ANNEX ONE

Stakeholder Responses to the GOC Consultation on the Education Strategic Review 2017

Note: All comments are verbatim i.e. any spelling mistakes or typographical errors have not been corrected.

ABDO (The Association of British Dispensing Opticians)

The Association of British Dispensing Opticians (ABDO) represents over 5,900 qualified dispensing opticians in the UK who are registered with and regulated by the General Optical Council (GOC). Only dispensing opticians registered with the GOC can practice in the UK, or use the protected title 'dispensing optician'.

All registered dispensing opticians have undergone a minimum of three years academic and practical training to qualify. ABDO are very proud that their FBDO members have had their qualification recognised as a Level 6 qualification on the National Framework of Qualifications by The Office **of Qualifications and Examinations Regulation (Ofqual**).

Changes in demand and the impact of changes in eye care delivery

Consultation question 1 – How might the needs of patients requiring eye care change over the next 20 years?

It is widely reported that due to the ageing population of the UK [1] demand for eye care will naturally be increased and these patients will probably present with a range of needs due to possibly living with multiple conditions. Enhanced services will primarily include low vision assessment and management, treatment of minor eye conditions (MECS) and monitoring of patients with a range of eye diseases.

Patients will require services offered in the community that could easily be delivered by Dispensing Opticians and Contact Lens Opticians. These eye care professionals are suitably qualified and have the time and relationship with their patients to focus on prevention as well as assessment, monitoring and treatment of eye conditions. This would dramatically reduce waiting times for appointments as well as monitoring conditions more effectively due to a greater number of patients being seen more frequently, easing the burden on Optometrists chair-time, General Practitioner (GP) surgeries as well as the Hospital Eye Service (HES).Benefits to the patient would consist of waiting times being reduced, a more familiar, convenient environment especially for those with mobility issues, reduction of repeat testing at referral appointments, access to a more complete eye care package and hence improved compliance.

Communication skills would need to be exemplary as many of these patients may also have impaired hearing or cognitive impairment such as dementia. Approaching the eye health needs of the patient in a more holistic manner means a range of vision-related services could also be offered such as nutrition advice, smoking cessation, falls prevention advice, protective eyewear, and daily living aids.

In addition to the ageing population, we also need to address the impact of technology and the changing environment for our younger patients. A full pre-school screening programme delivered in the community[2] would allow all children to have the ability to develop and learn without falling behind due to undetected poor vision[5] Myopia prevalence is reported to be increasing [3] and research findings into controlling myopia[4] should be adopted into more evidence-based practice from Optometrists, Contact Lens Opticians and Dispensing Opticians. Fitting spectacles effectively is of paramount importance for ensuring the child receives the full intended prescription or intervention at such a crucial stage in their development.

Education in eye protection for all patients, such as UV protection, home improvement/gardening risks and sports protection[5]/correction may help prevent ocular injury and trauma whilst opening up access to safer sports and activities for all ages and abilities.

Technology is driving spectacle lens design to maximise all areas of vision in the form of bespoke products. To individualise a spectacle lens, many measurements have to be taken into account relating to exactly where the frame is positioned on the patient's face. This is where Dispensing Opticians are embracing the technology driving forward but also have the knowledge to understand why a patient may not be suitable for, or tolerant of a particular product, for example, mobility or binocular vision issues and therefore will advise accordingly. Of course, with such detailed measurements, the final fit of the frame, performed by a Dispensing Optician, is pivotal to patient satisfaction.

Consultation question 2 – What changes in how and where eye care is provided will be required over the next 20 years in order to meet patient's needs, and what are the barriers to these changes?

In order to deliver a more holistic approach to eye care, more emphasis will need to be placed on eye care professionals working within a multi-disciplinary team[6]. The idea is to offer a more joined-up service so that valuable time and resources are utilised efficiently and therefore the patient will benefit from a reduced total number of appointments, shorter waiting times and access to faster treatment. With this approach it is much easier to individualise recommendations for eyewear based on the whole picture of both the patient's visual needs and lifestyle.

Minor Eye Conditions should be dealt with at practice level as it is more convenient and efficient for patients[7], as such the practice should be the first port of call for any vision-related concerns. Barriers to this would be educating the public about the range of services that can be offered at practice level in order to relieve the burden on HES, GP and A&E departments.

Dispensing Opticians are well-placed to deliver low vision assessment[8] and management, clinics in practice where further imaging or screening could easily be shared with ophthalmology, for example. Practical refraction could routinely be performed by multiple Dispensing Opticians in conjunction with an optometrist who may also be an Independent Prescriber and therefore the patient has access to, not only a complete eye health check, but an enhanced service if required within the practice. Within the normal cycle of a full eye examination, Dispensing Opticians could check the refraction to ensure the patient has their very latest correction prior to dispensing, but also have the knowledge and skill to detect issues and refer as appropriate.

All children should be dispensed by a suitably-competent GOC registrant as an effective intervention is so critical to their development in every sense. Once the prescription has been established, the prescription or intervention is negated if the child peers over the top of their ill-fitting spectacles. This discipline has already been singled out and enhanced as a dispensing competency[8] and this would need to be included at the same level for all registrants training in order to deliver effective eye care to children.

Excellent communication skills and standards of practice are going to be of paramount importance, especially when dealing with vulnerable adults[9] and children, for example, dementia, hearing impairment, mental health and behavioural issues, and therefore ABDO would like to see this entire group protected by re-regulating the dispensing process.

Community-based eye care services not only reduce the pressure on HES but are much more convenient to the patients and compliance in terms of regular attendance is much more likely. This could be in-practice or indeed in the patient's home environment if required.

Barriers are likely to be educating all eye care practitioners in overlap of roles and where resources can be shared for improved patient care, and encouraging practitioners to embrace these changes. How the information is shared securely and outside of the NHS infrastructure and funding decisions by commissioners for enhanced services needs to be considered carefully. Time with the patient could be seen as a barrier for some practices which is why the Dispensing Optician's skills need to be more fully utilised within the practice.

Career progression should be encouraged by creating a fluent pathway covering the whole profession of eye care. This would require a fair and consistent approach to accrediting prior learning and experience which should be placed at the discretion of the teaching institutes.

The current GOC Core Competencies would also be a barrier to these changes as they are too restrictive and prescriptive in their application to the changing practice model, and therefore would need extensive modification or a more holistic method devised, such as Continuous Professional Development (CPD)

Consultation question 3 - How are the roles of optometrists and dispensing opticians likely to change over the next 20 years, and what are the drivers for these changes?

The expansion of MECS and enhanced services in the community will mean fully utilising existing skills and offering a more direct healthcare service. A change in focus will be required on more traditional roles in order to embrace technology and less reliance on product sales. Optometrists should be encouraged to qualify as Independent Prescribers in order to deliver a wider range of services at home or the practice environment, and a closer link to ophthalmology established in terms of community eye care.
Dispensing Opticians are currently competent to deliver low vision services, paediatric dispensing (and dispensing to vulnerable adults), bespoke eyewear, referrals and give related eye-health advice. However, it is recognised that these skills may be currently underutilised post-qualification and therefore confidence may be lower for certain patient groups. Demand for these services will rise and in addition, practical refraction could be delegated more as technology advances. By using dispensing registrants to perform refraction, the capability to interpret results will only serve to protect the public, as the skills to refer where necessary will be utilised.

Consultation question 4 – How should the education of optometrists and dispensing opticians be structured to enable continuing professional development throughout their careers, e.g. core training followed by general or specialist practice?

Distance learning to encourage more clinical practice will undoubtedly make for better practitioners who then have experience of dealing with a diverse range of patients at the time of registration. This could be delivered by educational establishments working in partnership with optical practices and also encouraging a more diverse range of summer placements.
Interest in specialist practice could then be determined earlier and extra modules selected to learn alongside core training. Modular and flexible learning would enable a cross-over of shared inter-professional modules, delivered by appropriate professionals experienced in that field.

The Core Competencies need extensive review, or replaced with a system more flexible in order to relate to modern practice and be the definitive entry-level to the register and registrant CET. Specialist branches should be then encouraged for further education and speciality registration and this would form the basis of CPD to ensure the registrant remains ahead in their chosen specialist field.

Consultation question 5 – What are the implications for the GOC register of likely changes in roles and will the existing distinctions between registrant groups remains appropriate?

The register should reflect the skills of the registrant and be worded in simple terms in order for the public to be able to search for a specialist, in a particular location. The main distinctions need to be those offering eye examinations, contact lens services and dispensing services. Ideally, there would then be a GOC-approved sub-list for the specialist qualifications that those registrants hold, especially in terms of low vision, paediatric, MECS accredited and independent prescribers, for example.
The register should be promoted to the public as a resource tool in order to find the services they require locally with the assurance associated with the regulator.

GOC's approach to education

Consultation question 6 – What are your views on the GOC's approach to the accreditation and quality assurance of education programmes, including on whether this is an appropriate focus on outcomes and on the use of the competency model to set the standards of education?

A greater freedom by academic institutes should enable those applying to be selected based on their previous experience, commitment, emotional intelligence and communication skills as well as academic ability.

The accreditation visits need to be far more consistent and representative of panel members who are expert in that particular area. Too much emphasis is placed on the competency itself by the visitors and little attention is given to the importance of background knowledge and fundamental basic clinical skill.
There does need to be a definition of entry-level skills to the register but these would need serious debate in order to ensure some degree of academic freedom in terms of delivery and assessment, and a more flexible system of review to allow for changes reflecting modern practice.

Consultation question 7 – Should the GOC accredit and quality assure additional or different higher qualifications and if so, on what basis?

Yes, if the register is to show speciality then the GOC should accredit qualifications that appear. Current higher qualifications vary dramatically in terms of course length and delivery, clinical experience and assessment. This would serve only to confuse the general public if registrants appear on a speciality register that the regulator has not overseen, and put the public at risk as the variation in quality would be immense.

Content of education programmes

Consultation question 8 – What are the core skills, knowledge and behaviours which optometrists will need to have on first joining the register in the future?

An ability to enquire and acquire new skills as their career progresses, changing attitudes to post-registration learning and encouraging flexibility to meet demand.

Increased range of communication skills gained from increased exposure to clinical practice and an awareness and understanding of all the different roles in optical practice. Exposure to independent prescribing and shared care programmes.

For those entering practice with a requirement or desire to dispense spectacles, especially to children and low vision patients, a speciality module should be available. Similarly, a speciality module for contact lens practice that equates to the current standards and experience required for Contact Lens Opticians.

Consultation question 9 – How should the content and delivery of optometry programmes change to ensure that students gain the skills, knowledge and behaviours that they will require for practice and for new roles in the future?

More emphasis on clinical experience and communication skills which can only be gained by increasing clinic time and exposure to patients earlier in the programme.

In order to have sufficient room in the programme for shared care and enhanced service delivery, remove contact lenses and dispensing from the core programme and have post-registration modules for those who require these skills.

Consultation question 10 – How might post-registration training and registrable higher qualifications for optometrists need to change in the future?

Dispensing and contact lens courses for those wishing to practice regularly in these areas and this will include CPD to ensure the skills are not only utilised but practice is kept up to date. Specialist training should be completed in order to become a supervisor of trainees, and the type of trainee needs to be relevant to the skills of the optometrist. A wider and deeper involvement in current HES eye care.

Consultation question 11 – What are the core skills, knowledge and behaviours which dispensing opticians will need to have on joining the register in the future?

An ability to enquire and acquire new skills as their career progresses, changing attitudes to post-registration learning and encouraging flexibility to meet demand.

Experience gained in domiciliary work and working with vulnerable patients. More confidence in low vision abilities by increasing practical experience. Increased exposure to practical refraction skills, clinical screening and imaging technology during training. An understanding of evidence-based practice and how to analyse, interpret and problem-solve which are key to successful dispensing and reflect key skills only achieved at Level 6.

Consultation question 12 – How should the content of dispensing programmes change to ensure that students gain the skills, knowledge and behaviours that they will require for practice and for new roles in the future?

Increased clinical exposure lends itself very well to a distance-learning environment as long as supervision is adequate and appropriate. More emphasis on low vision and paediatric clinical experience during training with a link to HES and orthoptics.

MECS training would also need to be included with hands-on experience.

Consultation question 13 – How might post-registration training and registrable higher qualifications for dispensing opticians need to change in the future?

Core registerable Dispensing Optician skills as now – adequately trained and assessed to manage all patients including low vision patients and paediatric dispensing.

Specialist qualifications - to encourage those with an interest in these areas and keep them up to date with current practice via CPD in the areas they practice in. These will include higher qualifications in low vision, paediatric dispensing, practical refraction, research skills, diabetic screening, vision screening, MECS, refractive surgery care, dry eye management, supervising trainees, and contact lens qualifications.

Professionalism and consistent standards

Consultation question 14 – How can we ensure students have the professionalism needed to take on new roles, including through the admissions procedures used by education providers, patient experience, supervision and embedding professional standards?

Students need to have good communication skills on entry to courses and it should be encouraged for prospective students to gain as much practice experience as possible prior to and during their course. The concept of professional conduct and standards needs to be introduced early and fully understood by the student, especially the correct application of the standards and potential consequences if not adhered to.

Knowledge of and application of professional standards needs to be assessed more robustly with more freedom on method of assessment. Assessment in the form of solving a problem as then the correct application and proof of understanding can be assured.

The minimum hours and completion of the portfolio are useful tools in controlling the amount and type of clinical work, and also it shows an auditable level of supervision which is key to determining the level of training support. More than one supervisor is a favourable approach as different skill sets could then be accessed by the student.

Supervisors must undertake to deliver an appropriate level of supervision and support for their students as well as being suitably qualified to take on such a role. ABDO would encourage recognised and accredited supervisor courses which would lend themselves well to CPD and therefore raise the standards of the supervision experience. We would also seek to broaden the experience as much as possible by encouraging placements and specialist supervision in a wide range of environments.

Consultation question 15 – How should students be assessed prior to joining the register to ensure that there are consistent and appropriate standards of education, taking into account the different types of education programmes that are emerging?

Consistency can only be gained by an **external awarding body** delivering the same fair and rigorous assessment to all seeking registration. Appropriate assessments should be delivered that are as true to real-life practice as possible, pre-approved and monitored by the GOC. Allowing internal only assessments will encourage a ‘teach to test’ environment which can only be detrimental to the profession.

As the role of a Dispensing Optician is often used to solve clinical problems, there needs to be a greater emphasis on analytical skills and exposure to different problem-solving clinical scenarios. A more evidence-based approach to practice should be encouraged and the skills to analyse and critique research are therefore required. On that basis ABDO would like to see the GOC recognise this skill as vital for the best interests of the patient and therefore acknowledge that Level 6 is the correct level on the national framework for this qualification.

Barriers to change and other issues to consider

Consultation question 16 – What are the challenges and barriers to improving the system of optical education, including issues that may be outside the remit and control of the GOC, such as legislative change, workforce planning, the funding of education (including higher education, continuing education and training and continuing professional development) and the provision of student placements?

ABDO would welcome and support shared modules across the profession as a more integrated approach, this would solve many issues and create the more holistic approach we all appear to aspire to.

Common modules could be shared and specialist qualifications could be offered by the relevant body for all eye care professionals which would avoid duplication and make the process of accrediting prior learning much clearer. This may involve eye care professionals and organisations that fall outside of the remit of the GOC but that should not be a barrier for the willingness to integrate.

ABDO would wholly support the GOC in a review of the Optician's Act which is long overdue but would need urgent attention in order to allow the profession to evolve and improve our service to patients.

Funding for CET needs to be available for all and include supervision of trainees.

Consultation question 17 – Are there any other issues that we should consider in carrying out our review? If so, please set out what they are.

In order to protect the public there are categories of patients that should be considered as being a regulated function apart from paediatrics and low vision patients. These should include those patients most at risk of not receiving the very best in eye care, such as those classed as vulnerable, those with a high prescription, for example, over a +/-5.00D where the fitting and measuring process is absolutely critical to ensure clear vision. Protective eyewear, sports appliances and special optical appliance dispensing should also be a regulated function as the fitting and advice that accompanies this process should be delivered by a properly trained and competent registrant in order to properly protect the general public.

References

1. Office for National Statistics (2016) Population Estimates for UK, England and Wales, Scotland and Northern Ireland: mid-2015. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/bulletins/annualmidyearpopulationestimates/mid2015 (Accessed: January 18th 2017)

2. Toufeeq, A. Oram, A.J. (2014) 'School-entry vision screening in the United Kingdom: practical aspects and outcomes' *Ophthalmic Epidemiology,* 21(4) pp.210-216. Available at: http://www.tandfonline.com.openathensproxy.aston.ac.uk/doi/full/10.3109/09286586.2014.906627 (Accessed: January 25th 2017)
3. Holden, B. Fricke, T. Wilson, D. Jong, M. Naidoo, K. Sankaridurg, P. Wong, T. Naduvilath, T. Resnikoff, S. (2016) 'Global Prevalence of Myopia and High Myopia and Temporal Trends from 2000 to 2050' *American Academy of Ophthalmology*, 123 pp.1036-1042. Available at: http://www.aaojournal.org/article/S0161-6420(16)00025-7/pdf (Accessed: January 18th 2017)
4. Gifford, K. (2016) 'Evidence base for myopia control', *Optometry Today*, 6, p. 79.
5. Hoskin, A. Yardley, A. Hanman, K. Lam, G. Mackey, D. (2016) 'Sports-related eye and adnexal injuries in the Western Australian paediatric population' *Acta Ophthalmologica,* 6 p.407. Available at: http://onlinelibrary.wiley.com.openathensproxy.aston.ac.uk/doi/10.1111/aos.12911/epdf (Accessed January 19th 2017)
6. Clinical Council for Eye Health Commissioning (2015) Community Ophthalmology Framework. Available at: https://www.rcophth.ac.uk/wp-content/uploads/2015/07/Community-Ophthalmology-Framework.pdf (Accessed: January 18th 2017)
7. Baker, H. Harper, R.A. Edgar, D.F. Lawrenson, J.G. (2016) 'Multistakeholder perspectives of locally commissioned enhanced optometric services' *BMJ* Open 2016; 6: e011934. doi:10.1136/ bmjopen-2016-011934 Available at: http://bmjopen.bmj.com/content/6/10/e011934.info (Accessed Feb 8th 2017)
8. General Optical Council (2011) *2011 Dispensing Optics Core Competencies.* Available at: https://www.optical.org/en/Education/core-competencies--core-curricula/index.cfm (Accessed Feb 8th 2017)
9. Department of Health (2011) *Safeguarding Adults: the Role of Health Service Practitioners.* Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215714/dh_125233.pdf (Accessed Feb 9th 2017)

- END -

AIO (Association for Independent Optometrists and Dispensing Opticians)

The AIO Council responds to the Consultation as shown below:

Undergraduate study:

The principle issue is the sheer number of students being enrolled by university departments. There is an over-supply rapidly approaching. (Aston alone enrolled over 150 this year!) This means less time is spent with each student and the one-to-one interaction is nearly absent. There should be a fixed ratio of teaching staff to students if an upper limit isn't set on the number of students enrolled.

- Students need to be aware of their own responsibilities to the public (particularly in relation to the above statement) and they should not give in to unethical business practice such as conversion rate pressure.
- A certain percentage of (if not all!) teaching staff should spend time in 'real world' practice concurrently with any university work, so that they keep up to date with patient interaction. (Possibly an academic alternative to the CET scheme, where they have to log a certain number of hours working in practice outside the university clinics)
- Grading should be more rigorous - there is a number of students who just shouldn't be making the grade (as harsh as that sounds)
- Time should be spent by students in varied practice, both to improve student communication skills and to give them practical experience of the roles within a practice (optical assistants, receptionists etc.,), as well as different working environments.
- More time should be spent on the clinical tools used in practice, including OCT and retinal photography - particularly the students actually acquiring the images, not just interpreting.
- To improve awareness of optometric research, optometry students should sit a compulsory number of research hours like Psychology students have to (where the students have to sit for studies being run at the university), in order to both increase interest in research, but also show students in which direction the profession is headed.

Pre-registration scheme:

- Needs major over-haul on the competencies:
  - Procedures such as Goldmann tonometry only have to be performed a minimum of twice during the whole scheme. This is simply not enough times to show proficiency.
  - The number of dispensing cases required is unobtainable without significant difficulty, and simply becomes a numbers exercise. Instead, there should be fewer cases (say 50-100), but each should have a report written up with justifications for why a particular lens was dispensed and why another was not.
- There should be greater penalties for employers putting unnecessary pressure on their pre-regs - e.g. short testing times, conversion pressure etc.,
- The scheme needs to be graded similar to a degree ('Pass', 'Merit', 'Distinction' etc.) to both differentiate the skills shown but also to encourage people to do more than the bare minimum on the course.

Miscellaneous:

Students need to be made aware of business principles more clearly, but with direct reference to an optometric practice. How different models work (e.g. low cost, high volume Vs. high cost low volume etc.,) and importantly that as an optometrist, the student should not give in to excessive pressure, such as conversion rates.

- Students need to be made aware of the different career paths available to them - multiples, independents, domiciliary, hospital etc.,
- Independent prescribing rights should remain as a post graduate additional qualification available only to those that have been practicing as a qualified Optometrist for a minimum of 2 years.

- END -

AOP (Association of Optometrists)

The AOP welcomes the GOC's decision to undertake a review of optical education and its decision to invite evidence from individuals and organisations.

This document responds to the questions in the GOC's call for evidence. However, we also want to step back from those and pose a more strategic challenge.

We believe that the optical practices of tomorrow should be the "GPs of the eyes", providing and being recognized for providing comprehensive community eye care services including refraction, identification of disease, minor eye care services and community follow-up following discharge from secondary care. Also, on the principle of "making every contact count", we see optical practices as playing a wider part in health promotion and public health more generally.

Getting to that point will be influenced by many things other than education, including NHS commissioning decisions and the extent to which the dominant business model can be flexed to make such a change viable. But changes to education are also crucial to this, hence the importance of the GOC's review.

However we would ask the GOC also to consider its own role in relation to education as part of this review.

In common with other regulators the GOC has a role in accrediting institutions to offer training and education for people who will join the GOC register. But the GOC goes further than many other regulators, such as the Health and Care Professions Council and General Pharmaceutical Council, in the level of specified in the competencies that students should demonstrate. We recognise that the competency framework was designed in order to create the greatest possible objectivity and therefore consistency in assessment. It is our view that it has led to a "tick-box" approach to their education among some students and that as a consequence some emerge with a set of skills rather than what is needed: a rounded understanding of how to use those skills in order to make sound decisions with and for their patients based on sound clinical and scientific training. We would ask the GOC, as part of its review, to investigate whether there is anything to be learned from other regulators that have chosen not to be so prescriptive in their approaches.

Process in reaching our response

In reaching our response we have undertaken a number of activities to consult members, representatives and experts. The key milestones were:

- Significant discussion and workshops on the future of education at the AOP's October 2016 Council meeting
- Formation of an expert education review group to formulate the AOP response, with representatives from across the UK and from a range of modes of practice
- Input from members from across the UK to key aspects of the call for evidence through our community forums. We raised awareness of this opportunity to all our members via email and social media
- Full consideration of the AOP response at March 2017 Council

Changes in demand and the impact of changes in eye care delivery

Consultation question 1 – How might the needs of patients requiring eye care change over the next 20 years?

We expect to see an increase in the need for refractive correction across all age groups. Alongside this there will be an increase in eye disease and in the general vulnerability of older patients.

We are going to see a sharp increase in the prevalence of certain eye diseases. The *Foresight Report*[1] predicts that in the 20 year period between 2010 and 2030 AMD will increase by 80%, cataract by 64%, glaucoma by 52%, and diabetic retinopathy by 28%. With the ageing population, there is also going to be an increase in the prevalence of visual impairment. This will mean more demand for low vision services. There could be an increase in technology for these to aid people with visual impairment such as artificial eyes, virtual headsets/specs. More people will be living with one or more long term condition such as diabetes, AMD and dementia.

Also, myopia is on the rise internationally and optometrists will become more and more heavily involved in myopia control.

We may see the demand for ophthalmic surgery rise. The demand for cataract surgery will rise due to the larger numbers of older people. Innovations in refractive surgery will make it more easily accessible for patients. We are currently waiting for the results of trials but optometrists may well be using laser procedures for instance SLT (selective laser trabeculoplasty) and iridotomies as a first line in treatments for glaucomas. There is no reason why in the future specialist optometrists cannot perform these procedures.

As patient access to technology increases, people will increasingly be encouraged to take more responsibility for their own care and prevention of illness. We are likely to see self-monitoring and self-measurement of intraocular pressures. Patients could also be using technology to be able to take their own retinal photos or even carry out OCT for themselves. The role of the healthcare professional may therefore increasingly include using their knowledge and expertise to interpret and treat and support patients who are already self-managing their healthcare. Patients will need expert advice and guidance from registrants on use of available eye health technology.

Consultation question 2 – What changes in how and where eye care is provided will be required over the next 20 years in order to meet patient's needs, and what are the barriers to these changes?

As people live longer and the NHS will deal with more patients with co-morbidities, registrants, and all health professionals, will need to deliver more public health advice and intervention. Optics can play a part in a general shift towards whole population health promotion and disease prevention with an emphasis on healthy living, diet, smoking cessation and alcohol reduction.

More eye care will move from hospital settings into primary care, where it is more convenient for patients and more cost-effective for the NHS. Primary ophthalmic services need to integrate with the NHS "right care" agenda and care needs to become more patient centred. There will be new drug treatments for chronic eye diseases e.g. wet AMD and glaucoma. The recent Royal College of Ophthalmologists report, *The Way Forward*[2] shows that in the future that there will not be enough ophthalmologists to meet demand. It has recognised multi-disciplinary working as key to managing current and future demand in eye disease. Optometrists will need to be involved in delivering this care, both in hospitals and in the community as the prevalence of these conditions increases.

Greater inter-disciplinary working will be needed with good systems of communication; cross-referral and shared records. More health care advice to patients may need to be delivered remotely (virtual care). Patients will increasingly care for their own health and wellbeing with remote support from healthcare professionals.

[1] 2020 Heath (2016). *Foresight Project Report: A discussion of the potential impact of technology on the UK optical sector to 2030*

[2] Royal College of Ophthalmologists (2017) *The Way Forward*.

We will see greater use of technology for diagnosis and analysis, and perhaps the use of big data will increase in future medicines and health management. Technological developments may facilitate more remote and tele-health practice. The optometric role should be taking overarching responsibility for primary eye care, treatment and disease management and we will see more optometrists working in hospitals and in domiciliary care.

We also believe that optometrists will increasingly deliver part of an episode of care rather than a complete 'sight test' or 'eye examination'. Education and regulation need to recognise the optical professional as part of the wider healthcare team, rather than primarily as a tester of sight and issuer of prescriptions.

Barriers

Differences in commissioning across the UK, especially within England, have slowed progress towards more comprehensive community eyecare.

As MECs and other schemes develop they need to cover costs and indeed compete with the dominant optometric business model, which subsidises clinical work through the sale of appliances. The clinical contribution within an optical practice needs to be given its proper value and the business model needs to adjust to reflect that.

The Royal College of Ophthalmologists, as already mentioned, has published guidance based on best practice and innovation in ophthalmology. This practice is not yet comprehensive, although we are confident that others will follow suit and that the recent reduction in the follow-up tariff may encourage a shift in care from acute to community settings. We hope that ophthalmologists will increasingly feel confident in moving work into the community, given appropriate oversight and governance arrangements.

Referral between primary eye care services and to secondary care is made more difficult by the lack of connectivity with NHS IT systems. Also as there are a myriad of NHS IT systems (EMIS, System One etc). There are numerous examples in local health economies (between primary, secondary, community, social care and voluntary sector providers) of different IT systems being additional barriers to effective care for patients.

A further barrier is that patients and other health and social care professionals do not have a full understanding of the evolving roles of eye health professionals. Members of the public still see themselves as customers in relation to optical practices and their visit to an optical practice as a retail experience[3]. There will need to be considerable work done by the sector and regulator to change the public perception.

Consultation question 3 - How are the roles of optometrists and dispensing opticians likely to change over the next 20 years, and what are the drivers for these changes?

Optometry as a profession is well placed to take on an extended role that will include clinical tasks in therapeutics, disease management and some aspects of surgery. There should be greater involvement by registrants in all the components of primary eye care, especially services for minor eye conditions, glaucoma and cataract. This is already starting to take place.

Technology will enable some tasks to become more automated, which could in time be done safely by others, under the supervision of optometrists. We believe that prescribing optical appliances should remain within the optometric role to ensure patient safety, clinical governance and accountability. Likewise in all roles and functions the ultimate responsibility for the patient needs to be clear and rest with an identified individual.

[3] Enventure Research (2016) "Public Perceptions Survey 2016". *General Optical Council*

However we recognise that optometrists and dispensing optician could work increasingly with other eye health professionals including orthoptists, ophthalmologists and ophthalmic nurses. We can see the value of fewer divisions between professional groups. There is already considerable overlap between optometrists and orthoptists.

This should not just extend to eye care professionals but also our other primary care colleagues (GPs, Pharmacists etc). There is a common prescribing competency framework for all independent prescribers (GPs, dentists, nurses, pharmacists etc) which was developed by the Royal Pharmaceutical Society in collaboration with NICE[4]. There is scope for joint education which could facilitate inter-professional working and mutual respect and understanding.

We feel that a greater number of optometrists may also be working in hospitals in the future. There could also be a continuing trend towards more part-time and locum working. This could have a number of implications. If an optometrist's role becomes more clinical, then perhaps the locum role will change and become more like medical locums, who take on placements to cover for holidays, and illness, rather just for a day a week etc. Clinical qualifications will be much more important and relevant certification and experience is vital for these locums.

Drivers for change

There are a number of factors that will be driving these changes over the next 20 years. Hospital eye departments are overburdened and additional ophthalmologists are expensive to train. The evolving eye care needs of an ageing population can only be addressed by widening the role of registrants and moving more services into primary care. The recent work of the Royal College of Ophthalmologists both on a competency framework for non-medical optical professionals[5] and on innovative pathways for the main eye diseases[6] are both important contributions to the debate on this change.

Consultation question 4 – How should the education of optometrists and dispensing opticians be structured to enable continuing professional development throughout their careers, e.g. core training followed by general or specialist practice?

While the evidence is that adults learn more effectively in clinics than in lecture theatres, undergraduates do not generally arrive at university as independent learners, so a variety of approaches is needed.

We believe that a modular education model should be adopted. This would allow increased opportunity for optometrists and dispensing opticians to benefit from joint study alongside other eye health professionals and others where there are elements of a course in common.

Education should be structured so as to provide more flexibility for students to develop specialist interests and prepare for further specialisation after graduation.

Students should be taught to develop skills to allow them to adapt to changing professional requirements during their career. Undergraduate courses should be primarily focused on understanding 'why and to what end tests are done' as this will help practitioners adapt to changes in technology. However, the current stage 1 competency framework seems primarily focused on demonstrating 'how to' rather than understanding 'why and to what end'.

We feel that CET ought to become CPD, in common with many other professions in order to encourage professionals to see it as continually developing their skill base as well as validating their existing one. CPD is about gaining experience and acquiring new skills, not just about maintaining current entry level

[4] The Royal Pharmaceutical Society (2016) *A competency framework for all prescribers*
[5] Royal College of Ophthalmologists (2016) *Ophthalmology common clinical competency framework*
[6] Royal College of Ophthalmologists (2017) *The Way Forward*.

skills. Peer review and discussion is also an important component. The ability critically to analyse evidence and data as well as one's own clinical practice is also key.

Consultation questions 5 – What are the implications for the GOC register of likely changes in roles and will the existing distinctions between registrant groups remain appropriate?

As our answers to the previous questions indicate, we believe that functions rather than titles will become more important in future, although we do expect change to be slow. This may mean that in due course professionals will be registered to carry out a range of skills and functions rather than by a professional label.

One register for all eye health practitioners could act as public reassurance that all professionals are expected to act within their competence. We feel that career progression between professions needs to be reviewed and made more flexible.

GOC's approach to education

Consultation question 6 – What are your views on the GOC's approach to the accreditation and quality assurance of education programmes, including on whether this is an appropriate focus on outcomes and on the use of the competency model to set the standards of education?

We feel that the GOC is too 'input driven'. We would rather see the GOC specify reasonable outcomes. An example of an over reliance on inputs is the implementation of minimum real patient experience requirements. The provider would then be free to use its expertise to get students to satisfy the competencies. Less specificity in the definition of the competency framework would allow it to be better integrated into the undergraduate optometry programme, avoid a 'tick-box' approach and allow a better learning experience to be delivered. The GOC could, for example, define a set of outcomes describing understanding and abilities that a graduate should possess. This approach would enable universities to more easily embed the outcomes in learning modules and not need to 'tick them off'. This would mean that stage 1 (undergraduate) and stage 2 (pre-registration) competencies could also be better differentiated, with a list of specific competencies being more appropriate for stage 2 assessment.

If the option for some registrants to move into a more clinical model of practice exists, then there will need to be more freedom to make clinical decisions. There is a need for a core competency where the basic role is defined but clinical freedom is maintained.

We hope that as its review progresses the GOC will investigate the approach taken by other regulators and adopt a "right-touch" approach, focussed on the need to provide a good learning experience for students and produce professionals who provide a safe, high-quality service to patients. This is the approach to regulation that is recommended by the PSA[7] and is implicit within the Law Commissions' recommendations for healthcare regulation[8].

Consultation question 7 – Should the GOC accredit and quality assure additional or different higher qualifications and if so, on what basis?

We do not believe that the GOC should necessarily be involved in accrediting or quality assuring higher qualifications. These are covered by the service specification negotiated with commissioners which includes quality control.

The College of Optometrists has been successful at getting universities to buy in to its framework of higher qualifications, and this has been good insofar as it has given the same platform for a post-graduate refresher for optometrists providing enhanced services. Development of these qualifications

[7] Professional Standards Authority (2015) *Right touch regulation*

[8] Law Commission (2014) *Regulation of Health Care Professionals*

has been a response to demands in the NHS. It would be difficult for the GOC, in common with other regulators, to respond in a timely way to such evolving needs of the health system.

Greater involvement by the GOC would create confusion and potentially duplication and is unnecessary.

Content of education programmes

Consultation question 8 – What are the core skills, knowledge and behaviours which optometrists will need to have on first joining the register in the future?

The core skills, knowledge and behaviours which optometrists currently need to have on first joining the register are outlined in the current QAA benchmark for optometry[9].

We would broadly describe the education domains needed as prescribing, public health, technology, communication skills, detection and management of pathology, refraction, patient management, decision making and consistency with other health professionals.

We would argue that in the future greater emphasis will need to be placed on the ability of graduates to utilise primary research as an evidence base for practice, and apply this in conjunction with sound clinical skills, a problem-solving approach to clinical care, and the ability to self-reflect and critically analyse. This needs to be done at the same time as maintaining core clinical skills, which are best embedded through practical experience.

Consultation question 9 – How should the content and delivery of optometry programmes change to ensure that students gain the skills, knowledge and behaviours that they will require for practice and for new roles in the future?

As we have explained above, we believe that some elements of common core education in optics and eye health should be provided alongside other eye health professionals in training. We believe that the future optometrist undergraduate degrees should adopt the medical and nursing approach which focuses on general education that allows professionals to develop and work within their own set of competencies.

In our discussions we have found some members advocating much greater amounts of patient contact time in the optometry degree and suggesting that lack of practical experience hampers pre-registration students' effectiveness. The contrary argument is that the pre-registration year is precisely for learning how to use skills learned at university in patient-facing work. In other words there is a lively debate about the correct balance between practical clinical experience and the learning of technical skills and underpinning theory in the undergraduate degree.

In preparing our response we have considered a number of suggestions such as that all optometric undergraduate courses should become 4 year MOptom or even 5 year courses in which the fifth year is the pre-registration year. We have also considered the US model of a Doctor of Optometry. We are not advocating these models at this time as standard, although we do feel that the course length might have to be extended if there is more content to cover and in order to achieve the right balance between theory and practical experience.

We do feel that pre-registration training should cover all aspects of optometry, and that the pre-registration year should cover all modes of practice.

Consultation question 10 – How might post-registration training and registrable higher qualifications for optometrists need to change in the future?

The GOC should ensure that a suitable and widely accessible therapeutics qualification is available for all optometrists as a stepping stone towards the full IP qualification. This could be achieved by making

[9] Quality Assurance Agency. (2015) *Subject benchmark statement. Optometry*

the AS qualification more achievable, although it also needs to have a useful purpose. Placements required for IP should be able to be carried out with suitably qualified IP optometrists, not only with ophthalmologists. We also feel that there is potential for modular education to enable access to specialist roles.

We would argue, however, that IP should not be part of undergraduate education, because there is not enough IP work for such a large number of practitioners to remain current.

Consultation question 11 – What are the core skills, knowledge and behaviours which dispensing opticians will need to have on joining the register in the future?

We have described above our view that there should be elements of common joint study for eye health professionals where possible.

We have also said that while prescribing should remain the responsibility of an optometrist, we think that some other clinical processes could be delegated under the supervision of the optometrist, and with the necessary clinical governance.

Skills in occupational health and rehabilitation will be important to allow registrants to make dispensing decisions for patients with these needs. Given the ageing population and the consequent likely increase in people living with sight impairment, we would like to see the role of Eye Care Liaison Officer (ECLO) added to the core skill set for dispensing opticians. For the same reason, the skills within the existing LVA higher qualification could be added to the set of core skills for dispensing opticians.

Skills and knowledge in the use of highly customisable eyewear are likely to be needed as these devices become more prevalent. This may for example include Computer Aided Design (CAD) to place dispensing opticians as the first port of call for customised eyewear.

We believe that the titles of optometrist and dispensing optician will continue to be used for some time. However, as we have said above, we think that in due course professionals will be registered to carry out functions that they are trained and qualified to do, rather than be defined by their title.

As a separate matter, the process for overseas applicants joining the register should also be improved and simplified, whist ensuring that new registrants are fit and competent to practise.

Consultation question 12 – How should the content of dispensing programmes change to ensure that students gain the skills, knowledge and behaviours that they will require for practice and for new roles in the future?

Practice-based training is an important part of training but there currently exists a great variation in delivery on programmes. The supervision element potentially falls between two groups: the training provider and ABDO as the gateway to entering the register. Better clarity on the role of ABDO in this would be helpful.

More parity across training programme learning outcomes would be welcome across both higher and further education providers.

Components that could be added to dispensing programmes are:

- A placement day with hospitals in low vision units or sight loss charities.
- CAD training
- Counselling and modules for sight loss
- Use of new technology such as auto-refraction, imaging and glazing
- More content on eye disease, both sight threatening and minor eye conditions.

Consultation question 13 – How might post-registration training and registrable higher qualifications for dispensing opticians need to change in the future?

The contact lens specialty qualification training and assessment framework should be reviewed to ensure it meets evolving health system and workforce needs.

Dispensing opticians, in particular CLOs, are starting to be involved in the delivery of enhanced primary eye care services for minor eye conditions. Development of qualifications in diagnostic and investigative techniques, and triage would support their involvement in these schemes. However beyond the CLO qualification these should not be regulated by the GOC, for the same reasons that we stated in relation to optometric qualifications.

Professionalism and consistent standards

Consultation question 14 – How can we ensure students have the professionalism needed to take on new roles, including through the admissions procedures used by education providers, patient experience, supervision and embedding professional standards?

Some elements of professionalism are learnt and it is probably inappropriate to select people on the basis of already possessing them. There may be a case for teaching skills such as leadership, management and communication alongside core competencies to help equip students for the working world. The selection and admissions procedures adopted by education providers should assess students' ability to learn those skills.

If the OSCE system is examining the student, then part of the assessment should be of their approach and professionalism, though we recognise that this is harder to objectively assess than existing core competencies.

Consultation question 15 – How should students be assessed prior to joining the register to ensure that there are consistent and appropriate standards of education, taking into account the different types of education programmes that are emerging?

As we have said before, we believe that the GOC's approach to defining competencies is too detailed and too focussed on inputs. We believe this has led to a "tick-box mentality" among some students.

Assessment should cover the ability of students to synthesise the technical information gained from diagnostic tests with information gained from the patient, in order to make sound decisions with and for the patient.

Barriers to change and other issues to consider

Consultation question 16 – What are the challenges and barriers to improving the system of optical education, including issues that may be outside the remit and control of the GOC, such as legislative change, workforce planning, the funding of education (including higher education, continuing education and training and continuing professional development) and the provision of student placements?

We understand that it is not within the GOC's power to compel institutions to institute changes such as the development of common competency frameworks or joint study programme across professional groups. We are also aware that this would not be an easy change for the institutions themselves. We would however like to see the GOC mandate that some inter-professional education take place as part of the undergraduate programme for optometry students. The GPhC mandates inter-professional study for pharmacy programmes. We are also aware of examples in other parts of healthcare education. For example St George's University in London says "right from the start, students on all our courses learn with, from and about each other. The aim of this inter-professional learning is to reflect the multidisciplinary nature of delivering healthcare today"[10]. We hope that the education review will create a platform for the GOC and educational providers to discuss these ideas, involving other regulators and professional bodies in the discussion as appropriate.

[10] St George's University (2015) *Boost your career*

Consultation question 17 – Are there any other issues that we should consider in carrying out our review? If so, please set out what they are.

We welcome the fact GOC has engaged with stakeholders to this point. We would like to see that continue. The AOP looks forward to continuing this engagement as the review progresses, and after its completion.

- END -

Ashif Dhanani

Consultation question 1
Refraction will become automated. online C/L will be a further risk.Technology and treatment advances will cause further strain on Ophthalmology depts

Consultation question 2
Everything other than eye surgery needs to be community based

Consultation question 3
Optoms will become redundant unless their role changes into primary eye health giver

Consultation question 4
A lot more diagnosis training needs to be given at university. IP needs to be a qualification given upon graduation.

Speciality training lies with speciality practice with the exception of glaucoma as this needs to be moved into the community the training should be community led

Consultation question 5
Yes, changes if things are implemented at degree level so IP is not seperate but then speciality qualifications will need seperate registers.

Consultation question 6
If refraction becomes automated than the competencies need to be rewritten

Consultation question 7
Yes that is what a registrar should be doing

Consultation question 8
As current but with IP, improved diagnostics and glaucome speciality upon qualification

Consultation question 9
4 year course need to have hospital rotations

Consultation question 10
Just more training is going to be needed - evolve Optometry into a primary eyehealth medical course with the exception that surgery is not going to be an option for Optoms

Consultation question 11
Whatever doctors have to do we should be the equivalent

Consultation question 12
You are a registrar either value Do's and so all dispensing should be done by them or you don't which means that you completely deregulate the profession completely

Consultation question 13
AA

Consultation question 14
Common across dentists, GPs and pharmacists

Consultation question 15
More intensive training and experience is required

Consultation question 16

Legislation is the issue

Consultation question 17

GOC needs to workforce plan and also have the courage to limit numbers of courses until a time where there is a shortage of Optoms

- END -

Ashif Dhanani

Barbie Wheatcroft

Consultation question 1
As technology increases people may not need to see an optometrist for a prescription .

Consultation question 2
Screening of eye disease could happen more effectively if there was a pathway from optometry to ophthalmology that was robust and recognised optometrist

Consultation question 3
Optometrists may need to use diagnostic and clinical skills more that refractive techniques

Consultation question 4
Support for training in key areas which benefit the NHS e.g. MECS and diabetic screening

Consultation question 5
Distinction between those having accredited skills would be necessary

Consultation question 6
No idea

Consultation question 7
An independent prescriber has this accreditation recognised so yes

Consultation question 8

Consultation question 9
Better interaction with the ophthalmology pathway so good communications and understanding of skills

Consultation question 10
I do not no

Consultation question 11

Consultation question 12

Consultation question 13
No comment

Consultation question 14
Modelling by supervisors and encouragement of their skill set and interest

Consultation question 15
I do not know

Consultation question 16
Barriers include business of lives and therefore the challenge to be educated to s higher level once out of the student phase Challenge is to convince optometrists that this is necessary to provide a better service to the growing population

Consultation question 17
We need to be better understood by ophthalmologists so that our contribution is valued and skills utilised

- END -

British Contact Lens Association (BCLA) and British Universities Committee of Contact Lens Educators (BUCCLE)

Consultation question 1 – How might the **needs of patients** requiring eye care change over the next 20 years?

1-Well established that we will have an ageing population leading to economic burden. [1]

Visual needs of the changing demographic; visual demands will be greater for a longer period and the population will work for longer.

ECP's will need to correct presbyopia properly.

Low Vision will need to become not just a speciality for the hospital eye service

Ocular Health; in particular, the following conditions will become more prevalent in the aging population; Diabetes, Ocular Surface Disease, Dry Eye, Glaucoma and Cataracts.

Patients will expect availability within their high street to manage these with speciality ECP's

As refraction becomes more automated, the speciality comes in respect of managing any pathology – ability to interpret findings rather than gather them.

2-Prevalence of Myopia Increasing in children. [2]

Parents will expect to find that myopia management will be available by registered ECP's

Training on myopic control will need to be part of core curriculum, along with how to communicate and any risks associated,

Consultation question 2 – What changes in **how and where eye care** is provided will be required over the next 20 years to meet patient's needs, and what are **the barriers to these changes**?

Raise the profile of the Optometrist as the place to go for all eye care needs, NOT the GP or pharmacisy in the first instance. They are not equipped to review ophthalmological cases.
The practice needs to be community focussed, with a high level of advanced instrumentation.

Interdisciplinary/interprofessional services need to be better established.

Instrumentation is key; ensuring that support staff are trained to use the most up to date equipment as a diagnostic and monitoring tool. The skills lie in an optometrist being able to review, consult and guide the pathway for the patient.

Clinical decision making as opposed to prescriptive refraction.

True medical record sharing electronically across the UK is necessary to accompany the automation in consulting rooms.

Optometrists should all introduce a fee based system. GOS is not for an eye examination, but refraction. A funding programme needs to be put in place to divert the little funds that are available for anything other than refraction to be carried out in specialist optometric practice. Integrated pathways will be more common with multidisciplinary working.

Consultation question 3 - How are the roles of optometrists and dispensing opticians likely to change over the next 20 years, and what are the drivers for these changes?

The profession changes will be to support community optometry, based on advanced diagnostic and monitoring information provided by new instrumentation. All practice staff will need to upskill in their ability.
Setting up an optometry led practice with each professional taking a role in refraction, diagnostic measurements and then consulting on these outcomes.
Telemedical communication and services is gaining popularity in the USA, we may need a teleoptical services option for complex/rare cases to be rapidly managed.

Dispensing opticians, in addition to their commercials skills, will need to take the responsibility for many more diagnostic instrumentation measurements, including auto refractors and gain Low Vision training for the ageing population.

CLO; anterior eye specialism and perhaps acting as triage for any pathology cases that visit the practice. The development of anterior eye schemes (or a form of MECS) would be useful, to involve CLO's. Optometrist will need to focus on eye health, consult on outcomes of instrumentation information and devise and manage patient pathway.

Consideration is needed on the number of professionals specialising in key areas such as old age and children.

Drivers; stated in response to Q1;
Ageing Population
Increase in prevalence in Myopia in children
Instrumentation increase and community management of patients
Interprofessional requirements

Consultation question 4 – How should the education of optometrists and dispensing opticians be structured to enable continuing professional development throughout their careers, e.g. core training followed by general or specialist practice?

Two key areas of consideration; training for qualification and then ongoing skills training
Initial training model;
A basic framework with ophthalmic modules at difference academic levels to attain qualifications with students able to stop at any level and then add modules when needed.
EG; Optical Technician, (instrumentation),
Dispensing Optician
Orthoptist
Optometrist
Optometrist IP and other specialisms

Optometrist Specialist areas;
MECS
Diabetes
Glaucoma
Dry Eye

Myopia management
Advanced Therapeutics
Low Vision
Dispensing Specialist Areas
Contact Lenses
Low Vision

Contact lens Optician Specialist Areas
Dry Eye Management
MECS
Myopia Management

Consultation question 5 – What are the implications for the GOC register of likely changes in roles and will the existing distinctions between registrant groups remain appropriate?

There will be a need to be registration listed by competency/specialism level.
Untenable to register students for the future.

Refer to attached model.
Categories could be;
Ophthalmic technician
Optician – with ability to list specialism such as LV & CL
Orthoptist
Optometrist
Specialist Consultant Optometrist in the following areas; Glaucoma, Diabetes, Dry Eye, IP

Consultation question 6 – What are your views on the GOC's approach to the accreditation and quality assurance of education programmes, including on whether this is an appropriate focus on outcomes and on the use of the competency model to set the standards of education?

One of the main responsibilities of the GOC's is public safety. The regulator should base its approach on an Evidence Based model for quality assurance.
It is unclear what makes an ECP unsafe. There needs to be a mechanism in place to ascertain when and how an individual is unsafe and what has been missing in their learning to lead to an error or misjudgement when appearing in front of the GOC hearing panel.

Any review of quality assurance in education establishments need to be in line with the career ladder model and should be based on evidence based review focussed on safety. (see appendix of career model)

There needs to be a process for applications for accreditation in specialist areas, such as Dry Eye, myopia management
The competency framework needs to be able to accommodate new technologies as it develops.
National levels of blindness over a period of years may indicate how well we look after the nation's sight. They are falling currently.[3]

Consultation question 7 – Should the GOC accredit and quality assure additional or different higher qualifications and if so, on what basis?

Where appropriate, for minimising public risk in respect to safety -yes.

However, the GOC are not educational experts.
A working party, per speciality, is required with stakeholders to include experts in the field, consumer groups, research and professional institutions and the patient voice.

Consultation question 8 – What are the core skills, knowledge and behaviours which optometrists will need to have on first joining the register in the future?

Consideration should be focussing on public safety; the GOC remit.
Reviewing what an undergraduate and pre-reg need to equip these newly qualified individuals - should be evidence based on current skills and shortfalls. What are the most frequent GOC Hearing complaints, this should form a basis of this review.
In addition to this, optometrists should enter newly qualified status fully MECS trained including FB removal, red eye management and able to use all therapeutics within clinical management plans. IP should remain a postgraduate specialism to deliver clinical management of conditions beyond clinical management plans within a chosen specialism such as dry eye or glaucoma
Support process for those returning to the profession or those who have gaps in registration due to career changes.

Consultation question 9 – How should the content and delivery of optometry programmes change to ensure that students gain the skills, knowledge and behaviours that they will require for practice and for new roles in the future?

An option for integrated placements

Consultation question 10 – How might post-registration training and registrable higher qualifications for optometrists need to change in the future?

The registration body ensures that the training institute is delivering the competencies required as per the career pathway model.
Retraining will be needed to upskill in the newest technologies as they are discovered. Specialist areas will be added as knowledge advances as well as traditional CPD

Consultation question 11 – What are the core skills, knowledge and behaviours which dispensing opticians will need to have on joining the register in the future?

Refraction, instrumentation, low vision, paediatrics, contact lenses, communication

Consultation question 12 – How should the content of dispensing programmes change to ensure that students gain the skills, knowledge and behaviours that they will require for practice and for new roles in the future?

Based on the career pathway model including refraction, instrumentation,paediatric dispensing and business should be the DO entry level

Consultation question 13 – How might post-registration training and registrable higher qualifications for dispensing opticians need to change in the future?

Based on the career pathway model, refraction and instrumentation and paediatric dispensing should be the basis.
The choice of speciality for a DO will be Low Vision, Contact Lenses or business.
Contact Lens Specialist can then upskill to Dry Eye.
The career pathway model would then enable a DO to move to Orthoptics or Optometry.

Professionalism and consistent standards

Consultation question 14 – How can we ensure students have the professionalism needed to take on new roles, including through the admissions procedures used by education providers, patient experience, supervision and embedding professional
Consider interviewing all potential students as now required in pharmacy and other health professions, regulated by the HCPC.

Consultation question 15 – How should students be assessed prior to joining the register to ensure that there are consistent and appropriate standards of education, considering the different types of education programmes that are emerging?

Students should not be registered with the GOC (no other regulatory body in the UK does this) and indeed the student competency post completion of their degree should not be the GOC's remit unless there is evidence of a safety issue.
The accreditation of the bodies delivering undergraduate education should be enough as their application process will be reviewed when accreditation is awarded.
An option of integrated placements may be an option but this may reduce the intake per year.

Consultation question 16 – What are the challenges and barriers to improving the system of optical education, including issues that may be outside the remit and control of the GOC, such as legislative change, workforce planning, the funding of education (including higher education, continuing education and training and continuing professional development) and the provision of student placements?

There needs to be a process in place to ensure we work collaboratively with other health care providers and promote the work of GOC registration to build public confidence in our profession. We need systems to encourage those with the right behaviours to enter the professional across the UK to ensure the right work force needs.
The career pathway model should guide the right students to reach the right level.

Consultation question 17 – Are there any other issues that we should consider in carrying out our review? If so, please set out what they

Any proposed change to NHS services and commissioning.
There will be a '2 tier' eye exam system, refraction and eye health assessments
It is time to move away from the way we have done things for many years. Education has changed and the service delivery is failing the community we are trying to serve.

References;

1. GBD 2015 DALYs and HALE Collaborators (2016) Global, regional, and national disability-adjusted life-years (DALYs) for 315 diseases and injuries and healthy life expectancy (HALE),

1990-2015: a systematic analysis for the Global Burden of Disease Study 2015. Lancet. 8;388(10053):1603-1658
2. Williams KM, Bertelsen G, Cumberland P, Wolfram C, Verhoeven VJ, Anastasopoulos E, Buitendijk GH, Cougnard-Grégoire A, Creuzot-Garcher C, Erke MG, Hogg R, Höhn R, Hysi P, Khawaja AP, Korobelnik JF, Ried J, Vingerling JR, Bron A, Dartigues JF, Fletcher A, Hofman A, Kuijpers RW, Luben RN, Oxele K, Topouzis F, von Hanno T, Mirshahi A, Foster PJ, van Duijn CM, Pfeiffer N, Delcourt C, Klaver CC, Rahi J, Hammond CJ; European Eye Epidemiology (E(3)) Consortium (2015) Increasing Prevalence of Myopia in Europe and the Impact of Education. Ophthalmology. 122(7):1489-97.
3. Kirtland KA, Saaddine JB, Geiss LS, Thompson TJ, Cotch MF, Lee PP; Centers for Disease Control and Prevention (CDC). (2015) Geographic disparity of severe vision loss - United States, 2009-2013. MMWR Morb Mortal Wkly Rep. 22;64(19):513-7.

- END -

The Brain Tumour Charity

Consultation Questions

CHANGES IN DEMAND AND THE IMPACT OF CHANGES IN EYE CARE DELIVERY

Consultation question 1 – How might the needs of patients requiring eye care change over the next 20 years?

XXX

Consultation question 2 - What changes in how and where eye care is provided will be required over the next 20 years in order to meet patients' needs, and what are the barriers to these changes?

Figures from Cancer Research UK show that the incidence of brain, CNS and other intracranial tumours has increased over the last twenty years(1), with the likelihood that more patients will present to optical professionals with visual signs and symptoms, or other symptoms such as a loss of balance that could suggest a brain tumour.

Better working relationships between optometrists and GPs are required so that any patient presenting to a GP or optometrist with a persistent headache, loss of balance or vision related symptoms will be immediately referred for a scan.

This could be facilitated through shared education training sessions on brain tumour signs and symptoms between the General Optical Council and the Royal College of GPs, or by optometrists working out of GP surgeries to cement a closer working relationship.

Consultation question 3 – How are the roles of optometrists and dispensing opticians are likely to change over the next 20 years, and what are the drivers for these changes?

XXX

Consultation question 4 – How should the education of optometrists and dispensing opticians be structured to enable continuing professional development through their careers, e.g. core training followed by general or specialist practice?

XXX

Consultation question 5 – What are the implications for the GOC register of likely changes in roles and will the existing distinctions between registrant groups remain appropriate?

XXX

GOC's APPROACH TO EDUCATION

Consultation question 6 - What are your views on the GOC's approach to the accreditation and quality assurance of education programmes, including on whether this is an appropriate focus on outcomes and on the use of the competency model to set the standards of education?

XXX

Consultation question 7 - Should the GOC accredit and quality assure additional or different higher qualifications and if so, on what basis?

XXX

CONTENT OF EDUCATION PROGRAMMES

Consultation question 8 - What are the core skills, knowledge and behaviours which optometrists will need to have on first joining the register in the future?

Consultation question 9 - How should the content and delivery of optometry programmes change to ensure that students gain the skills, knowledge and behaviours that they require for practice and new roles in the future?

Consultation question 10 - How might post-registration training and registrable higher qualifications for optometrists need to change for the future?

Consultation question 11 - What are the core skills, knowledge and behaviours which dispensing opticians will need to have on joining the register in the future?

Consultation question 12 - How should the content of dispensing programmes change to ensure that students gain the skills, knowledge and behaviours that they will require for practice and for new roles in the future?

Consultation question 13 - How might post-registration training and registrable higher qualifications for dispensing opticians need to change in future?

Communication

There is a need to provide training to optometrists in soft skills so that they can better communicate with confidence to patients about different neurological conditions like brain tumours.

Anecdotal evidence from optometry conferences that we have recently attended, such as Optometry Tomorrow, suggests there is demand for such training sessions from optometrists.

The Brain Tumour Charity is well placed to provide such training sessions, drawing on materials that we have produced for the HeadSmart campaign such as the Decision Support Tool for healthcare professionals (more information about this is below).

It is crucial that optometrists are given guidance on when they should refer patients, and to which type of healthcare professional if they are concerned by a particular symptom or symptoms.

Technology

HeadSmart is a campaign that raises awareness of the signs and symptoms of brain tumours in children and teenagers. The HeadSmart website has a number of information resources and animations that can be utilised by the General Optical Council to help educate optical students about the signs and symptoms of brain tumours.

Other paper-based resources that can be downloaded online include our Quick Reference Guide and Sub-Specialty Poster. The Sub-Speciality poster for healthcare professionals shows the various signs and symptoms of a brain tumour according to the sub-speciality that may see them, including optometrists and ophthalmologists. These materials can be requested free of charge through the HeadSmart website.

The website also contains a Decision Support Tool which highlights cases of abnormal eye movements and blurred or double vision, and the course of action that is recommended for optometrists or other eye specialists. This tool can also be viewed in a mobile format, which is more accessible for optometrists in an optician store.

Clinical Knowledge

The Optometry Handbook 2015 currently includes one core competency for optometrists around understanding the signs and symptoms of neurological conditions, under the ocular disease section (2):

Assesses symptoms and signs of neurological significance	• Assesses the relevant symptoms and signs • Understands which signs/symptoms could relate to a neurological condition and the follow up information required to make a differential diagnosis • Manages appropriately

However, we believe that this criteria should be expanded to reflect the evidence-based guideline for healthcare professionals that has been produced to underpin the HeadSmart campaign.

The Brain Pathways Guideline to assist healthcare professionals in the assessment of children who may have a brain tumour was initially developed by the Children's Brain Tumour Research Centre at the University of Nottingham in 2008 and was revised in 2016 (3). The HeadSmart campaign is based on this guideline.

The guideline is supported by the Royal College for Paediatrics and Child Health (RCPCH) and outlines the main signs and symptoms that in combination may suggest a brain tumour. One of these sections relates to visual signs and symptoms and is most relevant to the work of an optometrist.

The guideline was comprised following a systematic literature review, looking at 148 studies which described symptoms at diagnosis for children who had an intracranial tumour of any type of location. Unspecified visual or eye signs ranked as the third most common sign/symptom at 10%. (3)

Out of the 68 studies looking specifically at the signs and symptoms at diagnosis for all children with brain tumours, 8% of cases referred to unspecified visual or eye signs.

The visual signs and symptoms identified as part of the research by the University of Nottingham went through a Delphi process, with the following being selected:

- Consider a brain tumour in any child with persistent visual abnormality (present for more than 2 weeks)
- Visual assessment requires assessment of:
    - Visual acuity
    - Eye movements
    - Pupil responses
    - Optic disc appearance
    - Visual fields (>/= 5 years)
- Pre-school and uncooperative children should be assessed by hospital eye service within 2 weeks of referral
- Parent concern alone warrants referral for visual assessment

CNS imaging is required with:

- Papilloedema
- Optic atrophy
- New onset nystagmus
- Reduction in visual acuity not due to reflective error
- Visual field reduction
- Proptosis
- New onset paralytic sprint
- Visual symptom with 1 or more symptom

There is a real imperative to raise awareness of signs and symptoms of brain tumours among optometrists. Last year saw the prosecution of Honey Rose, a locum optometrist who was found guilty of manslaughter after failing to spot abnormalities in the eyes of a boy who later died. The patient, Vincent Barker died in 2012, five months after a routine eye test at Boots Opticians in Ipswich. (4)

This conviction highlights the risk that optometrists could face from gross negligence charges through a missed diagnosis or referral for a scan.

Even where late diagnosis does not lead to reduced survival, brain tumours remain the biggest cause of preventable blindness in children.

Through the HeadSmart campaign, The Brain Tumour Charity has evidence-based resources that can help optometrists to understand and assess the signs and symptoms which may suggest a brain tumour. (5)

We fully recognise that even generalist healthcare professionals like GPs will see very few cases of brain tumour during their career, and so we want to equip eye specialists with the knowledge and confidence to know when to make a referral.

It is all the more important in the case of locums providing temporary cover for optometrists that they have some understanding of complex neurological conditions like brain tumours, and who may not have undertaken the same level of specialist training as other eye specialists.

Common pitfalls identified as part of the research into the HeadSmart campaign include a failure to fully assess vision (which may require a referral if necessary) and a failure of communication between community optometry and primary and secondary care.

PROFESSIONALISM AND CONSISTENT STANDARDS

Consultation question 14 - How can we ensure students have the professionalism needed to take on new roles, including through the admissions procedures used by education providers, patient experience, supervision and embedding professional standards?

XXX

Consultation question 15 - How should students be assessed prior to joining the register to ensure that there are consistent and appropriate standards for education, taking into account the different types of education programmes that are emerging?

XXX

BARRIERS TO CHANGE AND OTHER THINGS TO CONSIDER

Consultation question 16 - What are the challenges and barriers to improving the system of optical education, including issues that may be outside the remit and control of the GOC, such as legislative change, workforce planning, the funding of education (including higher education, continuing education and training and continuing professional development) and the provision of student placements?

XXX

Consultation question 17 - Are there any other issues that we should consider in carrying out our review? If so, please set out what they are.

References

1. Cancer Research UK. Brain, other CNS and intracranial tumours incidence statistics [Internet]. [cited 2015 Apr 7]. Available from: http://www.cancerresearchuk.org/health-professional/cancer-statistics/statistics-by-cancer-type/brain-other-cns-and-intracranial-tumours/incidence
2. General Optical Council. Accreditation and Quality Assurance Handbook: Routes to Registration in Optometry [Internet]. 2015. Available from: https://www.optical.org/download.cfm?docid=585C9509-2C54-4AAF-B282C47C3868453D
3. Children's Brain Tumour Research Centre, University of Nottingham. The Brain Pathways Guideline: Guideline to assist healthcare professionals in the asseessment of children who may have a brain tumour [Internet]. 2016 Oct. Report No.: Version 2. Available from: https://assets.headsmart.org.uk/live/media/filer_public/25/fc/25fc6308-1bd3-4b2a-8a7c-d705ca7166e7/brain_pathways_guidelines_v2_rcpch.pdf
4. Press Association. Optometrist who missed swelling in boy's brain guilty of manslaughter [Internet]. The Guardian. 2016. Available from: https://www.theguardian.com/uk-news/2016/jul/15/optometrist-honey-rose-guilty-manslaughter-negligence-vinnie-barker-boots
5. The Brain Tumour Charity. HeadSmart Campaign - Website [Internet]. Available from: https://www.headsmart.org.uk/

- END -

Academic Staff at University of Bradford

Consultation question 1

Ageing population: very strong link between age and demand for eye services (increased pathology, refractive correction)

- Internet makes people more aware (potentially more anxious) about their eyes/vision
- Potentially greater expectation that optical devices (specs, CLs) can/should be more available to buy online

Consultation question 2

- Ageing population means domiciliary demand will increase greatly
- With longer-living comes dementia: this will require considerable training in dementia-suitable approaches to examination (not simply a little CET). For example, there will likely be a need to shift to more objective means of assessment of visual function to serve these patients.
- With NHS under pressure, more of the caseload may move to primary care (optometric not GP), as is happening in Scotland. Barriers to this include suitable training within basic optometry training, as well as post-graduate training opportunities
- There is likely to be a significant move towards electronic referral (including attachment of fundus/slit lamp/OCT images) which will enable HES to make more effective triage decisions. Part of this may include the opportunity for optometrists to send across clinical data for consideration by HES who may ultimately advise that referral is or is not indicated (i.e. a 'virtual' clinic).
- However, such a shift to virtual clinics might reduce opportunities for optometrists to increase their caseload. In other words, the shift of routine HES appointments out of the hospitals and into virtual monitoring clinics might be run by trained technicians (not optometrists), perhaps mobile in the community. Optometrists might be seen as too expensive. A barrier to these virtual clinic schemes is that the holistic care of the patient is lost, as is the relationship between the patient and the clinician. Patients may not like being monitored as a set of data.
- If optometrists are to increase their scope of practice, carefully designed protocols will be needed to decide the conditions which can be treated in optometric practice (by suitably qualified individuals) and which conditions (or triggers) require referral to secondary care
- As opposed to HES or optometric practice, maybe eye care will be provided in centres located in the community that are staffed by combinations of eye care professionals (e.g. optometrists/orthoptists with ophthalmological support). There are already examples of such centres (e.g. referrals from school vision in Leeds) and they may provide a half-way house between primary and secondary eye care provision. Linked to this, will we also see a division appearing between the sale/supply of spectacles and the provision of eye health care?

Consultation question 3

- Ageing population means ophthalmology simply will not (or already cannot) cope with the volume of eye disease and treatment. We are already seeing ophthalmology initiatives which arise from a desperate need to reduce referrals into the hospital eye service.
- Optometrists are well placed to assist (subject to suitable training and carefully-designed protocols) with the increased eye-disease caseload. However, it is difficult to know the extent to which this will change the roles and responsibilities of optometrists: for some, they may function mainly as mini-ophthalmologists, while others will dabble only in MECS or stick with the older-model of eye examination and refraction.
- Because of uncertainty in how the role of the average optometrist in high-street practice role may change, it is unclear how the role of dispensing opticians might change. They may move into refraction (but see below) because optometrists efforts are increasingly dedicated to eye disease investigation & management (this would require legislative change to separate of eye health assessment from refraction; risks attached!). Or, will dispensing optics stay as a regulated profession? Very difficult to call which way it will go.
- For optometrists there is likely to be greater involvement in diagnosis, monitoring and (to a certain extent) treatment of eye disease. There will inevitably be a scale here, stretching from where the typical optometrist was 10 years ago (refraction + detection of abnormality) all the way through to IP

with monitoring of glaucoma, for example. The public will need practitioners across this spectrum and it should be down to individual practitioners to decide at what level they wish to practise.

- For DOs: They too could (and indeed, already can) upskill to become optometrists. We do not believe that DO's should take responsibility for refraction - it is not straight-forward to divorce refraction from assessment of ocular health. How does a practitioner make a sensible recommendation on a spectacle prescription without, for example, having knowledge of crystalline lens opacities or the health of the macular region? There's also the issue of investigating a chief complaint of "blurred vision", which cannot be done properly with either refraction or ocular health assessment alone. Thus we favour continuing with, and perhaps extending, the possibilities for DOs to convert to Optometrists, as the University of Bradford's Career Progression course currently does.

Consultation question 4

- Career structure (ladder) across the optical professions is needed. We are beginning to see this already with qualifications for optical assistants (e.g. BTEC Level 3 in Ophthalmic Dispensing) leading to dispensing optics training possibilities. In turn, DOs can take the Bradford Career Progression course to become optometrists and optometrists are, with training, in places, taking on roles and responsibilities that would normally have been for ophthalmologists only. This evolving career ladder approach is to be welcomed and it could, following this review, be given greater impetus through support.
- As with any ladder, people join at a level appropriate to the prior educational/training and they can move onwards and upwards with experience and training. This is a vastly better scenario than existed when optometrists, for example, qualified but opportunities for career development were extremely limited. For optometry, basic training allows one to join the register. What should this basic training look like? In other words, what is the minimum level & scope of training required to register as an Optometrist? There are those who believe there is no compelling evidence that the current 3 years BSc + pre-reg requires change. There are others, however, who will argue that the scope of basic training should be raised. This is a critically important debate, the outcome of which will require extremely careful consideration. For example, if the duration of undergraduate optometry was extended to 4 years in the UK (except Scotland, where it is already 4 years), would the aim b e to raise the standard (i.e. ensure graduates are better able to do what they have been trained to do) or to increase the scope of practice? Proponents of longer undergraduate training often refer to the need to include training and tuition n management/leadership, inter-disciplinary working, communication and in independent prescribing. All of these have potential merit but what is a required is an in-depth evaluation of the benefits and costs. For example, whilst no one would argue that communication skills are anything other than vital for a practising optometrist. However, communication is notoriously difficulty to teach via didactic lectures (it needs small group work in labs which is hugely resource intensive and notoriously difficult to assess objectively). If the duration of the undergraduate course was extended to 4 years, this would mean a 4 year degree which was still not registerable. It is unlikely that this would be seen as attractive to prospective students. Granted, it may improve patient care on the high street but only if all graduates get the opportunity to routinely make use of these extra skills. This would obviously require major concessions from ophthalmology.
- We can see the value in increasing undergraduate students' level of clinical experience (by increasing the minimum number of patient episodes, for example). This should develop their decision making abilities and communication skills. We are wary of making this recommendation, however, because it would almost certainly require a reduction in our current intake number. The issue of minimum number of patients and of range/breadth of patient episodes need extremely careful consideration.
- As is already the case, once experience has been gained in practice, for those wishing to develop their skills and scope of practice, a suite of additional qualifications is available to those interested in further training. These qualifications allow a wider scope of practice. The extra qualifications are reflected on the register so, for example, (i) the public will know for example who has expertise in say glaucoma, and (ii) employers can check the register to see who has the qualifications that are mandatory for participation in certain activities, e.g. working as part of a particular shared-care scheme.
- The above will require the GOC to have a clear view on which qualifications it will list (e.g. someone who has carried out a 1/2-day training course in something should not be allowed to list this on the register) and there's a danger that the register could become confusing for those consulting the register, especially members of the public.

- An increasingly important skill for optometry undergraduates to gain and develop will be to be able to understand what are evidence-based treatments and what are not (and to understand why some 'cures' like the Bates method and taking myopia tablets work to some degree – e.g. due to blur adaptation, placebo, confirmation bias etc.). This has implications for the research-awareness and critical appraisal skills of the staff who introduce these topics in the programme of study.

Consultation question 5

- As mentioned above, with additional post-graduate training leading to a wider scope of practice, not all registrants will have all of these qualifications; hence it will be necessary for the register to reflect the additional, approved qualifications.
- This will make the register more complicated than now.
- Perhaps the optometrist/DO distinction won't exist in the way that it does now. If not, and a sliding scale approach to qualifications is implemented, it will be vital that it is very clear to the public who is trained to do what, in order that they can choose the correct clinician for their needs. It will also be important that optometrists become more comfortable with referring patients to optometrist colleagues with particular specialities, as ophthalmologists routinely do.

Consultation question 6

- The competency approach is well intentioned but is fundamentally flawed because it encourages a 'tick box' approach. It portrays to students a shallow approach to learning/understanding the underlying theories and practical abilities.
- It encourages all students, in particular weaker students, to repeat techniques until they are just good enough on one occasion when they happen to be observed! 'Competence' indicates an ability to perform repeatedly to the required standard.
- The other issue with the GOC competencies is that they don't capture the fact that students at different level of their training demonstrate different ability levels (e.g. what is competent in ocular health examination for a first year optometry student is not competent for a second or a third year student). A spiralling approach to skills/knowledge/understanding captures how students learn and develop, not the big-bang single test of competency that takes place towards the end of the training.
- For the above reasons, the reliance upon the competency approach to setting education standards should be dropped.
- If the latter happens, something will obviously need to replace it. In the past, the GOC specified a lengthy core curriculum. This was not a useful approach either. Instead the GOC should specify in brief the basic topics which must feature as part of basic optometry and degree programmes, and the level to which they should be studied.
- Presently the GOC accepts a 2/2 or higher degree in optometry plus a statement that stage competencies have been passed, as the criteria necessary to start the College's SfR. Optometry degrees differ and the GOC should not aim to dictate and standardise how students are trained because this will stifle innovation.
- One possibility is that the GOC should aim to ensure standards in the various training institutions are equivalent. Can the GOC have sufficient confidence that a 2/2 degree in optometry from one training institution is in any way equivalent to the same degree classification from another institution? If not, the GOC might consider arranging examinations to be held at Universities to ensure consistency of students across the various training institutions. Inter-institutional variations in academic standards is already an issue and it is likely to become even more so with new courses starting, and with new approaches to teaching/delivery. Innovation can't be a good thing unless the standard is at the very least maintained (ideally raised). The approach of students from different training institutions taking a common assessment during undergraduate training exists in the USA, where students of optometry have to take State Board exams (at least one of which takes place during their optometry training at University). This approach would also allow the GOC to specify the outcomes it believes are important, and then to ensure that all students achieve these. Obviously this would be very big undertaking (and big decisions would need to be taken about the practical versus theory nature of this examination) but it would ensure that students entering the SfR had consistent levels of skills and knowledge/understanding. This approach would also offer economies for the GOC in that the need for regular, detailed accreditation visits to an ever expanding number of institutions would be less critical if a GOC-administered common undergraduate assessment created a common bar for all students, irrespective of the nature of their undergraduate training.

- The above suggestion would obviously represent a huge step for the GOC and it almost certainly would not be welcomed by the training institutions who are under intense pressure from their senior management to fill their programmes. It would be very damaging to an institution if large numbers of its students went on to fail the GOC exam. We raise the idea of GOC exam(s) at undergraduate level only as one possible means to deal with a crucially important problem, namely the need to ensure consistency and appropriateness of standards across undergraduate training.
- The GOC currently takes quite a hands-off approach to the College's SfR. It needs to be much more involved in its evaluation (e.g. pass/duration of SfR statistics from different training institutions etc.). There a real advantage to the GOC having a common final assessment for Optometry and IP but the GOC needs to robustly review these examinations, and possibly to invite tenders to run them (i.e. consider offering the examination to another provider if the GOC can be convinced that another provider/a different approach by the same provider would deliver better outcomes). The GOC should resist a situation where there are multiple registerable routes because of the difficulties of ensuring equivalence of standards. This has started to happen for DO training,
- The GOC's handbooks need to be much more prescriptive and clear about the things that really matter when it comes to training students; e.g. in relation to the number and expertise of staff, and about the value it places upon having a research culture amongst the staff to develop the students in evidenced-based practice. Also, much greater clarity is needed about the required facilities for training students (e.g. is an Eye Clinic required or not? are surrogate patients allowable or not? If so, then are they allowed for all patient categories/conditions? What exactly counts as a 'real' patient?). Greater evidence is also needed regarding the minimum number and range of patient contacts in the various categories, if these continue to be specified.

Consultation question 7

- Yes, and only those it accredits should be listed after names on the register. The GOC should periodically, in discussions, with other stakeholders (in particular, NHS/ ophthalmologists and employers), examine whether the additional qualifications it accredits cover the scope of practice that fits the roles its registrants are being (or might be) asked to do.
- Effective quality assurance requires effective handbooks, policies, procedures etc. The GOC have previously been criticised for inconsistency in decision making. Transparency in the level expected of all training providers would address this.

Consultation question 8

- Ability to provide competent basic eye care for all patient groups (from young children to patients with dementia). Ability to offer appropriate therapeutic treatment/management for common, benign eye conditions (e.g. for dry eye in older patients).
- Full training in independent prescribing should not be provided in the course that leads to first joining the register (though basic therapeutics should), unless the range and volume of patients with eye disease that are examined during training is greatly increased. Experience of working as a registered optometrist is needed before adding the considerable extra responsibility of IP.
- Therapeutics training is already part of most/all undergraduate optometry curricula. On joining the register, optometrists should be confident in managing conditions which current legislation permits non-IP optometrists to treat e.g. dry eye, blepharitis, conjunctivitis, corneal abrasion, allergic eye disease, episcleritis, sub-conjunctival haemorrhage etc.

Consultation question 9

- Greater use of technology to allow less time in lectures, freeing up time for case analysis and greater emphasis on actual case studies. This does not necessarily mean more actual patient contact. Greater use of computer presented cases of actual (not simulated) patients
- Content to include therapeutics, but not at the expense of certain topics that are often cited as those which should go (optics, binocular vision (BV); these topics have been eroded in most optometry programmes and more not less of these is required). BV has a strong link with testing children and is one of the optometry profession's most commonly cited weak points. Current University BV teaching is critical to producing graduates who can perform safe eye exams for children (something that is currently required by the public). Thus, any suggestion that BV should be de-emphasised significantly raises the risk of conditions like amblyopia going undetected. If optometrists were more

competent/confident in BV assessment and management, this would enhance the optometry caseload
- Exposure to new technology/equipment for assessment of the health and structure of the human eye (idea of an “emerging technology” module in the final year).
- Given the scope and volume of material that needs to be included in optometry training, there is a case to be made to increase the duration of the course from 3 to 4 years (but see earlier comments about this).

Consultation question 10
- Allow successful completion of higher qualifications to count towards CET requirements.

Consultation question 11

Consultation question 12

Consultation question 13

Consultation question 14
- Good admissions procedures that don’t rely only on academic qualifications, sufficient patient experience, training and assessment in knowledge and application of professional standards. Good communication underpins professional behaviour. While it is imperative that efforts are made to teach good communication, the task of producing good quality professionals will be made much easier if students are good communicators when they are selected for entry to training courses. The GOC currently has a very hands-off approach to admissions (other than student numbers). Is the GOC willing to be more pro-active? If so, what would the GOC want to see in relation to admissions?
- In relation to admissions, we would like to point out that with the grades required to study optometry having fallen over what is now an extended period, the solution is not necessarily simply to raise minimum A-level entry standards. An additional stream of prospective students could come from practice settings rather than direct from A-level. We have already seen very good students (who are perhaps not as academically strong in relation to A-level grades as school-leavers) come via this route. Indeed, a strong case can be made that such students are already triaged via their optical employment history. Communication skills are usually considerably better in these entrants compared to the average school-leaver.

Consultation question 15
In optometry this exists via the College’s SfR. However, as indicated earlier, this could be extended so that there is common assessment as part of the initial (university) optometry training (like the US state board optometry exams in the USA).
- There are many new models of optometry and dispensing optics training, and we will certainly see more developments in the models being offered. The GOC should not aim to stifle this development but it has to assure itself that standards are consistent irrespective of which route to registration was taken.
- The nightmare scenario for the GOC (because it will be so difficult to ensure consistent standards) is that there are different routes to registration and different final assessments.

Consultation question 16

- Public perception & the funding model: Our professions are frequently seen by the public to be sellers of glasses. This is not entirely unjustified because of how eye care is paid for. The eye examination fee is so low that it has to be subsidised by the proceeds from selling glasses and contact lenses. This financial model is a huge barrier to development of our professions and contributes to negative impression. There are positive developments in this respect in Scotland and these are to be welcomed. Should the GOC play a role in agitating for a roll out of the Scottish model across the UK, on the basis that it improves patient outcomes? Does the evidence exist to support whether patient outcomes have improved in Scotland since the change to the model? If not, who is responsible for gathering it?
- Workforce planning: The GOC has said that it can have no role to play in determining numbers of graduates. While at one level we accept this, we don't fully agree. . More and more optometry courses/students mean that the academic qualifications on entry to the various courses are falling (and they have fallen significantly in many/most UK training institutions offering optometry). At what point will the GOC, responsible for the protection of the public, ask whether the lower entry qualifications impact on the quality of the 'product'? Weaker students need more support and different approaches to teaching (more expensive) may be needed. What approaches are the training institutions taking in this regard? The GOC should be asking these questions. This is not because it should interfere directly in admissions, but because it may need to assure itself about the appropriateness of mechanisms in place to allow weaker students achieve the required standards of education and training.
- Gaining Provisional Approval: Should the GOC set a higher bar for new training providers to be awarded provisional approval. If the GOC was to set a higher standard for provisional approval (e.g. more than the 4.0 FTE staff currently required, specifying criteria such as the number of clinically-qualified staff, the number of staff with experience of higher education etc.), only institutions who take the idea of setting up an Optometry programme seriously, and are willing to invest in it, would be permitted to proceed with their application.
- Student fees: The funding model for UK higher education now offers an opportunity to increase the duration of optometry courses, if this deemed to be necessary. When fees were paid by government, increasing the duration of the course was financially unpalatable to the funder. Now that students are paying their own fees, increasing the course duration could meet with less resistance. However, one would have to ask how palatable this would be to the students themselves. A 4-year programme with no certain earnings advantage over the 3 year alternative might actually drive down optometry applications and hence lower entry standards.
- Student placements: The issue of quality and quantity of student placements is extremely important, not only during the SfR but also for placements during the undergraduate element of the training. The GOC needs to quality assure all placements (or put in place robust QA mechanisms for other bodies to conduct on their behalf) because of the importance of placement elements to the quality of the overall training. However, if the criteria for adequate placements are raised substantially, supervisors/placement providers may think that it not worth the effort. This could lead to a very difficult situation where students can't find pre-registration placements.
- Numbers of students: courses with a large volume of students have real difficulty in modifying their offering to include greater practical experience and training, including student placements. The GOC should consider the maximum allowable staff:student ratio very carefully (including provision of guidelines about precisely how it wants the ratio to be calculated), and thus, taking a harder line of the maximum numbers that training providers can accept onto the course.
- Legislative change: Depending upon the views expressed in the review, legislative change could well be needed to put in place the framework to allow the desired changes to occur. However there are inherent dangers in changing the act, through unintended outcomes.

Consultation question 17

- END -

Cardiff University School of Optometry and WOPEC

Consultation question 1

The demographics of the population will change. There will be:

- more older people.
- a greater prevalence of eye disease as the most common conditions are age related; glaucoma, cataract and AMD.
- A greater complexity of health needs as general health conditions are also more prevalent leading to more comorbidity. For example there will be more people with eye disease, hearing impairment, a stroke and dementia.

Advances in technology and treatment may mean greater pressure on health care systems, but this may also mean that patients can play a greater role in their own eye care.
People's expectations of living longer in good health are also rising.

Consultation question 2

Changes required in how eye care is delivered The hospital eye service is already struggling to provide timely care to everyone that needs it. In order to ensure good quality accessible care in future there will need to be:

- more care closer to home
- better integration of eye care across the primary and secondary care boundary
- greater sharing of information across the professional and provider boundaries
- a greater role for optometrists, orthoptists, ophthalmic nurses, dispensing opticians and ophthalmic technicians in the delivery of eye health care
- more multi-disciplinary working in hospitals, between primary and secondary care and in primary care
- a greater emphasis on prevention.

Barriers to these changes

In some areas change has happened at pace but in others no change has occurred or it has been slow. The barriers to change include:

- a national health care system that hasn't changed much in overall structure since the 1950s and isn't used to large scale change.
- a lack of an evidence base of cost benefits of enhanced optometry services.
- gaps in the data which makes it difficult to map the problem and model the solutions
- the way in which acute health care services and primary care services are funded
- the economy
- the political nature of health care commissioning
- the lack of funding for CPD and advanced skills training for optometrists compared to other UK health care professionals
- a misunderstanding and resultant mistrust of the abilities of allied professionals.
- poor public understanding of the skills and capabilities of different professionals
- the inability of NHS to develop improved IT infrastructures and electronic communication
- normalisation of long waits for care
- commercial interests of providers

Consultation question 3

Optometrists in many parts of the UK are already providing enhanced services as part of their service provision in primary care. In the last decade, WOPEC has trained and accredited over 10,000 optometrists in Wales, England and Northern Ireland in Primary Eyecare Acute Referral (PEARs)/ Minor Eye Conditions (MECS), Glaucoma referral and refinement, cataract referral and refinement and post-operative cataract management. In addition, more recently optometrists have been involved in wet AMD triaging and monitoring cases of suspect glaucoma and OHT. These enhanced services are likely to become more widespread throughout the UK. Independent prescribing may also become more widespread, enabling optometrists to play an even greater role in the management of people with eye disease.

Drivers for change include:

- Government policy to move care closer to home

- the availability of excellent diagnostic equipment in primary care such as visual field analysers, cameras and OCTs
- a demand and capacity mismatch in secondary eye care
- patient safety concerns in the hospital eye service due to delays in follow-up
- the evidence that enhanced services in optometry are effective and safe and liked by patients
- the desire of optometry and dispensing opticians to enhance their skills
- technological developments

Consultation question 4

Much of the 'enhanced' service training such as MECS and GRR are now mainstream and this could be taken into undergraduate training.

Education needs to be more clinically based and include clinical placements in order to respond to increased demand for management of patients in community, including delivering treatments for patients.

More emphasis should be placed on critical appraisal of the evidence so that practitioners can self- direct their learning and change in practice.

Problem based learning (PBL), designed to help students emerge with a set of problem solving abilities with lessons learned from medical education would also be helpful and instructive for students and enable them to respond to rapid developments to always ensure good patient care.
A system that encourages CPD rather than CET.

Consultation question 5

If optometrists become more involved in treating and managing patients with eye disease, there will be more career opportunities and different scopes of practice than currently. This will present challenges for the public. It is important that the different levels of qualification and experience are identified and monitored by the GOC.

The distinction between Optometrists and Dispensing Opticians must remain to reflect the differences in education, training and clinical responsibility. Any alternative approach would not be in the public interest.

Consultation question 6

The focus on outcomes is justified and appears reasonable.

The competency model is less fit for purpose. As healthcare changes the competency of the workforce will need to change to fit the changing needs of the public. Therefore, a competency model will go out of date quickly.

At undergraduate level the competency model has had the undesirable effect of producing a 'tick-box' approach rather than a focus on the all-round clinical ability of students.

Consultation question 7

It would seem reasonable for the GOC to accredit and quality assure additional qualifications that require a significant step up in clinical responsibility and hence risks. For example IP and the Glaucoma Diploma. However, accrediting and quality assuring all additional qualifications is probably unnecessary.

Consultation question 8

- Professionalism
- Good communication.
- Ability to listen to and work with the patient to make joint decisions to deliver patient focussed care.
- Ability to adapt swiftly and respond to the rapidly changing treatments, technology and pathways. Therefore, the ability to review the evidence and change practice accordingly.
- There will be a greater need for them to monitor and manage more eye conditions. In particular playing a greater role in AMD, Glaucoma and cataract and acute eye care.
- Optometrists will need to develop skills in clinical management decision and move away from just detecting and referring eye disease
- They will need to work more with other health care professionals in primary care and secondary care.
- The ability to audit and review their practice to continually improve patients care.

Consultation question 9

- A renewed focus on the value of clinical placements with exposure to more decision making
- Greater exposure to patients with eye conditions in particular AMD, Glaucoma, Cataract and Acute Eye Conditions and the monitoring and management of them, rather than just detection and referral pathways
- Basic Clinical audit skills and self-reflection should be taught.
- More focus on evidence based practice
- More emphasis on case based learning and less on narrow competency sign off so that the professionals of the future develop skills that could be applied to the rapidly evolving landscape of the future.
- More interdisciplinary learning especially with GPs and ophthalmologists.
- Greater emphasis on ethics and the complexities of delivering patient centred healthcare in a financially pressured system.

Consultation question 10

Having a clear and transparent pathway and competency framework for post- registration qualifications will be important for the public, optometrists, allied professionals and NHS commissioners. This would facilitate better career progression for optometrist and a workforce that could respond to need.
To safeguard quality and provide confidence, higher qualifications should be provided by independent bodies such as Universities and not be open to service providers to deliver.

Consultation question 11 N/A

Consultation question 12 N/A

Consultation question 13 N/A

Consultation question 14

Students should be selected for their ability to communicate and their problem solving and emotional intelligence skills and not just on their academic ability.

Ethical and professionalism principles should appear early in the undergraduate programme so that students are fully aware before they interact with the public.

Students should also have exposure to more patients with abmormal conditions. In addition they should have exposure to a range of practice environments including hospitals, independent practice and multiple during their University career so that they can develop a strong ethical and patient centred compass but also understand the complexities of the public/ private model we operate within. All of this will require additional funding.

Consultation question 15

Using outcome based measures that can be truly demonstrated and a larger number of skills/ behaviours etc. that are measurable. It should move away from a competency tick box process.

A significant challenge is maintaining a consistent approach in training during the pre-registration year, given the diversity of supervision and practice setting. It may well be preferable for this period to be overseen by a body whose remit is concentrated upon training rather than assessment.

Consultation question 16

Undergraduate funding is currently inadequate to support the desired improvements in clinical training of optometrists. In fact, many in the profession forget what a tremendous job the UK Optometry Schools actually do in terms of clinical training, all for a standard tuition fee. The optical profession must lobby government for appropriate clinical funding for improved clinical training of undergraduate Optometrists, as is the case in Medicine, Dentistry and Pharmacy.

Barriers to obtain higher qualifications include a lack of available placements and a lack of time or re-imbursement to pursue the placements. This would need to change with preferential access to placement for optometrists over GPs for example. In addition, optometrists do not have access to the same funding streams as other professionals. In Scotland where optometrists have access to NES funding the development of skills has been swift.

Continued legislative protection of the core function of the sight test is essential to protect the public and to encourage future applicants and to protect those currently qualified. Whilst there may be increase diversification of patient care, the sight test remains essential for early detection of eye disease and prevention of sight loss. If this was taken away the public eye health would suffer. In addition, the profession would struggle to recruit.

Consultation question 17 A quick response is required as practice is already changing.

- END -

Chris Jones

Consultation question 1
Older less able population

More need for home visits

Less eye deparments but larger and specialised

Ridiculous mistakes by online purchsed products causing massive increase in harm. Bypassed Opticians and GOC protection.

Consultation question 2
NHS fee is unsustainable leading to" Optometric deserts in deprived areas of the country. Patients having to take serveral buses or a self driving taxi fair of 50 pounds to get to the nearest Optician NHS has to find a way to provide care where needed. Some practices may be to vital to comunity to be allowed to fail financially so get state aid to continue.

Consultation question 3
DO to check refractions if less than recheck date or if Optom has seen OCT and fields and IOP Optoms to monitor stable glaucoma if within target IOP MECS rolled out instead of NHS exam

Consultation question 4
Core new practise skill made compulsory CET if needed because of new finding.
Instant CET update by email if vital new dry AMD drug arrives. Optoms read and fill in answers by return if very urgent update needed

Consultation question 5
More groups and roles

Consultation question 6
Watch College of Optoms, check training institions

Consultation question 7
International qualifications?

Consultation question 8
Present skills
Plus- better understanding of how to keep up to date in a quicker changing scientific role Be aware of how to specialise

Consultation question 9
Need enough hands on with real patients ie elderly so not going to crash out when the online modules stop.

Consultation question 10
Need to have locally delivered hands on training to add on to courses like WOPEC

Consultation question 11
Ability to recognise Optometric colleague that has mental or drink and drug problems. Be able to report and get them help early so damage to patient and proffesional is limited Need for a recovery service for sick opticians (both to limit public harm and to themself and family)

Consultation question 12

Need exceptional people skill with the vulnerablr groups.

Resolution skills for the online disasters

Consultation question 13
Refraction
Resolution of online issues
Vulnerable group expertise

Consultation question 14
Need an even stronger vetting of admissions.
No point in making unsuitable Opticians

Not having empathy/ care, criminal tendancy, dexterity is as important as academic ability

Consultation question 15
That they can do the skills with face to face exam with real patient and conditions

Consultation question 16
Pre regs seen as cheap labour. Supervisors should be doing it because they want to hand on skills to their replacements

Big business just want new staff they can manipulate

Consultation question 17
Not enough Pre reg in small groups.
Could be shared between supervisors to give a more rounded education before specialising

- END -

College of Optometrists

Consultation question 1

In the UK, the proportion of persons aged 65 and over increased from 15% in 1985 to 17% in 2010 (ONS, 2012); by 2030 it is projected that those aged 65+ will account for 22% of the total population. In terms of individuals, 2010–30 projections suggest a 50% rise in people aged 65+ and 100% more aged 85+ (ONS 2010, 2015). The average cost of providing hospital and community health services for a person aged 85+ is around three times greater than for a person aged 65 to 74 years (Cracknell, 2010). This means that there will be a considerable increase in the number of patients with eye disease and various co-morbidities, such as dementia or diabetes. It is also follows that more patients are likely to be in care homes or confined to their own homes. This may lead to a greater need from domiciliary and low vision services and for help for those with sight loss living alone.

Changes in technology mean that patients may well be able to self-refract or use a handheld OCT, either at home using a smartphone or in a booth in practices or elsewhere in towns and cities. There are likely to be advances in online sales as well, and possibly 3D printing. This may lead to a reduced need for optometry and dispensing optician input in relation to sight testing.

Ref: Foresight Project Report A discussion of the potential impact of technology on the UK optical sector to 2030 by 2020health March 2016 Commissioned by The Optical Confederation & The College of Optometrists There is also increasing evidence that the number of children with myopia will grow, and there will be more available interventions. This may lead to an increase in optometrists needing to be proficient in working with children and in the use of myopia control treatments.

Refs:

McCullough SJ, O'Donoghue L, Saunders KJ (2016) Six Year Refractive Change among White Children and Young Adults: Evidence for Significant Increase in Myopia among White UK Children. PLOS ONE 11(1): e0146332. doi: 10.1371/journal.pone.0146332

Katie M. Williams, Geir Bertelsen, Phillippa Cumberland, Christian Wolfram, Virginie J.M. Verhoeven, Eleftherios Anastasopoulos, Gabriëlle H.S. Buitendijk, Audrey Cougnard-Grégoire, Catherine Creuzot-Garcher, Maja Gran Erke, Ruth Hogg, René Höhn, Pirro Hysi, Anthony P. Khawaja, Jean-François Korobelnik, Janina Ried, Johannes R. Vingerling, Alain Bron, Jean-François Dartigues, Astrid Fletcher, Albert Hofman, Robert W.A.M. Kuijpers, Robert N. Luben, Konrad Oxele, Fotis Topouzis, Therese von Hanno, Alireza Mirshahi, Paul J. Foster, Cornelia M. van Duijn, Norbert Pfeiffer, Cécile Delcourt, Caroline C.W. Klaver, Jugnoo Rahi, Christopher J. Hammond, Increasing Prevalence of Myopia in Europe and the Impact of Education, Ophthalmology, Volume 122, Issue 7, July 2015, Pages 1489-1497, ISSN 0161- 6420,
http://dx.doi.org/10.1016/j.ophtha.2015.03.018.(http://www.sciencedirect.com/science/article/pii/S0161642015002808)

Walline, J. J., Lindsley, K., Vedula, S. S., Cotter, S. A., Mutti, D. O., & Twelker, J. D. (2011). Interventions to slow progression of myopia in children. The Cochrane Database of Systematic Reviews, (12), CD004916. Advance online publication. http://doi.org/10.1002/14651858.CD004916.pub3

Consultation question 2

Capacity issues in hospitals are likely to worsen both because of the ageing population and new treatments, which means that more care will have to transfer to the community, be that in standard optometric practices or community clinics. Technological advances in optometry equipment may mean optometrists have more time to spend on cases which are transferred from the hospital eye service.

There could also be benefits from inter-professional collaborations and the growth of polyclinics.

Ref: B Foot and C MacEwen, British Ophthalmological Surveillance Unit, The Royal College of Ophthalmologists, Surveillance of sight loss due to delay in ophthalmic treatment or review: frequency, cause and outcome, Eye (2017), 1-5 Barriers include:
IT – this is a significant challenge, as most optometry practices are not currently connected to hospitals and GP surgeries. This means that they cannot send data, or referrals, electronically and cannot easily receive feedback on data or referrals they send to the hospital eye service. This is a particularly significant problem in England, where the money has not been forthcoming to start this process. And although the Governments in the devolved nations have invested in IT, rolling it out is slower than had been hoped.

Governance - It is difficult to put clinical governance arrangements into community practices, as good clinical governance requires significant resources. The various elements of clinical governance (risk management, clinical audit, CPD, evidence- based care and effectiveness, patient involvement and staff management) require expertise, time and money to implement, manage and undertake. The current funding frameworks, particularly in England, do not support this and are heavily reliant on commercial transactions to survive as a business.

Clinicians who work in hospitals can take advantage of institutional systems and of mentoring by more experienced colleagues.

CPD (specifically) – The current system takes a limited approach to CPD and does not lend itself to optometrists personalising their development and creating learning plans that relates directly to their own practice. In addition, because they do not have protected learning time and work in a commercial environment, it is not always easy for them to do as much CPD as they might need to ensure they keep up-to-date and develop their knowledge and skills.

At all levels, as qualifications are gained, it is important for health professionals to consolidate their new knowledge and skills through experience with patients, and to have access to a good supervisor or mentor, on whom they can model their practice, whatever their stage in their career, and who will review their work and give them feedback and encourage reflection. This is difficult in a small community practice.

Increase in part-time work and locums: It is difficult for those who work part-time, and particularly for locums who work in different practices, to take part in clinical governance and CPD. When roles become more clinical, there will need to be some kind of assurance mechanisms that work for locums.

Consultation question 3

Technology is likely to remove some of the activities that dispensing opticians and optometrists currently undertake on a regular basis, as will the increase in online sales. This is particularly true for dispensing.

For optometrists, this will mean that their roles will become more clinical, as low risk patients with eye health issues will be managed in the community. Training will need to include more critical thinking and clinical decision making skills as well as knowledge, skills and experience in more specialist areas.

There are likely to be more large corporate brands and fewer small independent practices.

Ophthalmologists may move into community practice, so there will be greater scope for interprofessional collaboration.

There is likely to be an increasing domiciliary and low vision workload, as well as scope for broadening public health surveillance and advice for general health conditions.The drivers, as stated above, will be the ageing population, the availability of new treatments and interventions, and an increased use of technology. Further developments in globalisation, including the use of the internet, will also be a factor. Ref: Foresight Project Report A discussion of the potential impact of technology on the UK optical sector to 2030 by 2020health March 2016 Commissioned by The Optical Confederation & The College of Optometrists

Consultation question 4

Core training at undergraduate level should integrate knowledge, skills and professional behaviours that are revisited over the duration of the course so that students build on what they have learnt and look at it in more depth as they gain experience. Situated learning should be embedded from the start and built up through the curriculum, so that students can see how what they learn translates into actual practice. How to plan learning, and reflection skills, should be embedded from the beginning, and a range of teaching techniques used, which will allow students to take increasing responsibility for their own learning and be confident that they will be able to direct their own learning throughout their careers.

There should be a period of supervised and assessed practice to allow newly graduated optometrists to gain experience and consolidate their skills in a managed environment.

Continuing professional development, which is tailored to their own practice, is essential for all optometrists so they can maintain and develop their practice throughout their careers. This should involve planning learning, undertaking CPD, reflection, and putting what is learned into practice.

Those who want to work at a more specialist level should take the relevant qualifications and be able to consolidate their learning under appropriate supervision by gaining appropriate patient experience.

The aim should be to build up skills, knowledge, behaviours and experience in a way that each part of training builds on the previous parts. This allows knowledge, skills and behaviours to be taught at a point where they will be consolidated through experience. It is important that skills are practised and kept up-to-date, for example, surgeons must undertake a minimum number of particular operations to be allowed to continue in that field.

Studies showing whether inter-professional learning has a significant impact on future collaborative healthcare have mixed results and further research is needed.

Ref: Reeves S, Perrier L, Goldman J, Freeth D, Zwarenstein M, Interprofessional education: effects on professional practice and healthcare outcomes (update) (Review), 2013

Consultation question 5

It is anticipated that there will be a blurring of roles. That does not automatically mean, however, that there should not be distinctions between registrant groups, as they will have different levels of education, training and experience and undertake different ranges of activity. Optometrists will take on some work currently done by doctors, but this does not make them doctors. Similarly, dispensing opticians may take on some work currently undertaken by optometrists, but this will not make them optometrists.

Consultation question 6

We would prefer to see an outcomes model, as this is becoming the norm for other clinical disciplines. We acknowledge, however, that there is opposition in some quarters, where it is felt that outcomes based training reduces the thirst for education in the wider sense. However, clinicians have to be capable of undertaking their role with a limited time for training. We do not believe the current competency-based model works, as there are a large number of competencies ranging from the very small to the very broad. This encourages students to tackle the competencies separately, ticking them off, and not to look at them as part of a whole.

While we agree that an outcomes based approach is correct and institutions should have freedom to develop their own courses, we believe strongly that it is the role of the regulator to ensure that curricula and assessments are developed in line with modern methods of clinical education and that arrangements are in place to support students and teachers. The regulator's role is to verify that appropriate leadership is in place to ensure a good learning environment that allows students to meet the learning outcomes. Ensuring that newly qualified optometrists are fit to practise is the most important priority and measures must be put in place to ensure consistency of standards at that level.
We believe the GOC should put quality assurance and accreditation systems in place that allow for flexibility but that are clear, transparent and have good practice in clinical education and the safety of patients at their heart.

Ref: ASME, ed Tim Swanick, The Understanding Medical Education Text Book (2nd Edition), 2013

Consultation question 7

The College of Optometrists has accredited a broad range of service-specific higher qualifications. There are currently eight different qualifications being delivered by five providers. Over 700 certificates have been awarded. The qualifications are referenced in the NICE Glaucoma Commissioning Guidance and the Royal College of Ophthalmologists Common Clinical Competency Framework for non-medical ophthalmic healthcare professionals. We would suggest that we continue with this system and the GOC accredits us to do so, and, indeed, it has suggested this system to us in the past.

Consultation question 8

The safety of patients is paramount and the education system should include the core skills, knowledge and behaviours to support this. This includes professional skills as well as clinical skills.

Students should be well supported so that they emerge competent, critical and reflective practitioners, confident in their abilities.

We believe that, as practice is likely to change rapidly, it is also important that students learn to direct their own learning from the beginning of their undergraduate course.

If the profession wants to grow, students also need to begin to develop leadership, mentoring and evaluative skills.

Core skills, knowledge and behaviours we suggest are:

Basic and clinical science

- Basic and clinical sciences to underpin their clinical decision making skills and help in dealing with patients with different needs. This needs to be integrated so students understand why this is important for their clinical practice from testing to prescribing drugs to advising patients.

Clinical and practical skills

- History taking.
- Clinical assessment skills such as ocular examination, visual function, analysis of digital data, refraction (which will still needed for some time and will always be needed for some groups, for example those with learning difficulties or dementia)
- Critical thinking and problem solving to underpin clinical decision making skills, including which tests to undertake, interpreting results, diagnosis, management, prescribing drugs appropriately.
- Reflection skills.
- An ability to write clearly and concisely and with the information the recipient needs – no more and no less. This is particularly important for referrals.
- Communication skills: listening, explaining, and reassurance, involving patients in decision making
- Prescribing drugs appropriately but only in areas where they have the management expertise at registration. We believe it is really important that prescribing matches capability in terms of diagnosis and management and any higher level prescribing qualifications should be taken at the appropriate time after registration when the optometrist has the requisite experience and capability to diagnose and treat particular diseases. This is because skills must be practised regularly to avoid patient safety issues.
- Practical procedures that they need at the time of registration and continuing experience of doing them. So we believe that refraction is still important, and, by way of example, there is risk from students practising gonioscopy if they do not then go on to use it regularly.

Professional skills

- Information management from keeping accurate records, to writing clear and concise referrals, and finding and verifying information.
- Working in a multi-disciplinary team

- Understanding how to accept feedback, including negative feedback
- Working with patients
- Ethical principles and the law
- Equality and diversity
- Self-directed learning and reflection
- Clinical governance, including clinical audit to improve care.
- Understanding evidence and how to read a research paper critically
- Patient safety issues such as infection control and safeguarding.
- Public health, epidemiology and evidence based practice.
- Leadership skills and the ability to teach others.

Consultation question 9

We would suggest that the content and delivery of optometry programmes should put patient safety and needs at the heart.

Outcomes based learning

We would commend the system of outcome-based education, which is now used in medicine and other health-related disciplines. This builds the curriculum around the optometrist who will emerge at the end of the course, and helps prepare the student by looking at what he or she will need to be able to do once qualified. It should be put in context, however, so that the student understands that registration is not the end of learning but a stage on the way.

References:

AMEE Education Guide to Outcome-based Education 1999

Experiential situated learning

Optometry students have little exposure to patients with different needs and conditions compared with other clinical students and we believe this needs to be increased significantly, beginning with simple contact so they begin to understand the needs of different types of patients and building to more complex clinical abnormalities and diseases so that they get a breadth of clinical experience. Situated learning, throughout the course, that makes an explicit link between what they learn at university and actual practice, is present for all other health professions students.

Professionalism

We believe professional skills such as communication with patients and colleagues, clinical decision making, critical thinking, governance, including audit, ethical and legal considerations, basic research skills, epidemiology and understanding evidence should be woven into the curriculum, and their relevance to each aspect of the curriculum explored. They should not be taught as a separate module. Integrating professionalism into all aspects of the curriculum will help students understand how to do the right thing in relation to everyday practice as well as in more ethically challenging situations.

Universities should treat optometry students differently from non-clinical students, requiring them to behave professionally and holding them to the GOC's standards for optical students.

Methods

There is a considerable amount of research into the effectiveness of clinical education and assessment.

Optometry schools should use a range of teaching methods that build students' confidence and gradually allow them to take responsibility for their own learning. This means more small group work, problem-based learning, where learning is structured around clinical situations, and a gradual transition from more classroom based teaching to more clinically based teaching, allowing students to experience a variety of different clinical situations.

We believe that training and assessment institutions should use modern methods of clinical assessment and obtain permission for optometry courses to be run in the same manner as medicine and other health related courses. For example, we do not think all existing optometry courses use recognised methods of standard setting, as they are obliged to use the university pass mark. This is not appropriate for courses leading to registration as a health professional.

Scheme for registration
It is important that Pre-Registration trainees get the support they need from their supervisors. In some practices, the level of support may vary. A regulatory requirement for them to help trainees plan their learning, with regular review meetings, good feedback, case based discussions and a policy of inviting them to shadow the supervisor seeing patients with more complex conditions would help. The College has a supervisor competency framework which is designed to support supervisors through this period as well as help them develop professionally in the role. We would recommend this framework for all supervisors. We have also developed our own online training which is compulsory for all supervisors.

Consultation question 10

Post registration training
Just as in any profession, optometrists will have different aspirations. However, we must assume that they will be working for many years, whichever path they decide to take. To provide the best care to patients, they must ensure they are fit to practise in their chosen career and that will involve continuing professional development (CPD) so that they consolidate their original learning, build on and learn from their experience and have the ability to learn new knowledge and skills as their profession develops.

The current CET system does not fulfil this function. It is possible for optometrists to approach this as a tick box exercise, meaning that it does little to improve their performance in their areas of work. It is also onerous for providers and has been known to prevent small but good providers from undertaking CET sessions.

Research shows that, to be effective, CPD needs to be linked with and relevant to individual learning needs within the context of the professionals' own practice, and the needs of their patients, so it needs to be planned. Learning with others and reflection are known to help, and active learning is regarded as useful. The impact of CPD is shown through positive changes in practice, knowledge acquisition and learner satisfaction.

Follow up through informal learning, by discussing issues from CPD with colleagues, is also felt to be effective by professionals.

It is difficult to balance a more personal approach to CPD with a quantifiable system, but other professions are finding ways to tackle this. However, collecting a number of points can mean that the CPD does not improve practice but is an activity in its own right. Checking the effectiveness of CPD is a challenge, but imbuing an understanding of CPD is becoming more and more important now as the practice of registrants will change considerably through the life of their own careers. It is important that they know how to direct their own learning effectively to take responsibility for it and continue to provide good care for their patients.

Reference: http://www.college-optometrists.org/en/CPD/CPD-materials/effective- cpd.cfm
http://www.aomrc.org.uk/wp-content/uploads/2016/07/Core_Principles_CPD_0716- 2.pdf
Schostak, Jill et al, 2009, The Effectiveness of Continuing Professional Development, A report prepared on behalf of the College of Emergency Medicine, Federation of Royal Colleges of Physicians and Manchester Metropolitan University.
I Starke and W Wade, CPD Supporting Delivery of Quality Healthcare, Ann Acad Singapore. 2005
Karen J McConnell et al, The Impact of Continuing Professional Development versus traditional Continuing Pharmacy Education on Pharmacy Pracitce, The Annals of Pharmacotherapy, 22, 2010
Griseti O, Jacon J, Effectiveness of Continuing Education Programmes in Nursing: Literature Review, 2006, Blackwell Publishing Ltd
Woosung Sohn, DDS et al, Efficacy of Educational Interventions targeting Primary Care Provider's Practice Behaviours: An Overview of Published Systematic Reviews, Journal of Public Health Dentistry, 64, 2004
David A Davis et al, Changing Physician Performance A Systematic Review of Continuing Medical Education Strategies, JAMA, 274, 9, 1995

Bernard S Bloom, Effects of continuing medical education on improving physician clinical care and patient health: a review of systematic reviews, International Journal of Technological Assessment in Health Care, 21:3 (2005), 380-385
S Wallace and S A May, veterinaryrecord.bmj.com, 2016; 179: 551-520 doi:10.1136/vr.103862t

Higher qualifications

We believe that it is important that qualifications in particular areas of practice build on general experience and involve a period of supervised or mentored experience and relevant CPD to consolidate the learning from the qualification. Having a qualification without gaining experience by putting it into practice and keeping the knowledge and skills up-to-date can be dangerous for patients.

Putting in place a CPD system that requires a certain amount of experience and evidence of keeping up-to-date would overcome this. For example, surgeons are required to undertake a certain number of particular operations if they are to continue undertaking them.

We believe that the three tier system of higher qualifications that we have developed in various specialist areas and accredit other institutions to deliver, works well. We involve all relevant professionals in developing the qualifications, for example ophthalmologists, orthoptists or dispensing opticians. These range from just above core competency (professional certificate) to specialist hospital work (diploma). We have a detailed system of accreditation that covers curriculum content, structure, assessment, guidance for teachers and trainers, clinical placements, student support and feedback and quality assurance. The Royal College of Ophthalmologists used it as a basis for its common clinical competency framework https://www.rcophth.ac.uk/professional-resources/new-common-clinical-competency-framework-to-standardise-competences-for-ophthalmic-non-medical-healthcare- professionals/ and uses our glaucoma qualifications in its glaucoma commissioning guidance https://www.rc ophth.ac.uk/wp-content/uploads/2016/06/Glaucoma- Commissioning-Guide-Long-June-2016-Final.pdf (page 6 and table page 12). We understand some believe that the independent prescribing qualification contains sufficient learning about glaucoma to be equivalent to the College Diploma in Glaucoma. We believe that a comparison of the learning outcomes and indicative content for the two qualifications would show that this is not the case.

Consultation question 11
We recognise that these will change, in the way that those for optometrists will change. ABDO is better placed to comment on the detail but we would be happy to work jointly with them, if that would be helpful.

Consultation question 12
We recognise that this will change, in the way that it will for optometrists. ABDO is better placed to comment on the detail but we would be happy to work jointly with them, if that would be helpful.

Consultation question 13
We recognise that this will change, in the way that it will for optometrists. ABDO is better placed to comment on the detail but we would be happy to work jointly with them, if that would be helpful.

Consultation question 14
Students should be subject to a selection system to ensure that they have the appropriate characteristics for the role and know themselves that the profession is right for them. We believe that they should be asked to undertake work experience before applying so they can decide whether it is the right choice. Multiple mini interviews or group interviews would be a possibility for selecting people with the right aptitude and attitudes, and possibly an aptitude test, as it is important that they have the intellectual ability as well as the communication and ethical skills needed in the profession. There has been some research into this area, for example:

Ref: Identifying best practice in the selection of medical students (literature review and interview survey) Professor Jennifer Cleland Dr Jon Dowell Professor John McLachlan Dr Sandra Nicholson Professor Fiona Patterson, 2012

Professionalism needs to be embedded in the curriculum from the beginning, woven in so students understand that it is involved in every aspect from the legal aspects of practice, to working with patients and colleagues, prescribing drugs, research,and using evidence in practice etc.

Ref: https://www.college-optometrists.org/the-college/policy/professionalism-in-optometry.html

It is helpful if students see practitioners leading by example and acting as role models. However, care needs to be taken that the chosen role models are positive. In medicine, what is known as the hidden curriculum where teaching by humiliation sometimes occurs, is known to be a problem in some places.

Consultation question 15

It is important that appropriate assessment methods are used throughout the course Ref: ASME, ed Tim Swanick, The Understanding Medical Education Text Book (2nd Edition), 2013
Standards appear to differ across optometry schools. To ensure parity of standards at the point of registration, it is crucial that there is an independent assessment of all students after graduation and before entry to the register. This is currently done through the Scheme for Registration. The Scheme for Registration is a flexible programme and is being offered at the end of undergraduate courses as well as being incorporated into four year MOptom programmes. The Scheme allows students to have an extended period of situated learning to consolidate their skills while still under supervision.
Ref: College of Optometrists, The Scheme for Registration 2013-15, 2016

The General Medical Council has recently concluded that there has to be a comprehensive independent assessment of medical students at the point of graduation and doctors also have a period of supervised, assessed practice before entering the register.

Ref: https://gmc.e- consultation.net/econsult/uploaddocs/Consult790/MLA%20consultation%20document_English%20writeable_distributed.pdf

This ensures the best possible safety for patients and gives newly qualified clinicians the confidence they need to practise independently.

Consultation question 16

University funding
To make the undergraduate curriculum work, it would be ideal if optometry could have funding for a clinical stage. However, we realise that this is unlikely in the current climate where this type of funding is being restricted. Alternatively, it might be possible for optometry students to be funded for clinical placements in the manner of allied health professionals.

Optometry schools' resources are very tight and staff-student ratios need to be increased. A newly designed course with more clinical and small group work, and modern clinical assessment methods, would cost considerably more to run. In addition, they may need more optometrists with current practical experience on the staff to help with clinical skills. The multiples might be in a position to help with this if partnerships could be formed between universities and employers. The College could look at options for training the trainers so that practitioners had the necessary skills to undertake such a role.

Hospital placements
Hospital eye departments are well situated for students to to experience abnormalities and pathology that are too complex to be managed in community practice. However, placements are limited because the hospital departments have to accommodate medical students, junior ophthalmologists and other health professionals with an interest in eyes, as well as optometry students and trainees and those undertaking higher qualifications.

Funding for CPD and clinical governance activities
This is currently underfunded for optometrists. In addition, optometrists do not have protected time for CPD.

Practice funding
In England, particularly, optometry is funded by GOS and has to be heavily subsidised by the commercial aspects of optometry. This makes it difficult to allow space for training and professional development, and quality assurance. Contractual changes would be needed to enable those with the required skills level to pracise at the higher level and quality outcome measures would be needed.

Workforce planning
More optometrists are opting to work part-time or as locums. There is a danger that this would leave them outside any systems designed to assure the public that optometrists were safe to practise.

Ref: https://www.college-optometrists.org/the-college/research/research-projects/optical- workforce-survey2.html

Consultation question 17
Ultimately, the education of optometrists is about patient safety and the training should, therefore, be patient-centred at all stages.

- END -

Changes in demand and the impact of changes in eye care delivery

Consultation question 1 – How might the needs of patients requiring eye care change over the next 20 years?

Increasing numbers of older people with a longer life expectancy will lead to an increase in chronic disease and long-term complex health conditions. Mobility problems will increase with an effect on the need for domiciliary/mobile and generally service provision closer to home. This may include 'virtual clinics'. The prudent healthcare agenda calls for co-production and self responsibility for the patients' own health care, which will require a significant shift in culture stemming from improved patient education regarding health care. It is unlikely that the inequality in care relating to deprivation will improve.

Consultation question 2 – What changes in how and where eye care is provided will be required over the next 20 years in order to meet patients' needs, and what are the barriers to these changes?

The move from secondary to primary care based treatment is well underway. This will continue in the form of more community based shared care services. The workforce will be expected to up-skill and work at the 'top of their licence'. Multidisciplinary Teams will form a large part of the eyecare system. Technology change will continue to accelerate and the expectation by patients for practices and practitioners to keep up will increase. Fee structures may need to change and may not be supplemented by spectacle sales as now.

Barriers to change will include financial costs in training, technology, estates, equipment, IT and IT security, HR legislation, and costs, health and safety issues, (legislation), and professional indemnity. NHS fees may not be sustainable without review of government policy so private treatment and health insurance models will increase. This could lead to a separation of NHS/clinical practice and private practice. Patient education and a culture of prevention and healthy living will require massive effort from all stakeholders and will take time to shift. Finally the issues of safety in eye care as practices change could lead to lack of protection and support for patients and practitioners unless governance is robust.

Consultation question 3 - How are the roles of optometrists and dispensing opticians likely to change over the next 20 years, and what are the drivers for these changes?

The move more towards Health care professionals and away from 'sellers of spectacles' will require a widening of roles in areas such as low vision, independent prescribing, intravitreal injectors, minor surgery, laser eye correction, glaucoma shared care, paediatrics, domiciliary provisions. This will also require specialization in such areas too. Dispensing Opticians will up-skill into some of the above as well as further involvement in contact lenses. There will continue to be significant proportion of 'retail' service including internet based business, and the profession will need to work 'smarter'.

Drivers will include the ability of NHS services to cope with demand, the attitude of millennials to work, as less important than personal life; often preferring employed or flexible/part D time employment, and including career breaks to the constraints of owning an optical business with the challenges and commitments, as well as risks involved. On first joining the register Optometrists will need good interpersonal skills; clinical decision making; an understanding of legal requirements and implications; a commitment to CPD; aptitude for interprofessional

communication and collaboration (e.g. Primary Care Cluster Groups); and an overall understanding of the term 'professionalism'

Consultation question 4 – How should the education of optometrists and dispensing opticians be structured to enable continuing professional development throughout their careers, e.g. core training followed by general or specialist practice?

University applicants need to show desire and commitment to their chosen profession; to show ability in interpersonal skills, problem solving, and an indication they are able to cope with the stresses involved in day to day practice.

During the undergraduate course it may be possible to include specialization at an early stage, with modular teaching and include significant internship/patient interaction; more contact with NHS services; and encourage individuals to engage with third sector.

During the pre-registration year, undertaking more varied work with different supervisors including more hospital and other clinical experience.

Post registration, greater accessibility to further education would be beneficial; sponsorship of fees and visible reward or recognition for the completion of the qualifications. There needs to be a new culture of Continuing Professional Development within the profession.

Consultation question 5 – What are the implications for the GOC register of likely changes in roles and will the existing distinctions between registrant groups remain appropriate?

As the diversity of practice and qualifications continues there will be a need to distinguish between competencies but categories of registration will need to be streamlined. It will be important that there is clear governance of the professionals in extended roles.

GOC's approach to education

Consultation question 6 – What are your views on the GOC's approach to the accreditation and quality assurance of education programmes, including on whether this is an appropriate focus on outcomes and on the use of the competency model to set the standards of education?

There is an impression amongst the profession that it should be easier for CET providers to obtain accreditation for courses and it could be easier to have events authorised. Outcomes, competency areas, and development programmes should be as wide as possible for individual practitioners to control themselves.

Consultation question 7 – Should the GOC accredit and quality assure additional or different higher qualifications and if so, on what basis?

Additional qualifications must become more widely attained and therefore need to be quality assured. As Optometrists increasingly become Primary Healthcare Practitioners there is a need for confidence that the correct skills are being taught; partner professions need to be assured in our ability as we become part of multi-disciplinary healthcare teams. Within these teams a clarity of roles and responsibilities and appropriate professional indemnity will be required.

Content of education programmes

Consultation question 8 – What are the core skills, knowledge and behaviours which optometrists will need to have on first joining the register in the future?

On first joining the register Optometrists will need good interpersonal skills; clinical decision making; an understanding of legal requirements and implications; a commitment to CPD; aptitude for interprofessional communication and collaboration (e.g. Primary Care Cluster Groups); and an overall understanding of the term ‘professionalism’.

It is foreseeable there will be a reduction in traditional skills associated with Optometry, such as spectacle adjustments, dispensing and contact lens work.

Consultation question 9 – How should the content and delivery of optometry programmes change to ensure that students gain the skills, knowledge and behaviours that they will require for practice and for new roles in the future?

Firstly there should be a consensus obtained among the education providers and professional bodies to determine the core skills to be covered in the programmes. Thereafter there could be a freedom for individual establishments to pursue their chosen specialities and research projects. Regular reflection and review of topics and practical experience for students is paramount.

Qualifications that are transferrable to other disciplines would widen the career pathway of optometry graduates.

Consultation question 10 – How might post-registration training and registrable higher qualifications for optometrists need to change in the future?

The culture of training and education that exists will not change overnight; making it desirable, affordable, enjoyable and flexible will encourage practitioners to pursue further qualifications. The goal should be that CPD is a lifelong commitment.

Consultation question 11 – What are the core skills, knowledge and behaviours which dispensing opticians will need to have on joining the register in the future?

On first joining the register dispensing opticians will need good interpersonal skills; clinical decision making; an understanding of legal requirements and implications; a commitment to CPD; basic refraction and eye examination techniques; proficiency in using technology.

Consultation question 12 – How should the content of dispensing programmes change to ensure that students gain the skills, knowledge and behaviours that they will require for practice and for new roles in the future?

The dispensing programmes could make use of ICT in distance learning e.g. virtual classrooms, webinars, and practical experience in the new areas of practice mentioned in Q13. It may be possible to use local assessors similar to pre registration optometry scheme.

Consultation question 13 – How might post-registration training and registrable higher qualifications for dispensing opticians need to change in the future?

It might be desirable to review and update the qualifications relating to low vision; paediatric dispensing; refraction; vision screening; minor eye condition triage; supervision of trainee optometrists, dispensing opticians and non-professional staff; people and business management skills and contact lens practice.

Professionalism and consistent standards

Consultation question 14 – How can we ensure students have the professionalism needed to take on new roles, including through the admissions procedures used by education providers, patient experience, supervision and embedding professional standards?

It is important that students are not purely judged on their academic ability. Their interpersonal skills, communication, English language skills are important. Reflective learning, feedback, peer review, discussion, problem solving and collaborative work must be assessed.

Professional standards should be reinforced from the very beginning of their studies and regular periods in public facing environments will be extremely advantageous.

Consultation question 15 – How should students be assessed prior to joining the register to ensure that there are consistent and appropriate standards of education, taking into account the different types of education programmes that are emerging?

There should be independent assessment of University facilities, programmes and facilitators to provide a consistent standard of education.

The current pre-registration scheme is a high-quality system although there is some variation in the assessment and supervisors. Continual evaluation and updating will reduce unwanted variation in the standards.

Barriers to change and other issues to consider

Consultation question 16 – What are the challenges and barriers to improving the system of optical education, including issues that may be outside the remit and control of the GOC, such as legislative change, workforce planning, the funding of education (including higher education, continuing education and training and continuing professional development) and the provision of student placements?

Challenges to improvement include funding of further education, CET and CPD; funding of the NHS; attitude to work and lifestyle; and pressures of commerce reducing individuals' job satisfaction and remuneration.

Potential reluctance/inertia of large optical bodies to change; legislation including the living wage all increase costs to businesses and take priority over further education.

Consultation question 17 – Are there any other issues that we should consider in carrying out our review? If so, please set out what they are.

In carrying out the review the GOC needs to be bold, innovative and embrace the future. Continue in its remit to protect the public but support the profession as their responsibilities increase and the threat of litigation may reduce the appetite to progress and remain in the lowest common denominator of risk.

- END -

Cwm Taf University Health Board

Deacon Harle

Consultation question 1
Therapeutic eye health care, with the use of pharmaceuticals and laser will be an increasing burden on the health system unless optometrists are equipped to deliver such services

Consultation question 2
Optometrists must be able to deliver eye health services on qualification and registration. This needs a shift in the undergraduate training from detection of disease to treatment and management

Consultation question 3
Eye health delivery will be a major requirement as the population ages The optometrist must be able to meet the needs of this population

Consultation question 4
On qualification and registration all optometrists must be able to treat the common eye health conditions. Further specialisms will be shaped by the future prevalence of eye health needs

Consultation question 5
The GOC needs to ask itself why it is unable to register all eye health professionals and why ophthalmologist and orthoptists in particular sit outside its scope

Consultation question 6
Currently competency training is at best dumbed down The GOC need to reflect on how to best ensure optometrist are robustly trained and assessed as fit to practice

Consultation question 7
The GOC should ensure that training for ALL qualifications meets the eye health needs of the population

Consultation question 8
Ability to detect manage and treat all common eye health disorders both refractive, physiological and pathological

Consultation question 9
Look at the common basic training for medicine and dentistry. There is an obvious eye health model to follow

Consultation question 10
Simple; they need to meet the needs of the population as it changes

Consultation question 11

Consultation question 12

Consultation question 13

Consultation question 14
Do NOT make student registration requirements any different from those of other health professional training programmes. Use exactly the same process as dental medical or nurse students

Consultation question 15
Robust clinical assessments using well substantiated processes. Follow the medical model; it's well validated

Consultation question 16

The GOC is currently heavily influenced by commercial interests. It will need strong leadership to deliver true change to better improve the eye health of the population within this environment

Consultation question 17

Look at the other health councils. Do not set the GOC apart and try to adopt already well established models in medicine and dentistry

- END -

Dr Doina Ghergel

Consultation question 1
Our patients will be increasingly older. Therefore, ocular diseases associated with ageing are likely to increase. In addition, we will also face an increased number of patients with dementia .

Consultation question 2
The UG programmes need to teach diseases associated with ageing and care for the elderly patients or patients with dementia and sight loss. The education needs to start from our Optometry schools. Also more qualified optometrists need to have the opportunity to specialise in diseases of the old age or in patients with disabilities.

Consultation question 3
As primary care providers, optometrists are well positioned to screen, diagnose and manage a large variety of conditions, not only ocular but also systemic. Therefore, appropriate training is needed. With the increase in ageing population this will expand the scope of practice and enable optometrists to perform more informed diagnosis and referral of their patients.

Consultation question 4 See above

Consultation question 5 Cannot comment

Consultation question 6 Cannot comment

Consultation question 7 yes

Consultation question 8
The most important core skills are communication with patients of various abilities, diagnosis of sight and life-threatening conditions, interprofessional communication (extremely important!)

Consultation question 9 The education should expand beyond current practice. The students should have more contact with real patients with various ocular and systemic pathologies, have special classes/workshop in patients communication, have education in inter-professional communication, gain knowledge on patients with disabilities, gain knowledge on common health problems and smoking cessation advice.

Consultation question 10 More training to be available on the above

Consultation question 11 Cannot comment

Consultation question 12 Cannot comment

Consultation question 13 Cannot comment

Consultation question 14 See above regarding patient experience. In addition, a good staff-student ratio should be ensured. Access to up-to-date technologies

Consultation question 15 Cannot comment

Consultation question 16 There is not enough funding for innovative teaching among other things

Consultation question 17

- END -

Dr Doina Ghergel

Down's Syndrome Association

Consultation question 1

The increase in longevity predicted for the general population also applies to people with Down's syndrome /learning disabilities (LD). It is becoming increasingly well known that people with Down's syndrome /LD are at a much higher risk than members of the general population of eye and vision disorders. There have been a number of campaigns aimed at educating professionals and the public into the needs of people with Down's syndrome/ LD, evidenced by research studies, but the UK have not yet achieved 100% accessibility of eye care for its vulnerable citizens. The DSA continues to campaign for accessibility of eye care for people with Down's syndrome. The increasing numbers of people with Down's syndrome and learning disabilities seeking eye care will require professionals to receive the necessary education and training to meet this growing need.

Consultation question 2

Conventional hospital clinics, with long waits in overcrowded waiting rooms and short examination times, are unsuitable for the examination of children or adults with Down's syndrome. Patients with Down's syndrome need longer appointment times as they process information more slowly and need longer to respond to questions or instructions. Patient friendly non-threatening environments and staff educated and experienced in their communication needs are also necessary. These requirements can only be provided in specialised and dedicated hospital clinics, in community-based optometric practices, or in school-based services. In Wales, there is likely to be an eye-care service for pupils with special needs set up in the foreseeable future and the possibility of similar services in the other devolved administrations. The barriers for optometric practices are, currently, lack of training and experience, but mainly lack of a funding stream for examinations that ar e longer and potentially more frequent.

Consultation question 3

Consultation question 4

It is our understanding that, at present, there is no nation-wide career development pathway for eye care practitioners, but that local arrangements exist for practitioners to become involved in enhanced services, which offer extra remuneration. The DSA believes that there are a small number of areas with enhanced services for adults with learning disabilities. The DSA would like to see a nation-wide service for both children and adults with learning disabilities, or at the very least a consistency in local arrangements so that any person with Down's syndrome /LD can access good quality and appropriate eye care in their local community, wherever they happen to live. Subject to adequate funding, such a structure will require practitioners specialised in the eye care and communication needs of people with LD. The same practitioners would also be able to offer eye care to other vulnerable groups such as those with dementia. An opportunity to offer options withi n under-graduate courses for practitioners to specialise in eye care for vulnerable people exists and should be explored.

Consultation question 5

At present, it is not possible for a parent or carer seeking eye care for their relative/client with Down's syndrome/LD to identify an eye care practitioner with the skills, experience and willingness to carry out an eye examination. Families have to take pot luck and many experience distressing situations with practitioners lacking the skills or motivation to conduct successful eye care episodes. The result is that many families simply give up in trying to find eye care for their relative. This situation is unacceptable; qualifications and accreditation must be visible to the public.

Consultation question 6

Consultation question 7

As stated in response to question 5, the general public has a right to know which eye care practitioners are capable and willing to offer eye care to people with Down's syndrome/LD. Core competencies should cover the ability to:

- successfully communicate with the patient
- understand eye care needs
- manage conditions appropriately
- network with other professionals involved in the care of the patient
- successfully communicate vision status and needs to carers, educators and other health and social care professionals.

Unless the accreditation becomes an option within undergraduate programmes, a recognised post-registration qualification is needed, that the public can clearly identify within the registers.

It is the understanding of the DSA that hospital optometrists, who, at the moment see a large proportion of children with Down's syndrome/LD, have no additional training in the particular needs of their patients, beyond that offered in the university degree. This is a situation that the DSA finds unacceptable, and believes that vulnerable patients should only be seen in hospital clinics or in practice, by people with appropriate training and qualifications.

Consultation question 8

The DSA is very concerned with an item in the preliminary text to this question:
Given the potential for technology to be used to automate refraction in the future, there could be a case for devoting less time to practicing refraction.

Research exists, that shows that auto- refraction is significantly less reliable in adults with Down's syndrome than in typical adults. In addition many other people with LD (along with young children, people with physical limitations, people with dementia etc) are unable to access hi-tech equipment. Stillness is required when using the head-rest and chin-rest. The need to follow instructions and the need to hold fixation may all be too challenging. It is totally unacceptable that these significant groups of people within the population are to be left behind as optometry supposedly moves forward.

Retinoscopy is a case in point. In spite of being a core competency at present, many optometrists choose to abandon the technique in favour of auto-refraction. Recent (as yet unpublished) research shows that, when corneal topography cannot be used routinely, retinoscopy is the only means of identifying keratoconus in young people with Down's syndrome at an early enough stage for treatment. As a result, it is likely that young people with Down's syndrome are losing, and will continue to lose, their sight to this potentially treatable disease.

It is therefore essential in the view of the DSA that the low-tech practices with optometry continue to be taught at undergraduate level.

Optional undergraduate courses or post-registration high qualifications are needed in the field of eye care for vulnerable populations. The DSA also believes that all practitioners should have, as a core competency, the ability to triage a patient with Down's syndrome/LD and the knowledge of how to access a referral pathway to an accredited/qualified practitioner with appropriate speed.

Consultation question 9 and 10 are answered as part of the response to Question 8 above

Undergraduate programmes need to retain and emphasise the basic skills such as retinoscopy. When students do not have the accreditation as part of optional under-graduate training, post-graduate courses leading to accreditation or qualification are required to ensure that people with Down's syndrome/LD in the UK can access evidence-based eye care suitable for their needs.

Consultation question 10

Consultation question 11

Dispensing opticians play a vital role in providing eye care for people with Down's syndrome/LD, and as such, should receive training in the particular needs of this vulnerable population, including communication skills. Hospital clinics rarely have dispensing facilities, and most will issue a prescription that a family take to a local practice for dispensing. Dispensing opticians are even more likely, therefore, to encounter children and adults with Down's syndrome/LD in everyday practice than are non-hospital-based optometrists. Therefore, the same arguments about parents identifying practitioners skilled in dispensing for people with Down's syndrome/LD applies. Dispensing opticians with the skills, whether gained through optional modules during pre-registration training or through post-registration higher qualifications must be identifiable by the public in the GOC register.

Consultation question 12

When appropriate skills have not been developed during training, they should be gained through post-registration higher qualifications, which must be identifiable by the public in the GOC register.

Consultation question 13

In similar fashion to our recommendations for optometrists, unless the accreditation becomes an option within training programmes are recognised post-registration qualification is needed, that the public can clearly identify within the registers.

Consultation question 14

Consultation question 15

Consultation question 16

Consultation question 17

- END -

Dr Ewen S. MacMillan

Consultation question 1

Consultation question 2

Consultation question 3

Consultation question 4

Consultation question 5

Consultation question 6

Consultation question 7

Consultation question 8

Consultation question 9

Consultation question 10

Consultation question 11

Consultation question 12

Consultation question 13

Consultation question 14

Teaching emotional intelligence at university would improve professionalism and impact positively on patient experience. Self-awareness and being aware of others is often taught by business groups to improve harmony in the workplace. This would increase empathy from practitioner to patient that is often cited as a crucial, but not well executed, part of patient care.

Consultation question 15

Work based assessment should be amongst other things;

1. Valid i.e assess skills, knowledge, understanding and professional behaviours should be against a defined role that has been deconstructed into the framework competency elements set by the GOC.

2. Objective i.e assessment methods and judgements should be made against set standards and not what individual assessors think is appropriate. (This is what I think is missing from the SfR. This is different to the current "indicators" which merely guides the trainee to topic areas to be assessed. There is no common syllabus for trainees or assessors to refer to).

3. Reliable i.e it would not matter which assessor assessed the trainee at that point of time the method and standard of assessment, and trainee's result, should be the same. (Inter-assessor variation is what trainees perceive to be a problem currently).

Objectivity could improve by:

1. Introducing a portfolio of records and take out the perusal of previous records from the assessment. Introduce a basic marking criteria for the portfolio and take this out of the assessment visits. This gives good evidence that trainees are able to complete patient records consistently to the expected standard over a range of patient episodes.

2. Increasing the amount of assessment of working performance i.e more direct observation of trainees performing examinations and clinical tasks set by the College. This would include contemporaneous record keeping.
3. Introducing short answer knowledge and understanding questions -for those competency elements where no patient episode is required - where the questions and expected answers are provided by the College. Trainees could be directed to syllabus with evidence based references to guide learning.
4. Ask trainees to submit reflective logs to meet competence for example competency elements that require a different approach or what they would do differently to what they did to improve patient management.
5. Introduce case scenarios much like the OSCEs that have image / video interpretation, referral writing, clinical record interpretation and clinical results analysis. These are objective; structured by the College with expected answers.

Just a few ideas to discuss that may potentially reduce the subjective element of the assessor and reduce the variability of the assessors' approach thus making the assessment more objective, reliable, perceived by trainees as fairer and overall more robust to scrutiny.

Consultation question 16

Trainee numbers at universities are high which generates money for the university. This money may not be spent on the optometry department so that student clinical hours / patient contact time can be increased to a level that makes the trainee at a suitable base level for commencing the Scheme for Registration. My gut feeling is that there are more student optometrists starting the Scheme for Registration that are below the standard of 10 years ago. This may be evidenced by the number of trainees sacked from their pre-registration position which I feel may be on the rise. Perhaps feedback from supervisors within the Scheme for Registration may inform the GOC of this.

Consultation question 17

The GOC could consider changing the Scheme for Registration so that not all Core Competency Groups are assessed in the same way. For example, communication competency elements are difficult to assess with limited direct observation and patient records. Role play by assessors has been discouraged as a method of assessment by The College of Optometrists. Mystery shoppers /actors may be useful for this.

- END -

Consultation question 1

The demographics for the UK will change with people living longer and therefore a rise in the number of elderly patients. These patients present a challenge for all healthcare professionals.

Patients will have more complex health and care issues, often with multiple chronic conditions such as diabetes, hypertension, heart conditions and dementia. Age related eye conditions such as cataract, glaucoma and Age related macular degeneration (ARMD) will also increase significantly. The workload on hospital, secondary care for these eye conditions is already substantial and it is likely with further advances in treatment and increase in numbers of patients requiring treatment the demand will quickly outstrip the resources available in secondary hospital care. Therefore care for patients will shift towards community care and closer to home care (including care at home such as domiciliary visits).

In the more traditional scope of optometry practice, patients may need longer to complete an eye test or other health examination. An increase in the number of patients over the age of 70 years old will impact the length of time a sight test or eye examination takes as well as an increase in number of sight tests services. This will also be true for Low Vision services, domiciliary care and other models of eye health examinations such as Minor Eye Care Services or Eye Health Examination Wales.

Patients may be ready to accept technology more readily as they will have grown up with computers and, therefore, the traditional sight test and prescribing of spectacles may become more automated.

Consultation question 2

At present in Wales and parts of England, optometry practices in the community are seeing patients with low risk glaucoma, post cataract and ARMD for monitoring. This will undoubtedly increase with the possibility of further, complex patient cases in the future being monitored and treated in community based optometry. Training, registration and validation (as well as CPD) of these individuals will need to be carefully monitored so that the public can understand and have confidence in the service and in the individuals who provide it. Independent prescribing, medical retina and glaucoma qualifications will need to be suitably rigorous and recognised by the regulatory body. One of the barriers is that the public will not understand or cannot grasp the differences between members of the same profession and the differing levels of education and assessment they have been through to be able to offer extended eye health services. Potential public relations exercises ma y be required with different titles for different optometrists.

Other barriers include funding for community patient care and the realisation that there may be mixed models of funding, including from the NHS and from the patient themselves.

Consultation question 3

At present optometrists are being accredited or validated in skills to offer community eye health services such as the EHEW in Wales and MECS in England. Glaucoma repeated measures assessments are also undertaken by optometrists in England. Whilst these are current core competencies, it is apparent that commissioners need re-assurance that optometrists can deliver these services. Additionally, from the number of re-sits required, a number of optometrists have become de-skilled and need additional practice to perform assessments such as Goldmann tonometry, even though it is a core competency. This situation will probably remain for the next 5 years. After this time it would seem logical for undergraduate degrees to offer more training and education for minor eye conditions and the skills and instrumentation expertise and experience to be able to offer services once they graduate. In the future, Independent prescribing may also be offered at undergraduate level bu t this would need to incorporate a placement.

Enhanced training and skills in ophthalmological roles at an undergraduate level would also require a shift in emphasis in learning for optometrist from ‘traditional’ theory based learning to experiential learning and clinical placement with reflection.
This could be achieved due to undergraduate optometry courses changing and focussing on teaching more acute eye including covering some of the teaching of acute eye care and its treatment. Clinical placements would form an essential part of experiential learning. This may mean a longer undergraduate degree or longer placements being undertaken in pre- registration or early post registration. The drivers for this include: not enough numbers of medically trained professionals to fill posts, a lack of hospital space to cater for the increased numbers of patients and the shift towards care closer to home.
One area that optometry would need to change to offer more management and treatment of eye conditions is aligning optometry as a healthcare profession embedded in the NHS with better governance arrangements and patient accessibility.

Dispensing optician (particualrly contact lesn opticians) roles are likely to change in that they may be involved in areas outside traditional dispensing e.g. helping to triage acute eye care cases and dealing with anterior eye problems.

Consultation question 4

Alignment of current CET practice for optometry with CPD instead with a renewed focus on the value of clinical placements and self-reflection with progression at a pace and with appropriate knowledge, decided by each individual. This would be depend on the optometry career pathway chosen by the individual. The current model of undergraduate degree, pre-registration year and qualified optometrist would be removed in favour of different optometrist career pathways dependant on the individuals chosen pathway. Whilst all would need to start at the same level and cover the same initial basic core competencies but diversification into specialist clinical management of glaucoma; ARMD management etc. in later years would enable a more structured pathway.
A renewed emphasis on formative learning instead of summative learning would be more valuable for optometrists learning. For example, a new skill could be demonstrated in a non-threatening formative fashion with feedback given at the time. Formative theoretical learning could also be introduced with a shift away from a pass mark required and more towards feedback to help understanding. Formative learning with feedback would offer a more structured approach to learning which would benefit the learner.

Education needs to be more clinically based and include clinical placements in order to respond to increased demand for management of patients in community, including delivering treatments for patients.

A diversity of courses can produce a broader range of skills, capability and backgrounds into the professions. Modular and other flexible learning models would be valuable, as might the opportunity to train alongside other health professionals, such a pharmacists and medics.
Problem based learning (PBL), designed to help students emerge with a set of problem solving abilities with lessons learned from medical education would also be helpful and instructive for students.

Consultation question 5

If optometrists become more involved in treating and managing patients with conditions such as glaucoma, there will be a bigger range of abilities and scopes of practice in optometry than currently. This diversification will present challenges for the GOC and, therefore, it is important that varying levels of qualification and experience are identified and monitored by the GOC to provide assurances for the public. Registration of additional qualifications by competency or by the conditions the user can treat may be required.

Consultation question 6

The focus on outcomes is justified and appears reasonable. The competency model is likely to go out of date quickly and competency is a term that means the individual is fully competent. Undergraduates do not actually display ‘competence’ at the competencies they are trying to demonstrate; they do not have

the experience to do so. In reality they are demonstrating that they can carry out a technique or skill, not that they are competent at it.
Competency requires experience to hone and requires many attempts. The GOC could move towards formative learning over time in a fewer number of competencies so that students could properly demonstrate it. Alternatively, if it is deemed necessary for students to demonstrate, for example, Volk lens BIO, then it should be noted that the student knows how to do the technique. Rarely will they be competent at it in the short time they have in undergraduate level.

Consultation question 7

Yes, this will be required in the future as clinical management roles diversify. If the role is different and requires additional skills and knowledge outside of core competency then they should have GOC QA.

They should be accredited on the basis that the public would be aware of the difference in skill level between different optometrists.

Typically, having too many different qualifications will be harder for the public to understand and so they needs to be appropriate so that specialist qualifications allow the holder to carry out specialist roles.

For independent prescribing (IP) it would make sense for the GOC to continue to accredit the course but IP should just be based on understanding of drugs and pharmacology with additional add-ons of glaucoma and acute eye disease as separate courses. In this way if an optometrist wanted to be IP qualified they would do the basic IP qualification (whether at undergraduate or postgraduate) and then top up with either glaucoma and/or the acute eye course according to what they want to specialise in and where their IP skills would be most useful. This would also mean that the basic IP would be a smaller module. This is in contrast what happens at the moment where optometrists do the IP and all the basics of drugs and pharmacology with a bit of glaucoma and acute eye care thrown in but they would still need to do another glaucoma module if they wanted to sub-specialise in this area (and perversely not have to do an acute eye care higher qualification if they wanted to practice in this area).

The GOC should also accredit and QA these additional glaucoma and acute eye courses because they would enable an optometrists to practice using their IP with glaucoma or acute eye care or both.

Consultation question 8

Professionalism, the ability to converse with patients in a professional, courteous manner. The students should be empathic and be able to communicate with patients so that patients can easily understand what they are saying. This is not currently tested.

Consultation question 9

A renewed focus on the value of clinical placements and self-reflection with formative structured learning. Optometry programmes should have a spiral curriculum approach so that subjects are taught and can be evaluated and synthesised through practical application throughout the degree.

Consultation question 10

In order to facilitate experiential learning, post registration training should include elements of clinical placements in hospitals or community management/ treatment centres. This is pertinent for any qualification that allows an optometrists to carry out a specialist role.

There may be a larger range of higher qualifications in optometry than currently but it is important to note that having too many different qualifications will be harder for the public to understand. Therefore, qualifications should be limited and linked to the holder of such qualification being able to perform a completely different role to a regular optometrist.

Consultation question 11

They will need to have the same core skills, knowledge and behaviours as now with the addition of better understanding and how to recognise eye problems in patients that present with a red eye, for example, as it is likely that they may have a triaging role in community practice.

Consultation question 12
They should include basic optometry pathology recognitions skills and how to use a slit lamp to recognise basic eye pathology so that they could effectively triage eye disease. They could be trained in the same way as contact lens opticians.

Consultation question 13
Potentially, higher qualification in basic acute eye care of the anterior segment.

Consultation question 14
Students be selected for their ability to communicate and their emotional intelligence and not just on their academic ability. Ethical and professionalism principles should appear early in the undergraduate programme so that students are fully aware before they interact with the public.

Consultation question 15
Using an outcome based measures with a smaller number of competencies that can be truly demonstrated and a larger number of skills/ behaviours etc. that have been seen to occur (but may not be ‘competent at this stage due to lack of experience).

Consultation question 16
Barriers to obtain higher qualifications, such as IP, include a lack of available placements and a lack of time or re-imbursement to pursue the placements. This would need to change with preferential access to placement for optometrists over GPs for example.

Continued legislative protection of the core function of the sight test is essential to protect the public and to encourage future applicants and to protect those currently qualified. Whilst there may be increase diversification of patient care, the sight test remains essential for early detection of eye disease and prevention of sight loss. If this was taken away the public would not be afforded the same level of protection they are currently and the profession would struggle to recruit.

Consultation question 17
The review needs to be flexible and adaptable to take into account unforeseen threats or opportunities.

It should also consider if new or amendments to existing regulations are necessary to safeguard the public as a result of increasing roles for both optometrists and dispensing opticians

- END -

FODO (The Federation of Ophthalmic and Dispensing Opticians)

Changes in demand and the impact of changes in eye care delivery

Consultation question 1 How might the needs of patients requiring eye care change over the next 20 years?
We fully support the joint Optical Confederation's evidence. This submission provides FODO's further views.

There will be three main drivers which result in the needs of patients changing in the coming years.

Demographic changes

The population in the UK – as in most of the world – is ageing, and ageing rapidly.

Many eye conditions are mainly age related – macular degeneration, cataracts and glaucoma – and therefore we can expect increased demand for eye care for these treatable conditions to halt and reverse sight loss, prevent avoidable blindness and to maintain people's independence and quality of life as they age.

It is also likely that these patients will experience a variety of other long-term health conditions alongside eye care needs. An increasing number of frail patients and patients with dementia will mean that there will be a growing need for eye care services and support to be provided closer to home and in residential, nursing and other care settings.

There is also no sign that the obesity epidemic is in decline. There is therefore likely to be an ongoing increase in diabetes with more patients needing diabetic retinopathy screening and intervention at all ages.

There is also growing evidence that in advanced economies the proportion of children and younger people with myopia is increasing. There will also be a growing proportion of the population who will need correction for other refractive errors.

Advances in treatment – both clinical and technological

As outlined in the *Foresight Project Report*[1], one of the biggest drivers of change will be new technology. This is likely to mean that many services currently provided by optometrists and dispensing opticians will increasingly be delivered by technology – e.g. auto-refraction, on-line and 3D supply of spectacles, hand-held binocular OCT. However it will also mean that capacity can be freed up nearer to home and in the community to accommodate eye care services being safely delivered outside hospital by optometrists or dispensing opticians (working with, but not necessarily under the supervision of, ophthalmologists).

Patient expectations

And finally patients' attitudes and expectations of the care they expect to receive and how and where they expect to receive it are likely to change. Patients will increasingly have higher expectations of technology simplifying the services they receive and the convenience with which they should be delivered. As in other areas of life, they will expect choice, early intervention and to be listened to for healthcare services just as for any other service. At the simplest level, patients will expect to be able to book appointments on-line or by app, but they are also likely to want to design and buy on-line and expect what they perceive to be straightforward services, such as refraction, fields and pressures checks, to be largely automated, rapidly comparing their results via artificial intelligence with millions of others stored on line for pin-point diagnosis.

[[1]http://www.fodo.com/resource-categories/foresight-report]

Consultation question 2 What changes in how and where eye care is provided will be required over the next 20 years in order to meet patient's needs, and what are the barriers to these changes?

Care should be delivered in the most appropriate setting by an appropriately qualified person. Decisions as to how, where and by whom care is delivered need to prioritise patient safety but, within that, services should always be delivered in the setting that is clinically appropriate, cost effective (both to commission and provide) and most accessible/convenient for the patient.

It is widely accepted– by clinicians and by governments in all four countries of the UK – that in order to tackle excessive demand on GP surgeries, hospitals and A&E departments, and to provide better care, far more ambulatory and primary care, should be delivered in community settings.

Much of the care that is currently delivered in hospital settings is ambulatory and day case and, over the next 20 years, it is likely that increasing amounts of this care will be safely delivered in community settings by registered clinicians and teams other than doctors.

This means that community optical practices, optometrists and dispensing opticians will need to play a much greater role in delivering a far wider range of eye care spanning what is currently the primary and secondary care divide.

This shift is already underway in Scotland, Wales and belatedly in Northern Ireland. It is also occurring to a varying extent across England where non sight-testing primary care and secondary eye care is commissioned by small-scale Clinical Commissioning Groups often in isolation from one another and at high transaction costs for both commissioners and providers.

It is pleasing to see NHS England encouraging the move to commissioning at higher levels of aggregation (e.g. regions, sustainability and transformation plan footprints) and by NHS Trusts working with local LOC primary eye care companies. Nevertheless in England, at present the two most significant barriers to changes remain this weakness in commissioning and lack of IT connectivity between optical practices and the rest of the NHS.

Unlike the health service in other UK countries, the NHS in England has resisted investment in optical IT and so the sector will have to find its own solutions which again may add to costs for the NHS and patients.

At the same time, development in technology will mean the traditional roles of refraction and dispensing may well change. There is already growth in apps and on-line services and it is very likely that, in response, dispensing opticians will take over routine refraction and supply leaving optometrists to focus more on eye health, therapeutics and advanced eye care such as glaucoma, macular disease management and surgical work-up, support and follow-up. This may also involve optometrists and opticians working with other clinicians such as ophthalmologists, orthoptists, ophthalmic, nurses, practice nurses, physician assistants and GPs wither in teams or in new autonomous but integrated ways.

As optometrists and dispensing opticians take on new and wider roles it will remain essential that they are fully skilled and competent to do so. While many of the competences required to deliver extended primary eye care services are already within core competence training, it will be important that each individual practitioner continues to ensure that they maintain and/or update those skills once they have qualified, particularly if they have been working in an environment where they have not been called on to use them for some time. There are many ready ways of achieving this including employers' own training systems.

There is no need therefore for further regulation in this area beyond the existing GOC standards which require individual registrants to keep their skills up-to-date, only to practise within their scope of practice and for businesses registrants to support them in doing so.

The transfer of secondary eye care to the community may well require additional skills and training, or for registrants to specialise in particular areas of optometry. The same existing safeguards in GOC standards apply here too. However there should be scope for additional skills/scope of practice/qualifications/ use of titles, to be noted on and accessible via a unified GOC register.

There is also likely to be a growing demand for sight testing and wider primary and secondary care skills in domiciliary settings to meet the needs of a growing elderly and frail population often living with co-morbidities, disabilities and increasingly cognitive impairment and dementia, where further training and skills may be required. Again though the arguments above apply.

At present the content and structure of education and training is in part a barrier to this shift in roles which we anticipate this current strategic review of education will address. (See our response to Question 6 below.)

Consultation question 3 How are the roles of optometrists and dispensing opticians likely to change over the next 20 years, and what are the drivers for these changes?

As outlined in response to questions 1 and 2, we can expect to see significant changes in both the demand for primary and secondary eye care, and the ways in which they are delivered. This will of necessity change the roles of optometrists and dispensing opticians – indeed we may need several registered levels of optometrists and opticians.

The drivers for change are both logistical and financial. Hospital ophthalmology departments, A&E and GP services cannot cope with the current demands they face and these demands are increasing rapidly as new technologies come on stream (via NICE and SIGN), the population ages and there is more eye disease that the NHS can prevent or treat.

The Royal College of Ophthalmologists *The Way Forward*[2] report acknowledges that different ways of working are now required to meet the increasing demand for secondary ophthalmic services and highlights the development of multidisciplinary eye healthcare teams within both hospitals and communities as a consistent theme in new care models. This report shows that front line clinicians are finding their way to new models for care outside leadership from the traditional bodies. On the one hand this is good in that services are adapting to meeting demand, on the other this is piecemeal, situation and personality dependent which introduces risk. The Clinical Council for Eye Health Commissioning and NHS England should provide more assertive leadership in this regards and the GOC's education and training reforms should facilitate these developments.

A secondary driver is the reality that NHS funds are going to be consistently squeezed for the foreseeable future and NHS has to find ways of driving greater efficiency and doing more for less. The key to this is to ensure that services are delivered in the most cost effective and convenient setting for patients consistent with safety and effectiveness.

The solutions to these challenges are to:

- make better use of skills and skill mix
- substitute trained lower-skilled for higher-skilled workforce
- substitute lower-cost- for higher-cost facilities
- substitute capital for human resources i.e. technology.

This does not mean simply increasing the number of ophthalmologists nor is it just about creating multi-disciplinary teams in hospital settings, or even the community.

Many of the services currently delivered in hospitals by ophthalmologists or by A&E generalists could and should be delivered more efficiently and effectively by community optometry and optics where existing capacity can easily be expanded, commissioned or developed at lower costs than in the hospital sector. Recent examples are the new Austin Friars Diagnostic Treatment Centre in Newport and the AMD services in Brighton and Hywel Dda.

[[2] https://www.rcophth.ac.uk/wp-content/uploads/2015/10/RCOphth-The-Way-Forward-Executive-Summary-300117.pdf]

The most significant change will be optometrists and dispensing opticians in the community taking on wider professional roles in delivering, and supporting the delivery of both primary and secondary eye care and often working with wider clinical teams.

Some activities which to date have been treated as advanced or additional roles, such as prescribing, are likely to become core. Optometrists are also likely to take on new roles in the future which have traditionally been the preserve of ophthalmologists sometimes, but not necessarily universally, under the supervision of an ophthalmologist.

The role of a dispensing optician is also likely to change, with some of the traditional work of an optometrist (possibly including refraction, some minor diagnosis and treatment and almost certainly a bigger role in triaging patients) passing to them.

Optical professionals are also likely to play a greater role in wider health care. Seeing more patients with primary eye care conditions will mean that they see and will need more formally to recognise symptoms and refer on patients with other conditions (e.g. diabetes, high blood pressure). They are also likely to take on a greater role in public health work, for example in smoking cessation and healthy and active living – e.g. ensuring people are confident in walking outside in all light conditions and continue to participate in sports and exercise in both younger and older age.

This expansion of primary eye care services will require many optical professionals to work to the full range of their existing skills and in many cases to develop and extend their skill set.

Consultation question 4 How should the education of optometrists and dispensing opticians be structured to enable continuing professional development throughout their careers, e.g. core training followed by general or specialist practice?

The expanded scope of practice for both optometrists and dispensing opticians means that new approaches (and attitudes) to education, training and continuing professional development will be needed because it is neither practical nor realistic to teach the full range of skills and competences needed to perform across the full range of possible functions at undergraduate level (even if the pre-registration period is included).

This implies the need for a modular approach to education and training, with the undergraduate degree comprising a mix of core and specialist modules. At registration a professional should meet agreed core competences and may well have a specialism in a particular direction (e.g. therapeutics, surgical, medical retina). Over the course of their career they will to need to maintain and update existing skills in response to developments in technology and new clinical approaches. Many professionals will also want (or need) to gain additional skills or competencies to develop and advance in their profession. Registrants should therefore be able to qualify under further specialist modules as part of the continuing professional development system or separately and have these recognised on the GOC register.

This would be an important cultural shift away from the current system of continuing education and training, which was aimed primarily maintaining skills because that was all the health departments at the time were willing to part-fund.

This newer approach would create a pool of registrants with a broader range of skills, capability and backgrounds and would provide different career paths. Both optometrists and dispensing opticians, should be able to move up the skills chain at a pace of their choice. This may also involve more than one variety of registerable level of optometry.

Different methods of education and training should also be introduced, including training alongside other health or social care professionals and in different environments. Increased clinical training could be delivered in hospitals but could equally well be delivered in community optical practices that provide

primary and secondary eye care, or in GP practices or community health hubs as part of wider community clinical networks.

It will be important to ensure that all such training, including core skills, is not only properly assessed but also properly recognised in order to provide necessary assurance to the public, patients, other clinicians and commissioners. At present, accreditation to specific initiatives such as WECS and MECS is often required simply to give assurance to commissioners and professional colleagues, even though they are refreshed confirmation of core competences, not an additional qualification.

The professional bodies and employers should also look at new ways to support and develop registrants. In many larger companies registrants benefit from peer networking, peer support and learning groups. However similar support is not so easily available for those working in single-handed practices, small companies or for the self-employed. The GOC should work with employers, the College of Optometrists, ABDO and universities to encourage and support the development of traditional peer support and learning groups possibly across LOCs, ROCs and AOCs.

Consultation question 5 What are the implications for the GOC register of likely changes in roles and will the existing distinctions between registrant groups remain appropriate?

In order to protect the public, one of the roles of the regulator is to maintain a register of professionals qualified to provide optical services and to protect the right of those who are suitably qualified to use professional titles. The purpose is to ensure that optical services are only provided by those who are qualified and up-to-date to do so.

If registrants in future qualify with core skills and then over time add specialisms, then it will be important that the register records in a simple, accessible and clear way the competences or scope of practice of each registrant rather than simply the qualification they obtained at the single point of entry to the register. The GOC would update registrants' entries as appropriate to reflect any changes in their scope of practice.

This approach would provide the necessary flexibility for the functions of optometrists and dispensing opticians to change and be updated over time. Rather than a particular function being reserved to a particular profession, the delivery of that function would only be restricted to those who were trained, competent and maintained their skills to deliver that function. We would suggest that the right to use a protected title should depend on having a minimum set of core competencies for each professional title or level.

We note that the GMC and Academy of Medical Royal Colleges are moving in this direction, with the announcement on 24 February 2017 of their intention to undertake exploratory work to look at how to enhance the GMC's medical register by recording doctors' scope of practice. We would support something similar, although proportionate to the optical professions, by the GOC.

It is implicit in the above approach that we would favour a single integrated register for all registerable optical, optometric and primary ophthalmic eye care practitioners, which would be far simpler for the public to understand than the current system.

GOC's approach to education

Consultation question 6 What are your views on the GOC's approach to the accreditation and quality assurance of education programmes, including on whether this is an appropriate focus on outcomes and on the use of the competency model to set the standards of education?

It is a moot point whether health regulators should accredit courses (even though most traditionally have) or whether meeting educational standards should be left to the university systems and the

GOC focus simply on testing the outcomes and competences delivered before registrants are admitted to the register. Whatever happens in respect of this, we believe that there is significant scope for improvement in the current requirements imposed on undergraduate and preregistration education and how it is delivered and assessed. We are not convinced that the current system provides a proper focus on outcomes and competencies; it appears rather to seek to prescribe processes, inputs and activity instead. The GOC requires student to have completed certain modules or achieved certain patient numbers or contact hours. Many academics are concerned that this tick box approach, marking off competencies that have been taught rather than focussing on learning, understanding and progress to standards, is not only ineffective but can be counter-productive. Educators and students spend time ticking the boxes that would be better spent identifying learning needs and focussing on teaching, learning and acquiring the necessary skills. It takes no account of individual learning needs, nor does it guarantee competence. What might take one student 5 patient episodes to become competent could take another 15 patient episodes? Indeed many academics have reported to us that it is hard to see any clear rationale behind particular requirements. Whilst we understand the intent of the GOC, we do not believe this approach to be in the best interests of clinical teaching and learning, nor do we believe that it fits with competence-based teaching. The focus in our view should be on learning outcomes which would free up lecturers' and supervisors' focus on making each student competent in a particular subject or skill as demonstrated by assessment, examination and OSCE, rather than measuring inputs. A new approach is needed whereby educators/academics, along with employers and professionals agree with the GOC what competences are required for entry to and progress up the register. The educators/academics, as the experts, should then be allowed to determine the best way to teach skills and competences and should advise the GOC, the College and the ABDO of the best way to assess those competences. A model like this operates in Australia. Competence/outcomes-based education and training is of course dependent on the quality of the examinations/assessment systems. The quid quo pro of the profession/academics deciding on the content and structure of courses is that students have to pass rigorous clinical examinations.

Consultation question 7 Should the GOC accredit and quality assure additional or different higher qualifications and if so, on what basis?

If the education system is to move to a modular approach, with the expectation that all registrants will engage in continuous professional development, extending their competencies and scope of practice over the course of their career, with the GOC register recording competences and/or scope of practice, then it will clearly be important that additional or different higher qualifications are recognised by the GOC.

However if recognition/accreditation and quality assurance of courses continues, it needs to be light touch, depending on what the course is and who provides it. For example, the GOC should have the flexibility to accredit courses provided by other registered medical or health professional bodies, e.g. pharmacists or medical Royal Colleges, without necessarily putting them through a bureaucratic assessment. The outcomes of the training - i.e. the demonstrable competences of practitioners - is what should count.

Content of education programmes

Consultation question 8 What are the core skills, knowledge and behaviours which optometrists will need to have on first joining the register in the future?

We suggest that core competences need to be agreed by the GOC with practitioners, employers and educators and would welcome the opportunity to discuss further the detail of what should be included in core skills for optometrists and DOs when they enter the register. While not at this stage entering into any great detail about the contents of courses, there is widespread agreement that optometry graduates should, as standard, be competent in the management of extended primary eye care services (i.e. the delivery of GOS services in Scotland, MECs in England and WECs in Wales). This would also mean that

Level 1 prescribing (limited range of types of drugs prescribed within demonstrable competences) should be included in core competences. This would be short of the full scope of independent prescribing across the whole the BNF the scale of which is currently acting as an inhibitor to clinicians developing their optical prescribing skills. There should also be scope to bring other competences within the core training over time.

It has been suggested that, with the growth in accuracy and use of auto-refractors, that refraction should no longer be taught as a core skill for optometrists. However in our discussions with educators and professionals there was clear consensus that understanding refraction is the fundamental basis of optometry and must remain a core skill and we support this. However teaching refraction need not be lengthy or complicated or the primary focus of all optometric training. One subject that may no longer be necessary as a core competence for all optometrists is supply and fitting of spectacles (i.e. dispensing) other than general principles. This could instead become an optional module for those who plan careers more in retail than therapeutic optics. It is of course essential that spectacle supply and fitting remains central to DO core training. Communication skills, business management and public health are already covered on existing courses and training. However all are likely to become increasingly important for optical practitioners – who will be delivering a wider range of care and services to patients and will also need to communicate with a growing number of elderly and frail patients often with varying degrees of cognitive impairment.

Consultation question 9 How should the content and delivery of optometry programmes change to ensure that students gain the skills, knowledge and behaviours that they will require for practice and for new roles in the future?

As discussed in response to questions 4 and 8, optometry degrees need to cover a growing range of skills and competences and it is simply not realistic to expect the full range of skills and competences to be covered within the current format of a three year optometry degree (plus a pre-registration training period).

Whilst Glasgow Caledonian and Hertfordshire Universities already offer a four year degree (plus further pre-registration training), and Manchester University a four year integrated and fully registratible degree course, we are not convinced that extending all degrees to four years would be the best or most a viable solution. An additional year would put pressure on universities because it would require additional funding and additional teaching time. It may also be unattractive to students who would have to pay a fourth year of fees and it would mean the sector losing out on a whole year's cohort of newly-qualified optometrists which it can ill afford. There could be widespread support however for making optometry a clinical degree, and substantially increase the academic year. This could also bring additional government funding to universities via HEFCE etc. However one of the strengths of the current optical and optometry education and training systems is that they are flexible and numbers can be increased or reduced to meet sector need, patient demand changes or demographic change without bureaucratic process or overlong delays. It would be counterproductive if the move to a clinical degree brought optometry within government supply totals which have so impeded the progress of other professions and sectors. Either way we favour moving to a model, as already described in response to question 4, which combines both core components with elective specialisms, with the expectation that a registrant would add to their competences over the course of their career according to their personal, clinical and employment ambitions and as business and employment opportunities become available or in prospect. We also believe that the GOC could safely be far less prescriptive about the learning process and inputs, focussing more on outcomes that need to be demonstrated and allowing educators to determine the most suitable teaching methods to achieve these as in other areas of education and training (see response to question 6). This would allow for the introduction of different teaching and learning formats, such as more time in practice interacting with patients and building inter-professional confidence and communications skills with fellow professionals and patients. Structured case studies, to allow experiential learning across realistic scenarios, could be more beneficial than simply completing a

required number of patient contacts or hours. At present a significant amount of optometry teaching is delivered by ophthalmologists. In our view much of this could and should be taught by experienced optometrists. However there is a shortage of optometry professionals with the requisite levels of both clinical and teaching skills. This is compounded by the fact that universities unrealistically demand lecturers with PhDs as a consequence of modern degree inflation. We believe that there is a strong case for creating a new accredited cadre of optometrist educators/lecturers who could teach or supervise equally well in practice, clinic or academic settings. This would need be supported by employers enabling those with appropriate skills and the teaching qualification to spend a number of days each year out of the consulting room, teaching. However the pay-back could be enormous in terms of skills dissemination throughout the business and professionals' commitment and motivation. Such options should in our view be explicitly encouraged as part of the career progression of individuals. Such a new cadre of educators would fit well with the necessity for ophthalmologist training also to move into community settings as services increasingly shift to primary care in line with patient expectations, technology, the squeeze on HES resources and explicit NHS policy in the four UK countries.

We would be keen to explore with the College of Optometrists and the GOC the scope for recognising, registering, supporting and rewarding those who acquire such teaching and supervision skills in addition to their clinical skills e.g. by a new post-nominal. Ditto with the ABDO.

Consultation question 10 How might post-registration training and registrable higher qualifications for optometrists need to change in the future?

As discussed in response to several previous questions, we would like to see the education system move to a modular approach, with the expectation that most registrants will extend their competences and scope of practice over the course of their career and with the GOC register recording significant competences and wider scopes of practice.

For this to happen, the need for such training will need to be encouraged and registrants will need to pursue Continuing Professional Development rather than Continuing Education and Training. We appreciate that to date the focus has been on CET rather than CPD because this was all the government has been prepared to part-fund for registrants who deliver GOS. Nevertheless, with austerity making further significant funding for CET unlikely and the sectors' ability now to recover the costs of upskilling through fees for locally commissioned services beyond GOS, the time has come to move to a full system of CPD beyond CET to provide more flexibility for individuals and employers

We would also like to see the development of ongoing support for newly qualified registrants, for example creating peer support groups for new registrants, particularly for those joining independent practices or small companies which are less likely to be able to provide peer support groups and discussion or learning groups. Such groups could be set up or supported by the College, LOCS, ROCs and AOCs, Optical Confederation bodies and optical companies (or any combination thereof) working together.

Consultation question 11 What are the core skills, knowledge and behaviours which dispensing opticians will need to have on joining the register in the future?

Consultation question 12 How should the content of dispensing programmes change to ensure that students gain the skills, knowledge and behaviours that they will require for practice and for new roles in the future?

Consultation question 13 How might post-registration training and registrable higher qualifications for dispensing opticians need to change in the future?

Please see responses to questions 1-9 above.

Professionalism and consistent standards

Consultation question 14 How can we ensure students have the professionalism needed to take on new roles, including through the admissions procedures used by education providers, patient experience, supervision and embedding professional standards?

Universities and training practices for both optometrists and DOs already seek to instil professionalism into trainees and students. However if training modalities change to be more patient facing and community based the GOC may need to revisit its previous positions on registering students (Years 2 and 3?) as well pre-registration optometrists so that they are bound by the same professional standards as registrants when interacting with colleagues and patients. A key factor in improvement will be early and ongoing exposure to other professionals working in day-today practice and patients. It is at the coal-face and by watching good role models and leaders, delivering clinical skills in a business environment, that students will best learn what professionalism looks like and what the professional standards and expectations on them will be. This needs to start early and continue throughout basic education, training and, for optometrists, their pre-registration period. It will be tough to develop but a sector-wide professionalism or ethics examination or OSCE should be considered. As the skills base widens, student DOs and pre-registration optometrists well may need more than one supervisor during their training to support them across both core competences and any specialism they may have chosen. Many students also work during holidays (and often at weekends during term time) in optical practices, where they gain important insights into patient management, communication skills and the practicalities of practice management and optical businesses. This should be actively encouraged, supported and recognised as part of the optometrist learning process. We would also strongly suggest that the GOC should consider giving recognition, through the register (as part of scope of practice) to those who are competent to supervise pre-registration optometrists, and also to those who might want to act as optometrist educators. Finally, as already discussed, we suggest that it would be helpful to consider how ongoing support could be provided to those newly entered on the register via peer support groups and peer learning, to help embed their basic training or undergraduate learning, and to continue develop these skills once they are registered for autonomous practice for the first time.

Consultation question 15 How should students be assessed prior to joining the register to ensure that there are consistent and appropriate standards of education, taking into account the different types of education programmes that are emerging?

As already discussed, we believe that the GOC should be less prescriptive about the learning process and inputs and focus more on the outcomes that need to be demonstrated leaving educators to determine the most suitable teaching methods (see response to question 6) for each skill, competence and individual as they do in other disciplines. This would however require a rigorous assessment against competences rather than a confirmation that a student had completed a certain number of patient episodes. Australia provides one such model. We would be keen to work with the GOC, educators and others to discuss how this could best be achieved.

Consultation question 16 What are the challenges and barriers to improving the system of optical education, including issues that may be outside the remit and control of the GOC, such as legislative change, workforce planning, the funding of education (including higher education, continuing education and training and continuing professional development) and the provision of student placements?

We recognise that some of our proposals to change the way in which optometry and dispensing optician qualifications are accredited, assessed and the professions registered, in particular our proposal for modular education and the register recording scope of practice, might require legislative change. More importantly however they require leadership and courage, and the broader backing of the sector. Publicly

enforcing outmoded legislation is never wise whereas leading change and pushing the boundaries are more likely to lead to the legislation itself being rapidly brought into line and will be of more value and benefit to the public than hopeful waiting. WE suggest the GOC and sector seize all opportunities in the government's imminent green paper on health regulation to push the boundaries and to press hard for any necessary legislative flexibilities in the subsequent bill and at pre-legislative scrutiny stage.

Consultation question 17 Are there any other issues that we should consider in carrying out our review? If so, please set out what they are.

We would like to emphasize the importance, as we see it, of prioritising this review. The changes we have outlined are essential, if opticians, optometrists and optical businesses are to contribute their full potential in meeting primary and secondary eye care capacity challenges and improving the eye health of the four UK nations at a time of rapidly rising need and austerity in both public and private funding.

At every stage this review should seek to ensure that, whilst protecting the public and providing reassurance to clinical partner professions and NHS commissioners, the education system of the future has sufficient flexibility so that the scope of practice of both professions can rapidly change in response to advances in technology, skills and public need.

We would be keen to see this work taken forward in partnership– bringing together the expertise of practitioners, employers and academics – and with leadership, boldness and pace that have been too long lacking.

- END -

Glasgow Caledonian University

Consultation question Q1

Demographic projections show a continuing shift towards an older population. Given the increased prevalence and incidence of a wide range of ocular conditions with age (e.g. AMD, Glaucoma, cataract), this will inevitably result in an increase in eye pathology. This will be further exaggerated by an increase in the incidence of systemic conditions that lead to secondary ocular problems (e.g. diabetes; hypertension). Multiple pathologies and co-morbidities will also rise. Many of these ocular conditions are chronic and require life-long management. Other systemic conditions, such as dementia, will add further problems for the management and care of ocular conditions in older patients. The need for domiciliary eye examinations will increase.

The needs of patients at the other end of the age spectrum will also likely change. The increased incidence of myopia will bring an increased demand on eye tests and management of children and young adults. Treatments and vision therapies for these groups will need to carefully assessed, monitored and administered.

It is also expected that patients will become better informed about eye conditions as well as treatment options and prognosis. This will likely increase their expectations and demands. Issues such as Quality of Life and Perfect Health will increase in importance.

New technologies will also affect the needs of patients in the future. It is highly likely that ocular conditions will be detected at an earlier stage and, as a consequence, chronic conditions will require longer treatment/management time than at present. Early detection and increased life expectance will both contribute to this. New technologies will come with the need for trained health-care professionals who can administer and interpret test results and initiate treatment, refer or co-manage conditions. All of these will increase the need for skilled primary eye-care professionals.

New technologies will also likely affect how patients self-manage their conditions. This includes monitoring of symptoms and side-effects of treatment as well as disease progression. This might expand to include self-monitoring of various signs of disease.

Genetic testing is likely to become more readily available and will be used more widely in disease detection and management (e.g. individualised medicines).

New treatment modalities will become available, requiring a continuous re-consideration of best care to ensure that clinical practice remains safe, cost- effective and evidence based.

All these combined will increase the already existing pressure on the NHS and it is difficult to see how all of these demands can be met at secondary care. It seems reasonable to expect that primary eye-care will play an increasing role in all aspects of eye-care than is currently the case. While general demand on primary eye examination can be reasonably well predicted, the extent to which primary care might take over responsibilities currently carried out at secondary care level is less clear. Primary care eye-care, perhaps with extra training, provides a potential platform to decrease pressures on secondary care by taking on new and advanced responsibilities to manage a wide range of acute and chronic eye conditions. We expect that this is likely to happen.

In sum, all these issues will result in a substantial increase in the demand on primary eye-care:

- Ageing population with increased incidence and prevalence of ocular conditions
- Increased and complex co-morbidities
- Regular screening to detect disease at the earliest point and earlier detection of disease
- Management of an increased range of conditions in the community, including many acute and chronic conditions (e.g. low vision services, managing patients requiring cataract surgery, monitoring and treatment of glaucoma) that are currently managed in the hospital

Consultation question Q2

Changes in how and where eye care is provided in the future:

- It is unlikely that the increased demand of an ageing population with significant increases in disease incidence and prevalence can continued to be met within the current care pathway (see question 1 above).
- It is expected that some of this demand for eye care will be met in the community, with increased convenience for the patient.
- Taking on new and enhanced roles will require up-skilling of the optometric profession so that they can meet the demand.
- More screening, review and management of ocular conditions will be shifted from secondary to primary eye-care
- This is likely to require optometrists to manage independently a wide range of acute and chronic conditions at primary level.
- This may further extent to include minor surgical procedures with specialisation
- This will require an increased number of optometrists with specialist skills including IP.

Barriers:

- Eye-care pathways need to adapt to enable an increased amount of management of ocular conditions to take place in primary settings.
- Optometric training needs to provide increased clinical skills at under- and/or post-graduate levels. There is currently insufficient flexibility in the GOC requirements to support this. For example, training undergraduate students to IP level is currently not possible as the GOC requires a minimum of two years post-registration experience. This hinders Universities to train students to IP level.
- Funding: increased funding (both duration of funding and funding level) for undergraduate education is required to implement such changes.
- Funding of sight tests needs to reflect increased responsibilities in primary eye-care setting.
- Other disciplines involved in eye-care (GPs, Pharmacy, Ophthalmology) need to be engaged and need to buy into enhanced roles for primary eye care and be open to work within a multi-disciplinary professional network.
- The awareness of the (increasing) remit of Optometrists needs to change. This affects the general public but also other health care professions including GPs and Pharmacists. If optometrists are to become the first port of call for any vision and eye health related issues, it is important that this is widely know by the general public.
- Policy makers need to be lobbied to enable the financial framework that is required to allow these changes to take place.

Consultation question Q3

- It is unlikely that the increased demand of an ageing population with significant increases in disease incidence and prevalence can continued to be met within the current care pathway (see question 1 & 2 above).
- It is expected that some of this demand for eye care will be met in the community, with increased convenience for the patient.
- Taking on new and enhanced roles will require up-skilling of the optometric profession so that they can meet the demand.
- More screening, review and management of ocular conditions will be shifted from secondary to primary eye-care
- This is likely to require optometrists to manage independently a wide range of acute and chronic conditions at primary level.
- This may further extent to include minor surgical procedures with specialisation
- This will require an increased number of optometrists with specialist skills.

- Community optometry will likely become the first port of call for all aspects affecting vision and the eyes. It is conceivable that this will result in a re-design of acute hospital eye care, as is already the case in parts of Scotland (Grampian), where all ocular emergencies are seen in community first.

Implications on Optometry training at under- and post-grad level:

- The changes outlined above will require a different skill set from Optometrists. Entry level will have to rise and we anticipate that this will be at what is currently IP level. Training to that level will enable all optometrists to detect and manage a wide range of ocular conditions independently and only refer cases where more specialist care is required.
- Up-skilling of clinical skills, including diagnosis, differential diagnosis, management.
- To enable future optometrists to meet the demands of a fast developing profession (new technologies will affect how ocular disease is detected, monitored, and managed), their training/education needs to provide them with solid foundations on a range of basic aspects (optics, physiology, anatomy, pharmacology). We envisage this to be akin to medical training before specialisation. Such a solid grounding will enable graduates to adapt to future changes in clinical practice.
- Graduates will also require solid clinical skills (disease detection, differential diagnosis, disease management, monitoring management and disease progression) at entry level.
- At post-grad level, further specialisation can take place, e.g. via extended hospital training. This again could be similar to the model used for medical training where specialisation takes places following a period of general education. These specialised skills could include chronic conditions such as independent Glaucoma management but may also in the future extend to ocular injections (e.g. for AMD) or even minor surgeries (cataract).

Consultation question Q4

- For an Optometrist to be flexible and able to adapt to changes in their professional role – either due to changes in job profile, career development/path, changes due to new technologies, new diagnostic modalities and/or novel treatment options – they need to have a solid grounding in a range of general aspects underling ocular function, disease and management. These include, among others, optics, physiology, anatomy, pharmacology, immunology, microbiology. We believe that it would be detrimental to the ability of future optometrists to adapt to any professional changes if education was to remove any of these fundamental aspects.
- Another important aspect of general education concerns scientific literacy. Optometrists and dispensing opticians need to be versed in the critical appraisal of scientific literature in order to appropriately implement new technologies and management strategies into their clinical routine. The undergraduate syllabus needs to ensure that students have ample opportunity to acquire this critical skill.
- It is paramount that the education of optometrists and dispensing opticians provides graduates that are life-long learners. It is impossible to cover all conceivable aspects of what may be required from future graduates in today's syllabus, and many future advances cannot be predicted today. You can't educate for unknown technological and clinical improvements but you can, and should, create adaptable and flexible graduates who have the theoretical grounding to acquire and embrace any such novel advances.
- We favour an educational model where every graduate has the same core skills and can, if required, acquire additional and specialisation skills throughout their career. This is similar to medical training with common basic and subsequent specialist training.
- What should the core level of optometric education be? We think that the basic, common core level should be IP: providing graduates with the essential knowledge to operate independently and diagnose and manage conditions within their sphere of experience and competence. At the point of entering the professional register, the range of conditions that may be managed by a typical optometrist may not be very different from today's entry level but the graduate is equipped with sufficient pharmaceutical knowledge to take on increased responsibilities commensurate with their clinical experience.

- Further specialisation can then be provided either formally via post-graduate training or informally via hospital placements and peer-to-peer training and shadowing.
- To allow consistency for many different types of specialisation (e.g. orthoptics, paediatrics (including myopia control), glaucoma, medical retina, medical contact lenses, low vision, etc.), the general education requires a common platform and in our view that is best provided by training towards IP.
- This will likely require an increased duration of basic optometric training (from currently 3+1years in most parts of the UK to 4+1; from currently 4+1 in Scotland to 4.5+1)

Consultation question Q5

The GOC register needs to move to a more flexible system in order to accommodate any future changes. Changes may occur within as well as across the registrant groups; boundaries may shift with responsibilities and distinctions may become blurred. However, the basic distinction between Optometrists and Dispensing Opticians should remain to reflect differences in education, experience, responsibilities and scope of practice.

Regarding Optometry, we envisage a system similar to the current one, that consists of basic, entry level registrants as well as a range of specialities. We would predict that the number and types of speciality is likely to increase to reflect the varied post-grad qualifications, professional diplomas and clinical expertise that will be required to meet to changing demand within eye-care provision (see above). It is possible that individuals may acquire multiple specialities or work predominantly within a single speciality, similar to medicine.

Consultation question Q6

We view the GOC's accreditation and quality assurance visits of educational programmes a useful tool that should help to maintain a common level of undergraduate education and result in graduates that are fit for their future clinical role. In our experience, the implementation has, however, lacked consistency and proportionality. We would advocate a collegial and trusting partnership where best practice is promoted and an open approach from both the education programme and the visiting panel engaging in constructive discussion with the main goal of improving education quality.

We also would propose an accreditation approach that differentiates between those aspects that are critical for patient safety and should therefore be closely regulated and others that should be left to education institutions. Student examining patients under supervision is an example for the former; syllabus, teaching and assessment strategies should be less regulated. For those latter aspects, there should be a much more flexible set of standards of education than is currently the case. Standards that are less prescriptive about what the training is and how it is structured and assessed and an increasing weight on what the training achieves. The current focus by the GOC is very much input driven, which restricts how students can work within the university setting in general and in university clinics in particular.

It is essential that the accreditation and quality assurance approach is grounded on best available evidence. Consideration should be given a wide range of outcome measures: for example, how successful are graduates during their pre-reg period? Significant evidence that identifies short-comings of pre-reg students from one educational provider need to trigger action for the delivery of the under-graduate training.

Regarding competencies, in general we see a competency framework as a useful tool to try and achieve a common basic denominator for students. But a Competency model should be firmly rooted in best available evidence, including the use of quantitative research into correlations between syllabus, competencies and outcome measures. This should result in a much more flexible set of standards of education than is currently the case. To re-iterate what was said above about the education in general, standards for competencies should be less prescriptive on what the training is and how it is structured and an increasing weight on what the training achieves. The way competencies are being assessed

currently is too much of a ticking box exercise, with too much attention on passing a excessively detailed assessment and too little weight given to achieve the overall goal of safe patient management.

Moreover, the current GOC competency model lacks distinction between level 1 and level 2 competencies. Given the comparatively small number of patient episodes during University training and the significant number of patients during pre-reg, it is unclear how these competencies were defined with so little distinction. Much more consideration should be given to the distinction between 'knows', 'knows how', 'shows how', and 'does', as defined in Miller's pyramid.

With regards to Patient episodes, the minimum numbers outlined in the current GOC framework for educators lacks any evidence that would support that these numbers are required to achieve the desired outcome, ie. a requirement to start pre-reg period. It would be highly desirable if every effort was made to conduct the appropriate research that would allow these numbers to be firmly based on evidence.

Consultation question Q7

We see a potential danger for the public if additional/higher qualifications leading to specialities lack consistent and evidence based regulation. We believe that in order to ensure public safety, it is essential that a central process of accreditation and quality assurance is in place to guarantee that graduates have the clinical knowledge and skills required in their intended roles. Therefore, any credit bearing, additional or higher qualification that results in an enhanced professional role should be regulated and we would support the GOC to take on this role.

This may be embedded into a larger scheme of CPD, and perhaps away from CET, for all optometrists including those who want to gain specialised skills that result from additional or higher qualifications.

Consultation question Q8

Prescribing/ future entry level of Optometry registrants:

- We favour an educational model where every graduate has the same core skills and can, if required, acquire additional and specialisation skills throughout their career.
- This is similar to medical training with common basic and subsequent specialist training.
- To allow a profession to develop and adapt in ways that cannot be predicted today, we think that the basic, common core level should be IP: providing graduates with the essential knowledge and skills to operate independently and diagnose and manage conditions within their sphere of experience and competence.
- At the point of entering the professional register, the range of conditions that may be managed by a typical optometrist may not be very different from today's entry level but the graduate is equipped with sufficient pharmaceutical knowledge to take on increased responsibilities commensurate with their clinical experience.
- Further specialisation can then be provided either formally via post-graduate training or informally via hospital placements and peer-to-peer training and shadowing as part of CPD.
- To allow such specialisation, the general education requires a common platform and in our view that is best provided by training towards prescribing/IP level.

Knowledge/ technology:

- It is critical to provide students with a full understanding of currently available technology but it is impossible to predict future technological advances either for detection, monitoring or management of ocular conditions.
- Future practice will inevitably change and optometrists will be required to adapt to these changes.
- The best way to equip future practitioners for a changing technological environment is to provide solid foundation knowledge that spans optics, physiology, anatomy, pharmacology, immunology and microbiology.

- This needs to be embedded within an education framework that teaches students to become independent learners and foster the awareness that life-long learning will be an integral part of their professional career.

Communication skills:
- Communication skills is fundamental to all health-care professions. The need to train students to become efficient and successful communicators has long been recognised and this needs to remain soundly embedded in the education syllabus for all eye-care professionals.

Public health:
- Public health issues, including advice on healthy living, will likely increase in importance in the future and should be part of any undergraduate syllabus.

Consistency with the standards of other healthcare professions:
- We see such a multi-disciplinary (Optometrists, Dispensing Opticians and Orthoptics) teaching approach as best practice that should be employed where possible
- Where students are taught jointly, this approach fosters close professional links and future collaborations between different eye-care professions.

Refraction:
- In our view, refraction is a core skill that each discipline (Optometrists, Dispensing Opticians and Orthoptics) will have to fully understand conceptually and be able to perform on patients with a wide range of needs and conditions.
- Automatisation may play a role in the future but results from such procedures will be required to be interpreted and verified, and in some cases likely to be corrected. Without the background knowledge and clinical skills in refraction, this won't be possible.
- We see Refraction as a core skill that is required and cannot be removed from the syllabus for any eye-care professional.

Clinical experience:
- Optometry students have to be exposed to and gain experience with a wide range of patients with different demands and requirements. This is a pre-requisite for students to consolidate their knowledge and clinical skills in a real life scenario. It is unclear what the number and type of patient episodes need to be in order to be ready to start a pre-reg period and research is required to provide solid evidence to support these.

Consultation question Q9

It is unclear if either content or delivery of currently available optometry programmes is in need for a change. There does not seem to be evidence to suggest that changes are required. Indeed, optometry programmes such as the one at Glasgow Caledonian University, have been pro-active to anticipate future changes in the profession and always been able to adapt to professional changes. For example, the General Ophthalmic Service requirements in Scotland differ from those in other parts of the UK and this is reflected in Glasgow's undergraduate syllabus, which has continuously been revised to meet or anticipate future demands. There is no indication that this general approach, proactively driven by Universities, will not continue to be successful.

The following outlines our views of what future educational changes may be required in response to expected changes in practice.

Content: It is important that content and delivery of Optometry programmes are adapted regularly to reflect advances in best practice, development of new technologies as well as the introduction of new treatments for ocular disease. Therefore, the regulation of optometric education needs to allow for and support the flexible adjustment of the syllabus.

However, for an Optometrist to be flexible and able to adapt to changes in their professional role, they need to have a solid grounding is a range of general aspects underling ocular function, disease and management. These include, among others, optics, physiology, anatomy, pharmacology, immunology, microbiology. We believe that it would be detrimental to the ability of future optometrists to adapt to any professional changes which are inevitably occur if optometric education was to remove any of these fundamental aspects.

Apart from teaching core knowledge and skills, it is paramount that the education of optometrists and dispensing opticians provides graduates that are life-long learners.

Delivery:

- Staff involved in the delivery of optometry and ophthalmic dispensing programmes should have a solid grounding in research and scholarship.
- Optometry and ophthalmic dispensing teaching should be informed by evidence from carefully conducted research.
- The GOC framework should be flexible to allow integrated delivery of pre-reg period as well as IP training into under- or post-graduate programmes. As outlined above, we see a registerable Optometry degree combined with IP specialisation as a distinct possibility for the future.
- Aspects of teaching delivery are likely an area where substantial changes will occur in the next few years. Delivery of education is already seeing changes, e.g. flipped classrooms, recorded lectures, on-line chatrooms, inter-active discussion boards, blended learning etc.
- Future students are likely to prefer education that can be accessed when and from where they want.
- While this can't be accommodated for clinical and patient based episodes, much of the current classroom activities will have to be more flexible.
- An increasing emphasis should be placed on evidence based practice where students have to be able to demonstrate how they implement this into their clinical practice.
- Students should be introduced to Peer Review at an early stage to evaluate their skills, provide feedback and build confidence.
- Problem based learning should become more fully embedded into the education syllabus alongside with training students to become life-long, independent learners.
- It will remain a topic for educational research to determine the success of these alternative/novel methods of delivery compared to the current standard. Results from this research should be used to underpin the design and delivery of eye-care education.

Consultation question Q10

- As for undergraduate training, is important that content and delivery of post-grad training are adapted regularly to reflect advances in best practice, development of new technologies as well as the introduction of new medication and treatments for ocular disease.
- There is the additional need for post-grad training to align with the evolving needs of eye-care within the bigger context of the NHS.
- We foresee that some of the current specialist skills may be absorbed in the future undergraduate training and new specialities emerge.
- The range of specialities will likely be more extensive than at present and registered optometrists will have the opportunity within this framework to acquire new and advanced skills.
- The necessary training, theoretical and practical, will be delivered as part of post-registration training and registrable higher qualifications.
- Such specialist qualifications will allow for an adaptive environment that remains regulated and responsible with regards to the quality of those who participate in it.
- Professional assessment for specialist qualifications, including IP, should also be allowed more flexibility. At present, there is only one provider of a professional assessment for IP. It would be desirable for providers of the theoretical training to integrate the practical/clinic based training as well as the professional assessment into post-grad programmes.

Consultation question Q11

- Students should have various forms of communication skills to interact with both the general public (patients) and with professional colleagues and governing bodies.
- Students should be able to listen with empathy to patients and react according to the best interests of the patient (excellent customer service skills a priority).
- Students should be able to carry out a wide range of ophthalmic dispensing tasks in a confident and competent professional manner (manual dexterity / technical ability & attention to detail). Students should also be kept up-to-date with changes that are occurring in Optometry.
- Students should have a good understanding of how an optical business is efficiently managed / commercial awareness – including a clear understanding of the effects of sales v costs
- Students should have the ability to see the benefits of and play an integral role within a supportive multi-disciplinary practice team
- Students should have knowledge of current optical market developments / issues / new products, etc.

Consultation question Q12

- Syllabus changes to move in line with new technology
- Content should reflect changes affecting other areas of eye-care across the UK
- The required patient contact/practice hours should be revised and reduced to bring it in line with other comparable healthcare professions.

Consultation question Q13

The dispensing optician of the future will need to be able to take their place in a changing optical marketplace, therefore they may need to have ready skills to allow for a more prominent role in refraction or in the care of minor eye conditions.

Future CET provision should play a prominent role in this preparation.

The GOC should seek for parity and equality in the roles of the dispensing optician versus the current seemingly elevated role of the optometrist – especially in the provision & financial support of CET.

Consultation question Q14

- Regular audits of admissions procedures could be used to ensure that selection criteria are fit for purpose and graduates are continuing to meet the demand of their chosen profession, including professionalism.
- It is important to consider that students undergo substantial development during their studies especially with regards to their maturity, which impacts directly on professionalism. Interviewing students as part of admission carries a substantial risk at a point where maturity varies considerable across applicants and where little or no consideration may be give to the ability of prospective students to acquire professional standards during their studies.
- It needs to be borne in mind that professional standards are fostered throughout the University education via interactions with supervisors, staff, patients and other health care professions.
- With regards to patient experience, quality of student supervision and professional standards, these are all integral to Optometry programmes and have to follow stringent regulatory body requirements. We think that these requirements as outlined in the GOC handbook for education providers are useful to support and foster best practice.

Consultation question Q15

Guidelines and criteria for professional assessments should be formulated and form a requirement for any organisation that wishes to run such assessments.

It is essential that these guidelines and criteria are based on best practice and best available evidence and devised and reviewed following wide consultation with all stakeholders.

Consultation question Q16

Workforce planning: it would be desirable for the health of the profession if a regulatory body had influence on workforce planning by e.g. lobbying for extra governmental funding in times of workforce undersupply or capping student intake in case of an oversupply. This would allow some measured steering and respond to future changes to eye-care provision, funding and uptake.

Oversupply of Optometrists: related to the point above, we are concerned about the recent increased intake of optometrist students across the UK. Creating an oversupply of Optometrists is detrimental to the profession in a number of ways: affecting salaries, employment, job satisfaction and in turn quality and numbers of future students. A concerted effort should be made to carefully consider workforce planning and to avoid an oversupplying of Optometrists.

Funding of education: one of the biggest barriers and challenges: it is essential that funding of student places reflects the changing landscape of eye-care provision with increased responsibilities from graduates, increased demands from prospective students, increased clinical training and patient exposure and high quality supervision with low staff-student ratios. Governments, including those of the devolved nations, need to be continuously lobbied to guarantee that sufficient funds are being made available to educate high calibre eye-care professionals.

Funding of eye care & legislative changes: Funding and fees available for eye-care need to adapt continuously and reflect increased responsibilities. Free eye-care is available to all in Scotland. Moreover, supplementary eye examinations (not requiring a full eye exam) are available in Scotland and these are an essential component to allow optometrists to prescribe for ocular conditions and manage those to completion/discharge. Currently, this set-up does not provide for referral between optometrists, e.g. entry level to IP optom referral. This route should be considered. Although there are prescription pads available to IP optometrists in Scotland, prescribing itself cannot currently be charged to the NHS. Such issues require attention in order to make full use of the expertise available and provide best care for patients that is cost-efficient.

The general aspects of this model (free eye tests; supplementary test) should be considered for other parts of the UK.

Student placements: it is desirable for any form of placement (pre-reg, IP) to provide consistent and equal standards but this is difficult to monitor and achieve with the diversity of supervisors and placements. Nevertheless, any effort should be made to ensure high quality and equality of pre-reg placements.

Consultation question Q17

- END -

GMC (General Medical Council)

Consultation question Q1 We have no evidence to submit.

Consultation question Q2 We have no evidence to submit.

Consultation question Q3 We have no evidence to submit.

Consultation question Q4 We have no evidence to submit.

Consultation question Q5 We have no evidence to submit.

Consultation question Q6

We don't have views on the GOC's approach to the accreditation and quality assurance of education programmes but thought it might be useful to provide an update about how we are considering our approach for the future. The General Medical Council regulates medical schools by setting outcomes that graduates must meet. Medical schools to have flexibility as to how outcomes are implemented in their curriculum and this supports medical education that after foundation training leads to a wide range of higher specialty training. There is no UK-wide curriculum or assessment process and final exams (finals) vary substantially between the established medical schools. A major expansion in student numbers is now underway, potentially involving wholly new medical schools as well as new programmes, sometimes delivered overseas. In addition to the outcomes for graduates (which we are currently reviewing) we are looking at introducing a medical licensing assessment. This would create a single, objective demonstration that those applying for registration with a licence to practise medicine in the UK can meet a common threshold for safe practice.

We set standards for all stages of medical education and training in our document Promoting excellence. The standards apply across the UK in a range of complex education and training environments while acknowledging that the way in which organisations meet the standards may vary depending on the context in which education and training is delivered. We adopted the following principles when developing the standards: supporting transparency and sharing of information to reduce risk and improve quality; supporting professional and systems regulators working together in partnership in the shared learning environment; responding to changes in medical practice and care of patients in different healthcare settings; and allowing flexibility in delivery to promote quality improvement and innovation.

Consultation question Q7

We set standards and approve postgraduate curricula and assessment systems. We have recently agreed a framework of generic professional capabilities (GPCs) that are broader human skills, such as communication and team working, needed by doctors to help provide safe and effective patient care. They are common to doctors across all medical specialties. In future all postgraduate curricula will reflect the GPCs. We have also recently revised our standards for curricula and assessment systems that are used to approve medical specialty curricula. We are considering how the GPC framework will be reflected in outcomes for graduates.

Consultation question Q8 We have no evidence to submit.

Consultation question Q9 We have no evidence to submit.

Consultation question Q10 We have no evidence to submit.

Consultation question Q11 We have no evidence to submit.

Consultation question Q12 We have no evidence to submit.

Consultation question Q13 We have no evidence to submit.

Consultation question Q14 We have no evidence to submit.

Consultation question Q15 We have no evidence to submit.

Consultation question Q16 We have no evidence to submit.

Consultation question Q17 We have no evidence to submit.

- END -

Hampshire LOC

Consultation question Q1
With an increasingly elderly patient demographic and with increased pressure on secondary care then a lot of what is now done in secondary care will have to move out into the community therefore a workforce to support this has to be trained.

Consultation question Q2
Current secondary care provision will come under increasing pressure and therefor many appts which would have traditionally taken place in secondary care will as a result devolve to the community.

Consultation question Q3
Drivers for change include increasing numbers of people trying to access services,pressure on secondary care units and a current realisation that optometric practice is ready to take on (and is currently taking on)work which hitherto was in secondary care.

Consultation question Q4
Change to a 5yr training including the preregistration year and a subsequent year working to achieve enhanced service qualifications.
This can then be augmented for practitioners already qualified by the provision of enhanced service training by a combination of web based and practical skills assessment

Consultation question Q5

Consultation question Q6

Consultation question Q7 Yes

Consultation question Q8
A desire to do the job(sadly lacking in a lot of students!),the ability to communicate with the general public not just their peer group and an interest in furthering the profession.

Consultation question Q9
Too few contact hours at present fpr students in optometry degrees considering the amount of information they have to acquire.Also too modular in that they have no realisation when they get to practice that they need all their knowledge for every day as they can't legislate for what comes into their consulting room.

Consultation question Q10
There needs to be some form of reaccreditation for Mecs practitioners built into the GOC cycle of reacreditation in much the same way that this is already done for those with an IP qualification.We are already running up against this in the long established MECS services where there was no reaccreditation process put in place at the time of the contract.

Consultation question Q11

Consultation question Q12

Consultation question Q13

Consultation question Q14
Interview the students before offering places at university -the lack of workforce hours has been contributed to by students doing degrees for which they are unsuited and which results in their never practising once qualified

Consultation question Q15

The College of Optometrists scheme for registration comes as a big shock to most students as they have to come to terms with both working in practice and fulfilling the competency guidelines.

The scheme shows up the lack of patient interaction that there is in the universities and the lack of basic knowledge of some skills eg contact lens fitting with which students are equipped.

Consultation question Q16

Consultation question Q17

- END -

Irfan

Consultation question Q1
Optometrists are going to have more responsibility in health care related issues.
I foresee refraction no longer being an important part of the examination and additional services coming to the fore.

Be it glaucoma patients management or acute eye conditions management it will replace the traditional dig he test

Consultation question Q2
Main barrier will be optometrist lack of willingness to improve skills and owners of practice not willing to move away from sight test as they generate more money

Consultation question Q3
Incompetent government management of nhs services will result in under supply of ophthalmologists and hence less available appointments. Optometrist will need to help out.

Consultation question Q4
Compulsory training in core skills which all optometrists need to carry out.
Certain CET modules must be compulsory for example Wopec glaucoma or mecs

Consultation question Q5
Need to raise the standard of all Optometrists and not just the few that choose to.
Then those who are at IP level can be distinguished.

Consultation question Q6
It's not suitable for purpose.
IP registrants need to keep a log book. It is the only professional where this is the Case and it is extremely annoying to log all patients seen.
Need to give optometrists a bit of credit.
But then things like prof very are a waste of time. All this should be in university education

Consultation question Q7
Yes. It should not be done by the college.

Consultation question Q8
Goldmann Volk

Basic gonio understanding

Consultation question Q9

Consultation question Q10

Consultation question Q11

Consultation question Q12

Consultation question Q13

Consultation question Q14

Consultation question Q15

Consultation question Q16

Consultation question Q17

- END -

J M Woodhouse

Consultation question Q1
'Ageing population' applies to people with learning disabilities as well as to the general population and the inevitable increase in dementia will mean many more vulnerable adults needing good eye care

Consultation question Q2
Hospital eye clinics in which patient contact time is often short and inflexible are not appropriate sites for eye care for vulnerable children and adults. When all that is needed is refraction and vision testing (as opposed to treatment), vulnerable pateints should be seen in primary care

Consultation question Q3
Greater use of technology (not always a good thing as far as vulnerable patients are concerned), transfer of non-medical care to the community and development of roles in therapeutics and minor eye conditions

Consultation question Q4
I would like to see accreditation and specialisms post-registration, in paediatric and special needs eyecare (including vulnerable adults) as well as therapautics, glaucoma etc

Consultation question Q5
At present the public cannot distinguish between practitoners with special training and those without. There must be quite distinct registers to allow patients to choose their eye care practitioner appropriately

Consultation question Q6
No comment

Consultation question Q7
There should be quite distinct and recognisable qualifications for accreditation to certain roles, achieved either by undergraduate options or by post-graduate courses

Consultation question Q8
To the current competencies, I would add a better understanding of the needs of vulnerable patients and the skill to communicate with such patients. I argue strongly for accreditation to provide eye care for young children and for vulnerable patients of all ages, but mainstream optometrists must be able to triage such patients and make appropriate referrals

Consultation question Q9
Possibly the introduction of options into the undergraduate programme to allow students to begin specialisation. For example, contact lenses and advanced dispensing could become options, with all students taught enough of the basics to allow triage, but freeing up time within the programme for other options such as paediatrics

Consultation question Q10 As above, post-graduate courses leading to recognisable qualifications

Consultation question Q11
To the current competencies, I would add a better understanding of the needs of vulnerable patients and the skill to communicate with such patients. As above, I argue strongly for accreditation to provide eye care for young children and for vulnerable patients of all ages, but mainstream dispensing opticians must be able to triage such patients and make appropriate referrals

Consultation question Q12
No comment (I don't know enough about current programmes)

Consultation question Q13
As above, post-graduate courses leading to recognisable qualifications

Consultation question Q14
The equivalent of a Hippocratic oath

Consultation question Q15
No comment

Consultation question Q16
The funding of eye examinations is a huge barrier to practitioners developing any kind of specialist skill. There are some enhanced service arrangements, but these are local and very patchy and not an appropriate way to fund a national eye care service. There must be a major shift in GOS funding for eye examinations

Consultation question Q17

- END -

J M Woodhouse

Changes in demand and the impact of changes in eye care delivery

Consultation question 1 – How might the needs of patients requiring eye care change over the next 20 years?

We need to listen to the voice of the patient. They want better community access to services by skilled providers of eyecare. They also want more holistic care with integrated healthcare delivered by stakeholders e.g. GPs, Pharmacists, Social workers and Ophthalmologists.

Consultation question 2 – What changes in how and where eye care is provided will be required over the next 20 years in order to meet patient's needs, and what are the barriers to these changes?

The biggest barrier is a political will for all stakeholders to work together. Each has their own interest but must put public welfare foremost in its strategic plans. Optometrists, Clos and DOs have to upskill, Secondary care has to discharge more patients to primary care e.g. stable Glaucoma and Primary care has to monitor treat or refer more rather than refer as a default.

Consultation question 3 - How are the roles of optometrists and dispensing opticians likely to change over the next 20 years, and what are the drivers for these changes?

NHS Efficiencies and government initiatives will drive more commissioning of services and OOs, CLOs and DOs will be involved with more referral refinement such as MECS; and pathways for various diseases such as Glaucoma, Wet AMD, Cataract pre and post assessment and other misc. areas e.g. paediatrics.

Consultation question 4 – How should the education of optometrists and dispensing opticians be structured to enable continuing professional development throughout their careers, e.g. core training followed by general or specialist practice?

IP has to be taught at undergraduate level. Patient episodes must occur in each undergraduate year with an emphasis on communication and leadership skills in addition to communication skills. Innovative models of training need to be piloted e.g. surrogate patients, integrated degrees with GOC registration, flexible training using non-standard entry requirements. Post graduate training has to involve more peer to peer traing with peer review compulsory for all registrants every year. CPD should be a portfolio and the CET rolling 3 year cycle should be phased out and allow a more mature approach to self learning like other allied health providers e.g. Pharmacists.

Consultation question 5 – What are the implications for the GOC register of likely changes in roles and will the existing distinctions between registrant groups remains appropriate?

The registers should be replaced with one that lists the competencies of each registrant. All registrants should be called either Optometrists or Opticians with additional qualifications. This would make the register more accessible and comprehensive with less jargon for the public.

Consultation question 6 – What are your views on the GOC's approach to the accreditation and quality assurance of education programmes, including on whether this is an appropriate focus on outcomes and on the use of the competency model to set the standards of education?

The QA is not robust and requires extensive investment so the Education role of the GOC is fit for purpose.

Consultation question 7 – Should the GOC accredit and quality assure additional or different higher qualifications and if so, on what basis?

No. However it should review the IP qualification as asking for a log of prescribing decisions and requiring a portfolio of cases to be witnessed by an Ophthalmologist only (instead of also allowing peer to peer accreditation) is disproportionate to the risks and subsequent FTP cases. These initial safeguarding measures now need reviewed and nullified.

Consultation question 8 – What are the core skills, knowledge and behaviours which optometrists will need to have on first joining the register in the future?

Core skills Instrumentation, Law, Pathology, Basic Optics

Knowledge Patient management, pathways, holistic healthcare

Behaviour Empathetic, professional, effective communication

Consultation question 9 – How should the content and delivery of optometry programmes change to ensure that students gain the skills, knowledge and behaviours that they will require for practice and for new roles in the future?

Less focus competency model e.g. no of episodes

More focus on outcome model e.g. how does my input help the patients understanding of their condition

Consultation question 10 – How might post-registration training and registrable higher qualifications for optometrists need to change in the future?

Bottlenecks have to be identified and resolved e.g. training for IP Optometrists in England requires secondary involvement which is limited and expensive. Higher qualifications must allow professional advancement for the registrant to work in their area of expertise not withstanding that they will have to increase their knowledge by working sometimes at the boundary of their knowledge.

Consultation question 11 – What are the core skills, knowledge and behaviours which dispensing opticians will need to have on joining the register in the future?

Core skills Instrumentation, Law, Pathology, Basic Optics

Knowledge Patient management, pathways, holistic healthcare

Behaviour Empathetic, professional, effective communication

Consultation question 12 – How should the content of dispensing programmes change to ensure that students gain the skills, knowledge and behaviours that they will require for practice and for new roles in the future?

Flexible schemes e.g. work based placements and block learning

Business management and Leadership

Consultation question 13 – How might post-registration training and registrable higher qualifications for dispensing opticians need to change in the future?

Increase the scope of medicines used e.g. allow additional supply and supplementary prescribing as higher qualifications

Instrumentation e.g. interpretation of OCT scans, fundus photographs, visual fields

Refraction e.g. CLOs to allow accurate final CL prescriptions

MECS for CLOs Note Anterior e.g. AMECS

Consultation question 14 – How can we ensure students have the professionalism needed to take on new roles, including through the admissions procedures used by education providers, patient experience, supervision and embedding professional standards?

Mandatory interviews of candidates and station exams as appropriate e.g. ethical station, skill station, communication station etc.

Teach GOC standards within the programme

Use fellow peers for case studies not just hospital placements

Consultation question 15 – How should students be assessed prior to joining the register to ensure that there are consistent and appropriate standards of education, taking into account the different types of education programmes that are emerging?

The Pre-registration period need reviewed with increasing resits in all 3 stages of the process. The appeal process after the 2 year 3 months time bar needs an overhaul. An alternative assessment is required in some nations where the minimum level of skills is above core competency. Mandatory supervisor needs endorsed.

Consultation question 16 – What are the challenges and barriers to improving the system of optical education, including issues that may be outside the remit and control of the GOC, such as legislative change, workforce planning, the funding of education (including higher education, continuing education and training and continuing professional development) and the provision of student placements?

With market forces shaping service delivery e.g. CCGs commissioning, Free Eye Tests, etc. the will for legislative change may be slow. The GOC cannot control workforce planning and salaries will decrease with a parallel increase in student numbers year on year. A recruitment drive for supervisors may be required to ensure the correct skills and will to undertake this role are realised.

Consultation question 17 – Are there any other issues that we should consider in carrying out our review? If so, please set out what they are.

Scottish Independence following Section 50 will have a potential to create more division

Optometrists outside of Scotland have to sit a core competence exam, which may be replicated, in other nations

The effect of Brexit on allowing EEU professionals to apply for GOC registration

The effect of CORU on not accepting the Anglo-Irish agreement allowing free passage of professionals to work in the UK and Ireland and vica versa

The recognition of not having any registrant on the GOC executive to provide independent advice on Education requires the council to provide this knowledge which could be viewed as a weakness by external accreditors

The possibility of the Governments review of regulators to establish a generic body.

- END -

Melanie Hingorani

Consultation question 1 – How might the needs of patients requiring eye care change over the next 20 years?

There is likely to be much greater demand for eye care both in hospitals and in primary care and the community. There will be patients with multiple chronic eye disorders requiring long term monitoring and management and also with eye disorders associated with multiple systemic diseases.

Patients will require long term monitoring, ideally much done by virtual, telemedicine and data gathering exercises viewed remotely by clinicians or by assessments in primary and community clinics and as much as possible patients being able to be cared outside hospital, unless hospital based care unavoidable. Patients may be older, there may be more dementia and frailty.

Consultation question 2 – What changes in how and where eye care is provided will be required over the next 20 years in order to meet patients' needs, and what are the barriers to these changes?

Patients will need to be able to access care outside of hospital as much as possible and also be screened to avoid unnecessary referrals and also low risk or stable disease cared for and monitored outside of hospital. Much more will need to be done by non medical professionals and much more outside hospital.

Barriers to these changes:

Difficulties in exchanging and sharing information and images securely and IT issues

Lack of deep knowledge base in non medics of anatomy, physiology, biochemistry, microbiology, pharmacology, ophthalmic pathology, non ophthalmic disease, clinical governance practice especially in the community

Lack of focussed training in these areas and lack of nationally accessible consistent education for the knowledge and skills required

Difficulties with duplication of expensive equipment

Patients focussed on the need to see doctors and visit hospital

Ophthalmologists concern on risks, ophthalmologists no time to support non medical colleagues and develop new innovative working practices

Lack of clear clinical governance structures for new models of care

Consultation question 3 - How are the roles of optometrists and dispensing opticians likely to change over the next 20 years, and what are the drivers for these changes?

The drivers are those above plus need for financial sustainability and bigger workforce for ophthalmic care.

Optometrists will need to be at the forefront of delivery of care, avoiding unnecessary referrals and monitoring of low risk or stable pathology. Optometrists also need to be empowered to manage more risk within a suitable governance structure and to work with other professionals and commissioners to develop new ways of working and new pathways locally.

Consultation question 4 – How should the education of optometrists and dispensing opticians be structured to enable continuing professional development throughout their careers, e.g. core training followed by general or specialist practice?

Firstly all need a better basis for “medical” and extended role care within their core training. This includes teaching and training and competencies in anatomy, physiology, biochemistry, microbiology, pharmacology, ophthalmic pathology, non ophthalmic disease, clinical governance practice, commissioning, clinical leadership and how to develop and launch innovative pathways of care.

Then need accessible, cost effective and nationally delivered and recognised training modules for specific areas of care with achieved competencies, skills and knowledge which are accepted, recognised and supported by the relevant other professional bodies especially ophthalmologists, patients and user, commissioners, GPs.

Also may need locally developed training and methods to work with local partners and clinicians so that there can be seamless agreed pathways in a geographic area.

Consultation question 5 – What are the implications for the GOC register of likely changes in roles and will the existing distinctions between registrant groups remain appropriate?

Not sure about this.

Consultation question 6 – What are your views on the GOC’s approach to the accreditation and quality assurance of education programmes, including on whether this is an appropriate focus on outcomes and on the use of the competency model to set the standards of education?
Strongly believe the GOC should accredit and approve training however think for where there is “medical” type roles this should be somehow worked towards in close cooperation with medical national agencies such as the Royal College of Ophthalmologists, BIOS for orthotpists and possibly multidisciplinary input including patients, third sector, nursing, pharmacology bodies etc where appropriate.

Consultation question 7 – Should the GOC accredit and quality assure additional or different higher qualifications and if so, on what basis?

a. Content of education programmes
This need to include:

Basic understanding of basic sciences, pathology and disease

Clinical governance and managing risk for better patient safety

Prescribing

Technology only as very focussed on delivering care

Working with uncertainty and clinical risk, seeking support vs managing independently:

clinical knowledge and skills including understanding eye conditions

consistency with the standards of other healthcare professions – this is absolutely crucial and central. Where possible similar training should be delivered to the multidisciplinary team together with other professionals.

Melanie Hingorani

Consultation question 8 – What are the core skills, knowledge and behaviours which optometrists will need to have on first joining the register in the future?

As above more knowledge of the basic sciences, ophthalmic and systemic disease, pharmacology and therapeutics, more knowledge and skills on using ophthalmic diagnostics e.g. slit lamp, goldmann tonometry, OCT etc etc. They should have had a reasonable experience of examining, diagnosing and helping put together management plans for all common and relevant ophthalmic disease especially medical retina conditions, glaucoma, paediatric amblyopia and strabismus, cataract, minor eye conditions and acute red eyes perhaps with a log book of cases seen and competencies achieved. They may need assessments by ophthalmologists as well as optometry colleagues.

It is also particularly important that they have learned to be proper adult learners with appropriate approach to a life time of self development and the ability to balance independency of practice with knowing how and when to seek advice.

Consultation question 9 – How should the content and delivery of optometry programmes change to ensure that students gain the skills, knowledge and behaviours that they will require for practice and for new roles in the future?

Consultation question 10 – How might post-registration training and registrable higher qualifications for optometrists need to change in the future?

Mostly answered in the above I hope. Probably a longer prereg and then post reg modules and courses nationally recognised and consistent. The only other question for me is whether you go for more of a two tier system and have those who wish to be more traditional optoms and those who are really looking to be significantly medical and at what point you might separate out those groups to two different paths of training. This is a difficult question.

Consultation question 11 – What are the core skills, knowledge and behaviours which dispensing opticians will need to have on joining the register in the future?

Out of my area of knowledge

Consultation question 12 – How should the content of dispensing programmes change to ensure that students gain the skills, knowledge and behaviours that they will require for practice and for new roles in the future?

Out of my area of knowledge

Consultation question 13 – How might post-registration training and registrable higher qualifications for dispensing opticians need to change in the future?

Out of my area of knowledge

Consultation question 14 – How can we ensure students have the professionalism needed to take on new roles, including through the admissions procedures used by education providers, patient experience, supervision and embedding professional standards?

Would suggest following the examples of medicine and nursing student admissions to ensure suitable character as well as academic success.

Consultation question 15 – How should students be assessed prior to joining the register to ensure that there are consistent and appropriate standards of education, taking into account the different types of education programmes that are emerging?

There needs to be consistency and clear standards to achieve- where there are generic requirements e.g. clinical judgement, communication, professionalism, probity, clinical leadership, record keeping etc these should be standardised and cross cutting.

Melanie Hingorani

Consultation question 16 – What are the challenges and barriers to improving the system of optical education, including issues that may be outside the remit and control of the GOC, such as legislative change, workforce planning, the funding of education (including higher education, continuing education and training and continuing professional development) and the provision of student placements?

In terms of barriers with placements, as long as optoms can deliver some support to the clinical service and as long as the training time is properly resources and remunerated, they should be welcomed.

Funding and freeing up ophthalmic staff might be quite challenging given the current capacity issues in secondary care.

Consultation question 17 – Are there any other issues that we should consider in carrying out our review? If so, please set out what they are.

Wherever training involves an area not a core optometric expertise area, e.g. pathology, microbiology, clinical eye disease, non eye disease, please involve in planning and delivery of education all those who are expert in that area e.g. the microbiology world, physicians, ophthalmologists etc.

- END -

NES (NHS Education for Scotland)

Consultation question 1

As clearly outlined, the dramatically increasing ageing population will mean that demands across healthcare will rise steeply. Coupled with issues associated with co-morbidity and the availability of incredible new treatments, meeting the cost of healthcare will be a challenge. Patient expectation and feelings of entitlement are rightly high in the UK, and this is set to continue. The needs of the elderly and the very elderly for eyecare services will increase, and this sector of the population require more than the basic eye tests – requiring more medical and surgical interventions. This may in part be coupled by more self-prescribing by younger patients, especially when there is a cost involved with an eye test.

Consultation question 2

In Scotland, there is a drive to provide more care in a community setting to reduce the burden on the hospitals. Eye care is no exception and many more patients are already being cared for, treated and managed within community optometric practices. This will continue. As hospital eyecare moves to become ever more specialist, increasing numbers of patients can be safely seen by community optometrists; referring patients back to the hospital only when required for more specialist procedures. The traditional primary and secondary care settings will continue to be redefined and the interface between the two, continue to be developed. Care provided by community optometrists, and supported by the whole practice team, needs to be safe and high quality.

Optometrists need to be able to deliver primary care ophthalmology. They should be trained to be providing high quality, safe patient care. They will be required to work to the top of their competency levels most of the time, something that is frequently not happening in present practice.

There are various barriers to this happening. These include commercial pressures, challenges across the primary/secondary care interface with the sharing of health records in particular and optometrists not working to their top level of competence.

Consultation question 3

For optometrists the role has already become more one of healthcare provider and this will continue and develop. In Scotland, the optometrist is part of the NHS and the wider practice team has an important role to play caring for NHS patients. Optometrists and dispensing opticians are going to be required to work to a higher level within their competence than has often been required to date. This is clearly demonstrated already with MECS and the Scottish competency assessments, both no more than a “re-validation” of present scope of practice rather than a redefining of competence. Both good examples of a necessary process required in a profession “maintaining” their entry level of competence with CET, rather than a profession continuing to develop their skills and knowledge.

In the next 20 years optometrists and dispensing opticians must also improve their skills in leadership and management to support patient care. For optometrists in particular, it is no longer enough simply to be a good clinician and these additional skills are vital to supporting patient care, especially in an environment of delegation and highly technical equipment. This approach has been widely adopted within medicine and dentistry, and it is vital than such leadership skills to manage patient care are also adopted in optometry.

Consultation question 4

It is vital that optometrists and dispensing opticians strive to a career of continuous learning and improvement to support patient safety. E-portfolios, as a tool to support accredited training and reflective practice, are used by many other professions. An e-portfolio pilot is planned in Scotland to start in April 2018 to support IP training and CPD using a format that is already being used by 320,000 professionals across the UK. The portfolio can be developed to support training and development from undergraduate students though the pre-registration year and onto retirement.

Consultation question 5

The GOC register needs to be easily accessible, updated daily and clear to the public if an optometrist or dispensing optician has a specialist qualification. The information also needs to be correct.

Consultation question 6

Consultation question 7

It is important that recognition of advanced capabilities is given to optometrists and dispensing opticians to assure the public, service providers and employers that they have met and are maintaining UK standards in their advanced field. This is already done for the IP specialties and for contact lens opticians.

Care should be taken that higher qualifications are indeed that; there is presently considerable de-skilling of registrants. A framework for entry level and advanced standards is required. E-portfolios would support optometrists and dispensing opticians working towards higher qualifications. In professions where there is no requirement to develop as a practitioner, this is an obvious outcome and a risk to patient safety.

Consultation question 8

Optometrists require much more clinical training, leadership and management skills, an understanding of wider patient health needs, experience of multi-disciplinary working and an understanding of the importance of clinical governance. The need to understand how to communicate effectively with patients, deal with complaints and feedback, and understand their duty of candour.

On joining the register, they should be fully aware of their lack of experience, whilst confident and safe to practice and care for patients. In a profession where CPD is the requirement, this is more easily understood. In a profession that simply maintains a basic level of competence throughout one's professional life, there is no scope to improve and this is a risk to patient safety.

Consultation question 9

The traditional ophthalmic optics course was a scientific training and although there has been a shift in recent years towards a more clinical course there are still huge numbers of the remnants of that traditional optics training. In modern optometry, much of this knowledge is redundant. What is required is a much more patient centred training, with more experience of working with patients.

Students should be trained to be more in-line with other health care professionals; share modules with others were possible. They should gain a greater understanding of clinical governance, should cover leadership and management skills, and should have a much greater appreciation of the patient's general health needs.

Within the longer courses e.g. in Scotland, there should be an opportunity to incorporate therapeutic prescribing as part of the undergraduate course. There should be the expectation that these optometrists could become IP qualified within the first year or two after joining the register with the appropriate clinical experience.

Consultation question 10

Many points already covered above.

There needs to be a move away from the unevidenced, bureaucratic points system. There must be a process for continuing professional development in line with other healthcare professionals. This supports patient safety. Whilst the few may remain at the minimum safe level of basic practice, there should be a professional expectation that you will develop as a professional, training in a speciality, training as a trainer, mentoring others or undertaking research. There should be more of an emphasis on reflective practice, learning from errors and auditing procedures.

Consultation question 11

Consultation question 12

Consultation question 13
Many points already covered above and dispensing opticians should also follow a similar route to that outlined for optometrists and undertake a process of continuing professional development to support patient safety.

Consultation question 14

Consultation question 15

Consultation question 16
The GOC need to ensure that patient safety is prioritised. A culture that supports and values learners and those striving to improve, is vital to patient safety. This is not the present environment that CET and its simple maintenance of basic standards delivers. There needs to be a fundamental shift away from counting points, to a more reflective style of education with a drive to continual improve and develop as professionals.

Consultation question 17

- END -

Nick Rumney

Consultation question 1

Even if nothing changes in eye care demographics will significantly increase the numbers of people requiring active management because the most prevalent conditions are those involving the elderly. From age 50 the uptake of some form of optical appliance is in the high 90&'s.

The only resource available for an enhanced level of eyecare in numbers and scope is for optometrists to take over most non-surgical ophthalmic management.

Diagnosis and non-surgical treatment will need to be closer to the patient which is a question of access. In a very short time science will permit refractive manipulation, necessary to mitigate the effects of a world wide epidemic of myopia. Optometrists will be at the forefront of this.

Current NHS cataract management is basic and pressured yet some within ophthalmology cannot see the need for direct optometry led listing and still demand to see their patients for post-op visits. Forget the next twenty years this is NOW.

NHS patients are denied simple technically sophisticated intra-ocular lenses (toric, multifocal) yet these have huge potential ongoing quality of life gains. Optometrists are part of the team to determine ultimate recreative error in cataract.

Glaucoma care will probably go in a surgical direction but slowly. Current management is perfect in many places but poor in others with a backlog of delayed follow-up. Policy is dominated by large tertiary teaching hospitals where great research, much of it optometric, is based. Provincial Trusts and CCG's are utilising optometry sparingly (in England) and this is now completely out of step with Scottish practice. Even Guidance such as NICE only has partial relevance across the UK. The problem is in Optometrists are UNIQUELY placed to deliver this care but are nit being enabled to deliver this, educationally or contractually. Clearly the latter cannot come before the former.

Macular degeneration management is swamped by following up existing treatments without actually treating, this involves OCT and interpretation thereof. Optometrists are already assessing and injecting in some areas, they need equipping to do this because there will never be enough ophthalmology numbers.

The advancing capabilities and ageing population mean that many more people will be left with preserved if dominated visual function (fewer people go blind) and so there will be an exponential need for low vision care.

Consultation question 2

How and where discussed above. But essentially we need to move much eyecare out of large public hospitals and leave them to manage the more complex cases. Even surgery does not need to take place there. I can see large optical companies employing ophthalmologists in a surgical capacity only.

Premises could be anywhere but numbers (especially for cataract need to be massively increased.

1. Medical dominance of the eyecare agenda

2. The General Ophthalmic Services Sight Test is a wholly inadequate means to deliver any form of primary eyecare as it rewards lowest common denominator referral behaviour. The GOS Sight Test is statutorily defined and consists, broadly, of a limited history, a test to determine whether an optical appliance is required, a limited check of eye health and the issuing of a spectacles prescription.
3. The lack of a viable business plan to deliver cost effective primary care as opposed to optical retail 4. The present level of optometric training does not equip new registrants to engage in what are euphemistically called "Enhanced Services".

5. Confusion exists amongst professional bodies as to the difference between contractual obligations (the Sight test is very limited in scope) and "competence"

6. We are supposedly running a "competency" based education system for optometrists and dispensing opticians but in reality registrants emerge with "skills" which have to be hired into competence.

7. Optometrists do not have access to seeing enough disease fast enough to become "competent" at disease management. They are competent at recognition but lack confidence to manage and thus to treat.

8. Much monitoring of patients will, in future, take place outside clinical care with home OCT, IOP and fields assessment and much of this will be managed remotely. Optometrists at present do not have entry level competence in OCT which has been used by some for nearly ten years.

9. The UK has the lowest numbers of ophthalmologists per head of the population of any nation in the westernised countries including all of Europe and North America.

They struggle to cope with the workload of an elderly population requiring surgery for cataract, regular follow--up for glaucoma and injection for macular degeneration.

10. It is by far the norm that ophthalmology do not routinely report back on referrals initiated by optometrists.

This is insane. There is no high level requirement for consent and optometrists who regularly have a high false positive rate cannot be expect to reflect on their behaviour if they get no feedback. It is difficult to know whether such lack of communication is accidental or wilful.

Consultation question 3

1. In my opinion common law will not permit the separation of refraction from eye examination as this has been established and linked for over 100 years. Thus calls for DO's to be able to refract are not the logical way forward. However, developing a model to enable DO's to "test sight" within the legal definition (i.e. upgrade to an optometric scope of practice) will be feasible with the advent of better and better imaging systems and algorithms.

2. Optometrists will separate into two tiers; non-IP and IP. Non-IP will expand their role slightly but IP (with additional higher scope) will be seen as the appropriately regulatory target for keen graduates.

3. Much of the advanced scope of practice of optometrists takes place in an HES setting. Increasingly it will be in a primary care setting in various models.

4. Optometrists are, in enlightened areas, already the GP's of the eye despite GP service consuming the lions share of primary care NHS funds and coming under pressure. Optometrists can remove just under 10% of this load IF they had the mechanism and of course if the training is appropriate.

Consultation question 4

1. Optometry is not classified as a clinical discipline at university. Clearly it needs to be.

2. There are no NHS funded lectureships attached to optometry schools yet there are in many other clinical discipline such as medicine, nursing, physic, pharmacy.
3. The number of contact weeks of education at university is the lowest it has ever been. Thirty years ago it was probably 34 weeks per year but now it is around 26. Optometrists are expected to gain all of their clinical competence within their pre-reg year. Contrast this with paramedics who have a three year course with extensive secondment alongside university teaching and contact time of 42 weeks plus per year. In my opinion the first two years of optometry school are probably sufficient but year 3 and 4 should

be expanded into a registerable degree utilising the offices and skills of the College. Markedly increasingly clinical exposure will negate the need for a two year hiatus before moving into IP. It is important that the cries for "if IP what get dropped from the curriculum" are ignored. The IP Optometrist should have access to a 5 year course.

The Uk is the only international jurisdiction that has attained WCO level 4 status for optometrists (therapeutic prescribing) yet has not made any attempt to build this into undergraduate education despite the UK having a lower number of and lesser accessible number of ophthalmologists than the USA, Canada, Australia and NZ.

I think at least HALF of all optometrists should be enabled to IP at registration via an extended registrable degree.

Consultation question 5

1. Clearly medical ophthalmic clinicians (Dr's) will remain under the GMC but it is illogical to have orthoptics in a separate regulator (HPC).

2. I would strongly advocate retaining only ONE specialist register (CL for DO and IP for optometrists). Although optometric higher qualifications are growing in scope and number these are accredited by an external body and delivered by higher education providers. None of this is under GOC regulation. We do not need any more than two tiers for each profession.

Consultation question 6

1. I think the term "competency" is overused, registrants emerge with "skills" and may be competent in gathering data. this does not mean they are competent, at registration, with the clinical decision making required by the deployment if that data.

The present level of competence for optometrists has remained unchanged for a number of years since the framework was published nearly 20 years ago. Yet the potential for scope of practice has changed especially in relation to imaging for which optometrists remain untested. At the very least a mechanism to allow ongoing development of entry level competence must be created.

Consultation question 7

I do not agree with additional specialist registration categories so I fail to see the point of this. The Medical Royal Colleges oversee medical specialisms. This is therefore the role of the College.

Nevertheless the GOC should exercise its oversight of the governance of the scope of practice. In my opinion there has been confusion between what optometrists are contractually expected to do (and hence do do) and their competence. This has led to a dumbing down of the actuality of optometric competence as new guidance has emerged (such as NICE CG85 glaucoma). Much earlier evidence (2006; Banes et al BritJOphthal:90:579-585 and others) demonstrated clinical agreement between ophthalmologist and optometrists in glaucoma detection and referral yet we have gone backwards. The reason for any presumed high FP rate is due almost entirely to a contractual inability to undertake repeat measures under the GOS and has nothing to do with "competence".

Consultation question 8

1. Clinical decision making 2. Exposure to ophthalmic disease 3. The anatomy/physiology and pharmacology in the IP course is, by and large, merely revision and adds little value over the undergraduate course. Similarly disease recognition. It is the management of disease whether by therapeutics or not that is need for IP and much comes or direct clinical placement like in medicine. All students should be enabled to progress to IP with minimal delay by ensuring a developed course that flows into a fifth year.

Nick Rumney

Consultation question 9

I will answer this is three parts.

The first is comment from a very experienced clinical optometrist in Australia.

Jim Kokkinakis: "There is a simple and complex answer to this question.

More than 20 years ago I started working part time in a corneal surgery centre. The surgeons were surprised at how well educated optometrists were. In fact they refused to take referrals from GPs and said many times that the referrals they received from optometrists were far better qualified than from other ophthalmologists.

The simple answer is that if proper training is obtained (whatever that means) then there shouldn't be a limit on what optometry can do.

The complex answer is that ophthalmology will obviously block whatever optometry tries to expand into. If it was left to ophthalmology especially in Australia optometry wouldn't be able to put saline into an eye. The reality is that you do not need a medical degree to deliver high level eye care. You need clinical exposure. It doesn't matter how smart you are if you don't do things enough times you will never get good at it.

Eyecare which should include surgery should start as a basic optometry degree (3 years), followed by a therapeutic optometrist (a further 3 years) and then finally moving to an eye surgery degree (maybe a further 3 - 4), possibly it would be also a good idea to add 6 month clinical practice in between these phases with private clinic and hospital exposure.

A 6 year optometry course should include topical and oral medications.

You will get blood out of a stone before the above model would get through, so let's stick to optometry. A 6 year course will clinical exposure should allow all topical and oral therapeutics that are related to the eye. The US has been doing this for years and litigation is probably less against optometrists compared to ophthalmologists for similar treatments."

The second from the ex head of school in Melbourne.
Professor Algis Vingrys: "We are fortunate in Aust in that all of our prescribing for PBS (gov subsidized pharma) is documented and recorded so you can get some interesting stats from looking at the PBS site – this is a public site that you can access if you want

http://www.pbs.gov.au/info/browse/statistics

In Table G of the document for 2015 (attached) you will find that the 2500 or so optoms who are therapeutically approved in Aust wrote out 70477 scripts on PBS, being about 1 every second week. It is estimated that roughly a similar number gets written as private scripts (non government subsidized) so most optoms are writing a script every week at least. That feels low from my experience but there are many optoms who do more spectacle dispensing, so probably close to the mark as an average across profession. I think that the important thing to recognize is that we are a varied congregation.

The stats also show that of the TOP 10 prescribed drugs anti-glaucoma meds (38%) were the most common, followed by DED meds (27%), steroidal anti-inflamms (24%) and finally anti-infectives (12%). This is summarized in the table below for your convenience but comes from Table G of the attached document if you want the raw source details.
TOP 10 medical prescribing 2015
by Optoms
Total 70477
Rx/optom/yr 28

Nick Rumney

anti-glauc 37.9%
Anti-inf 12.0%
anti-inflamm 23.6%
DED 26.5%

Please do not be swayed by opinion regarding the numbers of patients to be seen to be effective prescribers. All professions have to start somewhere. Much treatment and prescribing is done by GP's who have neither the interest, training, competence or equipment. If those patients seeking primary ophthalmic care from a GP were to seek if from an optometrist there is more than enough work to go around; Mason & Mason, York University Economics 2002..

Consultation question 10
Post registration is developing well. The problem is that new registrants are qualifying at a lower level and cannot engage at "so-called enhanced services". All new registrants should be equipped to a minimum at MECS, Glaucoma certificate etc. You might call it a "competence step to the right" It is then up to those already registered to catch up. We are unusual in seeming to want to upskill those existing registered before we move the scope downwards. This is because the GOC has lost locus of what is necessary at undergrad and pre reg level. College, OC, AOP, ABDO and FODO all represent constituencies of existing registrants. Only the GOC can determine entry level. Once entry level is determined to be delivered at a higher level it is a much simpler task to expand onwards to IP.
We should cease concentrating on enhanced CET and move to a system of CPD. I would be embarrassed if after 20years in practice I had only ben able to keep up with entry level competence.

Consultation question 11
No comment

Consultation question 12
No comment

Consultation question 13
Better and more available conversion courses to basic optometric scope of practice. A tired structured career ladder from clinical assistant to DO to Optometrist would be mutually beneficial.

Consultation question 14
By continuing to hold them on the register.

Consultation question 15
I favour the development of much more widely available registrable degree for optometrists. At present there is only one registrable degree that has GOC QC approval (Manchester MSci, formerly M.Optom). I have been involved with this program delivering placement periods in practice for ten years and I am convinced that whilst it might not suit all it should available for more than 4 students per year.

Consultation question 16
1. Optometry classed as non clinical discipline

2. Control of the pre reg period being in the hands of one body who have an interest in the developed higher qualifications.

3. Lack of imagination by the NHS

Nick Rumney

4. Resistance by organised medicines to the loss of control

5. Lack of ambition by higher education providers

6. Lack of ambition by professional bodies

7. Although funding will be an issue it is important that a VISION is established as opposed to a slowly slowly, see how far we can get approach.

8. The irrelevance to Scotland, Wales, Northern Ireland of an England based approach.

Consultation question 17

Start from the premise that the main public health risk is from a pressured, unresponsive secondary care system clogged up because optometry is not enabled to manage primary care effectively. The GOS Sight Test encourages unnecessary referral and the payment by results system based on new to old patient ratios in secondary care is similarly perverse.
there should be no need to re-open the Opticians Act which is primary care and enabling in action. There are various sections of the Act enabling the GOC to write rules covering education and scope of practice.

- END -

Nick Rumney

Changes in demand and the impact of changes in eye care delivery

Consultation question 1 – How might the needs of patients requiring eye care change over the next 20 years?

As described in the Foresight Project Report, the expected increase in numbers of older people over the next twenty years will lead to greater eye health and care needs. More patients will have combinations of needs alongside any needs for refractive correction. For example many will be living with one or more long term conditions such as diabetes and/or cognitive difficulties such as dementia. There will be more people registered blind and partially-sighted.

These changes will not only affect hospital eye services, which will need to transform to meet rapidly expanding needs; they will also impact significantly on primary eye care as the range of services expands to meet changing needs and expectations including more patients needing low vision and eye health services. These services will, increasingly, be carried out in patients' own, residential and nursing homes alongside supporting social care services.

As the number of patients with more complex eye conditions such as maculopathy, glaucoma and diabetic eye disease increase, many other patients with less complex conditions, currently seen by ophthalmologists, will need to be diagnosed, treated and supported by other professions in community locations, freeing up ophthalmologists to see more complex conditions.

As patients age and are less able to travel, services traditionally seen as secondary care will need to move closer to patients' homes. There is also likely to be an increase in virtual clinics and an expectation for patients to take on more responsibility for managing their own health care. There is likely to be more self-monitoring by patients, including retinal imaging and OCT, and self- measurement and monitoring of IOPs. A different approach to health and social care is required to deal with the ageing population. There should be a move away from the tradition of advising the patient what to do to, to encouraging self care. Healthcare providers would then provide expert support and advice on interpretation of self monitoring results, and this will require good management and communication skills.

The needs of young people are also likely to increase pressure on services, with an increase in myopia among young people already clear.

All of the above will have implications for the modes and models of training for all eye health professionals with much more hands-on training and learning in the community under supervision. This may in turn lead to the need for a new cadre of optical and ophthalmic educators who work in community practice but also teach, supervise and train there as well as in traditional locations.

Consultation question 2 – What changes in how and where eye care is provided will be required over the next 20 years in order to meet patients' needs, and what are the barriers to these changes?

It is assumed that significant amounts of care will shift from hospital to community settings as that is the stated policy of all four UK governments and has been the professional direction of travel for some time. The speed and extent of this change will depend on several issues, not least the drive and will of governments and NHS leaders to expand services to meet the eye health needs of the population, and the opportunities created for professionals and community practices to embrace change whilst maintaining commercial viability. For example, care in Wales is already shifting strongly towards the

community. Experience there has shown how care can shift on a widespread scale, supported by a flourishing national university base.

While there is widespread support for an extension of community services, firstly, some ophthalmology departments have embraced change faster than others and second, not all optical practices can immediately embrace it. This is in part driven by local commissioning and the historical cross subsidy of service by product sales. The sight test fee is now worth less in real terms than when the NHS was established in 1948 despite the significant expansion in clinical requirements and a requirement to invest in additional equipment. The current funding system combined with inconsistent commissioning of extended primary eye care services has acted as a barrier to change. A national commissioning system in England combined with an economically robust commercial model for service delivery would be a great enabler.

The optometry degree currently focuses on performing sight tests, case finding, diagnosis, and management of eye disease and disorders. But there is not time within the degree to provide some of the additional skills that may be needed in extended roles. Increased HEFCE funding would facilitate the opportunity to add content to the degree without extending the length of the course.

Providing proof to commissioners that practitioners already possess the skills to deliver enhanced services is an additional barrier. Optometrists and dispensing opticians often need to demonstrate or be accredited in existing core skills in order to participate in services.

Qualifying students in all optical professions are likely to have a more diverse marketplace to enter into, and may require, or wish to obtain, specialist skills such as therapeutics, medical retina or advanced glaucoma, or even physician assistant-type skills on entry to the profession or in the first few years of specialist community practice. In dispensing optics this applies to skills in managing some minor eye conditions, advance paediatric dispensing, and advanced low vision management.

The OC suggests that a further potential barrier to the development of the right skill-sets in each of the optical professions is the fact that they have several regulators. If that situation continues there would be value in the relevant regulators working together to develop a unified approach to accrediting education in skills that are shared by more than one profession.

Consultation question 3 - How are the roles of optometrists and dispensing opticians likely to change over the next 20 years, and what are the drivers for these changes?

The Way Forward report by the Royal College of Ophthalmologists acknowledges that different ways of working are required to help meet the increasing demand in ophthalmic services and highlights the development of a multidisciplinary eye healthcare team within the hospital and community as a consistent theme in new care models.

Optometrists and opticians will also provide a far wider range of clinical services in community-based ophthalmic or medical eye centres as autonomous clinicians working independently or within multi-disciplinary teams either directly, virtually or remotely.

Although there will still be a need for highly skilled sight-testing and case finding by optometrists and dispensing and contact lens opticians, the expansion of extended primary eye care services will require optical practice to provide at least the full range of existing skills and often go beyond them into, for example, new therapeutic areas.

The required growth of out of hospital services to meet demand will be dependent on a willingness of optical professionals to up-skill and take on expanded roles, for example, monitoring of moderate risk glaucoma patients beyond the current core competences of optometrists. This will only happen if practices and professionals see sufficient remuneration attached to the new services. Technology developments will mean that refraction could be carried out by more people than currently (both professionals and members of the public). Refraction should remain part of the core contact lens dispensing and undergraduate optometry courses as it remains a core competence and could be added to the core competence of dispensing opticians.

Although not the whole profession, a large proportion (even a majority) will start to take on roles traditionally reserved for medically trained professionals such as GPs and Ophthalmologists. This is already well established in Wales, where much of glaucoma and medical retina care is being moved into primary care. The driver for this is a lack of medically trained professionals to fill posts, a lack of estates space, the cost of both of these, and a push towards care closer to home, which will be increasingly important with an ageing population.

Optometrists are likely to take on many more roles in the future, perhaps even performing minor surgery in clean room environments.

The role of the dispensing optician is also likely to change. It is likely that, as optometrists extend their areas of expertise, they will pass some aspects of their current core role to dispensing opticians.

As practice and education evolve it is also important that dispensing opticians and optometrists retain core skills in dispensing.

There will be a greater need for more pharmaceutical prescribers in community settings, although the volume of patient need means that not all optometrists will need full independent prescribing qualification and status.

Optical practices can and should play a greater role in general health promotion, for example in smoking cessation, healthy living and active ageing partnering, for instance with GP networks and healthy living pharmacies, hearing and dental networks. They can also play an enhanced role in identifying risk, for example of falls in older people, through lighting, contrasts advice and advice on trip hazards or in safe driving.

Consultation question 4 – How should the education of optometrists and dispensing opticians be structured to enable continuing professional development throughout their careers, e.g. core training followed by general or specialist practice?

Education needs to be more clinically and practice-based in order to respond to these changes and needs, but without removing the underpinning theory and ability critically to appraise technology.

Although we recognize that it is difficult to assess for some skills at the age of eighteen, students should as far as possible be selected for their ability to learn, their communication skills and their emotional intelligence as well as pure scientific and academic ability. Work experience/demonstration of interest and commitment and prior and reflective learning should also be factors in selection.

A diversity of courses of differing lengths can produce a broader range of skills, capability and backgrounds into the professions. The provision of a variety of entry points into learning together with clear routes of progression in the career ladder could help achieve this. Modular and other flexible

learning models would be valuable, as might the opportunity to train alongside other professionals both within and without the optical sector.

The Optical Confederation would welcome educational approaches that increase the amount of patient contact throughout the course, across the full range of practice. Community, hospital and specialist placements, and placements with GP practices could give the variety needed and help students develop a wider range of professional skills. It would be valuable to emulate courses that have clinical placements throughout, allowing students a wider experience of the work environments available to them. The Optical Confederation would recommend partnerships between educational institutions and training practices (a model from new medical schools).

The Optical Confederation also favours more problem-based learning (PBL), designed to help students emerge with a set of problem solving abilities as well as technical skills. The course should not be seen as “ticking off” a list of technical skills, but as building professional capabilities. Committee members suggested that a modular education system would offer the opportunity for individuals to build towards the kind of professional each wants to be.

This should include the professional understanding that care is more than episodic, that the patient has a history before they enter the practice, will continue to benefit from the eye intervention long after they have left the practice and will also be part of a cohort of the population which the optical practice will service as part of the wider health and social care system.

At the Committee’s workshop there was much discussion on the appropriate length of education. For example there was a suggestion of a tiered approach, involving a more flexible pre-registration period to enable some people to qualify for enhanced clinical or specialist enhanced services roles at the same time. Some suggested that to encourage the uptake of specialisms, the courses might need to be extended, might make better use of the current long vacation time for students or might even consider becoming clinical rather scientific degrees if this could be achieved without becoming subject to the current HEFCE-type funding caps.

There was no agreement on the appropriate length of undergraduate education and it was pointed out that an extended duration would have a significant effect on the optical sector, causing a shortage of qualified professionals during the transition period. There is an opportunity, however, in removing the constraints of the present academic year so that the more basic practical experience can be woven into the programme earlier and students prepared for a broadened/varied clinical role within the existing timeframe of study.

On supervision, it was felt that the supervisor role should be formalised, with a framework for supervision skills and knowledge (such as of local protocols and pathways). There also should be mentoring and support for supervisors, perhaps linked to new optical and ophthalmic educator roles as mentioned in response to Question 1.

It was also agreed that pre-registration optometrists would benefit from different supervisors for different specialisms and/or that one supervisor to multiple students could be a formalised future role evolution for highly skilled trainers and supervisors.

Post-qualification education could also be modular and flexible so that practitioners can develop specialties and respond to the way services are commissioned in their areas.

Optical Confederation

Consultation question 5 – What are the implications for the GOC register of likely changes in roles and will the existing distinctions between registrant groups remain appropriate?

It is recognised that boundaries between professions as currently understood are likely to change and it is likely that the diversity of practice and qualification within the groups will increase. For instance it is likely that optometrists will refract much less frequently – as happened with ophthalmologists in the past. It is important that these varying levels of practice, qualification and experience are identified and monitored by the GOC to provide assurances for the public, employers and the NHS. These may be more easily understandable and accessible to the public by means of a single competence-based optical register annotated with additional qualifications and specialisms. The GMC is similarly currently consulting on more detail for the medical register to assist public understanding in a similar way.

GOC's approach to education

Consultation question 6 – What are your views on the GOC's approach to the accreditation and quality assurance of education programmes, including on whether this is an appropriate focus on outcomes and on the use of the competency model to set the standards of education?

We are aware that the Optometry Skills Council is making its own separate response to the GOC's call for evidence and we do not propose to go into great detail in this response.

We acknowledge the inevitably subjective nature of visits and assessments but we would suggest that the principles behind accreditation should be:

- Right touch – an administrative burden that is proportionate to the risk
- The need for a balance of skills in the panels of accreditors
- Consistency of application of the standards – so that each insititution is treated equally
- Timely – with limited scope for (mis)interpretation at the different stages of the process

We have also noted that there is a need for cooperation between the regulators who regulate the different professions that contribute to eyecare pathways, again to ensure the greatest possible consistency in education requirements for each of the professions involved.

There is some concern that the competency framework might have encouraged a tick-box mentality among students and therefore discouraged a holistic approach to practice and patients.

Consultation question 7 – Should the GOC accredit and quality assure additional or different higher qualifications and if so, on what basis?

A number of new qualifications may be required but we do not think that these courses necessarily need to be accredited by the GOC. We do recognise that the GOC might have a role in assuring itself of quality when there is a public safety implication.

There will be several examples as services increasingly move from secondary to primary care. The GOC needs to monitor, pre-empt and enable activity taking place in community practice. There will be many examples over the next twenty years, some of which may not currently be predictable. Next likely areas for consideration might be:

- Minor lid surgery – Chalazion/skin tag removal etc.

- Laser surgery
- Corneal Services – complex contact lenses etc.
- Low vision aid provision, sight loss rehabilitation and CVI registration
- Intravitreal injection

Content of education programmes

Consultation question 8 – What are the core skills, knowledge and behaviours which optometrists will need to have on first joining the register in the future?

Clinical decision-making and a sense of what it means to have high standards of practice need to have higher prominence. See also our answer to Question 4. This question has also been considered in detail by colleagues from optometry schools, including those on the OC Education Committee, for submission to the GOC. Graduates need to have the ability to adapt to changes in technology.

Consultation question 9 – How should the content and delivery of optometry programmes change to ensure that students gain the skills, knowledge and behaviours that they will require for practice and for new roles in the future?

We also address this in the answer to question 4. There should be a modular approach to learning with more clinical experience built into timetables, and possibly longer terms, with a greater focus on practical experience and clinical decision-making alongside the important theoretical underpinning.

New learning modalities, such as distance learning and methods enabled by new technology should be made available as their validity is proved.

The content and delivery of courses needs to reflect the fact that optical careers may be fluid in future. People who have started in optics as apprentices need to be able to access higher education. Movement through the career ladder should be facilitated by course content and structure.

Consultation question 10 – How might post-registration training and registrable higher qualifications for optometrists need to change in the future?

Post-registration training and qualifications are currently harder to access than they should be due to difficulties in finding sufficient supervisors. Greater flexiblity is required, including the use of suitably-qualified optemetrists in place of ophthalmologists to supervise training.

Further changes in training are likely to be influenced by new NICE Clinical Guidelines. NICE is currently working on guidelines for cataract & macular degeneration, as well as reviewing the one on glaucoma.

Consultation question 11 – What are the core skills, knowledge and behaviours which dispensing opticians will need to have on joining the register in the future?

ABDO will respond in greater depth. The OC endorses ABDO's view that DOs need to join the register equipped with the ability to continue to develop their skills as their careers progress, and with problem-solving skills and the ability to work with the full range of patients, including those who are vulnerable, alongside the full range of technical skills.

Consultation question 12 – How should the content of dispensing programmes change to ensure that students gain the skills, knowledge and behaviours that they will require for practice and for new roles in the future?

ABDO's response states the importance of a greater emphasis on low vision and paediatric clinical experience.

Consultation question 13 – How might post-registration training and registrable higher qualifications for dispensing opticians need to change in the future?

Again, ABDO has responded to this question in greater depth. The OC agrees with ABDO's view that there should be a range of specialist qualifications, including low vision, paediatric dispensing, practical refraction, research skills, diabetic screening, vision screening, MECS, refractive surgery care, dry eye management, supervising trainees and contact lens qualifications.

Professionalism and consistent standards

Consultation question 14 – How can we ensure students have the professionalism needed to take on new roles, including through the admissions procedures used by education providers, patient experience, supervision and embedding professional standards?

As mentioned above, consideration should be given to students' ability to learn communication skills, their emotional intelligence and reflective learning as well as their academic and scientific ability.

Ethical principles and good habits should continue to be inculcated throughout the undergraduate programme so that these are second nature before students interact with the public and colleagues in real life. Students need to understand why it is important and also the consequences of non-compliance. Assessment should also include students' professionalism in complex situations.

Students will need to understand and demonstrate evidence-based decision-making. Peer review and problem based learning can facilitate building skills in confident clinical decision-making. More patient-centred education can support a less defensive approach to practice.

These skills must be reinforced during pre-registration training as well as the undergraduate syllabus.

It is equally important that registrants stay focused on this area after qualifying. Any changes in expectations need to be compulsory, interactive parts of CET.

Consultation question 15 – How should students be assessed prior to joining the register to ensure that there are consistent and appropriate standards of education, taking into account the different types of education programmes that are emerging?

We would simply say that there should be scope to change assessment regimes as new evidence-based methods prove themselves and become available.

Consultation question 16 – What are the challenges and barriers to improving the system of optical education, including issues that may be outside the remit and control of the GOC, such as legislative

change, workforce planning, the funding of education (including higher education, continuing education and training and continuing professional development) and the provision of student placements?

A significant barrier to attaining higher qualifications is the time required to complete the qualification. In some cases, such as IP and the higher glaucoma qualification, this is significantly more onerous than that required by other professions. Another significant barrier to attaining the IP qualification is the lack of available clinical placements. This could be alleviated by allowing those optometrists with appropriate higher qualifications and experience to supervise/mentor rather than the current requirements for ophthalmologists to do so.

Continued legislative protection of the core function of the sight test is essential to draw people to the profession and to protect their wider eye health. Despite the optometry and optical professions diversifying into other more specific avenues of patient care, the sight test remains the key public health measure for vision correction, early detection of eye disease and prevention of sight loss. Were this to be eroded, the optometry and optical professions would be less attractive to students and the workforce may dwindle, leaving another shortfall in qualified staff for all current and future aspects of optometric and optical care.

Consultation question 17 – Are there any other issues that we should consider in carrying out our review? If so, please set out what they are.

The review should attempt to be as future proof as possible, being open enough to allow for changes and adaption as the profession changes or begins to change. The regulator should lead and facilitate change, not follow or unnecessarily restrict.

The GOC should be aware of how practice is expanding at different rates and in different directions and flexibility to provide for this should be built into the review.

Increasingly professionals will be using their full range of competencies and this needs to be taken into account when things go wrong. Currently errors in judgement are treated harshly. As clinical judgements become more finely nuanced the regulator will need to take this into account in setting standards, in FtP judgements and in penalties.

We wish also to offer some reflections on CET that are relevant to this review.

A current issue identified by the Optical Confederation Education Committee is the inconsistency of examiners and assessors. The application process puts off smaller providers from applying to offer CET and there is inconsistency in what is accepted and what is not.

Many activities that should accrue CET points are not eligible eg – representing the profession, clinical discussions with colleagues, presenting at meetings, and participation in discussions at optical committees or national meetings. There should be a simple way of assigning credit to these activities which are not commercially run or organised but which develop optometrists and opticians professionally and benefit the health service and the public.

Moreover the CET system is overburdensome (despite recent improvements) and heavy-handed and not evidence of professions that have come of age and are comfortable in their own skins. It is now time to drop the term CET which was all the Health Departments would initially part-fund and expand the scope as above and change the name as for the other clinical professions to CPD. We do far more now than simply maintain our base levels of competence and terminology should be brought into line with other professions.

- END -

Optical Confederation

Optometry Consultancy

Consultation question 1

The population is estimated to grow by almost 10 million over the next 20-25 years. Our population will also be ageing. Clearly, this will lead to an increase in prevalence of ophthalmic disease. Combined with novel treatments requiring on-going ophthalmic intervention (eg Anti-VEGF drugs for vascular disease)it is likely that hospital eye services will be unlikely to meet this demand.

Consultation question 2

Hospital Eye Services are currently struggling to meet the demands of delivering eye care services, An ageing population with advances in treatment and increasing prevalence of ophthalmic disease will increase this demand.

One option would be to compartmentalise primary and secondary care ophthalmology services. However, there is currently no clear definition of which diseases would warrant primary and which secondary care management. Further, no agreed skills set exists whereby an ophthalmologist discharging patients to primary care could be sure that the primary care clinician has had the relevant training to manage the patient being discharged.

Categorising ‘diseases’ which are suitable for primary care has potential concerns, not least setting boundaries on development and potential as well as focussing on a disease rather than a patient and their symptoms. It is more reasonable to recommend a skills-set that is required for managing disease in primary-care. This skills-set could then be used for any patient fulfilling set criteria. Moreover, we are then not monitoring a ‘disease’ (which may be mis-diagnosed) but rather a process and clinicians would then be responsible for using their clinical acumen to implement management.

Access to on-going clinical training is a large concern for the primary care clinician. Optometrists would need a support structure to ensure that there is available support for clinical concerns and on-going clinical development. We cannot expect that optometrists working in primary care can be self-reliant following a short period of accreditation. This would be against the model for clinical development used successfully in medicine.

Consultation question 3

It is likely that the role of optometrists will diversify to work within a primary care ophthalmology setting. Ideally, this would be alongside ophthalmologists working in partnership.

Consultation question 4

There is a clear need to revolutionise the structure of optometry training in order to meet the demands of enhanced services.

The current format of CET is unstructured and not focussed towards a competency framework. Ideally, there should be additional didactic and clinical teaching (using simulation and technology) to improve the structure of CET.

The structure of CET should change to show progress in several domains of practice as a compulsory target. These could be divided into divisions such as clinical skills, knowledge, patient management, prescribing etc. All optometrists will need to demonstrate CET within each of these divisions. Further, there should be a personal reflection element for optometrists to reflect upon situations that didn't go as planned - complaints/inappropriate referral etc. Personal reflection will allow for this to used in a positive light as a learning experience for self-development.

Ideally, this would result in an appraisal that would be held at the end of a 3 year cycle to maintain registration.
To make this easier an on-line platform/portfolio should be used for optometrists to log this information.

Consultation question 5
Diversifying optometrists to stratify specific roles is likely to lead to inadequate provision of sufficiently trained optometrists for the additional roles needed. This will lead to difficulties with specifying additional requirements of registrants depending upon the role they fulfill. Ideally, the target should be for all optometrists to be able to hold sufficient skills to participate in primary care ophthalmology services. In essence the entry-point to the register for optometrists will need to be re-evaluated and a pathway to this level for existing optometrists developed.

Consultation question 6
I have no specific knowledge about the GOC in this area.

Consultation question 7
The GOC should work alongside other optical bodies to ensure that there is a uniform standard of competency that is managed by one body. Not doing this will lead to varying standards of competency.

Consultation question 8
There will be a need for additional clinical skills beyond what is currently taught. These can be defined. There is a significant need for a period of working within secondary care ophthalmology to gain experience in the common diseases that optometrists will encounter. There should be a need for core clinical skills to be signed-off within this clinical attachment to ensure competency.

Ideally, there should be a higher level of pharmacology taught which would exempt students from part of the current independent prescribing framework. In addition, there should be improved teaching of ophthalmic disease with more clinical teaching alongside the didactic teaching available. Changes such as this will likely lead to higher numbers of optometrists qualifying for enhanced services.

Consultation question 9
There is a need to increase clinical exposure from an early stage. Further, there is a need to improve history taking and diagnostic skills. A good way of doing this would be to use the model of a spiral curriculum. Clinical problem solving is an essential skill that needs to be developed. This could occur through simulated clinical scenarios and picture diagnostics.Ultimately, the consultation should be broken down into constituent pieces and each area targeted through the clincial syllabus. Didactic teaching should have a clear clinical focus to establish relevance and engagement.

Consultation question 10
There is a need to identify the skills needed to participate in enhanced services. The courses should then use these as curriculum aims and the GOC could use these to ensure that each accredited course is delivering a uniform standard.

Consultation question 11
I have no specific knowlege in this area

Consultation question 12
I have no specific knowledge in this area

Consultation question 13
I have no specific knowledge in this area

Consultation question 14
There should be a clear focus towards developing patient-centred optometrists. This would begin by including an assessment of the student at admission (using written information and perhaps a communication station at interview). There should be an on-going assessment of this through-out the students time at university with a requirement from each institution to declare any professionalism concerns for each student. Alongside this all optometry students and optometrists should receive a code of conduct document specifying the standards required.

As previously mentioned, all optometrists should reflect on patient complaints/incidents and this should be logged on their portfolio and reviewed at their 3 year appraisal.

Teaching optometry students the art of history taking using open-ended questions and exploring patient agendas should be introduced to the clinical aspect of the optometry qualification. An emphasis should be placed on creating patient-centred optometrists.

Consultation question 15
Prior to qualifying as an optometrist, there should be an assessment. Part of the current system could be moved to a declaration statement of competence following a final assessment at each university. The log-book of procedural competence during a clinical attachment and professionalism will ensure procedural competence. However, there should be a final pre-registration year examination that will need to focus on clinical problem solving. The emphasis here should be assessment of communication (breaking bad news/explaining a disease or test), knowledge base (1:1 with an examiner) using a clinical scenario, and management stations (using a simulated clinical encounter). This approach will move the focus from ability to do certain tests/tasks (procedural) to a more clinical focus. Such an approach will emphasise the importance of developing clincal skills and knowledge for its application in the real-world and increase readiness for enhanced services.

Consultation question 16
The costs of education will likely to increase in order to meet these demands. However, this could be addressed by altering the structure and content of current courses and utilising resources from other courses offered within an institution. In order to achieve this it may be that fewer students need to be trained per institution.

An increase in fees may be needed for the revamped CET system.
However, it should not be for the GOC to determine the above. Rather, a framework should be established that will deliver the much needed change and the GOC should focus on how this is being met. Providing unnecessary compromise will lead to inadequacy.

Consultation question 17
All interventions should be assessed for their relative impact. This could be done via qualitative and quantitative anlysis. This will allow development of a transparent educational framework and highlight areas for revision and improvement.

- END -

Optometry Northern Ireland

Consultation question 1 – How might the needs of patients requiring eye care change over the next 20 years?

Firstly, the increasing aging population will result in an increase in age related conditions including cataract, glaucoma and AMD which will subsequently lead to an increased demand on eye care services. Alongside this there will be an increased prevalence of general health conditions which impact on eye health such as diabetes and hypertension. All of this will result in increased patient need both in primary and secondary care and with secondary care currently under excessive strain some services will need to move out into the community. Furthermore, this aging population are more likely to have mobility and accessibility issues so being able to access appropriate services in the community will be hugely important. This particular demographic will also be more likely to have hearing difficulties, dementia and problems with cognitive function all of which present challenging communication issues.

Secondly, the population in general have become reliant on Display Screen Equipment (DSE), both in the workplace and for social use and increased use of these devices will result in increased eye problems, in particular dry eye problems.

Thirdly, there is clear evidence that myopia prevalence is increasing. Patients (and patient's parents) are no longer satisfied with traditional correction methods and these patients want practitioners who can offer solutions to myopia control.

Finally, the general population increasingly want services and results that are almost instantaneous and the advances in technology indicate that valid automated refractive error measurement is possible.

Consultation question 2 – What changes in how and where eye care is provided will be required over the next 20 years in order to meet patient's needs, and what are the barriers to these changes?

In order to meet the patient's needs the community optometrist needs to become the first point of contact with respect to eye care and eye problems. Secondary care is currently under increased pressure and this is likely to compound with changes in the population. The burden on secondary care can be relieved by primary care practitioners in two main ways. Firstly, minor eye conditions could be (and are being in some areas) successfully managed in the community (so do not need to enter secondary care at all) and secondly certain stable ocular conditions could be moved from secondary care to be monitored in primary care. Elderly patients do not want to wait inordinate amounts of time and do want to be managed in a setting which they can access easily.

Barriers:

- Adequate remuneration for delivered services in order to maintain a viable business model.
- Training and ongoing professional support for optometrists involved in an increased role and adequate remuneration for this training.
- Better inter-disciplinary communication with more efficient electronic referral between optometrists and other health care practitioners. There also needs to be access to 'live' patient information.

An increasing elderly population will produce an increase in individuals with mobility issues, resulting in more patients who are unable to journey away from their home and hence require domiciliary services. Alongside this, there is likely to be a greater proportion of the population living in nursing home accommodation.

Barriers:

- A review of the quality of eye care services delivered in the domiciliary setting to better understand and address the needs of this increasing aging population.

With increased time pressures, the working population are likely to acquire eye examinations for the purpose of refractive correction from automated sources.

Consultation question 3 - How are the roles of optometrists and dispensing opticians likely to change over the next 20 years, and what are the drivers for these changes?

As already pointed out in the answer to question two, the primary care optometrist and the dispensing optician need to become the first point of contact with respect to eye care and eye problems.

Driver:

- The burgeoning pressure on secondary care.
- Undergraduate and postgraduate training.

Optometrists and dispensing opticians will be required to have closer collaboration with other health care professionals (eg GPs and pharmacists). More optometrists will become Independent Prescribers which will help with these multidisciplinary relationships.

Driver:

- The burgeoning pressure on secondary care.
- Electronic patient records.
- Increased numbers of IP optometrists.

Specific tasks historically carried out by optometrists are likely to change with, for example, the role of refractionist becoming automated.

Driver:

- The advent of new technology.

Consultation question 4 – How should the education of optometrists and dispensing opticians be structured to enable continuing professional development throughout their careers, e.g. core training followed by general or specialist practice?

Optometric education should be structured as core training with the option of postgraduate specialization. Core training needs to be maintained as a two-part process within which there is an undergraduate programme followed by a period of time working under supervision (pre-registration). Exit at this point should mean that the individual could practice as a primary eye care practitioner with the ability to be a functioning part of 'standard' local eye health schemes (anywhere in the UK) such as a Minor Eye Conditions type scheme or a pre- and post-cataract management scheme. Further specialisms may be obtained after a specific period of time post-graduation which would allow optometrists or dispensing opticians to have a role in the management and treatment of more complicated eye conditions. As with undergraduate training, postgraduate training needs to be valid in any UK setting to avoid repetition.

Undergraduate provision needs to address how clinical skills are taught and it needs to be more modern in its approach to teaching and learning with more emphasis on e-learning. Core Competencies need an extensive review and consideration needs to be given to whether these are fit for purpose.

Compulsory Continuing Professional Development (CPD) throughout an optometrist's career is indisputable, however, there needs to be more flexibility and requirements need to move away from a 'one size fits all' approach. Peer review is a particularly effective tool within CPD and could be utilized more.

Consultation question 5 – What are the implications for the GOC register of likely changes in roles and will the existing distinctions between registrant groups remain appropriate?

Public understanding of the eye care professional's roles is key to publication of the GOC register. The general public need to have the facility to find an eye health practitioner to suit their specific needs and the GOC register should fulfil this need. It should be clear what those on the register are qualified to do and that they have maintained the relevant CDP to remain on the register.

Consultation question 6 – What are your views on the GOC's approach to the accreditation and quality assurance of education programmes, including on whether this is an appropriate focus on outcomes and on the use of the competency model to set the standards of education?

With respect to accreditation, the GOC have worked hard at trying to produce a fair and consistent model for the process but there is still much to be achieved. It is imperative that there is transparency and consistency with respect to the patient experience models used in universities as the patient experience is an integral part of the training process. Likewise there needs to be consistency in the GOC's quality assurance mechanisms and results of these

The GOC needs to recognize that the scientific content within optometry programmes is paramount and that students should exit with a science degree rather than a technical qualification.

The outcomes and competency model primarily lends itself to a tick box approach to standards which can be easily evidenced but may not be the correct method to judge competency. The optometric clinician needs to be a competent health care professional with excellent problem solving skills and not just someone who can perform a list of tasks.
Also, a tick box type of model does not necessarily sit well alongside university assessment requirements.

Consultation question 7 – Should the GOC accredit and quality assure additional or different higher qualifications and if so, on what basis?

The GOC should continue to produce a register which describes practitioner qualifications and in doing so these should GOC regulated. If the optometrist is only using the higher qualification for CPD purposes then these could be regulated elsewhere.

Consultation question 8 – What are the core skills, knowledge and behaviours which optometrists will need to have on first joining the register in the future?

- A core knowledge and understanding of optical principles and ophthalmic lenses.
- A core knowledge and understanding of ocular anatomy and physiology.
- A working knowledge and understanding of refraction.
- A knowledge and understanding of binocular vision anomalies.
- A knowledge and understanding of ocular disease.
- Skills in the use of key optometric instrumentation.
- A knowledge and understanding of aging.
- A knowledge and understanding of law and ethics relating to optometric prcatice.
- A knowledge and understanding of patient well-being.

- A knowledge and understanding of how to communicate with patients in the 21st century.

Consultation question 9 – How should the content and delivery of optometry programmes change to ensure that students gain the skills, knowledge and behaviours that they will require for practice and for new roles in the future?

Exposure to a wide range of patients both in university clinics and in hospital clinics is key to the learning process so different methods of achieving good patient experience needs to be explored. Further consideration needs to be given to the numbers of patients that undergraduates have exposure to during their training.

E-learning can play a bigger role in the delivery of programmes and new simulation methods to teach clinical skills and communication skills should be utilized. Peer learning has been very effective amongst qualified optometrists and should be used amongst undergraduates.

There needs to be greater emphasis on the teaching of communication skills within programmes along with an understanding of how patients function physically and mentally as they age.

The programmes should deliver content which allows a student on completion of their pre-reg year to work within all the standard level community eye care schemes in any UK location.

Consultation question 10 – How might post-registration training and registrable higher qualifications for optometrists need to change in the future?

There is currently no clear career progression path for optometry (unless the individual decides to go down the business route) and this is something that needs to be addressed.

Presently there are many excellent higher qualifications for optometrists and many optometrists have taken further qualifications but unfortunately do not have the opportunity to put these to good use.

Consultation question 11 – What are the core skills, knowledge and behaviours which dispensing opticians will need to have on joining the register in the future?

They need to have a knowledge of optics and ophthalmic lenses as now but incorporating a greater clinical understanding of ocular conditions and pathology. They will need to be taught the ability to refract as part of their basic training. People skills and emotional intelligence will be extremely important and new registrants will need training in the challenges faced when dealing with vulnerable patients alongside understanding of their obligation to protect the public. Emphasis needs to be placed on the GOC Standards of Practice to ensure registrants are aware of and fully understand their obligations in relation to providing health care and protecting the public.

Consultation question 12 – How should the content of dispensing programmes change to ensure that students gain the skills, knowledge and behaviours that they will require for practice and for new roles in the future?

The current programme needs more depth of knowledge regarding eye conditions. There needs to be mandatory hospital placements (similar to that undertaken by pre-reg optometrists) with opportunities to observe orthoptists, eye casualty departments and hospital eye clinics to have an understanding of the role of these health care professionals.

Dispensing opticians need to increase their skill set and be better equipped to triage and manage minor eye conditions as more and more of these cases will need to be seen in the primary care setting.

Consultation question 13 – How might post-registration training and registrable higher qualifications for dispensing opticians need to change in the future?

These qualifications need to be easily accessible via e-learning methods and supported with workshops and peer discussion forums.

The GOC need to be able to accredit learning in a more timely manner to allow for adaption in the face of change.

Dispensing opticians need to have more ways to broaden their skill set post-registration and then there will be many opportunities for the profession to utilize these registrants with respect to potential increased primary care activity.

Consultation question 14 – How can we ensure students have the professionalism needed to take on new roles, including through the admissions procedures used by education providers, patient experience, supervision and embedding professional standards?

Other health care related degrees use the Health Professionals Admissions Test (HPAT) to explore an applicant's non-verbal reasoning skills, problem solving ability and interpersonal understanding and this or a similar tool could be used within the optometric admissions process.

Input from the professional bodies early on and throughout the undergraduate programme is key to embedding professionalism. It is important that optometrists in training have exposure to non-academic optometrists as this can consolidate their understanding of professionalism in the real world setting.

Consultation question 15 – How should students be assessed prior to joining the register to ensure that there are consistent and appropriate standards of education, taking into account the different types of education programmes that are emerging?

Assessment prior to registration needs to be carried out by an external awarding body in order to ensure reliability and fairness.

Prior to joining the register students should be required to present a portfolio of case records of patients seen during undergraduate and pre-reg training. This should be presented in such a way that there is clear evidence of the student having seen a sufficient number and a broad range of patients.

Objective structured clinical examinations (OSCEs) should be used to assess knowledge, understanding, decision making and clinical skills.

Consultation question 16 – What are the challenges and barriers to improving the system of optical education, including issues that may be outside the remit and control of the GOC, such as legislative change, workforce planning, the funding of education (including higher education, continuing education and training and continuing professional development) and the provision of student placements?

Funding of higher education continues to be a political football and will remain so alongside other key political issues. Funding of continuing education and training and continuing professional development helps promote practitioner engagement but is not necessarily of paramount importance to practitioners. Clearly it is more important that practitioners can fully utilize their acquired skills.

Data related to workforce planning needs to be current for all areas of the UK in order to provide a consistent primary eye care service throughout the country. Workforce planning also needs to feed into planning for undergraduate places.

Consultation question 17 – Are there any other issues that we should consider in carrying out our review? If so, please set out what they are.

- END -

Optometry Schools Council

Changes in demand and the impact of changes in eye care delivery

Consultation question 1 – How might the needs of patients requiring eye care change over the next 20 years?

The proportion of older people in the population is expected to increase significantly with corresponding increase in the prevalence of eye disease, in particular cataract, glaucoma and age-related macular degeneration (AMD). In addition increases in prevalence of diabetes and hypertension are anticipated.

In the younger population, the increasing prevalence of myopia is well-documented, and the use of display screen equipment with intensive near-work demand is likely to result in increased prevalence of dry-eye conditions and asthenopia.

Older patients will need eye care that is accessible and wide-ranging. There is likely to be a greater need for ongoing monitoring of chronic conditions such as glaucoma and AMD, whether at home or in hospital/community clinics, and a greater demand for domiciliary and low-vision services.

Children at increased risk of myopia development, and with high near-work demand through educational and social use of display screens, should have ongoing eye and vision care, in particular through early and school years. To meet this need there should ideally be more comprehensive care, with optometry in a position to provide every service from refraction and dispensing, through assessment and management of sensory and oculomotor (binocular) vision anomalies, to ocular health assessment.

While recognising the likelihood of more use of familiar (e.g. phone or tablet-based) technology across all activities from refraction to ocular health assessment there will be patient groups, notably the very young and old and those with disabilities, for whom a technology-centred approach to assessment may not be feasible. To meet the needs of these patients it is essential that optometrists remain able to undertake assessment and management using traditional methods.

In the interests of patients of all ages, eye and vision care should be better integrated across relevant services. Also, vulnerable patients in particular should be protected from the risk of neglecting their health needs due to the fear of high cost and sales pressure; there will be an increasing need to separate health-related aspects of eye-care from the provision of appliances, and to regulate accordingly.

Consultation question 2 – What changes in how and where eye care is provided will be required over the next 20 years in order to meet patient's needs, and what are the barriers to these changes?

Capacity in hospital ophthalmology is currently failing to meet demand [Foot B. & MacEwan C. Surveillance of sight loss due to delay in ophthalmic treatment or review: frequency, cause and outcome. Eye 2017; 1-5, doi:10.1038/eye.2017.1]. More eye health care needs to be provided outside the hospital setting and by optometrists.

To meet eye-health demand, there will need to be a shift of the load from secondary to primary care. Some activities now carried out by ophthalmologists could be carried out by optometrists taking on a greater role in the assessment, diagnosis and treatment of ocular health conditions. This will require better integration of systems to enable joined-up management of patients' care across health (ophthalmologists, optometrists, GPs & others) and social care services.

To meet the needs of children, in whom the prevalence of eye disease is relatively low, there must be emphasis not only on eye health but also on visual development, and on ensuring clarity and comfort of vision at school.

To achieve this, optometry will need to be in a position to provide comprehensive eye and vision care at all ages from infancy, and parents and teachers will need more awareness of children's vision and the importance of better integration of health and educational services.

Barriers to these changes include:

1. Inadequate Funding – primary eye and vision (optometry) services are not funded adequately at present; all provision is currently subsidised by sale of appliances, as the sight-test fee barely covers the cost of refraction let alone the provision of additional services related to eye health and visual function. This is unsustainable and there will be no prospect of any effective progress towards meeting the future needs of patients unless an acceptable service-based funding model can be realised. [Shickle D, Davey CJ, Slade S. Why is the General Ophthalmic Services (GOS) Contract that underpins primary eye care in the UK contrary to the public health interest? *Br J Ophthalmol* 2015; 99: 888-892. doi:10.1136/bjophthalmol- 2014-305345]

2. Professional Insecurity – there is resistance in every profession towards relaxing control of its own domain, which manifests as lack of trust between professionals and unwillingness to embrace a shared approach. Such attitudes are a barrier to achieving the changes in scope of practice needed for optometrists to undertake activities currently associated with ophthalmologists and orthoptists, and for opticians to undertake activities currently associated with optometrists. It will be necessary to identify what the new landscapes of professional responsibility will look like and how they can integrate to ensure that each profession is properly recognised, respected and remunerated.

3. Inadequate communication between professionals – this is currently a problem with eye health services, both within primary care (GPs and optometrists) and between secondary and primary care (ophthalmologists and optometrists). Optometry practices are not fully regarded as part of the health service; they do not have a presence on the health service network and so cannot communicate electronically with other service providers. In addition, there often seems to be lack of regard for the role of the optometrist, in that feedback on referrals may be sent from ophthalmologist to GP but not to the referring optometrist.

4. Unwieldy care pathways – multi-professional working requires more streamlined methods of communication and also more agile and efficient pathways for patient management. It is no longer sensible for most referrals from optometry to ophthalmology to be routed via the GP, an outdated practice that generally adds little but cost and delay. To meet future, and indeed present, needs it should be possible for any professional within an effective integrated care structure to refer directly to any other.

5. Legal implications of reliance on technology and patient self-diagnosis – issues around how to regulate these, what information should be obtained by the professional in addition to that provided by the patient, and who is responsible for what?

6. Support for professional development – expansion of professional roles requires additional education and training. There will be a need to ensure that optometrists are given time for this and that the cost is covered. Currently there is variation across the country, and across employers, in terms of financial support and encouragement for optometrists to undertake additional training, including postgraduate qualifications. Closely allied to this is the fact that roles involving greater levels of responsibility require professionals to maintain and improve their knowledge and skills more assiduously than they may have done in other roles. This requires a culture of continuing education that is centred on CPD rather than CET.

7. Patient Trust – as noted above, optometry continually suffers from lack of funding for clinical services to such an extent that this provision must be subsidised by sales of appliances (spectacles and contact lenses). Although such provision is an essential and inseparable element of eye & vision care for the majority of patients, an effect of this business model is that optometrists may come under pressure from employers to maximise 'conversion' from sight-test to dispensing (that is, always to issue a prescription so that sale of an appliance becomes possible or likely). In turn, a consequence is that this practice may damage patient trust in optometrists. For older adults, for example, Shickle & Griffin (2014) conclude that "Not-for-profit services co-located with other public services are needed to address concerns about cost of spectacles, lack of trust in optometrists, and poor access to eye examinations in local settings." [Shickle D, Griffin M. Why don't older adults in England go to have their eyes examined? *Ophthalmic Physiol Opt* 2014; 34: 38–45. doi: 10.1111/opo.12100]. Similarly, for younger patients, Shickle et al. (2014) conclude "… young adults need to be made more aware of eye health issues, so that optometrists are seen as more than somewhere that sells spectacles" [Shickle D, Griffin M, Evans R, Brown B, Haseeb A, Knight S & Dorrington E. Why don't younger adults in England go to have their eyes examined? *Ophthalmic Physiol Opt* 2014; 34: 30–37. doi: 10.1111/opo.12099].

8. Awareness of Optometry – the issue of patient trust described in the previous point often goes hand in hand with lack of awareness of optometry and the role of optometrists in health care. To a large extent, optometry is rendered invisible to the public by two aspects of its position. One is that, although optometrists are employed by the NHS and work in hospital practice, optometry itself is not identified as a profession within the NHS [e.g. https://www.healthcareers.nhs.uk/]. On the other hand, the vast majority of optometrists who work in community practice are presented by their employers, and identified by the public, as 'opticians', with no recognition of the fact that the expertise, permitted activities and roles of optometrists and (dispensing) opticians are distinctly different.

Consultation question 3 - How are the roles of optometrists and dispensing opticians likely to change over the next 20 years, and what are the drivers for these changes?

We expect that optometrists will be more involved in the assessment and (co-) management of ocular health conditions and provision of a wider range of services, such as domiciliary care & visual rehabilitation, for the elderly. We also see a need for optometrists to be able to provide all eye and vision care services for children, including cycloplegic refraction, orthoptic and binocular vision management and spectacle dispensing as appropriate. Significantly this will include children with special needs and disabilities for whom the proper management of refraction, dispensing and oculomotor issues, in addition to ocular health monitoring, is especially important.

The essential aspect of the optometrist's role change is from 'refractionist' to 'eye & vision health practitioner'. The optometrist should be recognised, by the public and by other professions, as the 'GP for eyes and vision' – the optometrist should be the natural first port of call for advice on all aspects of eyes and vision. We note that the emphasis here must be on eyes AND vision, not on eye health alone. While it is clearly important and pressing for optometry to expand its role in eye health, it is equally important that members of the public should be able to consult a registered professional who can advise with authority on all sorts of issues involving vision. Optometrists are currently the only eye-care professionals whose undergraduate education involves detailed study of normal and abnormal visual perception, in addition to refraction and ocular health. Optometrists should also have the knowledge and expertise to evaluate published evidence relating to eyes and vision, to undertake assessments and treatments in accordance with available evidence, and to advise patients accordingly.

The drivers for these changes, some noted previously, include:

1) changes in population demographics leading to increased need/demand for services, 2) lack of capacity for ophthalmology-related services in secondary care, 3) the growth of provision, in response to demand, for vision 'therapies' to help children with progress in school, along with 4) the natural motivation of professions to 'upskill' and increase their scope of practice.

Consultation question 4 – How should the education of optometrists and dispensing opticians be structured to enable continuing professional development throughout their careers, e.g. core training followed by general or specialist practice?

Undergraduate education of optometrists should provide the strongest possible foundation for continuing professional development. To support this, there must be emphasis on:

1. Professionalism – not only to engender appropriate attitudes and behaviour towards others, but also to foster a mature approach to academic study, scope of knowledge and practice, use of evidence, etc., and the need to place this in a broad, long-term context that goes beyond the immediate priority of achieving success on the degree programme.

2. Perspective – the ability to integrate knowledge, skills and professional behaviour with awareness of the broader context of the optometrist's role and the needs of the patient. This takes time to develop and requires repeated reinforcement, especially for students who are relatively immature or inexperienced on admission to university.

3. Scientific Literacy & Evidence-based Practice – students must not only develop skills in routine aspects of clinical assessments, they also must understand underlying scientific principles of all their skills and have knowledge of where these principles come from and the essential literature associated with them. Through this approach, students gain a solid understanding of how and why their methods work, as well as of their boundaries and limitations. Also important in this context is the need for students to know how to read and interpret published literature, appraise new methods and undertake collection and analysis of data. Such skills are transferable to other disciplines as well as from earlier to later stages of a practitioner's career.

4. Clinical Skills – as is the case at present, optometry programmes must introduce students to clinical skills at the earliest possible stage, and allow enough time for these to be developed and consolidated until they can practise on patients. When students have developed their basic skills to a safe standard then they may be permitted to graduate from university and proceed to consolidate these skills in real practice settings. Thus, we establish a structure and principle that ongoing professional development of clinical skills will take place in the setting that gives the student/practitioner best access to patients, with supervision and mentoring by other practitioners with skills appropriate to that stage of development. The undergraduate programmes produce graduates who are safe to enter pre-registration training, but do not / cannot produce fully developed entry-level clinicians, especially if these should be expected to have higher-level (more specialised) knowledge and skills to meet future needs.

5. Communication – students and practitioners must be able to communicate their understanding of their discipline to patients, to other lay people (e.g. parents or carers) as well as to other professionals inside and outside of eye and vision care. For many students the ability to describe and explain things, and in doing so to evaluate and reflect upon their own understanding, has not been developed at school, and does not come naturally.

The structure of optometry education must be such that development of the students' ability to communicate descriptions, explanations, results of assessments and advice based on these results, should run parallel to development of clinical skills.

6. CPD and Postgraduate Qualifications – optometry education providers should be able to support continuing professional development through provision of higher-level programmes and qualifications, to complement development of practitioners' practice-based skills. Thus, staff in optometry education must themselves have higher-level qualifications and expertise, whether this is in clinical skills, non-clinical teaching and/or in research and scholarship related to the needs of optometry.

7. Recognition of Postgraduate Qualifications – these need to be fit for purpose within any UK geographic setting to avoid the need to 'retrain' when an optometrist relocates. Commissioners and service developers and providers should recognise the content of current university programmes and avoid re-training unnecessarily beyond up-dating practitioners' knowledge, equipment and skills and/or ensuring consistent approaches to agreed protocols. Curricula on accredited courses are published and learning outcomes transparent, and duplication of training should be avoided.

We note that undergraduate programmes in optometry already include, and place a good deal of emphasis on, the priorities discussed above. Undergraduate education based on this core foundation, followed by postgraduate study aligned to experience in both general and specialist practice, will provide a structure to support continuing professional development. Mandatory post-registration activity should also prioritise CPD rather than CET.

Consultation question 5 – What are the implications for the GOC register of likely changes in roles and will the existing distinctions between registrant groups remain appropriate?

Scope of practice and roles of the GOC-registered professions will change, but a distinction between optometrists and (dispensing) opticians should remain to reflect differences in education, training and the activities that the two professions are permitted to undertake. As noted previously, the public needs a clearer understanding of the different professions and their roles. The GOC has a responsibility to help this by maintaining separate registers when professions are substantively different, and also to indicate on each register when individual optometrists and opticians hold specialist qualifications.

GOC's approach to education

Consultation question 6 – What are your views on the GOC's approach to the accreditation and quality assurance of education programmes, including on whether this is an appropriate focus on outcomes and on the use of the competency model to set the standards of education?

The issue of accreditation and quality assurance of education programmes is fundamental to any review of the GOC's role in optometry education. Some would question whether the GOC should accredit undergraduate optometry programmes at all. It might be argued that focus on accreditation and periodic re-accreditation of undergraduate programmes, in which students necessarily gain a very limited amount of real-patient/practice experience, uses a great deal of GOC resource and diverts attention away from standards in the pre-registration period. This is where students get most of their real-patient experience prior to registration, and therefore where there is potentially a greater risk to patient safety unless the trainee is closely supervised.

Any such an argument against GOC accreditation of undergraduate optometry programmes would be set in the context of the following observations: 1) all degree programmes must be validated and periodically re-validated by their own host universities, and this process involves external experts, who are typically experienced senior academics from other universities, 2) all UK university optometry schools work to a benchmark for optometry programmes set by the Quality Assurance Agency for Higher Education (QAA) [http://www.qaa.ac.uk/en/Publications/Documents/Subject-benchmark-statement-Optometry.pdf], 3) all optometry schools recognise and conform to the standard required for students to enter the College of Optometrists' Scheme for Registration, which oversees the pre-registration period, 4) all university optometry schools are members of the Optometry Schools Council, which enables sharing of information on good practice, methods of assessment, etc., across all the schools.

Having said that, and given the assumption that the GOC will continue to accredit optometry programmes, the following points represent our broad consensus view of some important issues that we feel should inform the GOC approach:

1. Patient Safety – the natural rationale for involvement of the GOC in accreditation and quality assurance of undergraduate programmes is to protect the public. In this context the crucial issue is adequate supervision of students by registered optometrists. This is perhaps an example of where the GOC, and other bodies within the profession, may have a better understanding of acceptable standards than the higher education institutions (HEIs) themselves. Thus, the ability of the GOC to set accreditation conditions related to resourcing of programmes is important, and makes it clear to institutions that adequate staff-student supervision ratios are a *sine qua non* for provision of degree programmes in optometry.

2. Educational Standard – the QAA Optometry Benchmark Statement sets out a framework for optometry education that recognises the standard of university degrees in science-based subjects. It is important that the GOC should endorse this approach, and require that programmes maintain the standing they have achieved over the period of some 50 years since optometry in the UK became a graduate profession. The minimum standard of entry to the optometry profession must continue to be at BSc Hons level and it is essential that programmes are regarded primarily as degrees in scientific knowledge and understanding, and not as qualifications based principally on demonstration of clinical/technical skills. The recently published Foresight Report (http://www.opticalconfederation.org.uk/activities/foresight) details the probable significant changes in practice that will occur due to developments in technology. Therefore, now more than ever, we regard it as essential that undergraduates continue to be taught basic scientific principles which underlie such technology so that they can make reasoned decisions based on its output. Once again there is a role here for the GOC to ensure that programme providers provide adequate resources to achieve and maintain this standard of education; in particular this requires a sufficient number of highly-qualified academic staff having, between them, a wide range of expertise to provide serious in-depth teaching of basic principles in optometry and vision science.

3. Programme Length – to continue to assure the standards asserted in the previous point, and also to accommodate the expectation that the scope of optometry practice will widen to encompass higher levels of health-related knowledge and skills, our view is that there must be no pressure to shorten optometry degree programmes; for example by omitting basic educational content or by attempting to 'fast-track' 3-year programmes into 2 years by removing students' long summer vacation periods. Students need consolidation time for development of clinical skills and degree-level understanding of taught material, as well as for extra-curricular activities that are an essential part of normal student life at university. In addition, members of academic staff need time to design course activities, prepare teaching materials, conduct assessments and undertake other activities including research and scholarship. (Note: one exception to this principle, already successfully in operation, is the BSc Career Progression programme at University of Bradford, which students normally complete from start to finish in under two years. However, the students admitted to this programme are already registered dispensing opticians with at least two years of post-qualification experience in practice, so they start with a good deal of relevant prior knowledge and core skills. We do not consider that this approach would be feasible with inexperienced and less mature 'school leaver' students).

Optometry Schools Council

4. Consistency – it is important that GOC accreditation and quality assurance standards and procedures are applied consistently to all education providers. In terms of standards, this applies for example when universities require optometry programmes to adhere to internal regulations that may be markedly different to those in other institutions. Thus, a student in one institution may be permitted to progress between stages (years) of the programme with some marks below 40%, or without having achieved pass marks in all modules, while another institution might demand a higher standard of achievement. If the GOC supports or requires a particular standard for accreditation of one programme, this should be applied consistently across all accredited programmes. Here we note that, in general, OSC supports the principle that, within its accreditation and quality assurance role, the GOC should be able to require institutions to set standards in optometry that may be higher than those permitted in other programmes. A second element involving the need for consistency is in the application of the standards set out in the GOC Handbook for Accreditation. We appreciate that strenuous efforts have been made by the GOC in recent years to update the optometry handbook in an effort to improve consistency, and that this has been undertaken in cooperation with OSC. However we note that, in spite of this, standards recently applied in the (provisional) accreditation of new programmes seem inconsistent with those that have been applied to established programmes over the same period.

5. Outcomes-based approach – in general we welcome an approach to optometry accreditation based on identifying desired outcomes. This is consistent with the approach in clinical education across a range of disciplines. It is helpful for programme providers and prospective students to have a clear view of exactly where a programme is going and what its end results should be. However, we have two caveats. The first is a concern that focus only on outcomes without regard for the need to assure certain inputs runs the risk that providers may fail to recognise and provide the minimum level of resource needed to achieve the desired outcomes (points 1 and 2 above) – thus it is our view that the GOC should not necessarily define precisely the educational route that should be taken by a provider and its students to achieve the desired outcomes, but should define the minimum that a provider must do to comply with conditions necessary to enable outcomes to be achieved with the numbers of students enrolled. In effect the GOC, in discussion with OSC, the College of Optometrists and other relevant stakeholders, would introduce a resource model into the accreditation handbook, to guide the development and administration of optometry programmes. Our second caveat on an outcomes-based approach is that literal implementation of the principle, in the form of a specification list of required outcomes, quickly has the effect of diverting students from any broadly-based view of education towards a tick-box or checklist approach. This is a drawback of the competency model (see next point).

6. Competency Model – there are a number of undesirable features of the current two-stage competency model in optometry education. Briefly, these are:
    a. As noted in the previous point, specification of a list of competencies that students must achieve has the effect that all but the strongest students soon adopt a tick-box approach, sometimes to the extent that they become focused only on what they need to do to have a particular competency ‘signed-off’ that they lose all sight of its wider context.
    b. The concept of competence at undergraduate level is problematic – if a student is deemed ‘competent’ in a particular clinical skill then there is some degree of implication that they should be fit to apply that skill in practice, perhaps without supervision. Indeed, we are aware that this approach may be taken by some pre-registration supervisors, assuming that a graduate who has achieved all Stage 1 competencies needs no further supervision in respect of these. This does not seem to be in the public interest. We tend to the view that optometrists should only be deemed competent at the point of registration, when they are considered to be fit to practise unsupervised, and that this idea of competency is necessarily overarching and not piecemeal, in the sense that the optometrist is considered to be competent to practise, not competent in some basic skills and incompetent in others. At undergraduate and pre-registration level, therefore, we would favour an approach in which education providers focus on identifying students’ levels of clinical skill, and their ability to evaluate and interpret information and carry out various activities appropriately according to the clinical context, rather than ticking-off isolated competencies.

c. The existing competency model presents various anomalies – it involves some competencies that are small and precise but others that are broad and less precisely specified, and it also includes some competencies that appear to be essentially the same at both Stages 1 and 2.

7. Patient Episodes – the current handbook for optometry accreditation includes a requirement for students to see minimum numbers of 'real' patients in a variety of categories: primary care, contact lens, binocular vision, etc. To provide even this modest number of patient episodes for every student on a typical UK optometry programme is extremely resource-intensive in terms of staff and clinic facilities, and logistically complex for clinic timetabling. Programme providers nevertheless achieve these difficult requirements, even though: a) there appears to be no evidence to support the idea that a student needs to have seen a particular number of patients in order to be fit to enter pre-registration practice, and b) the amount of patient experience gained under these requirements is less than a pre-registration trainee would be expected to gain during the first few weeks in practice. Our broad consensus view is that, while students at university must be given opportunities to examine real patients, it is difficult to justify stipulating any specific number of patients to ensure that a graduate is fit/safe to enter pre-registration training.

Consultation question 7 – Should the GOC accredit and quality assure additional or different higher qualifications and if so, on what basis?

We are in favour of the GOC accrediting higher qualifications, such as independent prescribing, which enable optometrists to expand their scope of practice into specific areas that require additional specialist qualifications. However, we do not see the need for further regulation of higher qualifications such as many of those offered by the College of Optometrists in conjunction with the universities. These qualifications do not change the right to practise in specific areas, but are an aspect of continuing professional development, and it is appropriate that the GOC should continue to accredit the College of Optometrists and/or universities to oversee these.

Content of education programmes

Consultation question 8 – What are the core skills, knowledge and behaviours which optometrists will need to have on first joining the register in the future?

The core skills, knowledge and behaviours expected of students undertaking undergraduate optometry programmes (who are currently GOC registrants) are outlined in the current QAA Benchmark Statement for Optometry.

For optometrists joining the register as fully-qualified practitioners we propose the following requirements as priorities, which are mindful of possible developments in the role of optometry in the future as have been discussed previously:

- Patient Safety – there must be confidence that the registrant has the core skills and knowledge to ensure that patients are managed safely.
- Professionalism – there must be no evidence, through the period of study/training prior to registration, to support any concerns about the attitudes and behaviour of the registrant towards patients, colleagues and others, or about the honesty and integrity of the registrant.
- Knowledge – scientific foundations of the discipline, to support the application of core skills and clinical decision making; public health issues and the role of optometry; health care ethics; evidence that underpins clinical practice.
- Core Skills – all skills as now, none of which should be lost in the foreseeable future, including the ability to carry out subjective refraction and retinoscopy; ability to communicate verbally and in writing; ability to obtain and use primary research as an evidence base for clinical practice; ability to interpret evidence on the evaluation of methods of assessment and treatment.

Consultation question 9 – How should the content and delivery of optometry programmes change to ensure that students gain the skills, knowledge and behaviours that they will require for practice and for new roles in the future?

It is our view that the content and delivery of existing optometry programmes already ensures that students gain the skills, knowledge and behaviours required to enter pre-registration practice. We are not aware of any evidence to support a view that radical change in optometry programme content and delivery is necessary.

Naturally, of course, programme content and delivery develops progressively to anticipate and take account of changes in optometry practice and the profession. This has always been the case. In relation to technology, for example, universities have generally led these changes rather than following them – many generations of students have been introduced to new technologies and methods of assessment at university, long before these are commonly found in practice. The universities have always been proactive in terms of undertaking and promoting research that has the potential to change the future of optometry in practice. This forward-looking approach has also been supported over many years by the College of Optometrists, which publishes journals and funds research scholarships for optometrists. It would not be unreasonable to claim that the current standing of optometry as a health-care profession, which provides the basis for the now anticipated changes in scope of optometry practice, has been achieved largely as a result of academic and clinical leadership in education by the universities and the College of Optometrists.

Provision of optometry education is demanding – programmes are resource-intensive and expensive to deliver, but do not attract clinical levels of funding as is the case for programmes in medicine and dentistry. Optometry programmes are led and delivered by academic staff (principally optometrists) who have higher degrees and other higher qualifications, and who bring advanced levels of clinical expertise and specialist knowledge in both clinical and non-clinical areas. Most academic staff in optometry schools are involved in research and scholarship, and optometry teaching is informed by evidence from research.

Given this context, our views on the priorities for optometry programmes may be summarised as follows:

1. Sustainability – recent growth in the number of optometry schools and, therefore, in the total number of optometry students seems unsustainable. It is already the case that both established and new schools find it difficult to recruit staff with suitable academic qualifications and experience. It is also the case that the total number of applicants to optometry programmes in the UK now barely exceeds the number of places available – taking account of this alongside the facts that graduate salaries are falling and a very large majority of optometry students come from an ethnic minority sector of the population (i.e. there appears to be very little awareness of/interest in optometry in the majority of the population), it is difficult to see how optometry can continue to attract a sufficient number of applicants with the academic ability and qualities to succeed on the degree programme and gain professional registration.

2. Programme content and length – we commented on programme length in response to Question 6 above. Here we wish to reiterate that view and also to point out that we feel it is neither desirable nor feasible to remove significant amounts of content from current optometry programmes in order to make way for other higher-level material. The notable example here is refraction. In our view it is absolutely essential that optometrists should retain all of their present skills, including the ability to undertake both subjective and objective (retinoscopy) refraction. There are recent reports, for example, of how retinoscopy has been abandoned or discouraged in practice, due to the availability of auto-refractor technology, resulting in patients with certain conditions not being effectively assessed. Even if, in time, the majority of optometrists should cease to work as refractionists in favour of roles in ocular and visual health, refraction is so fundamental to the understanding of eye health and visual function that it must remain at the core of the optometrist's knowledge and skills. In overview, therefore, our broad consensus tends to the view that optometry degree programmes will need to be longer (minimum 4 years) if they are to do justice to inclusion of higher-level material on

ocular health assessment in addition to existing content. We understand that some within the optical professions are under the misapprehension that current optometry programmes include material that is irrelevant to optometry practice or involves only reiteration of basic A-level material. This is not the case. It is the case that existing optometry programmes do already include essential material on professionalism, communication, scientific literacy and evidence-based practice.

3. Delivery – there have been changes in optometry programme structures and modes of delivery. These include the introduction of integrated degrees, in which students undertake practice-based pre-registration training within the degree programme. This, in turn, encourages if not necessitates delivery of some course content electronically in a 'distance learning' format. A significant advantage of the integrated programme structure is that is recognises the benefits for students of gaining real practice experience as early as possible, and enables the teaching of basic scientific knowledge to be connected explicitly to clinical practice. Thus, it is a model that naturally supports the principles of outcomes-based learning in which curriculum content closely reflects the needs of the developing optometrists in practice, and experiential learning in which there is the opportunity for students to gain experience of a wide range of different patient types and conditions as they present in practice. The involvement of students in real practice at different stages of the programme also helps students to develop their understanding of professionalism and requires them to adopt appropriate attitudes and behaviours. There is some consensus in OSC that we would welcome and support a general move to a minimum 4-year integrated programme as the 'standard' model for optometry education in the UK. However, such a change would need a good deal of discussion and cooperation across the sector. Integrated programmes require that a sufficient number of practices are willing and able to take students for periods of practice-based experience, and those students cannot be treated as employees as they are under the traditional pre-registration system. It is not yet clear whether a sufficient number of optometry practice owners will have the level of commitment needed for integrated programmes to be a sustainable model for optometry education. Our view in OSC is that most of the clinical experience required prior to full registration should be obtained in real practice settings. Universities do not have the resources to provide all this experience 'in-house', nor would it be in the students' interest to do so. Whether students gain their practice experience through continuation of the established arrangement of a pre-registration period following graduation, or through the development of more integrated programmes, the onus is surely on the employers to increase their commitment to optometry education in order to ensure that students are fully supported to the point of registration.

Consultation question 10 – How might post-registration training and registrable higher qualifications for optometrists need to change in the future?

Post-registration training leading to higher qualifications is currently provided by the College of Optometrists and by the universities. Employers and other organisations also provide training for a variety of general and specific needs. It is difficult to specify any particular way that this needs to change. As with undergraduate education, post-registration training and qualifications will naturally adapt to needs and demands over time. In general, however, such training will need to support optometrists' varied and changing aspirations, and be of use in any UK setting. Perhaps the most important issue for post-registration training is the need for it to be set in the context of CPD rather than CET, in order to focus it around specific needs of individual practitioners and their patients.

Consultation question 11 – What are the core skills, knowledge and behaviours which dispensing opticians will need to have on joining the register in the future?

No response.

Consultation question 12 – How should the content of dispensing programmes change to ensure that students gain the skills, knowledge and behaviours that they will require for practice and for new roles in the future?

No response.

Consultation question 13 – How might post-registration training and registrable higher qualifications for dispensing opticians need to change in the future?

No response.

Professionalism and consistent standards

Consultation question 14 – How can we ensure students have the professionalism needed to take on new roles, including through the admissions procedures used by education providers, patient experience, supervision and embedding professional standards?

We would like to pose the question - what does the GOC and/or the profession consider is lacking in terms of the professionalism of current registrants? More information on how professionalism appears to be deficient would be valuable in determining how this issue should be addressed through education.

We might consider that procedures could be introduced to assess professional attitudes at the university admissions stage, which would improve student selection. However, a significant practical problem with this is that optometry nationally is now recruiting rather than selecting, as the total number of applicants does not greatly exceed the number of places available. Any method of selection may result in some schools being unable to fill programme places. A second difficulty is the following: while there are some students who exhibit appropriate professional attitudes and behaviours instinctively when they enter university, many do not because they are inexperienced and relatively immature. However, almost all students in the latter category develop their professionalism during their time as students, and practise it instinctively when they enter the pre-registration period.

The university optometry schools currently embed professionalism at all levels of their programmes. Some also have specific modules or curriculum streams focused predominantly on professionalism and ethics. What constitutes professionalism should be apparent and learnt through interaction with supervisors and lecturers at university and in pre-registration and post-registration practice. Institutions, including the College of Optometrists through the Scheme for Registration, should be confident that supervisors and lecturers/demonstrators exhibit professional behaviour in their student interactions.

Consultation question 15 – How should students be assessed prior to joining the register to ensure that there are consistent and appropriate standards of education, taking into account the different types of education programmes that are emerging?

We commented on the issue of consistency in our response to Question 6 above. The QAA benchmarking for Optometry should aid in the application of a consistent approach to optometric education across institutions. Academic institutions have both internal and external quality assurance. External quality assurance through QAA and External Examiner reports should be monitored by the GOC. In particular, the GOC should examine and follow-up on External Examiner reports in order to facilitate their process of accreditation and review. Where GOC review/accreditation visits make recommendations and/or requirements the standards applied to all institutions should be clear and consistent. If there is consistency in the educational approach, content and assessment procedures, this should allow a more consistent entry standard to the pre-registration period.

Notwithstanding differences in types of undergraduate programmes, and in the internal organisation of these programmes, the quality assurance arrangements described in the previous paragraph help to ensure consistent standards for entry to the pre-registration period. However, the question relates to assessment of students prior to joining the register, and the Scheme for Registration managed by the

College of Optometrists is a valuable arrangement for 'ironing out' variations in an effort to assure parity of standards at the point of registration. It seems essential that this arrangement should be retained, to provide a comprehensive, independent and consistent assessment before registration.

We note that the emphasis in this question is not only on assessment but also on 'consistent and appropriate standards of education'. It is important to observe that a large proportion of students' education prior to registration is in pre-registration practice, usually after graduation from university. A significant challenge is to ensure consistent and appropriate standards in this setting. It is widely reported, for example, that pre-registration trainees in some practices do not get the support they need, and some are expected to meet targets as employees rather than being fully supported as students.

Barriers to change and other issues to consider

Consultation question 16 – What are the challenges and barriers to improving the system of optical education, including issues that may be outside the remit and control of the GOC, such as legislative change, workforce planning, the funding of education (including higher education, continuing education and training and continuing professional development) and the provision of student placements?

A number of issues and concerns relevant to this question have been addressed previously, but the following points summarise our views of principal challenges and barriers:

1. University funding – this is currently not sufficient to support any increase in curriculum content or in the volume of 'in house' clinical experience in undergraduate programmes. To expand the curriculum in order to produce optometry graduates equipped to undertake more health-related work in the future, schools will need to increase programme length to obtain more study time and the income to support it. We must emphasise once again that university optometry programmes consistently, and over a period of many years, achieve high standards of academic education and clinical training for a standard tuition fee, with no additional DoH support such as is enjoyed by programmes in medicine and dentistry.

In spite of this lack of recognition of any case/need for clinical funding of optometry education, the university schools have led the development of optometry as a health-care discipline and responded to changes affecting the profession in practice.

Clinical practice in optometry has evolved far beyond the standard that was expected 30 or more years ago, but with no commensurate increase in funding for undergraduate education. It is unrealistic to expect significantly more of the universities now on existing funding. If there is a recognised need for more advanced clinical training at undergraduate level then additional funding must be forthcoming. Here the GOC and other significant stakeholders may have an important role to play in supporting an effort to secure clinical-level funding for university optometry programmes.

Even with such an increase, however, it must be expected that students will still need to gain most of their experience externally in practices or hospitals, which will have to bear much of the cost of providing this unless higher, clinical levels of funding for optometry education can be obtained. This, in turn, will bring further challenges in that there may be a shortage of good-quality pre-registration positions or (in the context of integrated programmes) practice placements. These problems are significantly exacerbated by the following issue …

2. Over-supply of graduates – with an ageing population and the increased need for basic and enhanced (primary) eye care services, there is potential for the role of optometrists to increase and become even more valuable than it currently is. Optometry should be a profession that attracts bright and motivated students. However, this will only happen if it is seen as a profession and career worth training for at least four years to enter. This will not be the case if the number of optometry programmes continues to increase and the number of students on each of those programmes also

escalates. This does not promote quality amongst applicants; it is already apparent that the increasing intake has driven down entry standards (see UNISTATS/KIS published data) and this will consequently be reflected in the calibre of those entering the profession. If the GOC and profession are truly seeking individuals who are receptive to and able to adapt to change as technology, patient demographics and treatments change, then it is in the patient and public interest that this issue is addressed. It is the 'elephant in the room'; HEIs are putting pressure on courses to take more students with no increase in the resources required to provide high quality training, and optical companies looking for willing (cheap?) workers are encouraging institutions to develop new courses. These larger or new courses will need to lower entrance standards to fill places, because the pool of applicants is now too small to be sustainable but, once enrolled, no university will want to fail its students. This may not lead to unemployed optometrists, but it is likely to lead to lower standards in the profession as salaries decrease and quality also drops. This is not in the public interest.

3. Pre-registration Period – the variation in standards of pre-registration training is a significant challenge. Currently, for example, there is no standard for the time allowed for a trainee to examine a patient, and standards of supervision are variable in spite of the best efforts of the College of Optometrists to assure quality of supervision through the Scheme for Registration. A significant advantage of integrated degree programmes in this respect is that the university is responsible for the quality of its students' education, whether this is within the university or in practice, so practice owners and supervisors must work in partnership with the university (and the College of Optometrists) and comply with the university's required standards. Although this is desirable in terms of quality, it poses a challenge in that: a) some practice owners may be discouraged from entering such an arrangement unless they can see direct benefit to their practice, thus putting further pressure on availability of placements, and b) the universities themselves will need the resources to undertake the intensive quality assurance required to be confident that every student on placement is being educated to the appropriate standard. Therefore, whatever model is adopted for practice-based experience, there are significant challenges to assuring consistency and quality in the practice setting.

Consultation question 17 – Are there any other issues that we should consider in carrying out our review? If so, please set out what they are.

The GOC needs to apply standards consistently across all educational institutions and settings, including pre-registration practice. Where possible, these standards should be evidence-based.

- END -

Peter Black

Changes in demand and the impact of changes in eye care delivery

Consultation question 1 – How might the needs of patients requiring eye care change over the next 20 years?

Eye care falls into several categories:

- The provision of clear vision to healthy individuals in need of vision correction. These people need an accurate assessment of their refractive state (i.e. a numerical prescription for spectacle lenses to correct myopia (short sightedness), hypermetropia (long sightedness), either of which may be in combination with astigmatism and / or presbyopia (additional help to focus close up, over and above any prescription for far distance). They then need an optical appliance, i.e. spectacles or contact lenses, made to their prescription so that they can see clearly. The provision of clear vision is a vital public health service without which these people would be unable to study, work or lead normal lives, however people availing themselves of these services consider themselves customers not patients.
- Eye health screening / opportunistic case finding
- Eye health examination, diagnosis and management
- Eye disease treatment including surgery
- Elective eye surgery on healthy eyes
- Assisting patients who have developed visual impairment through the provision of Low Vision Aids and Sight Loss Rehabilitation.
- Orthoptics – the correction of binocular vision problems such as squint in young children and in adult patients following for example a stroke

It is clear that with the possible exception of orthoptics all the areas above are set to increase as a result of an aging population, increased prevalence of myopia among children, and increased eye disease as a result of increased prevalence of diabetes.

Currently the sight test is artificially constructed to tie refraction to the provision of an eye health examination. Whilst refraction and measurement of visual acuity are undoubtedly useful diagnostic tools, they are not perceived as part of health care by the public. The public consider the determination of their prescription and provision of spectacles and contact lenses to be a normal customer relationship with a specialist retailer.

On the other hand people with systemic disease such as diabetes, or eye disease such as glaucoma, understand that they are patients and require regular eye healthcare interventions such as visual field assessment, retinal photography, optical coherence tomography or measurement of intraocular pressure.

Whilst refraction is an integral part of an eye test, many customers feel that they would be better catered for if they had the refraction from the same place as they purchase their spectacles and / or contact lenses, rather than the place they get their eye health care. Currently this is not possible even though it is the default position in the majority of countries in the world.

Patients with significant comorbidity will increase, in particular elderly patients with diabetes or glaucoma are also likely to suffer age-related macular degeneration. A diabetic with AMD undergoing Lucentis injections is likely to consult an eye health care professional between 2 and 14 times per year, and yet if they want a pair of spectacles will have to undergo a full eye exam in order to get a prescription, even though they have had their eye health checked numerous times. It is said that an eye health problem could be missed with refraction only consultations, however there is little evidence that this is true and it causes patients unnecessary inconvenience and expense and wastes NHS resources.

If there were evidence then surely NICE should recommend refraction and full fields, pressures, ophthalmoscopy etc as part of all eye health interventions – which would clearly be ridiculous.

The legal separation of refraction and prescribing of optical appliances from eye health examinations would be unlikely to change the default mode of practice in the short or medium term, especially with regard to GOS sight tests to which over 70% of people are entitled, however it could be of profound benefit to low vision patients and contact lens wearers. Currently contact lens opticians and low vision dispensing opticians must refer their patient back for an eye examination if they find any change in refraction when in fact they have correctly determined the refraction but are legally unable to prescribe it. This puts patients, and practices, and potentially the NHS, to unnecessary inconvenience and expense.

The number of spectacle wearers is set to increase due to earlier onset of myopia in children, and the aging population. Contact lens wear is also increasing year on year as lifelong disposable lens wearers now have realistic options when they become presbyopic in their forties, a time when most people would have dropped out of lenses altogether previously.

Although currently little used, largely because of time pressures, there currently exists refraction techniques that are not only fully automatic and deadly accurate, they can also correct for higher orders of correction. So called wave-front aberrometry is extensively used in refractive surgery, and most corneal topographers used in contact lens fitting already have this technology built in. Currently dispensing wavefront compensated spectacle lenses is impossible without another appointment for a new refraction, and it is ridiculous that an optometrist must sign off this refraction when it is unchanged from the refraction determined by the dispensing optician using the wavefront aberrometer / autorefractor..

Consultation question 2 – What changes in how and where eye care is provided will be required over the next 20 years in order to meet patient's needs, and what are the barriers to these changes?

Refraction technology to determine a person's spectacle prescription is already well advanced to facilitate remote and self-refraction using proprietary technology (in booths within supermarkets for example) and using tablet and laptop computers. Tying refraction legally to the eye health examination (which is also undergoing transformation via smart phones (e.g. PEEK – portable eye examination kit) is likely counter to the public interest since this technology is already well established. The ability for any competent person to refract professionally makes sense for patients with complex needs, however patients will expect their refracting optician to be qualified and therefore they will require suitable education. For dispensing opticians this would require bringing the existing FBDO R qualification held currently by a handful of dispensing opticians who examine refraction in Malaysia into the mainstream. In reality this means adding practical refraction to the pre-existing theoretical understanding. For existing FBDOs to qualify in refraction would require a refresher in the scientific theory that underpins understanding before embarking on practical learning and preparing for examination.

Much of eye health care that currently happens in the hospital and other secondary care environments will move into community primary care and high street settings. Many optometrists will work in an eye health environment that does not include the provision of spectacles or contact lenses where cross subsidy is unnecessary and enhanced optical services form the basis of the business model. Other optometrists will continue to provide eye health screening with or without refraction, opportunistically finding cases and referring as appropriate, however this model will likely decrease as the effect of referring patients to the competition will have a detrimental effect as patients naturally prefer a one stop shop for eye health, and a one stop shop for their vision correction, and may prefer to get both at one establishment.

The elimination of cross subsidy of eye health by spectacles and contact lenses will enable patients to experience the full breadth of spectacle lens technology at a more reasonable cost. Tailormade wave front guided optics such as Zeiss iScription and the American iZone will then offer state of the art optics

at a more realistic price and patients will be better served with different lens technologies for different activities.

Education of technicians, dispensing opticians and optometrists will need to deal with adaptive optics combining electronic and liquid crystal technology with high definition traditional optics. Design may need to be included if dispensing opticians are to find themselves making bespoke frames and lenses through 3D printing technology.

Optometrists need to be encouraged to use their current scope of practice with regard to P medicines, and ideally therapeutics should become part of the undergraduate syllabus. Dispensing opticians should then become pharmacist for eyes dispensing the medicines and eye drops to prescriptions issued by the optometrist just like they currently do for spectacles.

The truth is we do not know what the future holds, and therefore it is imperative that if the predictions of the Foresight Report come to pass and dispensing opticians are no longer required in their current form they can re-train and extend their scope of practice to meet the needs of patients without the need for primary legislation as now.

Consultation question 3 - How are the roles of optometrists and dispensing opticians likely to change over the next 20 years, and what are the drivers for these changes?

Both roles need to be adaptable to the needs of patients, employers, health care commissioners and businesses. It is essential that people specialising in certain services can qualify to be self-sufficient – for example all low vision practitioners need to be able to refract and prescribe to prevent patients being unnecessarily inconvenienced by long waiting times and re-referrals. With long waiting lists the last thing a patient wants is for them to need a new refraction by the time they get to see their low vision optician, but if they need one the LVO should be able to do it rather than having to refer back.

I can foresee the resurgence of pharmacist opticians able to supervise both functions in supermarket and large retail health and beauty stores, but also a potential new mode of practice linked to GPs, or as stand-alone businesses in smaller towns and remote or rural areas. An independent prescribing optometrist with an ophthalmology qualification working alongside a refracting optician who is also qualified as a pharmacist or audiologist could be a very powerful means of bringing quality eye and hearing care to elderly populations in their communities and satisfying the needs of this rapidly expanding demographic.

The point here is that healthcare professionals should be free to train and retrain in any way they see fit to satisfy the needs of patients. Protectionism should be outlawed, meeting unmet patient demand should be allowed not stifled.

Consultation question 4 – How should the education of optometrists and dispensing opticians be structured to enable continuing professional development throughout their careers, e.g. core training followed by general or specialist practice?

All training should be available on an “Earn while you Learn” basis in line with Government aspirations through blended learning (online distance learning, supervised employed practice, periods of block release at college or university, theoretical and practical examinations, practical assessment on the job etc).

The sector needs a genuine career ladder that people can stay on for as long as they wish, and get back onto at any time if their aspirations or personal requirements change.

Peter Black

Entry level could remain at 5 GCSE's for dispensing opticians, but with some form of additional accreditation of prior learning and / experience to bridge the gap to optometry entry requirements. An apprentice seeking employment at an opticians in the future may be required to train up to Level 2 or Level 3 to ensure more consistent patient care – these qualifications could then be used to get "on the ladder" as an alternative to A levels, for example:

- Entry: Level 2 or 3 Diploma in Optics or 3 A Levels
- Year 1: Optics and ophthalmic lenses, standards of practice and communication (gaining level 4 certificate / diploma e.g. SMC Tech)(Elective module – safeguarding)
- Year 2: Anatomy and physiology, pharmacology, visual optics, standards of practice, paediatric dispensing, ophthalmic lenses and dispensing (gaining FDSc)(elective module digital imaging and eye health screening)
- Year 3: advanced ophthalmic lenses, refractive management (inc practical refraction and prescribing), low vision, contact lens theory, (gaining BSc Hons and FBDO) (elective module Ophthalmic Public Health and Statistics)
- Year 4: contact lens fitting and aftercare, binocular vision and orthoptics, advanced pharmacology, anterior eye examination, intro to ophthalmoscopy and Volk. (Gaining FBDO CL)(Elective MECS)
- Year 5: Balance of optometry course (gaining MSc and MCOptom)
- Year 6: Therapeutics, independent prescribing, evidence based behavioural optometry, glaucoma, medical retina. (Gaining specialist register and additional services certifications in one go)
- Years 7 to 11: Graduate entry medical degree specialising in community ophthalmology

Consultation question 5 – What are the implications for the GOC register of likely changes in roles and will the existing distinctions between registrant groups remains appropriate?

We need a single register which then identifies specific competencies. This would allow registration of technicians and assistants like dentistry in the future if required but would also allow registrants to leave behind certain competencies as they progressed. IP optometrists who do not dispense or fit contact lenses might decide to no longer supervise others in these tasks.

GOC's approach to education

Consultation question 6 – What are your views on the GOC's approach to the accreditation and quality assurance of education programmes, including on whether this is an appropriate focus on outcomes and on the use of the competency model to set the standards of education?

It does not make sense to allow a new registrable qualification at a lower level to the pre-existing and pre-dominant registrable qualification as has happened with the Anglia level 5 qualification and the ABDO level 6. If this is to happen again the GOC should consult the pre-existing awarding bodies. It is possible both optometry and dispensing optics could change to remove the underpinning scientific knowledge and each profession be relegated to the role of thoughtless technicians operating machines for some higher power (an ophthalmologist or a cloud based computer) to make diagnostic decisions. My experience is that although technology is very accurate there are always a small number of occasions when it is unable to accommodate the needs of the patient – in these cases the underpinning knowledge becomes even more important not less so. Although less people may be required their underpinning knowledge needs to be even greater.

Consultation question 7 – Should the GOC accredit and quality assure additional or different higher qualifications and if so, on what basis?

As per Q4 all additional qualifications, plus qualifications that are currently outside the GOC and the traditional awarding bodies (e.g. behavioural optometry, school vision, sports vision) should be brought within the mainstream. Enhanced services should be within core competency for new graduates and should be easily achieved for existing registrants. In the future this will include drug releasing contact lenses, electronic monitoring of diabetes through contact lenses etc and this needs to be thought out now to ensure the system is flexible.

Content of education programmes

Consultation question 8 – What are the core skills, knowledge and behaviours which optometrists will need to have on first joining the register in the future?

Existing core skills should remain in the programmes until new flexible systems exist and after a period of appraisal decisions can be made as to future programmes. Optometry may wish to lose dispensing, low vision and contact lenses however the amount of supervision that optoms do in this regard means this is unlikely to be supported by large employers. Independent prescribing, or at least additional supply should become the norm, as should MECS accreditation and the common glaucoma, diabetes and cataract enhanced optical services.

Consultation question 9 – How should the content and delivery of optometry programmes change to ensure that students gain the skills, knowledge and behaviours that they will require for practice and for new roles in the future?

Optometry should move to an “earn while you learn” basis to enable a longer course with greater areas of competency and also enable employers to get optometrists where they need them and solve the age old manpower problem.

Consultation question 10 – How might post-registration training and registrable higher qualifications for optometrists need to change in the future?

This should be achieved by the adoption of the career ladder system in Q4. Specialist education providers may get involved in certain parts of the ladder but it is important that we have a nationally accredited system. Currently an optometrist credited for diabetic screening or glaucoma referral refinement in one area will likely have to get reaccredited to do the same job in the adjacent commissioning area. The same applies to dispensing opticians, even those with Honours qualifications, practicing low vision. It may help to adopt the World Council of Optometry definitions of optometry (in four levels) and / or the European Diploma system to try and set a consistent approach that could also be used to accredit practitioners from abroad.

Optometrists studying IP should be supervised by experienced IP optoms not only ophthalmologists.

The confusion between CET and CPD is spurious – HR professionals use the terms interchangeably – we should change the name to CPD but keep the system broadly as it is. Additional competency areas should be added and existing practitioners introduced to additional subjects in this way as a prelude to formal qualifications. Supervision should be a competency in its own right for anyone who supervises trainees, pre-regs or optical assistants who do pre-screening, dispensing or contact lens teaches / supply.

Consultation question 11 – What are the core skills, knowledge and behaviours which dispensing opticians will need to have on joining the register in the future?

The core syllabus for all registrant groups should be mainly left as it is until a flexible set of rules are available in terms of delivery and change and then the professional bodies and educational institutes consulted in detail. DOs and CLOs are currently lacking critical thinking skills and along with many optometrists lack the ability to make a clinical decision in the best interest of the patient, often being too risk averse, and covering their own backs at the expense of patient care. Adopting a learn while you earn approach will mean that employers will select people who have the requisite communication and people skills before they embark on their training – this could apply to optometry as well as dispensing.

The dispensing course might need to move to being degree level in due course, however to meet the needs of an increasingly elderly population low vision needs to be extended to include sight loss rehabilitation and practical refraction. Practical refraction including independent prescribing of glasses should be part of the standard dispensing opticians' course, and certainly must be included in the contact lens opticians' course. CL course should be expanded to include anterior minor eye conditions. All courses should be expanded to include ophthalmic public health, epidemiology, how to understand research and statistics.

Consultation question 12 – How should the content of dispensing programmes change to ensure that students gain the skills, knowledge and behaviours that they will require for practice and for new roles in the future?

This is mainly answered in 11, essentially awarding bodies need the flexibility to move with the times, add and remove competencies in discussion with the GOC in a timely manner as changing needs of patients and the market demands. If optometry reduces dispensing content any further it will become impossible for optometrists to supervise dispensing opticians – this could reduce the number of places for dispensing opticians.

It would make sense for dispensing opticians to be competent in school vision screening and orthoptics, and for that matter it would make sense for orthoptists to be competent in ophthalmic dispensing – currently they cannot legally even adjust a pair of glasses leading to more unnecessary patient journeys.

Consultation question 13 – How might post-registration training and registrable higher qualifications for dispensing opticians need to change in the future?

Practical refraction with independent prescribing should be part of the core dispensing course and the refraction course and examination (FBDO R – already in existence as examined in Malaysia and based on the former C.Optom exam) should be offered to all existing DOs and CLOs. Other courses should include registered school vision screener, registered orthoptist, minor eye conditions, ophthalmic public health and healthy living optician, safeguarding and special needs dispensing, refractive surgery pre and post op, dry eye and blepharitis (for DOs not just CLOs), eye pharmacy (use of P medicines for allergic conjunctivitis etc), imaging and eye health screening.

People (especially non-registrants) acting as directors of business registrants should have to complete a business standards course.

Professionalism and consistent standards

Consultation question 14 – How can we ensure students have the professionalism needed to take on new roles, including through the admissions procedures used by education providers, patient experience, supervision and embedding professional standards?

It is not fair to expect new students to have all the bed side manner skills of a qualified registrant – effort should be made to teach and examine these skills over the duration of the course. There seems to be a feeling that newly qualified optometrists in particular are lacking in this regard – I would argue this is the fault of the training not the admissions procedure. Having said that psychometric testing is proven more reliable than interviewing. The best way to ensure this is a “learn while you earn” modality as employers would then ensure only good communicators are put forward. Better training of supervisors would help, however this should not be so onerous as most supervisors are put off doing it as it is already evident many optoms and DOs do not want to supervise trainees.

Consultation question 15 – How should students be assessed prior to joining the register to ensure that there are consistent and appropriate standards of education, taking into account the different types of education programmes that are emerging?

Having had trainees on various programmes and spoken to many student DOs it is clear that standards of education and examination / assessment are in the main broadly similar. Where educational institutes offer their own examinations they are normally still working to the external FBDO qualification and therefore the supervision / accreditation / exemption provided by ABDO is a useful second tier of standardisation and consistency in addition to the oversight provided by the GOC.

It is important to note however that in my experience (and the opinion of OfQual) the level 5 registerable qualification from Anglia is not at the same level as the level 6 ABDO qualification. It is not in the public interest to have people placed on the register with qualifications that other registrants have but cannot use to register with. Many students of ABDO College, Bradford and City & Islington have Foundation Degrees in Ophthalmic Dispensing but cannot register with them (and nor should they be able to do as they have not finished their studies). The public would think the current state of affairs illogical and unfair.

IN principal I don’t see a problem with having competing qualifications from different awarding bodies however this was the situation immediately prior to my qualification with several dispensing awarding bodies and several optometry bodies. Rationalisation to one DO and one Optom body made sense and was at the behest of the Government of the day. Currently apprenticeships and vocational qualifications work to consistent standards across a number of awarding bodies so it is possible to do this, the difference here is that the level 5 course does not test the same underpinning scientific knowledge as the level 6 course – it does not make sense.

Barriers to change and other issues to consider

Consultation question 16 – What are the challenges and barriers to improving the system of optical education, including issues that may be outside the remit and control of the GOC, such as legislative change, workforce planning, the funding of education (including higher education, continuing education and training and continuing professional development) and the provision of student placements?

The genuine career ladder approach advocated in Q4 above would create a simpler and more responsive system. Individuals and employers could flex to meet manpower needs. There would be economies of scale for educators with common modules, even whole academic years across all disciplines (on the world council of optometry definitions of the four stages of optics / optometry).

This would make examination, accreditation of prior learning, including from people wishing to join the UK register from abroad so much easier. Undergraduate courses could be changed quickly and

additional qualifications to upskill existing registrants could also be provided easily on the back of these courses. Earn while you learn courses solves the problem of pre-reg placements as most students will have a job already. It is important however that the traditional full time course is not removed as this is a good option for straight from school students with A levels.

Consultation question 17 – Are there any other issues that we should consider in carrying out our review? If so, please set out what they are.

Currently ophthalmic dispensing is regulated but substantially de-restricted. Restricted dispensing is unusual in that it can be delegated to people who are not training as dispensing opticians / optometrists whereas all other restricted functions such as sight testing or contact lens fitting can only be delegated to registered optical students. It would make sense for the dispensing of children and blind / partially sighted patients to only be carried out by a registrant for the protection of the patients, employers and the reputation of the supervising professionals. Safeguarding training should be compulsory for trainees, and the GOC should consider Disclosure for all registrants for the protection of the public and simplification of approach given the current reliance on trust when registrants renew their registration.

The increasing elderly population means there will no doubt be many more vulnerable adults in the future. Delivery of spectacles to patients in their own home / care home is often carried out by lone personnel and for the protection of the public it is best that the person fitting the patient's new glasses is qualified, registered, and has completed adult safeguarding training. Therefore it would be appropriate to change the restricted categories to include vulnerable adults, and ideally patients with high prescriptions who need the additional skill of qualified individual. It may be difficult in practice to definitively identify vulnerable adults, an alternative proxy might be to make dispensing GOS vouchers restricted since this includes children, complex lenses, and adults that are vulnerable in some way or other as they are on a low income.

Dispensing Opticians may currently lack critical thinking skills and may struggle to make clinical decisions in the best interest of the patients and this has been exacerbated by the new standards, duty of candour, etc. The Enhanced CET scheme should make peer discussion compulsory for DOs as it is for all other qualified registrants. The GOC should prepare a case for DOs having access to DOCET funding – no extra money just access to the DOCET fund. The CET grant currently compensates practices for loss of business when the optom is at CET (or pays for a locum) – this is not case for DOs as they can be out of practice at the same event as the optometrist making the system more efficient and facilitating multidisciplinary team learning which is proven effective at improving standards.

- END -

Peter Charlesworth

Consultation question 1

Patients' fundamental requirements are not going to change. However, with an ageing population and new, advanced treatments requiring multiple visits, patients are putting a greater demand on the system, which will have to change. The current model of secondary care, centralised in hospitals is becoming increasingly unsustainable.

Consultation question 2

Secondary care is overwhelmed with demand created by an ageing population and new, advanced treatments requiring multiple visits. It is in patient's best interests to devolve much of the care currently centralised in hospitals to community level. To do this optometrists must become more skilled in the differential diagnosis and management of ocular conditions. They must also embrace technology and new ways of working with their ophthalmology colleagues (sharing data between hospitals and local community practices). It also requires a fundamental reorganisation of NHS services. While this has been resisted in the past, there is increasing recognition at all levels that the current system is broken and that the status quo is not an option.

Consultation question 3

This will impact on the role of dispensing opticians and optometrists. Advances in technology mean that refraction is likely to become more automated and more de-skilled. Auto-refractors are sufficiently accurate in most normal (undiseased) patients to be relied upon for sight testing and prescribing of glasses. At the same time, technology means that the acquisition of clinical data such as IOP, fundus images and OCT can be performed easily by trained support staff. Even the preliminary analysis of this data can be done by machine algorithms and AI. Therefore the basic functions of an eye examination could easily be delegated.

Advances in surgical instruments and robotic micro surgery may make it viable to carry out minor eye surgery (eg refractive surgery or intra-ocular injections) in the community too.

Optometrists will need to adapt the way they work. They are more likely to be asked to interpret and oversee data from many more patients. The procedural issues highlighted in the Honey Rose case will be even more important than before.

Optometrists will need to become more skilled in differential diagnosis and management of eye conditions and will need to develop new ways of working - with their practice teams as well as with their ophthalmology colleagues.

The changes for DOs are less clear. They might choose to up-skill to carry out some of the refraction duties or may decide to become more fashion and commerce oriented. Concentrating on selling a commodity with professional input. Changes are less likely to affect DOs.

Consultation question 4

It would make sense to up skill all optometrists to the level of a therapeutic optometrist. So that graduates are able to prescribe without additional training. These core skills would cover the management of ocular surface disease, red eyes and the more common medically-managed eye conditions.

Some many choose to undertake additional training to specialise. But it is the core skills that must change. Current graduates are woefully unprepared for anything other than basic refraction.

Optometry departments should look to their dentistry and medical schools to understand how to equip students with the necessary clinical skills and exposure to real patients prior to (and post) graduation.

Consultation question 5
Dispensing will remain a role and is unlikely to change in the near to mid future.

It has always been an anomaly that dispensing opticians fit contact lenses. This process is better suited to a clinician with proper anatomy and physiology training.

All optometrists should become therapeutic optometrists.

The existing distinctions should be reviewed so that they keep pace with new requirements.

Consultation question 6
The GOC should constantly review quality assurance processes. The current fashion in healthcare and education for risk-based quality assurance approaches, relying solely on the analysis of outcomes has had some recent high profile failures.

A competency based model of education works well as long as the competencies are well framed and regularly updated. They work better for undergraduate training than they do for continuous professional development - where the needs of ever-diversifying groups can be quite different.

Consultation question 7
Yes. The GOC is the regulator and as such should oversee final accreditation for all core training and higher qualifications relating to registrants.

Consultation question 8
In addition to existing skills they will need:

More in depth knowledge of the differential diagnosis and management of common ocular conditions

Experience of managing those conditions with medicines

Better understanding of (and more exposure to) advanced diagnostic techniques such as OCT

Better leadership, management and team communication skills to help develop new ways of working and to be able to oversee processes and multiple clinical assistants.

Consultation question 9
There needs to be more emphasis on core clinical skills and exposure to patients. This could be done through placements if necessary.

Optometry departments need more funding to keep their clinics up to date. Many clinics "make-do" with out of date diagnostic equipment

Consultation question 10
It remains to be seen how many optometrists will want to (or need to) specialise beyond core competencies. Higher qualifications can assist with this ongoing development as and where it becomes necessary.

Consultation question 11
Dispensing is less likely to change. Core understanding of optical principles and what lenses do and don't work for given situations could be complimented with more training in commerce and fashion sales.

Consultation question 12 See Qu11

Consultation question 13
Some DOs may be involved in the design and running of processes within practices. Those that are will need leadership and management training.

Peter Charlesworth

Some DOs may choose to up-skill to carry out clinical tests including auto-refraction. Those that do will need additional training.

Consultation question 14

My impression is that "Professionalism" is poorly taught at the UKs current universities. The increased number of students at each institution and their increasing propensity to live at home means that they are less likely to socialise with other opticians and do not build up an optical community in the way that universities did 10 or 20 years ago.

It is increasingly important that students are "taught" what it means to be a professional. Lecturers are unlikely to have a good understanding of this themselves and are unlikely to be involved in the development of standards or the application of fitness to practice.

The GOC and Universitioes could look to Medicine and dentistry to see how professionalism is developed in those courses of study.

Patient experience is also lacking in optometry education. Universities could be encouraged to open specialist clinics to give better exposure for students or pre-reg-type placements could be integrated into undergraduate studeis to ensure students get exposure to patients in different settings (high street, community and hospital)

Consultation question 15

I don't feel qualified to answer this question. The current selection systems based on A-levels or their equivalents seems to work. Otherwise access courses could be used.

Consultation question 16

Resistance to change is the biggest barrier. The NHS has been struggling for several years to meet its commitments and only now is an appetite for change starting to develop.

Trying to push for educational reform too early will meet greater resistance from people who don't see the changes coming. However, waiting too long will mean the profession is not ready to meet the challenges of a reforming NHS.

Funding will always be an issue.

But we can start by pushing for therapeutic qualification as standard (probably needs a 4 year course), more exposure to patients (integrating the pre-reg year to create 2 or 3 placements during the final 2 years could work) and exposure to more advanced diagnostic equipment (placements and better university clinic funding).

Consultation question 17

The educational review doesn't currently embrace CPD and revalidation. It is worth thinking about this. The existing system was designed to get around the requirement for ongoing revalidation. They CET system we have is probably superior to other HCPC profession schemes where the registrants are left to self-regulate with a small sample set being taken every year. Everyone knows that these professionals only prepare a portfolio when sampled by their regulator. However, our CET system is probably inferior to the system employed by medics. There are reasons why this might not work as well in our profession (optometrist are more likely to work in isolation and in competition so will find it more difficult to find an appropriate assessor). But it is worth thinking how changes to core training and the way the profession works will impact on CET/CPD requirements. Should the system still be competency based? Should there be new groups for new specialities? Is there a better way to get clinicians to engage with life-long training and development.

- END -

Roger Pope

With regard to the ophthalmic dispensing course I feel that it should embrace the needs of retail dispensing in the New Millennium.

The course is very technical and requires a high mathematical ability. One questions whether this level of expertise is necessary for the needs of a modern day dispensing optician. A more vocational element needs to be included to incorporate fashion, window display, frame purchasing and general retail knowledge and skills.

Successful dispensing opticians in the independent sector could contribute as visiting lecturers. Full time students could also undertake intern appointments. Existing teaching staff must be careful they are not living in a bubble and are regularly engaged in what is happening in the constantly changing world of current retail optics.

We should also be recruiting from a broader base rather than people who go on the course after working in an optical practice as support staff.

We must recognise that optics today has a large retail element. I am not sure this is truly embraced by the present curriculum and if incorporated it would widen people's horizons and the opportunities available in both the independent and corporate optical sectors.

I have a quote from an employer (not myself) to a trainee optician "You will learn a lot on the course of which 80% you will never use".

Surely a course of learning for any career should include elements relevant to what the job entails.

Another important area is CET which at present seems to have narrow clinical remit. I would like to see general retail matters business, vocational eyewear and technical products included. I feel that the whole CET program needs reviewing to incorporate all aspects of modern day dispensing.

If we can develop these skills they are vital elements to develop a successful and rewarding career as a dispensing optician.

Conclusion
Remember the public perception of an optician is principally promoted through an optician's premises. Do the majority of optical premises really represent the full range of frames and lenses available today? Could this be improved by a training course that would make students aware of these important aspects of Optical retailing.

- END -

RCOphth (Royal College of Ophthalmologists)

1. Introduction

1.1 The Royal College of Ophthalmologists welcomes the opportunity to respond to this consultation.

1.2 The Royal College of Ophthalmologists is the professional body for ophthalmologists and we champion excellence in the practice of ophthalmology on behalf of our members to optimise care for patients. We set the curriculum and examinations for trainee ophthalmologists, provide training in eye surgery, maintain standards in the practice of ophthalmology, and promote research and advance science in the specialty.

1.3 We work with leaders across the eye health sector to help shape eye services for the benefit of patients.

2. General comments

2.1 Overall we strongly support the GOC in carrying out a review of its education strategy in light of the changing nature of eye care delivery, to ensure that registrants can safely and effectively carry out the extended roles that many have already taken on.

2.2 We welcome that the GOC is gathering evidence on what an updated and current education strategy should look like. We also wish to stress that the complexity and scale of the challenges faced by the eye health sector mean that significant change is likely to continue long after this review. Therefore, we urge you to keep education under review, so that as a clearer picture of the eye care system of the future emerges, the GOC is ready to respond appropriately.

3. Changes in demand and the impact of changes in eye care delivery

Consultation question 1 – How might the needs of patients requiring eye care change over the next 20 years?

3.1 As identified in the consultation paper, the population is ageing and demand for eye care is increasing. Not only is the volume of patients increasing, but also the complexity of their needs. New treatments have led to an increase in stable disease which requires long term management. Older patients often have multiple conditions and social care needs, requiring a range of interventions by different services and professions. There is also set to be an increasing number of children and adults with learning disabilities, who are more likely to have serious sight problems than others.

3.2 Patient expectations are rising too, as other industries become increasingly customer focussed, offering greater convenience to consumers.

3.3 While we acknowledge the potential benefits of automating and enabling patients to play a greater role in their own eye care, we stress the need to view eye examinations as health checks, which require a level of professional oversight. We would therefore emphasise that automation and self-testing should not be seen as an alternative to eye examinations, but more complementary.

3.4 These factors create significant challenges for the consistent delivery of joined up, patient-centred care to necessary standards. One of our greatest concerns is ensuring that patient safety remains paramount as the sector adapts to these changes.

Consultation question 2 What changes in how and where eye care is provided will be required over the next 20 years to meet patients' needs, and what are the barriers to these changes?

3.5 We agree that, where feasible and safe, eye care should be provided closer to home and in ways that are more convenient to patients. By moving more care into the community, this can alleviate dangerous levels of pressure on hospital services and ensure patients are seen within clinically safe timeframes.

3.6 Patients who need complex or specialised care, or with co-morbidities, are likely to still receive their care from hospital services. However, patients with minor eye conditions, stable disease and post-operative cases are the best candidates for receiving their care in the community.

3.7 With more optometrists and dispensing opticians taking on extended roles, and an overstretched healthcare system that could benefit from their greater involvement, we support the direction of change, but there are several barriers to overcome.

3.8 A key barrier is lack of adequate IT systems that allow efficient and safe transfer of data between community and hospital settings.

3.9 Secondly, there must be better collaboration between hospital and community settings in order to decentralise services in a safe and joined up way. Otherwise patients may be 'lost' or transferred prematurely, which could result in inadequate eye care and ultimately sight loss.

3.10 Thirdly, ophthalmologists and community staff must have good working relationships and assurance that the latter have the necessary skills and experience to safely take on clinical work in a sustainable way.

Consultation question 3 How are the roles of optometrists and dispensing opticians likely to change over the next 20 years, and what are the drivers for these changes?

3.11 While there are many examples of excellent practice where optometrists and dispensing opticians are carrying out extended roles, it remains to be established what the best overall methods of including them in assessment, treatment and monitoring pathways are. As new models develop, it is important that their education continues to take account of these changes.

3.12 The RCOphth, along with other professional bodies, including the College of Optometrists, Association of British Dispensing Opticians and Local Optical Committee Support Unit, are exploring this, and we would welcome opportunities to work closely with the GOC on clarifying what good new models of eye care look like, and the necessary workforce needed to deliver them.

3.13 In February 2017, we published the findings from over 200 interviews with ophthalmic clinical leads across the UK about new and developing models of care, within the reports of a study we commissioned called *The Way Forward*[1]. A significant proportion of the reports' content relates to the use of non-medical eye care professionals in extended roles. We strongly advise drawing on the insights from the research and contacting us to discuss any aspect of it.

3.14 As the consultation paper identifies, funding of extended roles is a significant factor in determining how your registrants may work in the future. Commissioners may need to fund more, and/or commercial eye care outlets take on additional clinical work, however it is unclear how financial sustainability will be achieved by the latter.

3.15 The extent of appetite for taking on additional work by optometrists and dispensing opticians is clearly important and remains to be established.

[1https://www.rcophth.ac.uk/standards-publications-research/the-way-forward/]

3.16 We would welcome further discussion around your suggestion that registrants may play a greater role in promoting healthy living and providing advice. While we view eye testing as a part of the eye health system, we would urge caution around how optometrists and dispensing opticians are presented to patients, so that they understand the extent of healthcare and advice that can be provided by non-medically qualified professionals. This is especially important given the variation in focus on retail or healthcare between different practices.

3.17 The patient must remain at the centre of care provision and understand the roles and scopes of practice of those caring for them. Optometrists and dispensing opticians must be clear about their role and responsibilities within the wider eyecare team.

Consultation question 4 How should the education of optometrists and dispensing opticians be structured to enable continuing professional development throughout their careers, e.g. core training followed by general or specialist practice?

3.18 We agree that education needs to reflect changing scopes of practice, with a potentially much greater emphasis on clinical specialism. The structure should provide enough flexibility so that registrants can choose what focus their scope of practice has, whether more refractive or specific eye conditions.

3.19 In November 2016, we published a series of Common Clinical Competency Frameworks for non-medical ophthalmic healthcare professionals working in hospital eye services, including *optometrists*[2]. These are a set of clinical competencies agreed by the relevant professional bodies for AHPs in extended roles within Acute and Emergency Eye Care, Cataract, Glaucoma and Medical Retina services.

3.20 The frameworks are structured around three levels of competence, relating to the previous skills and experience of allied eye care professionals taking on extended roles. They should be used to inform the structure of continuing professional development for optometrists and dispensing opticians who wish to progress into health focussed roles.

Consultation question 5 What are the implications for the GOC register of likely changes in roles and will the existing distinctions between registrant groups remain appropriate?

3.21 The way that registrant groups are distinguished must remain clear to patients so that they know what to expect from their practitioner. This may mean a new designation for registrants with enhanced healthcare-oriented roles, and those with a more traditional refractive focus. Appraisal and revalidation similar to the GMC system may be required to ensure confidence in, and recognition of the new role.

Consultation question 6 – What are your views on the GOC's approach to the accreditation and quality assurance of education programmes, including on whether this is an appropriate focus on outcomes and on the use of the competency model to set the standards of education

4. GOC's approach to education

Consultation question 7 Should the GOC accredit and quality assure additional or different higher qualifications and if so, on what basis?

4.1 We would strongly welcome greater quality assurance of additional higher qualifications that support its registrants to take on extended roles. For example, the additional training on glaucoma and medical retina offered by several higher education institutions.

[2 https://www.rcophth.ac.uk/professional-resources/new-common-clinical-competency-framework-to-standardise-competences-for-ophthalmic-non-medical-healthcare-professionals/]
4.2 The most appropriate organisation to provide this quality assurance will largely depend on who is ultimately responsible for the care delivered. If optometrists are to bear clinical responsibility for patients, we would expect the GOC to assure the training that enables them to do so.

5. Content of education programmes

5.1 We have provided comments below on optometrists and dispensing opticians together.

Core skills, knowledge and behaviours which optometrists on joining the register in the future

5.2 Educational content will depend on the intended scope of practice; refraction or health, and any specialisations within health. Key areas include:

- Condition-specific skills and knowledge needed to accurately interpret eye exam results. False positives and unnecessary referrals must be minimised as this wastes resources and reduces the ability of hospital services to see patients with eye disease within clinically safe times.
- Education on diabetes, dementia and lifestyle factors should become part of core education for any registrants involved in clinical care.
- Education should also include awareness of NHS England's Accessible Information Standard, as well as on issues relating to children and adults with disabilities, and legal requirements to provide reasonable adjustments.

Content and delivery of programmes to ensure students gain the skills, knowledge and behaviours that they will require for practice and for new roles in the future

5.3 This depends on additional clinical responsibilities where taken on, however we consider the following essential elements.

- Continuous assessment of learning outcomes and reflection on practice.
- Adequate clinical experience, perhaps similar to that of the pre-registration Foundation 1 and 2 years that medics complete.
- Arrangements for consultant ophthalmologists and other highly experienced ophthalmic hospital staff to impart the necessary competencies, at the right level, to optometrists and dispensing opticians.

Post-registration training and registrable higher qualifications for the future

5.4 They will need to be enhanced to reflect additional clinical responsibilities where these are taken on. We advise that the Common Clinical Competency Frameworks are taken into consideration. As above, working closely with hospital eye services will be important. 6

Consultation question 8

Consultation question 9

Consultation question 10

Consultation question 11

Consultation question 12

Consultation question 13

6. Professionalism and consistent standards

Consultation question 14 How can we ensure students have the professionalism needed to take on new roles, including through the admissions procedures used by education providers, patient experience, supervision and embedding professional standards?

6.1 A key issue is how to manage potential conflicts of interest between the delivery of eye care and sale of glasses or contact lenses.

6.2 Patient and carer involvement and feedback is an important part of developing professionalism for trainee doctors, so we would encourage greater emphasis on this for all healthcare professionals.

Consultation question 15 How should students be assessed prior to joining the register to ensure that there are consistent and appropriate standards of education, taking into account the different types of education programmes that are emerging?

6.3 We agree that this is an important consideration to ensure that there is an appropriate level of standardisation. Where there is an increase in clinical roles, we would welcome opportunities for focussed discussion with ourselves and relevant education providers.

7. Barriers to change and other issues to consider

7.1 It is essential that patients' needs are the first consideration through these changes. Where there are commercial interests in the delivery of eye health services, we have concerns that these may be allowed to negatively impact on the care that patients receive, unless necessary safeguards are in place.

7.2 Appropriate education and training for staff is a fundamental part of this, as are standards that reflect patient needs and expectations.

7.3 Directing more healthcare to optometrists and opticians also means sharing more responsibility for patient safety. Delineating where responsibility lies will be an important task as these changes progress, and we hope to work closely with the GOC and organisations across the sector to establish this to ensure the best system for patients.

7.4 If responsibility is to be shared then we would expect optometrists and dispensing opticians to be held to standards comparable to those ophthalmologists must adhere to. Ensuring consistent standards across the eye care sector is essential for patient safety and confidence, as well as effective joined up working.

7.5 One important element may be the continuing education requirements. The GMC sets out a more prescriptive system of CPD and revalidation which seeks to provide more assurance that its registrants are safe to provide clinical care. With a shift towards healthcare provision, optometrists and dispensing opticians may also need to demonstrate proven practical competence.

- END -

Sean Matthews

Consultation question 1
As the population ages, the incidence of age-related eye conditions will increase, subsequently putting more pressure on secondary care as more people present with multiple pathologies.

Consultation question 2
More services will need to be delivered by the community (primary sector), to take the pressure off of ophthalmology services. Barriers to this include lack of funding for the primary sector (for education, accreditation and delivery) of such services.

Consultation question 3
The roles will become increasingly diverse, requiring additional education and training, and continuing education to enable them to deliver enhanced services safely.

Consultation question 4
Core training as present, followed by post-graduate qualifications which each have relevant CET to stay up-to-date.

Consultation question 5
The GOC register will need to become more diverse to distinguish between the various qualifications/specialties.

Consultation question 6
I believe that the GOC's current approach to accreditation & quality assurance are ideal, as they ensure professionals are at the same level in terms of education and training.

Consultation question 7
Yes, as this would fit in with the GOC's aim of protecting the public by ensuring practitioners are safe to practise.

Consultation question 8:
Everything as at present, but they should also cover professional conduct and possibly independent prescribing.

Consultation question 9
Possibly increase the degree to four years, which would include the pre-reg period.

Consultation question 10
Additional funding to help with the associated time spent studying & time spent out of practice to make the higher qualifications more accessible.

Consultation question 11
Greater knowledge of eye conditions in order to aid the optometrists & patients.

Consultation question 12

Increase length of course or add additional qualifications post-graduate as per optoms.

Consultation question 13
As per optoms.

Consultation question 14
Add a professionalism module to undergraduate training to highlight its importance.

Consultation question 15
Through workplace assessments using College assessors and finalised using OSCEs.

Consultation question 16
The GOC cannot create funding for the extra qualifications that practitioners would be expected to achieve in order to carry out enhanced services. The GOC cannot control the workforce in terms of number of practitioners. It cannot ensure that every pre-registration optometrist/trainee dispensing optician receives the same level of training.

Consultation question 17

- END –

SeeAbility

Consultation question 1

As a result of our contact with people with learning disabilities and their carers and supporters, SeeAbility is aware of some of the difficulties experienced by people with learning disabilities, particularly with more complex needs, in accessing sight tests. This includes:

- Uncertainties among people with learning disabilities and carers that the sight test will be accessible and also regarding which optometric service would be best suited.
- Difficulties in providing a sight test where the needs of the patient with learning disabilities were not identified before the appointment.
- Communication difficulties
- Inappropriate testing methods
- Inadequate feedback of sight test results
- Difficulties in prescribing suitable spectacles

We are aware of some very good practice and some less so. We are involved with a number of eye care pathways for people with learning disabilities around the country, including the LOCSU Pathway and we are also a General Ophthalmic Services provider sight testing in a number of special schools. SeeAbility is a CET provider and we provide training for optometrists in some of the LOCSU adult pathway areas and we are working to develop competency frameworks in testing children in special schools.

Resolving the barriers identified above on a UK wide level is going to take a mixture of system (including GOS) reform, political will, raised awareness amongst the public, as well as improvements to education and training, and therefore the GOC education consultation is very timely.

At SeeAbility we are currently campaigning for system reform in England to benefit people with learning disabilities with more profound and complex needs. Our comments on this consultation tend to centre on the barriers in England for this reason.

As well as the rising ageing population noted in the consultation, the increasing numbers of children and adults with learning disabilities, autism, and people with other comorbidities such as diabetes should also be noted in the GOC's document.

People with learning disabilities experience a much higher risk of having a sight problem compared to the general population and in 2016 numbers of people with learning disabilities and sight problems are at their highest level yet. These numbers will continue to increase according to work done by the 'Learning Disability Observatory' Improving Health and Lives, which is part of Public Health England.

For example, in 2016 number of children and adults with a learning disability in the UK who are visually impaired (including being blind) was estimated to be 124,982. By 2031 this will have risen to 137,495. The estimated number of adults with learning disabilities and refractive error will have risen from 600,027 to 650,765.

Consultation question 2

There will be an increasing need for optical professionals to be aware of their obligations to provide reasonable adjustments, and accessible information, as well as having a proper understanding of consent and capacity issues.

Given the rising complexity of people's needs, it is very likely that more formalised professional specialisms will be needed in the eye care of people with learning disabilities or dementia.

People will have to be supported by the education and training framework that promotes the right expertise and skills, as well as a reformed policy, funding and legislative framework for eye care.

Together this should strike the right balance between protecting vulnerable people and ensuring people get specialist attention if required, yet promoting flexibility of practice.

The barriers to achieving these changes are many, and include broader issues such as the lack of profile for eye care in policy, particularly in England. Particular issues SeeAbility has observed in terms of supporting people with learning disabilities include:

1) Difficulties recruiting optometrists and dispensing opticians, against a background where technological change and business pressures are leading to a loss of skills in the sector.

For example optical assistant roles are replacing those of dispensing opticians, although the latter have expertise and training that people with learning disabilities need eg. fitting for special facial characteristics or those who need support to get used to their glasses.

Additionally, retinoscopy is being replaced by an increasing reliance on autorefraction. This is not evidenced as being accurate and in many cases is not possible when assessing people with a learning disability. Autorefraction is also less sensitive than retinoscopy in identifying the early signs of keratoconus. Patients with learning disabilities, and specifically have a higher risk of refractive error and keratoconus (particularly those with Down's Syndrome).

Technological change also brings risks if vulnerable groups are not provided with the right information and advice, for example buying spectacles on the internet which may be ill fitting.

2) A General Ophthalmic Services (GOS) contract that provides limited recognition of the time and funding needed to provide more specialist reasonably adjusted or creative services within the community, does not identify people with learning disabilities as a high risk group, and does not make spares and repairs of glasses more readily available to people who are likely to need these.

As an example, SeeAbility receives the standard GOS payment of £21.31 for sight testing a child in a special school, as do practitioners that work in day centres. This payment does not reflect the additional time, and flexibility that someone with a learning disability needs. As another example, only fsix areas of the country have adopted the LOCSU learning disabilities pathway, where local commissioners are 'filling the gap' by paying for additional time and care for people with learning disabilities to access sight tests.

3) A fear of litigation or NHS England investigation on the increase, which makes it particularly hard to target vulnerable groups if they are unable to comply with or complete the requirements of an eye examination.

For example, we know of optometrists who have pulled out of delivering the LOCSU adults learning disabilities pathway citing the Honey Rose case. We also know of opticians that are loathe to apply for newly introduced Special Facial Characteristic vouchers under GOS as the claims will 'stand out' and trigger an NHS investigation.

4) The continued move towards a business model in optical care, which as the GOC has found itself causes some members of the public to perceive eye care as 'profit motivated' by the sale of glasses, and for some professionals to feel competing sales pressures.

For example, people with learning disabilities have told us they are worried about the costs of eye care, and if they are of working age, they are not listed as a high risk group who should have an NHS funded sight test as a matter of course. As the GOC does not regulate business practice, and the OCCS does, there remains low awareness of how to challenge poor retail practice eg. in respect of individuals being

able to understand and retain information on what prescription and frames they need and consent to parting with their money.

Consultation question 3

Some of our comments in this area are answered under Question 1. On a more positive note:

- We hope that the increasing needs of vulnerable groups, who will need specialist support and eye care, including properly fitting spectacles, and low vision aids, will ensure that there are rewarding roles for dispensing opticians and optometrists who can specialise in this area of eye care and health delivery.
- We also hope in the future that technological change may bring some real benefits to patients (for example, potentially reducing the need for cycloplegia or dilation, which can be distressing for some people with learning disabilities and autism).
- That there will be increasing opportunities for multidisciplinary education and training, and collaboration, so that optometrists and dispensing opticians can work more closely with orthoptists and ophthalmologists in delivering pathways of eye care for people with learning disabilities.

Consultation question 4

SeeAbility would support moves to ensure that the curriculum for optometry students includes a mandatory requirement to perform an eye examination on a patient with learning disabilities or dementia or another communication difficulty as part of their Stage 2 competencies. For dispensing opticians training should focus on specialist frames, communication with people with disabilities including some Makaton/BSL and aiding patients with spectacle adaption – particularly as people with learning disabilities will usually need much stronger prescriptions. This would benefit many ‘mainstream’ patients as well.

However we also believe that specialist pathways should be developed to support people with learning disabilities in the community, and this should have support of the GOC in its education strategy and reforms, whereby accredited optometrists and dispensing opticians provide eye care in both special schools and in the community.

People could search for those with specialisms and competencies in supporting people with more complex needs on the GOC register.

One area of primary health care that has adapted and flexed to support people with more complex needs, and supported specialisms to develop, has been Special Care dentistry. This often takes place in community dental practices, but is also available in domiciliary environments and hospital. The speciality was formally recognised by the General Dental Council (GDC) in 2008.

We also believe that regulations should be changed so that rules that ensure spectacle dispensing is by a qualified professional extends to people with learning disabilities, and that this move should be supported by the General Optical Council.

Consultation question 5

Consultation question 6

A level of central governance is critical. GOC registers of additional qualifications would allow for this with College/ ABDO accredited and monitored courses leading to registration. Systems must not allow for post graduate qualifications to be awarded internally in large corporate bodies.

Consultation question 7
See answer above

In terms of Dispensing Opticians, GOC should look into additional accreditation for working with those with disabilities, rather like the current options for Optometrists, and in some small way in low vision which joins the Dispensing Optician course, looking at communication, adaption (of test/dispensing), and adaptation to the use of spectacle lenses.

Consultation question 8
Developing core skills that recognise the need for additional time, and adapting your technique or communication strategy for a person who may be uncomfortable or anxious with the prospect of a sight test or onward treatment, including getting used to spectacles, should be part of anyone's training. Knowledge of the wider eye care landscape and different models of care should be embedded in undergraduate training.

Consultation question 9
We would be alarmed if, as suggested on page 17 of the consultation, that in the content of education programmes there is a case for devoting less time to refraction because of the increasing use of autorefraction.

Autorefraction is not viable on many children or adults with learning disabilities, and can be very unsuccessful due to abnormal head/eye posture and poor fixation. The instrumentation relies on steady central fixation.

In addition, as highlighted earlier, research is now showing that retinoscopy is the only accurate tool for diagnosing early signs of keratoconus which can then be treated through corneal cross linking. This opportunity will be lost if the keratoconus has progressed because it has not been picked up at a sight test.

Consultation question 10
See our earlier comments including to Q7. As suggested above we would propose a GOC governed scheme of registered specialisms - available to the public. Our work has highlighted significant difficulties in accessing care. GOC governed additional qualifications would also allow employers to recognise registrants are suitably qualified for a role.

Consultation question 11
Communication skills will become increasingly important. There is also an argument for dispensing opticians to be formally trained in areas of clinical assessment - for example measurement of visual acuity, visual fields and history taking.

This could follow the model increasingly used in hospital eye clinics where a patient is triaged by an ophthalmic nurse. This is happening informally in many places to cut down on optometrist chair time and could allow dispensing opticians to take on other community/ hospital roles

There will also need to be greater knowledge of facial shapes, necessitating frame adaption for facial asymmetry due to natural changes to faces due to race/disability, and low vision due given statistics and growing number of aged peoples.

Consultation question 12

Consultation question 13

Consultation question 14

We would hope that those being admitted to courses a value base that respects disability rights and that discriminatory judgments should never be made in terms of whether it is 'worth' someone having a sight test or having spectacles if they have profound or complex needs.

It is really important to embed the attitude that even if someone cannot work, drive or read, their eyesight will be crucial and they can be supported to have a sight test or get used to glasses.
Students will have to be aware of these issues as sight problems are experienced by an increasing number of people with complex needs.

Consultation question 15

Independent governance of all training schemes is a critical role for the GOC. The role of employing commercial bodies in the provision and award of further qualifications needs to be closely governed by the GOC

Consultation question 16

As previously noted the current GOS funding system does not allow for the recognition of specialisms. SeeAbility understands that the pre registration system of qualification has been used to the advantage of some employers, potentially to the detriment of students if they are seen as a cheap workforce.

As a lot of preregistration training is now in- house which can allow for the line between business and professional education to become blurred (for example if students are only aware of 'own brand' frames/ lenses/ contact lenses).

We recommend at least a degree of mandatory external CET for pre registration students and registrants. There is a need to ensure DOH CET grants passed on to performers.

Consultation question 17

For many optometrists their career goals may be to transition from being an employee to becoming a partner or owner of an optical business. Education has a part to play in continuing to encourage those aspirations in training optometrists and dispensing opticians so that they become the independent practitioners of the future, and ensure there is a diverse marketplace. Without that drive, and with the additional increase in locum practitioners, there is a danger that more optometrists will choose not to open an independent practice.

The reason we are concerned about the diversity of the 'marketplace' is that people with learning disabilities will always need to have a good choice of services near to them (multiple or independent) and a choice of spectacles (particularly those with special facial characteristics). As multiples increase their market share, and win national contracts (such as the DVLA contract), this has the potential to restrict patient choice, and as with any other sector.

- END -

Specsavers

Consultation question 1

The consultation document both references the Foresight Project Report and summarises the areas that the GOC has identified. The GOC summary (paras 1.3 – 1.4) focusses on the provision of a greater range of enhanced services, which is probably the most pressing aspect, but we would encourage the GOC to recognise the broader range of areas described in Foresight such as increasing incidence of myopia and new areas of service delivery resulting from advances in technology, automation and artificial intelligence. The immediate patient need is going to be in the four areas of glaucoma, AMD, diabetic eye disease and cataract. The demand here will undoubtedly expand over the next 20 years and GOC registrants are best placed to meet this demand.

Consultation question 2

We encourage the GOC to take note of the analysis provided in the Foresight Project Report in respect of the how and where, and also for an analysis of the barriers. Many of these are outside the control of the GOC (for example, the difficulty of moving NHS funding from secondary to primary care). The potential patient base for domiciliary services will grow and a much larger number of registrants will need to be enabled to gain the experience and skills required to meet this need.

As far as the Education Strategic Review is concerned, there is an opportunity to better equip practitioners with the skills they will need in order to be able to adapt to the changes in how and where eye care is provided. Many of the barriers associated with this are related to the lack of understanding and recognition by other healthcare professionals (doctors in particular) of the scope and standard of education and training of GOC registrants and hence of the capability of optometrists and dispensing opticians. A fundamental contributor to overcoming these barriers will be through enabling trainees to achieve a deeper understanding of diagnosis and management of ocular disease, and improved professionalism, clinical decision making, judgement / demonstrating accountability, communication, collaboration and leadership.

Consultation question 3

The ground here is again well covered in the Foresight Project Report so rather than repeat the points here, we assume the GOC has noted the relevant content. In summary, the principal changes will be in expanded clinical roles. Foresight points to the greater need for community expertise in low-vision correction and technologies, pre- and post-operative care, and monitoring of disease in the community. At the same time, the GOC needs to take account of the impact on all professions and professionals of automation and innovation. The central role that professionals play in people's lives will change as technology and the internet advances. As systems become more capable the roles of all health care professionals will change from being simply the 'owner' of knowledge, experience, skills and know-how, to being the interface between the patient and technology, guiding patients in their decisions while providing care.

Healthcare will continue to shift from being reactive to proactive and in the shift towards preventative medicine and health promotion, the role of opticians as public educators will expand. The challenge of delivering more professional service at lower cost is a struggle for all health organisations, but the two main responses to this challenge are to be found in efficiency (through reducing costs) and collaboration (through sharing costs) – both reliant on technology.

Consultation question 4

We welcome the identification and adoption of the four principles to guide this review – this should deliver outcomes that: take into account and anticipate how the delivery of eye care is likely to change; enable innovative approaches to education and eye care delivery; reflect evolving good practice in education; and, promote professionalism. We note that the GOC is looking separately at how the

system of CET needs to change, including how this can provide a greater focus on continuing professional development. We surmise that the GOC will extend the four principles to this further work. Adopting a structure in the early stages of training that is based around core / plus is sensible as this then follows through into career learning. However, at this stage it is difficult to see that what the GOC might change at undergraduate / trainee level could create new hurdles for post-qualification learning, so rather than attempt to think through how a structure of CPD could be worked backwards into undergraduate training, we believe it more important to concentrate effort at this stage at getting the early stages right, with CPD structure to subsequently build on this.

Consultation question 5

The range of emerging clinical opportunities, and diverging models of delivery across the UK, mean that sub-specialisation within the professions will increase. The GOC already manages several different registers and lists, which in comparison with some other healthcare regulators must appear to an outside observer to be unnecessarily complicated. We do not believe the GOC should look to expand the number of registers / lists but rather should look to consolidate these, to remove potential duplication and overlap and to prevent even further complication in the future. We would not be averse to a single register of qualified registrants, each individual accountable for practising to and within their competence, with it being incumbent on the individual to evidence this. Such an approach would also allow for change over time, as the way that different functions are delivered will be altered by technology, which in turn may move the boundaries on what is consid ered to be core competence.

Consultation question 6

The HE institutions will be well placed to answer this question in depth. Our observation is that the GOC tends to emphasise process and inputs, and less so on outcomes. It places specific requirements on the detail of what should be taught and how – rather than encouraging innovative approaches that embrace the best of the many-and-varied available approaches to education.

In the analysis of the current system of optical education provided in the consultation document, the GOC provides (at 2.6) an effective summary of the status quo and while recognising that new ways are emerging, it is difficult to break away from this traditional model which tethers thinking to a certain extent. Sections 2.7 to 2.9 possibly imply a relatively passive or permissive approach to consideration of new ideas and while it might be argued that it is only sensible to adopt a low-risk and cautious approach, we would challenge the GOC to adopt an approach of encouraging innovation and change rather than simply reacting to it. The GOC recognises that it needs to be flexible enough to cater for different models, but it should go further and proactively embrace new and innovative approaches. Competency-based training (CBT) is commonly found in medical and healthcare training across the world, but in many fields, as is the case with optometry in the UK, it is arguable that this is a ‘bolt on’ to an existing more traditional system of training delivery and assessment and as such has not been fully integrated. CBT has much to offer in terms of increasing the transparency and efficiency of training programmes, which is an essential requirement in a rapidly changing environment and time of uncertainty. The current system appears to be quite good a delivery a whole range of task-based skills, but in many of the areas where both optometry and dispensing optics need to ‘step up’ in order to deliver what will increasingly be required of them, the current system appears to fall short. These higher level competencies are in the areas of:

- professionalism
- clinical decision making
- judgement / demonstrating accountability
- communication
- collaboration and leadership

We support the use of a competency based approach, but work needs to be done to address some of the limitations that accompany this approach. We know that CBT is effective when teaching and assessing the basics of technical skills, but is not as effective in assessing decision making ability. The major weakness, which may only be partly addressed by the current HE exam structures and final

assessment undertaken by pre-reg trainees, is the danger of assuming that because a trainee can perform to a set standard in various competencies at specific moments, that they are proficient overall. What is lacking is a method of ensuring that trainees are capable of integrating all the skills they have acquired into the comprehensive care of a diverse range of patients in different settings. Optometrists need to be able to prioritise and amalgamate information and then integrate this with their skills and apply these appropriately – not follow a 'check list' approach to conducting a consultation. It is only through developing this approach at undergraduate level and then nurturing this beyond qualification throughout their career, that they will be able to effectively function in what will be an increasingly uncertain environment, managing both complexity and risk as a fully-fledged contributor to the wider healthcare team.

Higher order cognitive skills are not easily described in statements of competence and there is a real risk that because the current system is teaching towards a competency-based assessment, it doesn't address these higher order skills (they remain in the 'too difficult' box). The system in place prior to the introduction of the current scheme for registration, was criticised in part for the various biases that were inherent within a significantly subjective system. However, in moving to a pass/fail assessment which is, in turn, inherent within the competency based assessment, we have moved to a more simplistic approach which defines the 'minimum acceptable'. What is required is an approach that provides an incentive for learners to press for excellence and therefore one that gives much greater levels of feedback throughout – something that could be in part achieved through a more innovative approach to embedding clinical experience from the outset and throughout the training programme. Training more than ever before, must take place where day-to-day patient care is delivered.

Consultation question 7

We remain open minded on this question. The benefit could be that there becomes one nationally accepted standard, recognised by all commissioners, that evidences practitioners have met the competency standard to deliver whichever service / function at question. Additionally, this would maintain separation between educational provider / accreditation which removes the risk of the provider imposing requirements beyond those which a neutral and objective analysis would indicate are required. The fear is that it would create a new level of bureaucracy, which does not achieve recognition by commissioners (for example, many would argue that MECS is core competence and hence GOC registration in of itself should be sufficient assurance – yet commissioners require additional WOPEC certificates to verify competence) and would then be a burden on practitioners and a barrier to professional advancement in a rapidly changing world. On balance, we believe that the GOC should defer any decision on whether to move into this area until it satisfied that the core areas of education and training have been more completely addressed.

Consultation question 8

As a (generalised) observation, currently many optometry graduates lack basic management skills or sometimes even an understanding of why management plans are necessary. In many cases, the PRP needs to start with teaching conditions, understanding the effects, communicating and then implementing a plan (and this should be happening earlier in the education process). Optometry can learn from medical education in these areas, particularly in terms of how to develop management plans, communicate effectively, interpret information and show empathy. An increasingly common criticism is that the standard of referrals made by some optometrists suggests they are not comfortable with making decisions and/or accepting accountability for such decisions. This may in part be cultural (historically optometrists were trained to 'detect' rather than 'diagnose') but it does need to be addressed for optometry to fully achieve the confidence of the medical professions with which it interacts.

Ideally upon joining the register optometrists need to be able to deliver problem-oriented consultations and for this they should have critically reflective, analytical and evaluative skills and habits, effective communication, leadership and mentoring skills, in addition to the core scientific knowledge that underpins the clinical service that is provided.

Professionalism is often mentioned as a discrete requirement but it is quite integral to everything summarised above. In addition it relates to a range of transferrable employability skills such as multidisciplinary team working, delivering and receiving feedback, application of ethical principles and the law, respect for equality and diversity, psychology, written and verbal communication styles. Finally there should be a clear recognition that professionals need to be prepared with skills that enable them to be life-long learners and that to remain relevant they must be adaptable to develop throughout their careers.

Consultation question 9

As the Foresight Project Report highlights, online platforms have already revolutionised education and training across a multitude of professions and disciplines. Foresight provides some examples (see page 139 of Foresight Report) and refers to how distance e-learning fits with the earn-as-you-learn model which a number of universities now offer for a number of HE programmes. Indeed in education, blended learning may become a preferred way to organise teaching with some time spent online and the remainder in the 'classroom'. The basic method of teaching (optics is no different) has not changed for decades if not centuries. Small group of students, assembled in front of a teacher, delivering a session of broadly same duration and pace, to a fairly rigid curriculum – and one size fits all. There are many examples of online education networks, media platforms and virtual learning environments that are currently significantly under-utilised in optics. Fo r example, Khan Academy is a free online collection of almost 6,000 instructional videos (watched over 450 million times) providing over 100,000 practice problems with more than 10 million unique visitors a month. Among its offering it covers a number of subject topics that are directly relevant to trainee opticians, presented at a level of quality that would be difficult to replicate in a traditional teaching setting.

The Foresight report suggests: "Such is the speed of development across a wide range of technologies within the optical sector, institutional courses are liable to appear out of date almost as soon as revised modules are launched. It is therefore inevitable that workplace learning via apps and online platforms will be of ever greater importance to the practitioner who wants to remain cutting edge." (page 140) We observe that one of the challenges for HE providers is provision of a 'real world' clinical training environment in the relatively artificial setting of a teaching and research institution. Against the odds, all do a fantastic job, but the cards are stacked against them. As numbers have increased (and we would argue – for reasons of changing workforce demographics and working patterns, an ageing population, and simple health economics – need to increase more) the current system is working at full stretch. Yet the need to increase clinical training capacity remains and it is simply not practical to deliver this within the traditional university clinic model – the GOC needs to move beyond welcoming, to actually demanding, innovation. In this regard, the traditional approach followed by many training to become Dispensing Opticians, is better placed. Trainees must learn alongside those who are immersed in the treatment and care of patients – something that is less easily achieved in the more artificial environment of a university teaching clinic. In optometry in particular, best practice is evolving rapidly and it is essential that training occurs alongside where the optometrist in practice is delivering this patient care.

High quality placements, potentially outside current teaching time, must become a central part of the undergraduate programme. Blended learning programmes have great potential to support this new immersive approach to clinical education.

Researchers on the Foresight Project reported the desire to see a greater emphasis on patient experience within the BSc degree course as a common theme amongst recent graduates they spoke to, some having felt under-prepared for the 'real-life' work of their pre-reg year. Foresight also acknowledges the argument that more widely-placed courses around the UK might profit student-patient contact time, particularly in the HES, while encouraging the growth of an optometric workforce in underserved regions – something that we too consider worth exploring.

Consultation question 10

It seems that the first step is to identify the educational needs up to the point of entry to the register and then to consider the role of any further registrable higher qualification, however bridging the perceived gaps between new registrants and existing registrants will need to be tackled. There will be those who suggest that the new registrants will have fresh knowledge and newly learned skills but may lack experience, whilst longstanding registrants will have deeper levels of experience in some scope of practice but perhaps have a gap in skills and knowledge that have been acquired by their recently qualified colleagues. The main challenge will be to enable all to flourish so that all registrants have the opportunity to mature as professionals and that large swathes of an important primary-care ophthalmic workforce don't become marginalised.
The regulator can facilitate the process and encourage providers to deliver programmes that encourage optometrists to develop their skills in the areas of the practise that they choose to specialise. However, as at question 7, we remain open-minded on whether there is a need for higher qualifications to be registerable as such. Annotations of (evidenced) areas of interest against a registrant's entry in the register may suffice and enable to the register to remain dynamic enough to respond to emerging specialities, without the need to create specific registered sub-specialities.

Consultation question 11
(Many of the comments at 8 to 10 above when contextualised for the specifics of the different scope of practice, also apply to questions 11 to 13).

As a generalisation, Dispensing Opticians will need to have greater knowledge in areas of pathology and management. It may also be helpful to move some of the core learning and training from the CLO programme, into the core dispensing programme, so that the CLO programme becomes more about demonstrating experience and fitting contact lenses, than acquiring the basic knowledge. This would also assist progression into other areas (eg low vision, refraction).

As an observation, we assume that many of the responses to this call for evidence consultation will be from representative bodies and collective groups (including this). However, when it comes to the detail of Qs 8 – 10 and 11 – 13, we wonder if the GOC might consider whether these would make appropriate topics for stakeholder consultation / discussion events, as an approach that might offer greater depth of information than can necessarily be collected in a formal call for evidence.

Consultation question 12 (see comment in 11 above)

Consultation question 13 (see comment in 11 above)

Consultation question 14
Admissions procedures should be used to ensure that entrants to the courses have an equal foundation upon which to build. Some of that will relate to underpinning theoretical knowledge so that undergraduate time is not spent simply bringing all students up to the same level. The other aspects of the entry process should frame the applicants' expectations appropriately and try to address the issue of value based recruitment which is being used in other health professions (and currently probably absent from optometry / dispensing selection). Potential approaches include implementing group and individual interview processes; utilising registrant professionals from a clinical setting as part of the interview panel; or even including current undergraduate students as part of a peer assisted session. The challenge with this is likely to be the availability of adequate manpower to facilitate. Although there is a view that interviews tend to lead to the selection of the same candidates that would have been chosen on paper, the advantage of interviewing might be in framing expectations and enabling prospective candidates to form a bond with the educational establishment and their professional aspiration.

Blended learning could also contribute to this development – enabling the student to learn alongside the qualified practitioner at the point of delivery of patient care.

Consultation question 15

The review is an opportunity for innovation from the perspective of assessment. Portfolio based situated assessment in practice combined with OSCE has certainly tackled some of the issues that previously existed (accepting the risk identified in the answer to Q6 above that the current approach may be too simplistic, being defined by the 'minimum acceptable'). As the number of providers of undergraduate Optometry courses continues to increase it may be an opportune moment to consider e.g. the use of progress testing, using end-of-degree-course assessment goals, ideally co-developed and co-adopted by a number of institutions so that there can be benefits of collaboration whilst allowing for individual variations in the forms of delivery.

Consultation question 16

Funding of Education and student placements: In other allied health professions (such as orthoptics, dietetics, physiotherapy and podiatry), although university fees have recently been introduced for 2017 entrants, clinical placements will continue to receive funding assistance. This is an area which the optical industry has never received support for hospital and community-based placements and may be considered to be one of the barriers to the incorporation of the systematic use of situated learning via clinical placements in undergraduate programmes of study.

Consultation question 17

In this call for evidence the GOC has rightly identified and asked about both the 'how' of training, and the 'what' are we teaching. The second of these is the harder to answer as it is not possible to predict which currently unknown innovative services will inevitably emerge in the now technology-based environment in which all professionals operate. Among the 'next steps' in the consultation document, the GOC has highlighted that this all links into legislative reform. As far as education is concerned, the impact of this is more wide-reaching than the elements of legislation which simply relate to education itself. We need to recognise that registrants in the not-to-distant future will need to operate as 'networked experts' (ref 'The future of the professions' Susskind & Susskind 2015), increasingly delegate tasks to trained colleagues, embrace and apply new 'Artificial Intelligence' (AI) technology, navigate a different relationship with the increasingly expertly-informed consumer, and manage more complex systems. The education structure will need to equip practitioners to operate effectively in this environment, but legislation that is permissive or flexible enough to enable these new models to develop, must walk in step with this.

- END -

Tim Hunter

Consultation question 1
Increasingly older population with mulitple health neeeds and complex pathology. Also more informed patients and more expectations on quality of service and personalisation of health care. Possibly move towards more home centered, digital solutions?

Consultation question 2
I think there will be a move towards more home centered, digital solutions for patients. With conversley more specialised care concentrated in hubs. I think optometrists will need to embrace both.

Consultation question 3
Optometrists and DOs are likely to move away from issuing prescriptions and spectacles to managing complex visual and ophthalmological issues. Hopefully retail environment will be less prevalent.

Consultation question 4
We must improve our core training in paediatrics, with one or two honourable exceptions it is pretty poor at Univeristy and students come out ill prepared and lacking in confidence and ability to manage non adult patients. The PRP is hardly any better giving minimal requirements for any paediatric experience. The Honey Rose case is the extreme end of that spectrum. I personally believe managing children should be an enhanced role but in the absence of that we should be much better as a profesion at dealing with children. We also need to improve our ability to manage patients with ocular pathology and find a way of allowing optometrists to use IP to support our patients health needs throughout the UK.

Consultation question 5
I would hope the GOC would continue to exist and manage the optometry and dispensing professions. I would also hope that the profession moves as a whole into enhanced rioles and does not fragment into disparate skill sets and registrant groups. The GOC needs to stay ahead of the game and not be chasing to catch up with change, whcih is already here.

Consultation question 6
Looking at the quality of students produced from the Univeristy departments, the GOC has room for improvement. The sylabus is full of unecessary stuff and there is not enough focus on management of patients and clinical skills or practical tasks. There is also a disconect between the reality of clinical practice and University theoretical practice. I think the GOC needs to up its game here.

Consultation question 7
The more additional qualifications of relevance to clincial practice the better, I have always felt that we should have appropriate qualifications for any enahnced roles that we do.

Consultation question 8
Ability to manage paediatric and adult patients.
Would argue a lot of the rest is nice but not necessary

Consultation question 9
More clinical experience
More patient contact

More external involvement with optometry in it's different facets, community, hospital etc.

Consultation question 10
Better PRP in terms of assesing practical skills, heavy reliance on "case records" at present not so much on seeing it done More appropriate higher qualifications, more providers other than the Universties.

Consultation question 11
More low vision
Better at dispensing children
More complex dispensing skills

Consultation question 12:
No comment

Consultation question 13
No comment

Consultation question 14

Consultation question 15
More practical assessments,a pre-registration period in clinical practice post graduation. Students should NOT be registrable from University, this is a massive conflict of interets and not safe for patients or the profession.

Consultation question 16
Self interest of Univeristies, funding. GOCs power to intervene

Consultation question 17
Must address the conflict of being a health care provider with the significant pressure of being mostly employed by retailers.

- END -

Changes in demand and the impact of changes in eye care delivery

Consultation question 1 – How might the needs of patients requiring eye care change over the next 20 years?

- An aging population will mean a greater prevalence of certain ocular pathologies such as cataract, glaucoma and AMD
- An aging population will also mean an increase in the number of patients with multiple general health conditions which may affect their ability to access optical practices, or to participate in standard time-limited "sight tests".
- The prevalence of myopia is likely to continue to increase along with demands for treatment to slow progression
- Patient access to technology may lead to them taking greater responsibility for monitoring conditions e.g. taking fundus photos of their own eyes and emailing images to clinics
- Patient access to an unprecedented amount of information on a very wide range of "eye care" products and services, will mean they expect evidence-based expert opinions from their eye care professionals.

Consultation question 2 – What changes in how and where eye care is provided will be required over the next 20 years in order to meet patients' needs, and what are the barriers to these changes?

It is likely that a good deal of eye care will move from secondary to primary settings as currently demand outstrips supply in the hospital eye service (see 'The Way Forward' reports by the Royal College of Ophthalmologists). This will result in optometrists having a greater role in management and treatment of ocular disease. Optometrists are well placed to take on additional roles but the following barriers apply:

- NHS commissioning is variable across the country. In some areas optometrists are underutilised.
- Whilst many of the moves from secondary to primary care fall within the current competence of optometrists, commissioners often require extra proof of competence which increases the overall burden on the profession.
- There are areas which optometrists could move into with some extra training. But funding for this is often not forthcoming. One option would be to include extra clinical content in the undergraduate programme, but this would not be financially viable unless optometry received higher level HEFCE funding. Currently optometry is in price group B, but a move to price group A would be necessary to make extra placements/training feasible.

It also seems likely that technology will lead to more eye care being provided remotely and for optometrists to become the overseers of the output of technology rather than being data collectors. This change will occur organically and there are no specific barriers that need to be removed.

Consultation question 3 - How are the roles of optometrists and dispensing opticians likely to change over the next 20 years, and what are the drivers for these changes?

Optometrists are likely to spend more time managing and treating ocular conditions which would normally have been the preserve of secondary care. It is likely that they will move, due to technological developments, away from being data collectors to spending more time interpreting and communicating clinical data.

Consultation question 4 – How should the education of optometrists and dispensing opticians be structured to enable continuing professional development throughout their careers, e.g. core training followed by general or specialist practice?

Given the variability of NHS commissioning and lack of HEFCE higher level funding a longer degree course with more clinical content is not feasible at present. We suggest that the GOC should specify a set of evidence based outcomes for a 3 year BSc - which would offer core training. A set of evidence based competencies for the point of registration should also continue to be specified. This will allow providers to either offer a BSc only, pre reg period only or a course with an integrated pre-reg. The GOC could then develop competency frameworks for other areas where the scope of optometry practice may increase (e.g. minor surgery, general health monitoring). Initially these may be postgraduate qualifications but we would welcome the GOC's support in lobbying HEFCE for increased funding so that they could be introduced into a longer undergraduate course at some point in the future.

We do not believe that the scope of practice for dispensing opticians should extend to refraction for the following two reasons:

- The demand for refractive services is likely to be reduced as technology continues to change
- Refraction is not in addition to a clinical examination – it is in itself a clinical examination. Refractive changes can indicate ocular pathology (e.g. cataract and macula disease) and systemic pathology (e.g. diabetes). To allow professionals who are not competent at performing a full eye examination to refract in isolation leads to a risk that such pathologies will be missed.

Consultation question 5 – What are the implications for the GOC register of likely changes in roles and will the existing distinctions between registrant groups remain appropriate?

The current distinctions between optometrists and dispensing opticians should remain. But extra specialities will need to be added as practitioners increase their scope of practice into other areas, and the public will need to be fully informed as to the significance of these different specialities/qualifications.

GOC's approach to education

Consultation question 6 – What are your views on the GOC's approach to the accreditation and quality assurance of education programmes, including on whether this is an appropriate focus on outcomes and on the use of the competency model to set the standards of education?

The current model of focusing a large proportion of GOC resource on visiting universities who provide degrees in optometry is not the best way to protect the public. Most of student interaction with patients occurs during the pre-registration placement year and the main GOC focus should be there: ensuring that supervision and experience are to an appropriate standard.

The purpose of bachelors degree in optometry is to prepare a student for a pre-registration placement. Universities are not equipped, nor can they be without significant extra funding (e.g. Price group A HEFCE funding), to provide extensive clinical experience. What they are equipped to do and are expert in is teaching theory, scientific principles and evidence based practice (along with introducing students to clinical practice). Thus we do not think the term 'competent' or 'core competencies' should apply to graduates. These terms should be reserved for the point of registration.

We believe that the current stage 1 competency framework, containing 'ability to do competencies' leads to a tick box approach by students. We suggest that a more limited number of broader "understanding and abilities" should be specified instead. This could then more easily be woven into university module learning outcomes to take the focus away from ticking boxes.

Currently there is a strong focus on input - particularly with regard to the minimum patient numbers which need to be achieved at undergraduate level, or the number of students who can be involved in a particular interaction with a patient. These do not appear to be evidence based. The level of resource required to achieve these numbers is very significant - both in terms of clinical provision and audit. Perversely the substantial resource required to service the patient experience requirement diverts resource away from other teaching activities which would better prepare students for pre-reg. For example, we would argue that the time spent on getting a student from 14 to 18 primary care episodes could be better spent in a simulated environment where the student could be exposed to a whole plethora of ocular conditions. Prior to 2010 there were no minimum patient experience levels at undergraduate level. We are not aware of any evidence that introducing them has protected the public. We would caution the GOC against the attractive 'face validity' of real patient episodes. It would seem logical that if students need to learn how to prepare to do eye examination on real patients in the pre-reg period then undergraduate training should contain a substantial amount of real patient experience. However, there are many other ways in which this learning could be better achieved (e.g. simulated patients, volunteer patients, problem based learning).We are not arguing that 'real patient episodes' have no place in undergraduate education but that artificial minima are unhelpful.

We would suggest that GOC visitor panels are far too focused on input and auditing this than the quality of education provided. For example at our last full re-accreditation the panel spent a large proportion of their time auditing and counting patient numbers in logbooks. We understand the attraction of such an approach as it gives an objective number which can be reported/complied with. However, given that these patient minima have no demonstrable link with output the exercise is not helpful. A better model would be for a panel to scrutinise a programme curriculum, teaching strategy and assessment strategy remotely. This could then be followed up with discussions with academics, supervisors and students. Such a model would require visiting panels to be expert enough in pedagogy to offer valid criticism.

We have some concern about the current three stage process whereby the visitor panel reports to education committee who then report to council. There is potential for miscommunication. The recent innovation of having the chair of the visiting panel attending the education committee to present the results is a welcome change.

Consultation question 7 – Should the GOC accredit and quality assure additional or different higher qualifications and if so, on what basis?

The only higher qualifications the GOC should accredit/quality assure are those that they do not have current standards against which to deal with complaints. For example the GOC should not accredit higher qualifications in contact lens practice as they already have the tools to deal with a complaint if it should arise. They might consider accrediting and quality assuring a qualification in 'minor surgery' as they currently don't have the tools to deal with a complaint in this area if it comes up.

Content of education programmes

Consultation question 8 – What are the core skills, knowledge and behaviours which optometrists will need to have on first joining the register in the future?

The Foresight Report predicts technology will substantially affect how optometrists practice in the future. We do not believe that the GOC should attempt to put together a 'future proof' set of competencies for optometrists. The approach should be to set competencies for contemporary practice with the opportunity for periodic review. We believe the main way we prepare our undergraduates for an uncertain future is to give them a firm understanding of theory and science that will underpin new innovations. Thus graduates are able to make reasoned choices about whatever technology is developed. For this reason we are strongly against any move to significantly reduce the teaching of theory from undergraduate education.

We do not see how a student can make reasoned clinical decisions without a firm understanding of the underlying scientific principles.

Consultation question 9 – How should the content and delivery of optometry programmes change to ensure that students gain the skills, knowledge and behaviours that they will require for practice and for new roles in the future?

The GOC should not specify in detail the content or delivery (beyond outcome statements) for undergraduate education. Such specification makes it harder for institutions to be nimble in reacting to change and stifles innovation. Technological change has had considerable impact on education, and this should be reflected in less rigid specification of the structure of programme delivery.

Consultation question 10 – How might post-registration training and registrable higher qualifications for optometrists need to change in the future?

Post-registration training is likely to driven by the services which are commissioned by the NHS (Qu 2). As described in answer to question 7 - the GOC should only quality assure qualifications which extend the scope of practice beyond what can currently be considered in disciplinary proceedings.

Consultation question 11 – What are the core skills, knowledge and behaviours which dispensing opticians will need to have on joining the register in the future?

Consultation question 12 – How should the content of dispensing programmes change to ensure that students gain the skills, knowledge and behaviours that they will require for practice and for new roles in the future?

Consultation question 13 – How might post-registration training and registrable higher qualifications for dispensing opticians need to change in the future?

Professionalism and consistent standards

Consultation question 14 – How can we ensure students have the professionalism needed to take on new roles, including through the admissions procedures used by education providers, patient experience, supervision and embedding professional standards?

The GOC has published its standards for practice. The teaching and application of these standards should be the subject of visits to providers. We have an established personal and professional development programme at the university which prepares students for professional practice. It is unfortunate that the GOC standards for students do not refer to their professionalism within the educational context: for example, there is no specific requirement to engage meaningfully with the learning environment, and no specific mention of academic malpractice. Our admission procedure takes into account elements of professionalism. However we must be mindful of providing equality of opportunity, and widening participation initiatives. If recruitment is limited to those applicants who already show excellent communication skills at interview (for example), this is likely to reduce diversity. We believe that mandating particular entry standards for institutions is not consistent with an output focused approach.

Consultation question 15 – How should students be assessed prior to joining the register to ensure that there are consistent and appropriate standards of education, taking into account the different types of education programmes that are emerging?

The GOC should visit institutions who provide assessments which lead to access to the register. They should not be prescriptive in which assessments are used, but allow the institution to defend their methods, and be satisfied that whatever is used is reasonable and evidence based. Visiting panels performing this function will need a level of expertise in pedagogy.

Barriers to change and other issues to consider

Consultation question 16 – What are the challenges and barriers to improving the system of optical education, including issues that may be outside the remit and control of the GOC, such as legislative change, workforce planning, the funding of education (including higher education, continuing education and training and continuing professional development) and the provision of student placements?

- Higher level HEFCE funding would significantly increase resource available to training institutions to allow them to further improve
- Unlimited potential for expansion of institutions providing courses is likely to reduce the quality of students. This in turn will affect the quality of practitioners and increase risk to the public. Whilst we appreciate that the GOC has no formal role in workforce planning it is their role to protect the public. Thus we suggest that the GOC commission research into whether the increased numbers are to the detriment of graduate quality and therefore patient care. If this was shown to be the case then the GOC would have warrant to act.

Consultation question 17 – Are there any other issues that we should consider in carrying out our review? If so, please set out what they are.

- END -

The Worshipful Company of Spectacle Makers

Changes in demand and the impact of changes in eye care delivery

Consultation question 1 – How might the needs of patients requiring eye care change over the next 20 years?

Consultation question 2 – What changes in how and where eye care is provided will be required over the next 20 years in order to meet patients' needs, and what are the barriers to these changes?

Given the pace of change in the last 5-10 years, we believe we cannot know now what eye care will look like in 20 years' time.

Technological development and an ageing population have been very clearly signposted as catalysts for change in the *Foresight Project Report*, produced by 2020health on behalf of the Optical Confederation and the College of Optometrists and referenced in the consultation document. Whilst processes and standard procedures for testing, screening and diagnosis are likely to be different, we cannot tell yet what the response of patients will be and how fast will be the speed of change amongst providers in developing services which will deliver commercial benefits.

Patients are already more demanding and more litigious. They will expect ready access to a professional opinion, however that may be achieved. The level of loyalty to known providers, such as the family optometrist or the local hospital, is expected to diminish and a willingness to use technology may enable patients to seek advice from a wider number of sources. The issue will be the quality of that advice and its suitability for patients who have not been able to benefit from a holistic and personalised approach to eye health.

It is clear that communication will be key. Eye health professionals will need to communicate very clearly with their patients, to explain what images mean, to provide reassurance and to be able to give broader health advice, as we know many optometrists and dispensing opticians can do. Equally fundamental will be the development of safe, but much more efficient, mechanisms for sharing of data between teams of optical professionals, whether working in the community, in practices and in hospitals or even across national and international boundaries.

Patient protection may be more difficult, but will remain vital. Patients would benefit from a better understanding of the qualifications and competencies of those who are involved in their treatment, in order both to have trust in the advice they are receiving and to be able to question unspecific information and unjustified claims they find in various media.

The work done by the Royal College of Ophthalmologists and the College of Optometrists to develop an agreed Clinical Competency Framework has been very valuable and we trust that representatives of the different professional bodies within optics will continue to talk to each other and develop ways of working together in the pursuit of patient safety and improved eye health.

The priority must be to retain flexibility, be ready for constant review of training requirements and syllabi in response to change and respect and recognise the value of all those involved in high quality eye healthcare.

Consultation question 3 - How are the roles of optometrists and dispensing opticians likely to change over the next 20 years, and what are the drivers for these changes?

Consultation question 4 – How should the education of optometrists and dispensing opticians be structured to enable continuing professional development throughout their careers, e.g. core training followed by general or specialist practice?

These questions are best answered by the professional bodies concerned.

Consultation question 5 – What are the implications for the GOC register of likely changes in roles and will the existing distinctions between registrant groups remain appropriate?

There will be a continuing need for a register which provides an independent record of those qualified to work in eye health and which can be consulted by patients to give them confidence and assurance. It is also important that those on the register subscribe to high standards of professional conduct and maintain the currency of their knowledge, through ongoing training and development, to increase the confidence of patients in the sector as a whole.

In future, registration, like training and qualifications, is likely to need to reflect the scope of work which the individual or practice is qualified to undertake, and areas of speciality, rather than job titles. Patients consulting the current register would benefit from clearer indication of professionals who have achieved higher qualifications (eg Low Vision, Contact Lenses, Independent Prescribing), for example.

It is noted that patients cannot currently access information about eye healthcare professionals easily and in one place. There are different GOC registers and they have no link to the registration information maintained by the General Medical Council in respect of ophthalmologists, the records of the Health Professions Council, which regulates orthoptists and the Nursing and Midwifery Council which maintains the register of nurses, an increasing number of whom now are involved in eye health.

GOC's approach to education

Consultation question 6 – What are your views on the GOC's approach to the accreditation and quality assurance of education programmes, including on whether this is an appropriate focus on outcomes and on the use of the competency model to set the standards of education?

It is right that education programmes which seek to qualify individuals who will be responsible for a patient's eye health should be checked for their quality and reviewed on a regular basis but there needs to be a review of the assessment criteria, the approval mechanisms and the requirements for documented evidence and audit which can take up considerable time. The focus on outcomes is not always apparent and there is a danger of a "tick box" approach which does not measure fully the ability and readiness to practise of those who have successfully completed an education programme. The GOC has an important role in maintaining standards and ensuring consistency, so that all those who qualify are competent to practise safely. The GOC should also guard against accreditation and assurance systems becoming a barrier to the development of syllabi and changes in teaching methods.

Consultation question 7 – Should the GOC accredit and quality assure additional or different higher qualifications and if so, on what basis?

The higher level qualifications offered by the College of Optometrists are well regarded. It would seem sensible for the College to be permitted to provide qualifications in which they have expert knowledge and for them to be able to review the qualifications offered in line with changes in patient profiles, the development of new treatments and changing roles within teams and clinical environments.

Content of education programmes

Consultation question 8 – What are the core skills, knowledge and behaviours which optometrists will need to have on first joining the register in the future?

Consultation question 9 – How should the content and delivery of optometry programmes change to ensure that students gain the skills, knowledge and behaviours that they will require for practice and for new roles in the future?

Consultation question 10 – How might post-registration training and registrable higher qualifications for optometrists need to change in the future?

Consultation question 11 – What are the core skills, knowledge and behaviours which dispensing opticians will need to have on joining the register in the future?

Consultation question 12 – How should the content of dispensing programmes change to ensure that students gain the skills, knowledge and behaviours that they will require for practice and for new roles in the future?

Consultation question 13 – How might post-registration training and registrable higher qualifications for dispensing opticians need to change in the future?

The GOC should maintain its focus on patient safety and ensure that there are appropriate requirements for supervision and measures are in place to protect vulnerable groups.

Generally, for all members of the optical professions, excellent communication skills, empathy and emotional intelligence are, and should be, essential. We would support recommendations for greater patient contact and more clinical experience, achieved through a range of placements during qualification, for both dispensing opticians and optometrists.

It is recognised that this places great demands on smaller practices, where supervisors are already busy with their own clinical workload. There should be a mechanism for recognition for practices of all sizes who offer excellent training.

Professionalism and consistent standards

Consultation question 14 – How can we ensure students have the professionalism needed to take on new roles, including through the admissions procedures used by education providers, patient experience, supervision and embedding professional standards?

Consultation question 15 – How should students be assessed prior to joining the register to ensure that there are consistent and appropriate standards of education, taking into account the different types of education programmes that are emerging?

WCSM is primarily concerned with developing knowledge and skills among professional support staff at the lower levels (by which we mean Levels 2-4 of the National Qualifications Framework in England, Wales and Northern Ireland and levels 5- 7 in Scotland).

WCSM has long maintained that there is a need for nationally recognised qualifications for staff who are working in practices and labs. Below the registered professions, recognised qualifications for support staff provide essential background knowledge and help to develop key behaviours, communication skills and the important understanding of the boundaries for clinical authority. WCSM qualifications enable access to a clear career path for those who may wish to go on to become dispensing opticians or optometrists. Candidates who apply for dispensing or optometry courses with the benefit of these qualifications have already demonstrated commitment to eye care and will have gained background knowledge in key areas such as communication skills, basic anatomy of the eye and screening and fitting procedures.

Further assurance for patients could be generated by requiring all those working with patients to have undertaken training and to achieve recognised qualifications. This would help to increase standards of care and professionalism within the sector and for patients to gain a clearer understanding of the limits of authority within different roles.

The GOC cannot attempt to assess the capability of every student. It would be better to focus on assessment of a provider's capability to deliver high quality education, resulting in skilled professionals being ready to join the workforce. Where concerns arise and inadequacy is proven, the system of public censure could apply to education providers as well as individuals.

The GOC should allow approved education providers to make decisions about admissions, the progress of students through training and whether the student has achieved the necessary levels of competence to be awarded a qualification. However, more detail should be requested on competencies evidenced during training, following further qualification, or during peer review before granting, or renewing, a register entry.

The identification section of each application forms should have to be countersigned by a professional who is appropriately qualified in an optical profession and has knowledge of the candidate's competency, not just someone who has known them for two years.

Once registered, achievement of set targets for CPD should be a compulsory requirement for remaining on the register.

Barriers to change and other issues to consider

Consultation question 16 – What are the challenges and barriers to improving the system of optical education, including issues that may be outside the remit and control of the GOC, such as legislative change, workforce planning, the funding of education (including higher education, continuing education and training and continuing professional development) and the provision of student placements?

The Foresight Report and many other commentators have been united in recognising the challenge of facing the expected high demand for eye healthcare with the current shortage of qualified and skilled professionals currently available.

Competing for students

Despite the efforts of many bodies in the sector, information about the full range of careers which exist in optical healthcare is not always made available in schools. For some students, optical professions may be a second, or third, option; for others, they may not have the grades, family support, or the resources needed to progress straight away to a dispensing diploma or a university degree in optometry.

We face a challenge in attracting new entrants to optical professions and should be embracing the opportunities of new models, such as Government-approved apprenticeships in optical retail and optical manufacturing, Trailblazer standards for which are already in play, to bring in more individuals who could be capable of progression to registrable professions.

Registration at the appropriate time

We need to open up possibilities for more people to embark on a career in optics and to progress onwards and upwards, if they wish. The GOC should not insist on individuals making decisions and limiting themselves to one area of practice, or one professional stream, too early. This is one reason why we have urged the GOC not to seek to require registration of students taking qualifications at, or below, Level 4. Only once they have committed to further education leading to a registrable profession

should they be required to register. This also means that the GOC is focusing on the individuals who really do intend to practise and work with patients.

Reducing barriers to entry and progression

It is also vital that we continue to provide access to high quality training which will allow people at all levels to upskill. We do know that there are many people who take a job in an optical practice or laboratory, see the benefits of their work on others and decide to undertake further training.

WCSM has been working for several years to enable a smoother career pathway for those entering at lower levels to be able to train and progress. Our qualifications offer the possibility of earning credits incrementally and combine mandatory units with optional units reflecting the work which optical assistants and technicians do every day in practice. The GOC should recognise that not all entrants to optical professions will make an instant decision and may need encouragement. Within levels 2-4, our qualifications allow successful candidates to move forward at their own pace and claim exemptions from one level to the next, in respect of certain units.

We would urge the GOC not to delay in establishing a clear policy on recognition of prior learning undertaken at an earlier stage, before an individual finally commits to a course which leads directly to a registerable profession. There are regular examples of optical assistants and technicians who learn on the job, work hard and go on to qualify as dispensing opticians, some going on further to become optometrists. Some optometrists go on to study ophthalmology and they too deserve support. Optical professions have an excellent record of openness to people of all ages and all backgrounds who show commitment and develop the necessary knowledge, skills and behaviours.

We need more talent at all levels within optical professions, from the most junior assistant to higher level teaching posts and academic research. Flexibility must be maintained for individuals with the right attitudes and core skills to develop their competencies and move into different roles, over time and with appropriate supervision.

Requirements for Continuing Professional Development

Professionalism and currency of skills can be maintained best through compulsory ongoing training, personal development and peer review. Continuing Professional Development is a better descriptor (CPD) and would have greater parity with the requirements of other professional bodies, in a number of sectors.

There is an opportunity for the GOC to review ongoing professional development guidelines and perhaps set more stringent CPD requirements which give individuals opportunity for growth, highlight possible new areas of professional interest and recognise personal contributions to developing and sharing best practice and educating others.

It is acknowledged that many of those in smaller or more remote practices may find it difficult to set aside time from clinical practice but the GOC should not accept a culture in which some registered professionals seek only to achieve the bare minimum number of CET points, in the least possible time and with a minimum of effort, to remain on the register.

CPD could drive higher levels of competence. It should be possible to cover technical knowledge and skills, the use of developing technology, communication skills, information protection and usage, changes in clinical pathways and best practice, and professional conduct and ethical behaviour, and could perhaps focus on different areas in different years, to take account of rapid change. Varying CPD requirements from time to time would keep the programme fresh and give professionals the excuse they may need to look for training and development opportunities.

Consultation question 17 – Are there any other issues that we should consider in carrying out our review? If so, please set out what they are.

There are already some significant differences in practice between the devolved nations which could make it increasingly difficult for the regulator to cover all the issues that arise. The pace of change also means that regulations put in place now will be unlikely to cover all situations – therefore, flexibility of approach, close working with practitioners and reinforcement of priority areas through compulsory elements of continuing professional development will be important points to consider.

We encourage the GOC to maintain its concern for patient safely, to uphold standards of professional conduct and to take regulatory action to protect patients and the profession but also to welcome flexibility and new ways of team working which increase competencies and mutual respect within the range of optical professions and enhance trust and the reputation of eye health care professionals in the eyes of the general public.

- END -

Welsh Optometric Committee

Consultation question 1

Following the Foresight report the predicted increase in the older population will have a large effect on eye care. Patients will have needs alongside refraction, these will be related to dementia and low vision, also leading to more domiciliary work and more referrals to social care, including more work in practices. The needs of the younger population are also likely to increase, there is already evidence of more myopia in young people.

Consultation question 2

In some areas of the U.K. we can already see a shift of care from secondary to primary care, this is likely to increase depending on different factors, the intentions of commissioners and the willingness of professionals to embrace the change.

There is widespread support for the change to community services, although all practices may not be able to embrace these services. This will be the market in community optical services has developed over the years, clinical care being subsidised by product sales, although this has been addressed in some areas and the devolved nations.

Consultation question 3

Due to MECS and other community services being expanded all optical professionals will have to work to the full range of their skills and develop new ones. Technology developments will ensure that refraction will be carried out by more people but that it should remain a core competency.

Independent prescribers will become more common place in community practice, but this does not mean every optometrist needs to be qualified. Optical practices in general need to be involved in general health promotion in ares such as smoking cessation and healthy living, already being piloted in some areas.

Consultation question 4

It is generally agreed that education should be more clinically based, to respond to the changes ahead. Rather than educating individuals to perform specific functions (sight testing,fitting contact lenses and dispensing spectacles) we should be producing health professionals who can adapt and specialise as they develop in their careers.

The more diverse the courses offered, the more we can train practitioners with a broader range of skills. Modular and other flexible learning models would be valuable, as might be the opportunity to train alongside other health professionals, such as pharmacists.

Courses should not be seen as a ticking off list, a modular education system would offer the opportunity for individuals to build towards the kind of professional each wants to be. At this stage there is an opportunity to use the time off in the academic year to get more basic practical experience, this would prepare students for a more broader varied clinical role, within the existing time frame of study. There are already blended learning courses that could be expanded on to provide a broader training across the profession.

On supervision, the role of the supervisor should be formalized, with a framework for supervision skills and knowledge, to ensure the supervisor has the appropriate knowledge required to supervise that particular student (such as local protocols, pathways and appropriate knowledge for the form of supervision being undertaken). There should also be mentoring and support for supervisors.

Consultation question 5
The boundaries between professions as it is will be likely to change, career progression as it is needs to be changed to allow for the development of new skills to be recognised. There has to be a view on whether a more radical reassessment of roles needs to be attempted and will be around how roles will change and develop. This will also develop as the GOC' s approach to eduction is clarified.

Consultation question 6
Knowing that the student is competent is good, but these students have often not had face to face time with the public and a more blended approach would help. Providing the accreditation is enforced the same across all providers, the public can be assured of the quality of education and the GOC's approach.

Consultation question 7
Yes they should accredit and quality assure additional and different higher qualifications, by ensuring the content of the education programs are fit for purpose and all teach the appropriate skills for that program.

Consultation question 8
In the future the skills will need to be enhanced so that things like MECS schemes become part of the initial role, and are not seen as a more specialist or higher qualification.

Consultation question 9
As above, but will there be a need for all newly qualified to be registered with IP?

Consultation question 10
With the age population there are going to be skills need in Low vision and age related problems, as in some practices now there can be a cross over between primary and secondary care, each supporting the other. There will be a need for training in the support of things like injections for AMD.

Consultation question 11
The core skills of dispensing opticians may well need to be enhanced, there are new and exciting roles that could be taken on with the appropriate training, but the core skills still need to be taught.

Consultation question 12
The training need to constantly evolve to include new skills which will enable dispensing opticians to increase their scope of practice to fill the void that will be left as optometrists become more clinical in their roles.

Consultation question 13
As well as contact lenses there could be a role for dispensing opticians in refraction, evaluating the data received following additional tests performed aft an eye examination, and numerous other roles that may develop including support roles in a hospital setting such as medical contact lenses and other procedures.

Consultation question 14
Students should be selected for their ability to learn to communicate, also how they use their emotional intelligence should be a part of the intake process, students should not be accepted on a course only because they have the academic ability to succeed.

Consultation question 15

In full time courses there could be a requirement to show there has been some work with the public, to be put in front of a customer after years of academic instruction is a big step. Having some interaction through the educational years gives newly qualified opticians a good grounding, they start work with a positive mind happy to deal with the public.

Consultation question 16

Having a flexible approach to education is going to be a challenge, there will be barriers put up by many of the providers, but going forward students and registrants will want to be able to increase or change their scope of practice easily. As it stands there are many hurdles in the way, students often having to spend many months away from home and families, any form of blended learning will allow the student to be at work to learn and although they will need contact time it can be for less intrusive into their normal lives. If this system is modular it can be taught in full time and part time further education, it is now up to the GOC to provide a system for the future and bring all providers together.

Consultation question 17

None

- END -