Responsible officers in the new health architecture

A Public Consultation on the Amendments to the Medical Profession (Responsible Officers) 2010 Regulations

Consultation Document

April 2012

DH INFORMATION READER BOX

Policy	Clinical	Estates
HR / Workforce	Commissioner Development	IM & T
Management	Provider Development	Finance
Planning / Performance	Improvement and Efficiency	Social Care / Partnership Working

Document Purpose	Consultation/Discussion
Gateway Reference	16967
Title	Responsible officers in the new health architecture
Author	DH / Quality Strategy Branch
Publication Date	**April 2012**
Target Audience	PCT Cluster CEs, NHS Trust CEs, SHA Cluster CEs, Care Trust CEs, Foundation Trust CEs , Medical Directors, Directors of PH, Local Authority CEs, PCT Cluster Chairs, NHS Trust Board Chairs, Directors of HR, GPs, Communications Leads
Circulation List	PCT Cluster CEs, NHS Trust CEs, SHA Cluster CEs, Care Trust CEs, Foundation Trust CEs , Medical Directors, Directors of PH, Local Authority CEs, Directors of Adult SSs, PCT Cluster Chairs, NHS Trust Board Chairs, Special HA CEs, GPs, Responsible Officers, Organisations employing doctors, Royal Medical colleges
Description	A formal response to the consultation will be published
Cross Ref	Health and Social Care Act 2012. Health and Social Care Act 2008 and The Medical profession (Responsible Officers) Regulations 2010.
Superseded Docs	N/A
Action Required	N/A
Timing	
Contact Details	Michael Wright Quality Strategy Branch Room 423 Wellington House 133-155 Waterloo Road SE1 8UG 0207 972 1323
For Recipient's Use	

Contents

CHAPTER ONE

Introduction

The consultation

1.1 This consultation is being held under the HM Government of Practice on Consultation. The criteria for the consultation are reproduced in Chapter Five.

1.2 The consultation period will run from 18 April 2012 and will close on 25 July 2012. Details of how to respond are set out in Chapter Five.

The document

1.3 The document applies to England only. This Chapter provides a short background on responsible officers and the changes to the NHS architecture set out in the Health and Social Care Act 2012[1].

1.4 Chapter Two describes the background to the role of responsible officer and sets out the implications for changes in the NHS structure contained in the Health and Social Care Act 2012.

1.5 Chapter Three considers the responsible officer's role in checking the language competence of doctors working in England.

1.6 Chapter Four discusses the designation of further bodies in The Medical Profession (Responsible Officers) Regulations 2010 ("The Regulations") including those in public health.

1.7 Chapter Five explains how to respond to this consultation.

1.8 Annex 1 provides a hard copy of the consultation questionnaire which can also be found and completed online at www.dh.gov.uk/liveconsultations.

Background

1.9 The concept of the responsible officer, a senior doctor within a healthcare organisation with specific and personal responsibility for those aspects of clinical governance linking to medical revalidation and to the conduct and performance of doctors working in or for the organisation, was set out in the White Paper *Trust, Assurance and Safety* in

[1] Health and Social Care Act 2012 http://services.parliament.uk/bills/2010-11/healthandsocialcare.html

February 2007[2]. It forms one aspect of the wider programme of reform of professional regulation described in the White Paper.

1.10 The primary legislation enabling the role of the responsible officer to be established in Regulations was contained in the Health and Social Care Act 2008[3] in the form of amendments to the Medical Act 1983, and established free-standing regulation-making powers in relation to clinical governance functions which apply in England only. Following consultation, Regulations[4] were laid before Parliament in 2010. The Regulations came into force on 1 January 2011. In addition to giving responsible officers specific functions, the Regulations designate certain bodies that have to appoint a responsible officer. These bodies include Strategic Health Authorities (SHAs) and Primary Care Trusts (PCTs). Specific groups of doctors are connected to these bodies which will be abolished from April 2013 as set out in the Health and Social Care Act 2012 and, consequently, the Regulations will need to be amended.

The changes to the NHS architecture

1.11 The White Paper *Equity and Excellence: Liberating the NHS*[5] set out the Government's vision for health services. It described a new commissioning architecture for the NHS. Responsibility for local commissioning would rest with Clinical Commissioning Groups (CCGs) supported and overseen by a NHS Commissioning Board (NHS CB) that would hold the CCGs to account.

1.12 The Health and Social Care Act 2012 sets out that new structure. The structure was confirmed by the work of the Future Forum[6], the group established to 'pause, listen and reflect' on the content of the Health and Social Care Bill. The Bill, now Act abolishes PCTs and SHAs from April 2013. These bodies have already been clustered together in bigger geographical groups to provide more cost effective services and stability through the transition to the new structure.

1.13 The Future Forum recognised the important role of responsible officers at all levels. In its report on Clinical advice and leadership[7] it recommended that "The Department of Health and the NHS CB should ensure responsible officers continue to be in place to support doctors in improving care and ensuring their fitness to practice through revalidation". The Government's response[8] to the Future Forum report confirmed that it

[2] *Trust, Assurance and Safety: the regulation of health professionals in the 21st century,* Cm 7013 (TSO, February 2007)
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_065947.pdf
[3] Health and Social Care Act 2008: HMSO 2008: http://www.legislation.gov.uk/ukpga/2008/14/contents
[4] The Medical Profession (Responsible Officers) Regulations 2010: TSO; November 2010:
http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents
[5] Equality and excellence: Liberating the NHS: Dept of Health; July 2010
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_117794.pdf
[6] The Future Forum report
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_127443
[7] Clinical advice and leadership A report from the NHS Future Forum: June 2011
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_127542.pdf
[8] Government response to the Future Forum report; DH; June 2011
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_127719.pdf

would make sure that there continues to be a responsible officer where they are already present in organisations that provide NHS care. It also confirmed that the Department of Health would consult on the proposals for responsible officers in the new architecture. This document fulfils that commitment.

1.14 At the heart of the new commissioning structure are CCGs that will build on the role GPs and other front line professionals play in ensuring quality care for their patients. The CCGs will have the power and responsibility for commissioning local services.

1.15 The NHS CB's central role will be to ensure that the NHS delivers better outcomes for patients within its available resources. The Board's role is to commission primary care, specialised, military, prison and some public health services.

1.16 Detailed design proposals for the NHS CB have been published, as *'Design of the NHS CB'*[9]*,* on 2 February 2012. The NHS CB will have a workforce of about 3,500 of which 2,500 will be in 50 local offices, 200 in the sectors and 800 at the centre. It will have a Medical Director, a Deputy Medical Director and three Associate Medical Directors. In addition, each local office will have a medical lead.

1.17 While the new architecture will be in place from April 2013 there are already significant structural changes that have taken place in the NHS, with PCTs and SHAs grouped together in 'clusters'. Although the clusters are in place, each PCT and SHA continues to have its own legal existence and will have to nominate or appoint a responsible officer.

1.18 One of the key components of the responsible officer system is the networks that are being established in each SHA. These networks bring together responsible officers in all settings to share good practice and understanding. These networks continue to be maintained and supported through the SHA cluster Medical Directors.

[9] Design of the NHS Commissioning Board; February 2012-02-27
https://www.wp.dh.gov.uk/commissioningboard/files/2012/01/NHSCBA-02-2012-5-Organisational-Design-Recommendations-Final.pdf

CHAPTER TWO

Responsible officers in the new NHS architecture

Background

2.1 The Responsible Officers Regulations came into force on 1 January 2011. They designate bodies that are required to nominate or appoint a responsible officer. Generally organisations will have a single responsible officer. They give responsible officers in designated organisations in Great Britain functions relating to the evaluation of fitness to practise. In England, responsible officers also have functions relating to monitoring the conduct and performance of doctors. The role of the responsible officer is to support doctors to maintain and improve the quality of care they deliver, and to protect patients in those cases where doctors fall below the high standards they set for themselves. Where a designated body is a PCT in England, responsible officers also manage admission to Performers Lists. Medical revalidation, the process by which licensed doctors will regularly demonstrate that they are up to date and fit to practise is planned to commence, subject to an assessment of readiness by the Secretary Of State, in late 2012. When revalidation is introduced responsible officers in Great Britain will also be responsible for making fitness to practise recommendations to the GMC in respect of individual doctors.

2.2 Responsible officers are licensed doctors and, as such, must have their own responsible officer. In England, each responsible officer at local level has a statutory connection to a responsible officer at the appropriate SHA. Although the statutory role of SHA responsible officers is broadly similar to that of other responsible officers, they also have an important role in supporting responsible officers to fulfil their duties. In practice, this support will include running networks to enable responsible officers to share experiences and calibrate decisions.

2.3 The proposals for designating bodies in the new NHS architecture have been discussed widely with SHA Medical Directors, the Royal College of GPs, the BMA and in meetings with many of the existing responsible officers. We have revised the proposals to reflect those consultations where it has been sensible to do so.

2.4 The following discussion focuses on the Regulations as they apply in England, since the changes to the NHS architecture in the Health and Social Care Act 2012 will apply in England only.

Current connections to PCTs and SHAs

2.5 Under the Regulations, PCTs have prescribed connections to the following groups of doctors:

- primary medical care doctors on a Performers List in England (Reg 10(1)(b)); and
- secondary care locum doctors who contract through locum agencies outside the Office of Government Commerce (OGC) Buying Solutions framework

agreement[10] and whose address registered with the GMC is located within the PCT's area (Reg 10(1)(e)).

2.6 The Regulations also connect the following groups of doctors to SHAs:

- responsible officers (Reg 12);
- specialist trainees (postgraduate medical deaneries are part of SHAs) (Reg 10(1)(a)).

2.7 The future designation of organisations, and their connections to these groups of doctors, is considered below. Figure 1 on page 10 illustrates the effect of the proposed changes on the hierarchy of connections.

Primary care

2.8 In the new NHS architecture, it would be possible to envisage responsible officers for primary care sitting within either Clinical Commissioning Groups (CCGs) or the NHS Commissioning Board (NHS CB). The Health and Social Care Act 2012 provides for the NHS CB to hold national Performers Lists and gives it the power to direct CCGs to exercise any of its functions relating to the provision of primary medical services.

2.9 There is general support from those involved for the current link between the responsible officer role in primary care and the management of the medical Performers List being retained in the new NHS architecture.

2.10 A paper produced by NHS West Midlands for the Department of Health's Commissioning Development Team examined the processes and recommended that effective management of the Performers List required information from contract management and from the oversight of standards of clinical governance (including the responsible officer function). It suggested that, ideally, these roles should be within the same organisation and recommended that the optimum scale of operation should be similar to the PCT cluster 'footprint'.

2.11 While it is possible to envisage the responsible officer sitting in a CCG, feedback from those currently involved in managing Performers Lists is that this would remove the responsible officer from an important source of information (the contracting perspective) and create an unmanageable conflict of interest because of the close business relationship between the responsible officer and his or her partners. It might be possible to reduce or remove the conflict if the responsible officer were not to practise in the same geographic area, but this would still not give them access to an important source of information.

2.12 To ensure sufficient flexibility in the new arrangements, **we are proposing to designate the NHS CB in the Regulations and prescribe a connection to the NHS CB for all doctors on medical Performers Lists (who in future will be on a national medical Performers List held by the Board).**

[10] Framework operated by Office of Government Commerce - Buying Solutions (Health) http://www.buyingsolutions.gov.uk/frameworks/full.html?list_by=name&contract_search=medical+locums

2.13 We think that a single responsible officer at the NHS CB is too remote from the local information about doctors performance. Further, we do not think that is feasible or practicable for a single person to take on the level of accountability and the personal workload that would arise if all these roles were combined in one responsible officer. **We therefore propose that, unlike most bodies designated under the Regulations, the NHS CB should be allowed to determine the number of responsible officers it appoints.** This will enable the NHS CB to adapt to changing circumstances and to determine the most effective and efficient way of providing this important function.

2.14 This might mean, for example, nominating or appointing as many responsible officers as there are proposed NHS CB field force teams. It would also seem sensible that the number and location of responsible officers reflects the contract management arrangements established by the Board.

2.15 While it is important the NHS CB must be given flexibility to adapt to changing circumstances, doctors need clarity about who their responsible officer will be. Similarly, responsible officers need clarity about who they will be responsible for. We think there is value in the NHS CB publishing a clear, simple set of criteria that will unambiguously connect individual GPs to a named responsible officer.

.

2.16 The sub-national structures of the NHS CB are becoming clearer and are likely to be based around the current PCT clusters. Therefore, it should be possible to provide clarity by establishing a clear connection between a doctor and the NHS CB based on geography. We suggest that a key principle guiding the NHS CB should be that a responsible officer has a defined geographical area of responsibility. Individual doctors would then be linked to that area either by their work or by their GMC registered address.

2.17 We think the following first order criteria are helpful and would provide clarity for GPs and responsible officers:

- if you are a contractor, or in a salaried position in a practice, then the location of the practice determines your responsible officer; or
- if you are any other sort of General Medical Practitioner with a connection to the NHS CB, then your GMC registered address determines your responsible officer.

2.18 We also think there will need to be a second order criteria applied for those doctors who are not clearly linked to a responsible officer by the first order criteria, for example, if you hold salaried positions in more than one practice, or if your GMC registered address is outside the UK.

2.19 With both the detailed sub-national structure of the NHS CB and the eventual size of CCGs yet to be finalised, it is possible that a responsible officer structure based on either of these elements could be appropriate. What is clear, is the desirability of ensuring that the proposed designation of organisations to nominate or appoint responsible officers in primary care is sufficiently flexible to enable adaptation to reflect changes in NHS structures. At the same time we think it is important to give individual doctors reassurance about how they will know who their responsible officer is. It would not be possible to specify that detail in the Regulations themselves. **We therefore propose to amend the Regulations to require the NHS CB to set out how the**

connections between individual doctors and a responsible officer will operate in practice.

2.20 The advantages of this model are that it:

- is flexible and ensures future proofing;
- enables effective use of local intelligence and contracting information;
- enables economies of scale;
- maintains the link between the Performers List and responsible officer functions; and
- is aligned with the proposed duty on the Secretary of State to promote autonomy under the Act.

2.21 The disadvantages of this model are that it:

- without clear administrative arrangements it may make it more difficult for a doctor in primary care to identify their responsible officer.

Q2.1 Do you agree that the NHS CB should be designated in the Regulations and required to nominate or appoint responsible officers for primary medical care doctors? If not, please explain your alternative.

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

Secondary care locum doctors

2.22 PCTs have a connection with a very small group of locum doctors who work in secondary care, who contract through locum agencies outside the Office of Government Commerce (OGC) Buying Solutions framework agreement and who have no other connection (e.g. through a contract of employment). Part of the rationale for this connection was that PCTs have a duty to improve the quality of care for the public in their area. This is the essence of the responsible officer role and the Health and Social Care Act 2012 gives a similar duty to CCGs.

2.23 We had considered whether the connection for this group of doctors should be to CCGs. However, we understand that CCGs will not employ secondary care doctors and the proposals already set out in this document link primary medical care doctors to the NHS CB. CCGs therfore will not have a connection with any other group of doctors. It does not seem practical to require CCGs to appoint a responsible officer in these circumstances. **We are therefore proposing that the connection for this specific group of locum doctors is with the NHS CB.** In addition, we do not propose to designate CCGs unless they employ doctors not on a Performers List. As with doctors working in primary care, we propose to require the NHS CB, in the Regulations, to set out how the connections between individual doctors and a responsible officer will operate in practice.

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?

The intermediate tier (the responsible officer's responsible officer)

2.24 Responsible officers are licensed doctors and, as such, must have their own responsible officer. Under the Regulations, responsible officers in designated bodies in England are connected to SHAs. We estimate that there are some 600 designated bodies in England. The majority of these organisations are either part of the NHS or provide some care to NHS patients. These bodies are spread throughout the country, although about one third are located in London and the South East. In our view, the number and geographic spread makes it desirable to have an intermediate tier between the Department of Health and designated organisations.

2.25 The increasing diversity of provision in the NHS by any qualified provider suggests that the connection to an intermediate tier based in the NHS will remain desirable in the future. **We are therefore proposing that responsible officers in NHS trusts, independent hospitals, and other designated bodies in England, will have a connection to the NHS CB.**

2.26 This will result in both primary care responsible officers and those officers' own responsible officers sitting within the same organisation. We recognise that there would be a potential conflict of interest. We think that potential conflicts could be addressed either by providing additional guidance or by specifically addressing it in the national mandate that the Secretary of State will set the NHS CB. **Since the national mandate will set out expectations for the Board, we think it is more appropriate for it to be addressed through that route**.

2.27 We do not think it appropriate to set out the way in which the NHS CB will carry out its statutory duties, particularly in relation to how these layers of responsible officers will be appointed and relate to each other. In para 2.19 we said that we are proposing to require the NHS CB to set out how doctors in primary care would be connected to a responsible officer. That requirement will also extend to the connection between a responsible officer and his or her own responsible officer.

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? If not, please explain your alternative.

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? If not, please explain your alternative.

Postgraduate trainees

2.28 Under the Regulations, postgraduate trainees are connected to the postgraduate medical deanery responsible for their training. The consultation *Liberating the NHS:*

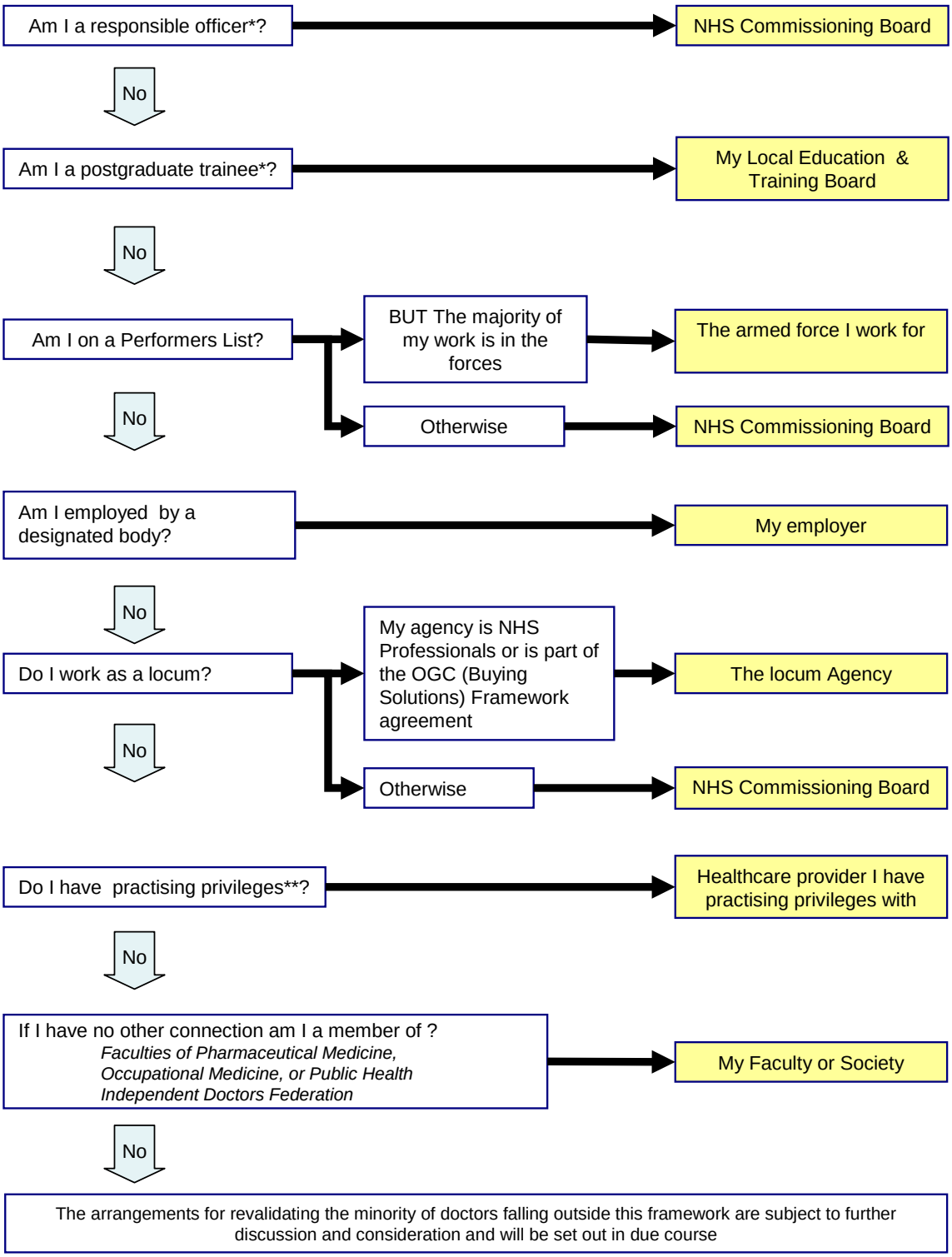
Developing the Healthcare Workforce: From Design to Delivery[11] set out plans for legally constituted Local Education and Training Boards (LETBs) to assume responsibility for postgraduate deanery functions from 1 April 2013. **We are proposing that, in England, postgraduate trainees will still be connected to those responsible for their training** thus maintaining the links between supervision of training and the management of their conduct and performance.

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

[11] Liberating the NHS: Developing the Healthcare Workforce From Design to Delivery, DH, January 2012 http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_132087.pdf

Figure 1

How to find my responsible officer in the new English NHS architecture
The hierarchy of responsible officer connections



CHAPTER THREE

Responsible officers and language checking

3.1 In giving the responsible officers in PCTs in England the function of managing admission to the Performers list we recognised that there is a synergy between the role of the responsible officer in primary care and the performers list system.

3.2 The Performers List Regulations[12] require PCTs to refuse admission to a Performers List if they are not satisfied that the performer (whether medical, dental or optical) applying for admission has the appropriate English language knowledge to enable them to carry out their function as a doctor in the PCT's area. This requirement is intended to ensure that doctors are fit for purpose and that patients are protected.

3.3 Responsible officers in England have similar functions under regulation 16(2)(a) of the Regulations which require them to ensure that medical practitioners have qualifications and experience appropriate to the work to be performed. There is no specific duty to check the language or other communications competence of those that are being employed or contracted with.

3.4 The Coalition agreement[13] set out a commitment to ensure that foreign healthcare professionals have the competence and language skills necessary to ensure that patients in the NHS are not put at risk of harm through an inability to communicate.

3.5 In respect of doctors, one way of meeting the commitment in the Coalition agreement would be to amend the Responsible Officers Regulations to give an explicit function to responsible officers to assess whether the applicant's competence in communicating with others, including patients and colleagues, was suitable for work to be done for the designated body.

3.6 The new duty could only apply to responsible officers working in England because the assessment of language skills is a clinical governance function, and clinical governance has been devolved to Wales, Scotland and Northern Ireland. We would therefore propose amending Part 3 of the Responsible Officers Regulations which imposes additional responsibilities on responsible officers in England under the powers of section 120 of the Health and Social Care Act 2008. We have been in consultation with the devolved administrations regarding the new proposals and would welcome their views in response to this consultation. **We think it is important to make the requirement clear in the Responsible Officers Regulations in the same way as it is in the Performers List Regulations.** This will ensure that the communications competence of all doctors linked to a designated body in England is verified regardless of which sector they were working in.

[12] The National Health Service (Performers Lists) Regulations 2004, http://www.legislation.gov.uk/uksi/2004/585/contents/made

[13] The Coalition: our programme for government http://www.cabinetoffice.gov.uk/sites/default/files/resources/coaltion_programme_for_government.pdf

3.7 An assessment of language skills would need to be carried out in a proportionate way which took account of the circumstances in which the doctor would be working before they were able to take up post. This would include in certain circumstances the proportionate use of language tests.

3.8 We think that rather than introduce express or prescriptive provisions in the Regulations about how this competence would be assessed, it would be preferable to develop guidance to explicitly address communications competence and how this ties into the applicant's qualifications and experience for the work. Such guidance would be produced jointly by the GMC and the NHS Commissioning Board. This approach would have the benefits of providing greater flexibility to take account of individual circumstances, be more accessible to those carrying out the role and consequently likely to be applied more consistently. Guidance could also be amended quickly to take account of changing circumstances, such as any scheme intended to apply across healthcare professionals more generally.

3.9 It is proposed that **responsible officers in England would be required under the new regulations to co-operate with the GMC in relation to assessing the skills and suitability of doctors.** We are exploring the feasibility of introducing a requirement that, where a responsible officer has assessed the suitability of any person who has not previously worked in a post in England, they would notify the GMC that the individual had been assessed by the responsible officer as being suitable for their first post, including in relation to their language skills. We are also exploring whether it would then be feasible for the GMC to **annotate the register to indicate that the doctor's suitability to work in a specific post had been assessed and verified.**

3.10 By annotating the register a general level of assurance on language competence would be provided. As explained in paragraph 3.5, the assessment of language is a clinical governance function and therefore the duty to carry out that function can only be imposed on responsible officers in England (though it is possible that the devolved administrations might propose alternative mechanisms for ensuring that similar checks are undertaken). As a consequence, it would not be possible to request responsible officers in the devolved administrations to co-operate with the GMC regarding the assessment of language. As a consequence, there will inevitably be a number of practical issues with regard to this proposal applying solely to England, and we wish to explore whether such an approach would be feasible and have value. It should be added that annotation of the register for the first post in England would not preclude future employers or contracting bodies undertaking checks as part of determining suitability for a particular role as individual roles require different competencies.

3.11 It is also proposed that the greater co-operation with the GMC will also include **notifying the GMC where the responsible officer has significant concerns on the language competence of an individual.** Our view is that this should apply on a UK wide basis as the purpose of this proposal is to ensure that where concerns about language ability are identified there is a mechanism in place for ensuring that appropriate action is taken. The mechanism by which concerns are identified might differ in different parts of the UK.

3.12 In terms of finance, the working assumption is that costs will be relatively low, and that benefits should outweigh the costs. Whilst the benefits of introducing a strengthened language checking system are clear, as part of the consultation we are seeking to undertake an exercise to secure better quantitative and qualitative evidence on actual benefits. In terms of cost, it is proposed that the main cost will relate to the use of language tests. Under the existing system PCTs and NHS Trusts are required to undertake checks, but the Department has no information on where the burden of responsibility for payment for language testing lies at the moment, where required. Specifically, it is unclear whether the cost is attributed to the individual doctor or the organisation.

3.13 As PCTs and NHS Trusts are already required to undertake checks on the language knowledge of doctors, for those organisations already fulifilling their recruitment duties effectively, we have presumed there should be little new cost even with the greater link to the GMC.

3.14 The European Commission is currently reviewing the Directive on the Mutual Recognition of Professional Qualifications (2005/36/EC) and, at the time of writing this consultation document, legislative proposals were due at the end of 2011. It is worth noting that policy options discussed in this chapter may be subject to further change to take into account any changes to the Directive in this area.

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

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 GMC and NHS Commissioning Board?

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 competency 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?

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

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 competency of an individual?

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 officers role?

Q3.6 a) Do you have evidence which you can share to help inform work on the potential benefits of a strengthened language system or any suggestions for data sources?

b) Do you have any evidence or data sources on the impact on equality through the use of language controls?

CHAPTER FOUR

Designating further bodies in the Responsible Officers Regulations

4.1 The Regulations broadly designate bodies that employ or contract with doctors in three areas. Those that:

- provide healthcare services;
- set policy and standards for healthcare; and
- a small number of organisations where the members operate independently of managed organisations.

4.2 In developing the Regulations, the Department of Health was clear that it was unable to designate every body that employs or contracts with a doctor but that we would consider extending the designation where it made sense to do so.

Public Health

4.1 The Government has an ambitious programme to improve public health. Local authorities will take the lead for promoting and protecting the health and wellbeing of local communities. They will take on functions currently undertaken by Primary Care Trusts that are already designated and have these responsibilities for the doctors they employ. Their new public health responsibilities will be funded through a ring fenced grant. Directors of Public Health, employed by local authorities, will support this critical new role. This, together with changes to death certification procedures means that local authorities are likely to become employers of licensed doctors. **We therefore intend to designate local authorities in England where they have a connection to a licensed doctor. Public Health England as an executive agency of the Department of Health is already designated under the Regulations.** The responsibilities in relation to revalidation of licensed doctors and responsible officers have been discussed with the Department for Communities and Local Government and are reflected in the agreed Local Government factsheet on public health[14].

4.2 Public Health England will be created as a new integrated public health service. It will provide national leadership and expertise across the breadth of public health practice and, as such, it will have an important role supporting public health professionals. There is an argument, therefore, that public health doctors employed by local authorities should be connected to Public Health England rather than local authorities in the Regulations. Although this could result in differing groups of doctors employed by local authorities having different responsible officers, it would fit well with Public Health England's role of providing professional support to those working in public health.

4.3 Under the structure currently set out in the Regulations, the prescribed connection for responsible officers in local authorities would be to the NHS CB. However, it is also

[14] Public Health in Local Government factsheets.- Professional appraisal and support and capacity building; Department of Health, December 2011.
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131904.pdf

possible to envisage a structure whereby the connection would be to Public Health England rather than the NHS CB. This might provide greater consistency of decision making within the public health community but would remove these responsible officers from the local networks that are supporting responsible officers and might propose inconsistency across the profession.

4.4 There is also a logic that maintains a connection between Public Health England, an agency of the Department of Health, and the Chief Medical Officer in the Department of Health so that the responsible officer in Public Health England should be connected to the Chief Medical Officer in the Department of Health rather than the NHS CB.

Q4.1 Should the responsible officer for public health doctors employed by local authorities be:

a) local authority;
b) Public Health England; or
c) other (please explain)?

Q4.2 If the connection in Q4.1 is to the employing local authority do you think the responsible officer for those responsible officers should be:

a) Public Health England; or
b) other (please specify)?

Q4.3 Do you think the connection for Public Health England's responsible officer should be to:

a) the Department of Health;
b) The NHS CB; or
c) other (please specify)?

Other bodies

4.5 We are currently discussing the possibility of designation in the Regulations with a number of organisations, some of which employ doctors who perform clinical work for other organisations and some who employ doctors who advise other doctors. There are also a number of doctors who operate outside of normal managed organisations but who treat patients. We are discussing designation with a number of organisations who represent such groups of doctors, to ensure that they have the necessary clinical governance systems and capability to undertake this role for what may be a small number of doctors.

4.6 The vast majority of organisations currently designated in the Regulations lie within a regulatory framework either run by the Care Quality Commission or the Office of Government Commerce Buying Solutions. These regimes require the organisations to demonstrate their clinical governance procedures on an on-going basis. We think that there should be similar reassurance for the quality of the systems in any new organisation designated in the Regulations. This recognition of the quality of clinical governance does not need to be an exhaustive and expensive formal procedure, but it does need to ensure a commitment on the part of the organisation's board to maintain the key clinical governance systems needed to support the responsible officer including systems for appraisal, oversight of complaints and concerns, information

handling, access to training. Initially, this assessment of new organisations will be undertaken by the Revalidation Support Team, however this organisation's role is purely to support the introduction of revalidation. It is unlikely to have an ongoing function once revalidation has been successfully established.

CHAPTER FIVE

Responding to the consultation

The consultation runs from the 18 April 2012 and will close on 25 July 2012.

You can respond to this consultation on the web at www/dh.gov.uk/liveconsultations or in writing.

Responding on the web

If you wish to respond online the questionnaire can also be found at:

www.dh.gov.uk/liveconsultations

The online questionnaire will be available from 18 April 2012 :

Responding by e-mail or in writing

If you wish to respond by e-mail please use the questionnaire at the back of this document. Once it is completed please e-mail to:

responsibleofficer@dh.gsi.gov.uk

If you wish to respond in writing, it would be helpful if you could do so by completing the consultation response form and sending it to the address below. If you do not want to use the consultation response form or are unable to do so, then please write with your answers and comments to the address below.

Consultation on responsible officers in the new health architecture
Department of Health
Room 423 Wellington House
133-155 Waterloo Road
London SE1 8UG

Criteria for consultation

This consultation follows the 'Government Code of Practice' in, particular, we aim to:

- formally consult at a stage where there is scope to influence the policy outcome;
- consult for at least 12 weeks with consideration given to longer timescales where feasible and sensible;
- be clear about the consultation's process in the consultation documents, what is being proposed, the scope to influence and the expected costs and benefits of the proposals;
- ensure the consultation exercise is designed to be accessible to, and clearly targeted at, those people it is intended to reach;
- keep the burden of consultation to a minimum to ensure consultations are effective and to obtain consultees' 'buy-in' to the process;

- analyse responses carefully and give clear feedback to participants following the consultation;
- ensure officials running consultations are guided in how to run an effective consultation exercise and share what they learn from the experience.

The full text of the code of practice is on the Better Regulation website at:

Link to consultation Code of Practice

Comments on the consultation process itself

If you have concerns or comments which you would like to make relating specifically to the consultation process itself please

contact Consultations Coordinator
Department of Health
3E48, Quarry House
Leeds
LS2 7UE

e-mail consultations.co-ordinator@dh.gsi.gov.uk

Please do not send consultation responses to this address.

Confidentiality of information

We manage the information you provide in response to this consultation in accordance with the Department of Health's **Information Charter.**

Information we receive, including personal information, may be published or disclosed in accordance with the access to information regimes (primarily the Freedom of Information Act 2000 (FOIA), the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004).

If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory Code of Practice with which public authorities must comply and which deals, amongst other things, with obligations of confidence. In view of this, it would be helpful if you could explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure of the information we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Department.

The Department will process your personal data in accordance with the DPA and, in most circumstances, this will mean that your personal data will not be disclosed to third parties.

Summary of the consultation

A summary of the response to this consultation will be made available before or alongside any further action, such as laying legislation before Parliament, and will be placed on the Consultations website at http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/index.htm

Annex 1

Consultation Questionnaire

Responsible officers in the new architecture

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 NO (if No please explain)

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

YES NO (if No please explain)

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?

YES NO (if No please explain)

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 NO (if No please explain)

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 NO (if No please explain)

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 NO (if No please explain)

Responsible officers and language checking

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 NO (if No please explain)

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 NO (if No please explain)

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?

YES NO (if No please explain)

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

YES NO (if No please explain)

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 NO (if No please explain)

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?

YES NO (if No please explain)

Q3.6 a) Do you have evidence which you can share to help inform work on the potential benefits of a strengthened language system or any suggestions for data sources?

YES NO (if No please explain)

b) Do you have any evidence or data sources on the impact on equality through the use of language controls?

YES NO (if No please explain)

Designating further bodies in the Responsible Officers Regulations

Q4.1 Should the the responsible officer for public health doctors employed by local authorities be:

a) local authority;
b) Public Health England; or
c) other (please explain)?

Q4.2 If the connection in Q4.1 is to the employing local authority do you think the responsible officer for those responsible officers should be to:

a) Public Health England; or
b) other (please specify)?

Q4.3 Do you think the connection for Public Health England's responsible officer should be to:

a) the Department of Health;
b) the NHS CB; or
c) other (please specify)?

Please let us know if you have any additional comments