

## **Framework for managing performance concerns:**

### **NHS (Performers Lists) (England) Regulations 2013**

Response to consultation document dated 17th of February 2014

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5. This response is made on behalf of the Optical Confederation
6. The Optical Confederation represents the 12,000 optometrists, 6,000 dispensing opticians, 7,000 optical businesses and 45,000 ancillary staff in the UK, who provide high quality and accessible eye care services to the whole population. The Confederation is a coalition of five optical representative bodies: the Association of British Dispensing Opticians (ABDO), the Association of Contact Lens Manufacturers (ACLM), the Association of Optometrists (AOP), the Federation of Manufacturing Opticians (FMO) and the Federation of (Ophthalmic and Dispensing) Opticians (FODO). As a Confederation we work with others to improve eye health for the public good.

The Local Optical Committee Support Unit (LOCSU) provides quality, practical support to Local Optical Committees in England, to help them to develop and implement local objectives, in respect of primary eye care services. LOCSU has developed a number of eye care pathways including cataract and low vision to provide expert advice, associated business cases, clinical training packages and implementation tools to assist with the commissioning of these pathways. For more information, please visit: [www.locsu.co.uk](http://www.locsu.co.uk).

The NHS England policy on management of performers lists and concerns of performers impacts directly on our members. In addition the abovementioned representative bodies work closely with our members in dealing with issues that may arise out of this policy.

We have some initial observations in respect of the introduction to this consultation document. We would observe that the introduction does not correctly set out the overarching principle of the NHS (Performers Lists) (England) Regulations 2013. The responsibility of NHS England under the regulations is to apply certain criteria contained within the regulations to those performers working under an NHS contract in order to protect the public

in the delivery of healthcare services. The wording of the current introduction implies a regulatory function rather than a commissioner of services function.

Throughout the document reference is made to Area Teams; this has the potential to lead to confusion. In our view the majority of references should be to 'NHS England' to reflect the legal position and reinforce the message about consistency with a clear statement at the outset that any reference to 'NHS England' includes 'Area Teams'.

## **Part 1 - Admittance to the Performers List**

(The above wording we believe is grammatically incorrect; it should read 'Admission' to the performers list. Admission means a figurative right to enter or allowing to enter, whereas admittance refers to the act of physically entering).

### **Knowledge of the English language**

It is agreed that in order to provide healthcare services proficiency in English is necessary for any performer. However, Part 1 of the consultation documents suggests that there is evidence to demonstrate a lack of consistency and standard in assessing language skills. This evidence is not provided. Therefore, we consider the current proposals are neither evidence-based, nor clear and are unnecessarily onerous. The General Optical Council (GOC) already assesses the English language skills of any applicant for registration who is not a UK graduate; this means that for any GOC registrant English has been assessed as competent for both private and NHS patients. In order to gain admission to the performers list a performer must be on the GOC register and it seems to us a duplication of function to re-assess the language skills of any optometric applicant and is an unnecessary burden both in time and cost for both NHS England and for the applicant.

In addition we have the following observations:

### **Paragraph 12**

- If NHS England is going to rely on language tests we consider that they should publish which tests are currently being relied upon by them.
- The requirement to provide both a certificate of graduation or post graduate training from a recognised educational establishment taught and examined in English **and** evidence of three months full-time professional employment from the past two years in a country where English is the first language...which is documented in references is unnecessary. These two requirements should be alternatives. In addition there is a lack of clarity as to in which countries NHS England considers English to be the first language.

### **Paragraph 13**

If an oral assessment is to be undertaken it must be carried out by a relevant/appropriate clinician experienced in the particular discipline of the candidate to be reviewed. We also consider clear information should be provided on what procedures are to be followed and training to be provided to ensure consistency of the process throughout NHS England for each discipline. In addition the tests must be conducted in a timely manner and must not delay inclusion on the list; thus any

assessor must be readily available and at times that are convenient to the applicant. For optometrist performers an NHS list number is prerequisite to securing a job offer.

#### **Response to question 7:**

No. We consider no further information is required for optometrists for the reasons set out above. In addition because of the lack of information provided by the process to be adopted by NHS England we cannot comment substantively on suggestions put forward.

#### **Response to question 8:**

The options given to delete as appropriate conflict with the proposals set out at paragraph 12. Consequently it is unclear what the proposals from NHS England are and we are unable to provide a reply.

#### **Response to question 9:**

No. For reasons set out above for optometrists we consider that an oral language assessment has already been conducted by the GOC and therefore a second duplicatory English language test is not required. For optometrists we consider any administrative cost would be onerous.

#### **Response to question 10:**

Please see our comments above.

### **Occupational health clearance to join the performers lists**

#### **Response to question 11**

No.

#### **Response to question 12**

We do not consider NHS England has provided any evidence to support their position that optometrists should undergo an occupational health assessment in order to join the performers list and we believe this to be disproportionate and unnecessary in the context of the delivery of community eye care. The GOC, recognising that we are a low risk profession, currently requires a declaration on health by registrants on a yearly basis only. In addition at the start of an optometrist's career they will not be working in isolation and in the unlikely event of any concerns these will be picked up by an employer and or colleagues. We would submit that an occupational health assessment on joining the list would provide no effective information for NHS England about a practitioner commencing a career in optometry. We strongly disagree with the list of recommendations contained at Annex 2. In the absence of any evidential risk in respect of occupational health assessment to either the public or the performer we consider that any requirement for optometrists beyond completing the annual GOC declaration (which has worked well for years) would be unnecessary and disproportionate.

## References

### Paragraph 19

The Performers List Regulations are clear that where 2 clinical references cannot be provided a full explanation as to why this is the case and alternative referees can be provided by the applicant. This is set out in paragraph 19. Given that there is discretion contained within the Regulations and 2 clinical references are not an absolute requirement for admission on to the performers list we are at a loss to understand why NHS England wishes to address this issue.

#### **Response to question 13:**

No.

#### **Response to question 14:**

We assume that NHS England when referring to a satisfactory reference in question 13 mean a satisfactory clinical reference as paragraph 20 makes reference to a second clinical reference for an applicant being provided by a new employer. We do not agree with the policy of conditional inclusion on the performers list where only one clinical reference has been provided. We do not agree for two reasons. Firstly, the regulations are clear that there is discretion on this point and it seems that to require two clinical references goes beyond the regulatory requirements. Secondly, it is not clear from the information provided whether conditional inclusion in the circumstances would afford the applicant protections in terms of procedure and appeal normally given to individuals conditionally included on the performers list. We would suggest that NHS England is seeking consistency where there is a clear intention in the legislation to provide for discretion.

### **Inclusion on the list**

#### **Child protection training**

#### **Response to question 15:**

No.

#### **Response to question 16:**

As the consultation document sets out there is no requirement within the regulations for performers to undergo child protection training. However the Optical Confederation accepts that those individuals who are in contact with children should have a basic level of training and has developed optical practice specific guidance and web-based training for this purpose. We are puzzled by NHS England's approach to limiting the requirement to child protection training however. Our guidance and training covers both and we believe that vulnerable adults should also be included.

As described above our sector specific guidance developed by the Optical Confederation and the Department of Health includes specific online training through a scheme provided by the Directorate of Continuing Education and Training (DOCET). This guidance and training has been approved and is referred to in the College of Optometrists guidelines for the profession.

The training is optometry specific and deals both with child protection and vulnerable adults. We consider that this training fully meets the requirements of NHS England and, indeed, was specifically designed to do so.

Given that there is no requirement to undertake this training under the regulations, it should not be a prerequisite to joining the performers list. Any additional obligations on optometrists over and above the current training undertaken would require separate negotiation with the profession both in terms of the training to be provided and compensation to be given to practitioners taking time out of practice to complete such training.

## **Application of the induction and refresher program (returners scheme) for general medical practitioners**

### **Response to questions 17- 25**

Not applicable to optometrists.

## **Part 2 - responding to concerns about primary care performers**

### **Response to question 26**

No. It is concerning that the advice provided by stakeholder groups, following a meeting with NHS England on the initial proposals for the PAG and PLDP, appears to have been ignored despite a consensus being reached at the time. We refer in particular to the proposed removal of representatives of Local Representative Committees (LRCs) from the PAG. We believe it is essential that a Local Optical Committee representative is a quorate member of the PAG when a concern about an ophthalmic performer is to be considered. Similarly a Local Dental Committee representative should be a quorate member if a concern about a dental performer is to be considered, and a Local Medical Committee representative should be a quorate member if a concern about a GP is to be considered. This will ensure that there is someone within the group with first-hand knowledge of clinical practice, contractual requirements and the discipline specific context in which matters are to be considered.

### **Response to question 27**

Yes.

### **Response question 28**

We note that the PAG will be an investigatory body and in the consultation states it will be 'a repository of expertise provided by individuals with in-depth knowledge of performance and professional standards able to provide advice on handling individual cases'. It is not clear from the information provided what training will be given to the PAG and what skill sets will be sought for anybody who sits on the PAG. We believe this is essential to ensure consistent and fair case management. In the event of training being given to the PAG, we would expect further consultation about the content and format of the training programme and would welcome confirmation that this will be done. Our current experience is that there is a wide variation of knowledge both in terms of professional standards and procedures that should be applied when reviewing the conduct of a peer group.

We hold a very strong view that a discipline specific practitioner should be a member of the PAG. The practitioner should also practise in the same sphere of practice as the individual under investigation. However, we disagree that for optometrists the inclusion of a senior manager from the nursing directorate in respect of patient safety and patient experience is appropriate as we do not consider nursing directorate would have the commensurate knowledge in respect of optometry. We consider that the PAG should be made up of the following members:

1. Discipline specific practitioner with appropriate experience from the LRCs
2. Senior NHS manager with a performance role
3. A lay person, acting as chair who brings a lay perspective (and specifically does not act as patient or public advocate and retains voting rights – please see our comments below)

Alternatively:

1. 2 discipline specific practitioners (one of whom is an LRC nominated representative)
2. A senior NHS manager with a performance role
3. A lay chair with no voting rights

We can see no merit for a lay member to act as a patient or public advocate. There appears to be no rights for the performer to have equal oral representation at a PAG. We do not consider that it is appropriate to have someone acting in an advocacy capacity at a first tier meeting and where the role of the PAG is defined as investigatory.

We also disagree that the medical director and senior NHS manager would automatically make up 2 member or a quorate membership of the PAG; in essence this results in two senior managers employed by NHS England; there is real risk of bias because of the employed relationship between these two individuals. We consider that only one senior NHS member is required.

We also note that at paragraph 31 it would not be NHS England's intention to specify in all cases who the third quorate member of the PAG should be as it may differ depending on the nature of the case being discussed. If NHS England adopt a procedure which allows for the third quorate member to be decided depending on the case we consider this must be set out clearly in writing to the performer and the reasons for NHS England's choice of PAG member.

In addition we also consider it essential there should be a mechanism by which a performer may object to a PAG member on the basis of conflict or perceived bias. It therefore follows that a performer must be advised in writing prior to a PAG meeting which individuals are considering the case and be given a timely opportunity in which to object to any panel member.

Until NHS England has clarified the membership of the PAG and confirmed a right to object to the panel members we cannot properly comment as to whether the proposed membership of the PAG provides a fair and transparent process for the performer and so cannot support the proposal.

We would specifically welcome the opportunity to offer our expertise and experience and to be involved in co-producing amendments to these proposals.

**Response to question 29:**

No.

**Response to question 30:**

Yes.

**Response to question 31:**

The LRC member should attend as a quorate member nominated as the discipline specific practitioner.

**Response to question 32**

Yes.

**Response to question 33**

We do not agree with either alternative proposed; the PLDP chair should have no voting rights. Furthermore the document seems to suggest membership of the PLDP will be quorate with 4 individuals. If the chair votes on every occasion he/she will also have to have a casting vote otherwise there will be an inability of the PLDP to form a majority vote if they are only quorate. If they are greater than quorate the panel will have to ensure there are enough members for a majority vote to be made. To have a chair who may or may not vote creates uncertainty and a lack of transparency

**Response to question 34:**

We agree that the quorate membership of the PLDP should include a discipline specific practitioner and that individual should be an LRC representative. However we cannot agree that the proposed membership of the PLDP provides a fair and transparent process for the performer where a lay member will act as the patient public advocate. If it is proposed that the lay member may also take on the role of a chair without voting rights it cannot be fair and transparent if that individual is also acting as the patient advocate. In addition if the lay chair does not vote with the PLDP we have additional concerns about the inclusion of two senior management members of staff employed by NHS England in relation to bias. We refer you to our response to question 28 on the proposals for PAG membership. There is an immediate perception of bias in respect of the procedure which does not equate with natural justice. NHS England will be aware that a decision made by the PLDP about a performer can have significant and potentially devastating consequences for that individual. It is therefore imperative that the procedures adopted by NHS England are fair and transparent.

We do not agree that where conditions are imposed by a regulator that these cases should be automatically referred to the PLDP. This appears to us to be a duplication of a regulator function which results in time and cost for all. If these cases are to be considered at all this should be by the PAG in the first instance. Given that there is a requirement under the regulations to notify NHS England of decisions made by a regulator we are at a loss to understand why as a Commissioner of services NHS England appears to wish to re-investigate every case.

## **National disqualification**

### **Response to question 35:**

Yes, but fraud must be proven in a court of law and to the criminal standard of proof. It would not be sufficient for such a bar to be based on the decision made by a panel on the civil standard of proof.

### **Response to question 36**

Option b - 24 months.

### **Response to question 37**

No further observations save for those set out above

### **Response to question 38**

Paragraph 3 makes the observation that all performers groups are governed by the respective professional regulator and the Care Quality Commission (CQC). This is incorrect as optometrists are outside the remit of the CQC.

Paragraph 4 states that the framework reflects the Regulations and NHS England's responsibility for the movement of performers between Area Teams and the maintenance of performers lists. We do not think this is quite accurate. We accept that the framework deals with the movement of performers between Area Teams in relation to management of concerns but the movement of performers between Area Teams where there is no issue is simply a case of transferring a name; this framework does not address that point.

In addition paragraph 4 states the framework encompasses NHS England's powers to manage suspension and removal from performers lists. If this framework accurately reflects the regulations it should also deal with contingent removal. We believe that the policy statement should make reference to contingent removal.

Paragraph 10 in relation to governing principles. The policy document states that all decisions made by NHS England relating to fitness for purpose and/or to practise will be made in accordance with the relevant statutory regulations. At no point in the document is fitness for purpose defined nor is it defined in the regulations. We consider it is imperative that both contractors who deploy the services of performers and make decisions in relation to the same and also performers themselves are entitled to know the standard to be applied. We believe fitness for purpose should be defined and how this varies from fitness to practise.

In paragraph 10 the policy states it is the duty of NHS England as an NHS body to put in place and maintain arrangements for the purpose of monitoring and improving the quality of healthcare provider by and on behalf of itself. We have no objection to this as a broad principle and it is right that services provided to the public continue to be reviewed for the purposes of improvement. However it is not clear whether this duty is a general approach to improvement or whether it is in relation to a specific duty to improve a poorly performing individual. If it is a general overarching improvement to the services we do not think that managing poor performance is an appropriate mechanism to discharge this duty; this is best effected by consultation and training within the sector.

Paragraph 13 sets out the key actions that are to be taken for the responsible officer/medical director in addressing concerns. Point 2 of the key action plan advises that they should seek advice from external advisers such as the National Clinical Assessment Service (NCAS); it should be noted that this service does not apply to optometrists.

### **Response to question 39**

Annex 2: Performance Advisory Group (PAG) terms of reference

We refer you to our response to questions 26 to 28 in relation to membership and quoracy of the PAG panel.

Specifically in response to the Annex:

Purpose of the PAG is

‘a) to provide advice, support and take action where performance concerns are raised’

We disagree that the PAG remit is to take action as it is defined as an investigatory body. If action is required to be taken, the matter should be referred to the PLDP or the performer invited to consider a voluntary undertaking.

We also consider (c) is not required and should be deleted. It does not add anything to the purpose of the PAG.

Objectives of the PAG - it is imperative that the standards of the PAG's objectives are consistent; we refer you specifically to (a) and (b) of the objectives below.

(a) - we disagree that concern ‘should be managed in the interest of patient safety and high (our emphasis) standards of patient care’; this should read ‘appropriate and relevant standards of patient care’.

(b) Practitioners whose conduct has given cause for concern should be supported should read as ‘to return to an appropriate standard’ not ‘a satisfactory standard’ as suggested in the draft.

We consider that objective (d) should be deleted as there is no remit for the PAG to undertake this work under the regulations

Duties

We consider the following amendments should be made:

(a) The words ‘To receive all intelligence’ are not appropriate and should be replaced with “To consider relevant information received by the PAG”.

(b) the final words of that sentence which read ‘the level of support required and the resources required’ should be replaced with ‘if any’. It is our understanding the PAG is an investigatory body and not a decision-making panel.

(h) where advice is given to the PAG to refer to external agencies it should be clearly stated. NCAS is not applicable for optometry and it would be helpful for all the primary care disciplines to have the representative bodies listed so that PAG are clear with whom they are able to consult.

We are also concerned that there is a reference 'to refer to occupational health' but we are unclear as to what that means and in addition who would bear the cost. We also note that nowhere is there a duty on the PAG to provide the performer with a written explanation including reasons as to the decision reached. The performer should also be advised of their right to reject that advice.

### Reporting

We are unclear as to why only the chair of the PAG will carry out referrals to the PLDP; we wondered whether for ease of management it might be appropriate to simply make the PAG responsible for any such referral.

We note that serious concerns related to a performer should be reported to the responsible officer/ medical director; we are unclear as to how this applies to optometrists. In respect of serious concerns advice should be taken from a discipline specific practitioner as to what steps should be taken.

### Response to question 40

We refer you to our previous responses to questions 29 to 34.

In addition we have a further comment in respect of the PLDP's objectives.

There is nothing contained within the objectives that require the PLDP to consider information from the performer at any meeting convened. In the absence of considering such information it is difficult to see how a PLDP panel will be a decision making panel. A failure to consider evidence from both parties renders any decisions flawed in law and against natural justice. In addition if the PLDP is entitled to consider whether action may be required under the regulations such as contingent removal, suspension or removal the Annex should set out clear timeframes in line with the regulations. These details are omitted from the Annex and we consider that is a significant failing in this document. We have experience of Area Teams not understanding the legal basis on which they are proceeding.

### Response to question 41

Not applicable.

### Response to question 42

Not applicable.

### Response to question 43

Annex 7 elements attaching to optometric performers

Terminology: this Annex attaches to the framework specifically for performers we are unclear as to why there is a detailed description of a contractor and believe this should be deleted.

Returners/Induction: this is not relevant to optometrists and we believe that is all that is required to be stated in the Annex.

Accessing patient records - this is a contractual matter and forms no part of managing performer concerns. NHS England may wish to include this in their standard operating procedures in respect of contractors.

#### Newly qualified optometrists' to join the performers list and definition of intention to work

Optometrists in training are permitted to apply to the NHS Ophthalmic Performers List up to a maximum of 3 months prior to the expected date of successful completion of their pre-registration period and registration with the GOC.

However some practitioners choose to await completion of their exams before applying. This means that, although qualified and legally permitted to carry out private sight tests, they may not perform NHS sight tests until they have been included on the Performers List.

Applicants must not be refused entry onto the Performers List solely because they have not yet secured a job offer. In some cases a job offer will be dependent on the optometrist [and OMP] already having a Performers List number and therefore they will not be offered a post until they are on the Performers List.

#### National Clinical Assessment Service (NCAS)

It is agreed that NCAS do not provide advice or support optometrists; the word currently should be removed from the wording in the Annex

Occupational Health - the sector remain of the view that optometrists do not require screening and self declaration should be sufficient.

#### GOC notifications under Regulation 9 of the NHS Performers Lists Regulations 2013

There was a change in the regulations in 2013 which extended the obligations on a performer in terms of notification to NHS England of investigations by their regulatory body. The regulatory body for optometrists is the General Optical Council (GOC). Previously the regulations had required notification of a GOC investigation and the nature of the complaint only. The performer was also required to update the PCT on the progress of the investigation and the final outcome. The current Regulations require disclosure of all documents in relation to the GOC investigation (within 7 days) and some teams are seeking to investigate the matter alongside the GOC by referring the GOC papers to the PAG. This is a duplication of investigation. Furthermore optometric performers are not able to comply with this requirement within seven days as the GOC does not provide full disclosure at the outset. Consequently it is possible for a performer to be in a position where he/she does not have access to any documentation and the only information he/she has is that a complaint has been made.

It may be this approach is being driven by a misunderstanding of the GOC's remit and procedures. The GOC investigates all complaints irrespective of merit and has no screen out function. This contrasts sharply with the General Medical Council (GMC) who will refer less serious matters back to NHS England to deal with or where cases have no merit decline to investigate. The General Dental Council (GDC) also has a 'screen out' procedure. The GDC

can elect that a matter will not be investigated and in clinical cases the complaint is sent to NCAS for review as to whether the complaint should be investigated.

Consequently only matters that raise issues are investigated by other regulatory bodies compared with the GOC which investigates all complaints.

If the GOC is investigating a complaint it is disproportionate and unreasonable for Area Teams to continue to do so in tandem or at a later date if the GOC has closed the case. Additionally if a complaint raises a matter that is potentially serious, giving rise to immediate and urgent concerns about patient safety, an Interim Order Application by the GOC can be made to suspend or place restrictions on the registrant's practice whilst the matter is fully investigated.

The Professional Standards Authority for Health and Social Care considers the GOC to be an effective regulator and meeting all of the standards of good regulation. Consequently NHS England can be assured that any optometrist on their ophthalmic performer's list being investigated by the GOC is being properly regulated, is safe to practise and that they need not intervene or investigate themselves.

The previous Performers List Regulations 2004, as amended 2008, setting out the obligation of the performer to notify of an investigation and the nature of the complaint without full disclosure of all relevant documents was effective for all parties because it was reasonable, workable and proportionate for optometry.

In terms of notification of a regulatory investigation under Regulation 9 of the Regulations 2013, reverting to the previous regulations would be appropriate for optometry in light of the above both in respect of the difference in approach to complaints by the GOC and the requirement of a public body to act in a proportionate manner. We remain of the view that this current regulation 9 results in duplication of regulation by NHS England; this is both costly and time-consuming both for the performer and NHS England. The authors of this document have first-hand experience of Area Teams applying the regulations retrospectively to cases that have been closed by the GOC in order to investigate further. This is unreasonable, a misuse the regulation and disproportionate for all concerned.

#### **Response to question 44**

We are disappointed with the content and format of Annex 7; despite the sector consulting with NHS England very little of the matters raised have been included.

We also consider generally the document lacks structure and clarity on many key issues and we are concerned that the final framework is at risk of being similarly flawed. The sector is experiencing very poor management by some Area Teams which we believe is outside the scope of the regulations. This consultation does not in any way reassure us that steps are being taken to provide clear and consistent procedures across NHS England Area Teams. A failure to do so will inevitably cause wasted time and money for both practitioners and NHS England. We do not believe that the obligations and additional burdens NHS England are seeking to place on practitioners will enhance patient care or improve patient safety or are what the Government intends.

**March 2014**