. For these doctors, with a prescribed connection, the oversight and understanding of scope of practice is very clear overall. However, some of these doctors will have a PC to a different IHS RO.
  4. The junior doctors working within the IHS are either:
    - a. In training posts elsewhere, including in research posts earning additional money when employed by the designated body, and have an RO at the Trust in which they are training, with links to the deanery;
    - b. Employed by an agency with an RO
    - c. May be employed directly by the DB in a full-time non-training role as an RMO.



A further challenge therefore, for the RO, is to ensure that all doctors with practicing privileges, whether they have a prescribed connection or not to the RO:

1. Will have completed an application to hold practicing privileges.
2. Will have provided references, including a reference from their existing RO.
3. Will have peer review through the medical advisory committee to ensure fitness to practice and review scope of practice.
4. For those solely in private practice, will undergo an annual review of practice.
5. For those with an NHS prescribed connection, will undergo a formal biennial review of practice.
6. Each doctor with practicing privileges will have to submit at least their full output form and PDP after each appraisal and there is a requirement that there is evidence that their private practice has been reviewed as part of the appraisal.
7. The RO must review regularly the general performance information held by the designated body, including clinical indicators relating to outcomes for patients identify any issues arising from that information relating to medical practitioners, such as variations in individual performance; and take all reasonably practicable steps to ensure that the designated body addresses any such issues.

**“The Independent Health Sector Responsible Officer must ensure that all doctors’ practice is safe and appropriate to scope when these doctors are working within the independent designated body.”**

In addition, working with the Senior Management Team (SMT) of the DB, the RO will need to ensure that these processes are quality assured and be able to demonstrate this both to the Board of the DB, as part of the annual board report, and as part of external quality assurance, such as by the CQC.

It is therefore essential that there are clear and open lines of communication between the RO with:

1. The SMT at each facility within the DB.
2. The medical advisory chair, committee and governance lead at each facility.
3. The NHS trust ROs where the consultants have prescribed connections.
4. The NHS trust or agency where the junior doctors have prescribed connections.
5. Other independent sector facilities where the consultants may have a prescribed connection or practicing privileges.
6. Other ROs for the IHS
7. Sites of practice overseas whether charitable or for remunerated work
8. The ELA from the GMC. >>

In addition, attending and actively engaging in the RO network meetings provides a forum for sharing of ideas, expertise and best practice across the NHS, training and IHS sectors. The Association of Independent Healthcare Organisations (AIHO) provides a forum for ROs to meet and share best practice and challenges in the IHS. Finally, open lines of communication with the ELA from the GMC, coupled with the twice-yearly regular meeting, provides an excellent resource again to discuss and ensure appropriate response when cause for concern is identified.

The RO also needs to work with the central SMT for the DB to ensure structures are in place to ensure:

1. Consultants are provided with a full data set of their private practice to enable appropriate and full discussion of scope, activity and outcomes at their appraisal.
2. That when cause for concern arises, that this is investigated safely and promptly with early use of a decision-making group and as part of the DMG, that a standard agenda is adapted, that each cause for concern, but that agenda contains the essential components to ensure:
  - a. Safe care of patients.
  - b. Careful and appropriate investigation.
  - c. Appropriate lines of communication with:
    - i. Patients or staff that have raised concerns.
    - ii. The consultant's RO when the PC is elsewhere.
    - iii. Other units where the consultant may be practising.
      - a. To ensure that the consultant undergoing investigation is given appropriate support.
      - b. That there is appropriate communication where necessary with the GMC.
      - c. When needed, there is appropriate communication with the NHS, CQC and with insurance bodies.

As part of the DMG the RO will also ensure that:

1. Appropriate measurements are taken to address concerns, which would include, but not be limited to, recommendations to the doctor regarding reflection or need for training or re-training.
2. The Doctor is offered appropriate rehabilitation.
3. Any systemic issues within the designated body that had contributed to the concerns had been identified.

4. Wherever the doctor's prescribed connections laid elsewhere, that their reflection, outcomes and learnings are discussed at their appraisal and that the RO receives appropriate communication.

Given that an independent sector RO is overseeing several hospitals and clinics at different locations, there is a need for the RO, along with the DB governance lead, to oversee, and also as appropriate, to provide:

1. Standard components to the MAC agenda and each facility, enabling appropriate quality assurance and appropriate collection of comparative data.

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2. Shared learning across the hospitals and clinics when cause for concern is identified, including discussion of the shared learning at each MAC and at each facility governance meeting.
3. Support for the development of multidisciplinary team meetings with appropriate agenda and output forms, in view of the increase in complex care being provided within the independent sector.
4. Case investigator training and reflection meetings at which best practice is identified and practice improved.
5. Appraisal training and, reflection and ongoing development of appraisal systems to match the appropriate assessments of full scope of practice for doctors working in the independent sector.
6. Meetings where members of the MAC from different facilities can meet with input from board members, the governance lead and from the RO, again, to further develop quality care to ensure shared learning.

Perhaps one of the most challenging areas is visibility and accessibility to individual consultants. This is vital in ensuring that doctors who have practicing privileges are

fully aware of the requirements to continue to hold practicing privileges, and how the designated body can help to ensure that they are complying with good medical practice, to help ensure that they are fully populating their appraisal with appropriate information across the whole scope of their practice, ensuring that they are aware of the support and help that can be given to them by the hospital facility that they are working to meet the ever increasing demands placed upon them in terms of:

1. Compliance with the Competition and Markets Authority ruling<sup>3</sup>.
2. Compliance with PHIN.
3. Ensuring that they are continuing to develop their own performance.
4. When cause for concern is identified, not only is the doctor being appropriately investigated, but also that the doctor is given appropriate support at a time that can be very challenging to them.
5. Access to help and support when unwell.
6. To assist doctors as they move towards retirement to safely transfer care of patients to others and store records appropriately.

The RO in the IHS must ensure that doctors are encouraged to maintain and improve their practice and by doing this, will play a crucial role in improving and maintaining the quality and safety of patient care wherever a patient receives treatment. ■

### References

- 1) 2010 No. 2841 HEALTH CARE AND ASSOCIATED PROFESSIONS DOCTORS The Medical Profession (Responsible Officers) Regulations 2010
- 2) <https://www.gmc-uk.org/registration-and-licensing/managing-your-registration/revalidation/revalidation-for-responsible-officers-and-suitable-persons>
- 3) [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/453465/Private\\_Healthcare\\_Market\\_Investigation\\_Order\\_2014.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/453465/Private_Healthcare_Market_Investigation_Order_2014.pdf)