General Osteopathic Council

Promoting professionalism, reforming regulation – response from the General Osteopathic Council

Introduction

The GOsC welcomes this consultation on the future of healthcare professional regulation. We have worked closely with the Law Commission, the Department of Health (England) and other regulators in seeking to shape reforms and are committed to continuing to do so.

We particularly welcome the reaffirmation of the principle set out in *Trust Assurance and Safety* that regulation is about sustaining and improving the practice of the majority as much as addressing the poor practice of the minority.

We have sought as a regulator to take a distinctive approach to supporting the development of the profession we regulate while seeking to engender high standards of care, in a practice context that takes place largely outside the National Health Service.

As a regulator our drive for innovation has been hampered by outdated primary and secondary legislation and we would welcome change. However, we also believe that across the sector – alone and in collaboration with others – there is more that we can do to improve regulatory outcomes without legislation, and would seek the support and encouragement of government, the Professional Standards Authority (PSA) and other stakeholders in doing so.

The osteopathic context

Osteopathy is a primary healthcare profession, and is recognised as an allied health profession within the NHS see (www.england.nhs.uk/2017/04/chief-allied-health-professions-officer-extends-her-remit-to-two-additional-professions).

There are around 5,300 osteopaths registered with the General Osteopathic Council who are able to practise osteopathy in the UK, with the register growing at a rate of approximately 2% a year. Osteopaths practise primarily in the independent sector but around 1 in 10 work in the NHS or treat NHS-funded patients.

All osteopaths are trained to be able to take a history, examine a patient, form a differential diagnosis and treat or refer. Osteopaths hold a variety of roles in the private and public sectors, in independent clinics, within NHS GP practices and secondary and tertiary settings. Osteopaths often practise alongside a range of other health professionals, and may also be dual qualified as medical doctors, nurses, physiotherapists or in other disciplines.

There are around 800 osteopathic students in nine educational institutions in the UK, these include health faculties at universities, and other higher and further education institutions.

All osteopaths must meet the requirements of the *Osteopathic Practice Standards* in order to be entered onto the register, and must undertake mandatory continuing professional development (CPD), providing assurance of their continuing fitness to practise, and which is designed to enhance practice and patient safety.

Our responses to the specific consultation responses are set out below.

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

We agree that it is appropriate for the views of the PSA to form part of the UK governments' approach to assessing which groups of healthcare professionals should be regulated, and we note that the PSA's advice was sought in this way in relation to the regulation of nursing associates.

We also believe that the PSA's advice should form just one part of a wider process in which the governments canvass a range of views before a profession is recommended for regulation or to be removed from regulation.

It is unclear why aspects of this process, or those to be involved, need to be contained in statute. To do so risks perpetuating inflexibility, one of the key problems that the consultation seeks to address.

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

The approach suggested by the PSA[1] is a good starting point for developing criteria, but these have not yet been widely debated among regulators and others. We also note that the criteria are précised in paragraphs 2.5 and 2.6 of *Promoting professionalism, reforming regulation*, and aspects of the PSA's approach are more detailed.

There are some areas that we consider require further thought. First, the issue of complexity of activities/interventions is more nuanced than just the risks from the interventions themselves. In a primary care context, such as the service provided by osteopaths, there are also the linked issues of failure to diagnose, misdiagnosis, inappropriate treatment and failure to refer. These risks may be significantly greater than those arising from the normal range of treatments provided.

Second, where an intervention takes place is not simply a matter of physical location, such as a hospital or an individual's home. What is more important is the clinical governance or oversight in relation to how the service is provided.

[1] www.professionalstandards.org.uk/publications/detail/right-touch-assurance-a-methodology-for-assessing-and-assuring-occupational-risk-of-harm

Third, the size of the practitioner group and size of the patient or service user group may provide misleading results, given that high risk activities may be undertaken by relatively small occupational groups or with small patient groups. Patient safety has to be the key consideration.

Q3: Do you agree that the current statutorily regulated professions should be subject to a reassessment to determine the most appropriate level of statutory oversight? Which groups should be reassessed as a priority? Why?

We agree that the appropriateness of the level of regulation for all occupational groups should be reviewed from time-to-time. However, this process may require different approaches and criteria for determining whether or not a group should become or remain statutorily regulated. Any reassessment will need to consider the potential consequences for a profession and its patients as a result of any changes. This would need to include whether the necessary alternative mechanisms could easily be put in place to maintain effective regulatory oversight, or whether there is a potential for deterioration in professional standards and the resultant impact of this on patients.

In addition, it must be acknowledged that these decisions will always have a political component, in that the requirement for regulation may be driven by public expectation or demand, rather than the application of a set formula that can be followed in all circumstances. It would be sensible to build into any approach appropriate mechanisms – including public consultation – to accommodate these considerations.

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

We believe that prohibition orders could have a potentially useful role in addition to statutory regulation in relation to individuals who continue to practise – albeit under a different professional title – following removal from a statutory register. We are aware of a number of former osteopaths who have been removed from the GOsC register for fitness to practise reasons who continue to practise using such titles as 'consultant spinal therapist' or under the guise of running a pain clinic. These individuals often can not be pursued for unlawful use of a protected title, but remain a risk to the public. Placing these individuals on a barred list or using a prohibition order could close an important regulatory gap.

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

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

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

These three questions are linked and we have chosen to respond to them together.

It is for the government to decide on how many regulators there should be and how they should be configured. We believe that the issues are more complex than an assessment of the current and future costs of regulation, but equally we do not think it is the role of regulators to argue for their preservation, unchanged and at all costs.

It is also helpful to apply some of the principles of 'right-touch regulation' to the proposal, for example:

- Identify the problem before the solution – has sufficient effort gone into exploring some of the challenges faced by regulators (articulated elsewhere in the document) before concluding there should be fewer regulators?

- Get as close to the problem as possible – is it clear that the challenges of more responsive regulation, which supports professionalism will be easier to facilitate with fewer multi-profession regulators?

- Check for unintended consequences – to what extent has the potential for unintended consequences been explored, for example around the issues of professional identities, the perceived legitimacy of regulation and the potential impact on patient safety?

We believe that among the most important drivers of regulation must be the context in which a profession practises and the maturity of the profession under regulation. Some aspects of context are provided in the proposed analysis of whether or not individual professions should be regulated, but equally it must be recognised that all professions are at different stages of development. For example, in recent years we have sought to work closely with the osteopathic profession to support its development (this being an additional statutory duty of the GOsC) and this continues to be work in progress. Challenges have arisen in relation to the maturity of other professions too, for example those identified in research into paramedics and social workers undertaken by the HCPC which suggests that not all professions can be regulated with a one-size-fits-all approach. The Government's decision to establish a new regulator for social work in England also suggests that it views these issues as a legitimate concern for regulators.

We believe that meeting the needs of specific groups of registrants is challenging within a large multi-profession regulator. On pages 22-23 of *Promoting professionalism, reforming regulation,* an example is given of the work that the GOsC is doing with registrants around communication and consent. This level of analysis and support would be difficult for a single combined regulator to provide in all contexts. This view has been echoed to us in discussions with the Osteopathic Board of Australia about the way in which the Australian Health Practitioner Regulation Agency works with its professional boards.

We have identified as a strength of a diverse ecosystem of regulators the ability to innovate in meeting the specific needs of a profession. For example, we have received considerable praise from the PSA for our approach to continuing fitness to practise which is focused on enhancing patient safety and practice in the specific context of the osteopathic profession This work was also supported by influential research we commissioned from McGivern et al (2015)[2] widely cited by the PSA and others.

We do not believe that basic cost models should be used as the key driver for reforms. While it is self-evident that smaller regulators are likely to be more expensive, the variation in costs exemplified in Tables 3 and 5 of *Promoting professionalism, reforming regulation* is not simply based on numbers of registrants. We also note that since this data was produced some regulators have reduced their fees significantly while others have needed to raise theirs. Some of the variations may be as a result of differences in their respective legislation (for example ways in which initial disposal of fitness to practise concerns can take place). While other variations will depend on how the regulator chooses to meet its statutory objectives (for example, how it seeks to promote standards or aims to ensure the continuing fitness to practise of its registrants). In addition, the inability to get legislation updated has inhibited efforts to reduce costs.

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

Yes. Unless there are particular reasons why a regulator requires supplementary powers (we note, for example, that some regulators have specific additional powers in relation to corporate bodies), then the powers available should be consistent.

However, we would caution against pursuing uniformity in approach across regulators as opposed to a focus on consistency of outcomes. The one aspect of the current approach that has been of benefit has been the constant, innovative evolution in the use of powers, adaptation of policies and procedures. Whatever approach is taken in future must ensure that such innovation continues to take place.

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

We question whether it is helpful to use the term 'mediation' which is more applicable to the resolution of disputes than the determination of whether an individual's fitness to practise is impaired or not. It is also the case that the purpose and expectations of the fitness to practise procedures may be perceived differently by patients, the regulator and its registrants.

This does not mean that there is not a useful role for discussion between the registrant, the complainant and the regulator at an early stage in the proceedings that may result in an improved outcome for all parties. We are attracted to the

[2] www.osteopathy.org.uk/news-and-resources/research-surveys/gosc-research/research-to-promote-effective-regulation

approach suggested by the PSA in its document *Right-touch reform* which it describes as 'meaningful remediation', thus recognising that the outcomes from current processes often do not fit this description.

The benefits from a new approach may include: satisfaction for the complainant that their concerns have been addressed; a less stressful experience for the registrant, which is more likely to result in positive future engagement with their regulator; and, possibly, a more efficient and cost-effective resolution of concerns.

Whatever term is used, it is difficult for this to be a simple bolt-on to current processes. Part of the problem at present is that once an issue reaches particular points, such as referral for investigation or to a panel, then it is difficult for the situation to be reversed.

Q10: Do you agree that the PSA's standards should place less emphasis on the fitness to practise performance?

The PSA's standards of good regulation have an important role in assuring the quality of regulation, however, there is currently an imbalance between fitness to practise and other areas of regulatory activity, as well as insufficient attention paid to areas such as governance and the sharing of best practice among regulators. There are currently 24 standards in total, with 10 of those related to fitness to practise. In addition, of the 42 categories of data collected by the PSA quarterly and annually, 27 relate to fitness to practise.

This focus, particularly on fitness to practise data, has the effect of skewing the behaviours of regulators and can lead to unintended consequences. For example, the focus on the timeliness of fitness to practise investigations may be antipathetic to quality of outcomes or a desire to reduce overall numbers of complaints (described variously as 'supporting professionalism' or 'upstream' regulation). Speed of resolution, while important, should not of itself be taken to imply effective regulation.

In assessing the standards of regulation, there needs to be an acknowledgement of the tension between the three objectives of regulators (as laid down in the *Health and Social Care (Safety and Quality) Act 2015*):

a. to protect, promote and maintain the health, safety and well-being of the public

b. to promote and maintain public confidence in the professions regulated under this Act

c. to promote and maintain proper professional standards and conduct for members of those professions

and the four main statutory functions of regulators variously described in legislation and reviewed by the PSA.

How a regulator exercises those statutory functions is a necessary but not sufficient part of how it meets its objectives. What the PSA's Performance Review does not do at present is assess how a regulator is performing against those objectives rather than against the four functions. However, we recognise that recent proposals for change perhaps could support such a model in future.

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

Yes, but we believe that the PSA should consider alternative approaches that would not require the review of all cases submitted by the regulators.

The approach taken by the PSA at present appears to be based on an outdated presumption that regulators do not share the same objectives as the PSA in ensuring effective prosecution and adjudication of cases, and does not, in our eyes, meet the principles of right-touch regulation. Since the introduction of these powers, significant change has taken place in regulation including the separation of regulators' councils from fitness to practise decision-making, and following the *Health and Social Care (Quality and Safety Act) 2015* the introduction of shared objectives for all the regulators and the PSA.

We believe it would be possible to develop a model in which regulators work in partnership with the PSA with a duty to refer those cases about which they have residual concerns, with appropriate audit/sampling of other cases by the PSA. We note in this regard that while the PSA was concerned that the General Medical Council should not be given power to appeal Medical Practitioner Tribunal Service cases, it has chosen to do so on more occasions than the PSA itself. This suggests to us that an alternative to the current arrangements could be equally or more effective.

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

We endorse the Government's view that regulators should play a role in supporting registrants to meet and retain professional standards. This has been our stance as a regulator for a number of years.

We also welcome the Government's reaffirmation of the principle set out in *Trust Assurance and Safety* that regulation is about sustaining and improving the practice of the majority as much as addressing the poor practice of the minority.

We think it is important that the term 'supporting professionalism' is not interpreted too narrowly and applied to matters of personal behaviour and ethics, rather than the whole breadth of standards of professional practice. We also believe that it is important to avoid the trap of thinking that the solutions in this area can be found primarily through improvements in initial education and training. Our research (and that of others) suggests that compliance with standards tails off over time and that it

is actually those who are mid to late-career who appear to be most at risk of complaints or concerns being raised against them

With the introduction across the regulators of regular assessments of continuing fitness to practise (in one form or another), the regulatory gap in this area is in the ongoing implementation of standards. There appears to have been a long-held assumption that publication and dissemination of standards is sufficient for their adoption in practice, while evidence from fitness to practise complaints suggests otherwise. In addition, as identified in the GOsC's research (and embodied in its new CPD scheme) and by the PSA in *Right-touch reform*[3], providing appropriate 'formative spaces' for registrants to be able to reflect on practice can play an important role in promoting high standards.

This regulatory gap requires regulators to undertake a range of activities, some of which may apply across a profession and others of which will be targeted in higher risk areas or practice, specific groups of individuals or practice contexts. To be effective this work is likely to need to be undertaken by the regulator but in partnership with professional bodies, patients and others. The types of approach that seem most likely to be effective are those that result in the highest levels of engagement from individual practitioners because they can easily see the relevance and benefits of their personal participation.

This type of activity is now being explored by the majority of regulators, the work of the General Dental Council in this area set out in their report *Shifting the balance*[4] exemplifies this approach. It would be helpful for the Department of Health (England) to go one step further and endorse these efforts by the regulators to change the course of current regulatory activity.

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

Our experience is that cooperation between regulators is more widespread and more effective than is often recognised. The challenges in developing further areas of cooperation arise for a number of reasons; in our experience these are often one or more of the following:

- differences or inconsistencies in legislation (primary and secondary)
- differences in corporate priorities
- differences in contexts between professions
- challenges of implementing effective governance arrangements

[3] www.professionalstandards.org.uk/docs/default-source/publications/thought-paper/right-touch-reform-2017.pdf?sfvrsn=5

[4] www.gdc-uk.org/api/files/Shifting%20the%20Balance.pdf

- costs (as the argument that collaborative working is automatically cheaper is not always borne out in practice, for example the experience of trying to establish the independent Office of the Health Professions Adjudicator).

As a smaller regulator, we welcome opportunities to collaborate and are often grateful for the practical support that we are given by others. Equally, we have sought to be open in our approach to collaboration, for example we are currently undertaking standards-related projects with both the General Dental and General Chiropractic Councils.

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

The four examples for joint working exhibit a number of the challenges identified above.

We would be concerned at some of the suggestions on cost grounds. For example, our preliminary analysis is that the cost per hearing day for the MPTS is higher than our own current hearing costs. We are also aware that elsewhere in the public sector, the National Audit Office has identified that savings gained from shared services are lower than anticipated following considerable additional investment.

It is also important to be clear on purpose around joint projects. A shared online register has already been explored jointly by the regulators, including a detailed analysis of IT requirements. However, it was not clear from that analysis that there would be any significant benefit to patient protection from such a project.

We are more attracted to the development of common standards but have found from experience in working on projects around the duty of candour and conflicts of interest, that problems often arise from differences in the context in which the standards apply. The challenge here is ensuring that the necessary compromises and accommodations required for generic documents, do not undermine the underlying purpose of the standards themselves. We have also found that perhaps more helpful than standards, is the learning resources and case examples to show how these apply to practice.

Q15: Do you agree that data sharing between healthcare regulators including systems regulators could help identify potential harm earlier?

We agree that data sharing between regulators can be helpful. However, in our experience, effective joint working is less about the procedural aspects of data sharing (including ensuring meeting information governance requirements), and more about effective interaction between people.

In the same way, memoranda of understanding between organisations do not of themselves guarantee effective joint working. This comes about through a common understanding of objectives, a corporately-driven presumption towards collaboration

and, often, informal positive interactions between individuals. All of these are more important components of success than formal documented agreements or statutory duties of collaboration.

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

Yes, we agree that this is essential to more effective regulation. However, we are concerned that the identified goal is only seen as being reachable following new primary legislation covering all of the regulators.

While some changes would require amendments to primary legislation, aspects of reform could take place immediately within the existing system to make it operate more effectively. For example, there are a number of minor uncontentious rule changes that would improve our procedures and which currently require input from Department of Health policy officials and legal advisers (a simple example would be our desire to appoint more fitness to practise committee members, numbers of which are currently contained in secondary legislation). We believe that these could be developed and implemented with much less 'hands-on' involvement from the Department. We would welcome discussion with the Department about how this might be done, including appropriate risk management arrangements.

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

We think that improved accountability of the regulators to all four parliaments and assemblies would be welcome. A good starting point would be the implementation of consistent and effective arrangements in the UK Parliament on which others could build.

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

Our starting point for any governance arrangement has to be that it is effective in ensuring that the operation of the regulator is to a high standard and it is meeting its statutory objectives. The structure of the board itself is of less importance.

Since 2016, the GOsC has operated with a Council of ten members and this arrangement has worked effectively. It is also the case that for many years, the senior management team of the GOsC has sat at the table with Council members taking part in all aspects of the meeting apart from formal decision making.

Our concern about unitary boards is their perceived legitimacy in the eyes of those they seek to regulate. While it has been entirely correct to remove the elected and representational memberships of Councils, it is important that their continued legitimacy is not undermined. Legitimacy appeared to be a key component of the acceptability of regulation identified by Quick (2011) in a literature review for the

PSA[5], and with only minimal participation from registrants under unitary arrangements this legitimacy could be undermined.

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

In some regulators the views of employers will be of considerable importance, in others less so. For example, only a very small proportion of osteopaths work in or under contract to the NHS, and there are only a small number of larger group osteopathic practices. However, we agree that it is important that graduates are fit for purpose for the roles they undertake.

It is perhaps counterintuitive and perhaps unnecessary to seek to include a representative voice for employers within regulators' Councils, rather than focus on the skills and competencies required for good governance and any specific requirements relating to the professions being regulated. What is more important is for regulators and their Councils to be able to demonstrate that the views of a range of relevant employers have been involved in the development of standards or considered and incorporated in their work depending on the context.

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?

In response to question 10, we identified the different challenge of achieving statutory objectives solely through the exercise of defined statutory duties. This question highlights this challenge, as the requirements for 'producing' or 'sustaining' fit to practise and fit for purpose professionals may be quite different and vary over time, and not fit neatly within the four key functions as normally defined.

In particular, maintaining 'fit for purpose' professionals requires an ongoing appreciation of the evolving needs of the healthcare economy and how individuals can and do expand their repertoire of skills over the course of their career to meet the needs of patients and the other healthcare professionals involved in patient care. This is a challenge for regulators who are focused primarily on setting and maintaining the standards expected of new graduates for a particular profession.

We would argue that the key way in which regulators should address such a requirement is through their regularly updated corporate strategies, rather than a new requirement. Legislation suggests these should be laid before Parliament by the Privy Council but it is not clear that this happens and perhaps needs to be considered alongside any revisions to accountability arrangements. We would welcome further interest from Parliament on behalf of the public in relation to the work we undertake to uphold patient safety, and hope that the governments will seek to encourage an enhanced level of scrutiny.

[5] www.professionalstandards.org.uk/docs/default-source/publications/research-paper/study-on-the-effects-of-health-professional-regulation-on-those-regulated-2011.pdf

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 reinvested?

All regulators should consider themselves to be under a duty to make proper use of their resources which derive primarily form the individuals that they regulate. In the period following the publication of *Enabling Excellence* we made significant savings and reduced our headline registration fee for registrants by 24%.

We agree with the analysis that greater consideration of the 'upstream' role of regulators and greater efforts to promote professionalism may generate potential savings. However, until this approach has been explored, developed, tested and implemented it can not be guaranteed that sufficient savings will be made to reduce fees. The number of concerns raised with regulators continues to grow and there may be factors that mean that all that can be achieved through upstream efforts is a slowing in this growth rather than any reversal.

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

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

Please explain your answer and provide an estimate of impact if possible.

Broadly we agree with the high-level impact assessment set out in the table. However, other than concerns we have raised within the main response, we can not provide any further clarity around costs and benefits at this stage.

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

It may be possible to identify and measure both quantitative and qualitative benefits arising from changes in the approach to regulation. However, it is important that this is not done in a way that simply removes from the system a requirement to consider particular types of concerns, rather than reducing the incidence of such concerns.

One area that would be helpful for regulators to consider collectively is an approach to impact reporting (already a requirement of a sort for those regulators that are registered charities). This would enable public protection and patient safety benefits to be assessed.

Q24: Do you think that any of the proposals would help achieve any of the following aims:

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

- **Advancing equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it?**

- **Fostering good relations between persons who share a relevant 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 should be changed so that they would help achieve those aims?

At this stage we have not identified any impacts – positive or negative – of this nature.