Faculty of Public Health

Of the Royal Colleges of Physicians of the United Kingdom

Working to improve the public's health

Faculty of Public Health comments on
Responsible Officer Regulations and Guidance

The UK Faculty of Public Health (FPH) is the leading professional body for public health specialists in the UK. It aims to advance the health of the population through three key areas of work: health promotion, health protection and healthcare improvement. In addition to maintaining professional and educational standards for specialists in public health, FPH advocates on key public health issues and provides practical information and guidance for public health professionals.

The FPH welcomes the opportunity to comment on to the proposal paper from the Department of Health (England) *Responsible Officer Regulations and Guidance* – a role which is at the heart of proposed systems for revalidation.

This response is divided into two sections. The first is a response as the professional body for public health specialists in the UK. This response focuses on the implications of the proposals on the senior public health workforce in the UK and the specialist expertise of public health and how it fits into the proposed system of Responsible Officers. The second part of the response is an organisational response as a 'designated body' in the proposed regulations. This will lay out the issues facing organisations which will be appointing a Responsible Officer.

<u>Response from the FPH as a professional body</u>

The consultation version of the responsible officer documentation is an improvement on previous drafts. The language and tone of the document is more supportive and inclusive. There is greater emphasis on the quality improvement elements of revalidation. There also seems to be greater recognition of the need for flexibility in the implementation of revalidation.

Overall, the emphasis seems to have shifted in the work of the Revalidation Support Team. No recognition of the public reassurance aspect of revalidation was in evidence in these consultation documents. The FPH understands that patient and lay representative organisations were not included in the main audience list or stakeholders associated with the consultation.

The legislation and guidance are being rushed to conform to a parliamentary legislative review timetable rather than taking the time to ensure that they are fully developed. This is a particular concern as there is now a lack of connection to other work being developed around revalidation including the GMC and specialties.

The FPH is cautiously pleased that the regulations and guidance explicitly acknowledge the difficulties of medical practitioners working outside NHS managed environments, or in non-mainstream healthcare settings. However, we remain concerned at the clinical focus of the documents, as not all medical practitioners (including a majority in public health) work in clinical settings. The draft legislation and guidance betrays a lack of understanding about the breadth of clinical settings in which doctors are employed. Doctors working in public health (and in other branches of practice) have a different

4 St Andrews Place • London • NW1 4LB • Tel: 020 7935 0243 • Fax: 020 7224 6973
Email: *enquiries@fph.org.uk* • Website: *www.fph.org.uk* • Registered Charity No: 263894

clinical paradigm to those doctors working in settings predominated by the delivery of direct patient care. The professional focus in public health is on the health and well-being of patients, communities and the public.

Additionally, there is huge potential for confusion across different clinical settings, seniority levels and the regulations for locum consultants across the four countries. Some of the previous documents suggest that all doctors registered with the GMC will need to relate to a responsible officer; however responsible officers will be undertaking differing roles in England, Wales and Scotland. Northern Ireland has not openly consulted on any proposed responsible officer structure. It seems unreasonable to demand that all doctors relate to a responsible officer, while Northern Ireland has not clarified their position and locums in England are 'still in discussion'[1]

The role of responsible officers is much wider than the emphasis in paragraph 1.4 on the three core components of quality described in *High Quality care for all*[2]. The introduction of an effective relationship between local healthcare organisations (and individuals) and the GMC will help guarantee the robust implementation of revalidation. In this way, professional standards can be enforced and developed further across the countries in a uniform manner. It will also help to underpin the importance of robust and equitable clinical governance systems at a local level.

The FPH remains concerned that the GMC and other leading organisations involved in the development of revalidation have seriously underestimated the number of doctors who will wish to take up a licence but do not fall neatly into traditional healthcare roles. The continuing emphasis on patient contact and prescribing privileges has obscured the nearly four hundred actions which are restricted in statute to licensed (currently registered) medical practitioners[3]. This has important implications for public health particularly, as the majority of public health specialists undertake roles which require licensing (currently appropriate registration) but do not involved direct patient care or prescribing medication on a regular basis. This group includes academics (especially those with an honorary NHS contract), medical managers, those working in national bodies and standard setters, as well as those involved in medical training in the deaneries. All of these groups have a greater or lesser requirement for registration and licensing, but may find it difficult to revalidate under the current proposals. For many of these individuals, maintaining appropriate specialist registration is often a condition of employment.

The FPH is concerned that the wider responsibilities of responsible officers (in England, Wales and Northern Ireland) may impact on existing legislation. If responsible officers are given additional functions, for example relating to systems for the recruitment of doctors, it may undermine or clash with the existing regulations governing the appointment of consultants[4].

Finally, the FPH is concerned by the apparent ongoing focus shifting towards performance management of individuals and away from professional competency and best practice.

---

[1] *The framework for responsible officers and their duties relating to the medical profession*, Department of Health, August 2009
[2] *High Quality care for all*, Department of Health, September 2008
[3] List published by GMC at http://www.gmc-uk.org/doctors/information_for_doctors/privileges.asp
[4] *The National Health Service (Appointment of Consultants) Regulations: Good practice guidance*, Department of Health, January 2005

4 St Andrews Place • London • NW1 4LB • Tel: 020 7935 0243 • Fax: 020 7224 6973
Email: *enquiries@fph.org.uk* • Website: *www.fph.org.uk* • Registered Charity No: 263894

Question 1
Possibly - The FPH believes that the list of designated organisations as described in Regulation 3 encompasses the majority of organisation which should appoint a responsible officer. As a side note, the names of the faculties should be capitalised (the Faculty of Occupational Medicine, the Faculty of Public Health and the Faculty of Pharmaceutical Medicine).

Question 2
The list of designated organisations may not be sufficient to accommodate all overseas doctors who wish to retain their licence. Under the current list, a doctor outside the UK who was not a member of the Independent Doctors Forum (IDF) or practising in occupational medicine, public health or pharmaceutical medicine would not be able to link clearly to a designated organisation.

The FPH suggests that Regulation 4 be amended to state that '*every designated body must nominate or appoint a responsible officer under section 45A of the act*' to include the clause that it is only as long as they are employing or contracting a doctor. This would reflect the very rare (but possible) situation that the IDF or the faculties might not have anyone wishing to be linked to their responsible officer. This limits the legal necessity of appointing a responsible officer who would not have any doctors linked to him/her. Alternatively, the three faculties could be moved from Regulation 3 (2) to Regulation 3 (3), which would have the same effect of only requiring the nomination of a responsible officer in circumstances where it was needed.

Question 3
The ability to nominate or appoint an additional responsible officer will be vital if serious conflicts of interest are to be avoided. Conflicts of interest will not be limited to the doctor and the responsible officer or the responsible officer and the organisation, but may also include conflicts between the appraiser and the responsible officer or the responsible officer and the standards setting body (often a medical royal college). The FPH must also strongly disagree that it would be inappropriate to address potential conflicts between the professional responsibilities and the demands of the organisation. The process of revalidation must be seen as a robust check on professional competencies and not be used to help organisations justify politically expedient actions. This must be made explicit in the regulations if the process is going to be embraced by the medical community. This would protect both the doctor and the employing organisation by explicitly stating the purpose of the process.

Question 4
It is extremely important that the conditions for nomination or appointment of responsible officers are clear and fair, while simultaneously reinforcing a robust system for revalidation. Responsible officers must have a licence to practise and the FPH agrees that this should be specified in Regulation 6. However, there is some ambiguity around Regulation 6(b)(ii). This could be easily resolved through the guidance, but it needs to be clear that '*practice as a medical practitioner or have done so within the previous 5 years*' should not restricted the nomination or appointment of a responsible officer to one who has undertaken clinical practice involving direct patient care. Not all doctors regularly undertake clinical practice and it would be an unintended and impractical consequence to exclude doctors who are in senior medical management posts, for example Medical Directors or the Chief Medical Officer.

Question 5

4 St Andrews Place • London • NW1 4LB • Tel: 020 7935 0243 • Fax: 020 7224 6973
Email: *enquiries@fph.org.uk* • Website: *www.fph.org.uk* • Registered Charity No: 263894

At this time, without piloting of the proposed process, the FPH is unable to specify any additional criteria where the responsible officer acts for another body.

Regulation 8 causes us some concern as it seems to be suggesting an unequal process across Scotland, Wales and England. Scotland and Wales are both provided with some level of independent consultation and/or scrutiny before the Secretary of State may directly nominate a responsible officer in an organisation. However, England is not afforded this level of protection.
This would give the Secretary of State the power of appointment to senior posts in England. As unlikely to be used as this power may be, it is still important for the regulations to describe a fair and equitable process.

Question 6
The term 'fitness to practise' is used repeatedly in this regulation. The FPH believes that this terminology should be avoided in this legislation; it is separate from the responsible officer function, as this role sits firmly with the GMC. There is a subtle, but very important, difference between the 'positive statement of assurance to the GMC' and a declaration of fitness to practise. There are profound legal and liability implications for responsible officers if this burden is to be placed upon them. This summary judgement is in some ways contrary to the stated aim of revalidation as a supportive and formative process to improve the quality of care and of life in the UK. The wording needs to be consistent throughout, to avoid confusion and consolidate the values that underpin revalidation. Terminology aside, the three areas of responsibility listed in paragraph 2.24 of the consultation document seem both appropriate and adequate to ensure a robust system of revalidation when it is introduced. However, the wording in the draft legislation in Regulation 9 goes far beyond these areas. The FPH believes that many of the actions and duties specified in Regulation 9 will be nearly impossible for the responsible officer to undertake with regards to any doctor who is linked to the designated body, but not employed by that body. It will be particularly difficult to impose that the designated body must carry out regular appraisals on medical practitioners who are not employed by said body (9.(2)(a)) or that responsible officer should take steps to ensure that any conditions or undertakings agreed with the GMC are complied with (9.(2)(d)). There is also an issue of how much information will be in the public domain and/or subject to information requests, for example under the Freedom of Information Act. FPH believes that many doctors will not be comfortable with the responsible officers holding extensive files, instead of simply retaining summary information once the recommendation to the GMC has been made.

The consultation documents outline a limited role of the Colleges/Faculties to only those cases where concerns are raised about fitness to practise. In contrast, the specialties want to provide support to appraisers, responsible officers and doctors throughout the process from collecting information, through appraisal and when considering the recommendation.

On the matter of remediation, limited information is given on the provision of remediation within revalidation. It is important that a distance is maintained between clinical governance and targets and the decisions on, and provision of, remediation support.

Question 7
The FPH does not believe there are any further functions that should be specified at this time.

Question 8

No.

Question 9
No.

Question 10
There are several issues of concern in the proposals on linking doctors with a responsible officer. Regulation 10(1) seems relatively clear however the interpretation in the consultation document raises more questions than it answers. Considering the increasing prevalence of portfolio careers, doctors who are on a Performers List may be extremely uncomfortable linking to the responsible officer in the Primary Care Organisation (PCO) if they only spend a minority of their time working in the PCO's area. Additionally, the Faculty of Occupational Medicine, the Faculty of Public Health and the Faculty of Pharmaceutical Medicine **must** be allowed to act as the designated organisation for all practitioners in those specialties who do not otherwise have a prescribed connection with a responsible officer, regardless of their membership status with the organisation. The FPH also remains concerned that locums in primary care in England seem to have been omitted altogether. The consultation document repeatedly states that further work is being undertaken with regards to locums in secondary care in England, but does not make mention of locums in primary care.

Question 11
While the decision to use the doctor's registered address as a final measure to identify an appropriate designated organisation seems appropriate, there are several practicalities of this system which need further work, as an organisation will not know who might be eligible to link with them. There must not be a duplication of the GMC's database in each authority. Additionally, it should be specified in Regulation 10 that where the registered address is used to determine the designated organisation, that organisation should be the PCO with geographical responsibility for that area (not 'the shortest distance from the practitioner's registered address').

Question 12
Regulation 11 does not explain in enough detail who will act as the responsible officer for nominated responsible officers. There is only a single tier of the system explained. Without a clear understanding of who will act as responsible officer for the extremely senior doctors in each country, the service may become dissatisfied that revalidation is a fair and robust system. Also, to promote equality across the four countries, FPH believes that similar systems should be used.

There also needs to be clarification on how the RO will be revalidated and the standards against which they will be measured. As this position may be full-time, responsible officers may not be able to recertify as they will not be undertaking specialist work. There is insufficient information on revalidation of the most senior medical professionals and anecdotal evidence shows growing distrust of a system where the most senior professionals in the field seem to be exempt.

Question 13
No. The FPH has serious concerns about giving the nominated responsible officer the ability or the obligation to consider the need for suspension or restrictions on practice. This is firmly in the domain of the GMC and in the future, the Office of the Health Professions Adjudicator (OHPA). Referral to these bodies should be sufficient action. It is also unclear what would constitute 'appropriately qualified investigators' in these circumstances. The FPH also believes that Regulation 16(2)(a) should be amended to read 'ensure that medical practitioners have qualification *and experience* appropriate to

4 St Andrews Place • London • NW1 4LB • Tel: 020 7935 0243 • Fax: 020 7224 6973
Email: *enquiries@fph.org.uk* • Website: *www.fph.org.uk* • Registered Charity No: 263894

the work to be performed'. Without this amendment, this regulation risks contradicting the Appointment of Consultant Regulations 1996.

Clarification is required of the relationship between the responsible officer and the GMC. There is also insufficient clarity at local level, on the relationship between the responsible officer and the Trust (or other designated body) Board.

There is no recognition of the potential conflict of interest for the responsible officer who will be responsible for both the legal and contractual elements of clinical and corporate governance and HR as well as promoting quality improvement through appraisal and revalidation FPH would like to see more definition around how the responsible officer will interact with the Board and what responsibilities and support they will have if issues arise that highlight problems with or contradict existing management practices and targets.

Question 14
The FPH does not believe that any additional functions should be specified at this time.

Question 15
Regulations 12-14 and 17-19 seem to have achieved the policy objectives set out in the previous consultation paper on the role of the responsible officer. However, without thorough piloting, it is impossible to say whether these regulations will be sufficient in practice.

Further information is needed on resources required for both the responsible officer role and for implementing the changes required in clinical governance processes. This may be highlighted through piloting, but the FPH expects these financial requirements to be substantial.

Question 16
The FPH does not feel that it is appropriate to comment on the guidance notes at this time. The guidance will need to be amended in line with any changes made to the draft legislation. Without seeing the final version of the draft legislation, no meaningful comments can be made.

However, the FPH notes that if the legislation is encouraged to be too detailed there will be limited scope for amendments to the process in the future. This legislation and the corresponding guidance need flexibility built in to allow for any changes following the implementation, embedding and evolution of revalidation processes.

Response from the FPH as a professional body

Perhaps the most important question is which regulations will be applicable to UK-wide bodies. It is unclear whether UK-wide bodies acting as designated bodies and therefore in a position to nominate or appoint a responsible officer will be subject to Regulation 16 and the extended responsibilities it entails.

As previously stated, the Faculty of Occupational Medicine, the Faculty of Public Health and the Faculty of Pharmaceutical Medicine **must** be allowed to act as the designated organisation for all practitioners in those specialties who do not otherwise have a prescribed connection with a responsible officer, regardless of their membership status with the organisation.

The FPH suggests that Regulation 4 be amended to state that '*every designated body must nominate or appoint a responsible officer under section 45A of the act*' to include the clause that it is only as long as they are employing or contracting a doctor. This would reflect the very rare (but possible) situation that the IDF or the faculties might not have anyone wishing to be linked to their responsible officer. This limits the legal necessity of appointing a responsible officer who would not have any doctors linked to him/her. Alternatively, the three faculties could be moved from Regulation 3 (2) to Regulation 3 (3), which would have the same effect of only requiring the nomination of a responsible officer in circumstances where it was needed.

The FPH believes that many of the actions and duties specified in Regulation 9 will be nearly impossible for the nominated responsible officer to undertake with regards to any doctor who is linked to the FPH, but not employed by the FPH. It will be particularly difficult to impose that the FPH must carry out regular appraisals on medical practitioners who are not employed by said body (9.(2)(a)) or that responsible officer should take steps to ensure that any conditions or undertakings agreed with the GMC are complied with (9.(2)(d)).