General Optical Council response to *The regulation of the non-medical healthcare professions* and *Good doctors, safer patients*.

Introduction

1 The GOC welcomes the emphasis on public protection which runs through both reports, particularly *Good doctors, safer patients*. We welcome and support the principle of greater consistency and collaboration between regulators and the other players in the UK health system. In this context, the dissonance between the two reports – particularly in respect of education and adjudication functions – is both surprising and disappointing. It is also disappointing that the review of non-medical regulation is less substantial than the CMO's review, and light on impact assessment. Considering the efforts made to involve stakeholders in the reports' preparation, it is surprising that some recommendations, including the proposal to move functions relating to education from the GMC to PMETB, were unexpected and do not we believe emanate from public or professional recommendations.

Overview/principles

- *Do stakeholders support the principles on which Good doctors, safer patients is based?*
- *Do stakeholders support the approach advocated in the two reports?*
- *What are the priorities for stakeholders in terms of implementation?*

2 The GOC has accepted, in its strategy, the Better Regulation Commission's principles of good regulation We are therefore in total agreement that regulation should be proportionate, accountable, consistent, transparent and targeted. In reflecting these principles, we have some reservations about the concept of a unitary approach to regulation. While there are many areas where greater commonality and consistency will be beneficial, it will be important to recognise the necessary differences in regulation of different professions resulting from differences in size, practice settings and risk, as well as the need to allow innovation.

3 The Council supports the argument set out in *Good doctors, safer patients* that the culture of regulation should change. The focus should be less on detecting and punishing bad practice, and more on supporting good standards of practice, including an emphasis on retraining and rehabilitation where problems arise. A more supportive culture could encourage individual practitioners and their colleagues to involve regulators earlier with substantial benefits to public safety.

4 The GOC would suggest that the following are the core functions of any regulatory body:
   i. Setting standards for entry to the register, including initial and continuing education and training, performance, conduct/character, health, insurance and communication ability.
   ii. Approving qualifications and experience leading to registration.
   iii. Maintaining a register of individuals who are qualified and fit to practise.
   iv. Investigating and acting where registrants' fitness to practise is impaired.

5 We have indicated priorities for action within the response below. The issue of English language testing has some urgency given the imminence of legislation in relation to the European Directive for the Recognition of Professional Qualifications. Work on the appropriate standard of proof should also be prioritised, as a clear policy decision would be a pre-requisite for any recommendation for the development of common sanctions and the introduction of shared adjudication systems.

Common themes

Changes to the governance and accountability of regulators (Theme 1)

Public protection

6 The GOC agrees that the public protection function of all regulators should be clarified and explicitly stated. We endorse the recent changes to the Opticians Act to include reference to the Council's responsibility 'to promote, protect and maintain the health and safety of the public'. The Council does not believe it is possible for a single body to deliver both regulatory and professional lead functions.

Investigation

7 The Council would support any developments which might make it easier for patients to navigate the various routes for reporting concerns, for example through development of common 'signposting' website or information service, provided that such a service did not prevent individuals reporting concerns direct to the regulator.

8 We would not support the creation of a single portal with responsibility for investigation of complaints. The Council has serious concerns about the ability of a centralised body to investigate cases across the spectrum of healthcare professions to the standard currently achieved by the GOC in investigating optical complaints. It is likely that investigation work would be

duplicated within such a system. We would have further concerns about the potential loss to the regulator of 'soft' intelligence where individual allegations are insufficiently serious to warrant further action, but which taken together might indicate a pattern raising concerns overall about performance or conduct.

9 We agree with the proposal for the CHRE to extend its audit role to sample decisions not to proceed where concerns were notified to the regulator. Some changes to procedures would be needed to ensure a workable approach, as the Council does not currently produce transcripts of its Investigation Committee meetings. If a 'sampling' approach was taken, a transcript could potentially be produced on request in relation to a particular case only. Alternatively, the CHRE could fulfil an audit function by sending a representative to some meetings.

Adjudication

10 The GOC supports a single independent adjudicator for all the healthcare professions. Panels should include representatives from the same profession as the defendant as well as lay members. The Council already operates this model in relation to the two optical professions.

11 An independent adjudicator should come under the overall control of the Department for Constitutional Affairs, and not the Department of Health. Appointment of hearings panel members should be by the Judicial Appointments Commission.

12 Should cases be heard by an independent adjudicator, the right of appeal against such decisions could revert to the individual regulators. Unless this happens, the CHRE should not be involved in establishing such an adjudication body, or with the recruitment or training of panel members, as this would compromise its present role in appealing Fitness to Practise decisions which are felt to be too lenient.

Education

13 We note the clear disjunction between the two reports on this issue. We endorse the view expressed in *The regulation of the non-medical healthcare professions* that 'setting the necessary standards and verifying that education providers and students meet them is at the heart of professional regulation'. Therefore, we strongly oppose the recommendation in *Good doctors, safer patients* to move education functions from the General Medical Council to the Postgraduate Medical Education and Training Board. Such a change would operate against the principle that regulators should be more like each other. We are not aware of an evidential case for such a move in relation to any of the regulators.

The importance of defined operationalised standards against which to regulate (Theme 2)

14 There are significant potential benefits to be gained from greater clarity and consistency about what constitutes good character in the context of healthcare regulation. However, the GOC is mindful of the real differences in levels of risk posed by different healthcare professionals, which appropriately result in different definitions of acceptable character and conduct. A common framework should identify barriers to registration based on activity and risk (eg substance misuse may be a bar to registration for a professional with prescribing responsibilities). Safeguarding Vulnerable Groups legislation will create a framework for the definition of good character which should provide the starting point for this work.

15 In relation to educational and clinical standards, some work has already been done to identify and establish common core competencies within UK healthcare. The development of regulatory standards in optics relies on close working with the optical professional bodies, and GOC standards operate interdependently with the professional bodies' guidance. Greater harmonisation with other healthcare professions may be difficult to achieve and the benefits of undertaking this work are unclear. Some impact assessment is needed before undertaking further work in this direction.

16 The GOC is mindful of the different systems and culture in Europe for dealing with issues of character and conduct. The GOC would not wish to see excellence in public protection weakened by different standards agreed between UK and Europe in the registration of healthcare professionals.

The appropriate standard of proof (Theme 3)

17 The standard of proof is fundamental to the Fitness to Practise process and the Council was surprised and disappointed that *The regulation of the non-medical healthcare professions* only addressed the subject in relation to links with *Good doctors, safer patients*. A common standard of proof is a pre-requisite for common sanctions and a shared adjudication function. The GOC's recent decision to clarify its rules on this matter was taken in the absence of policy guidance from the CHRE or government. Respondents to our consultation emphasised the seriousness of the available sanctions, citing in particular the effect of erasure on an individual's livelihood in support of maintaining the higher standard.

Proposals for a 'spectrum of revalidation across all healthcare professions' (Theme 4)

18 The Council welcomes the principle of revalidation, provided that any approach is proportionate. Any revalidation approach should include a practical assessment, and the consequences of failure should be considered including opportunities for retraining and rehabilitation.

19 The GOC has already considered possible approaches. Over 90% of registrants work outside the NHS but 95% provide NHS General Ophthalmic Services. We are aware of the personal costs to registrants in maintaining quality assurance frameworks and would welcome the NHS meeting the full costs of revalidation.

20 Unless paid for by the NHS there is concern that the number of independent registrants is so large that it would be more efficient for the GOC to manage this work in association with registered businesses/bodies corporate.

Devolution of some regulatory activity to a lower level (Theme 5)

21 Though the principle of devolved investigation is attractive, there are practical difficulties with its implementation in optics, given the diversity of employers, and mobility of both the patient base and workforce. We have addressed concerns relating to devolution of investigation work under 1. above.

The number of regulators for the non-medical professions (Theme 6)

22 The GOC welcomes the recommendation not to merge any of the regulatory bodies in the short term, which might have resulted in significant loss of professional ownership. In the long term RPSGB and PSNI should merge.

23 Multi-professional regulators will need to make additional efforts to engage with professionals where they regulate new groups.

The requirement to record post-registration qualifications (Theme 7)

24 The GOC already records specialty qualifications in contact lenses for dispensing opticians and therapeutic prescribing of medicines for optometrists. Regulators should establish clear criteria for deciding when a qualification merits 'specialist' status. Regulators should set standards and approve courses in relation to all registerable qualifications, and continuing education and revalidation requirements should apply to specialties. Where a specialty is marked in the register, there should be a legal restriction of title and function in relation to it.

The role of regulation for student healthcare professionals (Theme 8)

25 The Council already registers students on optometry and dispensing optics courses in the UK. Registration was introduced to ensure public protection. The GOC has further found that registration benefits students taking vocational courses by ensuring that they are made aware at the outset of a period of training if they would not be able to progress to full registration for any reason. Such early engagement with the regulator is also an opportunity to inculcate professional standards and a code of conduct. We welcome, therefore, the proposal to introduce student registration for other healthcare professions, and note that in many high profile cases including Shipman, character and conduct issues first emerged during training.

The need for standardised pre-employment English language testing (Theme 9)

26 The Council believes that good communication is critical for communication with patients and colleagues in the clinical setting. The GOC therefore welcomes the recommendation to introduce English language testing. Although English may not always be the primary language required for patient contact, a minimum standard of English is required to engage with professional guidelines and participate in clinical governance activities. The GOC has serious concerns about the implications of the European Directive on the Recognition of Professional Qualifications in relation to language testing, and we suggest that this issue should be addressed urgently.

Extending the scope of regulation to include healthcare support workers and new roles in healthcare (Theme 10)

27 Optical support workers pose a low level of risk to the public and currently work under the supervision of registered professionals. The GOC would not support further extension of regulation without a strong evidential case which addressed issues of risk and proportionality.

28 Where further regulation is appropriate, the great strengths of the GDC model of integrated regulation of the clinical team should be the model. Current registrants and support workers will have overlapping ‘competencies’. A system of team regulation by the regulator for the lead professional may also provide improved career structure and a more coherent experience for patients reporting concerns which may relate to several members of a clinical team.

The importance, or otherwise, of a lay majority on the governing bodies of the various healthcare regulators (Theme 11)

29 In relation to the constitution of governing bodies, we believe that an appropriate balance of members with the necessary skills and experience to carry out the Council's work is more important than a majority of either lay or professional members. A move to a lay majority may be appropriate given the potential to significantly improve public trust in regulation.

30 However, professional engagement is also key to successful regulation. We believe that election of some professional members is a critical factor in ensuring professional support for the Council's work. Experience within the GOC has shown that elected members do not face any greater conflict of interest within their role than other members.

31 The GOC values highly the ophthalmologist members and would wish to see them continue as non-registrant members.