Promoting Professionalism, reforming regulation – a paper for consultation: response from the Optical Confederation and Local Optical Committee Support Unit

The Optical Confederation represents the 13,000 optometrists, 6,000 dispensing opticians and 7,000 optical businesses in the UK who provide high quality and accessible eye care services to the whole population. The Confederation is a coalition of the 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 Opticians (FODO).

The Local Optical Committee Support Unit (LOCSU) provides quality, practical support to local optical committees (LOCs) in England to help them to develop, negotiate and implement local objectives in respect of primary ophthalmic services.

The AOP is also submitting its own response to the consultation. In this response we have briefly noted the key points on which the AOP's position differs significantly from that of the other Optical Confederation members.

Summary

We fully support the view that the UK's health care workforce needs to change to meet the challenges of health care in the future. This is particularly true in the case of the optometric and optical professions as much traditional ophthalmology work currently delivered in hospitals will need to transfer to and be delivered by these clinical groups in the community. This is the only way the UK will be able to meet growing national need driven by the ageing population and new technologies.

We fully support the propositions that

- workforce strategies will need to focus on "the development of innovative health and care roles"
- professionals in future, particularly in the community optical sector, "will need to have the flexibility to work across traditional boundaries".

We also agree with the PSA that the UK needs a "system of professional regulation that contributes to the delivery of this ambition and supports the development of high quality professionals". (Foreword)

We support the development of a learning rather than a blame culture and are supportive of regulators exploring new ways of achieving this (Foreword) and the proposal to give regulators powers "to handle fitness to practise cases in a proportionate way [which] will allow for a more preventative and supportive approach". (Executive Summary)

We also agree that professional regulators should work in partnership with employers, higher education providers and - we would argue - closely with the regulated professions themselves, "to ensure that the recruitment, education and training systems they assure and operate are developing the right people, that they are teaching the right things (through both formal and informal curricula) and that behavioural problems identified early in a professional's career are properly addressed." (Executive Summary and Paragraphs 3.30-3.31).

Finally, we fully support the PSA's aims to

- design a more responsive model of professional regulation which can swiftly adapt to changing patterns of health care, develop new roles and new ways of working without the need for frequent legislative change
- establish clear criteria to assess which level of regulatory oversight is appropriate for different professional groups
- consider whether the current number and set up of healthcare regulatory bodies is delivering efficient and effective public protection
- ensure that regulatory bodies have a consistent and flexible range of executive powers that allow them to take prompt and proportionate approach to concerns about an individual's fitness to practise
- enable regulators, working with professional bodies and others, to better support professionalism among regulated groups and to provide assurance on an ongoing basis that practitioners are competent and up to date
- increase joint-working, sharing functions and joint services between the regulators. (Executive Summary)

Caveats

We support all of these aims provided that the solutions which are developed

- maintain independence, fairness and impartiality in regulation
- improve efficiency
- ensure appropriate professional knowledge is utilised in the regulatory process so that sector specific needs and differences are taken into account
- reduce costs rather than increase them
- lead to lower regulatory fees for professionals proportionate to the risk and average income potential of those professions.

Professional Input to Regulation

We supported the proposals in the 2007 Government White Paper *Trust, Assurance and Safety – The Regulation of Health Professionals in the Twenty-first Century,* particularly that "the independence of regulatory bodies is vital to sustain the confidence of the public and the professions through demonstrable impartiality; and also that regulators need to be independent of government, the professionals themselves, employers, educators and all other interested bodies involved in healthcare." (Paragraph 1.3)

These principles remain valid. Nevertheless we have become aware since their implementation of a lack of appropriate professional advice and input into the executive functions of the regulators. In some cases this has led to embarrassing public errors which could have been avoided or corrected through taking advice from the professions regulated at an earlier stage. We can give examples of this if required.

It is vital therefore in our view that any new system ensures regular input from the professions regulated at all points – and we would point out that appropriate professional input to regulation is not the same as self-regulation. This input should go beyond tokenism on Councils and reflect the skills, experiences and insights which the regulated professions can bring to the work of their regulators.

Regulation of Optical Businesses

The draft paper points out in several places that the General Optical Council (GOC) regulates optical businesses. This is only half true; GOC registration is voluntary for optical businesses unless they are using a protected professional title in their name. (Paragraphs 1.4)

We consider that it is sensible that the GOC continues to regulate businesses in a proportionate and robust way, which balances the important duties of individual registrants and the duty of businesses to support their registrants. Indeed, we would far prefer that, as part of any reforming legislation, the General Optical Council were given powers to regulate all optical businesses which

- carry out restricted functions
- present themselves to the public or patients - by means of name, title or in any other way – as having, or implying that there is, a registered professional on the premises and/or overseeing services, e.g. Eye Centre, internet suppliers.

We appreciate this is difficult. However the GOC is beginning to think seriously about standards of practice for registered businesses. We would expect the sector to benefit from the clarity that review will bring and that any wider decisions on regulation would be informed by that review. We are keen to work on this with the GOC (or any successor body).

Common Standards

We support the proposal for "agreement on a statement of professional practice i.e. common professional standards agreed by consensus between regulators and accredited voluntary register holders [which] to apply to all registrants whether licensed or not" and that "professional/occupation-standards should be developed only where these are needed". This will keep costs to a minimum. (Table 2)

In addition to the comments above, our detailed responses to the consultation questions follow.

Q1. Do you agree that the PSA should take on the role of advising the UK governments on which groups of health professionals should be regulated?

A1. Yes.

Q2. What are your views on the criteria suggested by the PSA to assess the appropriate level of regulatory oversight required for various professional groups?

A2. We find it odd that the HCPC should be deemed to have an irresolvable conflict of interest in being able to recommend whether groups should be statutorily regulated and yet the PSA is deemed not to have a similar conflict. We are not clear what the evidence base for this is.

That said, we broadly support the criteria suggested by the PSA to assess the appropriate level of oversight professional groups especially

- the complexity of the activities/intervention undertaken
- where the intervention occurs (for example in a hospital or someone's home)
- the vulnerability/autonomy of the patient and their ability to make an informed choice about their care.

We also broadly support the second stage of wider external policy factors including

- means of assurance – the range of different ways in which the risk of harm can be reduced
- risk perception – the effect that regulation (or other means of oversight) would have on the confidence levels for the relevant profession
- unintended consequences for the preferred form of oversight.

We have strong doubts, however, about including

- "the scale of the risk – the size of the professional group or number of patients who are treated" – surely these are irrelevant to the issue of risk to individuals?

- "sector impact – the impact that regulation (or other means of oversight) would have on cost to supply of the work force". This looks to be a very odd criterion and we assume what is meant is affordability which is relevant. However we would much prefer to see a simpler weighing of the cost of regulation as realistically as possible against levels of genuine risk.

We would further propose that the second stage criteria should be applied not only to the fact but also the extent of regulation, for example the degree to which revalidation is/is not necessary for a given professional group and to ensure the burden and frequency of this is commensurate with risks.

Q3. Do you agree that the current statutory regulated professions should be given an assessment to determine the appropriate level of oversight? Which groups should be reassessed as a priority? Why?

A3: No. The current arrangements seem to work perfectly well to protect the public. Moreover, in the case of the optometry and optical professions, their clinical areas of expertise, i.e. eye health and vision, are crucial to healthy living and ageing and, with their scope of practice set to expand rapidly as care transfers from the hospital sector to the community, now would not be a good time to waste resources on a reassessment.

The AOP's separate consultation response notes that any change to the regulatory structure will provide an opportunity for regulation to take more account of the environments in which healthcare professionals work.

Q4. What are your views on the use of prohibition orders as an alternative to statutory regulation for some groups of professionals?

A4. We agree with the PSA that there is insufficient evidence to draw a conclusion about the effectiveness of prohibition orders in a health context at the present time. We would also be concerned that, a priori, prohibition would come too late in the process fully to protect the public. Attainment of professional standards, registration and maintaining registration on the basis of evidence seem to us to be better ways of protecting the public.

Q5. Do you agree that there should be fewer regulatory bodies?

A5. We do not believe it right to start from the principle of how many regulators there should be but rather what the purpose and role of the regulators should be and then how they can best be configured to deliver that.

Q6. What do you think would be the advantages and disadvantages of having fewer professional regulators?

Q6. The optical professions currently have a single dedicated regulator which has served both the public and professions well for many years and at affordable costs for the professions and sector. We have concerns about the potential for increased costs flowing from merger with other regulators as well as the risks of a loss of professional input into the work of a super-regulator at all levels.

Nevertheless we are very open to further exploration of these ideas subject to the caveats outlines in our summary above.

Q7. Do you have views on how the regulators could be configured if they are reduced in number?

A7. Yes. It would seem logical, on grounds of numbers and risk, to have regulators for the following groups:

- Doctors and dentists (both engaging in medicine and surgery at high risk level)
- Nurses and midwives (ditto but usually to lesser degrees or narrower scope)
- Social workers (new regulator just established)
- Pharmacists because of their specific roles in poisons, controlled substances, highly dangerous polypharmacy, oxygen supply and storage
- All other clinical professions which remain in regulation.

The AOP's separate consultation response takes a differing view of risk and suggests that optical professionals may best be regulated alongside other primary care professionals whose practise covers a comparable spectrum of risks to patients and the public, such as pharmacists and dentists.

Q8. Do you agree that all regulatory bodies should be given a full range of powers for resolving fitness to practice cases?

A8. Yes. We have fully supported the introduction of case examiners, consensual disposal, where appropriate, alternative dispute resolution and use of undertakings at the GOC. (Paragraph 3.3) We could not agree more that issues raised should be dealt with "in a timely, effective and proportionate manner" (Paragraph 3.8) and that fewer cases should proceed to full hearings. (Paragraph 3.3)

Q9. What are your views of the role of mediation in the fitness to practise process?

A9. This can be useful where used appropriately. Indeed a good model already exists and is made effective use of in the optical sector, the Optical Consumer Complaints Service (OCCS), which enables consumer issues to be dealt with swiftly, and more appropriately and cost effectively than via the regulator.

Q10. Do you agree that the PSA's standards should place less emphasis on fitness to practise performance and consider the wider performance of the regulators?

A10. Yes.

Q11. Do you agree that the PSA should retain its power to appeal regulators' fitness to practice decisions to the relevant court, where it is considered the original decision is not adequate to protect the public?

A11. In theory, if the proposals put forward in this paper are implemented, the PSA should have no need for this power. However, given that even the best laid plans can go awry, we would support the PSA retaining its powers to appeal regulators' fitness to practise decisions to a relevant court where they consider that the original decision is either too harsh or not sufficient to protect the public.

Q12. Do you think the regulators have a role in supporting professionalism and if so how can regulators better support and meet and retain professional standards?

A12. As a general principle, yes.

However while the GMC's regional liaison service model is a good one for GPs, it may be unnecessary and unaffordable for our sector. Solutions need to be proportionate to the level of risk, which in primary eye care is low.

Q13. Do you agree that the regulators should work more closely together? Why?

A13. Yes and, for the reasons set out in this consultation document, we would support a move to a system which places a statutory duty on regulators to work together.

In our sector multi-professional team working will become increasingly important as optometrists, opticians, ophthalmologists, orthoptists and ophthalmic nurses work more closely together to meet national eye health need across primary and secondary barriers and where issues raised may affect more than one regulator.

Q14. Do you think the areas suggested above are the right ones to encourage joint working? How would this contribute to improved patient protection? Are there any other areas where joint working would be beneficial?

A14. Yes.

The joint work that the nine health regulators did together on the Duty of Candour was both useful to the regulated professions and cost-effective from the point of view of regulator workload and we would encourage more of this on cross-cutting issues.

We would also support a shared on-line register, a single set of generic standards for all health professionals and, potentially, provided costs and professional input are proportionate and appropriate, a single adjudicator for all fitness to practise decisions. (Paragraph 4.11)

It might also be beneficial to have a common complaints portal for the public to avoid some of the confusion and barriers inherent in the current system. It may also be helpful to have an additional, separate complaints portal for employers or oversight bodies.

The consultation document rightly reminds us of the abandoned proposals for an Office of the Health Professions Adjudicator (OHPA) and states that for a variety of reasons these initiatives have not been taken forward" (Paragraph 4.8). One of the key reasons for the non-progression of OPHA was the disproportionate costs this looked likely to impose on GOC registrants. It would therefore be key for us that such disproportionate costs were avoided if a single adjudicator system were to be brought in. Equally, any system that made fitness to practise procedures any longer for registrants, patients and the public would not be acceptable.

We would, however, also highlight that the proposition that a single organisation conducting back office functions such as HR, finance and IT is automatically and inherently likely to more efficient is not borne out by evidence from other sectors. Mega-organisations and mega back-office functions rarely seem to work in the private, public or voluntary sectors and we are not convinced, therefore, that these would necessarily work amongst the nine health and one social care regulator.

Q15. Do you agree that information sharing between health bodies including system regulators could help identify potential harm earlier?

A15. Yes but this would need to be proportionate to the recognised level of risk. Clear safeguards for individuals would need to be instituted as there is a tendency of all regulators to become over-focussed on and pursue minor issues whilst being unsighted on the bigger issues of public safety – cf CQC ratings of NHS Trusts which subsequently reveal major service failings or tick box 'quality' systems which instil a false sense of safety irrespective of patient outcomes.

Q16. Do you agree that the regulatory bodies should be given greater flexibility to set their own operated procedures?

A16. Yes – this seems obvious.

The AOP's separate consultation response asks how regulators would be expected to respond if stakeholders strongly disagree with a proposed change in operating procedure.

Q17. Do you agree that the regulatory bodies should be much more accountable to the Scottish Parliament, the National Assembly for Wales and the Northern Ireland Assembly in addition to the UK Parliament?

A17. Yes. This is consistent with the direction of democracy within the United Kingdom. It has also become clear that the UK Parliament does not have the capacity to scrutinise the performance of all health regulators in sufficient depth or detail. Sharing some of this responsibility across the devolved administrations would provide a useful expansion of public scrutiny capacity.

Q18. Do you agree that councils of the regulatory bodies should be changed so that they comprise both executive and non-executive members?

A18. No. The evidence does not support this and the case is far from proven.

It is not clear to us that the Committee on Standards in Public Life's report *Striking the Balance – Upholding the Seven Principles in Regulation* in September 2016 is correct in its deduction that two tier structures cannot support effective accountability on the grounds that it is the Councils which make decisions but the Executives which carry out work. The logic here does not seem to flow correctly. The Council should set direction, in discussion with the Executive, and then hold the Executive privately and publicly to account for delivery. Parliament, or whatever oversight arrangements are in place, should then hold the Councils to account both for strategy, for the reasonableness of the plans they have endorsed and the effectiveness of the way in which they have held their Executives to account.

There is currently a fashion for unitary boards which include executive as well as non-executive members. We would argue strongly that the jury is still out on this and that there is currently an insufficient evidence base to make a universal change. Human beings, however good their training and however elevated their aspirations, remain human beings. In any group there is always a tendency for collusion and psychological pressure for people working together to become more tolerant of failings for which they have collectively been responsible. In boards of this type there is a risk of non-executives developing Stockholm Syndrome and also collusions – for the best of reasons – between strong chief executives and strong chairs where non-executives often feel excluded and not supported in carrying out their proper scrutiny role.

As above, from our perspective we cannot see anything wrong with the current system whereby

- a Council sets strategy and agrees a delivery plan for implementation with its Executive in line with the resources available
- the Council then holds the Executive to account for delivery against plan
- the Council is in turn held to account by a higher authority for strategy, the plan and the effectiveness of its performance management of the Executive in delivering that plan for the public benefit.

We do not support the proposition in paragraph 4.22 that the presence of senior employees of the regulator on the Board would enable the non-executives to hold the executives to account in a thorough fashion. In our view, quite the reverse would be likely.

Q19. Do you think the views of employers should be better reflected on the councils of regulatory bodies, how this might be achieved?

A19. This is an unproven hypothesis and might be a risky development if employers were to predominate, especially if they were also regulated individuals or bodies corporate themselves. The General Optical Council currently manages this well through

- the mix of experience and perspectives it recruits to the Council itself (which includes some employers)
- and also an established Companies Committee in which inevitably employers large and small predominate and make their views known.

We would prefer the issue to be dealt with in this way, by recruiting the skills necessary to inform Councils' work rather than through quotas, reserved places or other such means.

Q20. Should each regulatory body be asked to set out proposals about how they will ensure they produce and sustain fit to practise and fit for purpose professionals?

A20. Yes. This should be a standard expectation in any case.

Q21. Should potential savings generated through the reforms be passed back as fee reductions, be invested upstream to support professionalism or both? Are there other areas where potential savings should be re-invested?

A21. The assumption should be that any reforms will lead to lower costs for the regulated professions as well as better regulation for practitioners, providers and the public with any future fee increases being justified against need in the usual way.

There is wide evidence from the public sector that giving public sector/administrative - rather than earnings-based - organisations unallocated funds encourages them to find ways of spending them which are not necessarily the most effective use of resources or in the public interest. Every new area of expenditure, in our view, should be justified on the basis of a transparent and costed business case in the normal way.

Q22. How will the proposed changes affect the costs and benefits for your organisation or those you represent

- **an increase**
- **a decrease**
- **stay the same?**

A.22 Optical Confederation member bodies themselves are involved in professional leadership, guidance, the provision of CPD, professional indemnity and legal defence. These roles are likely to remain unchanged under the proposals in this consultation document.

Better and swifter fitness to practise procedures would be a significant benefit to registrants and complainants, in terms of reduced costs and stress. However, if as a result of changes fitness to practise arrangements become less effective (which is highly likely within aggregated systems) this would involve us in higher defence and legal costs. We would estimate an extra 10-20 per cent in annual costs to reflect this.

In terms of those we represent, i.e. regulated professionals and optical businesses, we have been clear throughout our response that we would expect any changes to improve efficiency and reduce costs rather than increase them.

We are concerned at the throw-away statement in Paragraph 4.25 that "the four UK governments have been clear that fee rises be kept to a minimum." (Our emphasis) As noted in our response to Question 21 above, a key goal of any reform of regulators should be that registration fees are lower in future than they are now, to reflect the ambitions for efficiency outlined in this consultation document.

Q23. How will the proposed changes contribute to improve public protection and patient safety (health benefits) and how could this be measured?

A23. The case that the proposed changes will contribute to any improved public protection or patient safety benefits is far from proven. However one could review the rates of near-misses, other patient safety incidents, the numbers of fitness to practise cases per suitable population denominator or the underlying causes (seriousness) of fitness to practise cases, and track these over time (provided one could identify and control for the confounding variables). However this would be an inexact science and any improvement would not necessarily be the result of any changes proposed in this consultation document. Nevertheless it should be possible to show by tracking indicators over time whether the professions are becoming safer, more professional in behaviour and more effective in delivering health care. That might be worthwhile in itself, with or without the changes proposed in this consultation.

Q24. Do you think any of the proposals would help achieve any of the following aims?

- **Eliminating discrimination, harassment or victimisation or any other conduct prohibited by the Equality Act 2010 and Section 75(1)(2) of the Northern Ireland Act 1998.**

- **Advancing equal opportunities of persons who share a relevant protected characteristic and persons who do not share it?**
- **Fostering good relations between persons who share a protected characteristic and persons who do not share it?**

If yes, could the proposals be changed so that they are more effective?
If not, please explain what effect you think the proposals will have and whether you think the proposals will be changed so that they would help achieve those aims?

A24. No. Regulators and regulated professionals are already committed and highly sensitive to addressing equality issues both in policy and practice.