Fourth meeting in 2021 of the Council held in PUBLIC
on Wednesday 8 December 2021 at 10:00 hours via Microsoft Teams videoconference

AGENDA

					Page No.	
1.	**Welcome and Apologies**		Oral	Chair	-	10:00 – 10:05 (5 mins)
2.	**Declaration of Interests**		C45(21)	Chair	3 – 5	
3.	**Minutes, Actions and Matters Arising**			Chair		10:05 – 10:10 (5 mins)
	3.1	**Minutes – 22 September 2021** For approval	C46(21)		6 - 12	
	3.2	**Updated Actions** For noting	C47(21)		13 - 14	
	3.2	**Matters Arising**				
4.	**Chief Executive and Registrar's report** For noting		C48(21)	LL	15 – 28	10:10 – 10:20 (10 mins)
5.	**Chair's report** For noting		C49(21)	Chair	29 – 30	10:20 – 10:25 (5 mins)
	STRATEGIC					
6.	**Education and Training Requirements for GOC-Approved Qualifications in Additional Supply, Supplementary Prescribing and/or Independent Prescribing Categories** For approval		C50(21)	LM	31 – 260	10:25 – 11:25 (60 mins)
BREAK (20 mins)						
	ASSURANCE					
7.	**Health and Safety Report** For noting		C51(21)	YG	261 – 292	11:45 – 11:55 (10 mins)
8.	**First draft Budget and Business Plan for 2022/2023** For discussion		C52(21)	LL	293 - 295	11:55 – 12:25 (30 mins)
9.	**Balanced Scorecard** For noting		C53(21)	SM	296 – 297	12:25 – 12:40 (15 mins)
10.	**Business Plan Assurance Report Q2** For noting		C54(21)	SM	298 – 300	12:40 – 12:55 (15 mins)

11.	**Finance performance report for the period ending 30 September 2021 and Q2 Forecast of 21/22 and 22/23** For noting	C55(21)	YG / MIM	301 - 321	12:55 – 13:10 (15 mins)
	OPERATIONAL				
12.	**Registrant Fees Rules and Future Fee Strategy** For approval	C56(21)	YG	322 – 329	13:10 – 13:15 (5 mins)
13.	**Council forward Plan** For noting	C57(21)	SM	330	13:15 – 13:20 (5 mins)
14.	**Any Other Business** (Items must be notified to the Chair 24 hours before the meeting)		Chair		13:20 – 13:25
	Meeting Close			13:25 hours	

Date of next meeting – Wednesday 16 March 2022

General Optical Council

GENERAL OPTICAL COUNCIL – REGISTER OF INTEREST 2021/22 (UPDATED 01 December 2021)

	Own interests				Connected Persons interests
	Current interests	**Professional memberships**	**Previous interests**	**GOC committee memberships**	
Sinead **BURNS** Lay Member	• Registered Psychologist: Health and Care Professions Council • Registrant Member: Fitness to Practice Panel, Health and Care Professions Council	• Registered Fellow: Chartered Institute of Personnel and Development	• Former Vice President Pharmaceutical Society Northern Ireland	• Lay Member: Council • Chair: Companies Committee • Member: Audit and Risk Committee • Member: Investment Committee	• None
Dr Josie **FORTE** Registrant - OO	• Employed optometrist and director (with shareholding): Specsavers (Plymouth Armada Way; Plymstock; and Plymouth Marsh Mills) • Consultant: Specsavers Optical Superstores • Lead assessor: Wales Optometry Postgraduate Education Centre, Cardiff University • Lecturer (occasional, visiting): Plymouth University • Vice chair (acting): Devon Local Eye Health Network • Vice chair (acting): Cornwall Local Eye Health Network • Board member: Federation of Ophthalmic and Dispensing Opticians • VisionForte Ltd (50% shareholding)	• Member: College of Optometrists • Registered with the Optometrists and Dispensing Opticians Board of New Zealand • Freeman: Worshipful Company of Spectacle Makers	• Member: Devon Local Optical Committee (end May 2017) • Optometrist: Specsavers Torquay (end Apr 2014) • Optometrist: Lascelles Opticians Plymouth (end Jun 2006) • Specsavers Plymouth Cornwall Street Ltd (ended April 2020) • Specsavers Saltash Ltd (ended April 2020) • Specsavers Devon2 Domiciliary (ended January 2020) • Board trustee: Inspiring Schools Partnership, Plymouth • Member: AOP[6]	• Member: Registration Committee • Member: Companies Committee	• None
Mike **GALVIN** Lay Member	• Non-executive Director: Martello Technologies Group Inc • Non-executive Director: ThinkRF	• Member: Institution of Engineering and Technology • Fellow: Institute of Telecom Professionals.	• None	• Lay member: Council • Chair: Education • Member: Audit and Risk Committee	• None
Lisa **GERSON** Registrant (OO) member	• Employee: Ronald Brown Group • Employee: Boots Optician • Primary Care Supervisor: Cardiff University	• Member of AOP • Member of College of Optometry	• Chair: Optometry Wales • Member: GOC Hearings Panel • Member/Acting Chair: GOC Investigation Panel • Member: GOC	• None	• None

	Own interests				Connected Persons interests
	Current interests	**Professional memberships**	**Previous interests**	**GOC committee memberships**	
			Education Visitor Panel • College Counsellor: College of Optometrists • Trustee: College of Optometrists • Trustee: AOP		
Rosie **GLAZEBROOK** Lay Member	• Chair of Research Ethics Committee, (Camden and Kings Cross) - Health Research Authority. • Member, Standards Policy and Strategy Committee - BSI	• None	• None	• Lay Member: Council • Chair: Registration • Member: Nominations	• None
Clare **MINCHINGTON** Lay Member	• None	• Fellow: Association of Chartered Certified Accountants • Fellow: Institute of Chartered Accountants of England and Wales	• None	• Lay Member: Council • Chair: Audit and Risk Committee	• None
Frank **MUNRO** Registrant - OO	• Director Munro Eyecare Limited (T/A Munro Optometrists) • Professional Clinical Advisor, Optometry Scotland • Acting Optometric Advisor, NHS Lanarkshire • Lead Optometrist, Glasgow City(South) Health & Social care Partnership • Visiting Lecturer, Glasgow Caledonian University • Visiting Lecturer, Edinburgh University (MSc Ophthalmology programme)	• Member of the College of Optometrists • Member NHS Greater Glasgow & Clyde Prescribing Review Group	•	• Member: Council	• None

	Own interests				Connected Persons interests
	Current interests	**Professional memberships**	**Previous interests**	**GOC committee memberships**	
Dr David **PARKINS** Registrant - OO	• Trustee: Spectacle Makers Charity • Chair: London Eye Health Network (NHS England) • Member: London Clinical Senate Council • Director: BP Eyecare Ltd	• Fellow: College of Optometrists • Fellow, European Academy of Optometry and Optics • Life Member: Vision Aid Overseas • Liveryman: Worshipful Company of Spectacle Makers • Member: British Contact Lens Association	• President: College of Optometrists (end Mar 2016) • Board Trustee: College of Optometrists (end Mar 2018) • Previous CET provider (ended 2015) • Vice Chair: Clinical Council for Eye Health Commissioning	• Member: Council • Member: Audit and Risk Committee	• Close Relative: General Optical Council Case Examiner • Close Relative: Member, College of Optometrists • Spouse: Director - BP Eyecare Ltd
Tim **PARKINSON** Lay member	• None	• Fellow: Chartered Management Institute	• None	• Lay member: Council • Chair: Investment Committee • Member: Remuneration Committee	• None
Roshni **SAMRA** Registrant - OO	• Locum optometrist (occasional): various high street or independent practices • Professional Clinic Manager: City Sight, City University • Student: City University (MSc in Clinical Optometry)	• None	• None	• Member: Council • Member: Registration Committee	• Works with a current General Optical Council Case Examiner
Glenn **TOMISON** Registrant - DO	• Lead director (for individual members): Federation of Ophthalmic Dispensing Opticians • Self-employed: dispensing optician • Senior clinical instructor: University of Manchester	• Fellow: Association of British Dispensing Opticians • Liveryman: Worshipful Company of Spectacle Makers	• Chair: Federation of Ophthalmic and Dispensing Opticians (ended December 2014) • Trustee: Birtenshaw and Birtenshaw Merseyside	• Member: Council • Chair: Remuneration Committee • Member: Nominations Committee • Member: Investment Committee	• None
Dr Anne **WRIGHT** CBE Lay Chair	• Unremunerated elected Director: Circa Residents Management Company Ltd. • Committee member: The Shaw Society (will finish end December 2021)	• None	• None	• Chair: Council • Chair: Nominations Committee	• None

General Optical Council

GENERAL OPTICAL COUNCIL

DRAFT minutes of Council held in public
held on Wednesday 22 September 2021 at 10:00 hours via Microsoft Teams

Present: Dr Anne Wright CBE, Sinead Burns, Josie Forte, Mike Galvin, Lisa Gerson, Rosie Glazebrook, Frank Munro, Clare Minchington, David Parkins, Tim Parkinson, and Glenn Tomison (Chair).

GOC Attendees: Claire Bond (Senior Lawyer) *(paragraphs 14 – 21),* Marcus Dye (Interim Director of Strategy), Yeslin Gearty (Director of Resources), Manori Izni-Muneer (Head of Finance) *(paragraphs 22 – 33)*, Lesley Longstone (Chief Executive and Registrar), Sarah Martyn (Governance and Compliance Manager), Leonie Miller (Director of Education), Dionne Spence (Director of Casework and Regulation), and Erica Wilkinson (Head of Secretariat).

	Welcome and Apologies
1.	The Senior Council Member and Chair opened the meeting and explained that he would be chairing the meeting on behalf of the Chair of Council who was unavailable for the opening of the meeting.
2.	The Chair **cited** paragraph 2.16 of the Council's Standing Orders that state: *"All Council members have a duty to attend ordinary meetings in person and contribute effectively until the Chair closes the meeting. Only in exceptional circumstances (with the agreement of the Chair) will a Council member be permitted to participate in an ordinary meeting via electronic means."* He noted that his permission had been granted in these extraordinary circumstances for all participation to be via electronic means. He then reminded the meeting, and external attendees, of the housekeeping rules.
3.	The Chair welcomed the visitors and observers to the public General Optical Council meeting. The Chief Executive and Registrar welcomed the Capsticks representative in sad circumstances and offered condolences to the family, friends and colleagues of John Witt who had recently passed away.
4.	Apologies for absence were received from Roshni Samra.
	Declaration of Interests C30(21)
5.	There were no new declarations and Council noted that due to an administrative error, Dr Josie Forte had been left off the register of interest. There were no further updates.
	Minutes of Previous Meetings C31(21)
6.	Council **approved** the minutes of the meeting held on 14 July 2021 as an accurate record of the meeting, subject to the following change: • the spelling of David Parkins' name
	Updated Actions C32(21)

7.	Council noted progress on the actions since the last meeting: • C4 – 14/07/2021, C5 – 14/07/2021, C16 – 14/07/2021, C58 – 14/07/2021 were completed.
	Matters Arising
8.	There were no matters arising.
	Chief Executive and Registrar's report C33(21)
9.	The Chief Executive and Registrar provided an update to her report as follows: • Student registration had been going as planned and there had been a boost to the income from students registering in 2021 after delays to exams. • The response to KMPG had been discussed by Council in a private session and the final response would be sent shortly. • The SPOKE (Sector Partnership for Optical Knowledge and Education) had been commissioned to provide facilitation for the sector. This knowledge hub was funded out of reserves and work was on-going to do something similar for specialist qualifications. • The CET and CPD changeover plans were going well alongside the supporting IT development. There had also been good liaison regarding the rules with DHSC. Communications had already been taking place with registrants and would continue to do so up to the end of the current cycle. Partner organisations were also ramping up their communications. • The latest median forecast for FtP cases at the end of August was on track after the challenges of Covid-19. • The EDI report showed that there were historic differentials between male and female registrants entering ftp processes in comparison to the registrant profile. • The *Speaking up Guidance* for staff was on the agenda; the *Speaking up Guidance* for registrants had been approved by SMT and would be issued shortly. • The GOC had received a Bronze ranking from Employers Network for Equality and Inclusion for TIDE (Talent Inclusion and Diversity Evaluation). • The GOC had hosted a session with the Opticians Trust where a registrant, and the Chair of the Trust, had spoken about rehabilitating ex-offenders. • Dr Paul Spry, a GOC expert witness who had practices at Bristol Eye Hospital had passed away. Condolences to his family, friends and colleagues were registered.
10.	A question was raised with regard to efficiency savings and looking for further efficiencies along the line due to the automation of services. Council noted that following the implementation of MyGOC updates registrants would be able to access the majority of services through the portal. This would free up staff time on data entry; this time would be put back into quality assurance processes and furthering other improvements.
11.	In response to a question related to the formal sign off process for the indicative guidance to supplement the Outcomes for Registration and the associated review process for clinical outcomes, Council noted that the procurement process for the Knowledge Hub had explicitly asked for the ability to publish the indicative guidance by 15 November 2021. The Expert Advisory Groups would be meeting to consider the document, and if any revisions were required the Education Committee and the Standards Committee would be consulted prior to a decision coming to Council for approval.
12.	Council noted the update on recent developments.
	Chair's Report C34(21)
13.	Council **noted** the report.
	STRATEGIC
	The Senior Lawyer joined the meeting.
	Illegal Practice Strategy Review C35(21)

14.	Council noted that the strategy review had been carried out to allow the GOC to be more proactive in this area and to provide clarity on the process. Key changes included earlier intervention to ensure complaints concerning offences under the Act were accepted for further investigation, forging relationships with on-line platforms, sending cease and desist letters at investigation stage and if it were suspected that sales continued, the GOC would carry out test purchases after cease and desist letters had been sent.
	10:28 hours - The Chair of Council joined the meeting.
15.	In response to a question about what this would mean for sole traders who could not register as a business under current legislation, it was noted that that was outside the scope of this piece of work, which was focussed on what could be done within current legislation.
16.	A question was raised as to whether the protocol would address the problem of people delivering potentially illegal services from outside the UK and whether there was a breakdown of where the bulk of the illegal practice took place. Council noted that the GOC had no jurisdiction outside the UK, and that the proposal was to tackle social media and other platforms advertising such services. There was little firm data regarding illegal practice and it was hoped that the call for evidence would help close this gap.
17.	A question was asked regarding the paucity of clinical information contained in the report and whether it could be worthwhile developing an objective in relation to this. There was also a question as to whether there could be an opportunity to get the OCCS involved in this area. The Director of Casework and Resolution advised that the literature review had been very broad and had not brought up a lot of new evidence. There had been a risk review around the harm of illegal practice in 2019.
18.	In response to a question regarding trading standards and whether there was a strong enough relationship with them, Council noted that trading standards officers had been met with during the development of the protocol, and that there was a single point of contact to pass cases over to. The relationship was good but clearly this would need to be monitored over time.
19.	Registrant Council members offered to share their comments on their review of the document itself. Concern was raised about statements in section 6 which talked about AI, modern internet facilities and advances in equipment. These were already heavily used in practice and the GOC should be embracing digital changes to use them for the betterment of the health of patients. It was noted that the authors' comments surrounding AI were not GOC policy.
20.	Council agreed the draft illegal practice protocol for submission to public consultation in October 2021.
	The Senior Lawyer left the meeting.
	ASSURANCE
	The Head of Finance joined the meeting.
	Annual report and financial statements for year ended 31 March 2021 C36(21)
21.	The Chair advised that Council was being presented with the annual report in public session, which was in line with good practice. However, the report was not to be made public as part of the papers for the meeting due to parliamentary requirements not to put the report into the public domain before it had been formally considered by Parliament. This report had therefore not been shared with the public.
22.	Council noted that the annual report and financial statements for year ended 31 March 2021 had been signed off by HaysMcIntyre (external auditors) and the Audit, Risk and Finance Committee. Feedback and points had been included from the Audit, Risk and Finance Committee in the final documents. Council also noted that the finance table on page 65 had been updated since to show reductions for fees for Tim Parkinson and Gareth Hadley and that there had been an increase in expenses for Gareth Hadley.

23.	It was noted that the Nominations Committee and Remuneration Committee members had considered and approved the statement in the annual report about their membership, role and remit for 2020/2021.
24.	Each of the Trustees who held office at the date of approval of this Trustees' report, confirmed that there was no information of which they were aware, which was relevant to the audit and of which the auditor was unaware. They have further confirmed that they had taken appropriate steps to identify such relevant information and to establish that the auditors were made aware of such information.
25.	Council: • noted and agreed with the Audit Risk and Finance Committee recommendation that when taken as a whole, the annual report for the year ended 31 March 2021 was fair, balanced and understandable and provided the necessary information to assess performance during 2020-21; • considered and approved the annual report and financial statements for the year ended 31 March 2021 (annex one); • delegated authority to the Chair to finalise the report taking into account comments made by Council, before submission to the Privy Council; • delegated authority to the Chair to sign the Letter of Representation at (annex two); • noted the GOC Senior Management Letter of Representation (annex three); • Nominations Committee and Remuneration Committee members considered and approved the statement in the annual report about their membership, role and remit for the preceding year; and • noted that Remuneration Committee members had approved the relevant sections of the annual report in relation to Council members' remuneration and expenses as required under their terms of reference.
	Corporate Policies C37(21)
26.	Council noted the following points with respect to the three policies in front of them for approval: • **Speaking up against the GOC**: the policy had been redrafted to make it clearer for those using it; • **Conflict of Interest:** there had been no material change but it had been revised into a compact document that still included the PSA requirements requested in January 2020 and previously incorporated. It should be noted that there would be robust training for each group to ensure that all nuances were captured for members, workers and staff. • **Anti-financial crime:** there had been no legislative updates for this first review.
27.	It was noted that the flowchart in the **Speaking up against the GOC** policy was incomplete and the contact details of the senior Council member would be corrected; these would be corrected before the documents were launched.
	Action: the Head of Secretariat to ensure that flowcharts in the Speaking up against the GOC policy were completed and the contact details of the senior Council member were corrected before the documents were launched.
28.	A question was raised with respect to paragraph 22 of the **Conflict of Interest** policy. The Audit, Risk and Finance Committee had discussed the responsibility of individuals and concluded that everything should be declared but that the GOC should decide what to include in the registers of interest.
	Action: the Head of Secretariat to reword paragraph 22 in the Conflict of interest policy to reflect that it was the responsibility of individuals to declare all potential interests and that the GOC would take the decision on what should be included on the registers of interest.
29.	Council approved the three policies, subject to the changes made in paragraphs 27 and 28: • Speaking up against the GOC

	• Conflicts of Interest • Anti-financial crime
	11:10 - 11:25 hours – Council took a break.
	Finance Performance reports: Quarter 1 ending 30 June 2021 C38(21)
30.	Council noted the introduction to the report and that the financial performance improvement had been due increased savings and delays in returning to the office.
31.	Questions were raised as to whether the performance improvements should be linked to the numbers of staff which were lower than budgeted for, whether the GOC were experiencing recruitment problems, that the HR team were appropriately skilled up to market vacancies through LinkedIn and whether short term contracts were being considered as well as retention of staff. Council noted that: • there was a lot of on-going recruitment with a further three jobs out for advert since the paper had been written; • there were some continuing issues in recruiting in specific areas and it was hoped to bring those particular issues to an end shortly; • benchmarking activity across sectors was planned for all grades across the organisation; • the HR team were using a range of ways to market vacancies, including social media and the use of Linkedin; • a new on-line recruitment platform would assist with both quantity and quality of candidates; • the probation system was used to confirm the appointment process.
32.	The next budget forecast would have input from the new Director of Change to take into account the priorities, design and governance of the GOC refresh, and would be considered by the next meeting of the Audit, Risk and Finance Committee.
33.	Council **noted** the report including the annex.
	The Head of Finance joined the meeting.
	Balanced Scorecard C39(21)
34.	Council **noted** the balanced scorecard.
	Business Plan 2021/2022 – Q1 Progress C40(21)
35.	Council **noted** the Q1 progress of the internal operational business plan 2020/2021.
	Equality, Diversity and Inclusion Annual Monitoring Report C41 (21)
36.	Council noted that: • the Secretariat team had worked with Fraser Consulting on revamping the report making it easier to identify where improvements had been made. The document was much more readable by placing the detailed data into an annex and would be produced internally in future. • there was disparity in the completeness of information for some groups. Council would be encouraged to lead from the top and provide their own data. • the data suggested an improvement in the ethnic disparity regarding fitness to practice referrals, though this was a small sample and gender disparities were still evident; • Council and staff had both taken part in open conversations about diversity and unconscious bias and members involved in fitness to practice decisions would be undertaking EDI training. • there was a determination review group which included an independent member from another regulator that looked at the outcomes and the determinations and there was more work to be done in this area to provide assurance around the perception of bias.
	Action: the Secretariat to circulate a request for information on personal characteristics to Council.

37.	In response to a question about whether people with specialities were potentially counted twice, it was agreed that the Head of Secretariat would check and ensure that the reporting was correct.
	Action: the Head of Secretariat to check that data regarding specialisms was properly reported.
38.	Council noted that it was not known whether the difference between the proportions of students and registrants reported as BAME was due to people dropping out after qualifying, or due to a shift in composition over time and it was good to see a rise in students from BAME backgrounds.
39.	Council noted the disparity between male registrants in FtP over female registrants in comparison to the registrant population and that work was underway to map allegations across wider characteristics. Council recognised that this may reflect broader societal activity and asked whether similar data was collated across COPOD (Chiropractic, Optical, Pharmacy, Osteopathic and Dental Co-operation Pod) or, if this would be possible in order to consider similar outputs across the health care environment. This would have difficulties due to the varied collation and recording methods used and in the interim, the GOC were mapping historic data in order to provide a larger, rolling data set.
40.	It was noted that two-thirds of Council were now women. A question was raised as to whether the right comparison was being made, on page 14 of the report, in comparing member profiles to that of registrants, given that many recruits were lay. This would be considered further for future reports.
41.	Council **noted** the EDI monitoring report 2020/21 (annex one).
	Advisory Panel minutes C42(21)
42.	Council noted that the questionnaire seeking feedback on the Advisory Panel had received just ten responses and the results would be provided at the next Advisory Panel meeting. .
43.	Council noted that there was a typo in paragraph 14 of the minutes “ready reckoner” should read “ready readers”.
44.	Council noted the minutes of the Advisory Panel that took place on 21 June 2021.
	OPERATIONAL
	Scheme of Delegation C43 (21)
45.	In seeking approval of the Scheme of Delegation, Council noted that: • All powers vested in Council or committees were set out in the Optician’s Act. • The second annex showed the proposed delegations to the Chief Executive and Registrar and through further discussion some of those would be delegated further. • Annex 3 proposed other activity the Council would want to approve itself. • Annex 4 detailed the slimmed down committee terms of reference; the administration information removed had been put in the Standing Orders and information about on-line meetings had been added. • The most substantial changes were to the approval of qualifications and institutions and the removal of approval, which was delegated to the Chief Executive and Registrar, except where removal followed a Serious Case Review.
46.	In respect of annex 3, comments were raised about the responsibility of Council in initiating judicial review proceedings and whether the conflict of interest policy was missing. Council noted that unless a judicial review was case related it was likely that the Senior Management team would discuss this with Council before taking any action and agreed to amend Annex 3 accordingly. The conflict of interest policy was included but had been called ‘management of interest’. It was agreed that there should be consistent naming and it should be renamed.

	Action: the Head of Secretariat to make amendments to the schedule of retained approvals as set out in paragraph 46.
	Action: Head of Secretariat to rename the 'conflict of interest' policy the 'management of interest' policy.
47.	In response to a question about Audit, Risk and Finance Committee terms of reference and its role in relation to the annual health and safety compliance report, the Chair of the Audit, Risk and Finance Committee advised that on behalf of the committee, she had reviewed the paper. She noted that the significant incident report was seen by the committee, and that RIDDOR reports were required to be reported to Council. She agreed that the compliance report should be added.
	Action: the Head of Secretariat to make amendments to the Audit, Risk and Finance Committee terms of reference as set out in paragraph 48.
48.	Council noted that the right to attend a council meeting had been clarified in all the terms of reference.
49.	Subject to the agreed changes, above, Council approved: • the revised Scheme of Delegation - Part 1 (annex 1) [Draft GOC Scheme of Delegation 2021]; • a schedule of retained approvals (annex 3); • revised Committee Terms of Reference (annex 4); • new Standing Orders (annex 5).
	Council Forward Plan C44(21)
50.	Council **noted** the report.
	Any Other Business
51.	There was no other business.
52.	Thanks were given to the members of the public who attended.
	Meeting closed: 12:20 hours
	Next meeting: 8 December 2021

PUBLIC
C47(21)

COUNCIL

Actions arising from Public Council meetings

Meeting Date: **8 December 2021** **Status:** **For noting.**

Lead Responsibility and Paper Author: Sarah Martyn, Interim Head of Secretariat

Purpose

1. This paper provides Council with progress made on actions from the last public meeting along with any other actions which are outstanding from previous meetings.

2. The paper is broken down into 3 parts: (1) action points relating to the last meeting, (2) action points from previous meetings which remain outstanding, and (3) action points previously outstanding but now completed. Once actions are complete and have been reported to Council they will be removed from the list.

Part 1: Action Points from the Council meeting held on 10 February 2021

Reference	By	Description	Deadline	Notes
C27 22/09/2021	Head of Secretariat	To ensure that flowcharts in the Speaking up against the GOC policy were completed and the contact details of the senior Council member were corrected before the documents were launched.	September 2021	**COMPLETED**: the documents were updated and put on IRIS for staff.
C28 22/09/2021	Head of Secretariat	To reword paragraph 22 in the Conflict of interest policy to reflect that it was the responsibility of individuals to declare all potential interests and that the GOC would take the decision on what should be included on the registers of interest.	September 2021	**COMPLETED**: the Conflict of Interest policy has been reworded and shared with members and staff. It has also been placed on the website and IRIS.
C36 22/09/2021	Secretariat	To circulate a request for information on personal characteristics to Council.	March 2022	**ON-GOING:** A form will be circulated to Council with the skills audit during December 2021.
C37 22/09/2021	Head of Secretariat	To check that data regarding specialisms was properly reported in the EDI report.	September 2021	**COMPLETED**: the EDI report was updated and put on the website.
C46 22/09/2021	Head of Secretariat	To make the following amendments to the schedule of retained approvals:	September 2021	**COMPLETED**: the Schedule of Retained approvals has

		- If a judicial review was not case related, it was likely that the Senior Management team would discuss it with Council, before taking any action.		been updated and put on the website.
C46 22/09/2021	Head of Secretariat	To rename the 'conflict of interest' policy the 'management of interest' policy.	September 2021	**COMPLETED**: the Conflict of Interest policy has been renamed 'Management of Interest' and shared with members and staff. It has also been placed on the website and IRIS.
C47 22/09/2021	Head of Secretariat	To make amendments to the Audit, Risk and Finance Committee terms of reference as set out in paragraph 48.	September 2021	**COMPLETED**: the terms of reference were updated and put on the website.

Part 2: Action points from previous meetings which remain outstanding

C14 14/07/2021	Director of Education	To work with the relevant teams to stress test the plans for communications related to the end of the CET cycle and the move to CPD.	September 2021	**COMPLETED:** Comms plan tested and enacted.

Part 3: Action points previously outstanding but now completed.

There are no actions outstanding from previous meetings.

PUBLIC
C48(21)

COUNCIL

Chief Executive's Report

Meeting: 8 December 2021 **Status:** For noting

Lead responsibility and paper author: Lesley Longstone (CEO & Registrar)

Council Lead(s): Dr Anne Wright CBE

Purpose

1. To provide Council with an update on recent developments.

Recommendations

2. Council is asked to note the CEO & Registrar's report.

Strategic objective

3. This work contributes towards the achievement of all parts of our Strategic Plan and our 2021/22 Business Plan.

Background

4. The last report to Council was provided for its September meeting.

Analysis

5. Since Council last met, the appointment of my successor has been announced. I would like to formally congratulate Leonie Milliner on her appointment and wish her the very best as she leads the GOC through its next stage of development. Leonie's appointment as CEO, from the beginning of January leaves a gap in SMT and we are preparing to go out advert for a new Director of Regulatory Strategy. Interim arrangements are being discussed internally.

6. The latest developments in relation to the pandemic are being watched carefully and staff continue to be supported to work from home where they are able to do so.

7. At the time of writing, we have not yet had sight of the KPMG report to the Department of Health and Social Care but have participated fully in several sessions with them to explore regulatory configuration and oversight. We have been alerted to further delay to other aspects of regulatory reform, beginning with the new GMC

legislation. This is not now expected to be enacted until the latter part of 2022.

8. Our 2021 PSA Review has begun with a more detailed look at a small number of standards, which is an encouraging start. The PSA are currently consulting on a new approach to performance reviews that will see a move away from annual reviews to a 3-year cycle, with scope for more frequent full or partial reviews where needed. We support the proposed change, which will ensure more proportionate oversight. In its current oversight role, the PSA have successfully appealed one of our high-profile cases to the High Court. We did not oppose the appeal and are now organising a fresh panel to consider impairment and sanction.

Education

9. Education **visits,** conditions management and triage of notifications of reportable events and changes (including temporary changes because of the pandemic) continue as planned, including onsite visits where appropriate (for example, to observe assessments). All completed visit reports are published on the education section of the GOC website. A provider workshop is planned for 26 January 2022. We have two qualifications under a Serious Concerns Review (SCR). Both qualifications are subject to a higher level of scrutiny and engagement in accordance with our SCR process in relation to management of open conditions and associated deadlines and quality assurance visits to both qualification providers are planned for Spring 2022.

10. The **SSSIG** met recently and were assured that implementation of ESR continues to progress with providers working hard to plan the adaptation of existing approved and provisionally approved qualifications to meet the updated requirements published in March 2021. Discussions about funding are taking place in the devolved administrations but it was recognised that there needs to be sector-led approaches and consistent communications to address similar issues in England, given the different commissioning system.

11. On 30 November we received the sector-led co-produced **indicative guidance** to supplement the Outcomes for Registration produced by the GOC-commissioned 'Sector Partnership for Optical Knowledge and Education (SPOKE).' The College of Optometrists is the lead partner for SPOKE and is supported by Association of British Dispensing Opticians (ABDO), Optometry Schools Council (OSC) and bodies from across the sector. The Expert Advisory Groups for Optometry and Dispensing Optics are meeting on 21 January 2022 to consider and respond to the guidance document.

12. Our consultation on new requirements for the approval of contact lens optician qualifications will conclude on 13 December and be brought to Council early 2022. A Registrants' webinar to explain the proposals is being held on the 1 December. Proposals related to additional supply, supplementary prescribing and independent prescribing are on the agenda separately, for Council consideration.

13. The end of the 3-year ***CET*** cycle is imminent and registrants have been receiving frequent communications to remind them of the approaching cut-off point. So far, completions for optometrists are tracking 5% lower than the equivalent time for the previous three-year cycle and for dispensing opticians, 8% lower. The exceptional circumstances policy that will be applied in considering any shortfalls has been published, and plans are in hand to deal with any increase because of the pandemic.

14. Preparations for the new CPD programme are well advanced. Providers now have access to the new ***MyCPD*** portal to upload their provision and registrants will have access in the new year after the normal close-down period. A guide for Registrants has now been published here: https://www.optical.org/en/Education/CET/new-cpd-scheme-2022.cfm and a Registrants' Webinar, which includes a demonstration of the new ***MyCPD*** portal is being held at 5pm on 14 December.

Registration

15. The registration of students over the past few months has gone extremely well, with all KPIs exceeded. The team completed 1419 applications, an increase of 45 Student Optometrists and 111 Student Dispensing Opticians compared to last year (up over 12% in total).

16. Looking ahead, the Standards Committee discussed the importance of continuing to influence standards set for students by their education providers if registration of students is removed through legislative reform. This is a likely outcome, but the timing is still very uncertain.

17. As we approach the end of the year and ***renewal***, plans have been made to handle a larger number of applications than usual for exceptional circumstances. Although the pandemic will not, of itself, supply justification for not having sufficient CET points, it will undoubtedly have made things more difficult for those facing other challenges. Joint work between the CET and registration teams is planned to allow for quick turnaround of applications.

18. Development work related to ***MyGOC*** is well underway in support of a revamp expected toward the end of 2022.

Casework and Resolution

19. The median closed ***case age*** is stable at around 100 weeks, which is a significant improvement on previous years and on the beginning of this year, though not yet as low as we are aiming for. In the context of the pandemic, this is nevertheless a significant achievement, with open case numbers continuing to be held at historically low levels, despite a recent pick up in referrals.

20. The PSA review, and later, challenge of the ***Honey Rose*** Case was upheld by the High Court meaning that we will need to form a new panel to hear aspects of the case again. This is likely to be held in Q1 of 2022-2023.

21. ***Hearings*** continue to be scheduled promptly, though disappointingly a few older cases recently have had to be re-scheduled or gone part heard. All, bar one, are now scheduled to conclude before the end of Q4.

22. The consultation about illegal practice is going ahead as planned and conversations with sector bodies have so far been positive. The limitations of the GOC's powers to act in certain circumstances are understood and our willingness to act where we can, appreciated.

Strategy

23. We are expecting the ***KPMG*** review to be sent to the Department by the end of the year, with a range of options to be considered by Ministers. Ministers will then consider the options and are likely to consult on a single or smaller number of them. This is not expected to happen until late Spring.

24. The ***Health and Social Care Bill***, which lay the foundations for legislative and regulatory reform of all regulators through order making powers is progressing through Parliament. It passed the report stage in the House of Commons on 22 November 2021 and is currently in preparation for its second reading in the House of Lords at the beginning of 2022. It is envisaged that the Bill will be completed by April 2022 to introduce new Integrated Care Boards (ICBs).

25. The development of the GMC order, which will establish an important reference point for our own ***legislative reform*** continues and we have welcomed the opportunity to input to that process. We have also begun to socialise with the sector our plans for a Call for Evidence. We had hoped to go out before Christmas, but we have been asked if we could begin this in the New Year instead, in view of other pressures in the run-up to Christmas.

26. We published our new speaking up guidance for registrants at the end of October, alongside our response to the consultation. This guidance helps registrants speak up when patient or public safety may be at risk. It acknowledges the barriers individuals might experience in speaking up and emphasises to businesses the importance of creating a culture where staff do not fear doing so.

27. We also published a revised version of the CET exceptions policy in October. The policy now focuses more clearly on public protection, setting out expectations around maternity, paternity and adoption leave. We give examples of our earlier decisions on

a range of distinct types of exceptional circumstances, increasing transparency in the decision-making process.

Resources

28. In preparation for business planning for next year and the annual setting of fees, the organisation has refreshed its five-year ***financial forecast***, which has been considered by Audit Risk and Finance. The cash-flow forecasts have also been shared with the recently established Investment Committee to ensure that any potential drawdowns are expected and then planned for.

29. The overall picture is still positive though we are acutely aware of on-going ***uncertainty*** given the pandemic and financial / market instability in general. It has been agreed that we will revisit our reserves and investment policies sooner than expected because of this general environment, but we are fortunate to be doing so from a position of strength.

30. This year the annual Staff Survey was delivered by a new partner, Survey Initiative and ran for two weeks, ending 23 November. The response rate of 76% was down on the 91% last year, but we are still pleased with the overall level of engagement. The results are being analysed and will be presented separately to Council.

Equality, Diversity, and Inclusion

31. We continue to make good progress in implementing our EDI strategy and plan. The ***training*** delivered for Council Members on sources of bias has been delivered in modified form to other groups across the GOC including Hearing Panel Members and Education Visitors. The Management Development Programme has included similar material and SMT have signed off on a multi-year programme of learning and development.

32. Our ***staff groups*** go from strength to strength with EmbRace putting on an amazing array of sessions for Black History Month that were fun, educational and very tasty! Our Women's and anti-racism groups have had some good discussions and this month we are celebrating Disability History with a range of sessions being made available.

Secretariat

33. The recruitment of two Council Associates is well underway, with an extremely strong field of applicants and final interviews are planned for 14 and 16 December 2021.

Change

34. Stage 1 of the restructure, involving the move from 4 to 3 permanent Directorates will take place on 4 Jan 2021, to coincide with Leonie's move to CEO. Stage 2, involving restructuring of teams within Directorates will begin in the New Year.

35. Recruitment of the change team is now underway, which will ensure that there is adequate support for the programme going forwards.

36. Communications are also being ramped up, with a staff survey to ascertain levels of knowledge and understanding helping set a baseline and identify communication preferences.

External Developments

37. The Director Education and I met with Mary Pooley and Craig Wade from the Northern Council for Further Education (NFCE) who have been awarded the contract to develop an Optical Care Services **T level**, which will allow for several progression routes from school or college: directly into work or into further study at levels 4,5 and 6, including university. The T level will provide 168 UCAS points. We were invited and agreed to join the Technical Education Advisory Meeting (TEAM).

38. Recently we have responded to a Medicine and Healthcare Products Regulatory Agency ***(MHRA) consultation*** calling for zero-powered contact lenses to be regulated in the same was as contact lenses with a medical purpose. We also argued for their ability to be able to regulate devices sold into the UK.

External stakeholder engagement

39. I chaired the Chief Executives of Health & Social Care Regulators (CESG) meeting on 23 September 2021 and will do so one final time before my departure. I have also chaired the regulatory forum Chief Executives of Regulatory Bodies (CEORB) twice and the Chiropractic, Optical, Pharmacy, Osteopathic and Dental regulatory bodies Co-operation Pod (COPOD) once.

40. I met individually with Duncan Rudkin who is the CEO and Registrar of the General Pharmaceutical Council (GPhC) on the 15 October 2021 and Ian Brack who is the CEO and Registrar of the General Dental Council (GDC) on 1 November 2021.

41. I have held meetings with Mark Bennet, Director from the Department of Health and Social Care (DHSC) and Alan Clamp CEO of the Professional Standards Authority (PSA) several times, in my role as CEO of the GOC and Chair of the inter-regulatory CEO groups. I also attended a PSA seminar regarding the Duty of Candour in Scotland and spoke on the topic of regulating in the commercial sector at the PSA Symposium: Bridging the Gaps on 9 November 2021.

42. I held several discussions with KPMG about the Professional Regulation Review in my roles of CEO of the GOC and Chair of CEORB. This included attending a workshop on 22 October 2021.

43. The Optical Sector CEOs (GOC, ABDO, AOP, CoO, and FODO) have met twice and I have had occasional calls/meetings with them individually. Along with the Director of Education I attended and spoke at the Sector Education Forum Association of Optometrists (AOP) on 5 October 2021.

44. I have chaired one Strategic Sector Implementation Steering Group (SSISG) meeting since Council's last meeting with broad attendance from across the optical sector, including the academic community.

45. I joined the Chair for her induction meetings with the Association of Contact Lens Manufacturers, (ACLM) on 25 October 2021 and with Helen Perkins, (CEO/Clerk) & Mr Ian Davies, (Master) of the Worshipful Company of Spectacle Makers on 12 October. I also joined the Chair in an introduction meeting on 26 October 2021 with David Quigley, (Chair) from Optometry Scotland and an introduction meeting on 28 October 2021 with Luke Stevens-Burt, (CEO) and Neil Retallic, (President) from British Contact Lens Association, (BCLA).

46. I attended a meeting organised by the Association of British Dispensing Opticians (ABDO) on 17 November 2021 regarding sustainability. I was also very pleased to attend the ABDO Graduation Ceremony on 24 November 2021.

47. I attended the Northern Ireland Optometric Society (NIOS) Annual Conference & Gala Dinner Dance, on 04 October 2021.

48. I met with Cathy Yelf (CEO) of the Macular Society & Action Against AMD, Wen Hwa Lee (CEO) on 17 November 2021 to discuss regulatory issues associated with a proposed research programme. On 11 November 2021 I met with David Hewlett and Harjit Sandhu from the Federation of Ophthalmic Dispensing Opticians (FODO) to discuss the issues raised in advance of a discussion with Optical Sector CEOs.

49. I met with Matt Broom, Donna O'Brien, Steve Kill and Lisa Donaldson of SeeAbility on 16 November 2021 to discuss areas of common interest.

50. I attended the Buckinghamshire Healthcare Trust's Macular Suite's 5 Year Anniversary held on 14 October 2021.

51. A range of other engagements by Directors are listed in Annex 1.

Finance

52. This paper requires no decisions and so has no financial implications.

Risks

53. The Strategic Risk Register has been reviewed in the past quarter and discussed with ARC.

Equality Impacts

54. No impact assessment has been completed as this paper does not propose any new policy or process.

Devolved nations

55. We continue to engage with all four nations across a wide range of issues.

Other Impacts

56. No other impacts have been identified.

Communications

External communications

57. This report will be made available on our website, but there are no further communication plans.

Internal communications

58. An update to staff normally follows each Council meeting, which will pull out relevant highlights.

Next steps

59. There are no further steps required.

Attachment

Annex one – Directors' Stakeholder Meetings

Meetings/visits since last Council meeting

Leonie Milliner **Director of Education**	**Marcus Dye** **Director of Strategy (Interim)**	**Dionne Spence** **Director of Casework and Resolutions**	**Yeslin Gearty** **Director of Resources**
22 September: meeting with AOP to discuss CET/CPD transition	**Weekly** 6 x UK Advisors Meeting with: • Raymond Curran – Head of Ophthalmic Services, Health and Social Care Board Northern Ireland • Janet Pooley – Chief Optometric Advisor to Scottish Government • David O'Sullivan - Chief Optometric advisor to Welsh Government • Daniel Hardiman McCartney – College of Optometrists • Sarah Schumm – Health Education Improvement Wales • Tim Morgan – Health Education Improvement Wales	**AOP – quarterly meeting** Ella Franci, Cassandra Dighton, **TIAA – internal auditors** Ashley Norman, Kelly Reid **Capsticks – quarterly review** James Penry Davey, Keziah Pearson, Nicole Curtis **Determination Review Group** Inc Rakesh Sharma (NMC)	TIAA (internal auditors) - Ashley Norman Director of Audit

Leonie Milliner **Director of Education**	**Marcus Dye** **Director of Strategy (Interim)**	**Dionne Spence** **Director of Casework and Resolutions**	**Yeslin Gearty** **Director of Resources**
27 September: Registrants' webinar to introduce proposals to update our requirements for AS, SP & IP.	**Monthly** Chaired 3 x GOC Sector Workforce meetings with representatives from: • ABDO • ACLM • AOP • AIO • BCLA • College of Optometrists • FODO • Optometry Northern Ireland • Optometry Scotland • Optometry Wales	**Multiples Round Table** Led by GOC and OCCS Alan Tinger, FODO Sanjay Patel, Specsavers Hayley Holford, Boots Jeet Sambi, Scrivens Sarah Joyce, Asda My Laux, Optical Express Nigel Best, Specsavers Nick Wingate, Outside Clinic Dan McGhee, Vision Express Claire Slade, Hakim Group Kyla Black, Boots Andrew Bridges, Leightons Opticians	Hayesmacintyre - (external auditors) Adam Halsey audit partner and Charlotte Williams audit manager
28 September: Evening CET/CPD providers' webinar		**OCCS – quarterly review** Jennie Jones, Richard Edwards, Sue Clarke	
29 September: Launch of the UCL Global Business School for Health (evening)		**Reach Society** In conversation with Lord Herman Ousely	
29 September: Duty of Candour in Scotland – online seminar hosted by Professional Standards Authority	**Monthly** 2 x UK-REACH STAG Project Board meetings – Government commissioned research into	**Professional Standards Authority – Symposium x3** Bridging the Gaps	Brewin Dolphin (investment managers) Phillip Payne – Investment Director

Leonie Milliner **Director of Education**	**Marcus Dye** **Director of Strategy (Interim)**	**Dionne Spence** **Director of Casework and Resolutions**	**Yeslin Gearty** **Director of Resources**
	impact of Covid-19 on diagnosis and treatment of ethnic minorities		
5 October: AOP Sector Education Forum	30.09.21 Induction session with Council member Frank Munro	**Resilient Heart Workshop** Claudette Brown-Principal	Lloyds Bank (bankers) - Katies Faramarzie account manager and Jack Martin associate director
7 October: informal meeting of Education Committee members	01.10.21 Discussion on remote refraction with optical sector bodies, accompanied by Head of Legal and Head of Policy and Standards: • AOP – Peter Hampson and Henry Leonard • ABDO – Debbie McGill • FODO – Alan Tinger • College of Optometrists – Daniel Hardiman-McCartney	**DHSE** S60 Drafting workshop x3	Farebrother property consultants - Malcolm Bradbury partner
7 October: meeting with Chair of Council		**DHSE and GPhC** Regulatory reform review	
7 October: Chaired meeting of the Technical Advisory Group	08.10.21 Chaired Inter-regulatory group on IMMDS review recommendations: GMC, GOsC, NMC, HCPC, SWE, PSNI and GDC representatives in attendance	**EDI Forum – bi-monthly** Association of Chief Executives	Fortesium (software developers) Robert Hawkins and Paul Jobson
14 October: Meeting with Enventure research	12.10.21 Meeting with Chair of Council, CEO and Policy managers to discuss reforms to Governance and operating	**Witness to Harm Research** Dr Louise Wallace	Arriga Mareeba (CRM developers) Mark Payne and Richard Boardman

Leonie Milliner Director of Education	Marcus Dye Director of Strategy (Interim)	Dionne Spence Director of Casework and Resolutions	Yeslin Gearty Director of Resources
	resulting from DHSC legislative reform		
7 October: meeting with Mike Galvin, Chair of Education Committee 2 November: IP Expert Advisory Group	12.10.21 Introduction meeting between Chair of Council and Worshipful Company of Spectacle Makers – Helen Perkins (clerk) and Ian Davies (Master)	**Case Examiner Training Day** Shannett Thompson, Kingsley Napley Leslie Cuthbert, independent legal specialist, 'bias in decision making' Sarah Ellson, Fieldfisher Stewart Duffy. RadcliffesleBrasseur	
3 November: meeting with Chair of Council	15.10.21 Meeting with Penny Bance of GCC on IMMDS recommendations	**Lay Advocacy Programme Launch and Pohwer presentation**	
3 November: meeting with Alistair Bridge (ABDO) and Adam Sampson (AOP) to discuss third sector participation in the SSISG.	19.10.21 Introduction meeting between Chair of Council and Local Optometric Committee Support Unit (LOCSU) – Richard Whittington (CEO) and Mike Fegan (Chair)	**Education and Standards Committee meetings**	
8 November: meeting with Chair of Council	02.11.21 Introduction meeting between Chair of Council and Optometry Wales – Sarah Schumm (Chair) and Sali Davies (CEO)		
9 November: meeting with Lizzie Ostler (Director of Education, CoO)	03.11.21 DHSC Eye Health Forum – discussion on issues affecting eye care across optometry, ophthalmology and orthoptry.		

Leonie Milliner Director of Education	Marcus Dye Director of Strategy (Interim)	Dionne Spence Director of Casework and Resolutions	Yeslin Gearty Director of Resources
	Representatives from DHSC, NHS, and sector groups.		
18 November: ESR Sector Strategic Implementation Steering Group	04.11.21 Inter-regulatory Online forum – to discuss issues with the regulation of care provided online. Representatives from UK health and social care regulators, DHSC, NHS, MHRA and CQC.		
18 November: UK Advisory Committee on Degree Awarding Powers	08.11.21 Meeting with DHSC and GMC regarding IMMDS review outcomes – Rebekah Thompson and Rosamond Ettridge (DHSC) and Thomas Jones (GMC)		
22 November: Education Committee & Standards Committee meetings	09.11.21 MHRA consultation meeting with sector – discussion on sector responses to MHRA consultation including representatives from ACLM, FODO, AOP, ABDO, BCLA and College		
	09.11.21 PSA Symposium – Bridging the gaps		
	16.11.21 GOC and Seeability meeting – accompanied CEO		
	17.11.21 Presentation to College of Optometrists Council on regulatory and legislative reform		

Leonie Milliner Director of Education	Marcus Dye Director of Strategy (Interim)	Dionne Spence Director of Casework and Resolutions	Yeslin Gearty Director of Resources
	19.11.21 Optical sector CEO meeting to discuss legislative reform and remote refraction		
	22.11.21 Education Committee and Standards Committee meetings		
	24.11.21 DHSC/GPHC/GOC meeting to discuss FTP legislative reform and timescales with Policy Manager and Director of Casework		
	07.12.21 Health and Social Care Regulators Forum Covid subgroup – shared learning discussion in relation to impact of Covid-19		

General Optical Council

PUBLIC COUNCIL

Report from the Chair of Council

Meeting: 8 December 2021 **Status:** For noting

Lead Responsibility and Paper Author: Dr Anne Wright, Chair of Council

Introduction

1. This report covers my principal activities since the last Council meeting on 22 September 2021. This last period has seen the recruitment campaign for a Chief Executive and Registrar to succeed Lesley Longstone reach a successful outcome with the decision of the Council to appoint Leonie Milliner to the post following an open competition. I would like to congratulate Leonie, and I look forward to working with her in her new role.

2. This will be Lesley's final Council meeting. I would like to place on record on behalf of Council our huge appreciation for her outstanding leadership of the GOC and to wish her the very best for the future. We will welcome Leonie to her new role from the beginning of 2022.

Management

3. I have had regular catch-up meetings with the Chief Executive and Registrar as well as briefings from members of the SMT, Leadership Team and Secretariat on a range of priorities including the ESR, GOC Refresh, FtP casework and resolution, governance, strategy and legislative and regulatory reform, IT, HR, finance, and facilities.

4. I chaired the Appointment Panel for the recruitment of the new GOC Chief Executive and Registrar.

5. I had an induction meeting with the new Director of Change.

6. I attended an all-staff meeting **(23 November)** as well as several meetings and activities of the GOC EDI networks including Black History Month events.

Council and Committees

7. I have chaired a meeting of the Nominations Committee **(30 November)**. Items included updates on recruitment of two Council Associates and preparation for the programme to include induction and training, together with plans for a Council skills audit ahead of recruitment of two new Council members in 2022. I attended meetings of the Investment Committee, the Remuneration Committee, and the Audit and Risk Committee. I also attended the second meeting of the ESR Sector Strategic Implementation Steering Group **(7 September)**, and a joint meeting of the Education and Standards Committees **(22 November)**.

8. I have chaired Council catch-up briefings with Council members and SMT **(7 September, 30 November)** and held catch-up meetings with individual Council members.

Stakeholders

9. My ongoing induction programme has included further introductory meetings with several sector bodies and stakeholders. These were LOCSU, the Association of Contact Lens Manufacturers, the British Contact Lens Association, Optometry Scotland, Optometry Wales, and the Worshipful Company of Spectacle Makers. Further meetings are planned in the New Year.

10. I participated in the first of three HEE Deliberative Events on a Strategic Framework for the Health and Social Care Workforce **(1 November)**. The second event will take place on 9 December. I also participated in three PSA Bridging the Gaps symposia **(8-10 November)**.

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Council

Education Strategic Review – Post-Registration Speciality Qualifications

Meeting: 8 December 2021 **Status:** For decision

Lead responsibility: Leonie Milliner (Director of Education)
Paper Author(s): Leonie Milliner (Director of Education) Simran Bhogal (Education Manager – Policy, Projects & Research) Ben Pearson (Policy and Project Support Officer)
Council Lead(s): Josie Forte

Purpose

1. To consider proposals to update our requirements for GOC approved qualifications leading to specialist entry to the GOC register in additional supply (AS), supplementary prescribing (SP) and independent prescribing (IP) categories

Recommendations

2. Council is asked to:
   - Receive **advice** from **Education Committee** and **Standards Committee** on our proposals to update our requirements for GOC approved qualifications leading to specialist entry to the GOC register, in additional supply (AS), supplementary prescribing (SP) and independent prescribing (IP) categories.
   - **Note** the outcome of the public consultation (Enventure Research consultation report); EDI impact assessment (Fraser Consulting); the impact assessment screening; literature review report (University of Surrey) and the outcome of the Delphi verification of the proposed outcomes (University of Hertfordshire);
   - **Approve** the proposed updated our requirements (full copies attached at annex one):
     - Outcomes for Approved Qualifications for Specialist Entry to the GOC Register
     - Standards for Approved Qualifications for Specialist Entry to the GOC Register
     - Quality Assurance and Enhancement Method for Specialist Entry to the GOC Register
   - **Approve** use of reserves of up to £60,000 of over a period of three years (2022 - 2025) to facilitate a cross-sector knowledge-led collaboration and information exchange central to the successful implementation of proposals in annex one; and
   - **Delegate** to the Chief Executive and Registrar authority to approve final scheme design, budget, contract specifications and tender process in accordance with our Scheme of Delegation for Financial Management and Contracts and Procurement Policy (should the proposals be approved by Council).

Strategic objective

3. This work contributes towards the achievement of the following strategic objective: World class regulatory practice. This work is included in our 2020/21 Business Plan.

Background

4. The Education Strategic Review (ESR) was launched in March 2016 as a key priority within our former 2017-2020 Strategic Plan.

5. In our 2020-2025 'Fit for the future' strategy we said we intend to build on this work to update our requirements for the qualifications we approve, an enormously important and complex piece of work that will enable us to maintain public protection as the roles of registrants evolve.

6. In July 2019 Council gave steers on the ESR proposals. This included the introduction of an integrated form of optical education, combining academic study with professional and clinical experience in a single GOC-approved qualification on a student/ trainee's journey to registration or specialist entry to the GOC register, with the aim of ensuring that the skills and abilities of our registrants remain up to date and responsive to the needs of the healthcare system.

7. Following extensive engagement and consultation during 2020, the updated requirements for GOC approved qualifications in optometry and dispensing optics (the ESR pre-registration qualification deliverables) were approved by Council on 21 February 2021 and replaced the Education Quality Assurance Handbooks for optometry (2015) and ophthalmic dispensing (2011) and associated policies. The updated requirements for optometry and dispensing optics are published here: https://www.optical.org/en/news_publications/news_item.cfm/new-education-and-training-requirements-published This concludes the ESR workstream for pre-registration qualifications.

8. In August 2019 the terms of reference and project plan for the development of the ESR post-registration speciality qualifications deliverables were approved by our Senior Management Team (SMT). The intention was to replicate (at pace) the drafting, research and consultation process undertaken for the pre-registration qualifications for dispensing opticians and optometrists, with leadership from two dedicated Expert Advisory Groups (EAGs), one for therapeutic/independent (TP/IP) prescribing and one for contact lens opticians (CLO). The EAGs for TP/IP and CLO qualifications have now met eight times between September 2020 and November 2021. A list of IP EAG members is provided at annex seven.

9. The current requirements for specialty TP/IP qualification approval (quality assurance handbooks and related competence frameworks) were published in 2008 and 2011 respectively and are at significant risk of being no longer fit for purpose. The proposal is to replace the 'Handbook for Optometry Specialist Registration in

Therapeutic Prescribing' published July 2008 and the 'Competency Framework for Independent Prescribing' published in 2011, including the list of required core-competences, the numerical requirements for trainees' practical experiences, education policies and guidance contained within the handbooks, and our policies on supervision and recognition of prior learning, which published separately, with updated requirements for approved qualifications for specialist entry to the GOC register (in the AS, SP & IP categories) at annex one.

10. At its meetings on 29 September 2020 and 21 June 2021 the Advisory Panel discussed early drafts of the proposed requirements for approved AS, SP & IP qualifications and associated proposals and provided advice on their impact and next steps to Council and the EAG.

11. In July 2021 we launched a 12-week public consultation seeking views on our proposals to update our requirements for GOC approved qualifications leading to specialist entry to the GOC register in the AS, SP and IP categories, specifically;

- Our proposed **Outcomes for Approved Qualifications for Specialist Entry to the GOC Register (AS, SP and IP)**, which describe the expected knowledge, skills and behaviours an optometrist must have for the award of an approved qualification for specialist entry to the GOC register.
- Our proposed **Standards for Approved Qualifications for Specialist Entry to the GOC Register (AS, SP and IP)**, which describe the expected context for the delivery and assessment of the outcomes leading to an award of an approved qualification for specialist entry to the GOC register.
- Our proposed **Quality Assurance and Enhancement Method for Specialist Entry to GOC Register (AS, SP and IP)**, which describes how the GOC will gather evidence to decide, in accordance with the Opticians Act, whether a qualification for specialist entry to the GOC register meets its outcomes and standards for approved qualifications for specialist entry to the GOC register.
- Our **outline impact assessment**, which describes our assessment of the impact of our proposals to update our requirements for GOC approved qualifications.

12. As is usual with this type of consultation, we commissioned a research partner to undertake qualitative work with stakeholders, including patients and service-users, and to assist with data analysis, which informed the development of our final proposals. As with our pre-registration ESR deliverables, alongside the public consultation, we also commissioned Fraser Consulting to undertake an Equality Impact Assessment (EIA) of our proposals.

13. In addition, we commissioned the University of Hertfordshire to verify the proposed outcomes using the established and tested Delphi method. The purpose of deploying the Delphi method was to test (verify) the veracity of the outcomes and the allocation of level (Miller's pyramid). Council received a verbal update on University of Manchester's findings from the first round of the Delphi Method to verify the Outcomes for Registration for optometry and dispensing optics at its meeting in

December 2020, and so the Council will be familiar with the use of the Delphi method to provide an additional level of assurance regarding the accurate allocation of Miller's pyramid level and description of expected knowledge skills and behaviours for specialty registration.

14. In November 2021, following the close of the consultation, the IP Expert Advisory Group met to consider the feedback gained from the consultation, the EDI analysis and Delphi verification and synthesised the results to further develop the ESR post-registration specialty qualification deliverables included at annex one ready for Council consideration in December 2021.

Council decision; advice from statutory committees

15. The Opticians Act (1989) requires Council to 'consult and seek advice' from both Standards and Education Committees as follows:

16. Under the Opticians Act Section 12(1)(a) (Education and Training), Standards Committee has a specific responsibility to advise Council on the 'competencies which a person must be able to demonstrate in order to be granted a qualification as an optometrist or a dispensing optician.'

17. Under the Opticians Act Section 12(1)(b) (Education and Training), Education Committee has a specific responsibility to advise Council on the 'the content and the standard of education and training (including practical experience) required for the purpose of achieving those competencies.'

18. As post registration specialty qualifications do not lead to qualification as an optometrist or a dispensing optician, there is no statutory requirement for Council to seek advice from the statutory committees. However, there is value in Standards and Education Committees' expert input into the development of the proposals in advance of Council consideration.

19. On 22 November 2021 the Education Committee and Standards Committee met to discuss the proposals (attached at annex one). Written advice to Council from both committees is included in annexes eight and nine. Following advice from Education Committee GOC requested feedback on our proposals from the Royal College of Ophthalmologists (who had been engaged in the development of the proposals as members of the IP EAG). The Director of Education contacted the Chief Executive of the Royal College of Ophthalmologists (RCOphth) who confirmed via email the RCOphth did not have any further comments on the IP proposals and welcomed the opportunity to review and comment upon the proposals ahead of presentation to Council.

Analysis

20. The proposed updated requirements will ensure the post-registration qualifications we approve leading to specialist entry to the GOC register in the AS, SP and IP categories are responsive to a rapidly changing landscape in the commissioning of eye-care services in England and in each of the devolved nations. They respond to the changing needs and expectations of patients and service users, changes in technology, improvements in the capacity of clinicians to treat eyesight loss with new and developed procedures and changes in higher education as well as increased expectations of trainees, commissioners and employers. They also develop and build upon the new requirements for GOC approved pre-registration qualifications, in particular the recommendation from the Quality Assurance Agency (QAA) regarding RQF level for qualifications we approve, and the use of Miller's pyramid of clinical competence to ensure progression in clinical skills and alignment to assessment design.

21. Previous commissioned research and impact analysis, feedback from our work with our EAGs and information obtained as part of broader stakeholder engagement including feedback and evidence of impact obtained from previous public consultations in 2019 and in 2020 has shaped the development of our proposals. In addition, in April 2021 we commissioned the QAA to review our emerging proposals and map to recommended RQF levels (RQF L7/11 for IP and RQF L6 for CLO), identifying gaps and supporting the EAG in their drafting of the outcomes, standards and quality assurance and enhancement method. The QAA's review (Dr Neil Casey, QAA Quality Manager) concluded; '*Close scrutiny of the overarching statements and the individual outcomes for the qualifications across both levels 6/10 and 7/11 provides clear evidence that the qualifications meet relevant thresholds, and for the most part, are distinctly pitched. This is a considerable accomplishment given the GOC's need to take account of multiple influences, including its own professional requirements, frameworks of other professional bodies, and Miller's Pyramid of Clinical Competence, as well as RQF levels*.'

22. The key proposals in annex one are:

    a. Trainees will acquire a single qualification approved by the GOC leading to specialist entry to the GOC register in the relevant category rather than the two approved qualifications gained either sequentially or simultaneously at present (which is the case for the majority of candidates).

    b. The approved qualification will be either an academic award or a regulated qualification at a minimum of Regulated Qualification Framework (RQF) (or equivalent) Level 7/11 for AS, SP and/or IP. At present we do not require that TP/IP qualifications we approve are either an academic award or a regulated qualification and so this is a significant enhancement upon our current requirements. In terms of current RQF levels, we do not currently specify a minimum RQF level for IP qualifications we approve.

c. There is no proposed minimum/maximum or recommended time or credit volume for an approved qualification or specified location or duration of clinical experience, other than the requirement that an approved qualification leading to specialist entry to the GOC register in AS, SP and/or IP categories must integrate approximately 90 hours of learning and experience in practice.

d. Trainees upon or shortly after admission to an approved qualification must have identified a suitably experienced and qualified designated prescribing practitioner (DPP) who has agreed to supervise their learning in practice. A trainee's DPP must be a registered healthcare professional in Great Britain or Northern Ireland with independent prescribing rights and be an active prescriber competent in the clinical area(s) they will be supervising the trainee in, have the relevant core competencies, and be trained and supported to carry out their role effectively. If more than one registered healthcare professional with IP rights is involved in supervising a trainee, one independent prescriber must assume primary responsibility for coordinating the trainee's supervision. That person will be the trainee's DPP. In addition, we propose that there must be agreements in place between the trainee, their DPP and the qualification provider that describe their respective roles and responsibilities during periods of learning and experience in practice. These must be regularly reviewed and supported by management plans, systems and policies which prioritise patient safety.

e. The provider of the approved qualification must, in the design, delivery and assessment of an approved qualification, involve and be informed by feedback from a range of stakeholders including patients, employers, trainees, supervisors, members of the eye-care team and other healthcare professionals. This requirement ensures that providers' approaches to detailed curriculum and assessment will remain current and responsive to local, regional and national patient, service-user needs and broader stakeholder requirements.

f. An outcomes-based approach is used to specify knowledge, skills and behaviours using an established competence and assessment hierarchy known as 'Miller's Pyramid of Clinical Competence' (knows: knows how: show how & does). For Additional Supply, Supplementary Prescribing and/or Independent Prescribing, outcomes are mapped to additional relevant external prescribing frameworks, including the (2021) Royal Pharmaceutical Society Competence Framework for all Prescribers (a framework aimed at developing skill and competence of existing prescribers, which has also been drafted to inform regulators in their development minimum standards/ benchmarks for prescribing programmes and to inform regulators' guidance.) This outcomes-orientated approach moves away from our current prescriptive numerical and competency-based methods for setting requirements for GOC qualification approval, grounded in what can be observed and in the assessment of technical proficiency. Our proposed outcomes-based approach focuses more on the development of professional capability, a combination of critical

thinking, clinical-reasoning and decision-making vital in the formation of a professional healthcare practitioner well-prepared to take responsibility for decisions and actions, responding effectively to changing patent and service-user needs and engaging in up-to-date, effective and research-informed clinical practice.

g. Providers of approved qualifications are responsible for the measurement (assessment) of students' achievement of the outcomes at the required level (on Miller's Pyramid) leading to an award of an approved qualification.

h. Providers of approved qualifications will be responsible for recruiting and selecting trainees onto a programme leading to an award of an approved qualification. Recognition of prior learning can be deployed to assist the progression of trainees whose progress to specialist registration has stalled, and the requirement for optometrist independent prescribing trainees to have been registered for at least two years prior to commencing clinical experience/ hospital placements for has been removed. This approach will assist those trainees (and their employers/ commissioners) who wish to acquire an approved qualification leading to specialist entry to the GOC register in the relevant category co-terminus with, or shortly after, a GOC approved qualification in optometry (for which a provider may charge a separate fee). This is a particularly attractive option in Scotland and the four nation optometric advisors and relevant commissioning/ statutory education bodies (HEIW, NES, HEE and Dept of the Economy) are fully engaged in our IP EAG.

i. At the point of retention, registrants in the AS, SP and/or IP categories will no longer need to supply details of prescribing decisions undertaken in the previous 12 months.

23. From a public and patient perspective, our proposals, with their outcomes-orientated approach, give more focus to the development of professional capability and the softer skills vital to shared-decision making, as well as critical thinking, research-informed clinical decision-making and evidence-based practice to ensure that new registrants' will able to respond far more effectively to changing patient and service user eye care needs given the challenges of our aging population and changing models of service delivery, and its potential for enhanced roles for optical professionals.

24. An urgent risk is that our current requirements for post-registration qualification approval (our QA handbook, competence framework and related policies) are not fit for purpose and as a result, we fail to meet our overarching statutory responsibility to promote and maintain high standards of professional education. For example, if a qualification we approve meets our requirements but nevertheless fails to prepare students to meet employer, patient and service user needs, putting future patients at risk of inadequate care.

25. Our prime intention is to ensure the qualifications we approve are far more responsive to local, regional and national patient, service-user and broader

stakeholder requirements and therefore more current, and aligned with our new requirements for pre-registration qualifications, leading to improved patient care. We also want to ensure continuing patient, public confidence in our ability to maintain and monitor high standards for qualification approval through our refreshed quality assurance and approval process and give greater assurance that our requirements are being met and risks managed appropriately.

26. The proposals mitigate the key risk that our current requirements for post-registration qualification approval; the core competencies, requirements for trainee's practical experiences and supervision, education policies and guidance become out of date and even less fit for purpose than they currently are. In particular, the urgent risk associated with the list of required core-competencies and requirements for practical experiences that no longer reflect contemporary optical practice or meet patient or service-user needs in the rapid transformation of hospital eye care services, and that our current requirements (handbook) for qualification approval do not reflect modern methods for statutory healthcare regulators in setting education and training benchmarks for qualification approval for entry into a specialist register category.

27. The proposals also address current workforce supply issues within IP, created in part by the current narrow and restrictive requirements within our 2008 Quality Assurance Handbook for Therapeutic Prescribing. These requirements, which date back to 2008, restrict clinical placements to the HES and appropriate GP practices, limit access to clinical placements to optometrists who have been registered for at least two years and require trainees to be supervised by a designated medical practitioner (DMP), most frequently an ophthalmologist. Moving forward, for qualifications in AS, SP and/or IP, the proposal is that the supervision of a trainee's learning and experience in practice is co-ordinated by an appropriately trained and qualified registered healthcare professional with independent prescribing rights (called a Designated Prescribing Practitioner or DPP) who is an active prescriber competent in the clinical area(s) they will be supervising the trainee in, have the relevant core competencies and be trained and supported to carry out their role effectively.

Consultation

28. The public consultation seeking views and evidence of impact of our proposals closed on 4 October 2021 was broadly supportive of our proposals. We received 55 responses from a variety of stakeholders, including providers of approved qualifications, individual registrants, students, patients and service users, businesses, professional associations/representative bodies and national commissioners, and held focus groups and interviews with stakeholders from across the sector and all nations of the UK. A description of the research methodology for this can be found in Enventure Research' consultation report located at annex two. For information on the consultation, including copies of the consultation documents, please see the accompanying documentation on the GOC consultation hub https://consultation.optical.org/esr/education-and-training-requirements-for-specialist

Verification, EQIA & Literature Review

29. Alongside our public consultation we commissioned three packages of work to further inform the fine-tuning of our proposals post-consultation by our IP EAG:

30. **Verification of Outcomes for Approved Qualifications for Specialist Entry to the GOC Register (AS, SP and IP)**. We commissioned the University of Hertfordshire to verify the outcomes. The purpose of the verification is to test the veracity of the outcomes and the allocation of level (Miller's triangle) through use of the Delphi method. The Delphi method involves gathering a consensus of expert opinion and has been applied to the development of competency frameworks and curricula for optometric and medical subspecialties (Clancy et al. 2009; Hay et al. 2007; Myint et al. 2010; Stewart et al. 1999). It involves a series of rounds to gather opinion anonymously. The advantage of the Delphi technique is that participants can express views without being influenced by others, most particularly to facilitate consensus on borderline outcomes. The EAG on 2 November 2021 received the final report from the University of Hertfordshire on their findings. The outcome of the EAG's review of the r University of Hertfordshire recommendations for adjustments to the outcomes is described in annex six.

31. **Equality, Diversity, Inclusion Impact Assessment (EQIA)**. We commissioned Fraser Consulting to undertake an EDI assessment of the impact of our proposals with reference to each of the protected characteristics as defined by the Equality Act (2010) across each of the four nations. This assessment focused particularly on EDI impacts (positive and negative) on students and future providers of GOC approved qualifications using qualitative and quantitative data analysis. Clare Fraser is an experienced equality and diversity consultant with a range of clients across the public and private sectors, and her report is attached at annex three.

32. **Independent Prescribing Literature Review**. We commissioned Surrey University to undertake a rapid review with the aim to identify known barriers and facilitators to implementing non-medical prescribing that impact on optometrist therapeutic prescribing, related to additional supply, independent and supplementary prescribing. An additional aim was to identify literature on the scope of the role of an optometrist therapeutic prescribing. The report highlighted potential benefits to be gained from a greater alignment with non-medical prescribing (NMP) competencies, educational and governance standards and frameworks for advanced practice career development. The recommendations of this review are timely given the role of non-medical prescribing in improving service capacity to meet increasing demand for medication. The literature review report can be found on our policy development research page and at annex four of this report.

Key responses: summary of feedback

33. We have reflected on the feedback provided by stakeholders and from our commissioned research, public consultation and impact assessment and identified

the following in relation to each of our proposals where Education Committee and Standards Committee may like to provide further advice, to ensure that the qualifications we approve in the future are fit for purpose and transitional arrangements are realistic.

34. In relation to proposal a; **'***Trainees will acquire a single qualification approved by the GOC leading to specialist entry to the GOC register in the relevant category rather than the two approved qualifications gained either sequentially or simultaneously at present (which is the case for the majority of candidates)'* there was broad agreement that this is a logical step to simplify and streamline the route to speciality registration. Some respondents suggested that this proposal would help to align optical independent prescribing qualifications with those of other NMP professions. It was felt that the current staged process, whereby optometrists gain two GOC-approved qualifications on their journey to speciality registration is confusing for registrants/trainees, patients and employers and that awareness of the current process for speciality registration is poor, which may deter some optometrists from gaining IP qualifications. Moving to a simpler route to speciality registration, with trainees acquiring a single, integrated GOC-approved qualification, may benefit patients as a greater number of optometrists may acquire prescribing rights, reducing workforce supply issues within service redesign. Some respondents commented that the Therapeutic Common Assessment provided by the College of Optometrists provides a useful commonly held benchmark assessment, the advantage of which is that it is applied consistently to all TP/IP trainees. These respondents expressed concern that if an AS, SP or IP qualification is offered and assessed by multiple providers (albeit to GOC requirements), this could pose a risk to the maintenance of standards. Some stakeholders, however, felt that the current Therapeutic Common Assessment was not an effective way of evaluating the knowledge and skill of an independent prescribing optometrist. An alternative option, to develop for speciality registration a two-stage knowledge and competence set of outcomes (and associated standards) for two sets of GOC approved-qualifications gained by candidates either sequentially or simultaneously leading to entry to speciality register was considered by the EAG in November 2021 and not considered viable, given it would not address the urgent risks or problems of the current system and require such significant revisions to the proposals at annex one to the extent that we would need to restart the drafting process. It was also noted that such an approach would not be in-step with the 2017 'concepts and principles' or later 2018-19 consultations, or with approaches taken by the majority of healthcare regulators. It was also noted that there was no guarantee that proposals for a two-stage qualification process leading to speciality AS, SP and/or IP registration would be less burdensome or less costly to students, providers or employers, offer greater protection for the public or increased resilience in the sector than the current proposed approach.

35. In relation to proposal b; *'The approved qualification will be either an academic award or a regulated qualification at a minimum of Regulated Qualification Framework (RQF) (or equivalent) Level 7/11 for AS, SP and/or IP'.* Most respondents agreed that

the qualification should be at a minimum of RQF level 7/11, to reflect the degree of clinical responsibility of trainee independent prescribers and alignment with pre-registration qualifications in optometry, which would be of benefit to the profession and patient safety. One respondent suggested the qualification should be at a minimum of RQF level 8/12 or equivalent FHEQ qualifications to provide the opportunity for academic progression, however, given academic qualifications at level 8/11 are generally PhD/DPhil or professional doctorates, this level was considered unsuitable for this type of short, non-research-based qualifications in AS, SP and/or IP.

36. Proposal c: '*There is no proposed minimum/maximum or recommended time or credit volume for an approved qualification or specified location or duration of clinical experience, other than the requirement that an approved qualification leading to specialist entry to the GOC register in AS, SP and/or IP categories must integrate approximately 90 hours of learning and experience in practice,'* was received positively, with the removal of the specified location requirement for clinical experience for the independent prescribing qualifications allowing for increased flexibility, increasing the range of settings in which trainees can gain experience. Some respondents suggested the GOC could further develop its proposals to retain some specific requirements for clinical experience to balance increased flexibility.

37. In relation to proposal d: *Trainees upon application must have identified a suitably experienced and qualified designated prescribing practitioner (DPP) who has agreed to supervise their learning in practice'* respondents were generally very positive, with some respondents stating that this proposal would significantly improve the ability for trainees to gain the breadth and depth of contemporary clinical experience they will need, especially given the difficulties for many trainees in securing clinical placements in hospitals and supervision by an ophthalmologist, difficulties which have been exacerbated by the Covid-19 pandemic. This proposal was described by focus group participants as 'a game changer.' In discussion at the EAG in November 2021 this proposal was further strengthened to respond to concerns expressed by some respondents regarding the impact of this requirement upon trainees' application, selection and admissions process, to make it clear that the experienced and qualified designated prescribing practitioner (DPP) should be identified upon or shortly after admission rather than at application stage.

38. In relation to proposal e: '*The provider of the approved qualification must, in the design, delivery and assessment of an approved qualification, involve and be informed by feedback from a range of stakeholders including patients, employers, trainees, supervisors, members of the eye-care team and other healthcare professionals. This requirement ensures that providers' approaches to detailed curriculum and assessment will remain current and responsive to local, regional and national patient, service-user needs and broader stakeholder requirements,'* respondents were generally of the view that this should already be standard requirement of qualifications approved by the GOC and offered clear benefits. Feedback from all relevant stakeholders was cited as important, as was patient input

to ensure public understanding and confidence. Feedback from employers to qualification providers was also considered key to securing employer support for optometrist employees undertaking independent prescribing qualification in the future.

39. In relation to proposal f: *An outcomes-based approach to specify knowledge, skills and behaviours using 'Miller's Pyramid of Clinical Competence' (knows: knows how: show how & does) and mapping outcomes to additional relevant external prescribing frameworks, including the (2021) Royal Pharmaceutical Society Competence Framework for all Prescribers,'* the response to the use of Miller's Pyramid of Clinical Competence as an underpinning organising tool for stratifying the proposed outcomes was generally positively. The most common response to this proposal was the view that adopting Miller's Pyramid for specialist qualifications was a logical given its use in the updated (March 2021) requirements for optometry and would therefore align with pre-registration approved qualifications and with prescribing qualifications offered in other non-medical prescribing professions. Some respondents commented that the Royal Pharmaceutical Society (RPS) Competence Framework for all Prescribers could have used instead of the proposed outcomes. The EAG considered this point and noted that the RPS Competence Framework for all Prescribers is aimed at developing skill and competence of existing prescribers rather than those training to prescribe and was drafted explicitly to inform regulators in their development minimum standards/ benchmarks for prescribing programmes rather than to replace such requirements.

40. In relation to proposal g: *Providers of approved qualifications are responsible for the measurement (assessment) of students' achievement of the outcomes at the required level (on Miller's Pyramid) leading to an award of an approved qualification'* some respondents commented that this proposal would remove the consistency provided by the College of Optometrist's Therapeutic Common Assessment. These respondents expressed concern that if an AS, SP or IP qualification is offered and assessed by multiple providers this could pose a risk to the maintenance of standards. Some stakeholders, however, felt that the College of Optometrist's Therapeutic Common Assessment was not an effective way of evaluating the knowledge and skill of an independent prescribing optometrist. Some respondents considered that the proposed, new quality assurance method should ensure providers are held accountable by the GOC for the maintenance of standards in assessment and open up opportunities for trainees and their employers to choose between providers, increasing flexibility for trainees, their employers and commissioners/ statutory education and training bodies.

41. Proposal h: *Providers of approved qualifications will be responsible for recruiting and selecting trainees onto a programme leading to an award of an approved qualification. Recognition of prior learning can be deployed to assist the progression of trainees whose progress to specialist registration has stalled, and the requirement for optometrist independent prescribing trainees to have been registered for at least*

two years prior to commencing clinical experience/ hospital placements for will be removed' was well received, particularly the removal of the two-year registration 'bar,' by respondents, as a logical solution to current workforce supply and progression issues, although concerns were expressed regarding trainees maturity and access to a suitable breadth of early clinical experience. The proposal to remove the regulatory bar preventing trainees from acquiring an approved qualification leading to specialist entry to the GOC register co-terminus with, or shortly after, a GOC approved qualification in optometry was considered particularly attractive option for providers and trainees in Scotland.

42. Proposal i: **'***At the point of retention, registrants in the AS, SP and/or IP categories will no longer need to supply details of prescribing decisions undertaken in the previous 12 months'* was well received. Respondents said that the current process of recording all prescribing decisions is onerous, time-consuming and offered limited value for current independent prescribers, as well as duplicating prescribing decisions already also logged elsewhere in patient records. In addition, respondents commented that a similar retention requirement is not requested by other statutory regulators, such as for nurses and pharmacists. Removing this requirement would make independent prescribing optometrists feel more trusted by the GOC in their decisions and abilities and would create equal status with independent prescribers in other healthcare professions.

Arrangements for existing providers of GOC-approved TP/IP qualifications

43. Our proposals include a commitment to working with each provider of GOC-approved TP/IP qualifications to understand at what pace providers will wish to adapt their existing qualifications or develop new qualifications to meet the updated requirements included in annex one. If the proposals are approved by Council in December 2021, we anticipate most providers will begin to adapt their existing TP/IP qualifications in 2022 (alongside adapting approved pre-registration qualifications in optometry) and that most providers will work towards admitting trainees to approved qualifications that meet the updated outcomes and standards by Sept 2023. Some providers may, in consultation with the GOC, agree an earlier or later start date. Separate arrangements will be made with the College of Optometrists to ensure that for students who graduate from qualifications approved before 2021, their route to GOC registration is maintained.

Proposed IP knowledge hub/ information exchange

44. A key risk for us in updating our requirements is to receive notifications of adaptation or applications for approval from poorly designed programmes that struggle to meet the outcomes and standards, struggle to recruit and fail to thrive. Should the proposals in annex one be approved by Council in December 2021, we will be asking education and training providers to make significant changes to their approved TP/IP qualifications, about which they are understandably nervous. To ensure a smooth transition between new and legacy qualifications, as with optometry and dispensing

optics, we need to support providers as they move to implementing the proposed outcomes and standards, with its inherent risks and investment costs, so that providers have the best possible opportunity in designing their programmes and preparing applications for approval or adaptation that are a success, and reduce the risk of failing to meet our outcomes and standards, struggling to recruit and consequent instability in workforce supply. It is important that we support the exchange of information between providers so they can learn from each other in developing their new, integrated AS, SP and IP qualifications, in addition to their participation in our assurance and enhancement method. GOC has assisted in building this capacity for optometry and dispensing optics with the establishment of SPOKE (Sector Partnership for Optical Knowledge and Education), led by the College of Optometrists in a partnership arrangement with ABDO, OSC and OASC.

45. Our proposed quality assurance and enhancement process is essentially a confidential process with each provider. Our role is to receive and consider applications and evidence in accordance with our published quality assurance and enhancement method and decide if the qualification meets our outcomes and standards. Within this process our capacity to share information, disseminate best practice and suggest more broadly how providers might organise themselves to meet our outcomes and standards is limited. Each application for qualification approval or adaptation 'turns on its own facts', or evidence, and as a regulator care must be taken not to advocate an approach (say, an assessment method) which may or may not be suitable for a provider in its specific context in meeting our standards and outcomes.

46. To better support providers and the sector to successfully implement the updated requirements for AS, SP and/or IP, and mitigate this key risk, we are seeking Council's agreement for £60,000 of reserves to further facilitate projects that will benefit the academic and non-medical prescribing community, specifically programme leaders and module coordinators in their design and development of new, integrated qualifications which meet the proposed outcomes and standards in annex one.

47. The proposal for activities knowledge exchange/ information hub to be organised into three themes, as follows:

    a. Projects: Three collaborative cross sector projects designed to support providers and trainees develop shared documentation and a digital archive of resources and published output. The purpose and scope of the three projects will specified in the Request for Proposals and centre around preparing the sector and providers to identify and support suitably experienced and competent optometrists with prescribing rights for their new role as DPPs; integrated assessment of the outcomes, particularly those outcomes at the DOES level; and arrangements for RPL/ advanced standing for trainees whose progress has stalled.

b. Community: Curate a vibrant interdisciplinary forum open (for free) for providers, sector bodies, employers, statutory education and training bosies and the GOC, providing leadership and support for the sector, bringing together the academic community, employers, trainees, healthcare professionals and the wider eye-care team, sector bodies, researchers, HEIs, and funders to assist providers in their design/ adaptation of new programmes/ qualifications to meet the proposed new outcomes and standards.;
c. Journal: Create, share, exchange and disseminate knowledge, ideas, insights, data and projects and build a digital archive of resources and published output (evaluations, studies, videos, reports, papers, etc.) to support academic staff and the sector to support providers in their design and development of new, integrated AS, SP and/or IP qualifications.

48. As with SPOKE, the purpose of this knowledge exchange/ information hub will be a neutral, independent forum for academic staff to exchange ideas, ask questions, develop indicative guidance and share best practice as they develop their new qualifications for GOC approval, independently curated on a contract basis on behalf of GOC, open to all providers, academic and college faculty and practice-based staff, including programme leaders, module coordinators, preceptors and supervisors, with all encouraged to contribute. The intention is to seek an external contractor to host the knowledge exchange/ information hub on behalf of GOC from spring 2022 for a three-year term (the lifespan of the project) with a break clause at eighteen months. If we are unable to appoint an external contractor, we would revert to hosting the hub ourselves, albeit at arms-length from our quality assurance and enhancement team (although this may incur additional cost). The proposal is that GOC's Head of Education will have oversight of the contractor's performance and adherence to the contract terms. The contractor will be responsible for the hub's day-to-day activity to meet its contracted purpose, intended aims, budget and reporting, coordinated through a joint advisory committee hosted by the contractor providing insight and guidance.

Contact Lens Opticians Qualifications

49. A further strand of the Education Strategic Review is to update our requirements for Specialist Entry to the GOC Register as a contact lens optician. Our consultation on updated requirements for GOC-approved qualifications for specialist entry to the register as a contact lens optician opened on the 20 September 2021 and will close on 13 December 2021. The consultation can be accessed via the GOC's consultation hub. Key proposals we are seeking views on are:

a. Candidates will acquire a qualification approved by the GOC leading to specialist entry to the GOC register as a contact lens optician.
b. The approved qualification will be either an academic award or a regulated qualification at a minimum of Regulated Qualification Framework (RQF) (or equivalent) level 6.

c. There will be no proposed minimum/maximum or recommended time or credit volume for an approved qualification or specified location or duration of clinical experience, other than the requirement that an approved qualification leading to specialist entry to the GOC register as a contact lens optician must integrate approximately 225 hours of learning and experience in practice.
d. The provider of the approved qualification must, in the design, delivery and assessment of an approved qualification, involve and be informed by feedback from a range of stakeholders including patients, employers, trainees, supervisors, members of the eye-care team and other healthcare professionals.
e. An outcomes-based approach is used to specify knowledge, skills and behaviours using an established competence and assessment hierarchy known as 'Miller's Pyramid of Clinical Competence' (knows; knows how; shows how; and does).
f. Providers of approved qualifications are responsible for the measurement (assessment) of students' achievement of the outcomes at the required level (on Miller's Pyramid) leading to an award of an approved qualification.
g. Providers of approved qualifications will be responsible for recruiting and selecting trainees onto a programme leading to an award of an approved qualification. Recognition of prior learning can be deployed to assist the progression of trainees whose progress to specialist registration has stalled.

Finance

49. Part of the agreed ESR budget include costs for consultation support, EAGs and research/ impact assessment projects listed above, which were awarded following a procurement process undertaken by experienced staff members in line with GOC policy. Currently the project is on track against all defined cost tolerances.

50. We are seeking Council's approval to use of reserves up to £60k over a three-year timeframe to support the knowledge exchange/ information hub scheme described above in paragraphs 43-47.

Risks

51. The proposals in annex one and their planned implementation will mitigate the key strategic risk that our regulation of education and training leading to specialist registration in the AS, SP & IP categories is not fit for the future and our current requirements (Assurance Handbook and related policies) become out of date. The proposal will help mitigate against the risk of failing to engage stakeholders and keep pace with changes to roles and scopes of practice and will ensure the qualifications we approve in the future are responsive to increased expectations of independent prescribers and their employers and commissioners, the rapidly changing landscape in the commissioning and delivery of eye-care services within service redesign, the needs of patients and service users and changes in higher education.

52. Failure to support the culture change necessary for successful implementation risks poor quality qualification redesign that fail to meet our proposed standards and

outcomes, fail to recruit, and fail to thrive, with resulting instability in the sector and consequential workforce supply issues.

53. Project risks, and less impactful secondary risks, are all documented on the project risk register which is reviewed regularly by the ESR Project Board. Risks in relation to potential impacts on stakeholders are documented in the 'Impact Assessment Screening Tool' at annex four.

Equality Impacts

54. An Equality Impact Assessment (EIA) was externally commissioned which informed the development of the proposals post-consultation and is attached at annex three.

55. As is good practice, we included questions about impact, including equality impact, in our public consultation to inform our reassessment of impact so that insights from both qualitative and qualitative consultation data collection could be taken into account in the fine-tuning of the proposals post-consultation.

56. As also required, an updated impact assessment screening tool using the GOC's standard form is attached at annex four. This impact assessment draws upon the draft impact assessment we published as part of our consultation and uses evidence of impact gained through consultation and stakeholder engagement to inform its assessment of cost, benefit and risks, including consideration of a counterfactual option.

Devolved nations

57. The proposed education and training requirements for GOC approved qualifications leading to specialist entry to the GOC Register in the AS, AS and/or IP categories will apply to providers across the United Kingdom.

58. Consideration of specific impacts upon providers, employers and relevant stakeholders in each devolved nation was included in the brief for the externally commissioned impact assessments and public consultation, the results of which have informed the development of the proposals and impact assessment post-consultation. In addition, the optometric leads (or their representatives) are engaged as members of our EAG.

Communications

59. We continue to offer all stakeholder organisations the opportunity for a bilateral conversation with the GOC's Director of Education/ Chief Executive and Registrar. The intention, if the proposals are approved by Council, is to publish the updated requirements online and provide copies to all approved and provisionally approved qualification providers, as required under the Act.

60. The intention, if the proposals in annex one are approved by Council, is to publish the updated requirements online and provide copies to all approved qualification providers, as required under the Act. Following Council's decision, a post-approval communication plan will be enacted. This will involve a careful and clear communication of each of the proposals listed in paragraph 22 to registrants, providers, professional associations and patients/ public representative bodies using GOC's communication assets.

Next steps

61. From January 2022 we will begin working with each provider of GOC-approved TP/IP qualifications to understand at what pace providers will be able to adapt their existing qualifications or develop new qualifications to meet the new outcomes and standards. If the proposals are approved by Council in December 2021, we anticipate most providers will begin to adapt their existing TP/IP qualifications in 2022 (alongside adapting approved pre-registration qualifications in optometry) and that most providers will work towards admitting trainees to approved qualifications that meet the updated outcomes and standards by Sept 2023. Some providers may, in consultation with the GOC, agree an earlier or later start date.

62. Separate arrangements will be made with the College of Optometrists to ensure that for students who graduate from qualifications approved before 2021, their route to GOC registration is maintained.

Attachments

Annex one: Proposed Education and Training Requirements for GOC-Approved Qualifications for Specialist Entry to the GOC Register in Additional Supply, Supplementary Prescribing and/or Independent Prescribing Categories
Annex two: Enventure Research consultation report
Annex three: Fraser Consulting EDI impact assessment
Annex four: Impact Assessment Screening Tool
Annex five: University of Surrey Independent Prescribing literature report
Annex six: Delphi Outcomes
Annex seven: EAG membership
Annex eight: Advice from Education Committee
Annex nine: Advice from Standards Committee

Education and Training Requirements for GOC-Approved Qualifications for Specialist Entry to the GOC Register in Additional Supply, Supplementary Prescribing and/or Independent Prescribing Categories

Introduction

This document describes our requirements for approval of qualifications for specialist entry to the GOC register in additional supply (AS), supplementary prescribing (SP) and/or independent prescribing (IP) categories. It is divided into the following sections:

- **Section 1: Outcomes for Approved Qualifications for Specialist Entry to the GOC Register (Additional Supply, Supplementary Prescribing and Independent Prescribing)** ('outcomes for approved qualifications') describes the expected knowledge, skills and behaviours an optometrist must have for the award of an approved qualification for specialist entry to the GOC register in AS, SP and/or IP categories.
- **Section 2: Standards for Approved Qualifications for Specialist Entry to the GOC Register (Additional Supply, Supplementary Prescribing and Independent Prescribing)** ('standards for approved qualifications') describes the expected context for the delivery and assessment of the outcomes leading to an award of an approved qualification for specialist entry to the GOC register in the AS, SP and/or IP categories.
- **Section 3: Quality Assurance and Enhancement Method for Specialist Entry to the GOC Register (Additional Supply, Supplementary Prescribing and Independent Prescribing)** ('quality assurance and enhancement method') describes how we will gather evidence to decide in accordance with the Opticians Act 1989 ('the Act') whether a qualification for specialist entry to the GOC register in the AS, SP and/or IP categories meets our outcomes for approved qualifications and standards for approved qualifications. This method statement is common to qualifications for specialist entry to the GOC register.

What do these documents replace?

Together, the outcomes and standards for approved qualifications for specialist entry to the GOC register (AS, SP and IP) will replace 'A Handbook for Optometry Specialist Registration in Therapeutic Prescribing' (published in July 2008) and the 'Competency Framework for Independent Prescribing' (published in 2011), including the list of required core competences, the numerical requirements for trainees' practical experiences, education policies and guidance contained within the handbooks, and our policies on supervision and recognition of prior learning (published separately).

Together these new documents will ensure the specialist post-registration qualifications we approve are responsive to a rapidly changing landscape in the delivery of eye-care services and fit for purpose in each of the UK nations. The documents allow for the changing needs of patients and service-users, enhanced roles for dispensing opticians within new models of service delivery (not least as a result of the COVID-19 emergency), and increased expectations of trainees and their employers, so as to ensure that the qualifications we approve are fit for purpose.

What have we consulted on previously?

These proposals are based on our analysis of our responses to our Call for Evidence, Concepts and Principles Consultation 2017-2018, feedback from our 2018-2019 consultation on proposals stemming from the Education Strategic Review (ESR) and associated research, and our public consultations held in July-September 2020 and July- October 2021. For more information, please see the GOC's consultation hub.

Pre-registration qualifications

We also approve two pre-registration qualifications for entry to the GOC register as either a dispensing optician or an optometrist. Our updated requirements for these qualifications (see our Requirements for Approved Qualifications in Optometry or Dispensing Optics: Outcomes for Registration; Standards for Approved Qualifications; Quality Assurance and Enhancement Method) were approved by the GOC's Council ('Council') on 10 February 2021.

How have we developed our proposals?

Our proposals have been guided by research and consultation and best practice from other regulators, professional and chartered bodies. You can read our research, background and briefing papers on our website.

In preparing this document we were advised by an Expert Advisory Group (EAG) and feedback from a range of stakeholder groups including our Education Visitors, our Advisory Panel (including Education Committee and Standards Committee) the optical sector and sight-loss charities.

We would like to thank everyone who took the time to help us develop our proposals to ensure they protect and benefit the public, safeguard patients and help to secure the health of service-users. You can read the EAG's terms of reference and membership on our website.

Arrangements for current providers of GOC-approved qualifications

From January 2022 we will begin working with each provider of GOC-approved post-registration qualifications to understand at what pace providers will be able to adapt their existing qualifications or develop new qualifications to meet the new outcomes and standards.

We anticipate most providers will work towards admitting trainees to approved qualifications that meet the outcomes and standards by Sept 2023, although providers may wish to admit trainees earlier.

Separate arrangements will be made with The College of Optometrists to ensure that for trainees who graduate from qualifications approved before 2021, their route to specialist entry to the GOC register is maintained.

Section 1: Outcomes for Approved Qualifications for Specialist Entry to the GOC Register (Additional Supply, Supplementary Supply and Independent Prescribing)

Introduction

The **outcomes for approved qualifications for specialist entry to the GOC register (AS, SP and IP)** describe the expected knowledge, skills and behaviours an optometrist must have to be awarded an approved qualification for specialist entry to the GOC register in the AS, SP and/or IP categories.

We will use the **outcomes for approved qualifications, standards for approved qualifications** and **quality assurance and enhancement method** together to decide whether to approve a qualification for specialist entry to the GOC register in the AS, SP and/or IP categories.

GOC-approved qualifications[1] will prepare trainees to meet these outcomes for specialist entry to the GOC register.

The outcomes are organised into six categories:

1. Uphold professional standards
2. Person centred care
3. Establishes and manages patient options
4. Prescribing practice
5. Ethics and standards
6. Manages risk
7. Learning and development

Each category includes an overarching statement and outcomes which must be met if a trainee is to be awarded the approved qualification. Each outcome is described using a level based on an established competence and assessment hierarchy known as 'Miller's Pyramid of Clinical Competence'[2] (knows; knows how; shows how; and does). We have provided a note on Miller's Pyramid on page 11 of this document.

The number of outcomes in each category varies; some categories have fewer outcomes than others. The number of outcomes in each category and their order within the category is not an indication of weight and/or volume of assessment, teaching and learning when providers design qualifications.

Approved qualifications for specialist entry to the GOC register in the additional supply category must meet the outcomes indicated with '(AS)'.

Approved qualifications for specialist entry to the GOC register in the supplementary prescribing category must meet the outcomes indicated with '(SP)'.

Approved qualifications for specialist entry to the GOC register in the independent prescribing category must meet outcomes indicated with '(IP)'.

[1] The Act gives GOC powers to approve' 'qualifications'

[2] Miller, G.E. (1990) The assessment of clinical skills/competence/performance. Acad Med 65: 563–7.

The Outcomes incorporate the updated Royal Pharmaceutical Society's (RPS) Framework for all Prescribers (2021) indicated by a corresponding reference beside outcome criteria relating to the framework (e.g. [RPS-9.3]). They have been contextualised for the purposes of AS, SP and IP registrant categories, and to meet the GOC's quality assurance requirements using Miller's Pyramid of Clinical Competence.

Outcomes for Approved Qualifications Leading to Specialist Entry to the GOC Register (Additional Supply, Supplementary Supply and Independent Prescribing)

Registered optometrists make the care of patients their primary concern. They take responsibility for their own actions and apply the knowledge, skills and behaviours required to practise effectively, safely and professionally.

1. Uphold professional standards

Registered optical professionals establish relationships with other professionals based on professional understanding and respect; acting as part of a multidisciplinary team they ensure that continuity of care across care settings is not compromised.

O1.1 Works collaboratively as part of wider MDT teams to ensure that the transfer and continuity of care (within and across all care settings) is developed and not compromised. (RPS-10.1) (IP) (SP) (AS) [Does]

O1.2 Establishes relationships with other professionals based on understanding, trust and respect for each other's roles in relation to the patient's care. (RPS-10.2) (IP) (SP) (AS) [Does]

O1.3 Undertakes the consultation in an appropriate setting, taking account of confidentiality, consent, dignity and respect in line with regulatory practice, legislation and contractual requirements. (RPS-1.1/1.2) (IP) (SP) (AS) [Does]

O1.4 Assesses the communication needs of the patient/carer and adapts consultation appropriately (e.g. for language, age, capacity, physical or sensory impairments). (RPS-1.4) (IP) (SP) (AS) [Does]

O1.5 Introduces self and prescribing role to the patient/carer and confirms patient/carer identity. (RPS-1.3) (IP) (SP) (AS) [Does]

2. Person centred care

An optometrist with a specialist entry to the GOC register (AS, SP and IP) must have a person centred approach, be adaptive and work collaboratively with others in the best interest of the patient, exercising initiative and personal responsibility, and understanding their role in the prescribing process.

O2.1 Demonstrates good consultation skills and builds rapport with the patient/carer. (RPS-1.5) (IP) (SP) (AS) [Does]

O2.2 Actively involves and works with the patient/carer in partnership to make informed choices, agreeing a plan that respects the patient's/carer's preferences including their right to refuse or limit treatment. (RPS-3.1) (IP) (SP) (AS) [Does]

O2.3 Explores the patient's/carer's understanding of a consultation and aims for a satisfactory outcome for the patient/carer and prescriber. (RPS-3.6) (IP) (SP) (AS) [Does]

O2.4 Considers and respects patient diversity, background, personal values and beliefs about their health, treatment and medicines, supporting the values of equality and inclusivity, and developing cultural competence. (RPS-3.2) (IP) (SP) (AS) [Shows how]

O2.5 Makes prescribing decisions based on the needs of patients and not the prescriber's personal preferences. (RPS-8.4) (IP) (SP) (AS) [Shows how]

O2.6 Identifies and minimises potential risks associated with prescribing via remote methods. (RPS-7.3) (IP) (SP) (AS) [Shows how]

O2.7 Explains the material risks and benefits, and rationale behind management options in a way the patient/carer understands, so that they can make an informed choice. (RPS-3.3) (IP) (SP) (AS) [Does]

O2.8 Builds a relationship with the patient, which encourages appropriate prescribing and not the expectation that a prescription will always be supplied. (RPS-3.5) (IP) (SP) (AS) [Shows how]

O2.9 Assesses health literacy of the patient/carer and adapts appropriately to provide clear, understandable and accessible information. (RPS-5.1) (IP) (SP) (AS) [Does]

O2.10 Guides the patient/carer on how to identify reliable sources of information about their condition, medicines and treatment. (RPS-5.3) (IP) (SP) (AS) [Shows how]

O2.11 Checks the patient's/carer's understanding of the discussions had, actions needed and their commitment to the management plan. (RPS-5.2) (IP) (SP) (AS) [Does]

O2.12 Ensures the patient/carer knows what to do if there are any concerns about the management of their condition, if the condition deteriorates or if there is no improvement in a specific timeframe. (RPS-5.4) (IP) (SP) (AS) [Does]

3. Establishes patient management options

An optometrist with a specialist entry to the GOC register (AS, SP and IP) assesses the patient to establish a diagnosis (sometimes in complex and unpredictable situations), determine and maintain an informed management plan for reviewing the patient's treatment, arrange appropriate follow-up aftercare and prescribe if necessary (within their individual scope of practice).

O3.1 Demonstrates appropriate consultation techniques and takes and documents an appropriate medical, psychosocial and medication history including allergies and intolerances. (RPS-1.6) (IP) (SP) (AS) [Does]

O3.2 Undertakes and documents an appropriate clinical assessment. (RPS-1.7) (IP) (SP) (AS) [Does]

O3.3 Identifies and addresses potential vulnerabilities that may be causing the patient/carer to seek treatment. (RPS-1.8) (IP) (SP) (AS) [Does]

O3.4 Accesses and interprets all available and relevant patient records to ensure knowledge of the patient's management to date. (RPS-1.9) (IP) (SP) (AS) [Does]

O3.5 Requests and interprets relevant investigations necessary to inform treatment options. (RPS-1.10) (IP) (SP) [Shows how]

O3.6 Makes, confirms or understands, and documents the working or final diagnosis by systematically considering the various possibilities (differential diagnosis). (RPS-1.11) (IP) (SP) (AS) [Does]

O3.7 Recognises and understands the condition(s) being treated, their natural progression and how to assess their severity, deterioration and anticipated response to treatment. (RPS-1.12) (IP) (SP) (AS) [Does]

O3.8 Reviews adherence to, and effectiveness of, current medicines. (RPS-1.13) (IP) (SP) (AS) [Does]

O3.9 Assesses adherence in a non-judgemental way, understands the different reasons for non-adherence (intentional or non-intentional) and how best to support the patient/carer. (RPS-3.4) (IP) (SP) (AS) [Shows how]

O3.10 Recognises when and where to refer appropriately or seek guidance from another member of the healthcare team, a specialist or appropriate information source when necessary. (RPS-1.14) (IP) (SP) (AS) [Does]

O3.11 Considers both non-pharmacological (including no treatment) and pharmacological approaches. (RPS-2.1) (IP) (SP) (AS) [Does]

O3.12 Considers all pharmacological treatment options including optimising doses as well as stopping treatment (appropriate polypharmacy, de-prescribing). (RPS-2.2) (IP) (SP) (AS) [Does]

O3.13 Assesses and manages the benefits and risks to the patient of taking or not taking a medicine or treatment. (RPS-2.3) (IP) (SP) (AS) [Does]

O3.14 Applies understanding of the mode of action, pharmacokinetics and pharmacodynamics of medicines, and how these may be altered by individual patient factors. (RPS-2.4) (IP) (SP) (AS) [Does]

O3.15 Assesses how co-morbidities, existing medicines, allergies, contraindications and quality of life impact on management options. (RPS-2.5) (IP) (SP) (AS) [Does]

O3.16 Considers any relevant patient factors and their potential impact on the choice and formulation of medicines, and the route of administration. (RPS-2.6) (IP) (SP) (AS) [Does]

O3.17 Encourages and supports the patient/carer to take responsibility for their medicines and self-manage their condition. (RPS-5.5) (IP) (SP) (AS) [Does]

03.18 Adapts the management plan in response to on-going monitoring and review of the patient's condition and preferences. (RPS-6.3) (IP) (SP) (AS) [Does]

4. Prescribing practice

An optometrist with a specialist entry to the GOC register (AS, SP and IP) is responsible for their role as a prescriber in achieving desired patient outcomes, prescribing safely, appropriately and in context. Working within their limits of competence and exercising professional judgement, they engage in evidence-informed clinical decision-making for all patients and can demonstrate self-direction in solving problems.

O4.1 Understands and uses available tools to improve prescribing practice (such as supervision, workplace competency-based assessments, questionnaires, prescribing data analysis, audits, and actively seeking patient and peer feedback). (RPS-9.3) (IP) (SP) (AS) [Knows how]

O4.2 Prescribes a medicine or device with adequate, up-to-date awareness of its actions, indications, dose, contraindications, interactions, cautions and adverse effects. (RPS-4.1) (IP) (SP) (AS) [Does]

O4.3 Understands the potential for adverse effects and takes steps to recognise, minimise risk and manage them. (RPS-4.2) (IP) (SP) (AS) [Shows how]

O4.4 Establishes and maintains a plan to monitor the effectiveness of treatment and potential unwanted effects. (RPS-6.2) (IP) (SP) (AS) [Does]

O4.5 Prescribes generic medicines where practical and safe for the patient, and knows when medicines should be prescribed by branded product. (IP) (SP) (AS) (RPS-4.4) [Does]

O4.6 Accurately completes and routinely checks calculations relevant to prescribing and practical dosing. (RPS-4.5) (IP) (SP) (AS) [Does]

O4.7 Prescribes appropriate quantities and at appropriate intervals necessary, to reduce the risk of unnecessary waste. (RPS-4.6) (IP) (SP) (AS) [Does]

O4.8 Stays up-to-date in own area of practice and applies the principles of evidence-based practice. (RPS 2.8) (IP) (SP) (AS) [Shows how]

O4.9 Accesses, critically evaluates, and uses reliable and validated sources of information. (RPS-2.7) (IP) (SP) (AS) [Does]

O4.10 Understands and uses relevant national, regional and local frameworks for medicines use. (RPS-4.3) (IP) (SP) (AS) [Shows how]

O4.11 Recognises when safe prescribing processes are not in place and acts to minimise risks. (RPS-7.4) (IP) (SP) (AS) [Shows how]

O4.12 Applies the General Medical Council's 'Remote prescribing high level principles' (co-authored by a range of healthcare regulators including the GOC) to ensure patients have effective safeguards in place to protect them when they receive advice and treatment remotely. (IP) (SP) (AS) [Shows how]

O4.13 Agrees the appropriate level of support and supervision (including when working remotely) for their role as a prescriber. (RPS-10.3) (IP) (SP) [Does]

O4.14 Provides support and advice to other prescribers or those involved in administration of medicines where appropriate. (RPS-10.4) (IP) (SP) [Does]

O4.15 Uses up-to-date information about the availability, pack sizes, storage conditions, excipients and costs of prescribed medicines. (RPS-4.8) (IP) (SP) (AS) [Does]

O4.16 Electronically generates and/or writes legible unambiguous and complete prescriptions which meet legal requirements. (RPS-4.9) (IP) (SP) (AS) [Does]

O4.17 Effectively uses systems necessary to prescribe medicines. (RPS-4.10) (IP) (SP) (AS) [Does]

O4.18 Documents accurate, legible and contemporaneous clinical records. (RPS-4.13) (IP) (SP) (AS) [Does]

O4.19 Effectively and securely communicates information to other healthcare professionals involved in the patient's care when sharing or transferring care and prescribing responsibilities, within and across all care settings. (RPS-4.14) (IP) (SP) (AS) [Shows how]

O4.20 Understands antimicrobial resistance and the roles of infection prevention and control. Applies antimicrobial stewardship measures e.g. considers alternative options and only prescribes antimicrobials when clinically appropriate. (RPS-2.10) (IP) (SP) (AS) [Knows how]

5. Ethics and standards

An optometrist with a specialist entry to the GOC register (AS, SP and IP) must uphold high professional standards and ethical responsibilities, and apply

legislation and relevant policies and guidance that impact on their prescribing practice.

O5.1 Accepts personal responsibility and accountability for prescribing, and clinical decisions, and understands the legal and ethical implications. (RPS-8.2) (IP) (SP) (AS) [Does]

O5.2 Understands and works within legal and regulatory frameworks affecting own prescribing practice (e.g. prescribing controlled drugs, unlicensed and off label medicines, supplementary prescribing, and prescribing for self, close family and friends). (RPS-8.3) (IP) (SP) (AS) [Knows how]

O5.3 Prescribes unlicensed and off-label medicines where legally permitted, and in the patient's best interest, and unlicensed medicines only if satisfied that an alternative licensed medicine would not meet the patient's clinical needs. (RPS-4.11) (IP) (SP) (AS) [Shows how]

O5.4 Follows appropriate safeguards if prescribing medicines are unlicensed, 'off-label', or outside standard practice. (RPS-4.12) [Shows how] (IP) (SP) (AS)

O5.5 Works within the NHS, organisational, regulatory and other codes of conduct when interacting with the pharmaceutical industry. (RPS-8.6) (IP) (SP) (AS) [Does]

O5.6 Knows how medicines are licensed, supplied and monitored. (IP) (SP) (AS) [Knows]

O5.7 Considers the wider perspective including the public health issues related to medicines and their use, and promoting health. (RPS-2.9) (IP) (SP) (AS) [Knows]

6. Manages risk

An optometrist with a specialist entry to the GOC register (AS, SP and IP) should be able to identify when people might be at risk and be candid when things have gone wrong. They should recognise when safe systems are not in place to support prescribing and act appropriately to ensure a safe environment for patients and the public.

O6.1 Acts upon inappropriate or unsafe prescribing practice using appropriate processes. (RPS-9.2) (IP) (SP) (AS) [Knows how]

O6.2 Recognises and manages potential misuse of medicines using appropriate processes. (RPS-4.7) (IP) (SP) (AS) [Shows how]

O6.3 Knows about common types and causes of medication and prescribing errors, and how to minimise their risk. (RPS-7.2) (IP) (SP) (AS) [Knows how]

O6.4 Recognises and reports suspected adverse reactions to medicines and medical devices using appropriate reporting systems. (RPS-6.4) (IP) (SP) (AS) [Does]

O6.5 Reports near misses, critical incidents, medication and prescribing errors using appropriate reporting systems, and regularly reviews practice to prevent recurrence. (RPS-7.6) (IP) (SP) (AS) [Shows how]

O6.6 Recognises and manages factors that might unduly influence prescribing (e.g. interactions with pharmaceutical industry, media, patient, colleagues, cognitive bias, prescribing incentives and targets). (RPS-8.5) (IP) (SP) (AS) [Shows how]

7. Learning and development

An optometrist with a specialist entry to the GOC register (AS, SP and IP) must maintain their clinical knowledge and skills appropriate to their scope of practice, make use of networks for support, reflection and learning, and be able to work within their area of expertise and competence to achieve desired patient outcomes.

O7.1 Takes responsibility for own learning and continuing professional development (CPD) relevant to the prescribing role by continuously reviewing, reflecting, identifying gaps, planning, acting, applying and evidencing learning or competencies. (RPS-9.4) (IP) (SP) (AS) [Does]

O7.2 Encourages and supports the learning and development of others with their prescribing practice and continuing professional development. (RPS-9.6) (IP) (SP) (AS) [Shows how]

O7.3 Ensures confidence and competence to prescribe are maintained. (RPS-8.1) (IP) (SP) (AS) [Shows how]

O7.4 Improves by reflecting on own and others' prescribing practice, and acting upon feedback and discussion. (RPS-9.1) (IP) (SP) (AS) [Does]

O7.5 Prescribes within own competence and scope of practice, and recognises the limits of own knowledge and skill. (RPS-7.1) (IP) (SP) (AS) [Does]

O7.6 Keeps up-to-date with emerging safety concerns related to prescribing. (RPS-7.5) (IP) (SP) (AS) [Does]

Note on 'Miller's Pyramid of Clinical Competence'[3]

Knows	Knowledge that may be applied in the future. (Assessments may include essays, unseen examinations, practical reports, oral examinations and multiple-choice questions (MCQs), etc.)
Knows how	Knows how to apply knowledge and skills in a defined context or situation. (Assessments may include essays, oral examinations, unseen examinations, short answer questions, multi-format

[3] Miller, G.E. (1990) The assessment of clinical skills/competence/performance. Acad Med 65: 56

	MCQs (single best answer, extended matching questions), practical simulations, portfolios, workbooks and poster presentations, etc.)
Shows how	Applies knowledge, skills and behaviour in a simulated environment or in real life repeatedly and reliably. (Assessments may include objective structured clinical examinations (OSCEs), simulated patient assessments, oral and poster presentations, designing, conducting and reporting an experiment, dispensing tests and taking a patient history, unseen examinations involving patient cases, etc.)
Does	Acting independently and consistently in a complex situation of an everyday or familiar context repeatedly and reliably. *(Assessments may include OSCEs, simulated patient assessments and observed practice, case-based assessments, portfolios, sustained research project (thesis, poster and oral presentation), etc.)*

Section 2: Standards for Approved Qualifications for Specialist Entry to the GOC Register (Additional Supply, Supplementary Supply and Independent Prescribing)

Introduction

The **standards for approved qualifications for specialist entry to the GOC register (AS, SP and IP)** describe the expected context for the delivery and assessment of the outcomes leading to an award of an approved qualification for specialist entry to the GOC register in AS, SP and/or IP categories.

We will use the **outcomes for approved qualifications, standards for approved qualifications** and **quality assurance and enhancement method** together to decide whether to approve a qualification for specialist entry to the GOC register in the AS, SP and/or IP categories.

GOC-approved qualifications[4] will prepare trainees to meet these outcomes for specialist entry to the GOC register.

The standards are organised under five categories:

1. Public and patient safety
2. Selection and admission of trainees
3. Assessment of outcomes and curriculum design
4. Management, monitoring and review of approved qualifications
5. Leadership, resources and capacity

Each category is supported by criteria which must be met for a qualification to be approved.

[4] The Act gives the GOC powers to 'approve' 'qualifications'

Standards for Approved Qualifications for Specialist Entry to the GOC Register (Additional Supply, Supplementary Prescribing and Independent Prescribing)

1. Public and patient safety

Approved qualifications must be delivered in contexts which ensure public and patient safety and support trainees' development and the demonstration of patient centred professionalism.

Criteria to meet this standard:

S1.1 There must be policies and systems in place to ensure trainees understand and adhere to the GOC's Standards of Practice for Optometrists and Dispensing Opticians.

S1.2 Concerns about a trainee's fitness to train or practise must be reported to the GOC. (The GOC acceptance criteria should be used as a guide as to when a fitness to practise/train matter should be reported.)

S1.3 Trainees must not put patients, service-users, the public or colleagues at risk. This means that anyone who teaches, assesses, supervises or employs trainees must ensure trainees practise safely, only undertake activities within the limits of their competence and are appropriately supervised when with patients and service-users.

S1.4 Upon admission (and at regular intervals thereafter) trainees must be informed it is an offence not to be registered with the GOC at all times whilst studying on a programme leading to an approved qualification for specialist entry to the GOC register (AS, SP and/or IP).

2. Selection and admission of trainees

Recruitment, selection and admission of trainees must be transparent, fair and appropriate.

Criteria to meet this standard:

S2.1 Selection and admission criteria must be appropriate for entry to an approved qualification for specialist entry to the GOC register (AS, SP and/or IP categories) including relevant health, character and fitness to practise checks. For overseas trainees, this should include evidence of proficiency in the English language of at least level 7 overall (with no individual section lower than 6.5) on the International English Language Testing System (IELTS) scale or equivalent.

S2.2 Recruitment, selection and admission processes must be fair, transparent and comply with relevant legislation (which may differ between England, Scotland, Northern Ireland and Wales), including equality and diversity legislation, and

evaluate the suitability and relevance of the applicant's prior clinical and therapeutic experience.

S2.3 Selectors (who may include a mix of academic and admissions/administrative staff) should be trained to apply selection criteria fairly, including training in equality, diversity and unconscious bias in line with legislation in place in England, Scotland, Northern Ireland and Wales.

S2.4 Information provided to applicants must be accurate, comply with relevant legislation and include:

- the academic, clinical and therapeutic experience required for entry to the approved qualification;
- a description of the selection process and any costs associated with making the application;
- the qualification's approved status;
- the total costs/fees that will be incurred;
- the curriculum and assessment approach for the qualification; and
- the requirement for trainees to remain registered with the GOC throughout the duration of the programme leading to the award of the approved qualification.

If offers are made to applicants below published academic and professional entry requirements, the rationale for making such decisions must be explicit and recorded.

S2.5 Recognition of prior learning must be supported by effective and robust policies and systems. These must ensure that trainees admitted at a point other than the start of a programme have the potential to meet the outcomes for the award of the approved qualification. Prior learning must be recognised in accordance with guidance issued by The Quality Assurance Agency for Higher Education (QAA) and/or Ofqual / Scottish Qualifications Authority (SQA) / Qualifications Wales / Department for the Economy in Northern Ireland and must not exempt trainees from summative assessments leading to the award of the approved qualification. (If necessary, separate arrangements will be made for the safe transition of trainees who have not yet completed GOC-approved therapeutic prescribing qualifications programmes prior to the introduction of the new outcomes and standards.)

S2.6 Upon or shortly after admission trainees and the organisation responsible for the award of the approved qualification (the provider) must have identified a suitably experienced and qualified designated prescribing practitioner (DPP) who has agreed to supervise the trainee's learning in practice. The trainee's DPP must be a registered healthcare professional in Great Britain or Northern Ireland with independent prescribing rights. (See also Standard 4.)

3. Assessment of outcomes and curriculum design

The approved qualification must be supported by an integrated curriculum and assessment strategy that ensures trainees who are awarded the approved qualification meet all the outcomes at the required level (Miller's Pyramid: knows; knows how; shows how; and does).

Criteria to meet this standard:

S3.1 There must be a clear assessment strategy for the award of an approved qualification. The strategy must describe how the outcomes will be assessed, how assessment will measure trainees' achievement of outcomes at the required level (Miller's Pyramid) and how this leads to an award of an approved qualification.

S3.2 The approved qualification must be taught and assessed (diagnostically, formatively and summatively) in a progressive and integrated manner. The component parts should be linked into a cohesive programme (for example, Harden's spiral curriculum[5]), introducing, progressing and assessing knowledge, skills and behaviour until the outcomes are achieved.

S3.3 Curriculum design and the assessment of outcomes must involve and be informed by feedback from a range of stakeholders such as patients, employers, trainees, commissioners, placement providers, members of the eye-care team and other healthcare professionals.

S3.4 The outcomes must be assessed using a range of methods and all final, summative assessments must be passed. This means that compensation, trailing and extended re-sit opportunities within and between modules where outcomes are assessed is not permitted.

S3.5 Assessment (including lowest pass) criteria, choice and design of assessment items (diagnostic, formative and summative) leading to the award of an approved qualification must ensure safe and effective practice and be appropriate for a qualification for specialist entry to the GOC register (AS, SP and/or IP).
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S3.6 Assessment (including lowest pass) criteria must be explicit and set using an appropriate and tested standard-setting process. This includes assessments which occur during learning and experience in practice.

S3.7 Assessments must appropriately balance validity, reliability, robustness, fairness and transparency, ensure equity of treatment for trainees, reflect best practice and be routinely monitored, developed and quality controlled. This includes assessments which might occur during learning and experience in practice.

S3.8 Appropriate reasonable adjustments must be put in place to ensure that trainees with a disability are not disadvantaged in engaging with the learning and teaching process and in demonstrating their achievement of the outcomes.

S3.9 There must be policies and systems in place to plan, monitor and record each trainee's achievement of outcomes leading to award of the approved qualification.

S3.10 The approved qualification must be listed on one of the national frameworks for higher education qualifications for UK degree-awarding bodies[6] (The Framework for Higher Education Qualifications of Degree-Awarding Bodies in England, Wales and Northern Ireland (FHEQ) and the Framework for Qualifications of Higher

[5] R.M. Harden (1999) What is a spiral curriculum? Medical Teacher, 21:2, 141-143

Education Institutions in Scotland (FQHEIS)), or be a qualification regulated by Qfqual, SQA or Qualifications Wales. Approved qualifications for specialist entry to the GOC register (AS, SP and/or IP) must be at a minimum Regulated Qualification Framework (RQF), FHEQ or Credit and Qualifications Framework Wales (CQFW) level 7 or Scottish Credit and Qualifications Framework (SCQF) / FQHEIS 11.

S3.11 A range of teaching and learning methods must be used to deliver the outcomes.

S3.12 To enable the development of trainees' clinical, diagnostic and prescribing skills to meet the outcomes, the approved qualification must integrate learning and experience in practice (as a guide, approximately 90 hours). The supervision of a trainee's learning and experience in practice must be co-ordinated by an appropriately trained and qualified registered healthcare professional (DPP) with independent prescribing rights. (See also S4.4-S4.6.)

S3.13 Outcomes delivered and assessed during learning and experience in practice must be clearly identified, included within the assessment strategy and fully integrated within the programme leading to the award of an approved qualification.

S3.14 The selection of outcomes to be taught and assessed during periods of learning and experience in practice and the choice and design of assessment items must be informed by feedback from a variety of sources, such as patients, employers, trainees, DPPs, members of the eye-care team and other healthcare professionals.

S3.15 Equality and diversity data and its analysis must inform curriculum design, delivery and assessment of the approved qualification. This analysis must include trainees' progression by protected characteristic. In addition, the principles of equality, diversity and inclusion must be embedded in curriculum design and assessment and used to enhance trainees' experience of studying on a programme leading to an approved qualification.

S3.16 Trainees must receive regular and timely feedback to improve their performance, including on their performance in assessments and in periods of learning and experience in practice.

S3.17 As part of the approved qualification, trainees must meet regularly with their DPP to discuss and document their progress as learners.

4. Management, monitoring and review of approved qualifications

Approved qualifications must be managed, monitored, reviewed and evaluated in a systematic and developmental way, through transparent processes that show who is responsible for what at each stage.

Criteria to meet this standard:

S4.1 There must be a clear management plan in place for the award of the approved qualification and its development, delivery, management, quality control and evaluation.

S4.2 The organisation responsible for the award of the approved qualification must be legally incorporated (i.e. not be an unincorporated association) and have the authority and capability to award the approved qualification.

S4.3 The provider must have a named point of contact for the approved qualification.

S4.4 There must be agreements in place between the trainee, their DPP and the provider that describe their respective roles and responsibilities during periods of learning and experience in practice. These must be regularly reviewed and supported by management plans, systems and policies which prioritise patient safety.

S4.5 A trainee's DPP must be a registered healthcare professional with independent prescribing rights and be an active prescriber competent in the clinical area(s) they will be supervising the trainee in, have the relevant core competencies[7] and be trained and supported to carry out their role effectively.

S4.6 If more than one registered healthcare professional with independent prescribing rights is involved in supervising a trainee, one independent prescriber must assume primary responsibility for coordinating their supervision. That person will be the trainee's DPP.

S4.7 The approved qualification must be systematically monitored and evaluated across learning environments using the best available evidence, including feedback from stakeholders, and action taken to address any concerns identified. Evidence should demonstrate as a minimum:

- feedback systems for trainees and DPPs;
- structured systems for quality review and evaluation;
- trainee consultative mechanisms;
- input and feedback from external stakeholders (patients, employers, DPPs, commissioners, trainees, former trainees, third sector bodies, etc); and
- evaluation of business intelligence including progression and attainment data.

This will ensure that:

- provision is relevant, current and informed by evidence, and changes are made promptly to teaching materials and assessment items to reflect significant changes in practice and/or the results of research;
- the quality of teaching, learning support and assessment is appropriate; and
- the quality of learning and experience in practice, including supervision, is appropriate.

S4.8 There must be policies and systems in place for:

[7] See https://www.rpharms.com/resources/frameworks/designated-prescribing-practitioner-competency-framework

- the selection, appointment, support and training of external examiner(s) and/or internal and external moderator(s)/verifiers; and
- reporting back on actions taken to external examiners and/or internal and external moderators/verifiers.

S4.9 Trainees, and anyone who supervises trainees, must be able to provide feedback on progress and raise concerns. Responses to feedback and concerns raised must be recorded and evidenced.

S4.10 Complaints must be considered in accordance with the good practice advice on handling complaints issued by the Office for the Independent Adjudicator for Higher Education in England and Wales (or equivalent).

S4.11 There must be an effective mechanism to identify risks to the quality of the delivery and assessment of the approved qualification and to identify areas requiring attention or development.

S4.12 There must be systems and policies in place to ensure that the GOC is notified of any major events and/or changes to the approved qualification, assessment and quality control, its organisation, resourcing and constitution, including responses to relevant regulatory body reviews.

5. Leadership, resources and capacity

Leadership, resources and capacity must be sufficient to ensure the outcomes are delivered and assessed to meet these standards in an academic, professional and clinical context.

Criteria to meet this standard:

S5.1 There must be robust and transparent mechanisms for identifying, securing and maintaining a sufficient and appropriate level of ongoing resources to deliver the outcomes to meet these standards, including human and physical resources that are fit for purpose and clearly integrated into strategic and business plans. Evaluations of resources and capacity must be evidenced together with evidence of recommendations considered and implemented.

S5.2 There must be a sufficient and appropriately qualified and experienced staff team. This must include:

- an appropriately qualified and experienced programme leader, supported to succeed in their role; and
- sufficient staff responsible for the teaching and assessment of the outcomes[8], including GOC registrants and other suitably qualified healthcare professionals.

[8] As part of the rationale for their choice of student:staff ratios (SSR) providers must regularly benchmark their SSR to comparable providers (alongside seeking student and stakeholder feedback) to determine if their SSR provides an appropriate level of resource for the teaching and assessment of the outcomes leading to the award of an approved qualification.

S5.3 There must be policies and systems in place to ensure anyone involved in the approved qualification is appropriately qualified and supported to develop in their role. These must include:

- opportunities for CPD, including personal, academic and profession-specific development;
- for registered healthcare professionals and DPPs supervising trainees, opportunity for training and support;
- effective induction, supervision, peer support and mentoring;
- realistic workloads for anyone who teaches, assesses or supervises trainees;
- for teaching staff, the opportunity to gain teaching qualifications; and
- effective appraisal, performance review and career development support.

S5.4 There must be sufficient and appropriate learning facilities to deliver and assess the outcomes. These must include:

- sufficient and appropriate library and other information and IT resources;
- access to specialist resources, including textbooks, journals, internet and web-based materials; and
- specialist teaching, learning and clinical facilities to enable the delivery and assessment of the outcomes.

S5.5 Trainees must have effective support for health, wellbeing, conduct, academic, professional and clinical issues.

Section 3: Quality Assurance and Enhancement Method for Specialist Entry to the GOC Register (Additional Supply, Supplementary Prescribing and Independent Prescribing)

Introduction

Our quality assurance and enhancement method describes how we will gather evidence to decide in accordance with the Act whether a qualification for specialist entry to the GOC register in the AS, SP and/or IP categories meets our outcomes for approved qualifications and standards for approved qualifications. This method statement is common to all qualifications for specialist entry to the GOC register.

We will use the outcomes for approved qualifications, standards for approved qualifications and quality assurance and enhancement method together to decide whether to approve a qualification for specialist entry to the GOC register.

The design of the new quality assurance and enhancement method supports our outcomes-orientated approach. It moves away from seeking assurance that requirements are met by measuring inputs to evidencing outcomes. This reflects approaches taken by other statutory healthcare regulators, professional and chartered bodies.

The method does not attempt to describe every permutation of assurance and enhancement. Instead, it establishes a proportionate framework for gathering and assessing evidence to inform a decision as to whether to approve a qualification or withdraw approval of a qualification. The method sets out arrangements for periodic review, annual return, thematic and sample-based reviews, as well managing serious concerns and the type and range of evidence a provider of an approved qualification might consider providing to support these processes.

Underpinning our approach is a greater emphasis on the views of patients, service-users, the public, NHS, commissioners of training and education, and employers, as well as the views of trainees and previous trainees in the evidence we consider. This is to ensure the qualifications we approve are not only responsive to the needs of patients and service-users but also to the rapidly changing landscape in the delivery of eye-care services across the United Kingdom (UK).

The method is organised in seven sections:

1. Legal basis for quality assurance and enhancement
2. Quality assurance and enhancement – definitions
3. Geographic scope
4. Arrangements for current (pre-2021) providers of approved and provisionally approved qualifications
5. Approval of new qualifications (from December 2021)
6. Periodic review, annual return, thematic and sample-based review
7. Scope of evidence
8. Decision-making

Quality Assurance and Enhancement Method

1. Legal basis for quality assurance and enhancement

Our powers to undertake quality assurance and enhancement are set out in sections 12 and 13 of the Act. The Act requires the GOC to approve qualifications 'granted to candidates following success in an examination or other form or assessment which in the Council's opinion indicates that the candidate has attained all the outcomes leading to the award of the qualification'.

In part approval will be based on reports of appointed visitors (called 'Education Visitors') who report to the GOC on the 'nature of the instruction given', the 'sufficiency of the instruction given' and 'the assessments on the results of which approved qualifications are granted' as well as 'any other matters' which the GOC may decide.

The Act also gives powers to the GOC to approve 'any institution where the instruction given to persons training as opticians appears to the Council to be such as to secure to them adequate knowledge and skill for the practice of their profession'.

2. Quality assurance and enhancement – definitions

Quality assurance provides assurance that the qualifications we approve meet requirements in accordance with the Act for *'adequate knowledge and skill'* (section 12(7)(a) of the Act), as described in our outcomes and standards for approved qualifications.

A quality enhancement process goes further than establishing that minimum requirements are met. Enhancement helps us demonstrate we are meeting our statutory obligation to understand both the *'nature'* and the *'sufficiency'* of instruction provided and in the assessment of trainees, and provides an opportunity to foster innovation and enhance the quality and responsiveness of provision to meet the needs of patients, the public and service-users.

3. Geographic scope

In addition to approving qualifications in the UK we may also approve qualifications outside the UK, provided that these are taught and assessed in either English or Welsh. Assurance and enhancement activity undertaken outside the UK will be charged for on a full cost recovery basis.

4. Arrangements for current (pre-2021) providers of approved and provisionally approved qualifications

From January 2022 we will begin working with each provider of GOC-approved and provisionally approved post-registration qualifications to understand at what pace providers will be able to adapt their existing qualifications or develop new qualifications to meet the outcomes and standards.

We anticipate most providers will work towards admitting trainees to approved qualifications that meet the outcomes and standards by Sept 2023. although providers may wish to admit trainees earlier.

Separate arrangements will be made with The College of Optometrists to ensure that the route to specialist entry to the GOC register is maintained for trainees who graduate from qualifications approved before 2021.

Providers of currently approved qualifications and provisionally approved qualifications will have three options for adapting their existing qualifications or developing new qualifications to meet the outcomes and standards for approved qualifications:

a. adapt an existing approved or provisionally approved qualification and seek approval (as a course change) to a timescale agreed with us;

b. 'teach out' an existing approved qualification or provisionally approved qualification to a timescale agreed with us, alongside developing, seeking approval for and recruiting to a 'new' qualification (using the process described in section 5, below); and

c. 'teach out' an existing approved qualification or provisionally approved qualification to a timescale agreed by us and partner with another organisation(s) or institution(s) to develop, seek approval for and recruit to a 'new' qualification (using the process described in section 5, below).

Providers may, in consultation with the GOC, wish to migrate trainees from an existing approved or provisionally approved qualification to the 'new' qualification.

During the transitional phase, 'A Handbook for Optometry Specialist Registration in Therapeutic Prescribing' (2008) and the 'Competency Framework for Independent Prescribing' (2011) including the list of required core competences, the numerical requirements for trainees' practical experiences, education policies and guidance contained within the handbooks, and our policies on supervision and recognition of prior learning will apply to all existing (pre-2021) GOC-approved and provisionally approved qualifications during the teach out or migration phase.

5. Approval of new qualifications (from 1 January 2022)

We will consider applications for approval of qualifications not currently approved by us in accordance with the risk-based staged approach described below.

For qualifications already approved by the GOC, please see section 4 above, 'Arrangements for current (pre-2021) providers of approved and provisionally approved qualifications.'

The number, frequency and specification for each stage for approval of new qualifications will vary depending on the proposed qualification's risk stratification, which can be summarised broadly as:

a. lower risk: a new qualification developed by an existing provider of approved speciality qualifications or provisionally approved speciality qualifications (option b. in section 4 above);

b. medium risk: a new qualification developed by a provider in a partnership or contractual arrangement with one or more organisations or institutions, one or more of which may have experience of awarding a speciality qualification approved by us; and

c. higher risk: a new qualification developed by a provider with limited or no experience of awarding a speciality qualification approved by us.

All new qualifications not currently approved by us applying for GOC approval on or after 1 January 2022 will be expected to meet the outcomes and standards in accordance with the stages outlined below.

Staged approach to qualification approval *(for approval of new qualifications)*

Stage 1. Initial proposal for the proposed qualification. This stage will explore the strategic intent for the proposed qualification, the rationale for its design, its proposed approach to integration and resourcing, the provider's corporate form and management, and how the views of stakeholders, including patients, servicer-users, employers, NHS, commissioners of training and education and the public will inform the development, teaching and assessment of the proposed qualification, the draft business case and an outline of the investment necessary to ensure its success, and identification of key risks. The evidence to support stage 1 will normally be a written submission, based on the evidence framework, and supported by a meeting with us (at our offices or virtually) if necessary. Stage 1 may be repeated, particularly for applications stratified as medium or higher risk, until there is confidence the outcomes and standards are on course to be met and the provider is ready to move on to stage 2. The output of stage 1 will be a report to the provider which may or may not be published.

Stage 2. Stage 2 will examine the proposed qualification design and its resourcing in more depth (including, for applications stratified as medium or higher risk, investment in key appointments and infrastructure made between stages 1 and 2). This stage will consider the business case, investment and proposed pedagogic approach, the development of learning, teaching and assessment strategies, the involvement of patients, servicer-users, employers, commissioners and the public in qualification design, delivery and assessment, and preparedness for delivery for the first cohort of trainees. By the end of stage 2 all arrangements with partners (if required) will be in place, as will the investment necessary to ensure the qualification's successful implementation. The evidence to support stage 2 will normally be a written submission, based on the evidence framework, and supported by a meeting with us (at our offices, on site or virtually) if necessary. Stage 2 may be repeated, particularly for applications stratified as medium or higher risk, until there is confidence the outcomes and standards are on course to be met and the provider is ready to move on to stage 3. The output of stage 2 will be a report to the provider which may or may not be published.

Stage 3. The purpose of stage 3 will be to assess the readiness of the provider to begin recruiting trainees. The focus will be on detailed curriculum and assessment design, approach to recruitment and selection of trainees, and preparedness to commence delivery of the approved qualification. Stage 3 will confirm that the resourcing of the qualification, as described in stages 1 and 2, is in place (including, for applications stratified as medium or higher risk, investment in key appointments and infrastructure made between stages 2 and 3). By stage 3 the provider will also be expected to evidence good progress in implementing plans approved at stage 2. As stage 3 represents a higher risk to the GOC in terms of its decision-making, the evidence to support stage 3 will normally be a written submission, based on the evidence framework and an on site (or virtual) visit based on the format of a periodic review. The specification of the periodic review required will be informed by the qualification's risk profile. Stage 3 may be repeated, particularly for applications stratified as medium or higher risk, until there is confidence the outcomes and standards are likely to be met and the provider is ready to move on to stage 4. The output of stage 3 will be permission to commence recruiting trainees. Providers are reminded that the qualification is not approved until a decision of Council is made at stage 5, and to ensure recruitment and advertising material conforms to our standard conditions of approval.

Stage 4 (a,b,c, etc.). Stage 4 is repeated each year until the first cohort of trainees, or trainees migrated across into the programme, reach the final year's study. The focus of stage 4 is on the delivery and assessment of the integrated qualification, including its staffing, resourcing and infrastructure, risk mitigation and progress in implementing plans approved at earlier stages, alongside preparedness for the delivery for the next, and most importantly, final, academic year. At stage 4 patient, servicer-user, employer, commissioner and public engagement in qualification delivery, assessment and review is expected, along with evidence of an increasing volume of inter-professional learning and patient-facing learning and experience as trainees progress through the qualification. At stage 4 (a, b, c, etc.) the provider's preparedness for, and implementation of, its plan for the integration of patient-facing learning and experience will be examined, as well as its reflections on implementing plans approved at earlier stages, and any changes it proposes to make to the qualification as a result of trainee and stakeholder feedback. As stage 4 represents a higher risk to us in terms of our decision-making, the evidence to support stage 4 will normally be a written submission, based on the evidence framework and, for applications stratified as lower risk, a meeting with us either on site or at our offices (or virtually if necessary). For applications stratified as medium or higher risk, the meeting will take the form of an on site (or virtual) visit based on the format of a periodic review. As at other stages, stage 4 may result in conditions being imposed, which can include halting recruitment for one or more cohorts, until we are reassured that the outcomes and standards are likely to be met and the provider is ready to move on to stage 5.

If a provider is asked to halt recruitment and/or if the decision is that there is no confidence the provider is ready to move to stage 5, the provider may cease to be considered for GOC approval, and trainees will not be eligible for specialty

registration. In these circumstances, the provider must inform us how the interests of trainees currently studying on the qualification will be best served, either by transferring to an alternative provider or by being offered an alternative academic award; any costs incurred will be the responsibility of the provider.

The output of stage 4 will be a report to the provider which may or may not be published. Providers are reminded that the qualification is not approved until a decision of Council is made at stage 5, and to ensure recruitment and advertising material confirms to our standard conditions.

Stage 5. Stage 5 considers an approved qualification's ability to meet the outcomes and standards. It is the final stage of the process and takes place in the academic year in which the first cohort of trainees will graduate. The evidence to support stage 5 will normally be a written submission, based on the evidence framework, alongside a periodic review and our attendance at the provider's final examination board (or equivalent). The specification for the periodic review will be based on the evidence framework and the risk stratification of the qualification, which includes factors such as, but not limited to the results of stages 1 to 4, discharge of previously applied conditions and/or any serious concerns reviews and a sample-based review of the outcomes. The prime purpose of a stage 5 periodic review is assurance about whether the outcomes and standards are met. Depending on whether the application is stratified as lower, medium or higher risk, the periodic review may be desk-based, involve an on site visit or visits, and/or physical or virtual meetings.

A decision by Council as to whether to approve the qualification will rely upon its consideration of the evidence gathered during stages one to five and will be informed by the advice of the Education Visitors. If the decision of Council is to *approve* the qualification (with or without conditions), the decision will specify the date from which the qualification is approved (normally the date of the examination Board for the first graduating cohort of trainees). The duration of the qualification's approval may be limited if necessary, according to its risk profile.

A provider's progress through the staged process for approving a new qualification is advisory only until Council decides whether or not to approve the new qualification. This must be made clear to all trainees and applicants until the qualification is approved by the GOC's Council.

6. Periodic review, annual return, thematic and sample-based review

Four methods of assurance and enhancement will together provide insight as to whether a qualification continues to meet our outcomes and standards:

- periodic review (of approved qualifications);
- annual return (of approved qualifications);
- thematic review (of standards); and
- sample-based review (of outcomes).

Periodic review. All approved qualifications and qualifications applying for approval will be subject to periodic review. Periodic review considers an approved qualification's ability to meet or continue to meet the outcomes and standards. It

may be desk-based, involve an on site visit or visits, and/or physical or virtual meetings. The frequency and focus of a periodic review will be informed by the risk profile of the qualification, which includes factors such as, but not limited to the results of annual returns, thematic and sample-based reviews, discharge of previously applied conditions and/or serious concerns reviews. The specification for a periodic review will be based on the risk profile of the qualification. The prime purpose of a periodic review is assurance as to whether or not the standards and outcomes are met.

Annual return. All approved qualifications must submit an annual return, which is a key part of our assurance method. We will publish the specification for annual returns from time to time, together with the timeframe for the annual returns. Failure to submit an annual return may contribute to a decision to refuse or withdraw a qualification's approval. Information submitted as part of a qualification's annual return will inform our risk stratification, the timing and specification of periodic review and the basis for our thematic and sample-based reviews. We may publish a summary report of annual returns from time to time.

Thematic and sample-based review. Thematic and sample-based reviews will be a key part of our enhancement method, providing evidence of the *'nature'* and *'sufficiency'* of approved qualifications and their assessment. They are both an assurance and an enhancement activity. Their focus is to draw out key themes, identify and share good practice, and address risk in an approved qualification or a group of approved qualifications. Thematic and sample-based reviews may be on a profession-specific/regional/national and/or UK basis. All providers of approved qualifications must participate in thematic and sample-based reviews if required.

The specification for a thematic review will be based on the criteria contained in the standards and published by us from time to time, together with the timeframe for participation.

The focus of sample-based reviews will be the outcomes, to better understand how an outcome is introduced, developed, assessed and integrated within an approved qualification, how a trainee's achievement of the outcome at the appropriate level (at Miller's Pyramid) is measured and the pedagogic approaches underpinning its teaching and assessment. Like thematic reviews, we will publish the specification for a sample-based review along with the timeframe for participation from time to time. Sample-based and thematic reviews may be undertaken as part of a periodic review or undertaken directly by us and/or co-commissioned from an external contractor.

Alongside annual review, thematic and sample-based reviews will inform our risk stratification of approved qualifications and the timing and focus of periodic reviews. We may publish a summary report of thematic and sample-based reviews from time to time.

7. Scope of evidence

Demonstrating that the outcomes and standards are met should not be unnecessarily onerous, and guidance is given below on the type of evidence a provider may wish to provide. In many cases, this evidence should be readily

available standard, institutional documentation which either provides context, such as published institutional-level policies, or qualification-specific information used at programme level by staff, trainees or stakeholders. Whilst we anticipate that the majority of evidence sources will be generic, some evidence may, of necessity, need to be bespoke for this assurance and enhancement method. However, wherever possible we will limit the requirement for bespoke evidence (e.g. programme mapping), and will continue to do so to ensure our assurance and enhancement method is manageable for providers and is proportionate to the decisions we need to make.

Providers are encouraged to have an early conversation with our Education team to ensure appropriate application of our standards in the light of the context, duration or location (e.g. for qualifications awarded by specialist institutions or higher education providers outside the UK) of the qualification.

Evidence sources providers may wish to consider including or referencing within their evidence framework template may include (but are not limited to) those outlined below.

In relation to the outcomes:

- Programme specifications, module descriptors, unit handbooks, module or unit evaluation reports, curricula, timetables, mapping of outcomes to programme specification, indicative documents / subject benchmarks, examples of teaching and assessment materials.
- Description of assessment strategy and approaches to standard setting, copies of academic regulations, policies for the quality control of assessments, examples of assessment schemes, mark sheets, model answers.
- External examiner reports and evidence of responses to issues raised, reports from internal and external moderators/verifiers, copies of external examiner / internal and external moderator/verifier recruitment, retention and training/support policies, examination board terms of reference, minutes.
- Trainee feedback and evidence of responses to issues raised.
- Evidence of stakeholder engagement and feedback, including from patients and carers, in qualification design, delivery and assessment, and evidence of responses to issues raised.
- Description of facilities and resource utilisation to support the teaching and assessment of the outcomes, supervision policies and safe practice, etc.

In relation to the standards:

- Information about the provider, its ownership, corporate form, organisation, leadership and lines of responsibility, evidence of the contractual relationships underpinning the delivery and assessment of the award of the approved qualification, service/local level agreements, agreements between stakeholders / placement providers, management plans, etc.

- Information about the approved qualification, its credit load, length, form of delivery, type of academic award; evidence of internal or external validation/approval by relevant awarding body, example certificate, programme management plans, diagrams, etc.
- Admission policies, admissions data, recruitment and selection information, application packs, recognition of prior learning (RPL) / accreditation of prior learning (APL) policies, advertising and promotional activity, fee schedules, evidence of selectors' training in equality, diversity and unconscious bias, fitness to train/practise policies, etc.
- Evidence of engagement with service-users, commissioners, patients and the public, trainees and former trainees, employers and other stakeholders in qualification design, delivery and assessment; copies of relevant policies, stakeholder identification strategies, minutes of stakeholder engagement meetings/events, feedback and evidence of responses/action to issues raised.
- Description of the provider's quality control procedures at institutional and qualification level, evidence of responses to external examiner / internal and external moderator reports, end of programme evaluations, National Student Survey results, reports from other quality control or assurance bodies, and responses to issues raised, copies of trainee feedback, minutes of staff-trainee committees, and evidence of action in relation to issues raised, copies of examination regulations, examination board minutes, verification reports, evidence of policies and their implementation in areas such as academic misconduct, adjustments, data protection, equality and diversity, complaints, etc.
- Description of strategies for teaching, learning and assessment, including approaches to assessment design, standard setting, assessment tariff and assessment load, approach to integration; copies of placement contracts; supervision policies; evidence of training and feedback from placement providers; progression data, equality and diversity, etc.
- Evidence that there are mechanisms for securing sufficient levels of resource to deliver the outcomes to the required standards, including historic and projected resource allocation and review, evidence of physical and virtual learning resources, accommodation, equipment and facilities and assessment of their utilisation, copies of risk assessment and risk mitigation plans, etc.
- Evidence that the staff profile can support the delivery of the outcomes and the trainee experience, including workload planning, staff CVs and staff deployment/contribution to the teaching and assessment of the outcomes, SSR, copies of policies describing the training, induction and support for those supervising trainees, external examiners, expert patients and other stakeholders and evidence of their efficacy, etc.

- Any other evidence the provider may wish to include to demonstrate its qualification meets the outcomes and standards.

A decision as to whether to approve a qualification or withdraw approval of a qualification will depend upon the evidence provided. For that reason, we rely on providers' responsiveness to provide the information we need to support our decision-making processes.

Our decisions will be based upon a fair and balanced consideration of the evidence provided, using an approach based on the stratification of risk to decide which criteria within our standards and outcomes we will require providers to evidence, how we will gather that evidence (the frequency and type of assurance and enhancement activity), how we will consult our Education Visitors in the consideration of the evidence provided, and how this informs our decision-making.

8. Decision-making

All decisions regarding qualification approval or withdrawal of approval or any other matter regarding approval of qualifications are the responsibility of Council. Council may delegate some or all of these decisions according to our scheme of delegation.

Decisions will be informed by the advice of our Education Visitors. In making its decision, Council, and those to whom Council has delegated authority, may choose to accept, reject or modify advice from our Education Visitors in relation to the qualification under consideration.

Council, and those to whom Council has delegated authority, may defer a decision in order to request further information/evidence from the provider, or to consult the statutory advisory committee and/ or Education Visitors, or seek other such advice as is considered necessary.

Date of approval

A decision to approve a qualification will include the date from which the qualification is approved, which shall normally be the date of the final examination board for the first graduating cohort of trainees.

Standard conditions

Standard conditions will be applied to approved qualifications and qualifications applying for approval, and adherence to standard conditions will be monitored through periodic review, annual return, thematic and sample-based review.

Conditions, recommendations and requests for information

As part of the assurance and enhancement process, conditions may be imposed, recommendations may be made and/or further information may be requested.

Conditions specified must be fulfilled within the stated timeframe to ensure the outcomes and standards continue to be met by the approved qualification.

Recommendations must be considered by the provider and action reported at the next annual review.

Information requested must be supplied within the stated timeframe. Failure to meet a condition or supply information within the specified timescale without good reason is a serious matter and may lead to the GOC conducting a serious concerns review and/or withdrawing approval of the qualification.

Notifications of changes and events

An important standing condition of approval is the expectation that providers notify us of any significant changes to approved qualifications, their title or other events that may impact upon the ability of a provider to meet our outcomes and standards. Failure to notify us of any significant changes or events in a timely manner may lead to the GOC conducting a serious concerns review and/or withdrawing approval of the qualification.

If we receive complaints, concerns and/or other unsolicited information about an approved qualification, or qualification applying for approval, we will consider this information as part of our risk stratification of qualifications and in the timing and focus of our future assurance and enhancement activity.

Serious concerns review

We reserve the right to investigate any matter brought to our attention which may have a bearing on the approval of a qualification. When making the decision to progress to a serious concerns review, we will consider factors such as, but not limited to:

- results of any assurance and enhancement activity;
- concerns regarding patient safety;
- evidence of significant shortfall in meeting one or more of the outcomes or standards;
- evidence of significant shortfalls in staffing and/or resources; and
- failure to meet a condition or provide information within the specified timescale.

A serious concerns review is a detailed investigation into the concerns raised about an approved qualification. Failure to co-operate with a serious concerns review or take action required as a result may mean that Council decides to withdraw its approval of the qualification.

Withdrawal

A provider may, by giving notice, withdraw its qualification from our assurance and enhancement process and GOC-approval. In these circumstances, the provider must inform us how the interests of trainees currently studying on the approved qualification will be best served. Withdrawal from our assurance and enhancement process does not preclude the provider from making a fresh application for qualification approval at some point in the future.

If, through assurance and enhancement (annual return, thematic and sample-based review and/or periodic review) a provider fails to demonstrate that their qualification meets our outcomes and/or standards for approved qualifications, and/or does not

co-operate with us in the discharge of our regulatory duties, we may decide to withdraw our approval from the qualification. Should we decide to withdraw approval, we will follow the statutory process as outlined in the Act. In these circumstances, we will work closely with the provider, who retains responsibility for, and must act at all times in the best interests of, trainees studying for the approved qualification.

Appeal

Providers have the right to appeal a decision to withdraw our approval of its qualification, in accordance with the provisions of section 13 of the Act. In the event that Council decides to withdraw or refuse approval of a qualification (whether entirely or to a limited extent), an appeal may be made to the Privy Council within one month of the decision of Council being confirmed in writing.

ENDS

Education and training requirements for GOC-approved qualifications for specialist entry to the GOC register in Additional Supply, Supplementary Prescribing and/or Independent Prescribing categories

Consultation report

General Optical Council

October 2021

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Executive Summary

Introduction

As part of its strategic plan, the General Optical Council (GOC) is committed to delivering and implementing a strategic review of optical education and training to ensure that the qualifications it approves are fit for purpose, meet patient or service-user needs, and ensure optical professionals have the expected level of knowledge, skills and behaviours and the confidence and capability to keep pace with changes to future roles, scopes of practice and service redesign across all four nations.

Once an optometrist or dispensing optician is registered with the GOC, they may wish to practice in areas of specialist skill and knowledge, requiring additional training and qualification, which is then registered with the GOC. Continuing its strategic review of optical education and training, the GOC has reviewed the suite of post-registration specialty qualifications that it approves for optometrists – Additional Supply (AS), Supplementary Prescribing (SP) and/or Independent Prescribing (IP).

To ensure that the current requirements for approved specialist qualifications do not cause increased risk by becoming out of date, and to ensure the qualifications the GOC approves in the future respond to the way the optical sector is evolving. The GOC plans to replace the current handbooks for therapeutic and independent prescribing with three new documents:

- Outcomes for Approved Qualifications for Specialist Entry to the GOC Register (AS, SP and IP)
- Standards for Approved Qualifications for Specialist Entry to the GOC Register (AS, SP and IP)
- Quality Assurance and Enhancement Method for Specialist Entry to the GOC Register (AS, SP and IP)

To understand the potential impacts of these proposed changes on all stakeholder groups, the GOC conducted a public consultation entitled ‘Education and Training Requirements for GOC-Approved Qualifications for Specialist Entry to the GOC Register in Additional Supply, Supplementary Prescribing and/or Independent Prescribing Categories.’ Enventure Research, an independent research agency, was commissioned by the GOC to support in the delivery of this consultation, completing independent analysis of the results and feedback. The findings of the consultation are presented in this report.

Methodology

A mixed-methodology approach, including both quantitative and qualitative methods, was used for this consultation, including:

- An online consultation survey, delivered by the GOC via the Citizen Space platform, which received 55 responses over a 12-week period
- Online focus groups with GOC registrants, delivered by Enventure Research
- Online focus groups with optical patients, delivered by Enventure Research

A more detailed description of the methodology for this research can be found in chapter 2 of this report.

Key findings

The following pages present some of the key findings from this consultation, following the structure of the report. For more detail, please see the relevant chapters within this report.

Consultation survey response

Consultation survey respondents answered a series of questions in relation to the three proposed documents that will replace the current handbook for independent prescribing and related policies. For each question, respondents were able to provide a free-text explanation. The key themes emerging from these comments have been drawn out and presented alongside the analysis of closed survey questions.

Outcomes for approved qualifications for specialist entry to the GOC register (AS, SP and IP)

- 75% of respondents thought this document would have a positive impact on the expected knowledge, skill and behaviour of future independent prescribing optometrists
- 13% thought it would have a negative impact, and 4% that it would have no impact
- 40% thought there was something missing from this document or that should be changed. Key explanations provided included:
    - A need for more defined requirements for the amount of clinical experience required
    - Outcomes may be difficult to assess, providers will need to change significantly
    - More clarity and detail needed in certain areas
    - Keep the two-year registration requirement in place
    - Financial impact of proposed changes to courses

Standards for approved qualifications for specialist entry to the GOC register (AS, SP and IP)

- 69% of respondents thought this document would have a positive impact on the expected knowledge, skill and behaviour of future independent prescribing optometrists
- 15% thought it would have a negative impact, and 13% that it would have no impact
- 36% thought there was something missing from this document or that should be changed. Key explanations provided included:
    - Increased flexibility for clinical experience setting may narrow the scope of experience received by trainees
    - Concerns raised about the removal of the two-year registration requirement
    - More detail required for the level of experience required for designated prescribing practitioners (DPPs)
    - More detail about how the proposals would affect those already in training

Quality assurance and enhancement method for approved qualifications for specialist entry to the GOC register (AS, SP and IP)

- 21% thought there was something missing from this document or that should be changed. Key explanations provided included:
    - The common final assessment should be retained to ensure consistency
    - More detail required about providers who may wish to partner with other organisations
    - Proposed timeframe may be too ambitious

Replacing the quality assurance handbooks

- 76% of respondents agreed with the proposal to replace the handbooks for independent prescribing optometrists and related policies with the proposed three new documents (Outcomes, Standards, Quality assurance and enhancement method). 11% disagreed with this proposal, and another 11% neither agreed nor disagreed

- Explanations provided included:
    - Necessary changes that have been required for some time
    - Changes have the potential to improve the current system
    - Proposals will create a simpler, more streamlined, easy to understand system
    - More detail required in certain areas
    - Documents must be carefully reviewed to ensure they remain current/up to date over time
    - Concern the documents may reduce standards
- 80% of respondents agreed with the proposal to remove the requirement to supply details of prescribing decisions undertaken in the previous 12 months. Just 9% disagreed with this proposal, and another 9% neither agreed nor disagreed
- Explanations provided included:
    - The current requirement is onerous, time-consuming, and unnecessary, with prescribing decisions recorded in other ways
    - Other healthcare professions do not have this requirement
    - CET/CPD and professional responsibility are sufficient to ensure prescribing knowledge is reflected upon
    - Concerns raised about a lack of audit and quality assurance
    - Concerns raised about revalidation and record keeping for infrequent prescribers

Impact of proposals

- The majority of survey respondents reported no positive or negative impacts of the proposals on certain individuals or groups
- Very small numbers reported that the proposals may discriminate or unintentionally disadvantage by age (4%), sex (4%), disability (2%), pregnancy and maternity (2%), and race (2%)
- Similar numbers reported that the proposals may benefit those who are pregnant or on maternity leave (9%), by age (5%), disability (2%), marriage or civil partnership (2%), and sex (2%)
- Explanations provided included:
    - Those on low incomes or working part-time may be disadvantaged due to the cost of training
    - More detail required to confirm the proposals would not disadvantage those already undertaking their training
    - Need to ensure geographical distribution of DPPs to avoid regions/nations being disadvantaged
    - Providers may be disadvantaged if they struggle to develop their qualifications within the timeframe
    - Younger optometrists and those who are pregnant or on maternity leave may benefit due to the removal of the two-year registration requirement
- 56% of respondents thought that the proposed changes will positively impact other individuals or groups. Explanations provided included:
    - Patients, with wider access to care in the community
    - Trainees, making it easier to qualify and providing a better qualification
    - Secondary care, with fewer referrals from primary care
    - Employers, having trained independent prescribing optometrists
- 20% of respondents thought that the proposed changes will negatively impact other individuals or groups. Explanations provided included:
    - Students/trainees, due to the potential increase in the cost of training and difficulty finding a DPP/placement
    - Providers, who will need to change/develop their courses and may face added pressures
    - The profession/workforce, if students delay starting their specialist qualifications
    - DPPs and their employers, due to financial and time implications

Registrant focus group feedback

The following paragraphs summarise feedback from five registrant focus group discussions. During the groups, participants discussed the nine key proposals of the consultation.

Changing from two qualifications to a single qualification

- Some participants provided positive feedback about this proposal, viewing it as a logical step to simplify and streamline the qualification process
- It was also suggested that this change would help to clarify the independent prescribing qualification for other professions, patients, and employers
- Some concerns were raised about the potential for varying or falling standards as a result of this change

Academic award or regulated qualification

- A number of participants felt that setting the qualification at a high level is justified and will help independent prescribing optometrists to be professionally recognised
- Some participants suggested that this change may attract more optometrists to undertake the qualification if set at a high level, but it may also deter others if they perceive that it will be overly academic or require a lot of their time
- It was suggested that the qualification should be set at an even higher level than proposed so that it exceeds the new optometry degree

Removing the duration and location requirements for clinical experience

- This change was viewed by some participants as providing increased flexibility for where clinical experience can be gained, due to the current difficulties experienced when arranging hospital placements
- It was regularly suggested that this was a logical change which placed more value on the quality of clinical experience, rather than the amount of time spent in a clinical setting
- However, some concerns were raised about the impact this change may have on the amount of hospital experience gained during training, which was seen as extremely valuable to the development of independent prescribing optometrists
- It was recommended that a balance could be found between providing increased flexibility and ensuring certain requirements were still met in relation to clinical experience, possibly by specifying certain patient interactions to be achieved, rather than focusing on an approximate amount of time

Requirement for a qualified designated prescribing practitioner (DPP) to supervise

- This change was generally viewed in a positive light, as it would significantly improve the ability of trainees to gain the clinical experience they need by allowing supervision to be conducted by those who are not ophthalmologists
- Some felt that supervision from an independent prescribing optometrist may actually be more beneficial for trainees than from an ophthalmologist, as they would be able to provide guidance and support that is more relevant to the realities of the role, in a more appropriate setting
- Participants discussed the required level of experience of DPPs, querying what ‘suitably experienced’ and an ‘active prescriber’ would mean. There was a suggestion that there could be a defined set of criteria for DPPs, such as a specific number of years actively prescribing or their level of experience with different pathologies, and that a training course could be provided for DPPs
- Some participants expressed concerns about the lack of hospital experience that this change might mean for trainees, as this setting can offer a much wider range of pathology and patient interactions

Providers must involve feedback from stakeholders

- This proposal was viewed by the majority of participants as an expected aspect of the provision of a training course, with clear benefits to including feedback from all relevant stakeholders, and was therefore viewed in a positive light
- A smaller number of participants questioned the relevance of gaining feedback from the stakeholders listed in the proposal

Use of an outcomes-based approach via Miller's Pyramid of Clinical Competence

- Feedback for this proposal was generally positive, as participants felt adopting Miller's Pyramid was a logical choice as it was already used for the optometry degree and in other healthcare professions
- This approach was also perceived to be easy to understand, providing consistency across optometry qualifications and flexibility for providers, moving away from a more prescriptive approach of measuring competence

Providers to be responsible for the assessment and achievement of approved qualifications

- Some participants were in support of this proposal, viewing it as a sensible approach, assuming that providers are held accountable by the GOC
- Concerns were expressed about how consistency would be maintained in the assessment of specialist qualifications if the College of Optometrists was no longer solely responsible for the final assessment of independent prescribing optometrists
- However, participants generally felt that this could be overcome by careful regulation from the GOC

Providers are responsible for recruiting trainees to course programmes, recognition of prior learning, removal of two-year registration requirement

- Participants had no strong opinions about providers being responsible for the recruitment of trainees, explaining that this seemed logical and that they already assumed this was the case
- The proposal to recognise prior learning to assist the progression of trainees whose progress to specialist registration has stalled was generally viewed as a positive change, as it would make the process more flexible for those who may have to take time away from work, those who struggle to find clinical experience, and those who have begun their education outside the UK
- Some questioned how prior learning would be measured to ensure the approach was fair
- Opinion towards removing the two-year registration requirement for optometrists before beginning their independent prescribing training was split amongst participants. Some were in favour as it provided opportunities for those who are keen to start their training as soon as possible, capturing their enthusiasm at the right time, and that newly qualified optometrists are actually sufficiently confident and knowledgeable to begin training at this stage
- It was also highlighted that this change would allow the training to become part of the optometry degree, which some participants were in favour of as it would produce optometrists better equipped to work in the current optical sector in the UK
- Other participants expressed concerns about removing the two-year registration requirement, as they felt the experienced gained by optometrists in the first two years of their registration was valuable and an important introduction to real-world optometry
- It was suggested that a measure of the quality of experience would be a more appropriate requirement than the number of years registered, as the level of experience during this time can vary significantly

Removal of the requirement to supply details of 12 months of prescribing decisions

- This was a very well-received proposal by the majority of participants, who said that it would remove an onerous and time-consuming task from their daily work life, which was also viewed as unnecessary as the information was recorded by other means
- Some participants felt that this proposal showed an increased level of trust in optical professionals from the GOC, and was more in line with prescribers in other healthcare professions
- A small number of participants expressed concern about the loss of opportunities to learn and reflect upon their prescribing decisions if this requirement is removed

Patient focus group feedback

The following paragraphs summarise feedback from two patient focus group discussions.

- Patient participants reported experiences of receiving high standards of care when visiting an optician, with some small frustration expressed at the measures in place during the Covid-19 pandemic
- Although there was little awareness of how optical professionals are regulated, there was an assumption that they are required to be suitably qualified to provide services
- There was some awareness amongst participants that optical professionals can diagnose some diseases and refer patients to other healthcare professionals as necessary
- Most participants explained that they would visit a GP if they experienced a problem with their eye or vision, but others highlighted benefits of seeing an optical professional in this situation
- There was an assumption amongst some participants that some optical professionals would be able to prescribe medication in some cases for eye conditions, linked to the understanding that some pharmacists are able to do so
- Patient participants were in favour of optical professionals being able to prescribe, as it improved access to required medication for patients, allowed them to be seen more quickly, and would relieve pressure on GPs and NHS services
- It was suggested that optical professionals' prescribing services should be advertised to increase public awareness, which would benefit both patients and optical businesses
- Participants explained that they had generally experienced good communication when visiting an optical professional
- Participants struggled to recall being asked for consent when visiting an optical professional, but felt that they had provided implied consent by visiting in the first place
- Attitudes towards shared decision making were mixed, with some viewing it as important, but others feeling that it was better to defer to the expertise of the optical professional

1. About this consultation

1.1 Background

1.1.1 The General Optical Council (GOC) is the regulator for the optical professions of optometry and dispensing optics in the UK, with the overarching statutory purpose to protect, promote and maintain the health and safety of the public.

1.1.2 To be registered as an optometrist or a dispensing optician with the GOC and practise in the UK, optometrist and dispensing optician students must complete General Optical Council approved qualification(s).

1.1.3 In recent years, the optical sector has changed and continues to evolve, resulting in the services that GOC registrants are expected to deliver changing to meet patient and service user needs. The main driving forces behind these changes are the increased prevalence of certain long-term health conditions and co-morbidities amongst an ageing population, the expanding roles of optical professionals, developments in technology, and system changes to the way healthcare is commissioned and delivered across the UK.

1.1.4 As part of its strategic plan, the GOC is committed to delivering and implementing a strategic review of optical education and training to ensure that the qualifications it approves are fit for purpose, meet patient or service-user needs, and ensure optical professionals have the expected level of knowledge, skills and behaviours and the confidence and capability to keep pace with changes to future roles, scopes of practice and service redesign across all four nations.

1.1.5 In 2016, the GOC launched the Education Strategic Review (ESR), which aimed to review and make recommendations on how the system of optical education and training should evolve so that registrants are equipped to carry out the roles they will be expected to perform in the future.

1.1.6 In February 2021, the GOC updated its requirements for approved qualifications for optometrists and dispensing opticians.

1.1.7 Once an optometrist or dispensing optician is registered with the GOC, they may wish to practice in areas of specialist skill and knowledge, which requires additional training and qualification. Once specialist training is completed and their competence assessed, practitioners then register their specialty with the GOC. Continuing its strategic review of optical education and training, the GOC has reviewed the suite of post-registration specialty qualifications that it approves for optometrists – Additional Supply (AS), Supplementary Prescribing (SP) and/or Independent Prescribing (IP).

1.1.8 To ensure that the current requirements for approved specialist qualifications do not cause increased risk by becoming out of date, and to ensure the qualifications the GOC approves in the future respond to the way the optical sector is changing, the GOC plans to replace the current ‘A Handbook for Optometry Specialist Registration in Therapeutic Prescribing’ (2008) and the ‘Competency Framework for Independent Prescribing’ (2011) with three new documents:

- Outcomes for Approved Qualifications for Specialist Entry to the GOC Register (AS, SP and IP)
- Standards for Approved Qualifications for Specialist Entry to the GOC Register (AS, SP and IP)

- Quality Assurance and Enhancement Method for Specialist Entry to the GOC Register (AS, SP and IP)

1.1.9 The GOC has conducted a public consultation, entitled 'Education and Training Requirements for GOC-Approved Qualifications for Specialist Entry to the GOC Register in Additional Supply, Supplementary Prescribing and/or Independent Prescribing Categories', to understand the potential impacts of the proposed changes on all key stakeholder groups. The GOC and Enventure Research, an independent research agency, designed an online survey to collect responses to the consultation. Additionally, Enventure Research conducted supplementary consultation activity in the form of qualitative research.

1.1.10 Enventure Research has independently analysed the data collected via the online consultation survey, combined with the feedback collated via the qualitative consultation activity. The findings of the consultation are presented in this report.

1.2 The documents for consultation

1.2.1 The consultation sought views on replacing 'A Handbook for Optometry Specialist Registration in Therapeutic Prescribing' (2008) and the 'Competency Framework for Independent Prescribing' (2011) and associated policies, with:

- Proposed '**Outcomes for Approved Qualifications for Specialist Entry to the GOC Register (AS, SP and IP)'**, which describes the expected knowledge, skills and behaviours an optometrist must have for the award of an approved qualification for specialist entry to the GOC register in AS, SP and/or IP categories.

- Proposed '**Standards for Approved Qualifications for Specialist Entry to the GOC Register (AS, SP and IP)'**, which describes the expected context for the delivery and assessment of the outcomes leading to an award of an approved qualification for specialist entry to the GOC register in the AS, SP and/or IP categories.

- Proposed '**Quality Assurance and Enhancement Method for Specialist Entry to the GOC Register (AS, SP and IP)'**, which describes how the GOC will gather evidence to decide in accordance with the Opticians Act 1989 whether a qualification for specialist entry to the GOC register in the AS, SP and/or IP categories meets the outcomes for approved qualifications and standards for approved qualifications.

1.2.2 The aim of these documents is to ensure that specialist qualifications the GOC approves in the future are responsive to the rapidly changing landscape in the commissioning of eye care services in each of the devolved nations. The GOC believes that the documents respond to the changing needs of patients and service users and changes in higher education, and will meet the expectations of the student community and their future employers.

1.2.3 In preparing these documents, the GOC has utilised analysis of responses to its Call for Evidence, Concepts and Principles Consultation 2017-2018, feedback from the 2018-2019 consultation on proposals stemming from the ESR and associated research, a public consultation held in July-September 2020, the advice provided by an Expert Advisory Group (EAG) and feedback from a range of stakeholder groups including our Education Visitors, an Advisory Panel (including Education and Standards Committee), the optical sector, and sight-loss charities.

1.2.4 For each section of this report that presents the consultation feedback, more detail will be provided about each document.

1.3 Key proposals

1.3.1 The three new documents set out a number of key proposals that will change the education and training requirements for GOC-approved qualifications for specialist entry to the GOC register in Additional Supply, Supplementary Prescribing and/or Independent Prescribing Categories. These proposals are summarised below:

a. Candidates will acquire a single qualification approved by the GOC leading to specialist entry to the GOC register in AS, SP and/or IP categories, instead of two GOC-approved qualifications (gained either sequentially or simultaneously) currently required for entry to a specialty registration category (AS, SP or IP).

b. The approved qualification will be either an academic award or a regulated qualification at a minimum of Regulated Qualification Framework (RQF) (or equivalent) level 7

c. There will be no proposed minimum/maximum or recommended time or credit volume for an approved qualification or specified location or duration of clinical experience, other than the requirement that an approved qualification leading to specialist entry to the GOC register in AS, SP and/or IP categories must integrate approximately 90 hours of learning and experience in practice.

d. Trainees upon application must have identified a suitably experienced and qualified designated prescribing practitioner (DPP) who has agreed to supervise their learning in practice. A trainee's DPP must be a registered healthcare professional in Great Britain or Northern Ireland with independent prescribing rights and be an active prescriber competent in the clinical area(s) they will be supervising the trainee in, have the relevant core competencies and be trained and supported to carry out their role effectively. If more than one registered healthcare professional with IP rights is involved in supervising a trainee, one independent prescriber must assume primary responsibility for coordinating the trainee's supervision. That person will be the trainee's DPP. In addition, we propose that there must be agreements in place between the trainee, their DPP and the qualification provider that describe their respective roles and responsibilities during periods of learning and experience in practice. These must be regularly reviewed and supported by management plans, systems and policies which prioritise patient safety.

e. The provider of the approved qualification must, in the design, delivery and assessment of an approved qualification, involve and be informed by feedback from a range of stakeholders including patients, employers, trainees, supervisors, members of the eye care team and other healthcare professionals.

f. An outcomes-based approach is used to specify knowledge, skills and behaviours using an established competence and assessment hierarchy known as 'Miller's Pyramid of Clinical Competence' (knows; knows how; shows how; and does), mapped to relevant external prescribing frameworks, including the draft Royal Pharmaceutical Society's (RPS) Competency Framework for all Prescribers (2021).

g. Providers of approved qualifications are responsible for the measurement (assessment) of students' achievement of the outcomes at the required level (on Miller's Pyramid) leading to an award of an approved qualification.

h. Providers of approved qualifications will be responsible for recruiting and selecting trainees onto a programme leading to an award of an approved qualification. Recognition of prior learning can be deployed to assist the progression of trainees whose progress to specialist registration has stalled, and the requirement for optometrist IP trainees to have been registered for at least two years prior to commencing clinical experience/hospital placements has been removed.

i. At the point of retention, registrants in the AS, SP and/or IP categories will no longer need to supply details of prescribing decisions undertaken in the previous 12 months.

2. Methodology

2.1 Overview

2.1.1 A phased mixed-methodology approach, including both quantitative and qualitative methods, was used for this consultation, including:

- An online consultation survey
- Focus groups with GOC registrants
- Focus groups with optical patients

2.2 Online consultation survey

2.2.1 A consultation questionnaire was designed by the GOC, with advice from Enventure Research, to ask questions relating to the proposed documents and the impact they would have. It was designed to allow completion by a range of stakeholders, including both individual and organisational responses. For reference, a copy of the consultation questionnaire can be found in **Appendix A**.

2.2.2 The online survey was managed and promoted by the GOC and hosted online via the Citizen Space platform. The consultation ran for 12 weeks from 12 July to 4 October 2021. During this time, 55 responses were received.

2.2.3 The majority of responses were from individuals (78%) and 22% were from organisations. ***Figure 1*** below shows that, of individual responses, 44% came from optometrists, followed by 37% from independent prescribing optometrists. Small numbers of trainee independent prescribers (12%) and optometry students (7%) took part.

Figure 1 – Individual respondent type
Base: All individual respondents (43)

Individual respondent type	Number	%
Optometrist	19	44%
Independent prescribing optometrist	16	37%
Trainee independent prescriber	5	12%
Optometry student	3	7%

2.2.4 As shown in ***Figure 2***, of the 12 organisational responses received to the consultation survey, four came from providers of GOC-approved qualifications, two came from optical business registrants, and two came from optical defence/representative bodies. Also represented in the feedback were an optical professional body, a current CET/CPD provider, and a commissioner of optical care.

Figure 2 – Organisation respondent type
Base: All organisational respondents (12)

Organisation respondent type	Number	%
Provider of GOC-approved qualification(s)	4	33%
Optical business registrant	2	17%
Optical defence/representative body	2	17%

Organisation respondent type	Number	%
Optical professional body	1	8%
Current CET or CPD provider	1	8%
Commissioner of optical care	1	8%
Other	1	8%

2.2.5 The following organisations took part in the survey and consented to being identified:

- BBR Optometry Ltd
- West Yorkshire & Harrogate Local Eye Health Network
- College of Optometrists
- NHS Education for Scotland
- Association of Optometrists
- FODO – The Association for Eye Care Providers

2.2.6 The following organisations submitted a response to the consultation outside the survey and also gave their consent to being identified:

- Professional Standards Authority for health and social care (PSA)
- Health Education England

2.3 Qualitative consultation activity

2.3.1 To supplement the quantitative online consultation survey, a programme of qualitative consultation activity was conducted. This included a series of online focus groups with GOC registrants and optical patients.

Online focus groups with registrants

2.3.2 Registrants from the following roles were recruited to attend the focus groups:

- Optometrists
- Independent prescribing optometrists
- Trainee independent prescribing optometrists
- Optometry students

2.3.3 Five focus groups were held, including representation of registrants from England, Scotland, Wales and Northern Ireland. As far as possible, a range of demographics were also represented across the groups, including a mix of gender, age group, and ethnicity.

2.3.4 A discussion guide was designed to cover the key proposals set out in the consultation in order to direct and stimulate discussion, and gain a more in depth level of insight into attitudes towards the consultation. A copy of the registrant discussion guide can be found in **Appendix B**.

2.3.5 In total, 23 registrants took part in the focus groups. The qualitative consultation activity with registrants took place in early September 2021.

Online focus groups with patients

2.3.6 Two focus groups were conducted with optical patients who had visited an optical professional in the last two years to explore a range of topics relevant to the consultation, such as communication between optical professionals and patients, shared decision making, consent, perceptions of optical professionals, and awareness and understanding of optometrists' ability to prescribe.

2.3.7 Participants were recruited from a broad range of backgrounds and locations, with each of the devolved nations represented, were equally split by gender, and included a mix of age groups.

2.3.8 A discussion guide was designed by Enventure Research, a copy of which can be found in **Appendix D**.

2.3.9 Six participants attended each focus group. The qualitative consultation activity with patients took place in September 2021. The feedback from these groups can be found in Chapter 6.

3. Reading this report

3.1 Interpreting survey data

Interpreting percentages

3.1.1 This report contains a number of tables and charts used to display consultation survey data. In some instances, the responses may not add up to 100% or the base size may differ between questions. There are several reasons why this might happen:

- The question may have allowed each respondent to give more than one answer
- A respondent may not have provided an answer to the question, as questionnaire routing allowed certain questions to only be asked to specific groups of respondents
- Only the most common responses may be shown in the table or chart
- Individual percentages are rounded to the nearest whole number so the total may come to 99% or 101%
- A response of less than 0.5% will be shown as 0%

3.1.2 For each survey question, the results are shown at an overall level (including all consultation survey responses), and split between individual and organisation responses. Due to the overall sample size of 55, with 43 responses from individuals and 12 from organisations, no direct comparisons between the two respondent types have been made. The results displayed in the charts are therefore indicative only.

Combining response options

3.1.3 The majority of consultation survey questions required respondents to indicate the impact of a proposed change on a scale of *'very positive'* to *'very negative'*. As differences between responses within this type of Likert scale are often subjective (for example, the difference between those who answered *'very positive impact'* and *'positive impact'),* these response options have been combined to create a total response. They are presented in charts and tables as *total* results (e.g. *'total positive'* and *'total negative'*).

Open-end responses

3.1.4 A number of questions in the survey allowed respondents to provide open-end responses in order to explain their answers to closed-end questions. These responses were thematically analysed, grouping similar responses together. Due to the small number of responses received to each open-end question, the main themes that have emerged are detailed in the report, supported by example verbatim comments.

3.2 Interpreting qualitative feedback

3.2.1 When interpreting the qualitative research data collected via focus groups, the findings differ to those collected via a quantitative online survey methodology because they are not statistically significant. They are collected to provide additional insight and greater understanding based on in-depth discussion and deliberation, not possible via a quantitative survey. For example, if the majority of optometrist participants hold a certain opinion, this may or may not apply to the majority

of all optometrists. Qualitative findings are collected by speaking in much greater depth to a smaller number of individuals.

3.2.2 Focus group discussions were digitally recorded and notes made to draw out common themes and useful quotations. Only common themes are detailed in the report, rather than every viewpoint that was expressed. Verbatim quotations have been used as evidence of qualitative research findings where relevant throughout the report. Quotations from the registrant and patient focus groups are anonymous.

3.3 Terminology and clarifications

3.3.1 Throughout this report, those who took part in the online consultation survey are referred to as ‘respondents’.

3.3.2 Those who took part in focus groups are referred to as ‘participants’.

3.3.3 In some verbatim quotations, the term ‘optom’ has been used to refer to an optometrist and ‘DO’ to refer to a dispensing optician.

3.3.4 The initialisms AS, SP and IP are used to refer to the specialisms of Additional Supply, Supplementary Prescribing and Independent Prescribing.

3.3.5 The term ‘stakeholder’ refers to those who took part in the consultation via the online consultation survey as a representative of the wider optical sector.

3.3.6 The term ‘provider’ refers to providers of GOC-approved qualification(s).

4. Consultation survey response

This chapter of the report details the analysis of responses to the GOC's online consultation survey.

4.1 Outcomes for Approved Qualifications for specialist entry to the GOC register (AS, SP and IP)

Document summary

4.1.1 The proposed 'Outcomes for Approved Qualifications for Specialist Entry to the GOC Register (AS, SP and IP)' describe the expected knowledge, skills and behaviours optometrists must have to be awarded an approved qualification for specialist entry to the GOC register in the AS, SP and/or IP categories.

4.1.2 GOC-approved qualifications will prepare trainees to meet these outcomes for specialist entry to the GOC register. The outcomes are organised into seven categories:

1. Uphold professional standards
2. Person centred care
3. Establishes and manages patient options
4. Prescribing practice
5. Ethics and standards
6. Manages risk
7. Learning and development

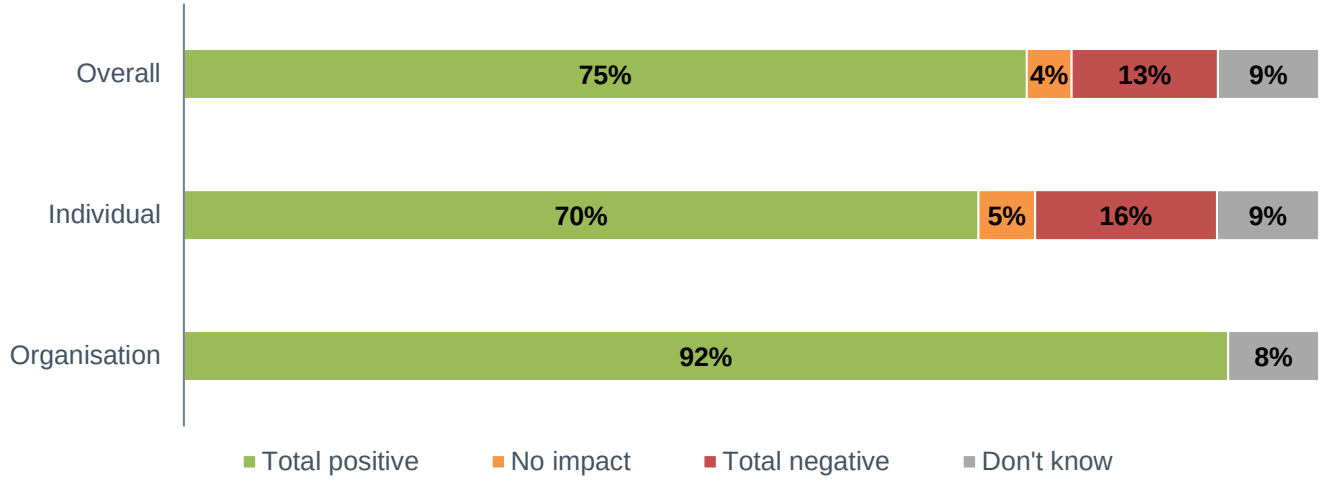
4.1.3 Each category includes an overarching statement and outcomes which must be met if a trainee is to be awarded the approved qualification. Each outcome is described using a level based on an established competence and assessment hierarchy known as 'Miller's Pyramid of Clinical Competence'.

Consultation survey response

4.1.4 Respondents were asked what impact they thought the 'Outcomes for Approved Qualifications for Specialist Entry to the GOC Register (AS, SP and IP)' would have on the expected knowledge, skill and behaviour of future independent prescribing optometrists.

4.1.5 As shown in ***Figure 3***, three quarters of respondents thought the impact of the 'Outcomes for Approved Qualifications' on the expected knowledge, skill and behaviour of future independent prescribing optometrists would be positive (75%). Just 13% thought that it would have a negative impact, and 4% that it would have no impact. The chart also presents the response to this question from individuals and organisations, where the majority of both respondent types see a positive impact.

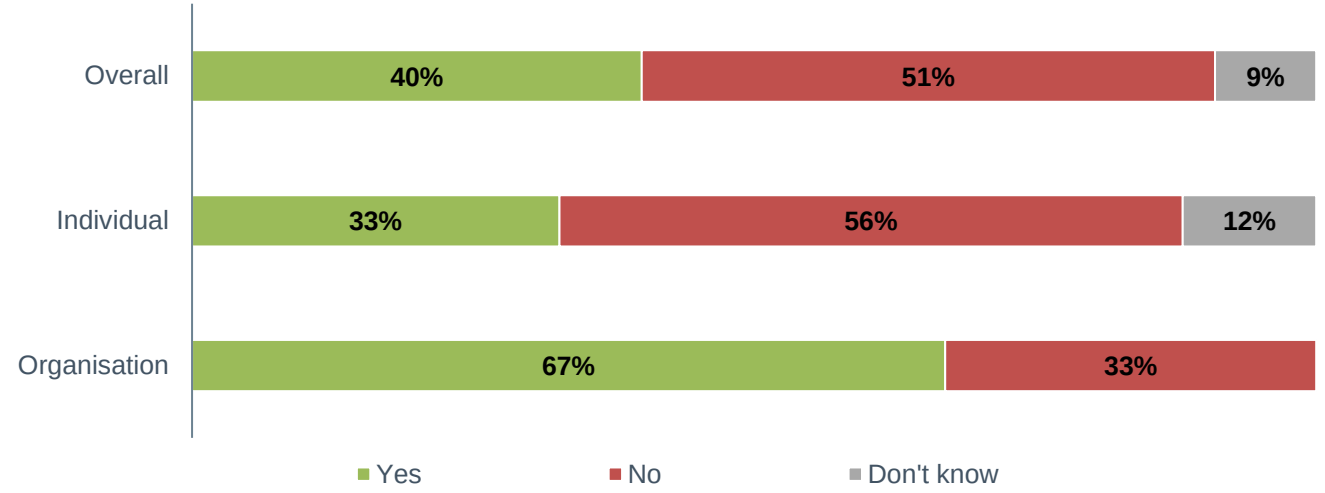
Figure 3 – What impact, if any, will introducing the proposed 'Outcomes for Approved Qualifications for Specialist Entry to the GOC Register (AS, SP and IP) have on the expected knowledge, skill and behaviour of future independent prescribing optometrists?
Base: Overall (55); Individual (43); Organisation (12)



4.1.6 Respondents were asked if there was anything in the criteria in the 'Outcomes for Approved Qualifications' that was missing or should be changed.

4.1.7 As can be seen in ***Figure 4***, 40% of respondents felt that there was something missing or that should be changed. Eight of the 12 organisation respondents (67%) said that there was something missing or that should be changed, compared with just 33% of individual respondents.

Figure 4 – Is there anything in the criteria in the 'Outcomes for Approved Qualifications' that is missing or should be changed?
Base: Overall (55); Individual (43); Organisation (12)



4.1.8 Respondents who thought there was something missing or that should be changed in the criteria were asked to explain by providing free-text comments. In total, 26 responses were provided.

4.1.9 It is positive to note that, as well as highlighting some areas that they felt were missing or needed to be changed, many comments stated that they were supportive of the proposed changes which increased flexibility and the move towards an outcomes-based approach. Agreement was expressed at aligning the outcomes with the Royal Pharmaceutical Society's competency

framework for prescribers, with some suggesting that this could go further towards complete alignment.

> *FODO is very supportive of this proposed updating for the AS, SP and IP training. We see this providing a more flexible framework for providers and registrants taking the qualifications.*
>
> FODO – The Association for Eye Care Providers

> *The proposed 'Outcomes for Approved Qualifications for Specialist Entry to the GOC Register (AP, SP and IP)' will allow greater alignment with extant processes which enable and assure non-medical prescribing qualifications for other healthcare professions (HCPs), and mirror RPS approaches. HSC Board welcomes the move to an outcomes-based approach (key proposal f) and support that this is strongly aligned with the Royal Pharmaceutical Society's (RPS) Competency Framework for all Prescribers (2021). In fact, we would suggest that it would be preferable to seek complete alignment with the RPS framework.*
>
> Commissioner of optical care

> *We agree with the proposal that the content of the learning outcomes is drawn predominantly from the Royal Pharmaceutical Society's competency framework (2021) for all prescribers . This seems logical as the RPS framework is the common learning standard that informs non-medical prescribing competence across UK healthcare.*
>
> Association of Optometrists

> *We support the movement towards a more outcomes-based approach. We welcome the alignment with the RPS competency framework.*
>
> Professional Standards Authority (for health and social care)

4.1.10 Some responses suggested that the Outcomes document should provide more defined requirements relating to the level of learning and experience that trainees must undertake to qualify to ensure that an appropriate amount of relevant and diverse experience is obtained, leading to a well-rounded independent prescribing optometrist.

> *Is there a defined minimal core of learning and experience that is required for all trainees irrespective of their expected area of clinical practice?*
>
> Independent prescribing optometrist

> *The proposed 'Outcomes for Approved Qualifications for Specialist Entry to the GOC Register (AP, SP and IP)' should create a framework to demonstrable minimum patient episodes for conditions should be included to assure a wide and appropriate level of prescribing experience is achieved during training.*
>
> Commissioner of optical care

> *Given the potential for trainees to undertake clinical practice in a wide range of environments, including primary, secondary, community and non-NHS environments, it would be appropriate to pay more attention to developing and understanding trainee scope of practice, perhaps by stipulating a core level of diversity of clinical experience that might be required.*
>
> Optometrist

4.1.11 A number of responses highlighted that the changes proposed in the Outcomes document may be challenging to deliver in reality, including the development and delivery of assessments to measure the achievement of the outcomes. It was highlighted that providers would need to significantly change and adapt courses to provide this, particularly to incorporate a sufficient level of patient pathology exposure.

> *There may be significant logistical and financial challenges to developing and delivering assessment regimes that are proportionate, but that address the full range of outcomes with sufficient rigour and consistency, including those that require observation of the trainee in clinical practice. We would also suggest that further review of the level of the outcomes should be undertaken to ensure that programmes can be responsive to the changing needs of patients and the profession, and evolving eye care pathways, and to encourage the deployment of modern and innovative approaches to assessment. Significant amendments at a substantial cost to providers or Optometrists (IP students) would have to be made to current programmes to facilitate assessments based on an outcomes-based approach.*
>
> Provider of GOC-approved qualification(s)

> *The move to an outcomes-based approach to qualification will require significant amendments to current programmes.*
>
> Optometrist

> *To become a proficient independent prescriber requires seeing enough pathology (both in numbers and variety) to become competent in recognising and treating it. Recognising the limits of one's scope of knowledge also depends on seeing enough "unusual" problems. Undergraduate education does not normally expose students to sufficient cases and clearly course design will need to change in order to provide enough exposure.*
>
> Association of Optometrists

4.1.12 In terms of what was missing from the Outcomes document, some responses stated that more clarity or detail was needed in specific areas. For example, it was suggested that there needed to be clearer requirements on the level of clinical experience required during training, a statement about how many trainees a designated prescribing practitioner (DPP) can supervise, and a specific definition about the scope of 'arrangement of aftercare'.

> *More information is required regarding the 90 hours of training and how this is to be split as well as information regarding how many students a DPP may supervise at any one time. The high demand for IP qualifications and likelihood of incorporating this into undergraduate courses will mean a high volume of students requiring supervision at the same time.*
>
> Provider of GOC-approved qualification(s)

> *A more specific definition of the scope of "arrangement of aftercare" in the introduction to outcome three would also be useful.*
>
> College of Optometrists

4.1.13 In terms of what should be changed in the Outcomes document, some responses suggested that the removal of the mandatory two-year period of registration before undertaking the independent prescribing qualification was wrong, and that this requirement should remain in place. The main reasons suggested typically focused on newly qualified optometrists lacking the required level of knowledge and experience, which they felt time working as a registered optometrist would give them, particularly in relation to patient safety.

> *Two years' post registration experience before undertaking the IP course should be retained. Newly qualified optometrists do not have the breadth of knowledge required to safely prescribe.*
>
> Independent prescribing optometrist

> *I believe there is a real need for optometrists to experience real-life optometric practice and autonomy before being able to prescribe. The Outcome 0.3.7 "Recognise, understand the condition being treated, their natural progression, how to assess their severity, deterioration and anticipated response to treatment (Does)" relates to this. In my opinion it is not going to be possible for a newly qualified fresh optom to really attain this outcome. I really think the GOC need to consider removing the 2 year between limit between qualification and starting the clinical placement.*
>
> Independent prescribing optometrist

> *It might be the case that not all undergraduate students are ready for the extra level of responsibility involved in independent prescribing at the point when they are studying for their BSc. The qualification should not be available to people who are not yet ready to demonstrate the extra competencies described in the outcomes. But nor should people be excluded from opportunities to develop those competencies later in their career.*
>
> Association of Optometrists

4.1.14 Some responses highlighted concerns about the financial cost the changes proposed in the Outcomes document would have. It was suggested that the change would require significant amendments to training courses, where additional training would need to be implemented to meet the required outcomes, and that it was likely that the cost of these changes would be passed on to trainees. This may, in turn, deter optometrists from undertaking the qualification if it is perceived to be too expensive, something which a respondent suggested was already the case.

> *The move to an outcomes-based approach to qualification will require significant amendments to current programmes and the increased cost of this will have to be met by the trainee. This increased cost may limit uptake and accessibility and the need for the change is not well evidenced.*
>
> Optometrist

> *Cost of study prohibitive for lots who would otherwise take on IP*
>
> Optometrist

4.1.15 Other comments made about the Outcomes document by single respondents included:

- IP optometrists should not be supervisors/ophthalmology input essential
- Hospital placements should remain
- Should be reference to non-pharmacological therapeutic treatments
- Final College assessment for IP should remain
- Implement a maximum time limit to completion or additional monitoring/testing
- Concern about the use of Miller's Pyramid being too restrictive
- Too many separate outcomes
- AS/SP requirements should be modified to fit into the new framework

4.2 Standards for Approved Qualifications for Specialist Entry to the GOC Register (AP, SP and IP)

Document summary

The 'Standards for Approved Qualifications for Specialist Entry to the GOC Register (AP, SP and IP)' describe the expected context for the delivery and assessment of the outcomes leading to an award of an approved qualification for specialist entry to the GOC register in AS, SP and/or IP categories.

GOC-approved qualifications will prepare trainees to meet these outcomes for specialist entry to the GOC register. The standards are organised under five categories:

1. Public and patient safety
2. Selection and admission of trainees
3. Assessment of outcomes and curriculum design
4. Management, monitoring and review of approved qualifications
5. Leadership, resources and capacity

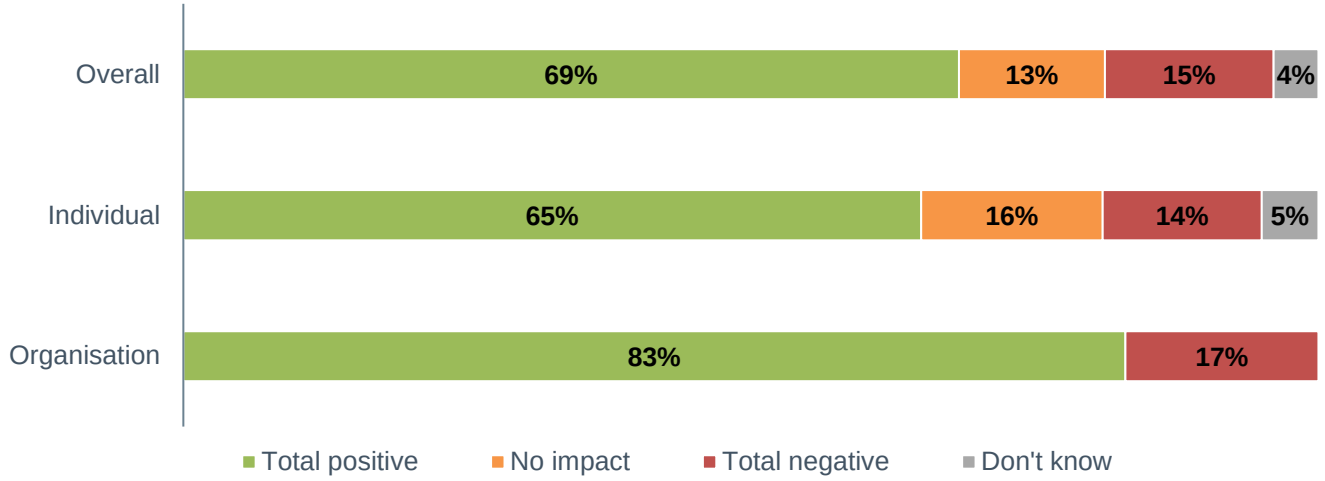
Each category is supported by criteria which must be met for a qualification to be approved.

Consultation survey response

4.2.1 Survey respondents were asked what impact, if any, introducing the proposed 'Standards for Approved Qualifications for Specialist Entry to the GOC Register (AP, SP and IP)' would have on the expected knowledge, skill and behaviour of future independent prescribing optometrists.

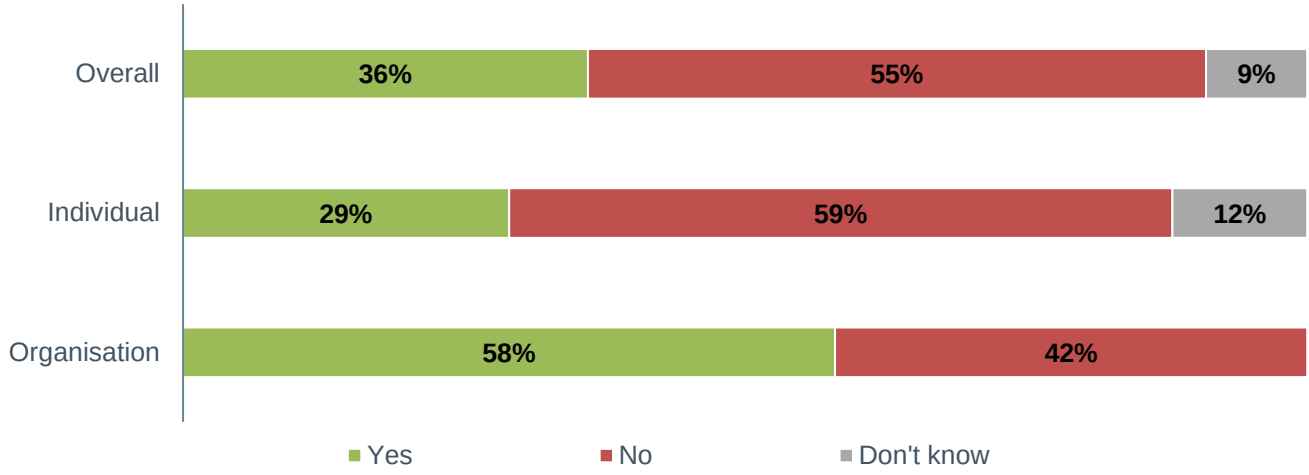
4.2.2 ***Figure 5*** shows the majority of respondents felt that the 'Standards for Approved Qualifications for Specialist Entry to the GOC Register (AP, SP and IP)' would have a positive impact on the expected knowledge, skill and behaviour of future optometrists and dispensing opticians (46%). Just 15% felt it would have a negative impact, and almost the same proportion felt it would have no impact. Of responses from organisations, 10 thought the impact would be positive and two thought it would be negative.

Figure 5 – What impact, if any, will introducing the proposed 'Standards for Approved Qualifications for Specialist Entry to the GOC Register (AP, SP and IP)' have on the expected knowledge, skill and behaviour of future independent prescribing optometrists?
Base: Overall (55); Individual (43); Organisation (12)



4.2.3 When asked if there is anything in the 'Standards for Approved Qualifications for Specialist Entry to the GOC Register (AP, SP and IP)' that was missing or should be changed, just over a third (36%) said there was, as shown in ***Figure 6***.

Figure 6 – Is there anything in 'Standards for Approved Qualifications for Specialist Entry to the GOC Register (AP, SP and IP)' that is missing or should be changed?
Base: Overall (53); Individuals (41); Organisations (12)



4.2.4 Respondents were asked to explain their answer, thinking about what is missing or should be changed. In total, 21 responses were provided.

4.2.5 The most common concern related to the suggestion that the increased flexibility that the Standards document offered in relation to the setting of where clinical experience can be gained may result in narrowing the scope of experience received by trainees. It was stated that perhaps there should be more explicit requirements established for training relating to the setting in which placements occur and the number of prescribing decisions, which it was felt would increase levels of safety for patients.

> *We suggest that the headline guidance of 90 hours is insufficient to ensure protection of the public. For a trainee who undertakes the majority of their clinical placement in community practices, or one who observes in a hospital setting rather than being actively involved with diagnosing and managing patients, 90 hours may equate to a relatively small number of patients and/or a very narrow scope of experience. We suggest that more explicit requirements on the number of prescribing decisions made as part of a clinical placement would help to ensure equity across training undertaken in different settings. We also suggest that this is an opportunity for the GOC to provide more explicit requirements relating to what happens within a clinical placement, and also mention the types of placements that are acceptable e.g. virtual placements and how these can be successfully conducted.*
>
> Provider of GOC-approved qualification(s)

> *Whilst increased flexibility of location and setting for trainees to undertake clinical experience is to be welcomed, it should be overtly recognised that some settings may focus on services for specific types of conditions and thus offer a more restricted range of clinical experiences. The diversity of cases observed may impact the trainees' scope of practice at qualification, and thus care should be taken to ensure that the range of experiences obtained are clearly defined and documented. It is also currently not clear what limits if any there might be on location. Could a trainee undertake clinical experience outside of the UK, for example, in a practice on Jersey, or even whilst volunteering with UK charities abroad?*
>
> College of Optometrists

As a provider, we would be reassured if minimum standard for the clinical placements could be defined in terms of the types of conditions to be encountered and the range of settings to be included in the experience (for example IP trainees should spend a proportion of their training in an eye casualty type HES environment). It would be worrying if the trainee completed all 90 hours in a community practice with no HES clinical experience.

Provider of GOC-approved qualification(s)

Many members who responded to our request for feedback on the proposals mentioned how valuable they had found it to undertake training in hospital clinics under an ophthalmologist. It will be crucial that during their hours of practical experience the trainees see a large number of cases and a wide range of pathology. This could not normally be achieved in a community setting at this time, and we think the GOC should look carefully at the proposed settings for clinical experience in order to ensure that the qualification will be based on wide-ranging experience. It may be necessary to strengthen the standards in order to make clear the requirement to provide access to sufficient breadth and complexity of cases.

Association of Optometrists

4.2.6 Another common concern expressed in relation to the Standards document related to the removal of the two-year post-registration requirement before beginning to study to become an independent prescribing optometrist. As highlighted in response to the Outcomes document, some respondents felt that newly qualified optometrists were not suitably knowledgeable or experienced to begin their training to become qualified as independent prescribers, and that the current two-year requirement was beneficial as it provided optometrists with some real-world experience before beginning their further training at an advanced level. It was highlighted that pharmacists are required to undertake a longer period of education and training before they are able to begin an independent prescribing qualification, and that the success of the integration of this qualification within the pharmacy route to registration has yet to be judged.

We have significant concerns, which were echoed by our survey respondents, that the levels of clinical experience and expertise of newly qualified optometrists will be insufficient to underpin the judgements and outcomes required of IP practitioners, if the two-year post-registration experience requirement is removed (key proposal h). This post registration period provides time and experience that allows consolidation of knowledge and working practices, and development of the self-assurance, that is key to the judgement and decision-making required of IP practitioners.

College of Optometrists

Surely optometrists require at least 2 years in optometric practice before undertaking advanced prescribing training/responsibilities?

Independent prescribing optometrist

It should be noted that even pharmacists, whose entire degree focuses on the use and effects of regulated drugs, are not expected to achieve prescribing rights until they have completed five years of pharmacy education and training, prior to registration. Indeed, integration of IP qualification with the route to initial registration as a pharmacist has only recently been introduced by GPhC, and so has yet to be demonstrated to be successful in practice.

Provider of GOC-approved qualification(s)

4.2.7 As with the Outcomes document, some responses focused on the need for more detail and clarity in certain areas. Some responses highlighted the changes proposed within the document to the supervision of trainees via the designated prescribing practitioner (DPP) role. Mixed attitudes towards this proposal were received, with some in support of the change to allow supervision to be conducted by other suitably qualified and experienced prescribers outside ophthalmologists, and others opposed. However, a number of respondents suggested that more detail should be provided about the level of experience required to take on this role to ensure a high standard of supervision is provided, which was viewed as lacking in the Standards document.

> *We strongly support the extended range of professionals who may act as supervisors and as DPP (key proposal d, S4.5). However, the amount of experience required to be appointed as a DPP, and the location of the responsibility for training and support for would benefit from more clarity and detail.*
>
> College of Optometrists

> *Clinical experience for IP is best gained in an acute hospital environment. In community practice IP learning events are sporadic at best day to day. No community IP Optometrists (like me) can guarantee the clinical experience required. I can't see how supervision in community would work in Northern Ireland. It's good that optoms can be supervisors but how will all these newly qualified optometrists find supervisors?*
>
> Independent prescribing optometrist

4.2.8 Linked to this, it was also suggested that the requirement for trainees to identify a suitably experienced and qualified DPP upon application may be unnecessary and potentially cause difficulties for trainees due to the availability of potential supervisors.

> *"S2.6: Trainees upon application must have identified a suitably experienced and qualified designated prescribing practitioner (DPP) who has agreed to supervise their learning in practice." We suggest that it is unnecessary to add this additional requirement. The current process, which does not have this requirement, has been shown to be successful. We would also anticipate that it would have an undesired negative effect on recruitment for programmes, limiting the number of optometrists training for IP and ultimately affecting patient care, working against the GOCs remit to promote public health. Further, it is likely that a number of students will find that the DPP which they originally identified is, through a change in circumstances, job role or workload, ultimately unable to offer clinical placement training at the point at which it is required to begin (which may be several months after the original agreement was put in place). The proposal has not considered this scenario, but it seems likely that affected students would not be required to withdraw from the programme, but would remain enrolled until an alternative DPP is found. This provision for a change in circumstances makes the rationale for including a requirement to have a DPP in place at the beginning of the programme unclear.*
>
> Provider of GOC-approved qualification(s)

> *The proposals indicate (key proposal d, S2.6) that it is for the trainee to identify their DPP before applying to the course. However, it is the responsibility of the provider to assure and manage this relationship. This appears to be contradictory. In addition, in practical terms, this is often difficult to arrange due to HES logistics (movement of staff in hospitals, clinic schedules, costs) particularly in post-covid-19 times when access to NHS clinics is increasingly difficult. IP trainees may already have links with HES departments with whom they wish to conduct their clinical placement as in the current system. If the responsibility*

for managing this part of the qualification was transferred to the provider, this would have significant financial implications in terms of staff time and fees for accessing clinics.

Provider of GOC-approved qualification(s)

4.2.9 It was also suggested that more clarity could be provided in relation to how the proposed changes in the Standards document would affect those already undertaking their training, and that measures should be put in place to ensure these trainees are made aware of the changes and are not disadvantaged as a result.

It is not clear how RPL (key proposal h, S2.5) might be deployed for trainees who have part completed the existing regime, in a way that does not disadvantage them financially or require them to repeat elements of study.

Provider of GOC-approved qualification(s)

No section on how this would affect the people who are currently doing the or just started the course. As this is a much better way of doing the course and a lot of people who's just started would want to know if the new regulations apply to them.

Optometrist

We welcome the recent GOC agreement to changes in the College of Optometrists' IP placement programme, to allow trainees to begin placements after the two-year time limit has passed, to allow for some remote experience and session sign-off by IP optometrists. We hope that those who have recently completed the theory element of the training are made aware of this change, and are supported to complete the qualification.

College of Optometrists

4.2.10 Other comments made about the Standards document by single respondents included:

- No justification for increasing clinical experience requirement from 72 hours to 90 hours
- Implement a maximum time limit to completion or additional monitoring/testing
- NHS should fund IP qualifications
- Would prefer complete alignment with RPS competency framework
- Feedback on specific wording within the document
- Dangerous reduction in time needed to gain qualification
- More guidance on accreditation of prior learning needed
- Needs to be incorporated as an option at degree level
- Needs to consider ongoing difficulties in arranging placements

4.3 Quality Assurance and Enhancement Method for Specialist Entry to the GOC Register (AP, SP and IP)

Document summary

The 'Quality Assurance and Enhancement Method for Specialist Entry to the GOC Register (AP, SP and IP)' describes how the GOC will gather evidence to decide in accordance with the Act whether a qualification for specialist entry to the GOC register in the AS, SP and/or IP categories meets our outcomes for approved qualifications and standards for approved qualifications. This method statement is common to all qualifications for specialist entry to the GOC register.

The design of the new quality assurance and enhancement method supports the GOC's outcomes-orientated approach. It moves away from seeking assurance that requirements are met by measuring inputs to evidencing outcomes. This reflects approaches taken by other statutory healthcare regulators, professional and chartered bodies.

The method does not attempt to describe every permutation of assurance and enhancement. Instead, it establishes a proportionate framework for gathering and assessing evidence to inform a decision as to whether to approve a qualification or withdraw approval of a qualification. The method sets out arrangements for periodic review, annual return, thematic and sample-based reviews, as well as managing serious concerns and the type and range of evidence a provider of an approved qualification might consider providing to support these processes.

Underpinning the approach is a greater emphasis on the views of patients, service users, the public, NHS, commissioners of training and education, and employers, as well as the views of trainees and previous trainees in the evidence the GOC will consider. This is to ensure the qualifications it approves are not only responsive to the needs of patients and service users but also to the rapidly changing landscape in the delivery of eye care services across the United Kingdom.

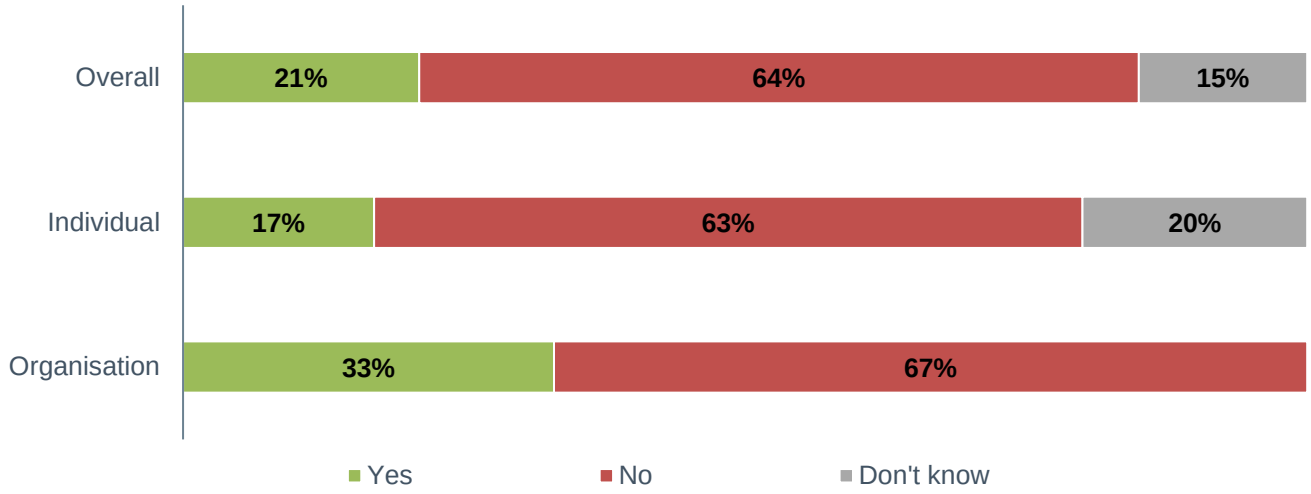
The method is organised in seven sections:

1. Legal basis for quality assurance and enhancement
2. Quality assurance and enhancement – definitions
3. Geographic scope
4. Arrangements for current (pre-2021) providers of approved and provisionally approved qualifications
5. Approval of new qualifications (from December 2021)
6. Periodic review, annual return, thematic and sample-based review
7. Scope of evidence
8. Decision-making

Consultation survey response

4.3.1 When asked if there is anything in the 'Standards for Approved Qualifications for Specialist Entry to the GOC Register (AP, SP and IP)' that was missing or should be changed, just 21% said there was, as shown in ***Figure 6***.

Figure 7 – Is there anything in 'Quality Assurance and Enhancement Method for Specialist Entry to the GOC Register (AP, SP and IP)' that is missing or should be changed?
Base: Overall (53); Individuals (41); Organisations (12)



4.3.2 Respondents were asked to explain their answer, thinking about what is missing or should be changed by providing free-text comments. In total, 15 responses were provided.

4.3.3 The most common theme found in these responses was that a common final assessment should be maintained for this qualification to ensure that independent prescribing optometrists are all trained to the same level. These responses suggested that removing this could result in significant inconsistency in the level of knowledge, skill and ability amongst newly qualified independent prescribing optometrists, despite the quality control measures set out in the Quality Assurance and Enhancement Method document.

> *A common final exam run by a body that does not provide an IP course ensures that all IP optometrists reach the same standard.*
>
> Independent prescribing optometrist

> *Current qualification standards are subject to the Therapeutic Common Final Assessment, and this assures consistent outcomes in IP registrants. It is not clear how EVPs will be enabled to ensure this level of consistency is maintained when assessment methods may vary significantly by provider? Equally, how will EVP members acquire the specialist understanding required for undertaking IP accreditation?*
>
> College of Optometrists

> *The current system of using the Therapeutics Common Final Assessment provides a robust, standardised means of assessing IP trainees from across the UK. It would be difficult to maintain consistency if this part of the qualification was delivered by individual providers. The current system ensures a minimum level of safety in prescribing to protect the public and maintain high standards across the profession.*
>
> Provider of GOC-approved qualification(s)

> *Current qualification standards are subject to the Therapeutic Common Final Assessment, and this assures consistent outcomes in IP registrants. There is a risk that consistent standards to deliver outcomes may be difficult to assess and assure over a range of providers proposed in the QA & Assessment Method for Specialist Entry.*
>
> Commissioner of optical care

4.3.4 It was also suggested that, by removing the common final assessment and allowing providers to carry out their own assessment, confidence in the independent prescribing qualification may be reduced, specifically amongst the public, if there are multiple routes to entry on to the specialist register.

> *Confidence in the qualification may be questioned by the public if a range of different access routes for the IP specialist register were to exist.*
>
> Commissioner of optical care

4.3.5 A number of responses referred to the absence of any information or guidance in relation to providers who may wish to partner with other organisations, something which it was felt may be more likely to occur under the new proposed system. For example, a provider respondent suggested that they may consider partnering with other organisations to increase the pool of DPPs they can call upon to find placements for their students, and highlighted that there was no information about this in the Quality Assurance and Enhancement Method document.

> *The QAE method and course management requirements (Standard 4) make almost no reference to partnership or collaborative provision, despite the likelihood of this model being preferred by some providers to enable delivery of integrated academic and clinical provision.*
>
> College of Optometrists

4.3.6 It was also suggested that the timeframe set out in the Quality Assurance and Enhancement Method document was too ambitious, and that flexibility would be required to allow providers time to introduce these changes.

> *"We anticipate most providers will work towards admitting trainees to approved qualifications that meet the outcomes and standards from July 2022." is too ambitious. The earliest an educational provider could achieve is Sept 2022 and I suspect this will be "some" rather than "most".*
>
> Optometrist

> *These changes are being brought in very quickly. There needs to be some flexibility in case the providers cannot meet this time line.*
>
> Independent prescribing optometrist

4.3.7 Other comments made about the Quality Assurance and Enhancement Method document by single respondents included:

- Potential decrease in quality of care/standards
- Robust quality assurance process needed
- Implement a maximum time limit to completion or additional monitoring/testing
- IP optometrists should not be supervisors/ophthalmology input essential
- Clarity about how the proposals will impact current trainees needed
- System to validate additional training should be included in the design of the new requirements

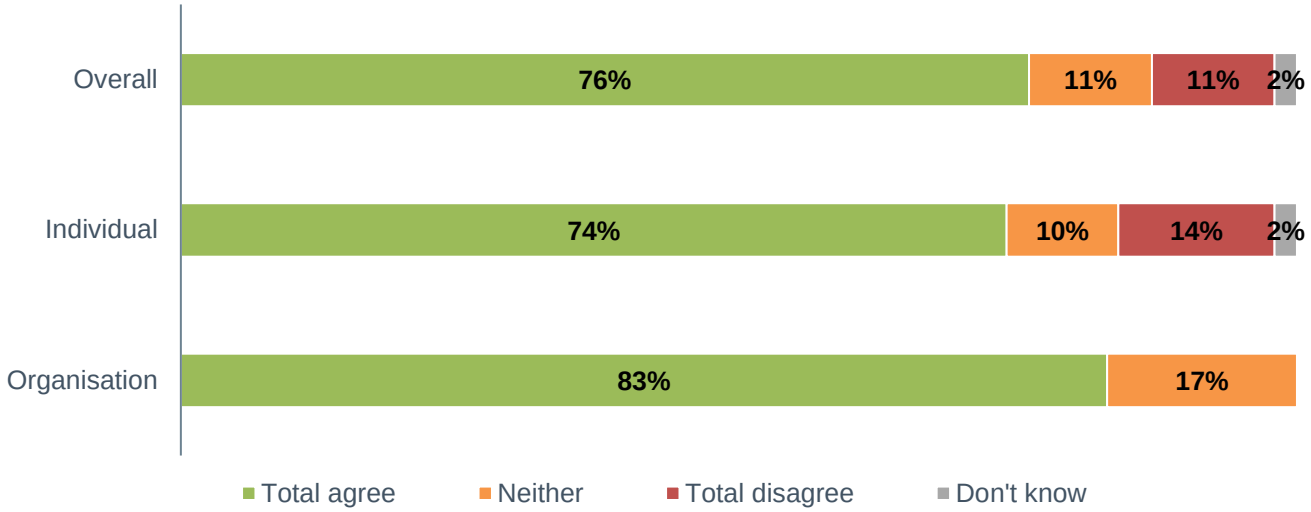
4.4 Replacing the Quality Assurance Handbooks

Consultation survey response

4.4.1 Respondents were asked whether they agreed or not with the proposal to replace the Quality Assurance Handbooks for optometry (2015) and dispensing opticians (2011) and related policies with the new documents presented in this consultation.

4.4.2 Three quarters of respondents agreed with the proposal to replace the Quality Assurance Handbook for optometry and related policies with the three documents (76%), and just 11% disagreed, as shown in ***Figure 8***. The majority of both individual and organisation respondents were in agreement.

Figure 8 – To what extent do you agree with our proposal to replace our handbook for independent prescribing optometrists and related policies with the proposed 'Outcomes for Approved Qualifications for Specialist Entry to the GOC Register (AS, SP and IP)', 'Standards for Approved Qualifications for Specialist Entry to the GOC Register (AS, SP and IP)' and 'Quality Assurance and Enhancement Method for Specialist Entry to the GOC Register (AS, SP and IP)'?
Base: Overall (54); Individuals (42); Organisations (12)



4.4.3 Respondents were asked to explain their answer by providing a free-text response. In total, 25 responses were provided.

4.4.4 It is encouraging to note that the most common theme across these responses was that the replacement of the current handbooks with the three new documents, and the changes proposed within them, were viewed as positive. Some comments explained that the changes proposed were necessary and had been required for some time. Others stated that the new documents were well-considered and had the potential to improve the current system in various ways.

Change is definitely required from the current systems in place
Independent prescribing optometrist

The handbook should be replaced for the reasons outlined in the consultation documents.
College of Optometrists

This is clearly a well-considered document, and I feel it would be presumptuous of me to think that I could add anything.

Independent prescribing optometrist

I think this will be an excellent improvement and long overdue.

Optometrist

The new outcomes, standards and quality assurance and enhancement methods offered, have significant potential to align the profession more closely to other NMPs, to support appropriate assessments, to facilitate an appropriate range of supervisors, and to support development of a culture of prescribing across all optometry in Scotland.

NHS Education for Scotland

4.4.5 Other positive comments related to the perception that the proposed changes across the three documents would create a simpler, more streamlined and easier to understand system of training and qualification for optometrists and providers, and would produce practitioners with a higher level of clinical knowledge.

Replacement of these documents will provide guidance in a more concise manner allowing providers to form courses around the new competencies. It will also provide clear guidance for students.

Provider of GOC-approved qualification(s)

Strongly agree as it keeps it much more simple and easier to understand

Optometrist

More structured process to be able to help patients enabling optometrists to have a higher level of clinical knowledge.

Optometrist

4.4.6 Some responses to this question were generally supportive of the proposal to replace the current handbook with the three new documents, but with the caveat that further clarifications and detail may be required. This included further information about the revalidation requirements for independent prescribers, support for independent prescribers to extend their scope of practice, and the need for further documentation relating to patient safety. It was also suggested that changes to the proposals may be required in relation to more specific requirements for clinical experience to ensure that trainees obtain the relevant levels of knowledge and skill.

Whilst there are some improvements to the current Handbook, we have some suggestions…that we feel would need to be implemented before a clear improvement to the current system is made.

Provider of GOC-approved qualification(s)

We are broadly supportive of this, given that currency should be assured via specialist CPD requirements. It is, however, not clear whether there will be an expectation that qualified practitioners will need to undertake some revalidation if not actively prescribing for an extended period, or how practitioners might best be supported to extend their scope of practice as service requirements develop. As a minimum standard, practitioners should be encouraged to engage with other IP Optometrists to discuss current prescribing practice and guidelines to maintain knowledge of up-to-date policies and thought in the area.

Provider of GOC-approved qualification(s)

> *It is essential that independent prescribing gains more prominence in optometry training and the changes proposed should help this. To ensure that all competencies are met, and, in line with proposed Education Strategic Reform (ESR) changes, it is, however, also essential that trainees gain sufficient and appropriate experience in all areas of practice. Quantifying time needed and minimum patient encounters is essential to ensure adequate experience and training.*
>
> Commissioner of optical care

4.4.7 It was also suggested that the wording of the documents should be carefully reviewed before being published to ensure that they remain current and up to date over time, for example, avoiding referencing other policies or documents which may become out of date, and allow for flexibility in the outcomes as the role of independent prescribing optometrist evolves in the future.

> *Replacing the handbook is a good thing. Care needs to be taken that the outcomes and standards are written so as not to be quickly outdated. For example references to the GMC remote prescribing or the Royal Pharmacy review could be worded so as to reflect 'latest' rather than current guidance*
>
> Independent prescribing optometrist

4.4.8 Some responses to this question explained that the proposed changes across the documents could result in a reduction of standards. One respondent who was currently undertaking independent prescribing training said that, compared to the process they were going through, the proposals would mean a reduction in learning which may not produce well-prepared and qualified independent prescribing optometrists. Another respondent highlighted how changes to the current system which move away from specifying an intended area of prescribing could result in practitioners lacking the required experience to make the correct prescribing decisions in practice.

> *I have almost completed the IP course at Cardiff University and when I compare the requirement I have had to meet with that proposed by the GOC, it is clear the GOC proposals are dangerously lightweight. I feel I may just about reach minimum standard for an IP practitioner after a 12-month intensive distance-learning course and a 12-day hospital placement. The suggested radical reduction in learning will not lead to competent, confident IP practitioners.*
>
> Optometrist

> *Newly qualified optoms will have no opportunity to fore-see which area of prescribing their interests will lie. At the moment, IP applicants must state their intended area of prescribing, i.e. glaucoma, routine community refractions, eye casualty etc. Newly qualified optoms coming out fully IP qualified will not have opportunity to consider this. If poor prescribing choices are made out of lack of real-life experience managing own patients, i.e. sight loss due to prescribing steroids in herpetic disease etc., this will reflect poorly on the whole profession.*
>
> Independent prescribing optometrist

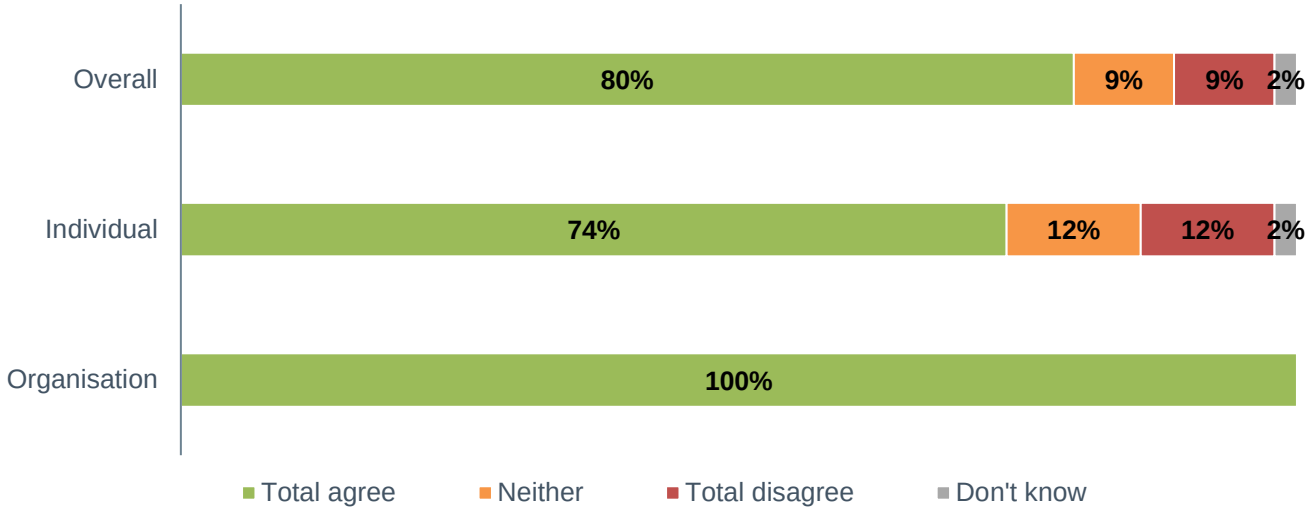
4.4.9 Other comments made about replacing the current handbook for independent prescribing optometrists and related policies with the three new documents by single respondents included:

- Support for IP optometrists to take on the role of DPP
- Will not improve quality of/access to training
- AS and SP qualifications should be dropped as soon as possible
- Will improve access to clinical supervision

- Don't fully understand the proposed changes or their implications
- Keep paperwork simple
- Not understood by the public
- Two-year registration period requirement before training should be retained
- Final common assessment should be retained

4.4.10 Four in five respondents agreed with the proposal to remove the requirement for registrants in the additional supply, supplementary prescribing and/or independent prescribing categories to supply details of prescribing decisions undertaken in the previous 12 months at the point of registration (80%), as shown in ***Figure 9***. Three quarters of individual respondents agreed with this (74%), as did all organisations.

Figure 9 – To what extent do you agree with our proposal that at the point of retention, registrants in the additional supply, supplementary prescribing and/or independent prescribing categories will no longer need to supply details of prescribing decisions undertaken in the previous 12 months?
Base: Overall (55); Individuals (43); Organisations (12)



4.4.11 Respondents were again asked to explain their answer, and 29 responses were received to this question.

4.4.12 The most common theme when respondents explained why they agreed with this proposal was that the current requirement of supplying details of prescribing decisions undertaken in the previous 12 months was an onerous, time-consuming and unnecessary burden for independent prescribing optometrists. As these decisions are recorded in other ways, and logging them in this way does not benefit patient safety, the proposal to remove this requirement was generally viewed as a very logical and positive step.

> *I feel currently it's a waste of time to log every single prescription that I issue, there is subjectivity in management of conditions and all is already logged in medical records if access is necessary*
>
> Independent prescribing optometrist

> *This is an arcane historical hangover from the introduction of optometric prescribing. It has served its purpose.*
>
> Optical business registrant

The annual process was time consuming for registrants and for the GOC to analyse the data provided adequately would take increased resources and likely provide little benefit to patient safety. As professionals, prescribers are expected still to maintain their own comprehensive records that could be used to produce a report should one be required.

FODO – The Association for Eye Care Providers

Prescribers of all levels undertake thorough record keeping and hence should not need to issue logs of prescribing decisions. Prescribing decisions can be complicated and clinicians may not be in a position to make a decision following just one appointment and may require numerous follow ups. Conveying this in a log can be difficult.

Provider of GOC-approved qualification(s)

We agree with this proposal because we know that the current process is mainly an administrative process, designed only to assess if a registrant needs to undertake more CET/CPD. IP optometrists should be recording diagnoses, decisions and treatments as part of the normal clinical governance process in their practice setting.

Association of Optometrists

4.4.13 Other explanations provided for agreeing with this proposal included the fact that keeping a log of all prescribing decisions is not a requirement in other healthcare professions, and that this type of record does not indicate competence, and therefore is unnecessary. It was also highlighted that CET/CPD is sufficient to ensure prescribing knowledge is reflected upon and maintained, and that it is part of professional responsibility to keep up to date to provide evidence of being an experienced and well-qualified practitioner.

Removing the requirement to provide prescribing activity details at the point of retention is welcomed. It is an unnecessary addition that other colleagues, such as GP's and dentists, do not need to undertake.

Commissioner of optical care

The number of prescribing decisions does not reflect the optometrist's level of competence. Furthermore, the College's Clinical Management Guidelines often encourage the Optometrist to consider conservative measures before prescribing to ensure patient safety. The prescribing log may place pressure on an Optometrist to prescribe in order to have a sufficient log.

Provider of GOC-approved qualification(s)

I agree with stopping the need to supply details of activity as I think keeping up with required CET will keep up skills and appropriate approach to cases.

Independent prescribing optometrist

It's a core professional responsibility to keep up to date. It is for the practitioner to ensure they prescribe appropriately or even stop prescribing at all if they no longer have the relevant experience.

West Yorkshire & Harrogate Local Eye Health Network

4.4.14 It was also suggested that, by removing this requirement, this would increase the level of trust given to independent prescribing optometrists by the GOC, who will no longer be expecting them to provide regular logs of their prescribing decisions.

Removing this need also strengthens trust between registrants and the professional body in question.

Independent prescribing optometrist

4.4.15 Despite strong levels of agreement with this proposal, some concerns were raised. The most common concern highlighted in the survey responses was that removing the requirement to keep a log of prescribing decisions would also remove an opportunity for audit, reflection, and quality assurance, which are perceived to be very important. Therefore it was highlighted that there would need to be clear guidance for how independent prescribing optometrists should audit and reflect upon their prescribing decisions so that a high standard of quality can be maintained.

How do you intend to monitor performance and safety? The requirement for additional CET is useful but that doesn't necessary translate to safe prescribing performance- an audit of prescribing habits is a better method of evaluating safe practice.

Optometrist

Registrant still need to make sure they regularly audit their decision management.

Trainee independent prescriber

We would encourage a good culture of quality improvement and safety; with appropriate, directed audit to support specific areas of practice.

NHS Education for Scotland

4.4.16 Another concern raised was that this proposal would need to clarify whether there would be any specific requirements for revalidation or additional record keeping for those who do not actively prescribe for an extended period of time, or who make infrequent prescribing decisions. It was suggested that additional peer-to-peer interaction between independent prescribing optometrists should be encouraged to help ensure practitioners remain up to date and maintain their knowledge.

Appropriate CET should ensure that prescribing knowledge is maintained, however if someone has not prescribed for a long period of time, it may be that that registrant would be lacking experience. This could be overcome by 'return to work' courses for those who have had a career break or a change to their career where they have been working in a non-prescribing role.

Independent prescribing optometrist

The main concern if practitioners who are not prescribing regularly and of course would constitute a higher level of risk, typically those who are not contracted in a prescribing pathways such as community ophthalmology or hospital ophthalmology services as these services usually use electronic systems to generate their scripts, as keeping a separate log adds to duplication and leads to wasted time.

Optometrist

As a minimum standard, practitioners should be encouraged to engage with other IP Optometrists to discuss current prescribing practice and guidelines to maintain knowledge of up-to-date policies and thought in the area. This peer-to-peer interaction, support, mentoring, and psychological safety requirement could be potentially met in Northern Ireland via a knowledge networked approach facilitated by Project ECHO.

Commissioner of optical care

4.4.17 Other comments made about the Quality Assurance and Enhancement Method document by single respondents included:

- Support for IP optometrists to take on the role of DPP
- Will not improve quality of/access to training
- AS and SP qualifications should be dropped as soon as possible
- Will improve access to clinical supervision
- Record keeping/number of prescribing decisions does not indicate competence
- Agree with the proposal, but need to recognise lost opportunity to gather data on IP interactions
- More consistent with changes in community practice
- Further information needed
- Supplying all details is in the patient's best interest

4.4.18 Respondents were asked to comment if they had anything else to say about the education and training of future independent prescribing optometrists. In total, free-text 29 responses were received to this question. Some respondents took the opportunity to express their support for the proposed changes set out for the education and training of future independent prescribing optometrists, or reiterated their queries or concerns. However, others highlighted areas they thought could be developed further, changed, or that required further detail or information.

4.4.19 A number of responses related to the suggestion that the independent prescribing qualification should be aligned more closely with the optometry degree. Some suggested that the independent prescribing qualification should be included as part of the optometry degree, as in other countries, which would produce optometrists already qualified to prescribe. Others stated that the independent prescribing qualification should be provided as an optional module or postgraduate course to enable optometrists to transition more easily to prescribing status following the achievement of their degree. It was explained that this could have a significant benefit on primary optical care in the UK, making it easier for patients to access a professional who can prescribe, reducing the burden on secondary care.

> *Independent Prescribing should be included in basic optometric training and qualification. This would be helped by the gradual reduction in the scope of basic optometry over recent decades.*
>
> Optometrist

> *I would like to see the possibility of a new entry point (post a 5th year) that enables a university to graduate prescribers at an early stage of their career without the 2 year wait.*
>
> Optical business registrant

> *AS/SP should be integrated into the undergraduate courses with their placement taken within their 'pre-reg' allowance. There should be then the provision for providers to develop an upgrade module and subsequent placement to gain IP status. I didn't see any mention of this anywhere and this would allow greater numbers in gaining this status.*
>
> Optometrist

> *To have a significant impact on primary care in the UK so that patients can benefit from local advanced eye care, freeing the hospitals to do advanced care, undergraduate optometrists need to qualify to practice with IP rights as they do in the USA, Canada, NZ and Australia. Anything that hinders this such as increasing the clinical hours from 72 to 90*

will negatively impact on this opportunity and has no evidence basis based on patient safety.

Optometrist

4.4.20 It was felt that this was important, as it would provide greater development opportunities for optometrists who are keen to gain further qualifications and skills.

With the recent GOC survey finding that almost half of those who completed the survey wish to take further qualifications in the next few years, it is critical we can provide future enablers to gain IP rapidly and effectively.

Optometrist

4.4.21 Another common theme which emerged in response to this question was the importance of clinical experience for optometrists undertaking the independent prescribing qualification. As previously highlighted, a number of respondents stated the benefits of gaining clinical experience that would provide a wide range of patient interactions and pathologies, providing trainees with sufficient breadth of experience during their placements. Some respondents felt it was crucial that this experience was gained in a hospital setting, where trainees would be more likely to see a variety of pathologies, and therefore thought that there should be requirements in place to ensure a certain amount of clinical experience is gained in this setting.

Although difficult to provide under the present circumstances, real clinical experience I believe is essential for giving confidence that the treatments prescribed actually work.

Independent prescribing optometrist

Although in theory all IP placement could be under a DPP who is an IP optometrist, the patient numbers (log book) and conditions (not policed or reviewed at all) need to be the drivers not "sessions". A single session in an ophthalmic casualty unit may give more episodes of diagnosis and treatment than a whole week even in a sophisticated prescribing optometry venue.

Optical business registrant

There was little mention of the placement experience the IP trainee should gain in order to gain a 'breadth of experience.' I feel working in a casualty/acute setting should be mandatory for any individual and should form a minimum requirement, i.e. 4 sessions to ensure safe practice when working in any setting.

Optometrist

4.4.22 Some responses focused on the need to ensure that there are sufficient numbers of DPPs available to supervise trainee independent prescribing optometrists, and that training and support should be available for DPPs to make sure they are operating at a required level, providing consistency of supervision for all trainees.

It is important to ensure there are a sufficient number of approved DPPs to supervise trainee IP optometrists. It may also be helpful for trainees to be supervised or undertake training across various disciplines and experts within the field.

Provider of GOC-approved qualification(s)

Work needs to be undertaken to ensure appropriate and adequate mentoring and practical experience is available to all trainees.

Commissioner of optical care

> *Suitable training for DPPs to offer supervision is an essential element of this reorganisation and could be recognised as a way of achieving CPD credits for supervisors. Such training should also ensure consistency of supervision that is again an essential element of this system.*
>
> FODO – The Association for Eye Care Providers

> *My reservations are with regards to competence of the DPPs and ensuring that they are up to standard to train. It's also about support mechanisms to help further develop confidence and skills of prescribers so that they can have more of an active role in prescribing.*
>
> Independent prescribing optometrist

4.4.23 Other comments made about the education and training of future independent prescribing optometrists by one or two respondents included:

- Common final assessment needed to ensure consistency
- Clarifications about DPPs needed (training, approval, number of trainees)
- Supervisors/DPPs need to be appropriately remunerated
- Evidence required to support 90 hours of clinical placement requirement
- Should not be an add-on to the undergraduate degree – need to gain experience before starting to prescribe
- Newly qualified optometrists should receive ongoing support/mentorship
- Empower therapeutic optometrists to make decisions and treat disease
- Single route of entry unnecessary step, now all universities offering IP training will be quality assured
- Governance of IP via the Clinical Management Guidelines requires revision – too open to interpretation
- Flexibility needed during period of change
- Agree with IP optometrists being clinical supervisors – will help trainees gain placements
- Common final assessment for IP should be reviewed
- Access to patient records/improvements to digital referrals and communications needed
- Need to ensure all potential specialty registrants are enabled to access training
- Proposed level 7 IP qualification might devalue the award
- Funding needed to finance IP training

4.5 Impact of proposals

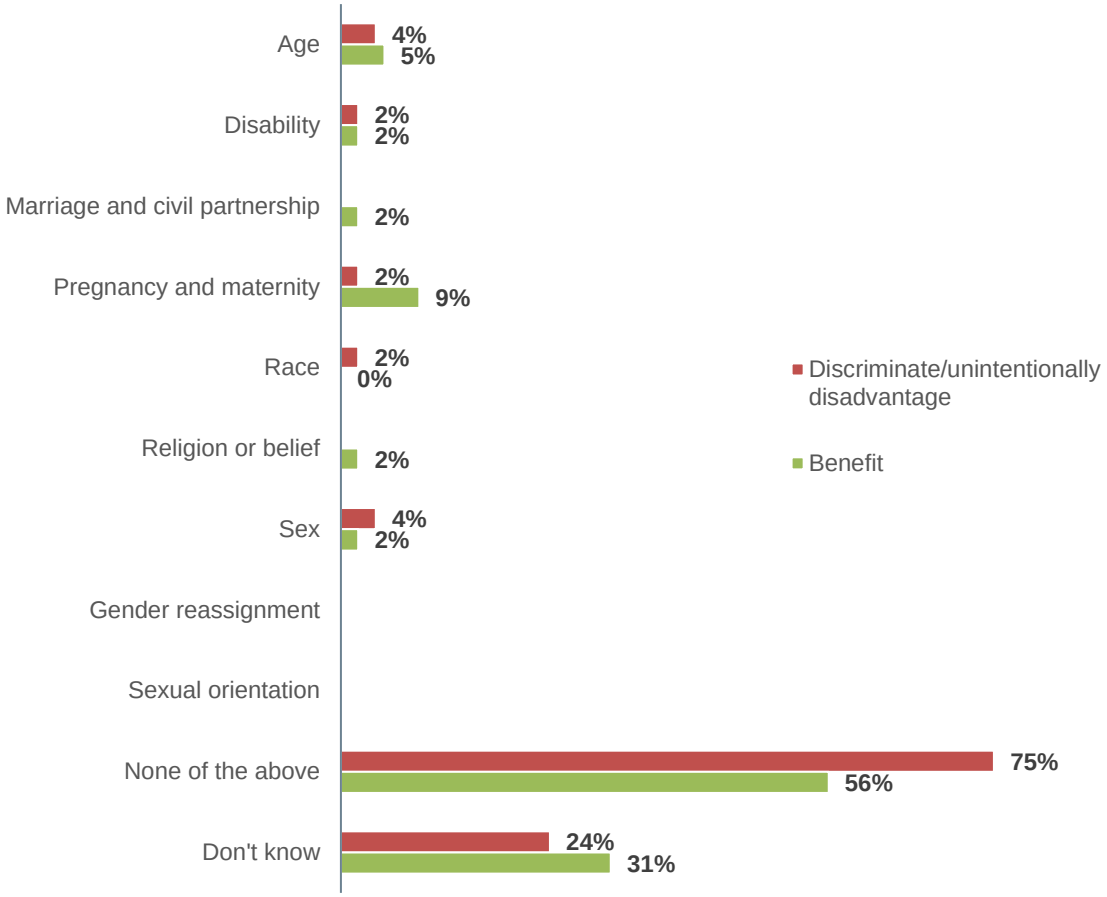
Consultation survey response

4.5.1 Survey respondents were asked whether they thought the GOC's proposals may discriminate against or unintentionally disadvantage any individuals or groups sharing any of the protected characteristics in the Equality Act 2010, and alternatively whether it might benefit any of these groups. Respondents were able to choose from a list and could select more than one in each case.

4.5.2 As shown in ***Figure 10***, three quarters of respondents said that the proposals would not discriminate against or unintentionally disadvantage any of the groups or individuals listed (75%). A further 24% answered that they did not know whether the proposals would discriminate or unintentionally disadvantage any groups. Only very small proportions of respondents reported that the proposals may discriminate against or unintentionally disadvantage by age (4%), sex (4%), disability (2%), pregnancy and maternity (2%), and race (2%).

4.5.3 Over half said that the proposals would not benefit any of the groups listed (56%), and a further 31% said they did not know if there would be any benefit. Again, only small proportions of respondents thought the proposals may benefit certain groups or individuals, including pregnancy and maternity (9%), age (5%), disability (2%), marriage and civil partnership (2%), and sex (2%).

Figure 10 – Do you think our proposals will have a negative or positive impact on certain individuals or groups who share any of the protected characteristics listed below?
Base: All respondents (55)



4.5.4 Respondents were asked to describe how the proposals may discriminate or unintentionally disadvantage the individuals or groups they had identified, with six responses provided.

4.5.5 Some perceived that there would be no groups who were discriminated against or disadvantaged as a result of the proposals, and instead they were likely to be of benefit to many groups due to the removal of the two-year registration requirement and the increased flexibility that they thought many of the changes would allow for.

> *No group appears to be disadvantaged. Removal of the 2 year timeframe is beneficial for many of the groups.*
>
> Provider of GOC-approved qualification(s)

> *The increased flexibility in delivering the training and its assessment should make it open to all.*
>
> Optometrist

4.5.6 Some highlighted that those on low incomes or those working part-time may be disadvantaged due to the cost of training.

> *As those not well off unlikely to pursue postgraduate education*
>
> Optometrist

> *Given the likely increased cost of the qualification, those in lower paying positions, working part-time (mainly women and younger clinicians) will be disadvantaged.*
>
> Optometrist

4.5.7 It was suggested that more information was required to confirm how the proposals would avoid disadvantaging those who had already begun their independent prescribing training.

> *More clarity is required on how "teach out" will be managed for those who have already started their IP training, to avoid them being disadvantaged.*
>
> College of Optometrists

4.5.8 It was also thought that additional consideration may be required in relation to the geographical distribution of potential DPPs who would be able to supervise trainees, to avoid specific regions or nations being disadvantaged with clinical experience being more difficult to access.

> *It is not clear whether the geographical distribution of IP qualified optometrists who could supervise IP trainees has been considered in sufficient detail to determine whether specific regions or nations may be relatively disadvantaged. This is particularly important when considering the clinical placement capacity.*
>
> College of Optometrists

4.5.9 Some respondents highlighted that the proposals may disadvantage training providers, who may struggle to update and develop their qualifications to meet the new requirements in time for approval in 2022, exacerbated by other changes required as a result of the Covid-19 pandemic.

> *As a provider we have concerns that we will struggle to devote the capacity to develop the new qualifications effectively in time for approval in 2022, given that the course team is are, currently , developing the new undergraduate qualifications. In addition, we are still working on post COVID changes to teaching and assessment arrangements and this will continue to be a significant source of challenge for our course team*
>
> Provider of GOC-approved qualification(s)

4.5.10 Respondents were also asked to describe how the proposals may benefit the individuals or groups they had identified, with eight responses provided.

4.5.11 Some responses stated that there would be positive impacts based on increased flexibility, and the reduction of restrictions and prescriptive requirements, which could have a positive impact across all groups. One respondent explained that the proposals would have a positive benefit on younger people due the removal of the two-year registration requirement.

> *It should remove most restrictions to learn by being less prescriptive unless the clinical experience hours are increased*
>
> Optometrist

> *They will have positive impacts across all groups as long as the IP optometrist is equally or better qualified to look after patients.*
>
> Independent prescribing optometrist

> *There is no longer a minimum in-practice length before beginning the specialist training*
>
> Optometry student

4.5.12 It was suggested that the proposal to remove the two-year registration requirement would also be beneficial for those who are pregnant or on maternity leave.

> *Having no restriction on time limit will be very helpful for women who are on maternity leave or are pregnant.*
>
> Optometrist

> *The removal of the two year timeframe will be of benefit for those who take time out of work due to maternity leave.*
>
> Provider of GOC-approved qualification(s)

4.5.13 Others explained that they did not see how the proposals could unfairly disadvantage or benefit any of the groups listed, as they perceived them to be fair for all.

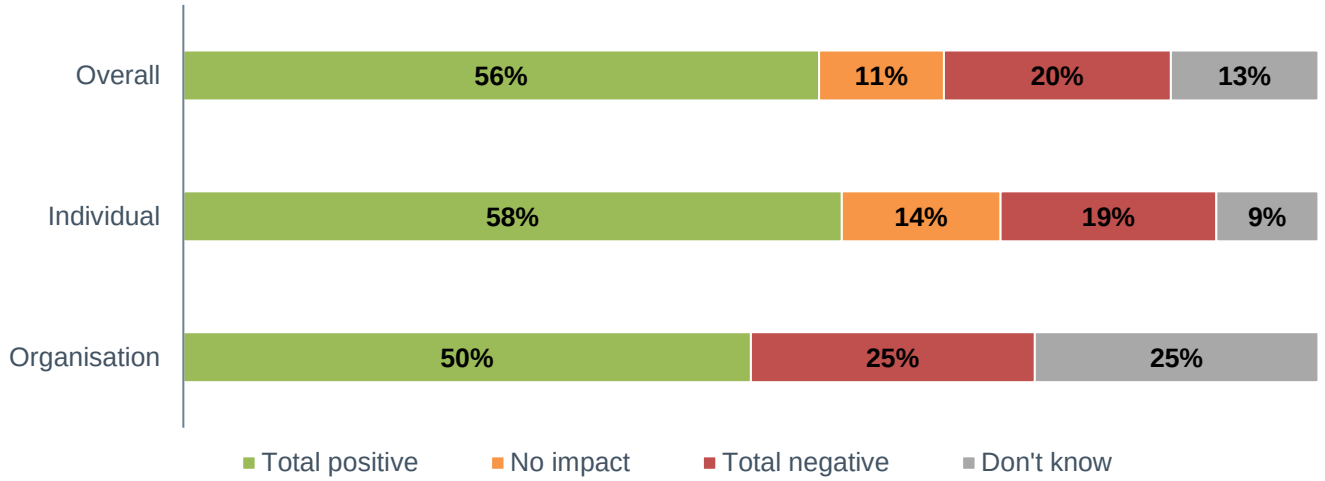
> *No positive or negative effect.*
>
> Independent prescribing optometrist

> *The proposals seem fair for all individuals, so we do not think that this will positively or negatively affect anyone in comparison to any others.*
>
> Provider of GOC-approved qualification(s)

4.5.14 Survey respondents were asked if the proposed changes will have any impact on any other individuals or groups. Examples were provided of trainees, patients and the public, current providers of approved qualifications, placement providers, employers and devolved nations.

4.5.15 ***Figure 11*** shows that over half of respondents felt that the proposed changes would have a positive impact on other individuals and groups (56%), whereas only 20% thought the impact would be negative. One in ten (11%) thought there would be no impact and 13% did not know.

Figure 11 – Do you think any of the proposed changes will impact – positively or negatively – on any other individuals or groups? For example, trainees, patients and the public, current providers of approved qualifications, placement providers, employers and devolved nations?
Base: Overall (55); Individuals (43); Organisations (12)



4.5.16 Respondents were asked to describe what impact and individuals or groups they were thinking of when answering this question, and 27 responses were received. Listed below are the main positive and negative themes which emerged within these responses, supported by some example verbatim comments.

4.5.17 Positive impacts:

- Patients, with wider access to care in the community

The lack of available IP optometrists and means by which they can engage with the NHS is patchy at best. This is massively discriminatory to those patients who attend an optometrist who may not be funded equitably for examination or access to prescriptions. These proposals will go a long way to making IP optometry more mainstream.
Optical business registrant

Will benefit patients, requiring less visits to A&E and more localised care
Optometrist

The more people are IP certified, the easier for the patients to get access to the meds they need. Rather than going the GP, they can get what they want right away.
Optometry student

Increasing numbers of a higher skilled workforce in the form of Independent Prescribers will benefit patients in community optometry.
Independent prescribing optometrist

- Trainees, making it easier to qualify and providing a better qualification

  More attractive qualification. Easier to maintain qualification.

  Independent prescribing optometrist

  Access to Hospital placements and ophthalmology mentors are often barriers to optometrists accessing this higher qualification. Practitioners will be able to qualify more easily by this new proposal

  Optometrist

  This seems to be a clearer better laid out programme for gaining the higher qualification and should prove less expensive. No longer needing the requirement to demonstrate prescribing decisions for the previous 12 months is very positive.

  Independent prescribing optometrist

- Secondary care, with fewer referrals from primary care

  Hospitals will receive reduced referrals from primary care

  Optometrist

  This will allow more conditions to be managed in community settings and save unnecessary visits to secondary care.

  NHS Education for Scotland

- Employers, having trained independent prescribing optometrists

  More practices will benefit from having IP optometrists on their premises.

  Optometrist

  The new proposals support the increase in demand for IP qualified Optometrists.

  Provider of GOC-approved qualification(s)

- Everyone, generally positive changes

  If the prescribing is supported by the NHS in the same manner as other professions' medical prescribing is supported, everyone benefits in every way.

  Optometrist

  The introduction of IP Optometrist supervisors is an excellent change and we believe with the safeguards a safe change for education and the public.

  West Yorkshire & Harrogate Local Eye Health Network

4.5.18 Negative impacts:

- Students/trainees, due to potential increase in cost of training and difficulty finding a DPP/placement

  Main discrimination is financial i.e. how the optom will finance this. They need funding by their practice.

  Independent prescribing optometrist

The new integrated route to qualification is also likely to require a significant increase in funding. A conservative estimate for the clinical learning elements (based on typical charges for clinical observation sessions in hospital clinics) is of the order of £3000 for 90 hours. When this is laid alongside the rather expensive assessment methods required for "Does" learning outcomes (direct observation, OSCE etc) and the current cost of delivering the academic learning, it would be unsurprising if the cost of qualification were to rise to more than £20k per trainee. This may significantly reduce access to and enrolment on the IP qualification.

Optometrist

The funding (personal or sponsored) requirements to deliver the programme and qualify a NMP are not clear, nor is the risk and impact on current course providers. Unfunded or inaccessible training may disadvantage both course providers and a move for social mobility.

Commissioner of optical care

I think IP will be a less attractive offering to HEIs if the proposals go forward and this will impact on cost which will negatively impact on uptake.

Optometrist

Can be quite difficult finding a designated prescribing practitioner who can supervise, especially in the more isolated, rural areas. People may have to relocate in order to complete the qualification

Optometrist

- Providers, who will need to change/develop courses and may face added pressures

There is a likely negative impact on Universities who will need to change their courses and get internal approval at very fast speed or withdraw.

West Yorkshire & Harrogate Local Eye Health Network

We have concerns that current and potential providers will struggle to devote the capacity to develop the new qualifications effectively in time for approval in 2022, given that those same course teams are, over the same period, developing their new undergraduate qualifications. In addition, many Universities are still working on post COVID changes to teaching and assessment arrangements and this will continue to be a significant source of challenge for course teams

College of Optometrists

If the provider is required to provide 90 hours of clinical placement integrated in the programme this would incur significant costs in terms of staff time and placement fees to arrange placements across a large number of hospitals or practices across the UK.

Provider of GOC-approved qualification(s)

- The profession/workforce, if students delay starting their specialist qualifications

The GOC agreeing to extend the old requirement to start a clinical placement within two years would be really helpful in these exceptional times. Failing to do this clearly and in public may cause new candidates to delay starting their course with the knock on effect on the eye health system in reduced workforce and availability of great care for the public.

West Yorkshire & Harrogate Local Eye Health Network

However, removal of the 2 year timeframe may also cause apprehension amongst registrants, particularly if IP programmes are integrated into undergraduate courses, due to the restricted clinical experience of students. However, robust assessment methods and training will avoid issues with clinical experience as well as continuing professional development.

Provider of GOC-approved qualification(s)

- DPPs and their employers, due to financial and time implications

The initial training of DPPs will place a financial burden on these individuals who may also have time constraints.

FODO – The Association for Eye Care Providers

Only concern is regarding financial incentives for DPPs and how many will be willing/able to train

Independent prescribing optometrist

5. Registrant focus group feedback

This section of the report details the feedback from the five focus groups held with GOC registrants. During the groups, registrants discussed the nine key proposals of the consultation, which are covered in turn within this chapter.

Each proposal is summarised, followed by explanations of the main themes which emerged during the registrant discussion groups, supported by verbatim quotations.

5.1 Changing from two qualifications to a single qualification

Summary of the proposal

Candidates will acquire a single qualification approved by the GOC leading to specialist entry to the GOC register in AS, SP and/or IP categories, instead of two GOC-approved qualifications (gained either sequentially or simultaneously) currently required for entry to a specialty registration category (the theoretical component, normally delivered by a university, followed by The College of Optometrists Therapeutic Common Assessment).

A logical step to simplify and streamline the process

5.1.1 Some participants provided positive feedback about this proposal, explaining that combining two qualifications into one would be logical, as both qualifications (the theoretical component and the College of Optometrists assessment) are required to practice as an independent prescriber. Therefore, it was felt that the current system was overly complicated and unnecessary, and that a single qualification would make more sense and be easier to understand.

> *It's a good move, everybody to a certain level of education. I think it's a positive step…In terms of the differentiation between the two [qualifications], practically speaking, the interim one is of little use in terms of significance clinically in practice. I think it should be all or nothing. I think the majority that do this are going to want to be full IP rather than just part.*
>
> Independent prescribing optometrist, England

> *It just seems simpler. Rather than having two separate qualifications, if it's one single one then you either truly have it or you don't. It just makes it a lot easier to understand.*
>
> Optometrist, England

5.1.2 It was also felt that changing from two qualifications to a single qualification would streamline the process for optometrists wanting to become independent prescribers. Some felt that the current system is confusing and that awareness of the process is low, which may deter some optometrists from gaining the qualifications. By moving to a single qualification, the process would become simpler which may encourage greater uptake, with optometrists more able to understand how to achieve it. It was also suggested that combining the qualifications into one might encourage more optometrists to undertake it if it is seen to be a simpler and more streamlined process.

> *I definitely agree with it because when I was applying for it, my understanding was that I'd do the university course and then I'd just sit an OSCE. I didn't realise that you've got the clinical placement in between that the university has got no links with. It was very difficult to get my head round it as well, it wasn't as straight forward as it could have been.*
>
> Trainee independent prescribing optometrist, England

I think it's more streamlined to have one qualification. And also it's less daunting for people that want to do the qualification, knowing that they will just have the single qualification that they need to do.

Optometrist, England

I do think that it would serve to help streamline post-registration qualifications.

Pre-reg Optometrist, Wales

Clarifying the qualification for other professions, patients, and employers

5.1.3 Some participants suggested that moving to a single qualification would have the benefit of providing clarity around what an independent prescribing optometrist is and how they can work with other healthcare professionals. It was also felt that this change may improve patients' understanding of optometrists as healthcare professionals with more than just the ability to test their eyesight, should they be interested in the qualifications of their optometrist, and may increase awareness of the ability of some optometrists to prescribe and treat eye health conditions.

I think it's a positive for the profession to be able to gain one qualification. I think it's more streamlined and it would be easier to understand, both for the professional side of things, but also from a public perspective. For the general public, it's easier for them to understand one additional qualification that an optometrist might have rather than two, and what's the difference and what does that mean? I think the perception would be better for the general public and easier to understand.

Independent prescribing optometrist, Scotland

5.1.4 It was also highlighted that a single qualification system could be easier to understand for employers seeking to employ an independent prescribing optometrist, who may not have detailed understanding of how the current system works.

Also employers…If they're looking to get someone it will be easier for them to understand, because a lot of employers might not be as clued up with everything like that.

Optometrist, England

Some concerns about variation in standards

5.1.5 Although most participants could see benefits of moving to a single qualification, some concerns were raised about the potential for varying or falling standards for the IP qualification. It was suggested that the Therapeutic Common Assessment provided by the College of Optometrists provided a consistency for all optometrists, ensuring that all who qualify are at the same level, and that if the qualification is to be assessed by the provider only, this could pose a risk. Some participants, however, felt that the current Therapeutic Common Assessment was not an effective way of evaluating the knowledge and skill of an independent prescribing optometrist, but that if this assessment was improved, it may still be beneficial for all optometrists to undertake the same one to ensure consistency of standards.

At the moment you do your qualification through one of the providers, pay your money over and do an exam with them, and then you do an exam with the College afterwards. So to me, having the College doing an exam that all IP people would do is better quality control. It makes sure that when they finish their course, then everybody has to be up to the same standard afterwards. So I think it's a risk. Having learning outcomes to meet by having the shared final exam that everybody does through the College I think is preferable.

Independent prescribing optometrist, England

> *I agree to a point, but I'm a bit concerned about lowering standards…It would need to be carefully monitored, and the competencies that need to be reached need to be carefully thought about. I would also say that the current final exam is not really fit for purpose anyway, it's basically learn off a table of lists, and if you know those lists you don't need to have much understanding of them in order to pass that exam. So if the final exam that currently existed was better, I might be more inclined to keep it as it is, but I think it makes a lot more sense to have it as just one good qualification that's carefully looked after.*
>
> Independent prescribing optometrist, Scotland

5.2 Academic award or regulated qualification

Summary of the proposal

The approved qualification will be either an academic award or a regulated qualification at a minimum of Regulated Qualification Framework (RQF) (or equivalent) level 7.

Setting the qualification at a high level is justified and will help IP optometrists to be professionally recognised

5.2.1 A number of registrant participants were in favour of the AS/SP/IP qualifications being set at a minimum of RQF level 7, as they felt that the qualification deserved to be set at a high level equivalent to a Master's degree. They explained that the qualification was challenging to achieve, and gave optometrists a much greater degree of clinical responsibility, which should be recognised by the level at which the qualification is set. It was also felt that, by setting the qualification at a higher level, it may increase the intensity and difficulty, which would be of benefit to the profession and patient safety.

> *Presumably, this proposal means that if you're getting a Master's, it's going to be more intense than what it is now, because it's only a diploma…If we're increasing the educational content it's only going to be a positive.*
>
> Independent prescribing optometrist, England

5.2.2 It was also suggested that, by increasing the standing of the qualification, this would help optometrists with an independent prescribing qualification to be professionally recognised by other healthcare professions and patients.

> *If it's a standard recognised and well known qualification, then there's an element of respect that comes with that from fellow professionals, such as your GPs and ophthalmologists at the hospital [who] might be more at eased and more convinced to sign off shared care schemes whereby we can look after patients in the community. They can be sort of reassured, almost, that the professionals they're putting their patient care into have been vetted and taught to a high standard.*
>
> Independent prescribing optometrist, Scotland

May attract more optometrists to undertake the qualification, but may also deter others

5.2.3 If the qualification is set at a higher level (Master's degree equivalent), some participants explained that this may help to attract more optometrists to undertake it. They felt the degree could be more appealing if set at this level, as it may bring more credibility and prestige to their careers.

I can see a lot of people being more inclined as well, just because it is saying that it's equivalent to a Master's. So for that reason, I think there will be quite a few people that think, 'Actually, this might be worth doing'.

Optometrist, England

It might look even more appealing because you come out with an extra qualification as well.

Optometrist, England

5.2.4 However, it was also suggested that setting the qualification at this level may have the opposite effect and deter optometrists. Some participants explained that optometrists may be put off if they associate a high level qualification with being overly academic and requiring a lot of their time, potentially taking additional years to complete, which may be difficult to balance alongside their other work and family commitments. It was felt that this could be a particular issue for those later in their careers, but may not be seen as a problem for more recently qualified optometrists. Other participants felt that setting the qualification at a high level may result in it becoming too academic and not sufficiently focused on the practical and clinical skills required for independent prescribing.

By pushing it to that equivalent, it might put people off due to the amount of undertaking, the amount of time that they would have to put into that, the amount of work and effort that might take them away from their working day, from their family, from their job. So it could sort of put people off.

Independent prescribing optometrist, Scotland

I would argue Master's level is far too academic. You want to be able to 'see one, do one and teach one'…I'm not saying let's cut out all the academic stuff and just get our feet dirty. I think we do need to bring our knowledge up to a standard. It may be that you can put some of the credits towards a Master's if one so desires. But why more?

Optometrist, England

5.2.5 Despite this concern, some participants felt that in reality the amount of time and workload would not deter optometrists who really wanted to achieve the qualification and become an independent prescriber. They explained that they would simply do what was necessary to achieve the specialist qualification.

It's like asking in medicine what happens if they have to work longer. At the end of the day you want to be a doctor, and if you want to be a good doctor, you are going to have to do your residencies, you are going to have to study longer. So if you want to be an IP optometrist and you want to be a good one, then that's what you should do, you should study a bit longer in order to do it.

Trainee independent prescribing optometrist, England

It should be set at an even higher level to exceed the new optometry degree

5.2.6 Although many participants were in favour of the qualification being set at a higher level as an academic qualification, some highlighted that if it was set at RQF level 7, this would match the level of the new optometry degree. They explained that this seemed at odds with the independent prescribing qualification being an additional qualification for optometrists, as in their opinion the qualification should be at an even higher level to differentiate from the optometry degree. It was felt that setting the independent prescribing qualification at an even higher level would recognise the additional knowledge, skill and responsibility of independent prescribing optometrists who have

gained the additional qualification. However, participants were unsure what level would be appropriate.

> *Maybe Master's is a bit low, because in the sort of context of the ESR and sort of redefining what the optometry undergraduate degree is….I think IP needs to be at a higher level.*
>
> Pre-reg Optometrist, Wales

> *There has to be some sort of definition, because I've come out as a regular optometrist and I've got a Master's degree, but it doesn't define me from somebody who can actually prescribe, who has gone through that level of training. It's an important distinction…I'm sure my colleagues do a lot more in the clinical setting than I probably do. So I think it should be recognised.*
>
> Optometrist, England

> *The new optometry qualification is proposed to be level 7, so where are they drawing the distinction?...This is additional training…I don't know why this is pitched at the same level.*
>
> Independent prescribing optometrist, Northern Ireland

5.3 Removing the duration and location requirements for clinical experience

Summary of the proposal

There will be no proposed minimum/maximum or recommended time or credit volume for an approved qualification, or specified location or duration of clinical experience, other than the requirement that an approved qualification leading to specialist entry to the GOC register in AS, SP and/or IP categories must integrate approximately 90 hours of learning and experience in practice.

Increased flexibility for where clinical experience can be gained

5.3.1 Some participants saw this proposal as a positive change, as they felt that the removal of the specified location requirement for clinical experience for the independent prescribing qualifications would allow for increased flexibility. They explained that gaining clinical experience as part of the qualification can be difficult, especially when attempting to secure hospital placements. By stating that there is no specified location for where clinical experience can be gained, it was thought that experience could be gained more easily in other settings outside a hospital, such as in the community. Some participants saw this as having an added benefit of increasing the range of settings in which optometrists can gain experience, which was viewed as particularly important when independent prescribing optometrists can work in a variety of locations.

> *That sounds better to me straight away. It will define learning and experience in practice. The caveat there seems to be that it's removing the need for a clinical placement. You're talking about clinical experience…You don't necessarily have to go to a hospital. Perhaps if you're good chums with a consultant ophthalmologist and they have their private clinic, then you could get practice and learning experience in that type of environment. It sort of expands the opportunity to look at more venues to gain that extra experience and learning.*
>
> Optometrist, England

> *I can understand why the GOC is making it more inclusive. IP optometrists will work in different scenarios, so if you're an IP optometrist working in a glaucoma clinic, you could do all your cases in glaucoma and get IP qualified but you'd only be able to work in glaucoma and then it would be incumbent on you as a responsible professional that if you started to work in another area, you would do some cases in that first.*
>
> Optometrist, Scotland

A logical change, as time is less important than quality

5.3.2 A common theme which emerged during the registrant focus group discussions was that clinical experience was only valuable if it was of a high level of quality, and that therefore the amount of time was less important. Some participants felt that removing the minimum and maximum time restrictions for clinical experience, to be replaced with approximately 90 hours, was a good proposal, as they felt it placed more focus on the quality of the clinical experience rather than the time spent.

> *You do your placement at the moment, but is it a good quality placement? Do you feel at the end of that you're really confident and comfortable working? You could spend 12 days in a clinic not actually dealing with any patients, but you get your box ticked and that's you done. So I think it's much more important that the quality of the placement is assured rather than the amount of time.*
>
> Independent prescribing optometrist, Scotland

> *It's 90 hours but do they have to produce evidence of independent prescribing, of things relevant to the qualification? Or is that just 90 hours logged, in which case they could just be doing mundane eye tests. So is it just 90 hours or does it have to be 90 hours with evidence of decision making?*
>
> Independent prescribing optometrist, Scotland

Concerns about the impact this may have on the amount of hospital experience

5.3.3 Although some participants praised this proposal for the increased flexibility it could provide by making clinical experience during training easier to achieve outside a hospital setting, a number of participants expressed concerns about the impact this may have. It was felt that gaining clinical experience in a hospital setting is very important for the training of independent prescribing optometrists, where invaluable skills are learnt via experiences and interactions with patients who present with specific pathologies which are unique to that environment. Furthermore, it was suggested that working alongside ophthalmologists was also seen as being extremely important for the development of independent prescribers, who are able to learn valuable lessons from them in relation to diagnosis and treatment of eye conditions and interaction with patients. Therefore, these participants thought that removing the requirement for clinical experience to be gained in a hospital could have a negative impact on the training of future independent prescribing optometrists, as they would not gain as much relevant experience as they would have done in a hospital setting.

> *Personally, I think hospital placements should still come into it because you just don't get the exposure to pathology that you need. It's the more serious things you have to tease out with the right questions and a few little trial and error tests. For me, it's essential to have some kind of hospital element to it. I just don't see how you can get the exposure to pathology in any sort of high street practice.*
>
> Independent prescribing optometrist, Scotland

Even though I didn't see masses of cases that were relevant, being with the consultant, having the chance to talk to them and just noticing how they talk to patients and question patients sort of gave me those underlying skills.

Independent prescribing optometrist, England

What you learn from an ophthalmologist in their clinic is invaluable. We don't think like medics think. I way with doctors every week, and the way they process and think, and put their investigations in place and put a management plan in – we're not taught to do that. And to learn from them, in that environment, is absolutely invaluable…So I do feel that there should still be an element of hospital experience.

Independent prescribing optometrist, Wales

Strike a balance between increased flexibility and some requirements

5.3.4 To counteract any potential negative impacts of removing the minimum and maximum times and locations for clinical experience, a number of participants suggested that the GOC could provide a balance between increased flexibility and retaining some requirements for clinical experience. Rather than specifying 'approximately 90 hours of learning and experience in practice', it was suggested that there could be requirements for a certain number of patient interactions instead, which it was felt would lead to better experienced and skilled independent prescribing optometrists. Participants often highlighted that time was less important in relation to clinical experience, as time could be spent seeing patient cases that do not provide useful learning opportunities for trainees. Therefore, they thought that specifying clinical experiences and patient interactions would be more valuable, whilst still allowing flexibility for trainees to gain the relevant experience.

I think it has to quantify patient numbers and patient episodes to ensure you have a broad experience of different conditions and patient experience, because 20 people could sit in the corner and watch one clinic and gain nothing from it based on the wording.

Independent prescribing optometrist, Northern Ireland

Is there too much emphasis actually on time, as opposed to in terms of numbers? And actually what they're observing being prescribed, and how much of it, and what they're actually seeing, rather than just a time? Would that be something that's more appropriate? In an acute setting we'd have days where casualty wasn't busy, so the poor individual that was in there on that day wouldn't necessarily see as much prescribing as another day.

Independent prescribing optometrist, England

Would it be better, instead of specifying the number of hours, specifying the number of patient cases, like we do with our pre-reges? Should we say you need to see X amount of glaucoma patients, X amount of AMD patients, X amount of corneal patients? Is that a better way to manage it, rather than just saying 90 hours?

Optometrist, England

5.3.5 Some participants highlighted that this proposal does not specify a required split between the time spent between learning and practical experience, which led them to be concerned that some trainees would focus too heavily on one over the other. In particular, participants were worried that some providers may not offer sufficient clinical experience, instead offering greater levels of academic learning, which they felt would not produce a well-qualified independent prescribing optometrist, with sufficient experience. Participants explained that this may be more likely to

happen due to the current difficulties of arranging clinical experience. Therefore, it was suggested that some additional requirements could be stated in this area to avoid any ambiguity.

> *It is a bit woolly saying '90 hours of learning and experience in practice'. It doesn't say at least 45 hours of experience in practice. In Miller's pyramid, the only way of showing how and doing is to actually have clinics. I would be a bit concerned if the GOC was approving courses of study which were more or less all theoretical.*
>
> Optometrist, Scotland

> *You could watch something online and I just think the learning is somebody showing you or asking you to do something. If you've got a group of people sitting and watching something, you don't really learn anything.*
>
> Independent prescribing optometrist, Northern Ireland

5.4 Requirement for a qualified designated prescribing practitioner (DPP) to supervise

Summary of the proposal

Trainees upon application must have identified a suitably experienced and qualified designated prescribing practitioner (DPP) who has agreed to supervise their learning in practice. A trainee's DPP must be a registered healthcare professional in Great Britain or Northern Ireland with independent prescribing rights and be an active prescriber competent in the clinical area(s) they will be supervising the trainee in, have the relevant core competencies and be trained and supported to carry out their role effectively. If more than one registered healthcare professional with IP rights is involved in supervising a trainee, one independent prescriber must assume primary responsibility for coordinating the trainee's supervision. That person will be the trainee's DPP. In addition, we propose that there must be agreements in place between the trainee, their DPP and the qualification provider that describe their respective roles and responsibilities during periods of learning and experience in practice. These must be regularly reviewed and supported by management plans, systems and policies which prioritise patient safety.

Will help trainees to gain clinical experience

5.4.1 A number of participants were very positive about this proposal, as they felt it would significantly improve the ability for trainees to gain the clinical experience they need. Participants explained that historically it has been difficult for optometrists to secure clinical placements when training to become an independent prescriber due to the limited number of hospitals and ophthalmologists with the time and capacity to take on a trainee, and that this had been exacerbated by the Covid-19 pandemic. They thought that this change would provide more options for trainees by removing the requirement for supervision to be conducted only by an ophthalmologist, making it easier to access the clinical experience they require. This proposal was described by some participants as 'a game changer'.

> *Personally, I think that's a great move. It opens up the scope to a lot more optoms to be able to undertake the training and complete the training. I did my placement three years ago now. That was pre-COVID, and it was hard enough to get placements at that point.*
>
> Independent prescribing optometrist, Scotland

> *For me this is a bit of a game changer really, in terms of access to reach a qualification.*
>
> Optometrist, England

> *From a purely practical perspective, if you want large numbers of optometrists to be independent prescribers, there's not going to be enough consultant ophthalmologists to supervise them all. So having somebody who has relevant experience to supervise just seems like a very pragmatic approach. I think it's a very good idea.*
>
> Optometrist, Scotland

Supervision from an independent prescribing optometrist may be more beneficial than from an ophthalmologist

5.4.2 Allowing supervision to be conducted by a registered healthcare professional with independent prescribing rights, which participants assumed meant an optometrist with the independent prescribing qualification, was seen by many participants as a sensible change from the current system, as these supervisors would be able to provide advice and guidance that was more relevant to the role. A number of participants felt that, although there were benefits to being supervised by an ophthalmologist, their role was quite different and in many ways removed from the work of an independent prescribing optometrist, particularly one working in the community, and that the ophthalmologist conducting the supervision may not be able to provide the most relevant advice and guidance for their future roles. It was suggested that an experienced independent prescribing optometrist taking on the supervising role would therefore be more appropriate, as they would be able to ensure they were trained to be well prepared for the realities of the role.

> *When we do our training in our pre-reg year, we have a supervisor who is a qualified optometrist. So I think this should be done in a similar fashion, because what you do every day isn't what an ophthalmologist does every day. So you should just do it with someone who is an IP and can give you the relevant training.*
>
> Optometrist, England

> *As a trainee, I'd feel more confident with a DPP because during my pre-reg when I was doing my hospital placement, there were a few consultants who didn't really know why I was there or what I was hoping to gain from the experience. I got my hours and my patient records, but there could've been more learning there. So maybe if I had an IP as my supervisor who knew exactly what I needed to get out of the experience, it would enhance my understanding a lot more.*
>
> Trainee independent prescribing optometrist, England

> *I would think it's a good thing to do. Because with the pressure in hospitals, there's going to be a shortage of eye doctors who want to take on IP optoms. The IP optoms who have got maybe at least ten years' experience would be very good at taking the younger ones under their wings. They have been through the experience before and I think it could really work…They know what's going to be expected and what level their trainees should be working to.*
>
> Independent prescribing optometrist, Wales

The required level of experience of DPPs

5.4.3 The level of experience required for someone to take on the role of a DPP was discussed. Participants queried what 'suitably experienced' and an 'active prescriber' would actually mean, and some expressed concerns about the impact this proposal may have for the supervision of trainees should a DPP with insufficient experience take on the role. Therefore it was often suggested that there should be a more defined set of criteria for those who choose to become DPPs to ensure that their supervision will benefit trainees.

Who is going to be deemed a DPP? Who is considered suitably qualified, and what is considered as an 'active prescriber'? How much experience does that individual have who is then teaching others? My worry is that it's just any practitioner working in a high street setting who doesn't have much experience in prescribing themselves. It is subjective as to what we're defining as 'enough experience'…You're just going to pass on bad habits if that individual is potentially not prescribing in an optimal way.

Independent prescribing optometrist, England

I think opening the doors to IPs being supervisors is a really good thing, but there has to be a really robust system for saying that supervisor is suitable to be a DPP…Who's going to make that decision? What's that decision going to look like?

Independent prescribing optometrist, Scotland

5.4.4 It was suggested that there could be specific requirements in the number of years of prescribing experience required. Some participants thought at least three years of prescribing experience would be sufficient, whereas others felt there should be even more, as this would ensure DPPs have spent enough time in their role to be able to effectively supervise a trainee independent prescribing trainee.

I think it should be at least three years with all the things you need to know, all the things you have to keep up with. I think somebody who's been working in practice full time, taking on a new pre-reg, having only worked two years themselves in a practice where it's been busy and they've just been doing test upon test is really not enough. Maybe three years would just give them a little bit more confidence.

Independent prescribing optometrist, England

5.4.5 Others thought specific patient and pathology experience was more important than the number of years spent prescribing, as the number of prescribing opportunities may vary significantly between independent prescribers, depending on where they work and the type of patients they see. Therefore it was suggested that a requirement of becoming a DPP could be linked to the amount of prescribing conducted, rather than the length of time spent in the role since the qualification was gained. It was also suggested that a training course could be provided for DPPs to the required knowledge and skills to effectively supervise trainee independent prescribing optometrists.

There needs to be an outset level of experience, whether it's time related or not I don't know. I do know some IP colleagues have been qualified as a number of years as an IP and have never used their qualification – maybe once or twice a month, if that. But then there are other IPs who qualified two years ago and are using it every day. Granted, they do say that not prescribing is also a prescribing decision, but I think there's a difference between how long you've been qualified and how much experience you have, and it's the experience that matters rather than the length of time you've been qualified.

Independent prescribing optometrist, England

I think it's important that if they're going to register as someone's DPP, they have to do a course or something…just so they're aware of what they're signing off, the process, whether they have to see certain patients – just so they're aware of all of this.

Independent prescribing optometrist, Northern Ireland

Concerns about the lack of hospital experience for DPPs and trainees

5.4.6 A smaller number of participants expressed some concerns about this proposal. They felt that by expanding the scope of supervision to include practising independent prescribers, the quality of supervision may fall due to the lack of hospital experience that these future DPPs may have, as they may not see as broad a range of pathology if they had spent their time as an independent prescriber working in a community practice setting. As highlighted in the proposal to remove the specified location requirements for clinical experience, some participants said that this change could reduce or remove hospital-based experience for trainees, which they felt may limit the quality of experience they could gain.

> *They [optometrists] simply don't see enough pathology so their range of experience can't be enough to pass on. I have a very active IP practice and I get a lot of eye problems from the GPs up the road and I wouldn't do it [be a DPP] because from my point of view, it would be a disservice to the person coming through. I don't think it has to be an ophthalmologist, but I do think it needs to be a full-time hospital employed prescriber. They need to see a complete range of things and where they have got access to a number of ophthalmologists to be able to learn the variety of conditions and the variety of treatments.*
>
> Independent prescribing optometrist, Northern Ireland

> *It's a shame that it wouldn't necessarily be with hospital work…Becoming an IP optometrist and working in the hospital with fellow healthcare professionals will not only give you more experience of a wider areas of practice, but will also let other healthcare professionals know what you can do. So that when you are in practice, rather than patients appearing in a hospital setting, they may be recommended to go to the optometric practice setting.*
>
> Optometrist, England

5.5 Providers must involve feedback from stakeholders

Summary of the proposal

The provider of the approved qualification must, in the design, delivery and assessment of an approved qualification, involve and be informed by feedback from a range of stakeholders including patients, employers, trainees, supervisors, members of the eye care team and other healthcare professionals.

An expected and positive proposal

5.5.1 This proposal was viewed by the majority of participants as an expected aspect of the provision of a training course. Some participants explained that they expected that a range of stakeholders would be consulted during the design, delivery and assessment of a training course for an approved qualification, and were therefore unsurprised and happy to see this proposal.

> *I think it's quite standard to involve a group of people like that now in things, isn't it?*
>
> Independent prescribing optometrist, Wales

> *I think that's reasonable. It's just governance and proper audit.*
>
> Independent prescribing optometrist, Northern Ireland

5.5.2 It was felt that there were benefits to including feedback from all listed stakeholders in the process. Some participants said that gaining feedback from other healthcare professionals was very

important due to increased multi-disciplinary working across healthcare and to increase awareness of the qualification. Others emphasised the importance of patient input into the process to ensure public understanding, and it was also felt that feedback from employers would be key to increased future uptake of the independent prescribing qualification, as more employers might put optometrist employees forward for the qualification.

> *It's got to be fit for purpose, and it's got to involve all the people that may be involved at different touch points of it as well. It's got to be applicable to the general public, they've got to understand what it means. It's got to fit in with employers as well. They are not going to want to be involved if there's not an advantage for that to take place…And other healthcare professionals have to be aware of it…they probably want an input to make sure it's fit for practice, and that moving forward it's going to be utilised and could bring the profession into the spotlight and highlight how we can help. I think it's right that everybody would have an input to ensure that their thoughts and queries were included.*
>
> Independent prescribing optometrist, Scotland

> *We have cluster groups, which involve GPs and nurses. For them to be involved in the qualification side of it is important. They're going to respect us more as a profession if they understand what we're doing to be qualified.*
>
> Independent prescribing optometrist, Wales

An unnecessary proposal

5.5.3 A small number of participants questioned the relevance of gaining feedback from the stakeholders listed in the proposal. Some felt that feedback from any of the stakeholders seemed unnecessary if the GOC has approved the qualification and the provider of the qualification, whereas others focused on the feedback of patients and employers, explaining that they could not see it as being useful to the design, delivery and assessment of approved qualifications.

> *The GOC, in my understanding, would come out with a new set of competencies, or the same range of competencies, and give them to a provider, and then the provider proves they can deliver the course. Why then do they have to go to stakeholders, if the GOC have approved them as a provider and are continuously monitoring them in their provision, which I'm guessing they're going to do? I don't really get where all of this feedback would be able to come in, never mind why they would ask for it.*
>
> Independent prescribing optometrist, Scotland

> *I just thought in some ways it was a little bit pointless. Just getting feedback from patients, colleagues, the eye care team. If it's regulated and there's a set structure, then you don't really need any of these other peoples' statements, or however they're going to do it.*
>
> Optometrist, England

> *It's maybe good to have a little bit of feedback, if you've got relationships with hospitals, what you think the students are missing. But patients and employers? Probably not.*
>
> Independent prescribing optometrist, England

5.6 Use of an outcomes-based approach via Miller's Pyramid of Clinical Competence

Summary of the proposal

An outcomes-based approach is used to specify knowledge, skills and behaviours using an established competence and assessment hierarchy known as 'Miller's Pyramid of Clinical Competence' (knows; knows how; shows how; and does), mapped to relevant external prescribing frameworks, including the draft Royal Pharmaceutical Society's (RPS) Competency Framework for all Prescribers (2021).

A logical choice as it is already used for the optometry degree and in the education of other healthcare professions

5.6.1 Registrant feedback in relation to the use of Miller's Pyramid was generally positive amongst most participants. The most common response to this proposal was that adopting Miller's Pyramid for specialist qualifications was a logical choice as it had already been adopted for the optometry degree, and would therefore provide consistency and familiarity for those who decide to continue their education and training.

> *I think it's a really good framework. And it's the same one that's being used to sort of redesign the undergraduate degree, so it would make sense if everything was sort of taught with the same ethos.*
>
> Pre-reg optometrist, Wales

5.6.2 It was also highlighted that this approach is used in other healthcare professions, and therefore it was important that optometry qualifications are brought in line to provide more equal standing and to highlight the level of skill and knowledge of independent prescribing optometrists.

> *I appreciate that if this is how other professions rank their knowledge and their learning, then I think it is probably important that we adopt similar strategies so that perhaps we can get that respect from other professions, and they can see that we have been vetted and looked at in a similar way. I think it stands us in good stead to highlight the level of training and benchmark.*
>
> Independent prescribing optometrist, Scotland

> *This qualification has to stand up with other professionals who have a similar level of qualification. And if this is one way to do it, then let's do it.*
>
> Optometrist, England

An easy to understand system that will provide consistency and flexibility

5.6.3 A number of participants thought this proposal was a good idea as they viewed Miller's Pyramid as a simple and easy to understand system of assessment, which would benefit both providers and trainees.

> *I think this is a good thing in that there's certain learning outcomes which obviously you just need to be aware of and then other things are obviously at the top of the pyramid, which you definitely need to be able to do safely and understand.*
>
> Independent prescribing optometrist, England

5.6.4 This proposal was also seen in a positive light as some participants thought that utilising Miller's Pyramid would better ensure consistency across providers of qualifications, and a specific level of knowledge and skill of newly qualified independent prescribing optometrists.

> *The current pre-reges, the third year students, they have these competency sheets…we know from doing it that you're signed off as being competent at things like Goldmann and stuff, but you've only done it once or twice. So I think this goes into 'knows how'. It's probably more relevant to different stages. Probably for IP there's maybe more at the top of the triangle than if you're undergraduate…It clarifies what you really need to know, what you can do competently, to what you almost need to just be aware of.*
>
> Independent prescribing optometrist, England

> *It's a positive thing. I just feel like people will be more confident, and it's more structured. So I thought it was quite a good idea.*
>
> Optometrist, England

5.6.5 At the same time as ensuring consistency, it was also suggested that adopting Miller's Pyramid would offer a greater degree of flexibility for providers of these qualifications, moving away from the current more prescriptive approach. It was felt that this would be a positive step, as it may enable providers to find new and improved ways of delivering specialist qualification courses, whilst still ensuring a consistent level of knowledge and skill.

> *What the GOC is doing is taking it from a very prescriptive approach…to saying 'there's more than one way of doing it'. They're allowing different providers within this framework to say 'but we'd like to do it this way'. So I think this works quite well, because it is still saying that you have to understand, but then you need to be able to demonstrate you can do it and actually do it. So if you're following this pyramid, and you've got a proper quality control, you're not going to approve a course that doesn't have a sufficient element of practical experience. It fits with everything else that they're proposing.*
>
> Optometrist, Scotland

5.7 Providers to be responsible for the assessment and achievement of approved qualifications

Summary of the proposal

Providers of approved qualifications are responsible for the measurement (assessment) of students' achievement of the outcomes at the required level (on Miller's Pyramid) leading to an award of an approved qualification.

A sensible approach

5.7.1 Some participants were in support of this proposal, as they saw it as a sensible approach, making the providers of approved qualifications also the assessors of those qualifications. The main explanation provided by these participants was that there should be no issues with this approach, as long as providers are held accountable by the GOC. They therefore placed faith in the new proposed documents, and felt that if these were enforced, giving providers the responsibility of assessing their own students was a positive step.

I think this is overall positive, as long as it's properly enforced. This is kind of leading to what we've all been saying since the start, that if there are good competencies specified, and if the providers are able to show that their students reach those competencies in a good way, then happy days, we've got really well qualified Ips at the end of the course. So I think having all of that responsibility in one place is a good thing.

Independent prescribing optometrist, Scotland

It seems quite straightforward. So they're going to be held accountable by the GOC on how they do this.

Independent prescribing optometrist, England

Some concerns about consistency

5.7.2 A number of participants discussed how consistency would be maintained in the assessment of specialist qualifications if the College of Optometrists was no longer solely responsible for the final assessment of independent prescribing optometrists. Some thought that, without the consistency provided by the current system of assessment, the difficulty of achieving the qualification may vary from provider to provider, creating some areas of the country where it is easier to become qualified than others. Others highlighted that providers may be more likely to pass their own students, perhaps unintentionally or to knowingly improve their pass rate, providing recent examples where this has happened, which may lead to reduced standards overall.

The way this works at the moment is that there is this level of consistency and benchmark that, regardless of what university or educational provider you've attended to get your theory, and whatever provider you've attended to get your practical, you're still being assessed by that same benchmark. I quite like that, because we're all getting assessed by the same means, and therefore the qualification is consistent across the whole of the UK. This change potentially leads to some providers being a bit easier than others, where it might be easier to get it in one part of the UK but harder to achieve in another, and not having the same benchmarks or the same consistency. So for that reason I would be a bit dubious about that outcome.

Independent prescribing optometrist, Scotland

There is a risk here. You've only got to look at what happened with the A levels. If you ask a teacher, or the provider of education, how their students have done, they will all say that they did better than had they been assessed by somebody else…You have to make sure that the GOC's approval of those courses is robust, otherwise you will find that people are qualified to IP level that really ought not to be.

Optometrist, Scotland

5.7.3 However, generally participants felt that this issue could be overcome by careful regulation from the GOC to ensure that all providers are working to the same standards, as set out in the new proposed documents. It was also thought that this change would reduce the current monopoly that exists in relation to the final assessment of trainees, opening up opportunities for other providers and increasing flexibility for both students and providers.

I agree, as long as providers have the same sort of standards. If there was one provider who's completely different to somewhere else…then there might be some issues. But generally I thought it was positive.

Optometrist, England

> *One side is that if you allow the providers to approve, then you are opening up the opportunities for reducing the monopoly that is currently existing. But on the other side, if the providers aren't governed and controlled then there will be huge flexibility in the levels that different providers think are suitable, and you end up with professionals that have the same qualification but are very different in their capabilities.*
>
> Independent prescribing optometrist, England

5.8 Providers are responsible for recruiting trainees to course programmes, recognition of prior learning, removal of two-year registration requirement

Summary of the proposal

Providers of approved qualifications will be responsible for recruiting and selecting trainees onto a programme leading to an award of an approved qualification. Recognition of prior learning can be deployed to assist the progression of trainees whose progress to specialist registration has stalled, and the requirement for optometrist IP trainees to have been registered for at least two years prior to commencing clinical experience/hospital placements has been removed.

No strong opinions about providers being responsible for recruitment of trainees

5.8.1 Registrant participants had no strong opinions about the proposal for the providers of approved qualifications being responsible for recruiting and selecting trainees onto a programme leading to an award of an approved qualification. Most explained that this made logical sense, or that they assumed this was already the case, as providers were financially driven to recruit trainees to select their courses.

> *I think that if a provider is providing a course, they should be confident and willing in going out there to signpost that they are the best, and therefore attract people to sign up for them.*
>
> Independent prescribing optometrist, Scotland

> *The universities recruit their own trainees anyway. You're led through either who's nearest to you or where you can get a place, financially I suppose. But they can also offer enticements in finding practical placements and things, I'm sure, to get a few more students their way. Because it's about money to them.*
>
> Independent prescribing optometrist, England

Recognising prior learning is a positive change which increases flexibility

5.8.2 The proposal to recognise prior learning to assist the progression of trainees whose progress to specialist registration had stalled was generally viewed as a positive change by participants. They thought it would make the process of undertaking the independent prescribing qualification more flexible for those who wish to do it, which would benefit certain groups of people such as those who may take time away from work to have children. It was also suggested that recognising prior learning increased flexibility as not all optometrists would start this training at the same stage in their career, meaning that levels of knowledge and experience will vary, and therefore this should be taken into consideration.

What I can take from it as well is that there's that opportunity to put it down and pick it up as well when you need to, when it talks about your progress, especially if registration has stalled. So if you start one year but life gets in the way. And that happened to me – I started IP ten years ago, and two children came along and prevented me from actually doing the placements and getting my final qualification in it, so I picked it up years later…So I think that's a positive to be maintained and kept.

Independent prescribing optometrist, Scotland

I think recognition of prior learning is great. Everybody's at different stages in their career and in their learning, and it's only fair that whatever that stage is, or whatever prior knowledge or learning you have, it can be quite rightly justified and utilised as well.

Independent prescribing optometrist, Scotland

5.8.3 Another perceived benefit of this proposal was that it would be helpful for those who struggle to find a clinical experience during their training, which can result in their progress to becoming qualified stalling.

I think the recognition of prior learning is good, because I think there'll be a lot of people stuck, not being able to get their placements in the last year or so who might be caught in a sort of bureaucratic nightmare trying to get seen on time.

Independent prescribing optometrist, Scotland

5.8.4 Recognition of prior learning was also viewed as beneficial for those who may have begun their education in other countries, as this proposal would mean their previous studies could be used towards their progression to become an independent prescribing optometrist, rather than having to start from the beginning unnecessarily.

The recognition of prior learning is good, particularly for those who are coming from the likes of America, Canada and Australia.

Independent prescribing optometrist, Northern Ireland

Some questions raised about how prior learning would be measured

5.8.5 Although attitudes were generally positive towards the recognition of prior learning, some participants raised questions about how this would work in reality. These questions focused on exactly how prior learning would be recognised, as participants wondered at what stage of the training certain levels of knowledge and experience would place an individual, and how their prior knowledge would be measured and verified to ensure a fair approach is taken.

The only question mark I would have on that is where does it put them [trainees] on the ladder? Does it mean they don't have to do various clinical placements? That they can get their clinical placement time reduced by X many hours? Does it mean that they don't have to sit some parts of the qualification at the end of it? I think that if you're saying that somebody who's experienced in that field don't necessarily have the qualification, but they know what they're doing, where do you put them on that journey to becoming qualified as an IP? It's great that there's the recognition of prior learning, but again, define prior learning.

Optometrist, England

Removing the two-year registration requirement is a positive change

5.8.6 Opinion towards the removal of the two-year registration requirement for optometrists before beginning their independent prescribing training was split in the registrant focus groups. Some participants were in favour of this proposal, as they thought there was significant appetite from newly qualified optometrists who want to undertake the training as soon as possible, but are forced to wait for two years until they are able to do so. These participants felt that requiring these optometrists to wait for two years was unnecessary, as they are enthusiastic and keen to continue their optical education and should be enabled and encouraged to, and that the two-year registration requirement may discourage them from seeking further qualifications. It was suggested that by capturing this enthusiasm at the right time and allowing newly qualified optometrists to immediately begin their independent prescribing training, this may significantly increase the uptake of this specialist qualification.

> *I work with a lot of pre-reg optometrists and a lot of newly qualified, and they are literally counting down the days until they are two years' qualified right now to be able to apply for the course. So I think it's great. A lot of the recently graduated optoms have got better knowledge than some of us as well, whether it's theoretical and maybe not experience, but they are raring to go and desperate to do this additional course. So I think taking away that restriction is great. And I think it will make it all the more competitive, and kind of the 'buzz course' that people will want to be doing. Anything that encourages people to learn and to achieve more is great.*
>
> Independent prescribing optometrist, Scotland

> *It's at a point where you've got students that are used to studying, and therefore they're more inclined to do it. So hopefully we'll have more uptake to do it once they're out of uni, rather than having to wait two years before they're allowed to do it. They're already in that mindset of studying. Particularly now, if we're talking about a Master's qualification as well, it kind of is the right time to do it.*
>
> Independent prescribing optometrist, England

5.8.7 It was also suggested that, at the point of qualifying, many optometrists are sufficiently confident and knowledgeable to begin training to achieve independent prescribing status, and therefore the choice to do so should be available to them. It was often suggested that the two-year registration requirement seemed arbitrary, without any justification being provided for this specific amount of time.

> *You're a qualified optom at a certain point, you've got your qualification. So at that point, you shouldn't have passed your pre-reg if you weren't ready. So I think that choice should be available there. If the optom feels confident to be able to do it, why not? If they don't, they can wait two years. Why keep the two-year minimum requirement, which has already been described as an arbitrary minimum figure? There will be certain settings where getting somebody doing their IP straight away is going to be a benefit to them in their career, or wherever they're working.*
>
> Independent prescribing optometrist, England

5.8.8 Some participants highlighted that removing the two-year registration requirement would allow the independent prescribing qualification to become part of the optometry degree. Some were in favour of this change, as they felt it would produce optometrists who are better equipped to work in the current optical sector in the UK and treat patients effectively. A number of participants said that this

style of training was already in place in other countries and worked effectively, and that progressing to a similar system in the UK was a positive step.

> *The removal of the two-year registration requirement will therefore enable this to be tagged on to an undergraduate course, so straight away I would agree with that.*
>
> Optometrist, England

> *I agree with having it part of the degree…I wish something like that would have been offered when I did it. It would have given me more of an incentive to maybe pursue that after university.*
>
> Optometrist, England

> *To me, the ideal is that optometrists can be able to prescribe straight away after they come out of university, but to do that they're going to need an awful lot more of patient experience than we give them at the moment. So yes, I would agree with removing the two years.*
>
> Optometrist, Scotland

Concerns raised about removing the two-year registration requirement

5.8.9 Despite a number of participants supporting the proposal to remove the two-year registration requirement, some participants raised concerns. These focused on the experience that optometrists gain during the first two years of their registration, which they explained was very valuable and helped to shape those leaving education and training into effective real-world optometrists, where experiences are gained which cannot happen during training. They therefore thought that it was important for newly qualified optometrists to go through these first two years of work before beginning their independent prescribing training in order to gain this experience, which would be lacking if this requirement was removed.

> *I'm not so sure about the two-year removal…I know some universities are very keen to include this in their undergraduate studies, but from my experience of third year students and supervising lots of pre-reges, it could be a bit dangerous…Some people coming out of university, I wouldn't trust them to do a lot of things during that first year or two in prescribing drugs. I just don't think they've got enough experience. I think there's a lot to learn during that first year or two.*
>
> Independent prescribing optometrist, England

> *I think a lot can be learned in the first two years in practice, and I'm wondering if it is a case of running before you can walk. And I think learning your sort of bread and butter optometry for at least two years is a good thing before starting IP, personally.*
>
> Optometrist, England

> *I think you need to be two years' qualified before you look to do it. I've experienced pre-reg after pre-reg after pre-reg, and they are wonderful, but when you come out you are still learning. And I think you need that clinical environment for two years before you go on to being let loose with an IP pad. I definitely couldn't have done it just on qualifying.*
>
> Independent prescribing optometrist, Wales

5.8.10 However, a number of participants thought that it made more sense to measure the quality of experience an optometrist has before beginning this training, rather than the number of years they have been registered. Participants explained that the amount of experience gained in the first two

years of registration would vary significantly from optometrist to optometrist, depending on a variety of factors such as their workplace setting, area of the country, and the type of patients they encounter and treat. It was also suggested that some optometrists may not have been practicing during their first two years of registration, and not gained any experience whatsoever. Therefore, it was explained that there may be some optometrists who, during those two years, have gained very little experience when compared with others.

> *You can get someone who enters the GOC register and they may take a year or two years out. Two years means nothing – I think it depends on the experience you've gained before you move to IP. It's arbitrary, really, because you're assuming that the optometrist has been working in those two years. I know some who have passed their pre-reg and haven't even tested once, so they could start an IP course and don't even know how to refract.*
>
> Optometrist, England

5.8.11 Therefore, as with a number of suggestions related to this consultation, it was suggested that a measure of experience should be the requirement to begin independent prescribing training, rather than an amount of time, as this would be a better way to ensure optometrists have a sufficient level of knowledge and skill.

> *I think the two years is a bit arbitrary. Who came up with two years and why would be my question. I certainly think when I first qualified I wouldn't have been in a good position to do IP, but then that's a long time ago, and I don't have an awful lot of contact with pre-reges at the moment, so I don't have great knowledge of what skills are like at that point. I think it comes back to the same thing. If the competency-based assessment is robust, then nobody's going to get through who isn't able to do the qualification. If that is not robust, then it's probably much safer to have some sort of minimum requirement of training.*
>
> Independent prescribing optometrist, Scotland

> *There's always going to be that bunch that want to come out, qualify and get as many letters behind their names as possible, but without any real experience in anything whatsoever. If you think about it, how many times do you see uveitis? You don't see it on a daily basis. You don't see corneal ulcers on a daily basis. So you've got to get that experience in all those different areas and see those conditions.*
>
> Independent prescribing optometrist, Wales

5.9 Removal of the requirement to supply details of 12 months of prescribing decisions

Summary of the proposal

At the point of retention, registrants in the AS, SP and/or IP categories will no longer need to supply details of prescribing decisions undertaken in the previous 12 months.

A very well-received proposal which will remove unnecessary paperwork

5.9.1 This proposal was by far the most positively received by the majority of registrant focus group participants. They explained that they found the process of recording all their prescribing decisions throughout the year to be very onerous and time-consuming, and it was often difficult to find the

time alongside other work commitments. It was also highlighted that recording this information was duplicating work, as their prescribing decisions are logged elsewhere in patient records and potentially other locations depending on the country. Removing this requirement was therefore very welcome and appreciated by current independent prescribers, who felt that they had been listened to by the GOC.

> *It's not only the ones you prescribe to that you're supposed to record, it's any decision…I've got other things to do, it's not practical at all. It doesn't help me, it's just a tick box exercise.*
> Independent prescribing optometrist, England

> *That's the biggest load of paperwork nonsense that I have to do…You just fill them in and they check a few of them randomly apparently.*
> Independent prescribing optometrist, Northern Ireland

Shows an increased level of trust, in line with other professions

5.9.2 Some participants explained that being required to provide a log of all their prescribing decisions meant they felt they were not trusted by the GOC, particularly as they were aware that this was not something required by independent prescribers in other healthcare professions, such as nurses and pharmacists. Therefore, they felt that removing this requirement would make independent prescribing optometrists feel much more trusted by the GOC in their decisions and abilities, and again would give them equal status with independent prescribers in other healthcare professions.

> *There's currently an element of 'Big Brother's watching', where I'm not to be trusted and have to be vetted at the end of the year to make sure I'm doing everything right. But I've got the qualification, I should be able to be trusted to do as I see fit. I'm more than happy to be audited if someone wants to audit me. I'm not aware of any other independent prescribers in other professions that have to do this either. Hopefully if this all happens, we'll be treated like any other prescriber in the community.*
> Independent prescribing optometrist, Scotland

> *There's an element of trust there. I think it's almost as if, 'We think we know what you're doing, but we're not quite sure, so we have to make sure that you know what you're doing'. That's the cynic in me saying that, so I think the removal of that would be very good indeed.*
> Optometrist, England

May remove an opportunity for learning and reflection

5.9.3 Only a very small number of participants expressed concerns about this proposal, explaining that recording prescribing decisions over the year was a useful process for learning and reflection for some optometrists, and that removing this requirement may therefore be detrimental. However, the majority of participants did not see a benefit to this process, and celebrated its removal in this proposal.

> *Think of it like revision. You had to submit it and go back over what you are doing. There were things that you learnt in January and then in November, you forgot. It's an academic thing to do. Done properly, there are things to learn from it. I don't particularly think you are a worse independent prescriber if you don't go back over what you did in the last 12 months, but you are missing out on the revision and the learning.*
> Independent prescribing optometrist, Northern Ireland

6. Patient focus group feedback

This section details feedback from patients in the two online focus groups with members of the public who had visited an optician within the last two years.

Receiving a high standard of care at the opticians

6.1.1 As also found in the ESR consultation conducted in 2020, participants reported experiences of good communication, friendliness, use of up to date technology and thorough examinations when visiting opticians, which resulted in high levels of satisfaction.

> *They're generally good and they have a reasonable selection of spectacles. They are pretty thorough, the equipment is pretty thorough. I'm used to that particular opticians. It's fine for me.*
>
> Male, England, 55+

> *My youngest broke her glasses last week and in the space of an hour they replaced them. It was a very good service.*
>
> Female, Northern Ireland, 45-54

6.1.2 However, a few participants felt that precautions and measures taken in practices due to the Covid-19 pandemic had resulted in more negative experiences when compared with their experiences of optical care before the pandemic. These participants explained that measures in place resulted in longer appointments and more time spent in practice, particularly if they tried on frames. A few also felt that trying on frames was more challenging when wearing face coverings. However, these participants acknowledged that the measures in place were necessary and were there to keep them and other patients safe.

> *I'd just like to highlight the Covid situation really. It's quite time consuming. They are constantly cleaning. You are holding lenses and having to put them to one side. I just found the whole thing time consuming, although it is important.*
>
> Female, England, 55+

> *Generally, it's been ok but obviously with the Covid situation, it's been slightly longer than usual with the precautions, but I totally understand. I've been using the same optician in Tesco, I think it's just changed to Vision Express. They have all my records. It's always done quite efficiently and thoroughly. No real complaints.*
>
> Male, England, 55+

6.1.3 As seen in previous research, participants thought that they always receive high standards of optical care in community opticians, as staff are professional, are very thorough with examinations and tests, and communicate well, which they equated with transparency. This gave them high levels of trust in optical professionals.

> *When they carry out the eye test, they try to be transparent, in terms of explaining to you step by step what they are doing, and they give you more information about the test result. When I wear the prescription, it also fits right so I trust them with what was done.*
>
> Female, England, 25-34

6.1.4 A few participants who tended to visit large high street chain opticians said that they trusted in the brand to provide a high standard of care, as they have a reputation to uphold. This led them to believe that large chains may provide a higher standard care when compared with independents, prioritising patient care over business.

> *I'd be a bit sceptical of some of the independents because it's a business to them. In a big business like Vision Express or Boots, I think they've got your interest. The optician probably doesn't have any interest in ramping up sales but if you go to a private one where it is an independent, for them if people buy more spectacles or glasses it's business for them. Someone like Boots, they change opticians all the time, like locums, so I don't think it's in their interest.*
>
> Male, England, 55+

Awareness of optical professionals' qualifications and regulation

6.1.5 There was an expectation amongst participants that there is some sort of requirement that all optical professionals are suitably qualified to provide optical services, but participants admitted they had very little knowledge of their qualifications. A few, however, recalled seeing qualifications displayed on walls in practices, but they had never looked at them in detail.

> *When you're going to the opticians, you're going to see an experienced professional but you wouldn't ask to see their credentials. You're happy to let someone give you an eye test on the basis that you understand they are an optician, the same way that when you go to the doctors you wouldn't ask to see their certificate from the General Medical Council. You just accept that they are qualified.*
>
> Male, England, 55+
>
> *My optician actually has his certificates in his room, they're on the wall.*
>
> Female, Northern Ireland, 45-54

6.1.6 There was also little awareness of how optical professionals are regulated, although most participants said they had assumed they were regulated somehow or had to go through a vetting process before they are able to see patients.

> *I'd expect them to be vetted anyway before I sit in the chair, like a check on their qualifications before offering them the job.*
>
> Female, England, 55+

> *Normally opticians and people like that have their certificates on the wall or something, but you don't normally look at them. I guess there is some sort of screening or body that regulates them.*
>
> Male, England, 55+

Viewing optical professionals as healthcare professionals

6.1.7 There was some awareness that optical professionals can diagnose some diseases and refer patients to other healthcare professionals as necessary. However, when asked where they would go if they had an eye problem, blurred vision or dizziness, some said they would contact their GP in the first instance. It was explained that bouts of dizziness or blurred vision might not necessarily be connected with an eye problem and therefore a GP would be best qualified to provide an initial

diagnosis. It was felt that the GP would then refer to another healthcare professional, such as an optical professional, as necessary.

> *My father went for an eye test and was complaining of pressure and his optician actually referred him to the eye hospital and he now is registered blind and has macular degeneration.*
>
> Female, Northern Ireland, 45-54

> *When you have something like dizziness, you don't know what it is. It could be a migraine problem, it could be an eye problem. It could be anything. The first point of call is generally the GP who knows the basics of diagnosis. If they felt it was something to do with the eyes, then they would refer you to an optician or an eye specialist. There's no point going straight to an optician because it could be something else like an ear problem.*
>
> Male, England, 55+

> *I don't know how qualified an optician is to deal with certain things. You could compare this with going to see a pharmacist or a doctor. Pharmacists are well qualified up to a certain point.*
>
> Male, England, 55+

6.1.8 Not everyone agreed, with some saying they would go to see an optical professional in the first instance, as they were the experts in eye health and care and were more qualified in that field than GPs. These participants also highlighted that optical professionals would have the appropriate equipment to be able to accurately diagnose many eye problems and, in some cases, they might already be familiar with a patients' eye health history.

> *I think they can tell a lot of things from the health of your eyes. I definitely won't go to a GP first about that sort of thing, I would go to an optician. They've got the right equipment.*
>
> Female, England, 55+

> *A GP's only got limited tools to be able to see the back of your eye and they know your health history.*
>
> Male, Scotland, 45-54

Awareness and understanding of optical professionals with prescribing qualifications

6.1.9 Some participants said that they had assumed some optical professionals would be able to prescribe medication in some cases for eye conditions, as they were aware that some pharmacists were also able to do so. However, not everyone was aware of this.

> *My brother is a pharmacist and basically, he can administer anything he pretty much needs to like a GP, so I'd assume an optician, within reason, can prescribe certain things related to their experience.*
>
> Male, England, 55+

> *I've never heard of anyone being given medication for their eyes apart from antibiotics, so it's all new to me.*
>
> Male, Scotland, 55+

6.1.10 When asked how they felt about optical professionals being able to prescribe medication, the majority of participants were in favour. A few suggested that it would relieve pressure on primary care and NHS services.

Doctors having a backlog of patients to see and hospitals, so it would free them.
Female, England, 55+

If they can prescribe medication, instead of them saying 'you've got this wrong with you, now you need to go to your GP for x prescription', it cuts out the drain on your local GP…It will save us walking into A&E as well.
Male, England, 55+

6.1.11 It was highlighted that optical professionals being able to prescribe medication would also be beneficial to patients, as they would be able to schedule an appointment and be seen more quickly than their GP or another healthcare professional. A few participants also suggested that it would cut down on the number of appointments for patients if they were able to have a condition diagnosed and be provided with a prescription in the same appointment with an optical professional.

There would be more available [optometrists] than GPs. If I tried to make an appointment with a GP and they told me to come back in two weeks, that's not good. You can probably get an appointment with an optician with that qualification within a couple of days, maybe even that day.
Male, England, 55+

I think it will save on multiple appointments. So if you go to your optician and they tell you that you need a certain prescription, you won't then have to make an appointment with a doctor to get the prescription. It will hopefully prevent delays and extra appointments.
Female, England, 35-44

6.1.12 In general, most participants said that they would feel comfortable being prescribed eye medication by optical professionals, as they were eye care specialists who they assumed would have the appropriate qualifications.

Definitely [would feel comfortable]. It's their specialism. It's what they do. If anybody is going to prescribe you something for your eyes, you can trust an optician to do so.
Female, England, 35-44

I would feel comfortable because they're still a specialist in the eyes. It would fill me with confidence and I'd be quite happy to go.
Male, England, 45-54

6.1.13 It was suggested that optical professionals who are able to prescribe medication should advertise this so more patients are made aware, which would both benefit patients and also drive business for those optical professionals.

They should say it in adverts that they've got these specialist people who can prescribe things, because before this I didn't know they could.
Male, England, 45-54

Communication

6.1.14 As seen in previous consultations, participants explained that they had generally experienced good communication when they visited opticians, reporting that it was always explained to them what was being done and why, and satisfactory information and advice were provided. It was also felt that sufficient time was allowed for appointments, which gave optical professionals the opportunity to go through patients' history and for patients to ask any questions they had.

I feel very satisfied. I tend to tell them what the problem is and what I feel, and they in turn tend to give me advice and information and even ask me if there are any other problems. I feel satisfied with communication.

Female, England, 25-34

They give you a lot of time. I have no problems with them.

Female, England, 55+

6.1.15 All participants thought that good communication is important, as a breakdown in communication can have negative consequences for patients.

Good communication is important…it goes without saying.

Male, England, 55+

I suppose ultimately you could lose your sight if they don't communicate problems with you or tell you where to go or what you need.

Female, Northern Ireland, 45-54

Consent and shared decision-making

6.1.16 Participants generally struggled to recall any specific instances of being asked for consent when visiting an opticians and some said it was not something they thought about. However, they assumed they were giving consent whenever something about an eye examination was explained to them, and some explained that they felt there was already implied consent through a patient agreeing to an eye examination in the first place.

I've never really thought about consent unless you are taking your children or elderly parents.

Male, Scotland, 55+

I think by just going along with it, you've given your consent. They've told you what's happening, and you are going along with it. I can't remember specifically if I've been asked for consent or not. I don't know. It's one of those things that can be slipped into conversation easily. You've agreed and you don't necessarily know that you have. You're there for them to assess you so I guess you've already given the consent.

Female, England, 35-44

6.1.17 When asked about shared decision-making, some felt that as optical professionals are the expert eye care professionals, they are best placed to make decisions for patients, particularly as patients themselves are not experts. Therefore, they saw shared decision making as potentially unnecessary. However, others acknowledged that shared decision making was important, although participants felt they would ultimately make decisions about their care and treatment based on recommendations from a healthcare professional.

It's a difficult one because you're not an expert. The whole point of going to a GP or optician is for them to make the best decision for you.

Male, England, 55+

It's nice to be informed of it and what the options are, but I would generally go with what is recommend by the professional. But to hear the other options and why they suggest other avenues is definitely beneficial.

Female, England, 35-44

C50(21) Annex 3

Education Strategic Review:

Updated requirements for specialist entry to the General Optical Council's register in the additional supply, supplementary prescribing and/or independent prescribing categories

Equality, diversity and inclusion impact assessment

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Contents

1. Executive Summary

Key Findings

1.1 This assessment finds comprehensive evidence that the General Optical Council (GOC) has systematically paid due regard to its statutory equality duties in its proposals to update requirements for specialist entry to the GOC register in the additional supply (AS), supplementary prescribing (SP) and/or independent prescribing (IP) categories.

1.2 The impact of the proposals should not only positively impact entrants who share protected characteristics but should also positively impact the wider public through increased access to more local therapeutics. This is highly relevant for protected groups who are more likely to face barriers to health care.

1.3 Currently there are barriers to specialist entry which disproportionately affect protected groups. The profile of current specialty prescribing registrants is less diverse than the profile of all registrants, with fewer younger people, Black, Asian and Ethnic Minority groups, and people with diverse religious beliefs. The introduction of a single approved qualification should encourage people to participate in activities where their participation is disproportionately low.

1.4 A single approved qualification will decrease the gaps between training and prescribing, which should reduce risk and could improve outcomes in Fitness to Practice, where individual cohorts can be at higher level of risk.

1.5 The proposed introduction of a Designated Prescribing Practitioner (DPP) (as opposed to an ophthalmologist) supports the advancement of equality and the elimination of discrimination. It should increase the number of potential placements which in turn could increase the diversity of specialty prescribing registrants.

1.6 The introduction of Designated Prescribing Practitioners should also support the advancement of equality with regards to the wider public health, particularly given the continuing impact of COVID-19. It should improve patient care by providing timely access to medicines and treatment and increase flexibility for patients who would otherwise need to see a doctor. It will increase efficiency by freeing up time for Ophthalmology departments which is currently the busiest outpatient speciality.

1.7 The GOC has effectively signaled the critical importance of equality, diversity and inclusion (EDI) throughout the draft Outcomes for Registration, Standards for Approved Qualifications and Quality Assurance and Enhancement Methods. The focus on patient centred care anticipates the diverse needs and preferences of protected groups. The learning methods and assessment should support the diverse needs of registrants. The emphasis on the views of patients, employers, students and other stakeholders will encourage greater participation by protected groups in decision making.

1.8 The proposed continuous improvement should enhance how the specialty attracts greater diversity and learns from the experience of underrepresented groups.

2. Introduction

Proposal

2.1 The General Optical Council proposes to update requirements that underpin the approval of qualifications for specialist entry to the GOC register, in additional supply, supplementary prescribing and independent prescribing. These specialties are referred to in this document as Independent Prescribing (IP) specialties.

Scope of Legal Obligations

2.2 In summary, in the exercise of its public functions the GOC is obliged to pay due regard to Section 149 of the Equality Act 2010 in respect of advancing equality, eliminating discrimination and promoting good relations.

GOC has a specific duty to assess equality with regards to its functions in Wales and Scotland. While there is no specific duty to assess equality impact in England, the process is accepted as best practice.

Northern Ireland is subject to devolved arrangements as per Section 75 of the Northern Ireland Act 1998, whereby public authorities must promote equality of opportunity and publish equality impact assessments.

A more detailed overview of each of the four nations legal obligations to pay due regard to equality considerations is set out in the Appendix.

Purpose

2.3 This Equality, Diversity and Inclusion (EDI) Assessment has been produced to:

- meet the GOC's statutory obligations with reference to the Section 149 of Equality Act 2010 and Section 75 the Northern Ireland Act 1998; and
- develop recommendations to support GOC in continuous improvement in equality, diversity and inclusion

Protected Characteristics

2.4 There are 8 relevant protected characteristics in the Equality Act 2010, namely:

- Age
- Disability
- Gender Reassignment
- Pregnancy and Maternity
- Race
- Religion or Belief
- Sex
- Sexual Orientation

2.4 Marriage and Civil Partnership as a protected characteristic applies only to employment and is not a relevant characteristic in terms of S149 of the Equality Act 2010.

2.5 The Northern Irish legislation includes additional protected groups, specifically political opinions and persons with dependents.

3. Current Profile of Independent Prescribing Specialities

Overview

3.1 Data is provided which compares protected characteristics of IP Specialty registrants to all General Optical Council registrants. This analysis explores Sex, Age, Race and Religion of Belief. Analyses of other protected characteristics has not been included given the small proportion of registrants' declarations (for example, less than 1% of Registrants have declared a disability and approximately 3% of Registrants state that they are lesbian, gay or bisexual).

Sex

3.2 Table 1 shows that the gender profile of IP Specialty registrants is broadly similar to the gender profile of All Registrants.

Table 1: Sex – IP Specialty Registrant Groups with All Registrants

	Independent Prescribing Specialty		Additional Supply Specialty		Supplementary Prescribing Specialty		All specialties		All Registrants	
Female	627	59.77%	634	59.70%	631	59.98%	2,289	61.32%	18,384	62.62%
Male	422	40.23%	428	40.30%	421	40.02%	1,444	38.68%	10.975	37.38%
Total	**1,049**	**100%**	**1,062**	**100%**	**1,052**	**100%**	**3,733**	**100%**	**29,359**	**100%**

Age

3.3 There are higher proportions of older IP Specialty Registrants compared to All Registrants.

Table 2: Age – IP Specialty Registrant Groups with All Registrants

	Under 25	25-34	35-44	45-54	55-64	65+	Total
Independent Prescribing Specialty	0	287	380	243	123	16	**1,049**
	0.00%	27.36 %	36.22 %	23.16 %	11.73 %	1.53 %	**100.00 %**
Additional Supply Specialty	0	285	379	246	131	21	**1,062**
	0.00%	26.84 %	35.69 %	23.16 %	12.34 %	1.98 %	**100.00 %**
Supplementary Prescribing Specialty	0	287	379	243	126	17	**1,052**
	0.00%	27.28 %	36.03 %	23.10 %	11.98 %	1.62 %	**100.00 %**
All registrants (excluding Students)	940	6792	6902	4510	3416	1031	**23,591**
	3.65%	29.33 %	29.04 %	18.97 %	14.37 %	4.36 %	**100.00 %**

Race

3.4 There is significantly less ethnic diversity in the IP Specialty Registrant group, where the proportion of White Registrants is 18.87 percentage points (ppts) higher than the proportion of All Registrants. Since 2017, the proportion of Black, Asian or Other Minority Ethnic (BAME) IP Speciality Registrants has stayed broadly the same while the proportion of All BAME Registrants has been on an upwards trend.

It is also noted that approximately 80% of NHS Ophthalmologists are from a White background compared to 60% of healthcare professionals in the NHS.[1]

Table 3: Race – IP Specialty Registrant Groups with All Registrants

	White	Black/Black British	Asian / Asian British	Mixed/Multiple	Other ethnic group	Prefer not to say	Total No.	Total
Independent Prescribing Specialty	67.90%	1.09%	20.52%	0.66%	0.76%	9.06%	**916**	**100%**
Additional Supply Specialty	67.67%	1.18%	20.40%	0.64%	0.75%	9.34%	**931**	**100%**
Supplementary Prescribing Specialty	67.76%	1.20%	20.48%	0.65%	0.76%	9.15%	**918**	**100%**
All Registrants	**49.03%**	**1.52%**	**32.74%**	**0.99%**	**1.61%**	**14.10%**	**29, 359**	**100%**

Religion or Belief

3.5 Table 4 shows a significantly higher proportion of Christian IP Specialty Registrants and a significantly lower proportion of Muslim Registrants.

Religion and Belief is often interrelated with Race, 99.5% of Muslims in the UK are BAME[2].

[1] Royal College Ophthalmologists Annual Report

[2] Census 2011

Table 4: Race – IP Specialty Registrants with All Registrants

	IP Specialty Registrants	All Registrants
Christian (incl. Catholic)	39.15%	**27.40%**
Muslim	6.73%	**17.12%**
Hindu	8.15%	**9.18%**
Sikh	4.07%	**4.08%**
Jewish	0.97%	**0.96%**
Buddhist	0.53%	**0.45%**
Any other religion/faith	0.00%	**0.00%**
No religion	27.46%	**21.81%**
Prefer not to say	12.93%	**18.99%**
Total	100.00%	**100.00%**

Fitness to Practise

3.5 While the numbers are low, there are a higher proportion of IP Specialty Registrants subject to Fitness to Practice (FTP) investigations compared to All Registrants.

Table 5: Race – Fitness to Practice IP Specialty Registrants and All Registrants

	Registrants subject to an FTP Investigation	% of complaints against total registrant specialism
Independent prescribing specialty	6	0.57%
Additional supply specialty	5	0.47%
Supplementary prescribing supply	5	0.48%
All Registrants	59	0.20%

4. Analysis of Current Profile of Independent Prescribing Specialities

Exploring Disparities

4.1 There are striking differences in the ethnic and religious profiles of IP Specialty Registrants and All Registrants. Procuring a clinical placement with an ophthalmologist is a competitive process, and the data may indicate that BAME Registrants who wish to become IP Prescribing Specialists are at a disadvantage compared with other Registrants.

While the definitive causation is unknown, it is anticipated that these disparities could be related to:

Cost

4.2 The Optometrist Therapeutic Prescribing Literature Review (2021), undertaken by the University of Surrey, noted that deterrents to undertaking non-medical prescribing training include the time and cost related to completing course prerequisites, combined with a lack of funding available for training.

Across the UK, more people from Black, Asian, and other minority ethnic backgrounds are likely to be in poverty (i.e., have an income less than 60% of the average household income) than white British people[3].

According to a study on **Health Equity in England**, in 2018, 50% of all Bangladeshis and 46% of all Pakistanis were in the most deprived fifth of the population after meeting housing costs, compared with 20% of all white British people.

Differential Attainment

4.3 Variations in professional attainment can be observed across groups when split by a number of protected characteristics, including race. There is no single agreed cause of these variations which can make it difficult to identify a single factor or specific area that should be targeted with an intervention.

While no publications which relate specifically to the optical profession are available, parallels may be drawn with medical specialties. Research published by the General Medical Council in 2016[4] showed that postgraduate medical training posed risks for BAME groups, including:

- Poorer relationships with seniors
- Problems fitting in at work
- Fewer learning opportunities
- Anxieties about potential bias
- Fear of being labelled as problematic

[3] BME Statistics on Poverty, Housing and Employment, Institute of Race Relations, 2020
[4] Fair Training Pathways for All: Understanding Experiences of Progression Final Report, GMC 2016

- less autonomy in job choice with increased likelihood of being separated from family and support networks.

5. Equality Impact Assessment of Revised Standards and Outcomes

Outline

5.1 This section considers how the GOC has paid due regard to Public Sector Equality Duty (PSED) in the revised Standards and Outcomes, the content of which are individually considered. This stage of the assessment will begin with a focus on two fundamental changes to the current process, namely a single GOC-approved qualification leading to specialist entry and trainee supervision under a designated prescribing practitioner instead of an ophthalmologist.

Single GOC-approved Qualification

5.2 It has been noted that cost and resources can be a barrier to specialist entry which can disproportionately affect protected groups. The cost is not limited to the cost of the course and/or learning materials – it will also involve extra time such as studying and travelling to the location of the ophthalmologist.

There are proportionately fewer younger IP Specialty Registrants (aged 25-44) and this could be related to the fact that Registrants in this age group are more likely to have younger children. This is particularly relevant in the optical profession where there is a higher proportion of females.

A potential link with socio-economic status and race/religion and belief has also been explored at 4.2 whereby BAME groups are more likely to be in poverty than White groups.

Completion of IP Specialty training and registration is a lengthy process sometimes with more than 2 years between the taught element, supervised practice and the final exam. This has resulted in long gaps before IP Specialty registrants were in a position to prescribe, leading to potential deskilling and lack of prescribing confidence. Deskilling may affect Fitness to Practice, and it was noted earlier that there is a higher proportion of investigations against IP Speciality registrants compared to all registrants. The most recent GOC EDI Data Monitoring Report (2021) showed evidence of worse FTP Outcomes from BAME registrants compared to White registrants.

Impact of Single GOC-approved Qualification

5.3 The introduction of a single approved qualification should therefore have a positive impact with reference to the PSED as it should advance equality of opportunity and it removes disadvantages faced by people due to their characteristics. It should also encourage people from protected groups to participate in activities where their participation is disproportionately low.

Proposed Designated Prescribing Practitioner

5.4 There is a severe shortage of ophthalmologists in the UK, and Ophthalmology is now the busiest outpatient specialty, with a 30-40% increase in demand predicted over the next 20 years. The majority (85%) of units in the UK are undertaking waiting list initiatives to meet demand.[5]

The COVID-19 pandemic continues to disrupt NHS care, with waiting lists at a record high. Infection control measures and the ongoing diversion of resources towards COVID services during the ongoing second peak of hospitalisations mean that this backlog of care will take even longer to work through as it continues to accumulate.

IP Specialty placements are usually based in hospitals where the "Patient First" value is even more pertinent given the waiting lists. There is a large backlog of people waiting (>2,000) to undertake IP Specialty, and hence a delay in people registering in IP Specialties. It is also possible that registrants who are clinically extremely vulnerable may not have been able to pursue IP Specialties given the perceived risk of the NHS workplace.

Impact of Proposed Designated Prescribing Practitioner

5.5 It is therefore anticipated that the change to supervision by a Designated Prescribing Practitioner supports the advancement of equality and the elimination of discrimination. It will increase the number of potential placements which in turn could increase the diversity of IP Specialty registrants.

The change should also support the advancement of equality and elimination of discrimination with regards to the wider public health. It should improve patient care by providing timely access to medicines and treatment, and increase flexibility for patients who would otherwise need to see a doctor. Increased prescribing capability can increase efficiency by freeing up doctors' time to care for patients with more complex health care needs. It can help avoid unnecessary hospital admissions and improve access to treatment particularly for patients with long term health conditions, and can deliver care closer to home.

Outcomes for Approved Qualifications for Specialist Entry to the GOC Register (AS, SP and IP)

Introduction

5.6 The Outcomes describe the expected knowledge, skills and behaviours an optometrist must have to be awarded an approved qualification for IP specialist entry to the GOC register. The Outcomes are organised into seven categories which are separately explored below.

[5] Royal College Ophthalmologist Workforce Census

Equality Impact

5.7 Observations are made on good practice in paying due regard to the PSED.

Clinical Competence

5.8 The use of Miller's Pyramid to demonstrate clinical competence should enhance confidence in the capability of meeting the needs of diverse groups as emphasis at the higher levels of competency is based on observed performance.

Outcome 1: Uphold Professional Standards

5.9 Working collaboratively in a multi-disciplinary approach should enhance the profession's ability to meet the diverse needs of patients. Multi-disciplinary approaches can improve services through robust decision making and can increase the likelihood of early intervention.

The focus on mutual trust, understanding and respect in relationships with other professionals complements an ethical approach and will assist with continuity of care.

Effective and personalised communication is needed for involvement of patients in decisions about medicines and for supporting adherence. Some patients who share protected characteristics may find it easier to communicate with healthcare professional than others. The Standard's focus on meeting communication and adapting consultation appropriately shows due regard to the need to advance equality.

Outcome 2: Person Centred Care

5.10 A person centred approach advances equality as it increases the likelihood that individual needs will be met. This includes needs based on people's equality characteristics such as disability, culture, language, gender, religion, sexual orientation.

5.11 The Outcome states that patient diversity, equality and personal values and beliefs about their health, treatment and medicines should be respected.

Assessing health literacy and adapting appropriately shows a commitment to take steps to meet the needs of protected groups. It highlights the importance of making reasonable adjustments and could also support an intersectional approach with socio-economic circumstances given the existing variation in health outcomes.

Checking the patient/carer's understanding reinforces the need for effective and personalised communication, which is highly relevant to equality and diversity.

Outcome 3: Establishes Patient Management Options

5.12 Taking a medical history which includes social factors. Awareness of the broader contexts that influence health supports respectful, patient-centered care that

incorporates lived experiences, optimises health outcomes, improves communication, and can help reduce health and health care inequities.

Medication adherence rates can vary and can be related to socio-economic status, which in turn is highly relevant for some protected groups, for example, poverty is especially high among families where there is an adult who is disabled. This Outcome requires the assessment of adherence in a non-judgemental way, understands the different reasons for non-adherence (intentional or non-intentional) and how best to support the patient/carer, which demonstrates taking steps to meet the needs of protected groups and support the elimination of discrimination.

Specialists are required to adapt the management plan in response to on-going monitoring and review of the patient's condition and preferences. Such preferences could be related to their protected characteristics, which is evidence of paying due regard to the PSED.

Outcome 4: Prescribing Practice

5.13 The use of a range of tools should increase the objectivity of decision making and reduce the risk of bias, which assists with preventing less favourable treatment of particular groups. Similarly, the use of critical evaluation with reliable and validated sources of information should decrease the risk of harm for all, including protected groups.

Staying up to date in practice should support the promotion of equality as it will enhance how professionals understand the needs of diverse patients.

The integration of the GMC's Remote Prescribing High Level Principles contains the key principle of understanding how to identify vulnerable patients and take appropriate steps to protect them.

Staying up to date in own area of practice and an evidence based approach should ensure that decisions are informed by the best possible information. Similarly, the use of critical evaluation involves constantly asking questions and keeping an open mind, which should reduce the risk of bias.

The electronic generation and/or the requirement to write legible unambiguous prescriptions should reduce the risk of discrimination for people with learning differences and/or their carer.

Outcome 5: Ethics and Standards

5.14 Independent prescribers are required to work within organisational codes of conduct, including the NHS Constitution when interacting with the pharmaceutical industry. The NHS values include patient first and respect and dignity, where every person is valued.

Considering the wider perspective of public health issues complements the advancement of equality as health inequalities are known to occur within population groups including groups which encompass protected characteristics.

Outcome 6: Manages Risk

5.15 The Outcome highlights the importance of a safe environment for patients and the public, and requires high levels of transparency, including the use of a comprehensive reporting system. This should decrease the risk of harm for all groups, including those who share protected characteristics.

The wide range of reporting should assist with the elimination of discrimination, as it is known that there is a significant disparity across different groups when it comes to providing feedback about healthcare services.

The Outcome requires recognition of factors that might unduly influence prescribing, including cognitive bias. Cognitive bias includes unconscious bias, and recognition of this as a risk should support the elimination of discrimination.

Outcome 7: Learning and Development

5.16 The requirement for continuing professional development should enhance the ability to meet the needs of diverse users, particularly in current circumstances where there is emerging evidence about the experience of different groups during the pandemic, and how this might affect health outcomes.

The requirement to support the learning and development of others, including engaging with mentorship, leadership and work development should support the career progression of protected groups and should assist with tackling differential attainment.

Standards for Approved Qualifications

5.17 These describe the expected context for the new delivery and assessment of the proposed Outcomes leading to an award of an approved qualification for specialist entry into the IP Specialty categories.

Standard 1: Public and Patient Safety

5.18 Adherence to the GOC's Standards to Practice should promote inclusion as the Standards are highly relevant to good practice in equality, diversity and inclusion, which include effective communication, respect and listening to the patient.

The arrangements to mitigate the risk of harm should assist with the duty to pay due regard to the need to eliminate discrimination.

Standard 2: Selection and Admission of Trainees

5.19 This broadly aligns with externally recognised best practice, namely the Good Practice In Admissions Guidance produced by Supporting Professionalism in Admissions and published by UCAS.

From the outset there is a clear focus on fairness and transparency, and the Standard makes it clear that educational providers must comply with relevant equality and diversity legislation.

Selectors should be trained to apply selection criteria fairly, including training in equality, diversity and unconscious bias. This reflects the intention to take steps to eliminate discrimination. Selectors may include a mix of academic/administrative staff, which should complement fair decision making. There is a specific requirement for selectors to be trained in applying selection criteria fairly including training in equality diversity and unconscious bias.

The Standard requires educational providers to provide comprehensive information about the course to applicants, including the entry criteria, description of the selection process and the total cost/fees that will be incurred. Protected groups can experience higher poverty levels, for example lone parents, and to support the promotion of equality it is important to provide plenary information to inform decision making.

Standard 2: Assessment of Outcomes and Curriculum Design

5.20 Miller's pyramid ranks clinical competence both in educational settings and in the workplace and its use should increase confidence in fitness to practice as observations on competence can take place in the setting that the service will be delivered.

Curriculum design and delivery must involve and be informed by feedback from a range of stakeholders who must be appropriately trained and supported, including in equality and diversity. This should support the profession in learning more about the needs of patients from protected groups and should assist with the amplification of their voices. It also encourages participation by people from protected groups.

Assessments must be valid, reliable, robust, fair and transparent, and ensure equity of treatment for students. Reasonable adjustments must be made to teaching and assessment for students with specific needs to demonstrate that they meet the Outcomes. This indicates taking steps to meet the needs of people from protected groups where these are different from the needs of other people.

The Outcomes provide that a range of teaching and learning methods must be used. The use of a range of teaching and learning methods should support engagement of students with diverse needs and preferences.

The selection of outcomes to be taught and assessed must be informed by feedback from a variety of sources, including patients and other healthcare professionals. This should support the amplification of diverse voices in curriculum design.

Equality and diversity data and its analysis must inform curriculum design, delivery and assessment of the approved qualification. This analysis must include student progression by protected characteristic. In addition, the principles of equality, diversity and inclusion must be embedded in curriculum design and assessment and used to enhance students experience of studying on a programme leading to an approved qualification. This focus on data supports the advancement of equality as it should facilitate the development of action to close gaps.

Standard 4: Management, Monitoring and Review of Approved Qualifications

5.21 Evaluation will include feedback from stakeholders and minimum evidence shall include trainees consultative mechanisms and a range of other input sources, including patients and third sector bodies.

Standard 5: Leadership, Resources and Capacity

5.22 Educational providers must provide effective induction, peer support and mentoring. This support will be particularly relevant for protected groups. Additionally, trainees must have effective support for health and wellbeing, which should advance equality and demonstrates taking steps to meet the needs of people who share protected characteristics. This is highly relevant in the current pandemic environment, where there has been a decrease in wellbeing and an increase in reports of mental health issues.

Quality Assurance and Enhancement Method

5.23 This describes how the GOC will gather evidence to decide whether IP Specialty students meet the Outcomes for Approved Qualifications for specialist entry to the GOC register in the additional supply (AS), supplementary prescribing (SP) and/or independent prescribing (IP) categories.

This approach is underpinned by a greater emphasis in the views of stakeholders, including patients, service users and the public. This greater emphasis should enhance how IP Specialists meets the needs and experience of diverse groups.

Separate arrangements will be made with the College of Optometrists to ensure that the route to specialist entry is maintained for trainees who graduate from qualifications approved before 2021.

Migration to the “new” approval includes “teaching out”. This longer-term perspective should support students from protected groups who may need to consider personal circumstances in the move to increased work-based learning.

A staged approach to qualification approval is used from the initial proposal to the final decision about whether the qualification is able to meet the outcomes and standards. Each stage includes a requirement for comprehensive evidence about quality, readiness and mitigation of risk. The later stages include patient, service user

and public engagement, which should assist with ensuring that qualifications result in practice which understands the needs of protected groups.

The proposed method of assurance and enhancement should assist with continuous improvement in learning from good practice and ensuring that professional knowledge stays up to date.

Evidence includes stakeholder engagement and feedback from patients and carers. It also refers to the requirement to provide evidence about selectors' training in equality, diversity and unconscious bias, which supports the elimination of discrimination.

The systematic approach to collecting and using equality data will enhance the mainstreaming of equality and the development of evidence based actions to better meet the PSED.

Evidence should be provided to indicate that the staff profile can support the delivery of the Outcomes and the student experience, including staff/student ratios. This should increase confidence in sufficient resources being available to support the needs of protected groups.

6. Continuous Improvement

Area	Action
Attracting diversity	Advise Educational Providers that marketing of courses must be inclusive and consider how to reach underrepresented groups. Learn from the experience of CLO registrants from underrepresented groups about what supports success and what can hinder progress. Explore interventions that address differential attainment, such as how non-supervisory mentors can support progression. Encourage Educational Providers to develop actions to address imbalances following equality data analyses.
Building competency	Promote CPD to enhance how the profession mentors specialty entrants. Commission research regarding differential attainment and disadvantage in specialty optical education.
Monitoring	Consider whether supplemental HESA analyses could enhance monitoring equality impact, such as analyses of indices of multiple deprivation. Measure the impact of diversity and unconscious bias training by asking participants to reflect on how the training has enhanced practice.

Annex: Applicable Legislation

UK Wide: Section 149 of the Equality Act 2010 (the Public Sector Equality Duty)

In the exercise of its functions as a public authority, GOC must have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not

The Act explains that having due regard for advancing equality involves:

- Removing or minimising disadvantages suffered by people due to their protected characteristics.
- Taking steps to meet the needs of people from protected groups where these are different from the needs of other people.
- Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.

The Act states that meeting different needs involves taking steps to take account of disabled people's disabilities. It describes fostering good relations as tackling prejudice and promoting understanding between people from different groups. It states that compliance with the Duty may involve treating some people more favourably than others.

Northern Ireland – Northern Ireland Act 1998

Section 75 of the Northern Ireland Act 1998 refers to devolved arrangements which are similar to the mainland obligations, specifically:
(1)A public authority shall in carrying out its functions relating to Northern Ireland have due regard to the need to promote equality of opportunity—
(a)between persons of different religious belief, political opinion, racial group, age, marital status or sexual orientation;
(b)between men and women generally;
(c)between persons with a disability and persons without;
and
(d)between persons with dependants and persons without.

Specific National Obligation to Publish Equality Impact Assessments.

Public Authorities in Scotland, Wales and Northern Ireland are obliged to publish Equality Impact Assessments. While there is no specific duty in England, the Equality and Human Rights Commission advise on this approach as best practice.

Impact Assessment Screening Tool

Name of policy or process:	**Education Strategic Review (ESR)**
Purpose of policy or process:	To update our requirements for GOC approved qualifications for specialist entry to the GOC register in Additional Supply (AS), Supplementary Prescribing (SP) and/or Independent Prescribing (IP) categories.
Team/Department:	Education
Date:	October 2021
Screen undertaken by:	Simran Bhogal (ESR Project Manager)
Approved by:	Leonie Milliner (Director of Education)
Date approved:	November 2021

This impact assessment screening tool is in two sections.

Section one considers the impacts of the Education Strategic Review (ESR) as a GOC project using a standard screening GOC-tool. Second two considers the impacts, costs, benefits and risks of our proposals to update our requirements for GOC approved qualifications for specialist entry to the GOC register.

In section two we assess impact of our proposals and whether they are proportionate, targeted and transparent. We also assess the likely effect of our proposals on each category of stakeholder and on the GOC.

Section two also includes an assessment of whether any of our proposals raise any particular equality and diversity issues. Alongside this consultation we are undertaking a Equality Impact Assessment which will be published in December 2021.

This impact assessment screening builds on and should be read in conjunction with our previous impact assessments, including the draft impact assessments we published in November 2019 and in July 2020, associated ESR research and reports published on our website along with our proposals and associated impact assessment approved by GOC Council in February 2021 (the ESR deliverables; Outcomes for Registration; Standards for Approved Qualifications and Quality Assurance and Enhancement Method).

It also draws upon evidence of impact gained through engagement with stakeholders and our Expert Advisory Groups (EAGs) and will be further developed as we receive feedback gained through consultation and from our externally commissioned equality impact assessments (commissioned 2021).

Assessing impact and likely effect on stakeholders is an iterative process. As such this is a live document. We will continue to seek information from stakeholders and to review and update our current assessment in light of the further evidence we gather.

Impact Assessment Screening Section One: ESR Project

A) Impacts	High Risk	Medium Risk		Low Risk	? or N/A
1. Reserves	It is likely that reserves may be required	It is possible that reserves may be required		No impact on the reserves / not used	
2. Budget	No budget has been allocated or agreed, but will be required.	Budget has not been allocated, but is agreed to be transferred shortly	Budget has been allocated, but more may be required (including in future years)	Budget has been allocated and it is unlikely more will be required	
3. Legislation, Guidelines or Regulations	Not sure of the relevant legislation	Aware of all the legislation but not yet included within project/process	Aware of the legislation, it is included in the process/project, but we are not yet compliant	Aware of all the legislation, it is included in the project/process, and we are compliant	
4. Future legislation changes	Legislation is due to be changed within the next 12 months	Legislation is due to be changed within the next 24 months	Legislation may be changed at some point in the near future	There are no plans for legislation to be changed	
5. Reputation & Media	This topic has high media focus at present or in last 12 months	This topic has growing focus in the media in the last 12 months	This topic has little focus in the media in the last 12 months	This topic has very little or no focus in the media in the last 12 months	
6. Resources (people & equipment)	Requires new resource	Likely to complete with current resource, or by sharing resource	Likely to complete with current resource	Able to complete with current resource	
7. Sustainability	Less than 5 people are aware of the process/project, and it is not recorded centrally nor fully	Less than 5 people are aware of the project/process, but it is recorded centrally and fully	More than 5 people are aware of the process/project, but it is not fully recorded and/or centrally	More than 5 people are aware of the process/ project and it is clearly recorded centrally	
	No plans are in place for training, and/or no date set for completion of training	Training material not created, but training plan and owner identified and completion dates set	Training material and plan created, owner identified and completion dates set	Training completed and recorded with HR	
8. Communication (Comms) / Raising Awareness	No comms plan is in place, and no owner or timeline identified	External comms plan is in place (including all relevant stakeholders) but not completed, an owner and completion dates are identified	Internal comms plan is in place (for all relevant levels and departments) but not completed, and owner and completion dates are identified	Both internal and external comms plan is in place and completed, owner and completion dates are identified	
	Not sure if needs to be published in Welsh	Must be published in Welsh, Comms Team aware.		Does not need to be published in Welsh.	

Please put commentary below about your Impacts ratings above:

Budget: The project's five-year financial forecasts and one-year budget include foreseeable costs, including approved use of reserves for development, consultation and associated project research costs, as well as additional approval and quality assurance activity required to support potential providers and existing providers prepare new qualifications or adapt existing qualifications to meet the proposed outcomes and standards for speciality registration.

Legislation, guidelines and regulations: Advice from the GOC's legal team has informed the preparation of these proposals in relation to our duties to approve qualifications under the Act. Where increased scope necessitates an enhanced or changed approach to skill development the high-level nature of the outcomes together with the requirement for providers to maintain the currency of approved qualifications through local responsiveness to stakeholder need will provide assurance. Where changed or increased scope also necessitates a change of GOC policy, rules or legislation, we would undertake a separate policy or legislative change exercise, including full stakeholder consultation before making any change. Nothing in these proposals changes scope as currently defined in legislation or GOC policy in relation to scope.

Future legislation changes: We expect DHSC to consult on changes to our legislation in 2022 or 2023. We will assess the impact of potential legislative change upon the ESR deliverables when further detail is available.

Reputation and media: The proposals to update our requirements for GOC approved qualifications leading to speciality registration in Additional Supply, Supplementary Prescribing and/or Independent Prescribing or as a contact lens optician continues to attract press and stakeholder attention, which has been amplified due to the negative impact of Covid-19 on higher and further education and ongoing issues with workforce supply/ progression in Independent Prescribing. Coverage in the broader media is likely to be very limited due to the positioning of optics in relation to other allied-healthcare professions.

We have taken a consultative and open approach to communicating with our stakeholders about our proposals. Our Expert Advisory Groups (EAGs) include staff and members from professional associations and representative organisations in optics and we continue to meet with stakeholders on a regular basis, including those in each devolved administration.

Resources (people and equipment): Subject to a decision by Council in December 2021, we anticipate completing this element of the ESR workstream (for post-registration qualifications) within agreed timescales and cost tolerances.

B) Information Governance	High Risk	Medium Risk		Low Risk	? or N/A
1. What data is involved?	Sensitive personal data	Personal data	Private / closed business data	Confidential / open business data	
2. Will the data be anonymised?	No	Sometimes, in shared documents	Yes, immediately, and the original retained	Yes, immediately, and the original deleted.	
3. Will someone be identifiable from the data?	Yes	Yes, but their name is already in the public domain(SMT/Council)	Not from this data alone, but possibly when data is merged with other source	No – all anonymised and cannot be merged with other information	
4. Is **all** of the data collected going to be used?	No, maybe in future	Yes, but this is the first time we collect and use it	Yes, but it hasn't previously been used in full before	Yes, already being used in full	X
5. What is the volume of data handled per year?	Large – over 4,000 records	Medium – between 1,000-3,999 records		Less than 1,000 records	
6. Do you have consent from data subjects?	No	Possibly, it is explained on our website (About Us)	Yes, explicitly obtained, not always recorded	Yes, explicitly obtained and recorded/or part of statutory duty/contractual	
7. Do you know how long the data will be held?	No – it is not yet on retention schedule	Yes – it is on retention schedule	Yes – but it is not on the retention schedule	On retention schedule **and** the relevant employees are aware	
8. Where and in what format would the data be held? (delete as appropriate)	Paper; at home/off site; new IT system or provider; Survey Monkey; personal laptop	Paper; Archive room; office storage (locked)	GOC shared drive; personal drive	Other IT system (in use); online portal; CRM; Scanned in & held on H: drive team/dept folder	
9. Is it on the information asset register?	No	Not yet, I've submitted to Information Asset Owner (IAO)	Yes, but it has not been reviewed by IAO	Yes, and has been reviewed by IAO **and** approved by Gov. dept.	
10. Will data be shared or disclosed with third parties?	Yes, but no agreements are in place	Yes, agreement in place	Possibly under Freedom of Information Act	No, all internal use	
11. Will data be handled by anyone outside the EU?	Yes	-	-	No	
12. Will personal or identifiable data be published?	Yes – not yet approved by Compliance	Yes- been agreed with Compliance	No, personal and identifiable data will be redacted	None - no personal or identifiable data will be published	

Please put commentary below about reasons for Information Governance ratings:

What data is involved/will the date be anonymised? During consultations personal data will be stored on our consultation platform (identifiable details like email address, place of work and a range of protected characteristics). We will only publish responses where individuals have consented to having their response published.

Will someone be identifiable from the data? Yes, respondents to consultations will be identifiable as their information will be linked to their own named record in Citizen Space. However, if we take statistics from Citizen Space for evaluation and monitoring purposes and publish these or disseminate them more widely than within the GOC, respondents will not be identifiable and information will be redacted.

What is the volume of data handled per year? The volume of data held on our consultation platform will not exceed 1,000 records.

C) Human Rights, Equality and Inclusion	High Risk	Medium Risk	Medium Risk	Low Risk	? or N/A
Main audience/policy user	Public			Registrants, employees, or members	
Participation in a process (right to be treated fairly, right for freedom of expression)	Yes, the policy, process or activity restricts an individual's inclusion, interaction or participation in a process.			No, the policy, process or activity does not restrict an individual's inclusion, interaction or participation in a process.	
The policy, process or activity includes decision-making which gives outcomes for individuals (right to a fair trial, right to be treated fairly)	Yes, the decision is made by one person, who may or may not review all cases	Yes, the decision is made by one person, who reviews all cases	Yes, the decision is made by an panel which is randomly selected; which may or may not review all cases.	Yes, the decision is made by a representative panel (specifically selected). No, no decisions are required.	
	There is limited decision criteria; decisions are made on personal view	There is some set decision criteria; decisions are made on 'case-by-case' consideration.	There is clear decision criteria, but no form to record the decision.	There is clear decision criteria and a form to record the decision.	
	There is no internal review or independent appeal process	There is a way to appeal independently, but there is no internal review process.	There is an internal review process, but there is no way to appeal independently	There is a clear process to appeal or submit a grievance to have the outcome internally reviewed and independently reviewed	
	The decision-makers have not received EDI & unconscious bias training, and there are no plans for this in the next 3 months.	The decision-makers are due to receive EDI & unconscious bias training in the next 3 months, which is booked.	The decision-makers are not involved before receiving EDI & unconscious bias training.	The decision-makers have received EDI & unconscious bias training within the last 12 months, which is recorded.	
Training for all involved	Less than 50% of those involved have received EDI training in the last 12 months; and there is no further training planned	Over 50% of those involved have received EDI training, and the training are booked in for all others involved in the next 3 months.		Over 80% of those involved have received EDI training in the last 12 months, which is recorded.	

Alternative forms – electronic / written available?	No alternative formats available – just one option	Yes, primarily internet/computer-based but paper versions can be used		Alternative formats available and users can discuss and complete with the team.	
Venue where activity takes place	Building accessibility not considered	Building accessibility sometimes considered		Building accessibility always considered	
	Non-accessible building;	Partially accessible buildings;	Accessible buildings, although not all sites have been surveyed	All accessible buildings and sites have been surveyed	X
Attendance	Short notice of dates/places to attend	Medium notice (5-14 days)of dates/places to attend		Planned well in advance	
	Change in arrangements is very often	Change in arrangements is quite often		Change in arrangements is rare	
	Only can attend in person	Mostly required to attend in person		Able to attend remotely	
	Unequal attendance / involvement of attendees	Unequal attendance/ involvement of attendees, but this is monitored and managed.		Attendance/involvement is equal, and monitored per attendee.	
	No religious holidays considered; only Christian holidays considered	Main UK religious holidays considered	Main UK religious holidays considered.	Religious holidays considered, and ability to be flexible (on dates, or flexible expectations if no alternative dates).	
Associated costs	Potential expenses are not included in our expenses policy	Certain people, evidencing their need, can claim for potential expenses, case by case decisions		Most users can claim for potential expenses, and this is included in our expenses policy; freepost available.	
Fair for individual's needs	Contact not listed to discuss reasonable adjustments, employees not aware of reasonable adjustment advisors.	Most employees know who to contact with queries about reasonable adjustments		Contact listed for reasonable adjustment discussion	
Consultation and Inclusion	No consultation; consultation with internal employees only	Consultation with employees and members	Consultation with employees, members, and wider groups	Consultation with policy users, employees, members and wider groups.	

Impact Assessment Screening Section Two: ESR Deliverables (for post registration speciality qualifications)

Step 1: Scoping the IA

Name of the policy/function:	**Education Strategic Review**
Assessor:	Simran Bhogal (ESR Project Manager)
Date IA started:	2016
Date IA completed:	October 2021
Date of next IA review:	March 2022
Purpose of IA:	To assess the key impacts of our proposals to update our requirements for GOC approved qualifications for specialist entry to the GOC register in Additional Supply (AS), Supplementary Prescribing (SP) and/or Independent Prescribing (IP) categories.
Approver:	Leonie Milliner, Director of Education
Date approved:	November 2021

Q1. Screening Assessment

- Has a screening assessment been used to identify the potential relevant risks and impacts? Tick all that have been completed:
  - ☐ Impacts
  - ☐ Information Governance (Privacy)
  - ☐ Human Rights, Equality & Inclusion
  - ☐ None have been completed

Q2. About the policy, process or project

- What are the main aims, purpose and outcomes of the policy or project?
- You should be clear about the policy proposal: what do you hope to achieve by it? Who will benefit from it?

Aim: To assess the key impacts of our proposals to update our requirements for GOC approved qualifications for specialist entry to the GOC register in Additional Supply (AS), Supplementary Prescribing (SP) and/or Independent Prescribing (IP) categories.
Purpose and Outcome: Following the launch of the Education Strategic Review in March 2016, in July 2019 Council gave steers on the ESR proposals. This included the introduction of an integrated form of optical education, combining academic study with professional and clinical experience for specialist entry to the GOC register in Contact Lens Optician, Additional Supply, Supplementary Prescribing and/or Independent Prescribing categories. Two Expert Advisory Groups (EAGs) for therapeutic/Independent Prescribing and Contact Lens Opticians were tasked with advising on the development and drafting of the new, proposed, Outcomes for Registration, Standards for Approved Qualifications for specialist entry to the GOC register in Contact Lens Optician, Additional

Supply, Supplementary Prescribing and/or Independent Prescribing categories, and an updated quality assurance process to be held in common for both Contact Lens Optician and Independent Prescribing approved qualifications. The outcomes and standards for approved qualifications for specialist entry to the GOC register (in the Additional Supply, Supplementary Prescribing and/or Independent Prescribing categories) will replace our 'Handbook for Optometry Specialist Registration in Therapeutic Prescribing' published July 2008 and the 'Competency Framework for Independent Prescribing' published in 2011 including the list of required core-competences, the numerical requirements for trainees' practical experiences, education policies and guidance contained within the handbooks, and our policies on supervision and recognition of prior learning, published separately. Together, these documents mitigate the key risk that our current requirements become out of date. They have been drafted to ensure the post-registration qualifications we approve are responsive to a rapidly changing landscape in the commissioning of eye-care services in each of the devolved nations and so that the skills and abilities of our registrants remain up to date.
Who will benefit: Patients and the public; registrants; employers: other healthcare professionals, local/national workforce training/commissioning bodies and the NHS; GOC staff, EVPs and committees: providers of GOC approved and provisionally approved qualifications and their trainees.

Q3. Activities or areas of risk or impact of the policy or process

- Which aspects/activities of the policy are particularly relevant to impact or risk? At this stage you do not have to list possible impacts, just identify the areas.

Key proposals
a. Candidates will acquire a single qualification approved by the GOC leading to specialist entry to the GOC register in Additional Supply, Supplementary Prescribing and/or Independent Prescribing categories.
b. The approved qualification will be either an academic award or a regulated qualification at a minimum of Regulated Qualification Framework (RQF) (or equivalent) Level 7.
c. There will be no proposed minimum/maximum or recommended time or credit volume for an approved qualification or specified location or duration of clinical experience, other than the requirement that an approved qualification leading to specialist entry to the GOC register in Additional Supply, Supplementary Prescribing and/or Independent Prescribing categories must integrate approximately 90 hours of learning and experience in practice.
d. For qualifications in Additional Supply, Supplementary Prescribing and/or Independent Prescribing the supervision of a trainee's learning and experience in practice must be co-ordinated by an appropriately trained and qualified registered healthcare professional

with independent prescribing rights (called a Designated Prescribing Practitioner or DPP) and be an active prescriber competent in the clinical area(s) they will be supervising the trainee in, have the relevant core competencies and be trained and supported to carry out their role effectively.
e. The provider of the approved qualification must, in the design, delivery and assessment of an approved qualification, involve and be informed by feedback from a range of stakeholders including patients, employers, trainees, supervisors, members of the eye-care team and other healthcare professionals.
f. An outcomes-based approach is used to specify knowledge, skills and behaviours using an established competence and assessment hierarchy known as 'Miller's Pyramid of Clinical Competence' (knows: knows how: show how & does), mapped to relevant external prescribing frameworks, including the draft Royal Pharmaceutical Society's (RPS) Competency Framework for all Prescribers (2021).
g. Providers of approved qualifications are responsible for the measurement (assessment) of students' achievement of the outcomes at the required level (on Miller's Pyramid) leading to an award of an approved qualification.
h. Providers of approved qualifications will be responsible for recruiting and selecting trainees onto an programme leading to an award of an approved qualification. Recognition of prior learning can be deployed to assist the progression of trainees whose progress to specialist registration has stalled, and the requirement for optometrist independent prescribing trainees to have been registered for at least two years prior to commencing clinical experience/ hospital placements has been removed.
j. At the point of retention, registrants in the Additional Supply, Supplementary Prescribing and/or Independent Prescribing categories will no longer need to supply details of prescribing decisions undertaken in the previous twelve months.

Q4. Gathering the evidence

- List below available data and research that will be used to determine impact of the policy, project or process.
- Consider each part of the process or policy and identify where risks or implications might be found for: 1) Impacts; 2) Information Governance and Privacy implications; and 3) Human Rights, Equality and Inclusion.

Available evidence – used to scope and identify impact
Research and consultation: • Call for evidence (report June 2017) • Research to learn from other professions/overseas (Nov 2017) • System leaders' roundtable (Nov 2017) • Consultation on concepts/principles (report April 2018) • Research with newly qualified/employers (June 2018) • Development of standards/learning outcomes with Committees, Expert Advisory Group other external stakeholder groups (summer 2018) • Consultation on draft Education Standards and Learning Outcomes (November

2018-Feburary 2019)
- Education Visitor Panel and Advisory Panel feedback (Jan-Dec 2020)
- Expert review and input from the Quality Assurance Agency (April-June 2020 and Oct-Nov 2020)
- Roundtable on funding (March 2020)
- Consultation on draft Outcomes for Registration, Standards for Approved Qualifications and Quality Assurance and Enhancement Method for optometry & dispensing optics (August 2020 – October 2020)
- QAA RQF Levels Research Report (November 2020)
- Expert Advisory Groups developmental activity and feedback (September 2019 – May 2021).
- Commissioned literature review undertaken by University of Surrey for IP/AS/SP (June 2021)
- Commissioned EDI Impact Assessment (Oct 2021)
- Consultation on draft Outcomes for Registration, Standards for Approved Qualifications and Quality Assurance and Enhancement Method for AS, SP & IP (July 2021 – Sept 2021)

Q5. Evidence gaps

- Do you require further information to gauge the probability and/or extent of impact?
- Make sure you consider:
    1) Impacts;
    2) Information Governance and Privacy implications; and
    3) Human Rights, Equality and Inclusion implications.

If yes, note them here:

We have undertaken extensive activity to gauge the extent of impact of the ESR. We continue to work with stakeholders to gather evidence of probability or extent of impact, and will review and update this impact assessment in light of new information

Q6. Involvement and Consultation

Consultation has taken place, who with, when and how:

A patient and public consultation was held for 12 weeks from July 2021-September 2021 and included an online survey hosted via our Citizen Space platform (with quantitative and qualitative questions), online focus groups with optical patients and interviews with a range of stakeholders conducted and analysed by our independent research partner.

Summary of the feedback from consultation:

Consultation responses were independently analysed by our research partner, Enventure Research, and a consultation report prepared by Enventure Research to be published on our website.

Link to any written record of the consultation to be published alongside this assessment:

Our response to Enventure Research's report and updated proposals once approved by Council will be published on our website.

Step 2: Assess impact and opportunity to promote best practice

- Using the evidence you have gathered what, if any, impacts can be identified? Please document your findings and the strand(s) affected.
- What can be done to remove or reduce any impact identified?
- Consider each part of the process or policy and identify where risks might be found for equality, human rights and information governance and privacy.
- Ensure any gaps found in Q5 are recorded as actions and considerations below.

Impact assessment methodology

The following categories or groups of stakeholders will potentially be impacted by our proposals:

- GOC
- Patients and members of the public
- Providers and potential providers of GOC approved speciality qualifications
- Supervisors / DPPs/ DMPs
- Trainees studying GOC approved speciality qualifications
- Representative organisations, professional bodies, employers and other stakeholders.

The impact assessment in step 2:

- Identifies the proposals that address the need for change;
- Includes a qualitative discussion of the costs, benefits and risks associated with each key proposal; and
- Makes an initial estimate of the costs and benefits and summarises mitigating actions or counter measures to the extent that it is possible or proportionate to do so.

Assessment of costs, benefits, opportunities and risks

Our assessment of costs, benefits and risks of our key proposals will inform rather than determine our decision. There are two reasons for this. First, fulfilling our statutory duties involves taking account of issues that fall outside of a narrow consideration of costs and benefits. Second, it will only be possible to precisely quantify all the costs and benefits once providers of approved qualifications begin to adapt their existing qualifications to meet the new outcomes and standards and providers of qualifications applying for approval begin their application process. The magnitude and nature of costs will vary according to the qualification design decisions made by each provider. We have described the costs and benefits qualitatively and described who bears the costs (in broad terms). Where we have included an assessment of cost we have provided information about our key assumptions and the evidence used to inform our assessment of best estimate and likely range. As stated above, we continue to seek evidence of anticipated costs and to receive information that would enable us to quantify these costs. Benefits are harder to quantify as they tend to be more uncertain and are often spread across many stakeholders.

Evidence and options

The 2017 concepts and principles report, subsequent roundtable and 2018-19 consultation considered the evidence base for change and sought feedback on options. This evidence base and options were described in various reports published on our website and informed the 2019 steer for an integrated approach to qualification approval, with candidates acquiring a single GOC-approved qualification (rather than two as at present) leading specialist entry to the GOC register in Additional Supply, Supplementary Prescribing and/or Independent Prescribing categories, supported by an outcome-orientated approach to specifying the required knowledge, skills and behaviour required for specialist annotation. This approach to post-registration qualification approval was considered the most appropriate, given the urgent need to ensure the GOC's standards and requirements continued to equip future professionals to meet service needs and patient demand as they evolve and, wherever they practise in the UK, continue to protect the public.

Final Options

Because of the iterative approach taken to development of the proposals, including taking steers at key points, the two options available at this stage are:
Option 1. Continue with the current (2008) 'Handbook for Optometry Specialist Registration in Therapeutic Prescribing,' and the (2011) 'Competency Framework for Independent Prescribing,' the (2007) and related education policies and guidance.
Option 2. Require all GOC approved qualifications leading to specialist entry to meet the proposed outcomes and standards to the timescale outlined in the QA&E Method.

Costs and benefits of option 1

The benefits of option 1 are defined as zero; the additional costs as low/ medium. This is the counterfactual against which option 2 is appraised. The analysis of cost, benefit and risks of option 1 is outlined below.

Costs and benefits of option 2

The analysis of costs, benefits and risks of option 2 is outlined below.

Summary

	Additional cost: ongoing	Additional cost: one off	Benefit	Wider impact	Proport-ionate	Targeted	Transparent
Option 1	Low-Medium	None	None	Weaknesses, risks and opportunities of current system not addressed	No	No	In part
Option 2	Low-Medium	Medium	Higher standards of post-registration education	Proposed requirements reflect contemporary optical practice and patient/ workforce needs	Yes	Yes	Yes

Option 1 (counterfactual)

Under this option we continue with the current quality assurance handbooks for approved qualifications leading to specialist entry in the GOC register including our current list of core competencies, supervision and numerical requirements for trainees' practical experiences.

Costs There are potential additional costs of retaining the current quality assurance handbooks from addressing failure due to the inadequacy of our requirements (provider failure and fitness to practice cases)

Benefits There are no additional benefits of retaining the current quality assurance handbooks. However, any uncertainty, risks or cost related to updating our requirements for qualification approval are avoided.

Wider impacts As discussed in previous impact assessments, associated ESR research and reports published on our website, there are a number of weakness in our current system:

- Continuing public, registrant and student confidence in our ability to set and maintain high standards for entry to specialty registration categories (as an Additional Supply, Supplementary Prescriber and/or Independent Prescriber) given how long ago they were written;
- Prescriptive list of competences limits innovation and responsiveness to changing patient and service-user needs, and extended roles; given need to consult;
- For trainees in Independent Prescribing, numerical requirements and 2-year time bar for clinical supervision by a consultant ophthalmologist within the hospital eye service restrict placement opportunities and limits workforce development/ progression;
- For trainees and their employers, limited choice (in price and quality) of GOC approved 'stage two' final qualifying qualifications leading to speciality registration; and for trainees in Independent Prescribing, lack of availability of placements limits progression.
- The current system does not promote achievement of earlier, better quality direct patient contact, inter-professional education and more varied clinical experience, which would better prepare trainees for advanced or specialised roles; and
- Limited engagement of stakeholders, including patients, service-users and commissioners in the design and delivery of GOC approved qualifications for entry to specialty registration categories.

Risks The risks of option 1 are as follows:

a. We fail in our overarching statutory responsibility to promote and maintain high standards of professional education and public confidence in the professions because our requirements for qualification approval for entry to specialty registration categories are out of date and unfit for purpose.
b. Risk of challenge to GOC qualification approval decisions from trainees, providers, potential providers and sector bodies if grounds for approval depart from current (but out of date) Quality Assurance Handbook and related requirements.

c. Risk we would not be able to take action if a qualification we approve meets our requirements but nevertheless fails to prepare trainees to meet employer, patient and service user needs, putting future patients at risk of inadequate care.
d. Risk our requirements and processes do not reflect modern methods for statutory regulators in setting education and training benchmarks for qualification approval and do not reflect contemporary optical practice or meet patient or service-user needs, thereby bringing the profession and its education into disrepute.

Summary Our current requirements for qualification approval for entry to specialty registration categories do not address the risks, potential for enhanced roles for optical professionals within service redesign or the challenges of meeting an increased demand for eye-health care given our aging population. Requiring trainees to acquire two GOC approved qualifications either sequentially or simultaneously for entry to the specialty registration categories is unnecessarily burdensome and provides few benefits. An outcomes-orientated approach to specifying the future knowledge, skills and behaviours of an Additional Supply, Supplementary Prescribers and/or Independent Prescriber at the point of specialty registration is required, better aligned with regulatory systems for qualification approval deployed by other healthcare regulators and in line with GOC's new requirements for pre-registration qualifications.

Costs	Potential high additional costs addressing failures because of the inadequacy of our requirements (provider failure and fitness to practice cases)
Benefits	No additional benefits
Wider impacts	Weaknesses of current system not addressed by retaining current requirements for qualification approval for entry to specialty registration categories
Proportionate	Current requirements do not reflect contemporary optical practice or meet patient or service-user needs, address the risk of the GOC not meeting its statutory objectives or its strategic aim of being a world class regulator
Targeted	No- current requirements are not targeted satisfactorily on areas of greatest risk
Transparent	In part. A list of GOC approved qualifications is published on our website. Current requirements are complex, frequently poorly expressed and open to interpretation, and at risk of being out of date.

Option 2 (Our proposals)

Under this option we would require all GOC approved qualifications for entry to specialty registration categories (as a Additional Supply, Supplementary Prescriber and/or Independent Prescriber) to meet the proposed outcomes and standards to the timescale outlined in the QA&E method.

Costs There will be additional costs to GOC of this option of:

- An on-going cost of increased approval and quality assurance support (1 new FT permanent A&QA post and 1 x FT QA project, policy & research manager – in budget);
- A one-off cost for drafting and seeking feedback on frameworks and SOPs to support implementation (from reserves – already agreed); and
- An on-going cost of thematic and sample-based reviews (which may be externally contracted – in budget).

There may be additional costs to providers/potential providers of approved qualifications for:

- A one-off cost in designing and preparing new qualifications for GOC approval; *or*
- A one-off cost in adapting existing GOC approved qualifications to meet the proposed outcomes and standards to the timescale outlined in the QA&E Method;
- An on-going cost in integrating learning and experience in practice within the approved qualification, stakeholder engagement and enhanced teaching and assessment quality control to meet the new requirements; and
- For one provider (the College of Optometrists) a one-off and ongoing cost of Ofqual registration (if desired).

There may be additional costs to trainees:

- For current Independent Prescribing trainees whose progression has stalled, and who wish to transfer (potentially with advance standing/RPL) into the new, integrated approved AS, SP & IP qualifications, an additional fee may be payable to the provider (the amount will vary according to type and location of approved qualification and any local workforce support/ funding that may be available);
- For some trainees, there may be additional costs and expenses for periods of learning and experience in practice;
- For trainees who wish to gain a GOC approved qualification for entry to a specialty registration category (as a Contact Lens Optician or Additional Supply, Supplementary Prescribers and/or Independent Prescribers) at the same time, or shortly after gaining an approved qualification in dispensing optics or optometry, there may be additional fees, and costs and expenses for periods of learning and experience in practice (the amount will vary according to type and location of approved qualification and any local workforce support/ funding that may be available).

There may be additional costs to local/national workforce training/commissioning bodies:

- There may be increased fees payable to the provider by those commissioning/ purchasing training (the amount will vary according to type and location of approved qualification and any local workforce support/ funding that may be available).

There may be additional costs to patient and public representative organisations, employers and other stakeholders:

- A one-off cost in working with providers in qualification design;
- An on-going cost in working with providers in qualification delivery and assessment, review and feedback; and
- An on-going cost to employers in offering short periods of learning and experience in practice (for which trainees may or may not be remunerated) and associated supervision.

Benefits The potential benefits to the GOC are:

- Patients and public would benefit from this option. Updated standards for for entry to specialty registration categories (as an Additional Supply, Supplementary Prescriber and/or Independent Prescriber) leading to improved patient safety;
- Patient, public, registrant and trainee confidence in our ability to maintain and monitor high standards for qualification approval for specialty registration will increase;
- Qualifications we approve will be more responsive to local, regional and national patient, service-user and broader stakeholder requirements and therefore more current, and better aligned with GOC's new requirements for pre-registration qualifications;
- This option, with its refreshed quality assurance and approval process, will give greater assurance that our requirements are being met and risks managed appropriately; and
- This option, with its outcomes-orientated approach, focuses more on the development of professional capability, critical thinking, research-informed clinical reasoning and decision-making vital to responding effectively to changing patient and service user needs, evidence-based practice and new models of delivery.

The potential benefits to providers/potential providers of approved qualifications are:

- Additional opportunities for current providers of pre-registration approved qualifications to offer to trainees at the same time a GOC approved qualification leading to entry to specialty registration;
- Greater flexibility in compliance and responsiveness in qualification design and delivery;
- All providers will be placed under the same obligations to maintain standards, which will safeguard standards and ensure a level playing-field in the sector;
- Simplification of our requirements for qualification approval with a more transparent and proportionate framework for quality assurance and approval focused on risk reduction;
- Some providers may, depending on qualification design, benefit from additional funding council or local/national workforce training/commissioning bodies support of L7 qualification; and
- Providers (Awarding Organisations) offering an Ofqual-regulated L7 qualification may choose a candidate registration fee and/or centre approval business model.

The potential benefits to trainees:

- Greater choice of approved qualifications leading to entry to the register with earlier and better-quality learning and experience in practice and inter-professional learning;

- This option requires providers to give students' accurate information about qualification at application, including the provider's intended curriculum and assessment approach, RQF level and the total costs/ fees that will be incurred; and
- This option, for most students and their employers, removes the necessity for up-front payment of examination or assessment fees for a stage 2, 'registerable' qualification (and associated membership fees) and instead gives the potential, depending on provider's qualification design, for fees/maintenance to be supported by student loans.

The potential benefits to local/national workforce training/commissioning bodies of:

- Better alignment of commissioning (funding) post registration speciality qualifications, particularly independent prescribing qualifications, with approved qualifications leading to entry to the register;
- Greater responsiveness to devolved administration workforce development needs, with potentially a better-skilled workforce, particularly in therapeutic prescribing qualifications.

The potential benefits to patient and public representative organisations, employers and other stakeholders;

- Patients, public and employers would benefit from this option as a result of updated requirements for specialty registration leading to improved patient safety;
- Patient, public, registrant and trainee confidence in our ability to maintain and monitor high standards for post-registration qualification approval will increase;
- Qualifications we approve will enable stakeholders to inform and be involved in post-registration qualification design, delivery, assessment, quality control and review;
- Qualifications we approve will be more responsive to local, regional and national patient and service-user needs and stakeholder requirements and so entrants to specialty registration categories (as an Additional Supply, Supplementary Prescriber and/or Independent Prescriber) will be better-prepared to work in enhanced roles in dynamic, multi-professional settings and engage in up -to-date, effective and research informed practice for the benefit of patients;
- This option, for eligible employers, removes the necessity for employers to support trainees' course, examination or assessment fees for two approved qualifications (gained either sequentially or simultaneously) required for entry to a specialty registration category; and
- Employers and trainees will have a greater choice of qualifications for entry to specialty registration categories (as an Additional Supply, Supplementary Prescriber and/or Independent Prescriber).

<u>Wider impacts</u> As discussed in previous impact assessments, associated ESR research and reports published on our website, there are a number of impacts, positive and negative:

- We are conscious of the potential negative impact on a professional association (the College of Optometrists) offering market-leading GOC approved 'registrable' post-registration qualifications due to increased market competition, and are continuing dialogue with the College;

- This option specifies a minimum RQF level for qualifications we approve with potential impact on trainees recruitment, selection and widening participation;
- Provider vulnerability due to covid-19 with potential negative impact on local/ regional workforce supply (and potential to meet future patient and service-user needs).

Balanced by:

- Entrants to specialty registration categories better prepared to meet patient needs, especially in the softer skills, clinical reasoning and decision-making, underpinned by consistently applied academic standards at relevant RQF level;
- Qualifications better aligned with other healthcare disciplines and funding mechanisms, leading to closer collaboration in assessment, interprofessional learning and multi-disciplinary working, potentially a positive impact on cost through shared resource, economies of scale and increased resilience in the sector;
- In this option, replacing the prescriptive list of competences and patient episodes with an outcomes-based approach to specifying the knowledge, skills and behaviours expected will build registrants' skill and capability for new and evolving roles to meet workforce development needs;
- In this option, flexibility in qualification design enables greater responsiveness by providers to trainees with different preferences and from diverse backgrounds;
- A potential positive impact in the enhanced influence and attractiveness of professional associations as Awarding Organisations offering GOC approved qualifications.

Risks The risks of option 2 are as follows:

a. We fail in our overarching statutory responsibility to promote and maintain high standards of professional education and public confidence in the professions because our requirements for qualification approval become out of date and are unfit for purpose. *Mitigation*: planned and budgeted longitudinal research will provide the data we need to measure and review the effectiveness of our outcomes and standards on registrants' competence, confidence and capability, providing the evidence for potential adjustment at regular intervals (subject to consultation);
b. Risk that current providers and potential providers do not adequately prepare qualifications to meet the outcomes and standards necessary for GOC approval; qualifications fail to recruit; fail to thrive, or providers decide to withdraw their qualifications. *Mitigation:* for existing providers, we will work with each provider individually to support transition at a pace that works for them; for new providers the risk-based staged approach to qualification approval decision now includes interrogation of providers' business and delivery plans to ensure qualifications only progress if we are confident they will thrive and risks managed;
c. Risk of challenge to GOC qualification approval decisions from trainees, providers, potential providers and sector bodies if grounds for approval depart from proposed outcomes and standards. *Mitigation*: the proposed outcomes and standards are now far clearer, proportionate to the risks posed and less open to interpretation than current requirements, reducing the risk an approval decision does not logically follow from evidence of compliance.
d. Risk that employers fail to engage with providers in qualification design and delivery. *Mitigation:* Ongoing engagement with employers' representative bodies and national

commissioners supplemented by our requirement in the standards that providers similarly engage with employers, local/national workforce training/ commissioning bodies and NHS commissioners;

e. Risk that proposals create a regulatory bar, preventing providers, trainees or optical practices access to existing funding streams. *Mitigation:* Ongoing engagement with devolved administrations and local/national workforce training/ commissioning bodies and NHS commissioners to identify and resolve regulatory bars preventing access to existing (or new) funding streams.

Summary This option would enable us to address the risks, problems and potential opportunities with our current requirements for post-registration speciality qualifications. It will provide us with contemporary and up-to-date requirements for post-registration qualification approval that in turn will mean providers will better prepare entrants to specialist post-registration categories for enhanced or extended roles within service redesign, meeting the challenges of increased demand for eye-health care given our aging population. Requiring trainees to only acquire a single GOC approved qualifications for entry to specialty registration simplifies our regulatory framework and introduces greater trainee and employer choice. An outcomes-orientated approach to specifying the future knowledge, skills and behaviours of a future Additional Supply, Supplementary Prescriber and/or Independent Prescriber at the point of registration better aligns with other healthcare regulatory systems for qualification approval and post-registration specialty annotation.

Costs	Medium additional one-off costs for providers Potentially low to medium additional on-going costs for providers Potentially further course fees for current trainees whose progression is stalled to transfer to new, integrated qualifications (depending on recognition of prior learning & qualification design) Potentially lower course fees for new trainees
Benefits	Updated standards of post-registration specialist education Greater assurance providers meet required standards Better preparedness of future registrants for enhanced/ extended roles Improved progression for trainees (in particular, for independent prescribing, with move from DMP to DPP and greater flexibility for clinical experience)
Wider impacts	Weaknesses of current system addressed by proposed updated requirements for post-registration qualification approval
Proportionate	Proposed requirements reflect contemporary optical practice and future patient/ workforce needs, addresses the risk that GOC may not meet its statutory objectives or its strategic aim of being a world class regulator.
Targeted	Proposed requirements target areas of greatest risk
Transparent	A list of GOC approved qualifications will be published on our website. Proposed requirements are straightforward, simple to understand, not at risk of wide interpretation and are up to date.

Step 3: Monitoring and review

Q6. What monitoring mechanisms do you have in place to assess the actual impact of your policy?

Longitudinal Research

We believe that it is extremely important to measure the impact of our proposed changes on the competence, confidence and capacity of future registrants. We intend to commission a longitudinal research project to provide the empirical data required to measure the effectiveness of the new qualifications we approve and adjust our outcomes and standards as required (subject to consultation).

Impact Measurement

We will also measure the impact of our proposed changes through:

- Implementation timescales and data;
- Repeat consultations and surveys: newly qualified and employers; providers; representative and membership bodies;
- Risk reviews as part of our Annual Monitoring process.

CPD impact

The Director of Education also leads our work to review our CET system. From January 2022 we will be introducing our new requirements for Continuing Professional Development. The ESR Project Team continues to work closely with CPD Project Board to share pertinent information about skill gaps in the transition from optical students to fully-qualified registrants and onto specialty registration, which could impact the 'additional requirements' domain for registrants (or sub-set of registrants) in any given cycle.

International Registration impact

We continue to work closely with Registration team on impacts of ESR and Brexit on international registrants.

Financial Impact

Our outline impact assessment published as part of our ESR consultation gave some consideration of financial impacts of our proposals, in particular the financial impact for future providers of GOC approved qualifications (a mix of Further (FE) and Higher Education (HE) providers and private membership-based organisations) across the UK; on students and placement providers/ employers, drawing upon the outcome of our funding roundtable held on 13 March 2020 and its subsequent report 'Further and Higher Education Funding of Optometrists and Dispensing Opticians' published on our website. As stated above, we continue to seek evidence of anticipated costs and to receive information that would enable us to quantify them more precisely.

Equality Impact Assessment

We have commissioned Fraser Consulting to undertake an Equality, Diversity and Inclusion (EDI) assessment of the impact of our proposals with reference to each of the protected characteristics as defined by the Equality Act (2010) across each of the four

nations. Clare Fraser is an experienced equality and diversity consultant with a range of clients across the public and private sectors, and her report will be published on our website. This EDI assessment will focus on EDI impacts (positive and negative) on trainees and providers of GOC approved qualifications using qualitative and quantitative data analysis and will be undertake alongside the public consultation.

Please provide a review date to complete an update on this assessment.

Date: November 2021 and annually thereafter

Optometrist therapeutic prescribing:

A rapid review of the literature

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Submitted 4 June 2021

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The views expressed are not necessarily those of the General Optical Council

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Abbreviations

AC - Advanced Clinical

A&E – Accident and Emergency

AMED - Allied and Complementary Medicine Database

APCOS – Acute Primary Care Ophthalmology Service

AOS - Acute Ophthalmic Service

AS - Additional Supply

CoO – College of Optometrists

CFA – Common Final Assessment

COM-B – Capability, Opportunity, Motivation, and Behaviour model

CPD – Continuing Professional Development

CUES - COVID-19 Urgent Eyecare Service

DMP – Designated Medical Prescriber

DTC – Drug Therapeutic Committees

GPhC – General Pharmaceutical Council

GP – General Practitioner

GOC – General Optical Council

GOS – General Ophthalmic Service

GRRS – Glaucoma Referral Refinement Scheme

HCPC – Health and Care Professions Council

HEI – Higher Education Institutions

HES – Hospital Eye Service

IP – Independent Prescribing

IPs – Independent Prescribers

IPOS – Independent Prescribing Optometrist Service

MCQ – Multiple Choice Questions

MDT – multidisciplinary team support

MECS - Minor Eye Conditions Service

NHS – National Health Service

NMC – Nursing and Midwifery Council

NMP – Non-medical prescribing

NMPs – Non-medical prescribers

OHT – Ocular Hypertension

OSCE – Objective Structured Clinical Examinations

OTP – Optometrist therapeutic prescribing

PEARS - Primary Eye-care Assessment and Referral Service

PRISMA – Preferred Reporting Items

RCO – Royal College of Ophthalmologist

RPL – Recognition of Prior Learning

RPS – Royal Pharmaceutical Society

SP – Supplementary Prescribing

SPIDER – Sample, Phenomenon of Interest, Design, Evaluation, Research Type

TDF – Theoretical Domains Framework

UG – Undergraduate

UK – United Kingdom

1 Executive summary

Background: Optometrists in the UK can undertake training that entitles them to prescribe a range of medicines for patients with eye conditions. This training, and registration as an Optometrist therapeutic prescriber, is overseen by the General Optical Council (GOC).

Aim: This rapid review was commissioned by the GOC with the aim to identify known barriers and facilitators to implementing non-medical prescribing that impact on Optometrist therapeutic prescribing, related to additional supply, independent and supplementary prescribing. An additional aim was to identify literature on the scope of Optometrist therapeutic prescribing.

Methods: This rapid review comprises:

1. A review of systematic reviews to identify common barriers and facilitators to non-medical prescribing across all relevant professions,
2. A review evidence on Optometrist therapeutic prescribing (OTP) and additional supply to identify scope of OTP, state of current evidence base and barriers and facilitators to OTP
3. Conversations with key informants to identify key challenges and facilitators to OTP

Data: A total of 13 systematic reviews were included in the review of systematic reviews, 11 articles (8 empirical and 3 reviews) were included in the review of OTP and 8 conversations were held with key informants involved in OTP across England, Northern Ireland, Wales and Scotland.

Findings: A range of barriers and facilitators were found to impact on non-medical prescribing in the following stages: i) preparatory stage ii) training iii) early transition and iv) sustainment and development. This included the extent of organisational readiness, leadership, preparation of the infrastructure to support NMP (such as policy, access to prescription pads and a prescribing budget), practitioner readiness, continued support and professional development. Limited evaluative research evidence was available on OTP, with a lack of information about the current scope of OTP practice or service delivery. Challenges to OTP included a) limited practitioner skills and motivation, b) access to clinical practice training, c) limited organisational support and d) a lack of external/local policies to facilitate prescribing. Many of these barriers remained unchanged over the past decade and were also reported by key informants. A number of further challenges raised by key informants included: a need for greater strategic visioning and commissioning of OTP services; better alignment with governance, clinical and educational standards applied to other non-medical prescribing professions; preparation

of optometrists for the prescribing role (including undergraduate training); improvements to supervised practice; and greater support for transition and long-term sustainability of OTP. Innovative approaches to service commissioning and support for OPT taken in some of the devolved nations were reported to have reduced many barriers to implementation. Key informant conversations reiterated the important position of OTPs in meeting the needs of patients with acute and non-acute ocular conditions, providing accessible care and reducing burden on general practice and acute services.

Discussion and conclusion: The limited evidence base on OTP indicates that i) it has a positive impact within enhanced services in community and acute settings and ii) barriers and facilitators are similar to those experienced by other non-medical prescribing professions. Key differences were identified in the way that OTP is governed at national and organisation level compared to other NMP professions, however the justification for these differences were unclear. There are potential benefits to be gained from a greater alignment with NMP prescribing competencies, educational and governance standards and frameworks for advanced practice career development. Bottlenecks in accessing practice placements and a lack of integration and feedback between educational and practice components were a particular concern for key informants. Solutions to reduce barriers to the uptake and use of OTP were evident in some of the devolved nations, such as: improving strategic vision, pro-OTP leadership, and service commissioning to facilitate novel OTP roles, training costs and infrastructure support. There is potential to improve the sustainability of OTP and facilitate the development of novel and innovative OTP-led roles by greater recognition and support of OTP scope of practice. The recommendations of this review are timely given the role of non-medical prescribing in improving service capacity to meet increasing demand for medication.

2 Background

The 1999 Crown Report[1] recommended extension of independent prescribing (IP) responsibilities to a number of non-medical professional groups. In the UK, registered optometrists were already using a restricted range of prescription-only medicines in professional practice, under exemptions listed in the Medicines Act (1968), to support diagnostic procedures and management of common ocular conditions posing limited risk to sight. Examples include topical antibiotics for bacterial conjunctivitis, and pupil dilators such as cyclopentolate hydrochloride. In 2005, necessary changes were enacted to various relevant legislation to implement the recommendations of the Crown Report, followed by further amendments in 2008[2]. This created additional prescribing roles outlined in Table 1[3]. Introduction of these prescribing rights was intended to supplement existing shared care models for management of sight-threatening ocular disease[4].

Optometrists who wish to become independent prescribers (referred to in this report as Optometrist Therapeutic Prescribing) must have a minimum of 2 years in practice prior to undertaking the three stages of IP training. Stage one comprises completion of an ocular therapeutic course at one of the five approved UK universities. Secondly, a clinical placement comprising 24 x three-hour clinical sessions under the supervision of an ophthalmologist based in secondary care must be undertaken within two years of completing the theoretical component. The final step is successful completion of the Common Final Therapeutics Assessment (TCFA) via the College of Optometrists (GOC)[2]. Optometrists are awarded the dual qualification of independent and supplementary prescriber, with requirement for yearly renewal with GOC and a detailed log of prescribing activity. When qualified, optometrists should work within their scope of practice and acknowledge limitations of their practice[2].

Evidence suggests that there is consensus regarding barriers and facilitators to implementation of non-medical prescribing, which are known to commonly occur during i) preparation for the role ii) early integration and iii) on-going sustainment. Given the dearth of evidence exploring optometrist IP, this review will therefore consolidate the wider body of literature exploring non-medical prescribing and then map this against knowledge related to Optometrist Therapeutic Prescribing (OTP).

3 Aim

This rapid review addresses the following questions:

a) What are the known barriers and facilitators to implementation of non-medical prescribing that impact on Optometrist therapeutic prescribing, related to additional supply, independent and supplementary prescribing?

b) What is the scope of Optometrist therapeutic prescribing?

4 Objectives

1. Undertake a review of systematic reviews to identify common barriers and facilitators to non-medical prescribing across all relevant professions.
2. Review evidence on Optometrist therapeutic prescribing (OTP) and additional supply to identify scope of OTP, state of current evidence base and barriers and facilitators to OTP.
3. Undertake conversations with key informants, to identify key challenges and facilitators to OTP.

5 Methods

5.1. Review of systematic reviews of barriers and facilitators to non-medical prescribing

Adopting a rapid review[5] a narrative synthesis was conducted on the topic of barriers and facilitators experienced by non-medical prescribers including nurses, pharmacists, and optometrists.

5.1.1 Search strategy

A systematic search of literature reviews of barriers and facilitators to non-medical prescribing was conducted in March-April 2021, using search terms developed according to the Sample, Phenomenon of Interest, Design, Evaluation, Research Type (SPIDER) tool[6]. These were tested based on abbreviations of words related to non-medical prescribing by nurses, pharmacists, optometrists, and other relevant professional groups. Wild card and Boolean Search Operators were used. Search strings included keyword terms, such as (non-medical prescrib*) plus (optometr*, nurs*, pharmacist*) plus (e.g., meta-synthesis, meta-analysis). Search terms, and full example search string are available in Appendix 1. Databases included EBSCO (MEDLINE, CINAHL), OVID (EMBASE) and ProQuest (British Nursing Index, Nursing & Allied Health). Publications were searched from January 2010 to March 2021. Retrieved citations were downloaded to EndNote V.X9 software and duplicates removed.

5.1.2 Screening and eligibility

Two reviewers (JE, SvE) independently appraised titles and abstracts for eligibility in relation to the inclusion criteria shown in Table 2. Full texts of the remaining reviews were screened independently by all members of the research team (NC, KS, MC, JE, & SvE) using the Joanna Briggs Institute Critical Appraisal Checklist for Systematic Reviews and Research Syntheses[7]. All reviewers confirmed the eligibility of the identified reviews. Any disagreements about possible inclusion were resolved during group discussions. Reference list hand searching supplemented database searching. An overview of the selection process and search results are available in Figure 1.

5.1.3 Data extraction

Data extraction was conducted by one researcher (SvE) resulting in a bespoke table adapted from recommended templates[8]. The table included the basic outline of the evidence under study such as aims, study design, sample size (number of papers included), time frame, model of prescribing (independent/supplementary), profession (nurses/pharmacists/mixed), and care setting. To help contextualise barriers and facilitators, main findings were included (see Appendix2). Data extraction was iterative and involved repeated review and update between subsequent stages of analysis[9].

5.1.4 Data analysis and assessment

Data analysis followed a four stage, iterative process[10] (see Table 3).

Barriers and facilitators to implementation of non-medical prescribing, identified from the review of systematic reviews, were grouped under the following stages: i) preparatory stage ii) training iii) early transition and iv) sustainment and development (see Appendix 3).

5.2. Review of literature on optometry prescribing and scope of practice

5.2.1 Search strategy, screening, and eligibility

A secondary systematic search of literature on optometrist therapeutic prescribing and medicines administration/supply/optimisation conducted in the United Kingdom between 2010 and 2021 was undertaken in April 2021, using inclusion/exclusion criteria shown in Table 4. The search was designed to capture any literature relevant to IP in optometry, including primary and secondary research, non-empirical reviews, and reports. Search terms were developed following the PICO format and tested based on truncations of words related to prescribing, medicines optimisation, administration and/or supply, optometrists, and optometry. Wild card and Boolean Search Operators were used to capture relevant studies. Search strings, examples of which are shown in Appendix4, were adapted for 4 databases including MEDLINE, EMBASE, CINAHL and AHMED.

Identified citation records from electronic database searches were exported into EndNote V.X9. Screening followed a three-step process as shown in Figure 2 PRISMA to select studies according to inclusion/exclusion criteria. Titles were initially reviewed to identify and exclude non-NMP relevant literature (n=201), abstracts were then screened (n=28) and full texts of those appearing relevant sought (n=14). Reference list hand searching was additionally completed to maximise inclusion.

5.2.2 Data extraction and synthesis

Study data were extracted to a bespoke table designed to capture information on key study characteristics including study aim, design, setting, sample, main findings and - where evident- barriers and facilitators to implementation.

5.3. Conversations with key informants

Using established contacts and networks, and a snowballing technique, contact was made with leaders and key informants involved in OTP across England, Northern Ireland, Wales and Scotland (n=13). Conversations (n=8) were held with to gain insight into the evolvement of OTP and opinions on key enablers and challenges.

Additional relevant literature, including that recommended by informants, were used to further inform the review.

Handwritten notes made on informal conversations were analysed to identify key barriers, enablers, and suggestions for optimising OTP.

5.4 Data analysis and synthesis

Barriers and facilitators to implementation of non-medical prescribing, identified from the review of systematic reviews, were grouped under the following stages: i) preparation for the role ii) training iii) early integration and iv) sustainment and development. Using a process of framework analysis[11], these key barriers and facilitators were mapped against knowledge relating to OTP from the literature review and conversations with key informants in order to identify key issues and challenges and inform recommendations. This synthesis provides the basis of the discussion and recommendations.

Findings from each section are reported separately and then the overall synthesis is discussed.

6 Results

6.1 Review of systematic review of barriers and facilitators to non-medical prescribing

6.1.1 Search outcome

In total 3,474 total records were identified from initial database searches using MEDLINE (n=865), CINAHL (n=410), EMBASE (n=1,148), British Nursing Index (n=603) and Nursing & Allied Health (n=448). After duplicate removal (n=955) and exclusion of articles by title (n=2,337) and abstract (n=131), 51 full text articles were reviewed by the research team. A further 41 were excluded for reasons shown in PRISMA Figure 1, leaving 10 full text articles eligible for inclusion. Hand searching reference lists generated 3 more reviews fulfilling inclusion criteria; in total 13 systematic reviews were included.

6.1.2 Study characteristics

Thirteen articles fulfilled the inclusion criteria and were reviewed. This included: 9 systematic reviews using mixed methods [12-20], 3 systematic reviews focused on studies using qualitative methods[21-23], and 1 review included quantitative studies only[24] .Statistical meta-analysis was not possible due to the heterogeneity between studies[15, 20, 24] .Instead, findings were presented in a narrative form[13, 15, 16, 24], with qualitative data being analysed thematically [13, 14, 16-18, 20, 21] .In two of the reviews a meta-synthesis was conducted[19, 22] .One systematic review conducted a meta-ethnography[23] and one used framework analysis to synthesise the data [12]. All systematic reviews were international and included studies from the UK, apart from one systematic review[14] which focused on the UK only.

Studies addressed community (n=4), primary care (n=11), secondary care (n=9) and tertiary care (n=3). Participants included independent prescribers (n=13) and supplementary prescribers (n=9). Non-medical prescribing professions included: pharmacists (n=8), nurses (n=9), physiotherapists (n=2), podiatrists (n=2), radiographers (n=1).

6.1.3 Thematic synthesis findings

Several factors were identified that can inhibit or facilitate the uptake and implementation of NMP (see Appendix 3). For the most part, it appeared that NMP was largely acceptable to both service users and health care professionals. However, barriers are consistently reported and a lack of strategic planning to support wider scale implementation of NMP identified [14, 18, 23]. The implications of this are discussed in more detail below.

Theme i) Preparatory stage

a) Organisational readiness

Following approval of legislative frameworks and the appropriate regulatory body, optimising organisation readiness is key to supporting successful implementation of NMP. Having an up to date NMP policy; pro-NMP leadership, buy-in at a senior level and a supportive inter-professional climate were all factors reported to contribute to a conducive environment for NMP implementation

Local policy and infrastructure to support prescribing

In additional to professional registration, Trust policy and ratification of NMP, for each profession, must be in place within the organisation to enable NMP[14, 19]. For example, scope of prescribing is agreed by Drugs and Therapeutic committees and a prescribing budget identified[18 14]. Delays in registration of newly qualified NMPs were known to occur, particularly if they were the first NMP in the trust and there was, for example, no trust NMP policy in place[18 20]. Additionally, delays could occur where the infrastructure was not in place to provide access to prescription pads[17-19, 22] or access to medical records[18 13-15, 17, 18, 20]. Practicalities, such as space and time to engage in prescribing also needed to be considered[18 15, 17-19]. Pharmacist NMPs had concerns about not having access to private consultation rooms (i.e., lack of privacy[15]). They also reported issues regarding accessing confidential medical records and the necessity of being able to record prescribing actions in patients' medical notes within a community pharmacy setting [15].

NHS trusts had their own drug formularies, which imposed limits on which medications could be prescribed [14, 18, 19, 22, 23 14]. These formularies required updating and regular review to ensure they were fit for purpose for NMP use[18, 21]. In addition, some trusts required individual prescribers to have a personal formulary, which is an agreed list of medicines that they could prescribe [14, 19]. This could be useful in defining scope of practice but could also be a barrier if too restrictive and time consuming to adapt when NMPs want to expand their prescribing remit[18].

Leadership, support, and strategic vision

Strong pro-NMP leadership facilitated the development of NMP within an organisation [14, 19]. A lack of strategic vision for NMP[14 23] hampered innovative NMP-led service development and resulted in a perceived lack of need for NMP within an organisation[17]. Thus, it was important that stakeholders recognised the demand for NMP[17], that they had positive attitudes towards NMP and could see the

benefits associated with NMP in relevant roles [15, 18, 21, 22]. Funding to optimise the workforce could improve the supportive climate for NMP[15, 17].

A lack of management and Multi-disciplinary Team (MDT) support[12 17 19, 21]hindered the uptake of NMP, together lack of regular clinical supervision[21] and mentoring support [17]. Formal support mechanisms, including (clinical) supervision and feedback on NMP practice, were viewed as helpful [13, 21]. Support for NMP by doctors and MDT was crucial to facilitate NMP uptake and implementation from pre-training through to post-training [15-17, 19-22].

A lack of clarity regarding NMP roles often led to ambiguity, particularly regarding professional and legal boundaries of the role[14, 18, 19, 21, 22]. This was made worse by poor communication networks with NMPs expressing the need for better communication within MDTs [12, 14]. Furthermore, NMP often had to deal with role dissonance which manifested itself as a lack of acceptance, opposition, resistance, and professional rivalry, mostly from doctors [13-22, 24], but also from other pharmacists[17]. Some of the reviews used the word 'conflict' in this context[16, 20].

b) Practitioner readiness

Aspects highlighted as important to practitioner readiness included: practitioner selection, expectations, and motivation. It was recognised as beneficial that managers and HEI course providers select appropriate practitioners to undertake the prescribing programme, based on clearly defined criteria [18]. In addition, it was important that candidates had realistic expectations about what the NMP programme provided to avoid misunderstanding about the generic nature of NMP programmes that were multi-professional[12, 18]. However, variation in the content of NMP prescribing programmes[21], particularly in relation to pharmacology[12, 18, 22], and adherence to selection procedures were reported[18] .

Motivation to undertake NMP training included: an increased sense of autonomy [14, 18, 19], the desire to make better use of professional skills and expertise[22]. In addition, practitioners felt that it helped with their professional development [22] and that it increased their clinical competence, for example by improving their pharmacological knowledge[12, 19, 22]. Training as an NMP also provided practitioners with professional satisfaction[14, 15, 17-19, 21, 22]. Deterrents to undertaking NMP training were the added responsibility that came with prescribing[12, 17] together with a lack of financial renumeration[14, 18, 19]. The time and cost related to completing course prerequisites[18], combined with a lack of funding available for training[14, 18] made it less attractive for practitioners to train as NMPs.

Theme ii) Training

Feedback on the prescribing programme has highlighted inadequacies, according to the views of some NMPs[12, 13, 17, 21, 22]. Mainly, it was considered that applied pharmacology within courses was not adequate to compensate for the lack of grounding in pharmacology and bioscience at undergraduate level, particularly for nurses and physiotherapists [12, 19, 20, 22, 23 18]. Other shortfalls included preparation for assessment, physical examination, therapeutics, and diagnostic skills training[12, 15, 17, 21-24]. While some of the shortfalls mentioned may relate to poor pre-course selection, preparation and expectations, there were reports of disparity across NMP courses including duration, content, and relevance[21].

A multifaceted mixed methods approach was found to work well when undertaking training for the prescribing role[12]. For example, pedagogical methods, such as podcasts and virtual patients, facilitated history taking and developed diagnostic skills[12] . Repetition of key concepts and the opportunity to apply knowledge in the workplace further helped to consolidate NMP abilities acquired through training[12] .

Practitioners often had difficulty identifying an appropriate person to act as a designated medical prescriber (DMP), which in turn could prevent candidates from undertaking the training [12, 18]. Both peer and professional support were reported as lacking[14], and DMP supervision was patchy and sometimes poor quality[20] . Additionally, the course was reported to be challenging in terms of time and course commitments[14, 17].

Theme iii) Early transition

Transitioning to the prescribing role was commonly reported as a time of vulnerability where newly qualified NMPs needed to build confidence in prescribing[12, 13, 16, 17, 19, 20, 22, 23] . Some studies reported poor knowledge of pharmacology and therapeutics, and a need for CPD on pharmacology and drug interactions[16, 22] . At this time, continuing support and supervision from MDTs, management, and peers, appeared to be crucial, however was sometimes lacking [12, 17, 18] , leading to feelings of isolation, in particular for newly qualified NMPs[17].

The experience of prescribing was key for developing expertise, competence, and capability [12, 16, 19, 22]. NMPs who experienced a delay in putting their skills into practice and starting to prescribe resulted in a loss of confidence. At times, delays occurred due to local or national administrative processes required to obtain professional registration and authorisation to prescribe[18].

Newly qualified NMPs reported being fearful of making mistakes[12, 13, 17, 19, 20, 23 18], suggesting that they experienced a 'blame culture' within their workplace[19]. The anxiety associated with making mistakes was linked with increased accountability[12, 19], fear of liability[15, 18, 20]and litigation, particularly with respect to the perceived lack of legal protection practitioners had when working as an NMP[13, 18, 23]. This was further exacerbated by the excessive workload NMPs often had, which in turn was viewed as a risk factor when making difficult prescribing decisions [14, 17, 19] . Conversely, having appropriate clinic time meant that practitioners had enough time to assess and make appropriate prescribing decisions[13]. However, this was often not possible due to time pressures experienced in busy clinics[12, 16, 19] .

An additional area that newly qualified NMPs found challenging was establishing boundaries and expectations with colleagues and patients as to what they could prescribe[13, 16, 23]. A team approach to prescribing with support and encouragement from management, MDT, and doctors built NMPs confidence[12, 14, 17, 18, 22] and helped them to resist pressure from patients to prescribe[12, 16]. Peer support post- training [12, 13, 16, 18], including a buddy system and regular multidisciplinary continued professional development (CPD), was also found to have a positive impact on maintaining evidence-based medicines use[18].

Theme iv) Sustainment and development

Although benefits of NMP were clear, e.g., it provided improved access to healthcare [15, 17, 20, 21, 24] and better quality of care [20, 21] , there were still issues with developing and maximising NMP roles.

A lack of access to ongoing CPD to update and extend prescribing knowledge and remit was considered a barrier in the development and sustainability of NMP[12, 14, 19, 23] . This included the ability to keep up to date with evidence-based practice, including pharmacology, as well as regular updates on prescribing policy[12]. CPD that was offered to NMPs often lacked structure, with some NMPs not being able to access formal CPD and others turning to colleagues and peers for support[12, 23]. This was of particular importance in the context of expanding NMPs formulary[22]. NMPs who had completed specialist training were found to prescribe more items, from a wider range of medications [12].

The importance of governance and support for audit of prescribing practice was raised as a means to ensure transparency, accountability and safety of prescribing within areas of competence[18, 21]. Audit was also flagged as an important means to gather evidence on the cost-effectiveness NMP[18].

6.2 Review of literature on optometrist prescribing and additional supply

6.2.1 Study characteristics

Eleven articles including 8 empirical studies and 3 narrative reviews fulfilled inclusion criteria and were reviewed (see Table 4 and Appendix 5). However, due to the paucity of empirical studies identified, a relevant study outside published the review time was additionally included[25]. Empirical studies therefore included 7 quantitative studies, 1 qualitative study and 1 mixed-methods study. Quantitative designs included audits[26-28], national surveys[25, 29, 30], and 1 diagnostic agreement study [31]. Qualitative and mixed method studies employing interviews[32, 33], with the latter additionally employing focus groups and surveys [33].

Studies addressed community (n=3), acute eye hospital (n=2) and mixed community/hospital (n=4) optometry. Participants included optometrist independent prescribers (n=7 studies), non-prescribers (n=4), and relevant stakeholders including GPs, commissioners, and patients (n=2).

6.2.2 Focus of studies

Broadly categorised, studies focused on:

1. Auditing IP optometry service delivery [26-28]
2. Exploring views on extended prescribing [25, 30] and non-prescribing roles [33]
3. Describing prescribing practices [29, 31]
4. Identifying barriers and facilitators to OTP implementation [32].

6.2.3 IP service delivery

There was a lack of large UK national surveys which precluded overall estimate of IP adoption by the optometrist profession or enabled overview of the pattern of OTP service delivery. The literature was biased to community based optometry, with the majority of studies focusing on acute and/or chronic community/primary care ophthalmology services [26-29, 32], and fewer reporting optometrist IPs working in acute eye hospital services [29-32]. This is in contrast to Rumney's 2019 narrative reporting a bias in England to hospital uptake[34]. Estimates for Scotland (with analysis restricted to community-based optometrists proving eye examinations under the GOS) however suggested uptake of around 34%. Although overall studies reported an increase in the number of supplementary eye examinations undertaken within the community by optometrists since the 2012 Health & Social Care Act, there was no analysis indicating whether IP has facilitated/aided transfer of care to the community, although one study comparing pre-post lockdown figures estimated IP optometrist workload had increased by 20% following Covid-19. Studies looking at referrals from community optometrists to hospital eye

services reported a stable rate of around 4%, indicating 96% of patients could be independently managed to care completion by optometrist IPs, with one study asking optometrist IPs about referral patterns indicating that 20/39 qualified IPs (51%) believed they referred patients onwards less frequently post-IP [29].

6.2.4 Scope of IP practice

Data on scope of practice was restricted to prescribing frequency, drugs prescribed, independent case management (as above), referral sources, with some limited data on conditions managed by IPs. Loeffler found 87% of OTPs prescribed on a daily/weekly basis, amounting to prescription issue every 2 days, and a median of 10 prescriptions each month [29]. However, only 33% (n=18/54) of optometrists reported using a prescription pad to prescribe, with 33% (n=18/54) and 24% (n=13/54) indicating they requested prescribed medicines via a GP/ophthalmologist or used a written order. Asked their intentions to use IP to specialise in specific clinical areas, 75% (n=50) stated that they intended to or already had used IP to specialise in primary care conditions, with 61% (n=41/67) indicating glaucoma specialism. Although 40% of this sample of IPs (n=16) indicated that IP enabled them to manage conditions that they could not formerly address [29], there was no other data indicating how IP expanded scope of practice. One study presented clinical diagnostic agreement data for optometrists with standard reference to consultant ophthalmologist diagnosis/management, and although it addressed agreement in prescribing management, it did not provide finer details on prescribing or medicines management decisions related to IP skills [31]. However, the study identified 19 conditions which were considered as independently manageable by optometrist IPs.

6.2.5 Barriers and facilitators to optometrist IP implementation

Three empirical studies provided evidence of barriers and facilitators to OTP implementation including 2 cross-sectional surveys [25, 29] and 1 qualitative study [32]. Both surveys were conducted over a decade ago, either pre-legislation (and hence recruiting non-prescribers) [25], or in 2011 during early national adoption [29]. The latter recruited a mix of qualified OTPs (n=39) and those in part-training (n=21). IP pertained predominantly to community (independent and/or multiple practice) based optometrists (around 50%) with 20% [29] and 31% hospital based [32]. Studies collected data from Scottish, English and Welsh [29] and English and Welsh OTPs [32], with none reporting data from Northern Ireland. With only the recent study (set in England and Wales) focusing specifically on identifying factors to inform future implementation the contemporary empirical evidence base for implementation and its challenges is extremely limited.

Nevertheless, Spillane et al (2021)[35] and Loffler et al (2011)[36] identified a range of barriers to OTP, with some common challenges to implementation persisting over the review decade. Broadly categorised, barriers related to a) practitioner skills and motivation, b) training, c) organisational support and d) external/local policies.

a) Practitioner skills and motivation

IP was reported to be essential to hospital optometrist roles, proffered increased job satisfaction, enhanced professionalism and improved clinical autonomy and patient management [32]. Prior clinical experience and communication skills were deemed essential requisites, both to reinforce prescribing (and non-prescribing decisions), for patient treatment adherence and for holistic management [32]. Motivational deterrents to undertaking IP included lack of fair remuneration [25, 32] (a greater concern for independent optometrists, $p<0.001$[25]), a perception of increased workload (how workload increased was not fully elucidated), difficulty securing funding, fear of litigation, lack of time for training and costs incurred [25].

b) Training

From Loffler et al.'s 2011 survey (n=60 optometrists), satisfaction ratings for various components of OTP training were in general high, with 75% believing training was relevant and helpful to practice. However, 25% indicated they did not have adequate exposure to relevant clinical conditions/number of patients during training or had less opportunity for discussion of prescribing decisions with ophthalmologists. The main barriers to training were identified as difficulty finding a hospital clinical placement and the length of time it took for placement completion (38% took 6 months to 1 year).

c) Organisational support

Optometrists reported three main challenges to development of competence and prescribing scope of practice post NMP qualification: limited clinical caseload exposure, lack of availability of learning support and the constraints of College of Optometry practice guidelines [32]. In general, greater confidence was expressed by hospital optometrists, or those with access to support and/or IP peers, than those in community and/or independent settings. The latter reported isolation and less access to support channels. While College of Optometry clinical guidelines were a facilitator to early prescribing, they were perceived as draconian, outdated and at conflict with organisational clinical guidelines by more experienced optometrists. Overall, optometrists expressed strong desire for greater organisational input for continued professional development, including updates and targeted

educational events. Optometrists overall perceived the scope of prescribing practice as well as the utilisation of optometry IP in services was constrained by this lack of development opportunities.

d) External/local policies

Key policy/contractual limitations were a major barrier limiting the use and scope of community OTP with up to 50% of optometrists lacking access to prescription pads [29]. This required community OTPs to rely on private prescription issue in England (incurring patient costs) and/or GP referral for accessing medicines needs. Although OTP could in theory streamline and offset identified bottlenecks in medicines pathways for locally commissioned enhanced optometric services (as described by Baker et al (2016)), this lack of contractual agreement severely limited the ability to enact and engage in prescribing activities and hence develop and enhance services. It also restricted access to certain medicines which impeded equitable medicines access for community patients.

6.2.6 Summary of main findings

Overall, the review found a relative paucity of empirical work carried out on OTP within the past decade, with a tendency to small scale, local audit, and lack of national evaluation. As a result, there is limited knowledge and understanding about the current scope of OTP practice, its service delivery, and the challenges for national implementation. However, there was some evidence to suggest that barriers to implementation arise in four main areas including a) practitioner skills and motivation, b) training, c) organisational support and d) external/local policies, and that many are prevalent and unchanged over the past decade.

6.3 Conversations with key informants

There was agreement that Optometrists have a key role in supporting current government policy and transforming services to provide care that is safe and accessible close to home[37]. It was acknowledged that the knowledge and skills of optometrists mean that they are well placed to meet the needs of patients who present with acute and non-acute stable ophthalmology conditions, compared to services previously provided by general practitioners.

Discussion around the history and development of the General Optical Council provided an insight into some of the challenges experienced by the regulator over the past few decades. A number of difficulties arose from the historical association with the Royal College of Ophthalmologists. Concerns

were expressed about the GOC regulatory framework, comprising four professional groups, which currently bear little resemblance to original registration, and frustration regarding an apparent reluctance to modernise this aspect of the register by improving recognition of current practice, and associated nomenclature

There was evidence of some top-down resistance (at least initially) to OTP and a lack of support for autonomous practice from the Royal College of Ophthalmologists. Overall, there appeared to be a sense of resistance to change and a belief that OTP was somehow different to non-medical prescribing by the other professional groups e.g. nurse, pharmacists, and allied health professionals, although the basis for this understanding was not clear.

Conversations with the key informants focussed on a number of issues including: i) Strategic vision and commissioning for OTP services; ii) OTP preparation; iii) Supervised practice; iv) Undergraduate training; v) Early transition; vi) Long-term sustainability

6.3.1 Strategic vision and commissioning for OTP services

A lack of evidence exploring the benefits of OTP for patients and services limited understanding and appreciation of the value and potential scope of OTP in both primary and secondary care. This was thought to be hindered by the lack of recognition for different roles/ titles for OTP use within GOC and commissioned services. Despite the lack of evidence, and similarly to other professional groups of NMPs it was noted that OTP is more than just issuing a prescription. Eye conditions need to be considered holistically and this requires experience, knowledge, and skill. There also needs to be wider recognition of other decision making that requires prescribing skills, e.g., decision not to prescribe, deprescribing, and medicines optimisation activities. There were mixed views regarding how optometrists might align with HEE framework for Advanced Clinical Practice, and the potential opportunities this could offer to further extend optometrist scope of practice in new and innovative areas of practice.

OTP led services were reported to be very popular by GPs who were able to ensure access to care for patients within 36 hours. Patients prefer care that is provided closer to home, and commissioners value the fact that OTP is cheaper (90% of tariff cost) and helps reduce waiting lists.

Despite the popularity of OTP led services, different approaches to commissioning were evident across the devolved nations. The extent of commissioned services across the devolved nations varied, resulting in a wide range of service models. In England for example, service commissioning was patchy,

and lacked joined up thinking. Services had to adapt and follow the money over time. Examples of long-running and well established multi-disciplinary services were discussed, with reports of multiple NMPs working in teams providing services that had been responsive to Covid-19 challenges. The complexity of funding in England was highlighted and a need for local commissioners to be innovative, which had in some cases led to funding being drawn down from acute service budgets in the first instance.

In contrast, in Scotland and Wales, a strategic drive to invest in OTP models of care has resulted in OTP services as first contact, diverting patients from GP and from acute services. There is a current drive to support all primary care based optometrists to undertake IP training. Consequently, the Scottish government has allocated funds for IP training courses and placements, but not backfill. Similarly, in Wales there are commissioned IPOS (independent prescribing optometrist service (enhanced services)), to deal with a backlog of patients waiting to be seen with eye conditions. However, it was evident that are still some issues regarding spread and availability of OTPs who tend to be concentrated in urban rather than rural locations, leaving gaps in rural service provision. This is part of a shift from secondary to primary care optometry services in Wales called 'Transforming eye care in Wales', which has opened more opportunity for optometrist independent prescribing roles. More recently during 2021 a cohort of Optometrist IPs had been commissioned to undertake the theoretical component of the training by Health Education England, and commissioned practice placements in Northern Ireland were in the process of being introduced. Wales has similarly put in measures to increase the number of available placements.

Despite positive comments regarding OTP, concerns were expressed about ophthalmologists who appeared to be protecting their role and its potential erosion by OTP. Challenges were noted around the commercial aspects of Optometrist practice, many of whom were employed or self-employed in High Street Opticians, plus a lack of critical cases in primary care.

6.3.2 Pre-course requisites

Current guidance states that those wishing to undertake OTP must have a minimum of two years post-registration experience. Informants agreed that current undergraduate Optometrist curriculum and preparation is limited in its clinical component. There was agreement regarding a general desire to improve UG role preparation where, similarly to nurses, optometrists would be more 'prescribing ready' at initial registration or, that OTP became embedded into undergraduate preparation and initial registration.

6.3.3 OTP preparation

Mixed views on the adequacy of preparation for the OTP role were expressed amongst the key informants. Pre-course expectations regarding the role were felt to be adequate by course providers, but concerns were raised regarding how 'prescribing ready' OTPs were on qualification, and an apparent lack of awareness regarding the wider aspects of the NMP role e.g. prescription pad safety, and governance aspects of the OTP role.

Higher Education Institutes reported good success rates on the taught aspect of OTP preparation, which comprised blended learning, and commonly 45 credits at master's level. Assessments were reported to have a strong clinical focus e.g. MCQ, OSCEs, case scenarios, computer-based exams. In contrast to other NMPs there was no provision to assess numeracy @ 100% and or requirement to obtain 80% in a pharmacology-based exam. Upon completion of the practice element one course provider explained how OTPs can apply for Registered Prior Learning of clinical placement 15 credits so students can exit with a post-graduate certificate.

Current preparation for the OTP role is however fragmented and there is poor alignment between OTP standards, competencies and learning outcomes for OTP. Additionally, there is poor alignment between current OTP competencies and the RPS prescribing competency framework[38] which has been adopted by all other NMP professional groups.

The theoretical aspect of OTP is currently delivered only to optometrists, resulting in a lack of interprofessional learning compared to other NMP programmes, the majority of which are taught together. However, it was not clear if the different registration process for OTP meant that training needed to be separate as well. In contrast to other NMP programmes theoretical and practice-based components of OTP training are separate, leading to a potential disconnect between theory and practice, delays in obtaining practice hours and course completion. The disjointed approach and lack of joined up thinking between HEI providers and practice means no one person or organisation has oversite of the OTP preparation journey, with little opportunity for students or ophthalmologists undertaking the supervisory role to provide feedback, and or address any issues that may arise.

6.3.4 Supervised practice

Clinical placements, organised only at the point of completion of the theoretical component, are quite separate, and unaudited, resulting in a lack of quality assurance and there are no links between HEIs and placement providers. There is an over reliance on hospital-based systems to provide placements

for supervised practice. The prescriptive nature of clinical hours, where Ophthalmologists, in secondary care, are the only people who can provide this, has resulted in a large backlog of people waiting (>2,000) to undertake this aspect, and hence a delay in people registering as IPs. Additionally, there is a cost to students for OTP supervised practice placements many of whom are required to self-fund. As noted above, this is in contrast to other professional groups who routinely undertake supervised practice within their home organisation.

Suggestions to overcome the backlog included, aligning with other professional groups who have recently enabled any NMP to take on the role of practice assessor/ supervisors. The use of telometry was also suggested as way of addressing the need to develop clinical skills using a tablet device or split lamp linked up to Ophthalmologists, which was reported to has been successfully used in practice during the current pandemic.

6.3.5 Early transition

Completion of OTP training and registration is a lengthy process sometimes with more than 2 years between the taught element, supervised practice and the final exam. This resulted in long gaps before OTPs were in a position to prescribe, leading to potential deskilling, lack of prescribing confidence and implementation. The level of available support from HEIs, and practice supervisors to OTPs during this time was not clear. As with other NMPs, it was evident that a team approach enabled peer support and opportunities for multi-professional learning.

Initial governance procedures in some of the devolved nations were discussed and appeared robust in nature. However, the extent to which these are in place, particularly when providing a non-commissioned service, across the UK needs further exploration. Implementation of the OTP role was much easier when part of a commissioned service, providing access to prescription pads and a prescribing budget e.g. in NI, Wales and Scotland. In England where commissioned services are patchy, a lack of prescribing budget and pad were reported to hinder OTP practice, although the proportion of OTPs that this affects was not clear. There were mixed reports on the scope and frequency of prescribing practice, with some OTPs prescribing infrequently, for a narrow range of products, whereas others were quite prolific and prescribed across the formulary. Reasons for this variation in terms of scope and frequency are unknown and would benefit from further exploration.

There were mixed reports regarding the amount and type of formal and informal support for OTPs in practice. The majority of OTPs work in isolation, and concerns were raised about a lack of peer support and clinical supervision. Examples of good practice were mentioned including peer to peer support, a

'Whats App' group and regional OTP events. A lack of remuneration and or increased banding in recognition of IP status was reported and the approach to managing this inconsistent across the UK, with particular challenges noted in Wales.

6.3.6 Long term sustainability

There was agreement regarding the importance that OTP develops in a way that is responsive to wider changes in the NHS, patient needs and to manage long term sustainability. Examples of long-running services, where NMP was integral were discussed. Wider benefits of having an embedded service were highlighted including enhanced relationships in the local landscape, and improved referral systems in and out of the service. Similarly, the ability of commissioned services to adapt and continue during the pandemic, ensuring stable access to services for patients, provided further confirmation of a successful OTP commissioned service.

Frustrations were expressed regarding the regulatory requirement to record every prescribing decision, regardless of whether a prescription is issued, and for it to be available for inspection as an audit by the regulator that has no current mechanism to manage this process. A lack of CPD relevant to current practice and or NMP was also found to be frustrating. Knowledge and awareness of the various types of support available to other NMPs however appeared limited, and or how OTPs might engage with the wider body of NMPs across the UK through national NMP events and/ or the Association for Prescribers.

7 Discussion

This rapid review has systematically explored the evidence of barriers and facilitators to non- medical prescribing across all professions, including optometrist therapeutic prescribing along with conversations with key informants to identify key challenges and potential solutions. Given that non-medical prescribing is likely to be increasingly important for services to overcome predicted workforce deficits and inadequacies, this review is timely and of significant importance.

The results suggest a lack of joined up thinking which appears to have hampered advancement and improvement in relation to many aspects of the preparation, education and use of the prescribing role by OTPs. Evidence reporting benefits of OTP is limited but indicates that that OTP-led community services are able to manage the vast majority of the case load (96%) independently, with few referrals being made from these services to acute care[36]. There is evidence of isolation between OTPs and other professional groups who are NMPs. 'Silo' thinking, resulting in a lack of shared learning,

threatens to hamper the development of novel and advanced roles for OTP that are occurring in other NMP professions to meet the increasing demand for medication.

Organisational level

Issues were identified at a national/GOC level in terms of recognition of OTP scope and the leadership and support of developing innovative OTP roles. Concerns about role erosion and examples of resistance to NMP, in particular from the medical profession, have been long noted as a barrier to the acceptance and implementation of NMP [13-15, 19-22]. Indications from this review are that similar resistance exists with regards to OTP. Gaining acceptance and approval for OTP from key stakeholders and leaders is a crucial step towards uptake within an organisation and is also essential for supporting the implementation and individual development of NMPs throughout each stage. Negative views and concerns about NMP are known to dissipate once colleagues gain experience of working alongside NMPs, understand the benefits and have opportunity to develop a trusting relationship[39].

Discussion of advanced practice within optometry services was lacking, particularly non-clinical components such as leadership and research[40] . In other professions, the development of roles and agreement of competencies for advanced practice have coincided with the development of prescribing, and more recently the HEE ACP framework, providing[40] a backbone to career development and clinical pathways e.g., paramedics and physiotherapists. The alignment of prescribing with advanced clinical practice career development is a strong motivator for paramedics undertaking prescribing training[41].

Delays in organisational preparation to provide the infrastructure required to support NMP, such as access to a prescribing budget, prescribing pads and access to medical records were barriers experienced by OTPs [35, 36, 42]. Similar barriers reported by other NMPs [13-15, 17-20, 22]. Such problems are usually overcome once the first NMPs have become established in an organisation, however problems of accessing patient medical records and agreements to prescribe across primary care networks have been persistent barriers in community services[43]. A strategic approach to commissioning, as reported by key informants, can help facilitate the development and longevity of innovative service models, within which IP is key to providing care.

Practitioner readiness

Barriers and facilitators to undertaking NMP reported by optometrists are similar to those reported by other NMPs, in particular lack of remuneration, lack of funding and the time required to complete

NMP training[35, 36, 42] . Motivation to undertake NMP training, as reported by other NMPs, is primarily to gain the autonomy of practice to be able to improve patient care (e.g., by reducing waiting time and improving the quality of care [14, 18, 19, 22]. Where barriers are in place, as is the case with OTP access to prescribing pads or budget[35, 36, 42], the motivation to undertake training is reduced. A common secondary motivation is to improve job satisfaction and professional status [14, 19, 22]. These motivational aspects often win out over deterrents, such as lack of renumeration, time and effort to complete the course[14, 19, 21]. There is little information on the uptake of OTP but was reported as 34% in one study[44]. It is likely that barriers to OTP and additional complications such as payments for clinical practice placements, can act as deterrents that need to be addressed to promote uptake and implementation of the OTP role[35, 42] .

OTP role preparation

Pre-course requisites

There were mixed opinions regarding current guidance which states that those wishing to undertake OTP must have a minimum of two years post-registration experience. There is a lack of consensus within other regulators who have adopted different approaches to supporting uptake of the IP role. For example, recent regulatory changes have increased accessibility to independent/supplementary prescribing training for nurses as the requirement for post registration experience has been reduced from 3 to 1 years[45, 46]. Original policy supporting prescribing by allied health professionals, such as physiotherapist, podiatrists and paramedics [47, 48] however, recommended that only clinicians working at a highly skilled and specialist level, in a relevant clinical/service area should progress to independent prescribing, with at least 2-3 years post registration experience prior to undertaking the prescribing programme.

OTP preparation

Preparation for OTP is very different to all other groups of NMPs. OTP prescribing training is for example divided into three distinct stages (academic modules, practice-based learning, and final exam). This is in contrast with prescribing programmes for other NMPs who simultaneously undertake the taught component along with the required period of supervised practice. Practice-based learning which is integral to the prescribing programme is a Health and Care Professionals Council (HCPC) requirement [49] central to which is the integration of theory and practice[49]. Separation of these components may prevent consolidated learning in practice; a positive educational process that enable students to translate theory into practice. There is also a lack of alignment between prescribing standards set out by the GOC and those in the RPS Competency Framework for all Prescribers, adopted

by all the other professional groups who undertake NMP training[38]. This makes it difficult to compare OTP prescribing competencies with those of other NMPs in the UK. The taught component of OTP is uni-professional, and hence there is missed opportunity for multi-professional learning for OTPs and a lack of awareness amongst OTP HEI course providers of how other NMP programmes work. This prevents shared understanding of best practice in NMP education. By training together, NMPs from different professions gain mutual understanding of their professional roles, which can enhance communication and working across boundaries.

The restriction of practice-based learning to an acute ophthalmic care setting under the supervision of an ophthalmologist was reported to problematic in terms of availability and accessibility, creating a bottleneck in the availability of clinical placements. For those working in community settings, it was argued that low frequency of relevant clinical cases required to complete supervised practice could create further delays. The problem of a shortage of relevant clinical placements and problems accessing practice supervisors is not isolated to OTP and has been reported by other NMPs. Recent regulatory changes have allowed suitably qualified NMPs to undertake the role of practice assessor [45, 49, 50] , a role that previously could only be undertaken by a medical doctor or dentist, known as 'designated medical practitioner' (DMP). However, there was significant concern that limited availability of DMPs in some areas was acting as a barrier to those wishing to access training[51-53]. The growing workforce of experienced NMPs and a desire to make best use of their skills led to the regulatory changes outlined above[45].

It was found that there were few effective 'feedback loops' through which OTP course providers and practice-based educators could learn from student experiences, preparation for the prescribing role, or outcomes/success in practice or quality assure clinical placements., This is similarly in contrast to the HCPC, whose standards for prescribing set out the need for regular and effective collaboration between education providers and practice education providers.

There is a lack of clear justification for the differences between OTP educational and clinical standards for prescribing training and those of other NMP professions. From the little feedback that exists on OTP learning experiences, a quarter reported a lack of clinical exposure and support from practice educators[36] . Delays in initiating prescribing are known to reduce confidence[18] . The extended time between educational and practice components for OTPs may reduce confidence in prescribing practice and thereby reduce use of the qualification. Financial barriers deterring OTPs from undertaking practice placements also need to be considered.

Early transition

The extent to which NMPs use their qualification in practice is one indicator of the success of NMP implementation. However, it is important to capture the range of ways that prescribing knowledge can be used in addition to issuing prescriptions. For example, to acknowledge benefits of providing advice or information to patients on medication and deprescribing inappropriate medicine, and the longer-term cost implications of these actions[54]. Once qualified, the rate at which NMPs issue prescriptions, as highlighted by key informants, is known to vary enormously depending on the role and setting in which they work[43]. Those working in urgent and emergency services such as A&E and walk-in-centres tend to prescribe more frequently than NMPs in mental health, community nursing. Prescribing rates by OTPs[36] appear to be in line with average prescribing rates of other NMPs, which fall between 1-10 items per week. However, Loeffler et al.'s finding that 33% were referring patients to a GP for a prescription or using written orders suggests that barriers may be preventing greater use of prescribing, as found by Spillane et al 2021[35] .

Ongoing sustainment and development

Problems faced by OTPs over the long term include isolation, poor access to clinical supervision and CPD to support development of the prescribing role. These issues, as discussed by key informants, can be resolved, by schemes such as buddying [18], peer support [12, 13, 16, 18]and pan organisational provision for CPD[12, 14, 18, 19, 23] opportunities, and improved awareness of generic NMP study days and conferences, and support offered by the Association for Prescribers. Long term sustainability could be facilitated by more strategic approaches to service commissioning for OTP services, including robust service evaluation, to avoid instability, with services 'chasing the money' to survive.

7.,1 Limitations

This rapid review would have benefited from the input of a wider range of key informants including patients, OTP students, practicing OTP prescribers and ophthalmologists supervisors. As this was a rapid review, there was no assessment of the quality of included articles, however the review of NMP literature excluded reviews that did not follow a systematic process which is an indicator of quality. Furthermore, the timescale of literature included in these reviews reflects historical issues throughout the progression of NMP, some of which have since been addressed, such as provision of preparatory education on physical assessment and diagnosis prior to entering NMP programmes. The impact of changes, such as recent regulatory changes to NMP the practice supervision and assessment, have yet to be assessed. Literature on non-medical prescribing outside of the UK was excluded, limiting the international relevance of this review.

8 Further Research

The review indicates a number of issues related to OTP that may warrant further investigation. We recommend:

1) Evaluation on the uptake, use and impact of OTP on patient care and service delivery.
2) Exploration of the wider benefits of improved knowledge gained from OTP training on quality of care, safety and services provided by optometrist independent prescribers. This work should feed into commissioners and service leaders to inform future service development.
3) Evaluation of patient and carer views.
4) Evaluation of the appropriateness and effectiveness of OTP preparation.
5) Research into the medicines management activities of OTPs e.g. deprescribing, decision not to prescribe. This would help improve understanding regarding the true value of OTP with respect to patient outcomes and efficiency of care processes.
6) Research into the cost effectiveness of OTP.

9 Recommendations

These recommendations are designed to support OTP implementation by addressing reported challenges and building on good practice.

It is recommended that:

1. There is a need for review and alignment of current GOC standards for prescribing with those of other regulatory bodies i.e., HCPC, Nursing and Midwifery Council (NMC) and General Pharmaceutical Council (GPhC) and adoption of the RPS Competency Framework for all Prescribers.

2. Current professional preparation programmes are reviewed with respect to improving the integration of basic pharmacology within this provision and potential to revise existing pre-course requisites for Optometrists to have acquired 2 years post-registration experience prior to undertaking preparation for the OTP role.

3. There is a need to establish robust systems to capture data on OTP involvement in medicines management activities to support ongoing evaluation and clinical audit.

4. The use of the ACP framework to support Optometrist advanced clinical practice is reviewed in more detail with a view to providing guidance for clinicians with respect to developing innovative service models in primary and secondary care.

5. Those involved in OTP preparation should reconsider opportunities for shared learning with other groups of professionals undertaking NMP training.

6. There is a need to review current arrangements and provision for practice placements and consider alignment with recent changes adopted by other regulatory bodies and the newly introduced Competency Framework for Designated Prescribing Practitioners[55].

7. A national UK evaluation is required in order better understand uptake, scope and implementation of OTP and its impact on team configuration, costs and patient experience.

8. There is a need to review current governance arrangements, practical challenges associated with accessing prescribing budgets for non-commissioned services, and provision of CPD and support for OTPs who work in different practice settings.

10 Conclusion

This rapid review has identified similar barriers and facilitators that impact on the uptake and use of non-medical prescribing and optometrist therapeutic prescribing across different stages, from initial preparation through to long-term sustainability. A review of relevant literature on OTP, together with input from key informants, has highlighted key challenges along with potential solutions. While research evidence is limited, OTP has been positively received. There is however clear scope to further extend it OTP in order that its potential is fully realised.

A lack of joined up thinking appears to have hampered advancement in relation to many aspects of the preparation, education and use of the prescribing role by OTPs. Future development of OTP would benefit from greater strategic oversight and alignment with educational and governance procedures in place for other NMPs. Arrangements for practice placements require review to address bottlenecks in course completion and the impact this has on prescribing practice. Acknowledgement and support for novel and advanced roles for OTP may facilitate role development in line with other NMP professions. These changes are timely given the role of non-medical prescribing in improving service capacity to meet increasing demand for medication, especially considering current and predicted workforce deficits in primary and secondary care, particularly ophthalmology.

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Tables

Table 1: Additional prescribing roles

Prescribing role	Role description	Training requirements	Prescribing access (As Prescription-Only Medicine)
Additional supply	Write orders for, and supply in an emergency, a range of drugs in addition to those which can be ordered or supplied by a normal optometrist according to CoO Formulary	2 years post-registration experience Taught educational course Clinical placement hours (6 x 3-hour sessions) Pass CoO Common Final Assessment	Acetylcysteine Atropine Sulfate Azelastine Hydrochloride Diclofenac Sodium Emedastine Homatropine Hydrobromide Ketotifen Lodoxamide Nedocromil Sodium Olopatadine Pilocarpine Sodium Cromoglicate
Independent and supplementary prescribing (includes additional supply)	Take responsibility for clinical assessment of patient, establish diagnosis and determine clinical management required (including prescribing where necessary)	2 years post-registration experience Taught educational course Clinical placement hours (24 x 3-hour sessions) Pass CoO Common Final Assessment	Any licensed, non-controlled medicine for ocular conditions, affecting the eye and adnexa, within the recognised area of expertise and competence of the optometrist. Drugs requiring injection excepted.

Table 2: Inclusion and exclusion criteria barriers and facilitators non-medical prescribing review of systematic reviews

Inclusion Criteria	Exclusion Criteria
► Systematic reviews (with meta-analyses or meta-synthesis)	► Literature and scoping reviews without documented transparent and replicable process
► Qualitative, quantitative, and mixed methods systematic reviews	► Primary research
► Reviews addressing NMP (this includes NMIP by legislated non-doctor health care professionals, reviews addressing supplementary and/or collaborative models of prescribing)	
►Reviews addressing NMP in primary/ community/secondary/mixed primary and secondary care	
► Reviews presenting empirical evidence of barriers and/or facilitators to NMP implementation	
► Peer reviewed, full text articles published between 01 January 2010 and 25 March 2021	► Abstracts, conference reports
► Reviews published in English	► Reviews published in non-English language

Table 3: Four stage, iterative process of data analysis

Stage 1: In-depth reading and familiarisation with individual systematic reviews and data extraction. **Stage 2:** Inductive line-by-line coding by one reviewer (SvE). Using NVivo 11 the reviewer created a codebook which included an overview of all the individual codes. **Stage 3:** The individual codes were discussed with the full research team (NC, KS, MC, & JE). Wherever there was any lack of clarity or consensus about the naming of a code or the interpretation of a concept, this was discussed and where appropriate the coding was revised accordingly. Further to these discussions the reviewer (SvE) grouped the codes into descriptive themes. This codebook created in NVivo was applied to all papers. **Stage 4:** Descriptive themes were organised into analytical themes (see Appendix 3).

Table 4: Inclusion criteria optometrist prescribing and additional supply review

Inclusion Criteria
►Primary and secondary empirical studies, abstracts, conference reports, literature reviews, reports
►Studies employing any quantitative, qualitative or mixed methods design
►Studies addressing non-medical prescribing (including supplementary and independent prescribing), medicines administration and/or supply undertaken by legislated optometrists
►Studies addressing IP in any healthcare setting
► Full text articles published between January 2010 and March 2021 in the English language
►Studies undertaken in the United Kingdom

Figures

Figure 1: PRISMA flowchart of paper selection process for barriers and facilitators in non-medical prescribing review of systematic reviews

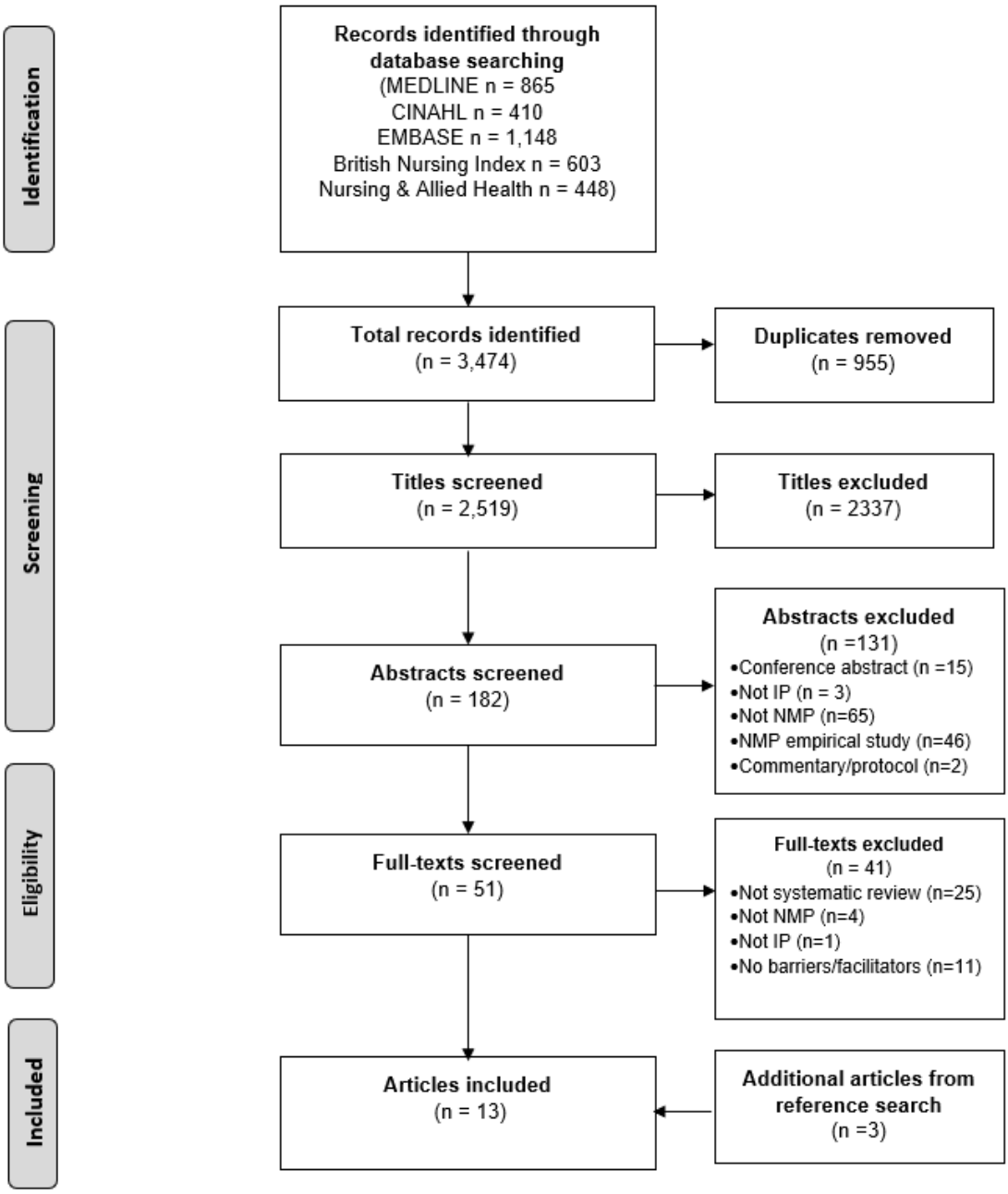
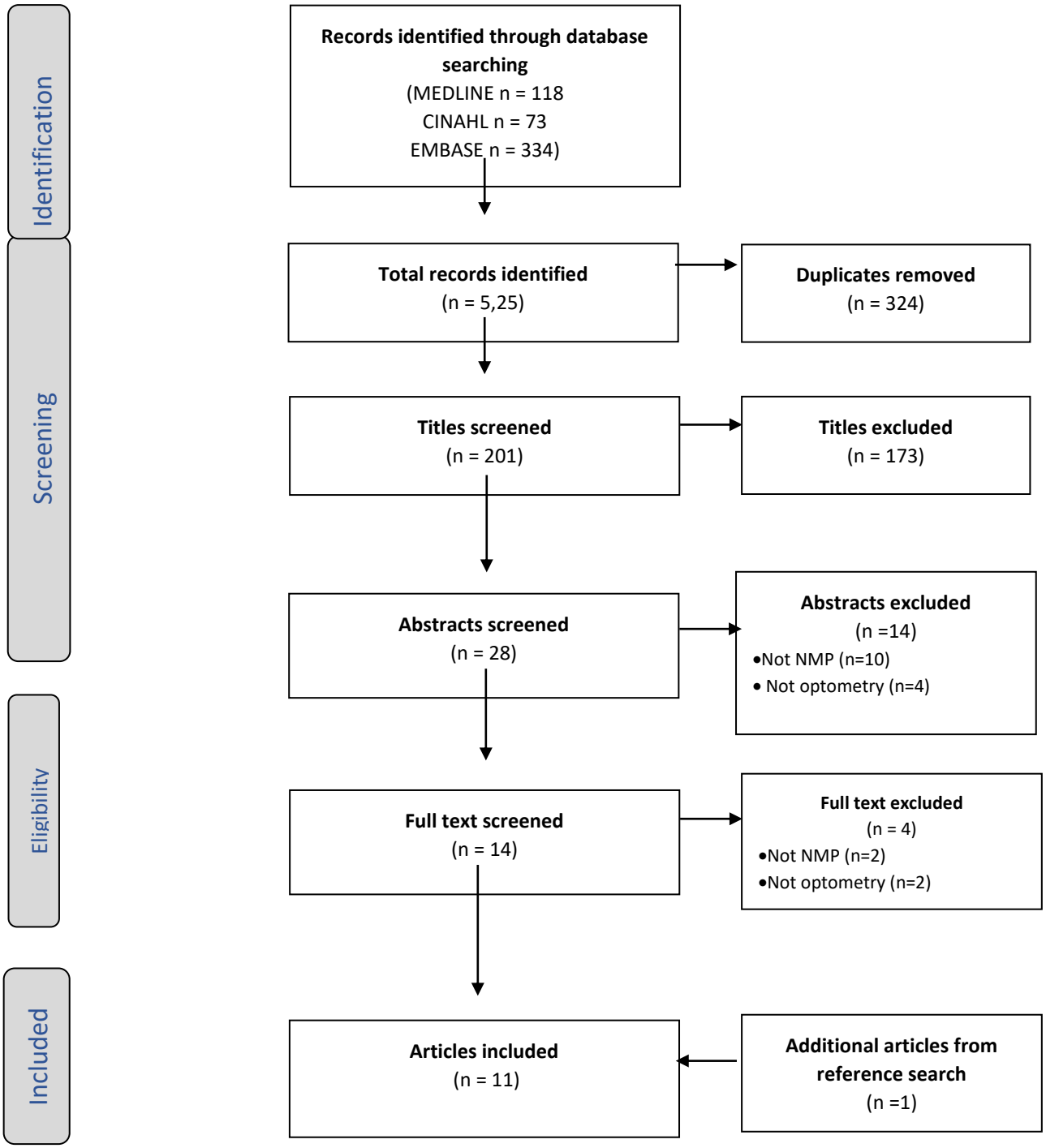


Figure 2: PRISMA flowchart of paper selection process for optometrist prescribing and additional supply review



Appendices

Appendix 1: Example search string for barriers and facilitators to non-medical prescribing

	EBSCO host; CINAHL	
1	AB prescrib* OR TI prescrib*	154,192
2	AB independent prescrib* OR TI independent prescrib*	510
3	AB non-medical prescrib* OR TI non-medical prescrib*	173
4	AB patient group direction* OR TI patient group direction*	260
5	AB exemption* OR TI exemption*	3,593
6	AB medicine* exemption* OR TI medicine* exemption*	20
7	AB medicine* endorsement* OR TI medicine* endorsement*	41
8	AB standing order* OR TI standing order*	884
9	AB medicine* administration* OR TI AB medicine* administration*	3,297
10	AB medicine* supply OR TI medicine* supply	904
11	AB medicine* optimisation OR TI medicine* optimisation	268
12	AB medicine* management OR TI medicine* management	5,024
13	AB medication administration OR TI medication administration	8,004
14	AB prescribing right* OR TI prescribing right*	152
15	AB prescribing authority OR TI prescribing authority	205
16	OR/1-15	162,670
17	AB nurs* OR TI nurs*	462,694
18	AB physiotherap* OR TI physiotherap*	26,750
19	AB physical therap* OR TI physical therap*	30,633
20	AB pharmacist* OR TI pharmacist*	34,605
21	AB (podiatr* OR chiropod*) OR TI (podiatr* OR chiropod*)	3,293
22	AB radiographer* OR TI radiographer*	1,764
23	AB (dietician* OR dietician*) OR TI (dietician* OR dietician*)	1,770
24	AB paramedic* OR TI paramedic*	8,019
25	AB optometr* OR TI optometr*	4,888
26	OR/17-26	560,565
27	16 AND 26	14,369
28	AB nurse N3 prescrib* OR TI nurse N3 prescrib*	1,599
29	AB pharmacist N3 prescrib* OR TI pharmacist N3 prescrib*	1,261
30	AB physiotherap* N3 prescrib* OR TI physiotherap* N3 prescrib*	162
31	AB paramedic* N3 prescrib* OR TI paramedic* N3 prescrib*	10
32	AB podiatr* N3 prescrib* OR TI podiatr* N3 prescrib*	23
33	AB dietician* N3 prescrib* OR TI dietician* N3 prescrib*	6
34	AB dietitian* N3 prescrib* OR TI AB dietitian* N3 prescrib*	32
35	AB radiograph* N3 prescrib* OR TI radiograph* N3 prescrib*	97
36	AB optometr* N3 prescrib* OR TI optometr* N3 prescrib*	62
37	OR/20-28	3,148
38	19 OR 29	14,483
39	(MM "Systematic Reviews as Topic")	8,923
40	AB systematic review* OR TI systematic review*	207,733
41	AB scoping review* OR TI scoping review*	8,579
42	AB realist review* OR TI realist review*	472
43	AB "literature review*" OR TI "literature review"	358,083
44	AB "rapid review*" OR TI "rapid review"	3,135
45	AB meta-synthesis OR TI meta-synthesis	1,002
47	AB metasynthesis OR TI metasynthesis	361
39	AB "qualitative review*" OR TI "qualitative review*"	7,633

Appendix 2: Summary of barriers and facilitators to non-medical prescribing

Authors	Aims/objectives	Number of papers included	Time frame	Model of prescribing	NMP profession	Care setting	Main findings
Abuzour (2018)	To explore whether McLellan et al.'s (2012) theory of expertise development model - true competence in prescribing demands expertise, regardless of the simplicity of the task at hand- is applicable to iNMP and to assess the factors underpinning expertise development reported in the literature.	34	2006-2016	Independent prescribing	Pharmacists & nurses	Primary, secondary, & tertiary care	Focused on transition of prescribing into practice. Knowledge, pre-registration education, experience, support and confidence were some of the intrinsic and extrinsic factors influencing IPs. Difficulty in transferring theory to practice due to lack of basic pharmacology and bioscience content in pre-registration nursing rather than the prescribing programme. Students saw interventions using virtual learning or learning in practice as more useful with long-term benefits. IPs were able to develop their expertise when integrating their competencies in a workplace context with support from colleagues and adherence to guidelines.

Chater (2020)	To identify what evidence exists regarding the influences of NMPs antimicrobial prescribing behaviour and analyse the operationalisation of the identified drivers of behaviour using the Theoretical Domains Framework (TDF).	8	All relevant papers published up to July 2019	Independent prescribing	Mixed	Not specified	Review aimed to identify what evidence exists regarding the influences on NMP's antimicrobial prescribing behaviour and analyse the operationalisation of the identified drivers of behaviour using the Theoretical Domains Framework (TDF). Key issues centred around strategies for managing challenges experienced during consultations, managing patient concerns, peer support and wider public awareness of antimicrobial resistance. The two most common TDF domains highlighted as influences on prescribing behaviour, represented in all studies, were social influences and beliefs about consequences.
Cleary (2017)	To identify and summarize qualitative research that focussed on mental health nurse prescribing, synthesize findings, and outline key themes discerned.	12	Not specified	Independent & supplementary prescribing	Mental health nurses	Not specified	Three general themes were identified: (i) patient-centred care; (ii) professional role; and (iii) professional support. Nurse prescribers embrace a patient-centred approach, providing timely and effective medication management. Adequate education and continuing professional development inclusive of clinical supervision enable competency development in nurse prescribing, supportive professional relationships, and patient safety.
Darvishpour (2014)	This review aims to combine and interpret existing literature reviews and systematic studies to obtain new insights on nurse prescription.	11	No time limitation used	Independent & supplementary prescribing	Nurses	Primary & secondary care	Eight themes were identified: leading countries in prescribing (i.e., the UK), positive views on nurse NMP, features (i.e., prescribing patterns, areas of nurse prescribing, confidence in prescribing and quality and safety of practice), infrastructures, benefits (i.e. for health system, patients and nurses), disadvantages (additional work, safety concerns), facilitators (educational factors, managerial factors, organisational factors) and barriers (legal limitations, executive factors, humanistic factors, educational deficiencies and, research weaknesses) of nursing prescription.

Djerbib (2018)	The aim of this review is to discover and understand the factors that influence prescribing decisions made by iNMP nurses in primary care.	10	1994 - July 2016	Independent & supplementary prescribing	Nurses	Primary care	A total of 14 common descriptive themes were identified across the papers included in the review. These were further analysed and gave rise to three interpretative themes: perception of confidence, perception of risk and impact on the patient. Appropriate education and training are pivotal in improving prescribers' competence, reducing risk and preventing harm to patients.
Graham-Clarke (2017)	The aim of this review is to evaluate the use of, as well as facilitators, and barriers of independent non-medical prescribing in primary and secondary care in the UK.	42	2006 - 26 March 2017	Independent prescribing	Mixed	Primary & secondary care	This systematic review & thematic synthesis focused on b & f's of NMP - please note that the authors argued that each theme and subtheme could act as a barrier or facilitator depending on the circumstances: a. Where there was a lack of understanding on NMP role, or lack of trust in the individual NMP, then the factors were more inclined to be barriers. b. For example, medical professionals were less likely to support NMP where there was a lack of clarity about who took responsibility for the prescribing practice. c. Because of budgetary constraints factors may become barriers, such as the use of restrictive formularies as a cost saving measure. d. Themes and subthemes do not stand in isolation, but are interdependent on each other
Jebara (2018)	The aims of this systematic review are to: (1) critically appraise, synthesize and present the available evidence on the views and experiences of stakeholders on pharmacist prescribing and (2) present the perceived facilitators and barriers for its global implementation.	65	No date limit until November 2017	Independent & supplementary prescribing	Pharmacists	Primary care, community, & secondary care	The main benefits were ease of patient access to healthcare services, improved patient outcomes, better use of pharmacists' skills and knowledge, improved pharmacist job satisfaction, and reduced physician workload. The main barriers were pharmacists' skills (clinical examination and diagnostic skills), resources (workforce, access to medical records, space, time), physicians and organisational support, funding, legal aspects (accountability, conflict of interest), pharmacy practice recognition.

McIntosh (2016)	To critically appraise, synthesize and present evidence on the influences on prescribing decision-making among supplementary and independent NMPs in the United Kingdom.	3	2003 - June 2013	Independent & supplementary prescribing	Mixed	Primary care	Regarding prescribing decision-making, complex influences were evident such as experience in the role, the use of evidence-based guidelines and peer support and encouragement from doctors; these helped NMPs to feel more knowledgeable and confident about their prescribing decisions. Opposing influences included prioritisation of experience and concern about complications over evidence base, and peer conflict.
Mills (2020)	To explore the views, opinions, and attitudes of pharmacists and graduates towards non-medical prescribing.	14	January 2003 - September 2017	Independent & supplementary prescribing	Pharmacists	Primary care & community setting	NMP was considered a natural extension to the role of a pharmacist despite difficulties in completing the required training. The ability to then prescribe was dependent on funding and access to medical records, time, and support staff. Pharmacists experienced professional rivalry with both support and resistance from members of the primary care team. The provision of training was frequently referred to as unsatisfactory. Pharmacists were motivated to prescribe, deriving increased job satisfaction and a sense of professionalism; however, they often felt underprepared for the reality of unsupervised practice. Furthermore, pharmacists reported a cautious approach with a fear of making errors frequently discussed.
Noblet (2017)	To explore the factors that affect the implementation or utilisation of independent non-medical prescribing (iNMP)?	43	2001-2011	Independent prescribing	Mixed	Primary, secondary, & specialist care	Qualitative studies identified barriers and facilitators to non-medical prescribing in political/ organisational factors; whether a formulary is used; education and support; personal and professional factors among the medical profession, other professions, and service users; and financial factors. Quantitative studies confirmed these factors.

Nuttall (2018)	To develop an understanding of the existing theoretical perspectives around nurse prescribing and to identify any gaps in knowledge which would support further research into the lived experience of the nurse prescriber in the primary care setting.	37	1999-24 April 2015	Independent & supplementary prescribing	Nurses	Primary care	Nine themes were identified: patient-centred care; benefits to the service; the need for knowledge (particularly pharmaceutical); professional accountability and boundary-setting; safety consciousness; barriers to effective prescribing (e.g., lack of access to training, lack of support); role-preservation; power-shifts and interprofessional relationships and culture of prescribing.
Poh (2018)	To synthesize the best available evidence on the safety and effectiveness of pharmacist prescribing on patient outcomes in patients who present to hospital.	15	Until 24 January 2017 (from database inception?)	Independent & supplementary prescribing	Pharmacists	Secondary care	This review explored the impact of pharmacist NMP on patient outcomes in a hospital setting. It provided low to moderate evidence that pharmacists could prescribe to the same standards as doctors. Pharmacists were better at adhering to dosing guidelines when prescribing by protocol and made significantly fewer prescribing errors when charting patients' usual medications on admission to hospital.
Stenner (2018)	To systematically review physiotherapy and podiatrist prescribing and medicines management activity, including evidence of impact on patient care, levels of knowledge and attitudes towards extended medicine's role.	21	January 1985 - May 2016 (physiotherapy) + January 1968 - May 2016 (podiatry)	Independent & supplementary prescribing	Physiotherapists & Podiatrists	Primary & secondary care	This review focused on physiotherapist and podiatrist NMP. No studies were identified that specifically evaluated prescribing by physiotherapists or podiatrists and no studies relating specifically to podiatry met the inclusion criteria. Four main themes were identified in the data relating to physiotherapy: 1. Extent of involvement in medicines advice or administration; 2. Knowledge levels and training needs relating to role in medicines management or advice; 3. Attitudes towards physiotherapist prescribing or extended medicines role; 4. Care outcomes and costs.

Appendix 3: Overview of barriers and facilitators to non-medical prescribing

Analytical themes	Barriers	Facilitators
1a. Preparatory stage - Organisational readiness	• No local legislation and policies in place (Noblett 2017; Stenner 2018) • Administrative processes are long and arduous and can lead to delay in practicing (Noblett 2017) • Restrictive formularies are used as a cost saving measure (Graham-Clarke 2018) • Lack of agreement regarding budgetary arrangements (Noblett 2017) • No access to prescription pads (Darvishpour 2014; Mills 2020; Noblett 2017; Nuttall 2018) • No access to medical records (Chater 2020; Graham-Clarke 2017; Jebara 2018; Mills 2020; Noblett 2017; Stenner 2018) 1. Lack of space and time to prescribe (Jebara 2018; Mills 2020; Noblett 2017; Nuttall 2018): 2. No access to private consultation rooms (Jebara 2018) 3. Issues with confidentiality regarding accessing patients' medical records (Jebara 2018) • Formulary limitations making scope of what NMPs can prescribe too restrictive (Darvishpour 2014; Djerbib 2018; Graham-Clarke 2017; Noblett 2017; Nuttal 2018) • Lack of strategic vision (Djerbib 2018; Graham Clarke 2017; Noblett 2017) • Perceived lack of need for NMP (Mills 2020) • Lack of management and MDT support (Abuzour 2017; Cleary 2017; Mills 2020; Nuttall 2018)	• Clear local NMP policies, guidelines, and protocols in place (Chater 2020; Djerbib 2018; Graham-Clarke 2017; McIntosh, 2016; Noblett 2017; Nuttall 2018; Poh 2018) • Scope of prescribing agreed by Drug Therapeutic committees and a prescribing budget identified (Noblett 2017; Graham-Clarke 2017) • Regular review and updates of policies and formularies (Cleary 2017; Noblett 2017) • A strong pro-NMP leadership (Graham-Clarke 2017; Nuttall 2018) • MDT and doctors understand and appreciate NMP (Cleary 2017; Graham-Clarke 2017) • Acceptance and positive attitudes towards NMP (Cleary 2017; Darvishpour 2014; Jebara 2018; Noblett 2017) • Funding to optimise the workforce (Darvishpour 2014; Jebara 2018; Mills 2020) • Formal support mechanisms, including (clinical) supervision in place (Chater 2020; Cleary 2017; Nuttall 2018) • MDT and doctors support NMP (Cleary 2017; Darvishpour 2014; Jebara 2018; McIntosh 2016; Mills 2020; Nuttall 2018; Stenner 2018)

	• Lack of regular (clinical) supervision (Cleary 2017) • Lack of mentoring support (Mills 2020) • Ambiguity around NMP roles led to lack of clarity regarding professional and legal boundaries (Darvishpour 2014; Cleary 2017; Graham-Clarke 2018; Nuttall 2018) • Poor communication networks (Abuzour 2017; Graham-Clarke 2017) • Role dissonance from doctors (Chater 2020; Cleary 2017; Darvishpour 2014; Graham-Clarke 2017; Jebara 2018; McIntosh 2016; Mills 2020; Noblett 2017; Nuttall 2018, Poh 2018; Stenner 2018) and from colleagues (Mills 2020)	
1b. Preparatory stage - Practitioner readiness	• Inadequate pre-training knowledge of pharmacology and numeracy (Abuzour 2018; Noblett 2017) • Added responsibility is perceived as a deterrent (Abuzour 2018; Mills 2020) • Lack of financial renumeration (Cleary 2017; Graham- Clarke 2017; Noblett 2017; Nuttall 2018) • Time and cost of completing course prerequisites (Noblett 2017) • Lack of funding for training (Graham-Clarke 2018; Noblett 2017)	• An increased sense of autonomy (Darvishpour 2014; Graham-Clarke 2018; Noblett 2017; Nuttall 2018) • Making better use of existing skills and expertise practitioners (Darvishpour 2014) • Helps with professional development and increases clinical competence (Abuzour 2017; Darvishpour 2014; Graham-Clarke 2018; Nuttall 2018) • Professional satisfaction (Cleary 2017; Darvishpour 2014; Graham-Clarke 2018; Jebara 2018; Mills 2020; Noblet 2017; Nuttall 2018)
2. Training	• NMP training is inadequate (Chater 2020; Cleary 2017; Darvishpour 2014; Mills 2020), due to lack of: 1. Applied pharmacology (Abuzour 2018; Darvishpour 2014; Djerbib 2018; Noblet 2017; Nuttall 2018; Stenner 2018) 2. Bioscience (Abuzour 2018) 3. Advanced clinical activities training (Abuzour 2018; Darvishpour 2014; Cleary 2017; Djerbib 2018; Jebara 2018; Mills 2020; Poh 2018)	• Multi-faceted mixed methods approach to teaching students how to prescribe (Abuzour 2018) • Pedagogical methods (e.g., podcasts and virtual patients) (Abuzour 2018) • Identify learning needs of students, e.g., repetition of key concepts and applying knowledge in the workplace (Abuzour 2018)

	• Difficulty finding DMPs and/or mentors (Abuzour 2018; Noblett 2017) • Lack of peer and professional support during training (Graham-Clarke 2018) • Lack of quality supervision during training (Stenner 2018) • Time and course commitments make completing NMP training challenging (Graham-Clarke 2017; Mills 2020)	
3. Transition – post-training	• Lack of confidence (Abuzour 2018; Chater 2020; Darvishpour 2014; Djerbib 2018; Graham-Clarke 2017; McIntosh 2016; Nuttall 2018; Stenner 2018) • Delay in obtaining authorisation to practice as NMP after qualifying can mean that practitioners lose confidence • Fearful of making mistakes (Abuzour 2017; Chater 2020; Djerbib 2018; Mills 2020; Noblett 2017; Nuttall 2018; Stenner 2018) • Anxiety is associated with (increased) accountability (Abuzour 2017; Nuttall 2018) • Fear of liability (Jebara 2018; Noblett 2017; Stenner 2018) and litigation (Chater 2020; Djerbib 2018; Noblett 2017) • Lack of legal protection (Chater 2020; Djerbib 2018; Noblett 2017) • Time pressure and excessive workload (Abuzour 2018; Graham-Clarke 2018; Mills 2020; Nuttall 2018) • Lack of support by management and MDT (Abuzour 2018; Graham-Clarke 2018; Noblett 2017) • Lack of peer support (Noblett 2017) • No adequate supervision post-training (Noblett 2017) • Feelings of isolation (due to lack of support) (Mills 2020)	• Increasing expertise, competence, and capability by gaining experience of prescribing (Abuzour 2018; Darvishpour 2014; McIntosh 2016; Nuttall 2018) • Having enough time to make prescribing decisions (Chater 2020) • A team approach to prescribing (Abuzour 2018; McIntosh 2016) • Adequate support from management (Graham-Clarke 2017), MDT and doctors helped build NMPs' confidence (Abuzour 2018; Darvishpour 2014; Noblett 2017) • Peer support post-training (Abuzour 2018; Chater 2020; McIntosh 2016; Noblett 2017)

	• Problems with setting boundaries with patients (Chater 2020; Djerbib 2018; McIntosh)	
4. Development and sustainability	• Difficulty accessing formal CPD (Abuzour 2018; Djerbib 2018; Graham-Clarke 2018; Nuttall 2018) • Lack of structure in CPD (Abuzour 2017; Djerbib 2018) • Need for adequate and up-to-date knowledge not met (Abuzour 2018; P 2020; Nuttall 2018)	NMP has lots of benefits: • Improved access to healthcare (Cleary 2017; Jebara 2018; Darvishpour 2014; Mills 2020; Poh 2018; Stenner 2018) • Better quality of care (Darvishpour 2014; Cleary 2017; Stenner 2018) • NMPs who had completed specialist training prescribed more items from a wider range of medications (Abuzour 2017)

Appendix 4: Example search string for OTP

	EBSCO host; MEDLINE/CINAHL	
1	(MM "Family Practice")	42, 101
2	(MM "Primary Health Care")	51,956
3	(MM "Physicians, Family")	11,166
4	(MH "Community Health Nursing")	19,631
5	(MH "Community Health Workers")	5,455
6	(MH "Community Health Services")	31,960
7	(MH "Community Health Centers")	117, 681
8	TI (community N1 health) OR AB (community N1 health)	41, 115
9	TI (community N1 care) OR AB (community N1 care)	13,480
10	TI (community N1 clinic) or AB (community N1 clinic)	3,944
11	TI (primary N1 health) OR AB (primary N1 health)	28,106
12	TI (primary N1 care) OR AB (primary N1 care)	137,751
13	TI (general N1 practice*) OR (AB general N1 practice*)	45,372
14	TI (general N1 practitioner*) OR AB (general N1 practitioner*)	53,331
15	TI (family N1 practice*) OR AB (family N1 practice*)	10,889
16	TI (family N1 practitioner*) OR AB (family N1 practitioner*)	2,941
17	TI (gp N1 practice*) OR AB (gp N1 practice*)	2,042
18	TI (gp N1 service*) OR AB (gp N1 service*)	428
18	TI (gp N1 clinic*) OR AB (gp N1 clinic*)	336
19	(MM "Secondary Care")	373
20	TI (secondary care) OR AB (secondary care)	12,642
21	TI hospital* OR AB hospital*	1,314,737
22	TI acute care OR AB acute care	39,857
23	TI outpatient* clinic* OR AB outpatient* clinic*	44,771
24	TI ambulatory care OR AB ambulatory care	14,090
25	TI outpatient service* OR AB outpatient service*	8,357
26	TI outpatient care OR AB outpatient care	16,227
27	TI health centre* OR AB health centre*	41,779
28	TI health center* OR AB health center*	17,060
29	TI walk in centre* OR AB walk in centre*	173
30	TI residential care OR AB residential care	5,783
31	TI day centre* OR AB day centre*	2,032
32	TI long term care OR AB long term care	29,507
33	OR/1-32	518,224
34	TI prescrib* OR AB prescrib*	151, 614
35	TI independent prescrib* OR AB independent prescrib*	501
36	TI non-medical prescrib* OR AB non-medical prescrib*	205
37	TI supplementary prescrib* OR AB supplementary prescrib*	123
39	TI dependent prescrib* OR AB dependent prescrib*	239
39	TI collaborative prescrib* OR AB collaborative prescrib*	97
40	OR/34-41	155,308
41	TI nurs* OR AB nurs*	979,276
42	TI physiotherap* OR AB physiotherap*	26,282
43	TI physical therap* OR AB physical therap*	30,126
44	TI pharmacist* OR AB pharmacist*	34,045
45	TI (podiatr* OR chiropod*) OR AB (podiatr* OR chiropod*)	3,264
46	TI radiographer* OR AB radiographer*	1,730
47	TI (dietician* OR dietician*) OR AB (dietician* OR dietician*)	1,733
48	TI paramedic* OR AB paramedic*	7,872

Appendix 5 Summary of barriers and facilitators to OTP

Author	Title	Aim	Design	Setting	Sample	Findings	Barriers/ facilitators
Ansari 2021 England	*Acute Community Ophthalmology Services Provided by Independent Prescribing Optometrists Supporting Hospital Eye Services during the COVID-19 Outbreak. Journal of Optometry 2021*	Describe re-organisation of emergency eye services in Kent.	Audit pre/post Covid-19	Acute Primary Care Ophthalmology Service (APCOS)	n=1032 cases seen by APCOS January-June 2020.	Transfer of referral/ care from hospital to community with introduction of Acute primary Care Ophthalmology services (with optometrist IP).	No barriers/facilitators or data relevant to implementation
Baker 2016 England	*Multi-stakeholder perspectives of locally commissioned enhanced optometric services*	To explore views of stakeholders regarding operation of community-based enhanced optometric services (including IP).	Qualitative study using mixed methods	Minor eye conditions scheme (MECS) and glaucoma referral refinement scheme (GRRS) provided by accredited community (non-IP) optometrists.	189 patients 25 community optometrists (non-IP) 4 glaucoma specialist hospital optometrists (non-IP) 5 ophthalmologists 6 GPs 4 commissioners.	Inability to prescribe resulted in re-referral to GP, multiple consultations. Service pathway bottle necks, lack of service streamlining. Suggested PGDs may overcome.	entified clinical/service need for prescribing, and service gap
El-Abiary 2020 Scotland	*Assessing the effect of Independent Prescribing for community optometrists and referral rates to Hospital Eye Services in Scotland*	Determine distribution of IP optometrists and associated hospital referral rates across Scotland. Assess impact of IP on referral rates into Hospital Eye Service since 2010.	Audit	Service data on community optometry visits and outpatient hospital attendances 2010-2019	278 /1189 (23.4%) community optometrist IPs in Scotland	• 23% optometrists hold IP • Strong positive correlation between location of IP optometrists and population served. • No association between number of IPs and referral to Hospital Eye	• Uptake of IP higher in population dense areas; limited uptake in rural areas

						Services, i.e. no impact of IP on referral rates.	
Golash 2021 England	*Specialised Independent Prescribing Optometrists Delivering a Community Shared-Care Glaucoma Service: A Pilot Study*	Contribution of IP to stable glaucoma and ocular hypertension (OHT)	Retrospective service audit	Community Ophthalmology Team - shared care scheme run by specialised IP optometrists for stable glaucoma and ocular hypertension (OHT)	N=2 optometrist IP N=80 patients (157 eyes)	• Community follow-up of stable glaucoma and ocular hypertension by IP optometrists was safe, with stability of disease maintained and few referrals back to HES	• IP enabled independent care episode completion • No barriers or facilitators
Harper 2015 UK wide	*Scope of practice of optometrists working in the UK Hospital Eye Service: a national survey*	Describe results of national survey on scope of practice of UK hospital optometry.	Cross-sectional survey – hospital eye service optometrists	70 hospital eye service units/departments (N = 60, 86% in England),	N=67/70 (96%) HES stated included optometrists in extended roles. N=32 (48%) in IP roles	83% used GP prescriptions 48% used IP formulary 14% used PGD 8% requested via GP 1 (<2%) SP	• Availability of medical support underpins extended role activity; 33% clinics always require medical input. • Calls for national qualifications in specialist areas of practice
Loffler 2011 UK wide	*Therapeutic prescribing for optometrists: an initial perspective prescribing for optometrists: an initial perspective*	Describe impact of the IP by therapeutic optometrists on practice.	Cross-sectional survey (1 HEI)	32 (53%) community 20% hospital 27% mixed community/hospital.	n=60 optometrists who had completed theoretical training for IP qualification.	47 (78%) completed clinical placement; 39 (65%) passed common final assessment. 92% improved confidence with diagnosis & management. 75% regarded IP helpful for practice (rating ≥8 scale 1-10. 93% would recommend IP. 87% prescribing at least weekly	70% prescribed via GP, ophthalmologists, or OTC. 50% no access to FP10.

						(median 10/month).	
Needle 2009 UK wide	*A survey of the scope of therapeutic practice by UK optometrists and their attitudes to an extended prescribing role*	Investigate clinical practices in ocular disease management within UK optometrists, elicit views on extended prescribing roles.	Cross-sectional survey	90% community.	N= 1288 members of the College of Optometrists.	8% respondents in training for extended prescribing role (additional supply or supplementary prescribing)	Describes conditions treated with IP, prescribing rates, views about training, confidence levels, patient satisfaction. 51% referring less patients to secondary care; 41% reported no noticeable difference in referring behaviour
Rough 2017	*The challenges of rural optometry and how independent prescribing has helped*	Narrative on role of IP in rural optometry	Narrative				Describes one optometrist's experience of IP and use in rural community optometry in Scotland. No barriers and facilitators.
Rumney 2019	*Optometry and independent prescribing*	Describes the pathway to independent prescribing, both professionally and individually.	Narrative – discusses education/training for IP, clinical placement, governance and barriers and argument for NOT including IP as undergraduate training.				Piecemeal CCG-led approach to commissioning affected IP optometry. English DH resisting change by GOS and national contract – promotes local developments to formalise optometric skills. IP underutilised and cannot find a way to include NHS prescribing to IP qualified optometrists.
Spillane 2021	*Factors influencing the prescribing behaviour of independent prescriber optometrists: a qualitative study using the Theoretical Domains Framework*	Identify barriers and facilitators using TDF, map to COM-B to identify behaviour change techniques for intervention	Qualitative: interviews	Hospital (n = 6) Community (n = 10)	16 optometrist IP	Used TDF imp framework to analyse data; 8 key themes identified facilitating behaviours for implementation.	•**Organisational readiness** - MDT Support - Lack contract with hospital (i.e. for prescribing) led to GP referral for medicines - England and NI – IPs issue private prescriptions – cost to patient - No access to prescribing budget

							- Good relationships - Role clarity/ identity **•Practitioner selection/ preparation** - Communication skills - Clinical experience - Lack of motivation/ remuneration - Job satisfaction **•Transition support** - GOC guidelines barrier **•Sustainability** - Increased workload
Todd 2020	*Agreement in clinical decision-making between independent prescribing optometrists and consultant ophthalmologists in an emergency eye department*	Test concordance between 4 IP optometrists and 9 consultant ophthalmologists for diagnosis and management	Prospective diagnostic agreement study	Eye hospital	321 patient presentations	Percentage-agreement between all IP optometrists and the staged reference standard per diagnosis was 82.0%	Agreement between IP optometrists and ophthalmologists was: 'almost perfect' for diagnosis (K = 0.882 ± 0.018), 'substantial' for prescribing decision (K = 0.745 ± 0.034) and 'almost perfect' for onward management (0.822 ± 0.032).

Proposed Outcomes for Specialty Registration (AS, SP and/or IP) Expert Advisory Group Response to Delphi Verification Exercise (November 2021)		
Original Outcome (2021 Consultation)	**Delphi Recommendation**	**IP Expert Advisory Group View**
O1.1 Works collaboratively as part of a wider multidisciplinary eye care team to ensure that the transfer and continuity of care (within and across all care settings) is developed and not compromised. (RPS-10.1) (IP) (SP) (AS) [Does]	Remove the words "eye care".	Delphi recommendation accepted.
O1.3 Undertakes the consultation in an appropriate setting, taking account of confidentiality, consent, dignity and respect in line with regulatory practice and contractual requirements. (RPS-1.1/1.2) (IP) (SP) (AS) [Does]	After "regulatory practice" insert "legislation".	Delphi recommendation accepted.
O2.1 Demonstrates good consultation skills and builds rapport with the patient/carer. (RPS-1.5) (IP) (SP) (AS) [Does]	Merge O2.1 and O2.3 to create: "Explores the patient/carers understanding of a consultation; demonstrates appropriate consultation skills based on the patient's individual requirements; builds rapport with the patient/carer, and aims for a satisfactory outcome for the patient/carer and prescriber. (IP) (SP) (AS) [DOES] (RPS-1.5/3.6)	Delphi recommendation rejected and original outcome kept.
O2.3 Explores the patient's/carer's understanding of a consultation and aims for a satisfactory outcome for the patient/carer and prescriber. (RPS-3.6) (IP) (SP) (AS) [Does]		
O2.5 Makes prescribing decisions based on the needs of patients and not the prescriber's personal preferences. (RPS-8.4) (IP) (SP) (AS) [Shows how]	Change Miller's Pyramid of Competence level to "Does".	Delphi recommendation rejected and Miller's "Shows how" level kept.
O2.8 Builds a relationship which encourages appropriate prescribing and not the expectation that a prescription will	After "relationship" insert "with the patient," and after "that a prescription will" insert "always".	Delphi recommendation accepted.

be supplied. (RPS-3.5) (IP) (SP) (AS) [Shows how]		
O2.10 Guides the patient/carer on how to identify reliable sources of information about their medicines and treatment. (RPS-5.3) (IP) (SP) (AS) [Does]	Change Miller's Pyramid of Competence level to "Shows how".	Delphi recommendation accepted.
O3.5 Requests and interprets appropriate investigations necessary to inform treatment options. (RPS-1.10) (IP) (SP) [Knows how]	Change Miller's Pyramid of Competence level to "Does".	Delphi recommendation rejected but Miller's level changed to "Shows how".
O4.8 Stays up-to-date in own area of practice and applies the principles of evidence-based practice. (RPS 2.8) (IP) (SP) (AS) [Does]	Change Miller's Pyramid of Competence level to "Shows how".	Delphi recommendation accepted.
O5.3 Prescribes unlicensed and off-label medicines where legally permitted, and unlicensed medicines only if satisfied that an alternative licensed medicine would not meet the patient's clinical needs. (RPS-4.11) (IP) (SP) (AS) [Shows how]	After "where legally permitted, and" insert "in the patient's best interest, and".	Delphi recommendation accepted.
O6.2 Recognises, minimises risk and manages potential misuse of medicines using appropriate processes. (RPS-4.7) (IP) (SP) (AS) [Shows how]	Delete "minimises risk" and after "potential misuse of medicines" add "by patients".	Delphi recommendation to delete "minimises risk" accepted. Recommendation to add "by patients" not accepted.
O7.2 Supports the learning and development of others with their prescribing practice and learning journey, by engaging in mentoring, leadership and workforce development. (RPS-9.6) (IP) (SP) (AS) [Does]	Change Miller's Pyramid of Competence level to "Shows how".	Delphi recommendation accepted.

General Optical Council

Expert Advisory Group – Independent Prescribing Optometry

Name	Organisation	Sector
Leonie Milliner	GOC/Director of Education	Chair
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Colin Davidson	University of Hertfordshire	Programme lead, IP
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Dr Doina Gherghel	Aston University	Senior lecturer
Professor Barbara Ryan	University of Cardiff	Director of Postgraduate taught programmes
Sally Gosling	College of Optometrists	Professional body, CET provider
Prof. Lizzy Ostler	College of Optometrists	Director of Education
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Dr Michelle Hennelly	City University	MSc Programme Director
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Raymond Curran	Health and Social Care Board, Northern Ireland	Head of Ophthalmic Services
Fiona North	Health and Social Care Board, Northern Ireland	Optometric Advisor
Mike Galvin	General Optical Council	GOC Council
Kiki Soteri	Specsavers	Head of Optometry Development
Nicholas Rumney	BBR Optometry	Managing Director

Expert Advisory Group – Contact Lens Opticians

Name	Organisation	Sector
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Dean Dunning	Bradford College	Programme Leader
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Dr Michelle Hennelly	City University	MSc Programme Director
Cheryl Donnelly	ALCON	International Head of Professional Affairs
Indie Grewal	BCLA	President
Rosemary Bailey	Formerly ABDO	Former Chief Examiner
Alexandra Webster	ABDO	Head of CPD

Mark Chandler	ABDO	Head of Examinations and Registration
Andrew Price	ABDO	Fellow
David Hewlett	FODO	Director for Leadership, Transformation and Strategic Partnerships
Luke Stevens Burt	BCLA	Chief Executive
Claire Mallon	University of Manchester	Lecturer in Optometry
Simon Rodwell	Association of Contact Lens Manufacturers Ltd (ACLM)	Secretary General
Helen Thompson	Boots Opticians	Division Contact Lens Lead
Jeet Saimbi	Scrivens Opticians	Professional Services Director
Andrew Symons	Specsavers	Contact Lens Business Manager
Poonam Sharma	NHS	Clinical Advisor, Optometry
Glenn Tomison	General Optical Council	GOC
Jeanette Brook	Specsavers	Dispensing Optician

GENERAL OPTICAL COUNCIL
DRAFT Minutes of the Education Committee breakout session
held on Monday 22 November 2021 at 10:00 hours via Microsoft Teams

Present:	Mike Galvin (Chair), Geraldine McBride, Mary Wright, Andrew Logan and Neil Retallic.
GOC Attendees:	Leonie Milliner and Nadia Denton (Governance Officer) *Minutes.*

	Welcome and Apologies
1.	The Chair welcomed the members of the group to the breakout session
2.	Hilary Tompsett and Imran Jawaid were absent.
	Declaration of Interests
3.	It was noted that Andrew Logan (Education Committee) declared a new interest as an External Examiner at the University of Sheffield.
4.	The Education Committee were asked to: • advise Council on proposals to update requirements for GOC approved qualifications leading to specialist entry to the GOC register, in additional supply (AS), supplementary prescribing (SP) and independent prescribing (IP) categories. • note the outcome of the public consultation (Enventure Research consultation report); EDI impact assessment (Fraser Consulting); the impact assessment screening; literature review report (University of Surrey) and the outcome of the Delphi verification of the proposed outcomes (University of Hertfordshire) • note the progress of Expert Advisory Groups (EAGs) for Contact Lens Opticians as set out in the 'Analysis' section of this paper.
5.	It was noted that to be awarded qualifications leading to specialist entry to the GOC register, there was an overarching frame and structure organised into 7 categories: 1. Uphold professional standards 2. Person centred care 3. Established and manages patient options 4. Prescribing practice 5. Ethics and standards 6. Manages risk 7. Leaning and development
6.	In discussion the following points were noted: **<u>Providers</u>** • the GOC Director of Education reported to the committee that if the proposals are approved by Council, the next step will be to develop an evidence framework (similar to the evidence framework developed for optometry and dispensing optics). The evidence framework will describe the range and type of evidence

	providers might like to consider submitting to GOC as part of the proposed Quality Assurance and Enhancement Method to evidence that the standards and outcomes are met. • the GOC has run a couple of sessions for IP providers to make them aware of the proposals; • it was recommended that a staged approach to the provider roll out should be considered as it might be ambitious to change the training programmes all at once as the committee was concerned that some providers could not meet a single changeover date • when asked what provider's plans for adaptation to the new requirements might be, the GOC Director of Education reported that all providers had been asked in this year's annual monitoring for an early indication of their plans for adaptation and to indicate which academic year they are aiming at recruiting their first cohort into; and that the GOC will work at provider's pace and will be cognizant of their circumstances; • whilst GOC establishes requirements for qualification approval, the committee commented that it also should have a role in encouraging the sharing of good practice amongst providers; the GOC Director of Education then outlined the role of the GOC-commissioned knowledge hub (SPOKE) as a vehicle for sharing best pracrice. The panel also indicated that up to now the GOC had focussed on dealing with failure (i.e. non-compliance). It needed to take the lead in promoting best practice. • The committee noted that advice and guidance will be given to providers by the GOC on draft applications for adaptation or new qualification approval prior to submitting their formal application so that informal feedback can be given and providers get an idea about whether they are roughly on the right track or not; • the committee expressed concerned that a risk was that some students on some optometry programmes may not be ready for IP practice at the point of graduation. In discussion it was agreed and confirmed that the proposals are written so that approved qualifications in optometry and IP are two separate and distinct qualifications. It would be a provider's decision as to whether a whole or part of a cohort of optometrists would be admitted and allowed to progress onto an IP, AS or SP qualifications at the same time. Trainees will get two certificates and potentially pay two sets of fees; • providers will need to provide data on progression and attainment and the GOC will, as part of it annual monitoring, decide what data it collects and for what purpose. This will be an important part of measuring the success of the changes. • it was commented that it would be possible but unlikely that a commercial organisation could apply to Ofqual to become an awarding organisation to deliver a level 7 qualification, and then apply o GOC for qualification approval, but the economic and business case from a commercial perspective may preclude this; as an alternative, a commercial organisation could acquire degree awarding powers from the OfS/ Privy Council, however, it was commented that such a proposition would also be highly unlikely given the difficulty for commercial organisations to achieve degree-awarding powers. • providers may have challenges if DPPs are unable to provide an adequate amount of supervision to trainees within the required timeframes; and • it was noted that September 2023 was likely to be that date that most providers would begin admitting trainees into IP qualifications that meet the new proposals but noted that providers could agree pace of transition with the GOC.
7.	**<u>Role of the DPP</u>** • providers will be responsible for deciding who is a suitable DPP either upon application or admission. The RPS competency framework will be the key tool that providers will use to assess whether a DPP is appropriate or not. The Optometry sector may wish to create their own competency framework to assess DPPs in the future;

	• the provider will have input into the trainee's selection of the DPP and the Education Visitor panel members will scrutinise the provider's quality controls in assessing the suitability of the DPP; • it is expected that DPPs will be supported by their employers to undertake the responsibilities of the role; • the role of the DPP is a voluntary role and would need to be kept under review to determine if employees were being pressured to take up the role as DPP or if there were commercial pressure or conflicts of interest around discharging the responsibilities of a DPP, or that registrants might be pressured into acting as a DPP to support the commercial aims of their employers; • there is an issue around the protection of DPP's time to supervise in context of commercial pressure on supervisors. This is a safeguarding issue that needs to be considered in terms of number of students a DPP is allowed to train; • DPPs will need to have sufficient time in practice to carry out supervision in the context of commercial pressures. This may need to be considered in the framing of the role. Stresses placed upon the DPP in their role will impact the quality of the training that the student will receive; • It was noted although the proposals contained a number of controls around the relationship between the DPP, provider and trainee; and that assurance will be gained by through EVPs scrutiny, including evidence of stakeholder feedback as well as attrition and attainment rates in relation to whether students are meeting outcomes, providers would need support to identify, train, and support DPPs and build the capacity of the profession in all parts of the UK to undertake the role of the DPP.
8.	**<u>Other Points</u>** • it was suggested that it was worth looking at how optometrists and their employers might be able to gain funding; • it is understood that Health Education England are looking to boost the capacity in IP in the optometry sector; • not in natural DNA of Optometrists to supervise in same way for other clinical practitioners. This habit needs to be fostered earlier on in training programmes so that it is part of the eco-system; and • whilst a member of the Royal College of Ophthalmologists have a member of the GOC's EAG and involved in shaping early drafts of the proposals, it was noted that they had not submitted a formal response to consultation.
9.	**ACTION Director of Education to an have urgent conversation with Royal College of Ophthalmologists to ensure they are up to speed with the proposals.**

GENERAL OPTICAL COUNCIL
DRAFT Minutes of the Standards Committee breakout session
held on Monday 22 November 2021 at 10:00 hours via Microsoft Teams

Present:	Glenn Tomison (Chair), Joy Myint and Marcus Weaver.
GOC Attendees:	Lesley Longstone (Chief Executive Officer and Registrar), Marcus Dye (Director of Strategy), Ben Pearson (Project & Policy Support Executive), Simran Bhogal (ESR Manager) and Ivon Sergey (Governance Officer) *Minutes.*

	Welcome and Apologies
1.	The Chair welcomed the members of the group to the breakout session
2.	Apologies were received from Paula Baines, Cecilia Fenerty and Nigel Best.
	Declaration of Interests
3.	Joy Myint declare a conflict of interest as she runs the IP programme and was a member of the IP EAG.
4.	The Standards Committee were asked to: • advise Council on proposals to update requirements for GOC approved qualifications leading to specialist entry to the GOC register, in additional supply (AS), supplementary prescribing (SP) and independent prescribing (IP) categories. • note the outcome of the public consultation (Enventure Research consultation report); EDI impact assessment (Fraser Consulting); the impact assessment screening; literature review report (University of Surrey) and the outcome of the Delphi verification of the proposed outcomes (University of Hertfordshire) • note the progress of Expert Advisory Groups (EAGs) for Contact Lens Opticians as set out in the 'Analysis' section of this paper.
5.	It was noted that to be awarded qualifications leading to specialist entry to the GOC register, there was an overarching frame and structure organised into 7 categories: 1. Uphold professional standards 2. Person centred care 3. Established and manages patient options 4. Prescribing practice 5. Ethics and standards 6. Manages risk 7. Leaning and development
6.	The group considered the overarching statements, criteria for each of the seven categories and discussed each IP proposal. Some categories had fewer outcomes than others. It was noted that approved qualifications for specialist entry in additional supply categories would need to meet the outcomes indicated with Additional supply (AS).

7.	It was noted that the outcomes incorporated the updated Royal Pharmaceutical Society's Framework for all Prescribers. All outcomes had also been through the Delphi process and the Expert Advisory Group.
8.	It was discussed that additional supply (AS) and independent prescribing (IP) categories were in different levels and whether there was a danger in (AS) masquerading as (IP). Each of the criteria levels differed, and there were a couple of criterions which did not relate to (AS). It was noted that (AS) and (IP) having to undertake the same outcomes except for one or two could potentially cause confusion but there was nothing that could be done as this was part of the legislation.
9.	Colleagues in Scotland were looking to integrate (AS) and there was a concern whether this would lead to confusion to public perception. It was noted that as long as registrants had the appropriate designation, if patients were looking for a particular service there was a website to point them to individuals who could provide them with that service.
10.	There were concerns that some registrants had difficulties getting placements, particularly in hospital settings, which was a noted blockage in the system. These proposals should assist those who were unable to progress due to placement availability. The issue of remote placements and the inability for supervisors to intervene was also discussed.
11.	Additional mentoring schemes needed to support Designated Prescribing Practitioner's (DPP's) training.
12.	It was agreed that the quality assurance aspect of the work read very well and there was broad support for the proposal. The group approved the updated requirements which would go to Council for approval.

PUBLIC
C51(21)

COUNCIL

Health and Safety Policy Update

Meeting: 8 December 2021 **Status:** For noting

Lead responsibility: Yeslin Gearty (Director of Resources)
Paper Author(s): Jacob Sanchez (Facilities Manager)
Council Lead(s): there is no Council lead for this work

Purpose

1. To enable Council to note the updated Health and Safety compliance audit

Recommendations

2. Council is asked to note the contents of the report

Strategic objective

3. This work is included in our 2021/22 Business Plan.

4. This work forms part of Business as Usual whilst also contributing towards the achievement of the following strategic objective:
    - Building a culture of continuous improvement

Background

5. The annual audit was undertaken on 17 May 2021 reviewing the existing Health & Safety Management System in line with a wide range of industry standard guidance on safe practices.

6. This year the visit was conducted in-situ observing all guidance recommended by the UK Government and measures implemented in line with that guidance, for the safety of all parties involved.

Analysis

7. A full, independent, health and safety audit was carried by Stallard Kane Associates Ltd. on 17 May 2021 and the report received on 6 June.

8. The objective of the audit was: to review the organisation's existing health & safety management system and its effectiveness; identify the hazards and risks to the organisation, its employees and any third parties; and make recommendations for action required to improve the health, safety and welfare standards and levels of compliance with relevant legislation and industry standards. In particular, the audit focussed on the measures being taken to control the spread of Covid-19 and

considered the company's return to work program appropriate and on schedule in accordance with the government guidelines at this time.

9. The overall rating of the audit was positive and increased by 11 points from the previous year to 94.26%, reaching a Silver standard. In the executive summary it was mentioned, "…*the General Optical Council are responsible for maintenance, upkeep and management of their demised areas within the first floor, which has been completed to an excellent standard*."

10. There were no high priority actions identified and only three medium priority actions as follows:

- Firefighting equipment, extinguishers and automatic systems should be inspected at least annually by a competent person. Some fire extinguishers were missed during the 2020 maintenance visit, which was unsupervised due to covid restrictions.
    - Service providers rectified the issue on 02/07/2021.
- For staff driving to third-party locations on GOC business, ensure driving licence checks are completed electronically using the DVLA system at least annually, and that their own vehicles have been taxed and insured.
- For staff driving to third party locations on GOC business, ensure that a driving policy is in place and that this made available to all drivers of organisation vehicles.
    - The points relating to driving are in development (a policy is in draft and will be subject to our consultation process). This was de-prioritised due to Covid restrictions and was considered as low risk because GOC employees or workers very infrequently drive during the course of their employment and largely not at all during the last 18 months or so. The new policy work is planned for completion during Q1 2022-23 and will reinforce existing control measures within our current policy for business related journeys where driving is required.

11. There was one action proposed as goodwill advice:

- The subcontractor's Control of Substances Hazardous to Health (COSHH) assessments were noted to be out of date. Liaise with the cleaning contractor to ensure that COSHH assessments are available for all currently used hazardous substances, that these are reviewed annually (ensuring the site folder is updated) and communicated to all their employees who are exposed to them.
    - Some of the updates for cleaning products had been missed due to Covid related absence. Our cleaning contractor produced updated COSHH sheets for their products on 02/08/2021.

12. The full report is set out at Annex one.

Finance

13. The budget has been reviewed and approved for the associated costs.

Risks

14. No additional or imminent risks were identified but recommendations were made to strengthen the current measures in place.

Equality Impacts

15. No adverse effects were identified but additional driving checks may help to identify staff that may require additional assistance.

Devolved nations

16. N/A

Other Impacts

17. N/A

Communications

External communications

18. None required in this instance.

Internal communications

19. The Health and Safety page on IRIS is up to date and contains the current H&S Policy, GOC H&S statement of intent, H&S booklet as well as relevant forms for staff to easily access.

Next steps

Attachments

Annex one: The General Optical Council - H&S Compliance Survey May 2021

HEALTH & SAFETY | TRAINING | HR & EMPLOYMENT LAW | COMPLIANCE

Compliance Survey

The General Optical Council

General Optical Council

May 2021

Contents

Executive Summary

This audit was undertaken at the organisation's site at 10 Old Bailey, EC4M 7NG on 17/05/2021, in order to carry out a full review of the organisations existing Health & Safety Management System in line with a wide range of industry standard guidance on safe practices. For example; HSG65 - Managing for Health & Safety.

The objective of the audit was to review the organisation's entire Health & Safety Management System. Also, to identify hazards and risks to the organisation as well as its employees, visitors etc. make recommendations for action required to improve the health, safety and welfare standards and levels of compliance with relevant legislation and industry standards.

The General Optical Council maintain an excellent set of offices on the first floor of 10 Old Bailey, London. The building is managed by a third-party management organisation, who are responsible for communal areas and plant, such as the lifts, the electrical systems, the water systems, fire alarms and some of the reception and security personnel. However, the General Optical Council are responsible for maintenance, upkeep and management of their demised areas within the first floor, which has been completed to an excellent standard. A number of small gaps have been identified and these should be resolved at the earliest opportunity.

Recommendations for improvement have been identified, many of which require only a commitment of time and effort. Recommendations are detailed in the "Hazard Identifiers and Action list" on the following page. The actions requiring attention have been categorised in separate Action Plans, following a RAG System (Red, Amber, Green, with a final table of "Goodwill Advice" – each having guided timescales for completion, based on the level of priority.

This allows you to easily identify the higher priority actions which require urgent attention.

Following the Action Plans is the main body of the report detailing all findings and recommendations as a result of the Audit.

Your overall score for this Health & Safety Compliance Audit is 94.26% which is a Silver standard.

Jonathan Ely
Health and Safety Advisor
Stallard Kane Associates Limited

Hazard Identifiers & Action List

HIGH PRIORITY	Deficiencies should be addressed within 1 month or time specified
MEDIUM PRIORITY	Deficiencies should be addressed within 3 months
LOW PRIORITY	Deficiencies should be addressed within 6 months
GOODWILL ADVICE	Recommendations should be considered

Action Plan - Medium Priority

Item No.	Section	Action to eliminate or reduce risk	Target Date	Completion Date	Completion Signature
M1	Fire Management	As discussed, firefighting equipment, extinguishers and automatic systems should be inspected at least annually by a competent person. A number if extinguishers were noted to be overdue their annual inspection. Ensure that all extinguishers are inspected to ensure that they remain operational.	23/08/2021	2.7.21	
M2	Driving Risk Management	For staff driving to third-party locations on GOC business, ensure driving licence checks are completed electronically using the DVLA system at least annually, and that their own vehicles have been taxed and insured.	23/08/2021	Re-scheduled for Q1 2022	
M3	Driving Risk Management	For staff driving to third party locations on GOC business, ensure that a driving policy is in place and that this made available to all drivers of organisation vehicles. We can assist with this if required.	23/08/2021	2.8.21	

Action Plan - Goodwill Advice

Item No.	Section	Action to eliminate or reduce risk	Target Date	Completion Date	Completion Signature
G1	Control of Hazardous Substances (COSHH)	The subcontractor's COSHH assessments were noted to be out of date. Liaise with the cleaning contractor to ensure that COSHH assessments are available for all currently used hazardous substances, that these are reviewed annually (ensuring the site folder is updated) and communicated to all their employees who are exposed to them.	23/08/2021		

Note that completion of any of the above requirements does not necessarily imply compliance with current Building, Local Authority, Fire, Environmental, Health and Safety or other Legislation. It is your duty to ensure that you comply with all aspects of current legislation.

Health & Safety Compliance Survey

Name of Client:	Name and Position of Person Seen:	Number of Employees:	Date of Survey:
The General Optical Council	Jakob Sanchez, Facilities Manager	90	17/05/2021
Name of Surveyor: Jonathan Ely	**Marking Guide:** • N/A - Not Applicable • 0 - Fails to Meet Requirements • 1 - Low Level of Compliance • 2 - Medium Level of Compliance • 3 - High Level of Compliance • 4 - Fully Meets Requirements		

Section	Remarks	Score	Action Recommended	Compliant?
COVID-19 Control Measures				
Has a Covid-19 risk assessment been developed for the organisation/site and has it been communicated to the relevant staff?	A suitable and sufficient Covid-19 risk assessment has been completed for the organisation/site and has been communicated to all the relevant staff. It is displayed in the kitchenette.	4	No further action required.	Yes
Have suitable measures been implemented to reduce the transmission of Covid-19, such as social distancing, signage, enhanced cleaning procedures and increased hygiene, sanitation and washing facilities?	At the time of the inspection, there were suitable and sufficient control measures implemented to reduce the transmission of Covid-19. These included social distancing, enhanced cleaning procedures and increased hygiene and washing facilities.	4	No further action required.	Yes

COVID-19 Control Measures				
Have the Covid-19 control measures, guidance and advice been adequately communicated to all staff?	Covid-19 control measures, guidance and advice have all been suitably communicated to staff via signage, toolbox talks and briefings.	4	No further action required.	Yes
Specific Risk Management				
Are risk assessments in place for workers under the age of 18 (young Workers)?	There are no young workers employed within the organisation.	N/A	No further actions are required.	N/A
Does the organisation employ anyone with a disability?	There are employees with disabilities that might affect their work and risk assessments have been undertaken and communicated.	4	Continue with good practice.	Yes
Does the organisation employ any new or expectant mothers?	There are new or expected mothers and risk assessments have been undertaken and communicated.	4	Continue with good practice.	Yes
Does the organisation employ non-English-speaking employees?	There are non-English speaking employees, procedures are in place and have been communicated	4	Continue with good practice.	Yes
Is lone working carried out in the organisation?	Lone work is carried out on several operations in the organisation, is assessed and a method of communication is in place and documented. High risk activities are avoided.	4	Continue with good practice.	Yes

Liability Insurance				
Is an in date, organisation liability Insurance certificate displayed?	The employer's liability insurance certificate is in date and displayed in a prominent position.	4	Continue with good practice.	Yes
What insurance organisation does the organisation use?	The organisation use Hiscox as their employer's liability insurance provider.	4	No further actions are required.	Yes
Safety Policy Management				
Does the organisation have a Health and Safety Policy?	There is a signed and dated health and safety policy available.	4	Continue with good practice.	Yes
Is there a Health and Safety Statement of Intent in place?	There is a signed and dated health and safety statement of intent available.	4	Continue with good practice.	Yes
Does the organisation issue Health and Safety Booklets?	Health and safety booklets are issued to employees and the acknowledgment sheet is complete.	4	Continue with good practice.	Yes
Has the nominated person or director for health and safety had any formal training in H&S?	The director(s) and/or nominated person(s) for health and safety have undertaken NEBOSH qualifications.	4	Continue with good practice.	Yes

Risk Assessments				
Have suitable and sufficient risk assessments been carried out for all tasks and activities?	There are risk assessments in place to cover all significant risks.	4	Continue with good practice.	Yes
Have the findings of the risk assessments been explained to employees?	Risk assessments have been communicated to employees and signed as acknowledgement.	4	Continue with good practice.	Yes
Safe Working Practices				
Does the organisation develop safe operating procedures, safe systems of work or safe working practices?	The type of work carried out by the organisation does not require safe systems of work to be developed.	N/A	No further actions are required.	N/A
Have safe operating procedures, safe systems of work or safe working practices been explained to employees?	The type of work carried out by the organisation does not require safe systems of work to be developed.	N/A	No further actions are required.	N/A
Mains Supply Services and Gases				
Has the organisation had an electrical fixed mains inspection carried out?	A fixed mains inspection has been carried out and is in date. This is understood to have been completed in July 2020.	4	Continue with good practice.	Yes
Are mains gas appliances serviced annually?	There are no mains gas appliances used. All gas appliances are under the control of the managing agent.	N/A	No further actions are required.	N/A
Does the organisation use Liquid Petroleum Gas (LPG) and other bottled gas?	There is no LPG, or any other cylinder/bottled gas used.	N/A	No further actions are required.	N/A

Mains Supply Services and Gases				
Does the organisation use compressors and pressure systems?	There are no compressors and/or pressure systems used.	N/A	No further actions are required.	N/A
Is there bulk oil or fuel storage on site? Over 201L requires a double bunded container. Over 3500L requires a double bunded container and a relevant risk assessment covering the location in line with the Oil storage regulations for businesses?	There is no bulk oil or fuel storage on site.	N/A	Continue good practice	N/A
Contractors and Sub-contractors				
Has a formal process of approving contractors / sub-contractors been adopted?	Health and safety information is obtained formally from contractors / sub-contractors, held on record and an approved contractor / sub-contractor register is updated.	4	Continue with good practice.	Yes
Is the Health and Safety performance of contractors audited?	Contractor / sub-contractor performance is audited and recorded. Several have Safe Contractor status.	4	Continue with good practice.	Yes
Machinery and Equipment				
Are statutory inspections in place for all machinery and lifting appliances?	The organisation do not own work equipment or machinery requiring statutory inspections as they are not required. Lifts and other equipment are managed by the managing agent.	N/A	No further actions are required.	N/A
Are ladders, steps and other access equipment placed in a register and inspected?	There is no access equipment used by the Organisation.	N/A	No further actions are required.	N/A

Machinery and Equipment				
Is all machinery and equipment sufficiently guarded / does the organisation recognise that they need to have the correct guarding in place before every use?	The Organisation does not have any machinery or equipment that requires guarding to be in place. Lifts and other equipment are managed by the managing agent.	N/A	No further actions required.	N/A
Are routine (pre use) equipment checks carried out and recorded?	There is no work equipment and machinery used deemed as requiring recorded checks. Lifts and other equipment are managed by the managing agent.	N/A	No further actions are required.	N/A
Is a documented planned maintenance scheme in operation?	There is no machinery used requiring planned maintenance. Lifts and other equipment are managed by the managing agent.	N/A	No further actions are required.	N/A
Are employees trained in the safe use of all machinery and equipment?	The organisation does not use any machinery or equipment. Lifts and other equipment are managed by the managing agent.	N/A	No further actions are required.	N/A
Is there a program of Portable Appliance Testing (PAT) in place?	PAT has been completed to portable electrical appliances and records held.	4	Continue with good practice.	Yes
Are local exhaust ventilation systems (LEVs) subject to thorough inspections by competent persons?	There are no LEV systems installed at the premises.	N/A	No further actions are required.	N/A
Does the organisation use abrasive wheels (grinding/cutting wheels)?	The organisation does not use abrasive wheels.	N/A	No further actions required.	N/A

Environmental Management				
Does the organisation have an environmental policy statement?	There is a signed and dated environmental statement of intent available.	4	Continue with good practice.	Yes
Are waste transfer notes available?	Non-hazardous waste is not moved from the premises/site.	N/A	No further actions are required.	N/A
Is the organisation a hazardous waste producer?	The organisation is not classed as a hazardous waste producer.	N/A	No further actions are required at present.	N/A
Does the organisation have a current waste carriers license?	The organisation does not transfer any waste.	N/A	No further actions are required.	N/A
Does the organisation have a spills kit available?	The organisation do not use any hazardous substances that require a spill kit.	N/A	No further actions are required.	N/A
Has the nominated person received any environmental training?	Due to the scope of works undertaken by the organisation, formal environmental training is not deemed as necessary.	N/A	No further actions are required.	N/A

Accident and Incident Management				
Does the organisation have an accident book or other means of recording accident information?	There is a means for recording accidents available, all accident entries are kept separate in a secure location.	4	Continue with good practice.	Yes
Do accident trends and significant accidents get investigated?	There are not any accident trends to review but significant accidents have been investigated.	4	No further actions are required.	Yes
Does the organisation have a near miss or incident reporting procedure in place?	There is a formal process in place for recording near misses, they are recorded, actioned and findings are communicated back to employees.	4	Continue with good practice.	Yes
Has the organisation had any enforcement actions over the last year?	The organisation has not been issued with any enforcement action in the past year.	N/A	No further actions are required.	N/A
Have accidents been recorded and reported, where necessary to the enforcing authority, in accordance with RIDDOR in the last 12 months?	The organisation are fully aware of the requirements for reporting accidents and incidents under RIDDOR but there has been no requirement to do so.	N/A	No further actions are required.	N/A

Health and Safety Communication				
Is induction training undertaken?	A recorded induction is completed with new starters and held on file.	4	Continue with good practice.	Yes
Are toolbox talks or safety briefings carried out?	Other methods of communication are used in the organisation. A central website maintains all necessary documentation and communication, and urgent communiques can be dispatched via emails.	4	No further actions are required.	Yes
Does the organisation have external Human Resources Support?	HR is covered in house.	N/A	No further actions are required.	N/A
Occupational Health				
Are employment medical questionnaires issued?	Medical questionnaires are issued to new starters and reviewed periodically for all employees. The organisation is aware of members of staff with medical conditions.	4	Continue with good practice.	Yes
Are employees who use RPE as part of their role, face fit tested?	It is not deemed a requirement for employees to wear RPE as part of their role. Therefore, face fit testing is not required.	N/A	No further actions are required.	N/A
Is a program of occupational health surveillance in place for employees who are exposed to asbestos, noise, vibration, dust, welding fumes, paints, thinners and oils?	Following risk assessment, occupational health surveillance is not deemed necessary.	N/A	No further actions are required.	N/A

Occupational Health				
Has a mental wellbeing and physical first aid risk assessment been conducted and actioned?	A first aid risk assessment has been recorded and actioned. Adequate numbers of suitably trained first aiders and mental health first aiders are available on site	4	Continue with good practice.	Yes
Are adequate mental first aiders and physical first aiders available?	There are an adequate number of trained first aiders and mental health first aiders.	4	Continue with good practice.	Yes
Are notices displayed indicating locations of first aiders and the first aid boxes?	There are notices/certificates to indicate the location of first aid boxes and names of first aiders and mental health first aiders.	4	Continue with good practice.	Yes
Are first aid boxes available and inspected once a month to replace any used or out of date items?	There are first aid boxes available and recorded inspections are completed periodically.	4	Continue with good practice.	Yes

Manual Handling				
Have manual handling risk assessments been carried out?	Manual handling risk assessments have been completed as part of the risk assessment process and are reviewed annually. The risk has been determined as low, within an office environment.	4	Continue with good practice.	Yes
Have findings of the manual handling assessments been communicated to effected employees?	Manual handling assessments have been communicated to employees involved in these tasks, and signatures have been obtained. This is managed centrally by the Facilities Team.	4	Continue with good practice	Yes
Have employees been trained in manual handling?	All affected staff have completed formal manual handling training. This is managed centrally by the Facilities Management team.	4	Continue with good practice.	Yes
Display Screen Equipment				
Have DSE assessments been carried out?	All DSE users have completed workplace assessments any issues raised are actioned. This is managed centrally by the Facilities Team.	4	Continue with good practice.	Yes

Audits and Inspections				
Are factory, yard, warehouse or site safety audits conducted & recorded?	Site audits are completed on a regular basis and documented, and any actions raised are completed before that audit is closed out. This is completed by a third party contractor as part of the M&E contract, and overseen by the Facilities Team.	4	Continue with good practice.	Yes
Personal Protective Equipment				
Have any PPE assessments been undertaken?	PPE assessments have been completed this have been incorporated as part of the risk assessments that are in place (COVID-19 only).	4	Continue with good practice.	Yes
Have employees been trained in the correct use, storage and replacement procedure for PPE?	Employees have been trained in the correct use, storage and replacement procedure for PPE; this is covered in the induction and through toolbox talks or safety briefings	4	Continue with good practice.	Yes
Is Personal Protective Equipment issued and recorded?	The organisation has a replacement policy and all PPE issued is signed for by the member of staff and records are kept in their personnel files.	4	Continue with good practice.	Yes
Noise Management				
Has a noise risk assessment survey been undertaken?	Noise is not an issue in the organisation.	N/A	No further actions are required.	N/A
If required is hearing protection available?	Not applicable as noise is not an issue in the organisation.	N/A	No further actions are required.	N/A

Hand Arm and Whole-Body Vibration				
Where HAV WBV is a potential issue is individual vibration monitoring competed?	Not applicable as no employees are exposed to Hand Arm Vibration.	N/A	No further actions are required.	N/A
Where HAV WBV is a potential Issue has a risk assessment been completed?	Not applicable as no employees are exposed to Hand Arm Vibration.	N/A	No further actions are required.	N/A
Dust and Fumes				
Where there is the potential for dust exposure and have steps been taken to reduce this at source?	Not applicable as there are no dust emitting process undertaken.	N/A	No further actions are required at present.	N/A
Where dust emitting processes are undertaken on transient sites are dust suppression techniques used e.g. wet cutting with a Stihl saw?	Not applicable as there are no dust or fume emitting process undertaken.	N/A	No further actions are required.	N/A
Does the organisation carry out annual health surveillance for employees exposed to RCS, chemicals, welding fumes etc?	Not applicable as organisation employees are not exposed to harmful dust, chemicals, welding fumes etc.	N/A	No further actions are required.	N/A
Where flammable dust or fumes are created as part of the organisation operations, has a suitable and sufficient dangerous substances and explosives atmosphere assessment been carried out (DSEAR)?	Flammable dust is not emitted as part of the organisation's operations	N/A	No further actions are required.	N/A
Where compressed air fed RPE systems are used (e.g. Spray Booths), does the organisation carry out air quality tests of the system at no more than three monthly intervals?	The organisation does not have any airfed RPE systems in operation.	N/A	No further actions are required at present.	N/A

Dust and Fumes				
Where there is the potential for Welding / Burning fume exposure and have steps been taken to reduce this at source?	Not applicable as the organisation do not carry out welding / Burning operations.	N/A	No further actions are required.	N/A
Do substances used or processes carried out by the organisation create hazardous fumes (Excluding Welding) and are they adequately controlled?	The organisation do not produce hazardous fumes as part of their activities.	N/A	No further actions required.	N/A
Fire Management				
Has a fire risk assessment been carried out?	A suitable and sufficient fire risk assessment is in place and is reviewed at least annually. This document is then sent to the Building Manager as proof of compliance.	4	Continue with good practice.	Yes
Are fire plans available for the premise?	Fire plans are available and are displayed in prominent positions around the site.	4	Continue with good practice.	Yes
Is firefighting equipment available and inspected?	Firefighting equipment is available but some of it hasn't been inspected within the last year. All extinguishers should be inspected again to ensure that they are in good condition.	1	As discussed, firefighting equipment, extinguishers and automatic systems should be inspected at least annually by a competent person. Ensure that all extinguishers are inspected to ensure that they remain operational.	No
Are fire procedures displayed in appropriate locations?	At the time of the audit fire procedures were displayed in various locations around the site.	4	Continue with good practice.	Yes
Have fire wardens been appointed and trained?	Fire wardens appropriate to the risk are in place, suitably trained and are aware of their duties.	4	Continue with good practice.	Yes

Fire Management				
Are escape routes and assembly points adequately signed?	At the time of the audit all escape routes were clearly identified with directional and exit signage.	4	Continue with good practice.	Yes
Are fire evacuations carried out at least annually?	Fire evacuation training drills are carried out at least once a year and recorded.	4	Continue with good practice.	Yes
Are alarms activated weekly and recorded?	Fire alarms are activated every week same day, same time, using a different call point each time and the fire record log is completed. This is managed by the managing agent.	4	Continue with good practice	Yes
Has emergency lighting been inspected, tested and recorded?	Emergency lighting is inspected and tested each month and the relevant documentation recorded in the fire logbook.	4	Continue with good practice.	Yes
Are all employees familiar with fire extinguishers and the types of fire they are used to extinguish?	Employees have not been trained in the use of firefighting equipment, but signage is installed around site identifying the types of extinguisher.	4	No further actions are required.	Yes
Do all employees receive basic fire safety awareness training annually?	Employees received formal basic fire safety training which is refreshed annually by toolbox talks or safety briefings.	4	Continue with good practice.	Yes
Where premises are occupied by more than one occupant have fire emergency procedures been shared between all occupants?	There are other occupants within the building and fire procedures are shared and understood by all occupants.	4	Continue with good practice.	Yes

Fire Management				
Are all alarms, emergency lighting, and other fire protections systems maintained by competent engineers?	Alarms, emergency lighting and other fire equipment are subject to regular inspections and testing by a competent engineer and recorded. These responsibilities are shared equally between the client and managing agent, based on the arrangements as defined by the leases.	4	Continue with good practice.	Yes
Does the organisation have an emergency cut off system installed to stop equipment such as extraction, gases, in the event of an emergency?	There is no requirement for such a system in the organisation. Any cut off systems present within the building are managed by the managing agent.	N/A	No further actions are required.	N/A
Does the organisation carry out "Hot Work" on or off site as part of their activities such as welding and burning?	The organisation does not carry out hot works. Any hot works undertaken within the building are managed by the managing agent.	N/A	No further actions are required.	N/A

Control of Hazardous Substances (COSHH)				
Are COSHH assessments available for all significant substances?	The organisation do not use any substances that require a COSHHH assessment. This is managed by a third-party cleaning organisation who provides copies of documentation to site as part of their contract.	1	The subcontractor's COSHH assessments were noted to be out of date. Liaise with the cleaning contractor to ensure that COSHH assessments are available for all currently used hazardous substances, that these are reviewed annually (ensuring the site folder is updated) and communicated to all their employees who are exposed to them.	No
Are hazardous substances stored in suitable secure cabinet or store?	Yes, all substances are stored correctly by the cleaning organisation.	4	Continue with good practice.	Yes
If the organisation uses flammable liquids, gases or significant amounts of flammable dusts as part of their day-to-day operations has the organisation carried out a suitable and sufficient Dangerous Substances and Explosive Atmosphere Assessment as required under the DSEAR regulations?	The organisation do not use significant quantities of gas or flammable liquids.	N/A	No further actions are required.	N/A
If the organisation uses water-based machine fluid (Coolant), are biological test carried out (Dip Slide Tests)?	The organisation does not use water-based coolants or metalworking fluids.	N/A	No further actions are required.	N/A
Have all relevant members of staff received appropriate COSHH Training?	The Organisation does not have any COSHH. Subcontractors provide evidence that their staff have been appropriately trained.	N/A	No further actions are required.	N/A

Safety Signage				
Is a copy of the latest health and safety Law poster displayed and contact details completed?	The Health &Safety Law poster is displayed, with contact details complete and is the most up-to-date version of the poster.	4	Continue with good practice.	Yes
Is health and safety signage adequate throughout the premises?	Signage is in place and audited regularly to ensure missing signs are renewed or replaced and new hazards identified.	4	Continue with good practice.	Yes
Working at Height				
Has a working at height risk assessment been carried out?	The organisation does not carry out any work at height as part of its activities.	N/A	No further actions are required.	N/A
Have employees who undertake work at height been trained to the correct standard, including working from MEWPS (IPAF) and Tower Scaffolds (PASMA) where required?	The organisation does not carry out any work at height as part of its activities.	N/A	No further actions are required.	N/A
Driving Risk Management				
Do employees who drive organisation vehicles carry out recorded checks?	Employees do not drive organisation vehicles.	N/A	No further actions are required.	N/A
Are regular driving license checks completed?	No driving licence checks are undertaken for staff who use their own vehicles when visiting off-site locations.	0	Ensure driving licence checks are completed electronically using the DVLA system at least annually, and that their own vehicles have been taxed and insured.	No
Does the organisation have a driving policy?	There is no organisation driving policy in place at present.	0	Ensure that a driving policy is in place and that this made available to all drivers of organisation vehicles. We can assist with this if required.	No

Welfare Arrangements				
Is suitable welfare available and appropriate to the work environment?	There is suitable welfare provision in place and is cleaned on a regular basis	4	Continue with good practice.	Yes
Are welfare arrangements for transient site-based personnel in line with CDM 2015?	The organisation activities do not fall under the CDM regulations.	N/A	No further actions are required.	N/A
Is heating, ventilation and lighting adequate for the workforce inside and out?	Heating, ventilation and lighting provision throughout site is adequate.	4	Continue with good practice.	Yes
Asbestos Management in Non-Domestic Premises				
Has an asbestos survey been conducted to determine the possible location, type and condition of asbestos containing materials (ACM) on or within the premises?	The building was constructed post 2000 therefore does not require an asbestos survey.	N/A	No further actions are required.	N/A
Has an asbestos management plan for the premises been completed and actioned?	The building was constructed post 2000 therefore does not require an asbestos survey.	N/A	No further actions are required.	N/A
Where employees may potentially disturb or discover asbestos or ACM's, are they trained in asbestos awareness or none licensed asbestos work? Training should be UKATA approved?	Asbestos training is not required by the organisation.	N/A	No further actions are required at present.	N/A
Where employees have been trained in asbestos awareness or non-licensed work, have they had refresher training within the last 12 months?	N/A as the organisation do not carry out work associated with asbestos.	N/A	No further actions are required.	N/A

Asbestos Management in Non-Domestic Premises				
Are asbestos surveys commissioned or made available on transient sites prior to starting intrusive works?	The organisation does not carry out intrusive works off site.	N/A	No further actions are required.	N/A
Traffic Management				
Are designated protected pedestrian routes available in areas where people and mobile plant operate?	The organisation do not have any areas where mobile plant / vehicles operate in the vicinity of pedestrians	N/A	No further actions are required.	N/A
Does the organisation have a documented traffic management plan in place?	There is no requirement for such a plan in the organisation.	N/A	No further actions are required.	N/A
Are relevant employees trained in vehicle / plant marshalling / banksman?	This is not required due to the nature of the business / premises.	N/A	No further actions are required.	N/A
Additional Observations				
Is smoking in the workplace controlled and specific covered areas designated?	Smoking is not allowed anywhere on site, in line with the Organisation's no smoking policy.	4	No further actions are required.	Yes
Has a legionella risk assessment been conducted?	Yes, a legionella, leptospirosis risk assessment has been complete and actioned. A copy has been provided to the Building Manager as proof of compliance and ongoing checks are undertaken by the Facilities Team.	4	Continue with good practice	Yes

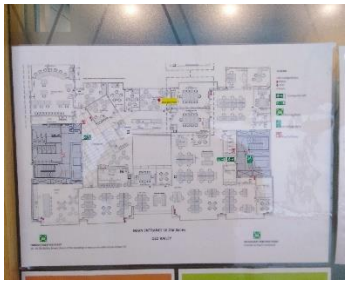
Additional Comments:
Nil

Overall Mark	
Possible Score:	244
Actual Score:	230
Percentage:	94.26%

Appendix One - Photographs

Section	Evidence
Section: COVID-19 Control Measures **Question:** Has a Covid-19 risk assessment been developed for the organisation/site and has it been communicated to the relevant staff?	 Covid risk assessments displayed within the kitchenette
Section: COVID-19 Control Measures **Question:** Have suitable measures been implemented to reduce the transmission of Covid-19, such as social distancing, signage, enhanced cleaning procedures and increased hygiene, sanitation and washing facilities?	 Wipes and gels available in various locations around the premises
Section: Machinery and Equipment **Question:** Are statutory inspections in place for all machinery and lifting appliances?	 All common area plant and machinery is managed by the managing agent.
Section: Occupational Health **Question:** Has a mental wellbeing and physical first aid risk assessment been conducted and actioned?	 Risk assessment conducted and actioned. Lists of first aiders available on posters.

Section	Evidence
Section: Occupational Health **Question:** Are adequate mental first aiders and physical first aiders available?	 Trained personnel available, with lists available in prominent locations
Section: Occupational Health **Question:** Are notices displayed indicating locations of first aiders and the first aid boxes?	 First aid signage available in prominent locations
Section: Occupational Health **Question:** Are first aid boxes available and inspected once a month to replace any used or out of date items?	 First aid equipment available throughout the premises
Section: Fire Management **Question:** Are fire plans available for the premise?	 Fire evacuation plans available in various locations
Section: Fire Management **Question:** Are escape routes and assembly points adequately signed?	 Illuminated running man signage available throughout the premises

Section	Evidence
Section: Fire Management **Question:** Where premises are occupied by more than one occupant have fire emergency procedures been shared between all occupants?	 Fire plans and fire procedures are available through shared sites, as controlled by the managing agent.
Section: Safety Signage **Question:** Is a copy of the latest health and safety Law poster displayed and contact details completed?	 Health & Safety Law Signage available within the kitchenette

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C52(21)

Council

First draft Budget and Business Plan for 2022/2023

Meeting: 8 December 2021 **Status:** For decision

Lead Responsibility: Lesley Longstone, Chief Executive and Registrar
Paper Author(s): Sarah Martyn, Interim Head of Secretariat
Joshua Hamilton, Performance and Planning Officer

Purpose

1. To provide the first draft of the GOC budget and business plan for 2022/2023 for Council consideration.

Recommendations

2. Council is asked to:
   - note that the draft business plan supports the current five-year strategic plan;
   - note that the final plan will be on the basis of a balanced budget or better;
   - provide comments on the draft.

Strategic Objective

3. This work does not flow from any particular strategic objective but affects them all.

Background

4. The draft business plan supports year three of the five-year plan.

Analysis

5. The strategic plan outlines the strategic objectives over a period of five years from 2020 to 2025. This is supported by annual business plans. This is the third year of the strategic plan.

6. Most of the planned activity for years 1 and 2 of the strategy has been completed, the main exception being those areas related to legislative reform, which are outside the GOC's control. We have been engaged in the development of policy underpinning the new legislation, but it is likely to be some time before this is concluded. These activities will be taken forward as and when the legislative programme allows.

7. Many additional and unplanned activities related to Covid-19 have also been undertaken, including provision of additional briefing notes for the sector as the pandemic unfolded and related policy development. Regulatory activities such as registration and education quality assurance moved rapidly and successfully into a virtual environment, as did our FTP processes, avoiding backlogs experienced elsewhere.

8. We are therefore well-placed overall, to continue to focus on delivery of year 3 of our strategic plan, which will have been met by the following:

- Commencing a review of business regulation.
- Consulting on new standards of practice for individuals - we had previously intended to implement during year three, but this is now likely to slip to year four due to unplanned activity above and slippage of the legislative reform project.
- Launch of the new CPD programme to replace MyCET.
- Agreement of requirements for specialist qualifications as part of the Education Strategic Review (ESR).
- Ongoing preparations for receipt of new entry level qualifications for approval.
- Fine tuning of the new website and update of MyGOC.
- CRM improvements, including in support of FTP Case Management System.
- Implementing a secure portal for access to sensitive information for FTP panels etc.
- Organisational change programme *GOC Refresh* set up.
- Work on regulation of care that is delivered into the UK to ensure patients are kept safe when accessing care from outside of the UK. This will now form part of a bigger piece of work on GOC-led legislative reform.

Finance

9. The draft business for 2022/2023 has yet to be fully costed, but we are confident it will be able to be delivered within a balanced budget.

Risks

10. As the business plan and budget underpin the entire work of the GOC, the whole of the corporate risk register is appropriate to consider in terms of risks to delivery.

Equality Impacts

11. Impact assessments will need to be undertaken for any new work agreed as part of the business plan.

Equality Impacts

12. Work continues on the EDI strategy and elements that fall in 2022/2023 and are included in the business plan are:

- Roll out of mandatory EDI training
- Production of the EDI annual report
- Roll out of EDI friendly recruitment plan
- Roll out of EDI learning and development plan
- EDI research related to FTP

Devolved Nations

13. The plan takes account of differences between the devolved nations in terms of healthcare delivery and commissioning and communication channels. All consultation work linked to projects and operations will involve representatives from devolved governments and professional associations and regular meetings are maintained with both to understand specific needs and issues throughout the year.

Other Impacts

14. The following other impacts have been identified:
    a. Impact on GOC staff roles and objectives
    b. Impact on external stakeholders and the work that they do

Communications

External communications

15. Once finalised a high-level summary of the business plan will be published on the GOC website.

Internal Communications

16. The more detailed version of the business plan will be communicated clearly to staff to inform staff roles and individual objectives.

Next Steps

17. A final version of the business plan, incorporating comments from Council, along with an associated budget will be brought to March 2022 Council for approval. Council will receive updates on the new business plan from the end of Q1.

Annexes

Annex 1 Draft Business Plan 2022-2023 (circulated separately)

Quarterly Performance Dashboard – Q2 21/22

Better than last quarter	Off track C53(21)
Roughly same as last quarter	At risk
Worse than last quarter	On track

FINANCE

Budget Operate within budget with a positive variance.	↑
Reserves Operate within our reserves policy	↑
Efficiency Programme progress Realise 90% of planned efficiencies	↔

PERFORMANCE

FTP Timeliness 67% of concerns will be resolved within 78 weeks	↑
Education timeliness in assessing conditions 92% conditions reviewed on time	↔
Registration quality & accuracy 96% accuracy overall	↔

PEOPLE

Investment in People Realise 90% of planned events	↕
Sickness Absence 2.6% or less (minus COVID)	↔
Engagement Index Achieve an upward trend in the staff engagement score	↓

CUSTOMER

FTP timely updates 85% of customers receive an update every 12 weeks	↔
Registration 90% of all application forms completed within target	↔
Education quality of CET provision 90% of CET provision meets registrant expectations	↔

* Tier 1 errors are the most serious and are reserved for errors where the applicant should not have been put on to the register

KPI status (current)	Bullet points about the RAG status of the KPI and a comparison from last quarter and what/how/when improvement(s) will take place	Budget implications	Associated risks
PEOPLE Engagement Index Achieve an upward trend in the staff engagement score	• Engagement indications from the Pulse survey remain volatile, but the definitive measure will come from the annual survey due in November 2021.	• None	• Disengagement from staff could have serious implications for performance and retention
PERFORMANCE FTP Timeliness 67% of concerns will be resolved within 78 weeks	• Since 1 April 2021, case examiners and the FtPC have concluded 46 cases (26 substantive CE decisions and 20 substantive FtPC decision). Of these, 43% concluded within 78 weeks. • Comparison with last quarter – We see an improvement on last quarter (38%) but it is still far below target, continuing to reflect the passage of older cases through the system to closure. • Improvement – In Q1, we implemented a revised structure within case progression to dedicate a senior-level focus on the active progression of a number of remaining complex cases. In Q2 we have added additional case officer resource via secondment of trainee lawyers from our panel law firms, and we are expecting a case progression lawyer to start in November whose function will be solely to support the case officers with case progression, providing dedicated legal support that has been lacking at investigation stage. • The age profile of cases at pre-CE stage is improving. The median age of active investigations (cases not yet at case report stage) at 30 September were 27 weeks from date of complaint and 20 weeks in stage 2, In May 2021, we had 22 active investigations aged over 100 weeks – this is now reduced to 7 cases. Stage 3 remains a challenge with a reduced in-stage median (15 weeks) masking a number of cases that have been at this stage too long (for varying reasons). • Difficulties recruiting a replacement in-house advocate has caused some delay with case progression in Q2 – a replacement is now in place but while they are learning the role we are seeking to supplement with external barrister support.	• Some additional spend required in Q3 on external legal input.	• Re-implemented COVID restrictions delaying or adjourning a small number of substantive hearings. • Number of new referrals projecting at 50% increase on 20-21, with 50% increase in investigations being opened.

Public
C54(21)

General Optical Council

GOC Internal Operational Business Plan 2021- 2022

Quarter 2 Council Report

This document provides Council with a top-line status report on internal business as usual and project-related tasks directly linked to the external business plan and aligned to our strategic objectives. Where the status of a task is either at risk or missed, or where the change is negative, a full update will be provided.

Priority — **Critical**: Absolutely must be in place for the GOC's continued existence; **Essential**: Must be in place to support day-to-day operations

Status — **On track**; **At risk**; **Off track**

Change — **Better than last quarter**; **Worse than last quarter**; **Roughly same as last quarter**

Department	Timing	Status	Priority
Case Progression	Q2	2x on track 1x off track	Critical
Case Progression	Q2	1x at risk	Essential
CET (BAU)	Q2	3x on track	Critical
CET (BAU)	Q2	5x on track	Essential
Comms	Q2	3x on track	Critical
Comms	Q2	5x on track 1x off track	Essential
Education	Q2	2x on track	Critical
Education	Q2	1x on track	Essential
Facilities	Q2	3x on track	Critical
Facilities	Q2	1x on track	Essential
Finance	Q2	2x on track	Critical
Finance	Q2	9x on track	Essential
Hearings	Q2	1x at risk	Critical
Hearings	Q2	2x on track	Essential
HR	Q2	N/A	Critical
HR	Q2	1x on track 1x at risk	Essential
IT (BAU)	Q2	1x on track 1x at risk	Critical
IT (BAU)	Q2	1x on track 1x at risk	Essential
Legal	Q2	N/A	Critical
Legal	Q2	1x on track 1x at risk	Essential
Policy & Standards	Q2	1x on track	Critical
Policy & Standards	Q2	2x on track 1x at risk	Essential
Registration (BAU)	Q2	5x on track	Critical
Registration (BAU)	Q2	2x on track	Essential
Secretariat	Q2	6x on track	Critical
Secretariat	Q2	7x on track	Essential
Standards	Q2	N/A	Critical
Standards	Q2	N/A	Essential

Department and Task	Bullet points about the Status & Change grading	How/when task will be brought back on track	Budget implications and associated risks
Case Progression – **PSA task** *FTP timeliness* Q1-Q4 | 🔴 Off track | ➔	• Decision/closure medians continue to be high as older cases progress through the system. However, the age of the triage caseload (median of 1 week at end Q2), and the stage 2 caseload median of 41 weeks (active median 29 weeks) from date of complaint have reduced significantly • This is an indicator of improved future end-to-end performance.	• We estimate that we have lost approximately six to eight months on our 2019 projections over the last year, which suggests that our objective of achieving a 78-week end-to-end median by the middle of Q3 this year has slipped to early Q1 of the following year. • A restructured casework leadership team will provide greater case direction for investigators and help build manager capability. • Increased legal recruitment albeit delayed, should improve the pace of decision-making throughout case progression	• Far lower than projected disclosures on hearings have increased age profile at stage 3 which is a critical risk for our end-to-end deliverable. • This will result in delayed costs to our hearing function for 2021/22 (see below) • Due to delays in legal recruitment and an inability to recruit at the level required for our more complex work, more cases will have to be instructed out – likely increase to legal charges will be in the region of £100,000 for the second half of the year
Case Progression *115 substantive case examiner decisions* Q1-Q4 | 🟡 At risk | ➔	• Number of decisions to be made by case examiners during the year.	• 45 substantive decisions made by CEs for the YTD (36% of objective). There are a significant number of cases at pre-CE stage, though, and an increasing stage 2 caseload so our expectation is that we will be close to the forecast figure by end of Q4.	• Limited for year end. • Expected to recover during Q3 and Q4.
Comms *Consultation Framework* Q1 | 🟢 On track | ➔	• Sets out the code of best practice for consulting with our stakeholders	• Delayed due to sickness absences in both Policy & Standards and Comms – to be completed in Q3	• Whilst halted for a while due to the new website launch now planned for Q3, this work is underway and now back on track.
Hearings *300 hearing days (c 50 decisions)* Q1-Q4 | 🟡 At risk | ➔	• 38% by end Q2 – hearing days reforecast to 276 at end of Q1 and 248 at the end of Q2 – now at 45.5% of revised objective.	• Will be reviewed further at Q2 forecast. We hope to recover to some extent during Q4	• Delayed spend and closures – reduced costs for this financial year which has moved to 2022/23 budget. • Increased hearing closures for 2022/23.
HR *Recruitment* Q2-Q3 | 🟡 At risk	• Despite the challenges of remote recruitment and an increasingly difficult market, recruitment continues successfully in the main. • Some roles have proved challenging, possibly due to salaries not paying market rates but we will shortly be receiving salary benchmark data to check this against. • On the positive side, *Hireful* has proved popular with end users and has enabled a significant increase in the number of roles we can run simultaneously	• Salary benchmarking exercise underway with initial data due back in late November. • Broadening the advertising of our roles, particularly the challenging ones, to ensure they are more targeted. • Use of Crown Commercial agencies when required.	• The key risk is delays to projects through inability to fill roles
IT (BAU) *Exploring opportunity for collaboration across regulators* Q1-Q4 | 🟡 At risk | ➔	• Discussion with other regulators to explore opportunities.	• This process did not start in Q2 due to work volume but will start in Q3.	• Possible savings through joint procurements although unclear on appetite for such activities. • Minimal risk with documented requirements.
IT (BAU) *IT Policy* Q1 | 🟡 At risk	• Explains to users their key responsibilities for the proper usage of GOC IT systems including security, care of equipment, use of the internet and email, data storage, and training.	• A draft of the new policy went to SMT in July and a revised version is being consulted upon with the business. An equalities impact assessment has been drafted and this will go back to SMT with the revised policy in Q3 ready for implementation in Q4.	• Increased costs for setup, training, and licences, although not significant compared to the overall IT budget. • Aim of policy changes and use of GOC licences is to reduce risk through secure data exchange and usage.
Legal *Carry out annual review of FTP guidance: Warnings, Rule 16, CEs, IC, FTPC* Q1. Now Q4 | 🟡 At risk | ➔	• FTPC guidance has been reviewed and ISG fully updated. • Other policies delayed due to a long-term in-house legal vacancy.	• New lawyer now due to start in late Q3 who will be tasked with reviewing warnings, R16, and Case Examiner guidance with a view to have a draft completed by end Q4.	• Considered a minimal risk as legislative changes have not touched on these areas and so existing guidance is likely to be suitable.
Policy & Standards *Carry out background research into Standards of Practice for individual registrants* Q1-Q2 | 🟡 At risk | ➔	• Revision of standards for individual registrants in line with strategic plan in order to ensure continued public protection • Taking opportunities to harmonise standards across the different healthcare professions likely to work together as part of multi-disciplinary teams.	• This is potentially at risk due to long-term staff absences and the need to prioritise the CET project. Tried to partially address through recruitment of administrator but this was not successful – considering other options. • Initial work has now begun with discussion at Education and Standards Committee. A business case and project plan will be produced to agree the work plan and timescales going forward, taking into account the call for evidence on the Opticians Act (as Standards is one of non-regulatory levers through which we can effect change).	• Budgetary implications: we will make savings of £40k to be transferred to 2021/22. • Delay considered a minimal risk as we are still within the timescales we have committed to in the Strategic Plan and we have now started the work in Nov 2021 with a discussion at Education and Standards Committee.

PUBLIC
C55(21)

Council

Financial performance report for the period ending 30 September 2021 and Q2 forecast of 21/22 and 22/23

Meeting: 08 December 2021	**Status:** for noting
Lead responsibility: Yeslin Gearty (Director of Resources)	**Paper author:** Manori Izni-Muneer (Head of Finance)

Purpose

To provide a summary of the financial reports and the latest forecast for years 21/22 and 22/23 presented to ARF.

Recommendations

1. Council is asked to:
   - **note** the financial performance for the six months ending 30 September 2021 in Annex one
   - **note** the Q2 forecast for the current year 2021-22 in Annex two, and
   - **note** the latest forecast for 2022/23 under Q2 forecast year 2 in Annex two.

Strategic objective

2. This report is relevant to delivery of all our strategic objectives.

Background

3. The forecasts for 21/22 and 22/23 relate to years 2 and 3 of the current strategic plan. The 21/22 forecast is consistent with delivery of the current year's business plan. The 22/23 forecast ensures that we can deliver the objectives set out in the strategic plan.

Analysis

4. The results for the period ending 30 September 2021 compared with the approved budget and Q1 forecast made in July 2021 show a healthy surplus of £769k before portfolio gains (Ref page 3 of Annex 1). The performance improvement was due to remote working, delays in some operations, efficiencies in work methodology, and other savings. Detailed analysis of the impact on performance and the risk of achieving the budget is included in the report (Annex 1).

5. The Q2 forecast was made in October through a quarterly exercise, by reviewing and updating the Q1 forecast made in July. Actual performance and future predictions are both involved in calculating the forecast. The Q2 forecast for the current year is included in Annex two.

6. The latest forecast available for 2022-23 (prior to setting the budget) is the Q2 forecast Year 2 (Annex two). We have based our fee rules on this forecast.

7. The forecast, which includes GOC refresh, and all other approved projects enables us to make better decisions regarding new projects, working capital, cashflow, and reserves management.

Finance

8. There are no additional financial implications of this work.

Risks

9. The following risks are associated with finance, as identified in the finance risk register:
   - Poor financial planning leads to depletion of reserves below required levels and threatens the organisation as a going concern.
   - Poor financial management leads to a large fee increase for registrants.
   - Non-compliance with Charity Commission regulations by maintaining excess long-term reserves.
   - Serious (unplanned) financial impact on reserves arising from additional cost of Covid-19 and/or reduced income, impacting delivery of core functions.

10. Reporting and monitoring financial performance against budgets and forecasts are a fundamental part of managing and mitigating these risks.

Equality Impacts

11. No equality impact has been undertaken.

Devolved nations

12. There are no implications for the devolved nations.

Communications

External communications

13. None planned.

Internal communications

14. The financial report and the forecast are shared with the Leadership Team and SMT as part of the regular financial reporting process.

Attachments

Annex one: Financial performance report for period ending 30 September 2021.
Annex two: Q2 Forecast for 2021-22 and 2022-23.

Financial Performance Report for the Period ending 30 September 2021

General Optical Council
Financial Performance Report for the 06 months ending 30 September 2021

Contents

General Optical Council
Financial Performance Report for the 06 months ending 30 September 2021

G O C :- Summary P & L to 30 Sept 2021

	Actual £000's	Budget £000's	Variance £000's	Q1 Forecast £000's	Variance £000's
Registrant Income	4,972	4,782	190	4,971	1
Other Income	167	113	54	127	40
Expenses - BAU	(4,093)	(4,858)	765	(4,279)	185
Surplus/(Deficit) -BAU	**1,046**	**37**	**1,009**	**819**	**226**
Project expenditure	(277)	(335)	58	(226)	(51)
Surplus/(Deficit) -before portfolio Gains/Losses	769	(298)	1,067	593	175

Highlights

The results before unrealised gains/losses for the period ending 30 September 2021 show a positive variance of £1,067k against the budget and £175k against Q1 forecast. The results before strategic projects (BAU) show a positive variance of £1,046k against the budget and £226k against Q1 forecast.

The total registrant income of £4,972k is £190k higher than the budget and £1k higher than the forecast. The total expenditure (including projects) of £4,370k is £823k favourable to budget and £134k to forecast.

The above budget is the originally approved budget. We have incorporated subsequent approvals into the Q1 Forecast. E.g., additional funding to Case Progression to improve the operations and close more old cases. Return to Old Bailey project was approved with £365k new budget from reserves. GOC Refresh will add further changes. Both Return to Old Bailey and GOC Refresh are strategic projects and will not impact the BAU surplus. Return to Old Bailey is a capital budget that will use reserves over the remaining lease term of the office premises.

Key drivers of the improved performance

Remote working and efficiencies continue to deliver savings. Making efficiencies and financial cost awareness has become embedded in the organisation. Q1 forecast captured delays in planned hybrid working and incorporation of lessons learned in remote working.

The second quarter had more delays and changes in planned timings than definite improvements. Smaller savings were made in several areas e.g., using fewer EVP visitors per visit, planning more remote hearings, renegotiated cost of Microsoft Dynamics licenses.

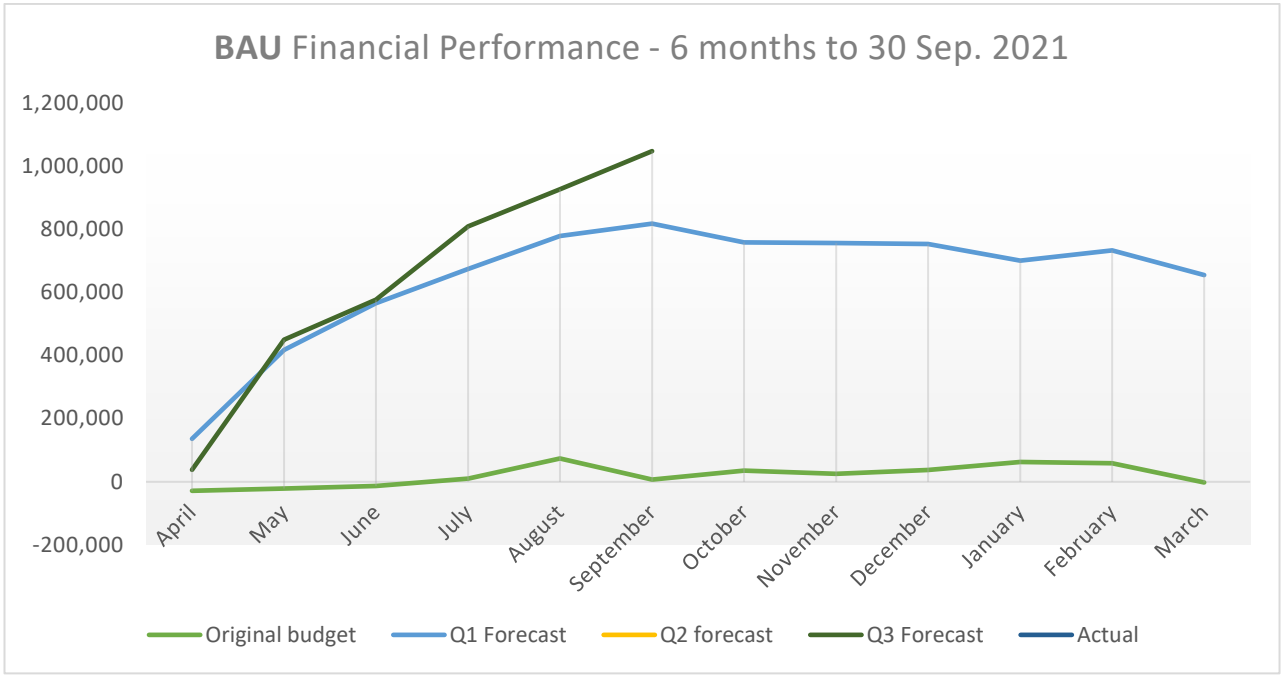
Risks to achieving Q2 Forecast

Delays and difficulties in recruiting suitable staff have impacted on workload and led to delays in some areas. Several recruitment campaigns are currently underway and there has been a challenge to recruit staff with appropriate experience in some areas. Post lockdown economic recovery has impacted the recruitment market, making recruiting the right candidates at the bottom to mid of our current salary bands a challenge for some specialist areas. Staff headcount is at 86, less than the Q1 forecast of 95 (ref. table 4, page 7).

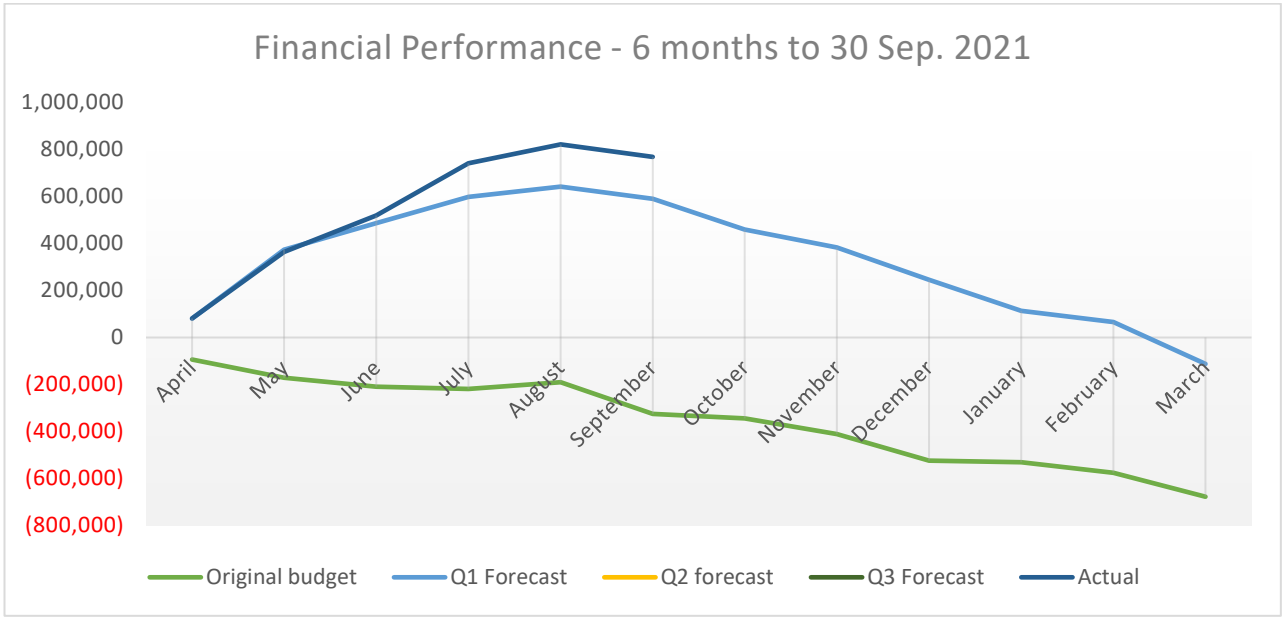
The forecast depends on assumptions made on legal cases progressing to Case Examiner levels during the current year etc. These timings could be changed and will be kept under review at each forecast.

General Optical Council
Financial Performance Report for the 06 months ending 30 September 2021

Graphical analysis on Financial Performance and Variance

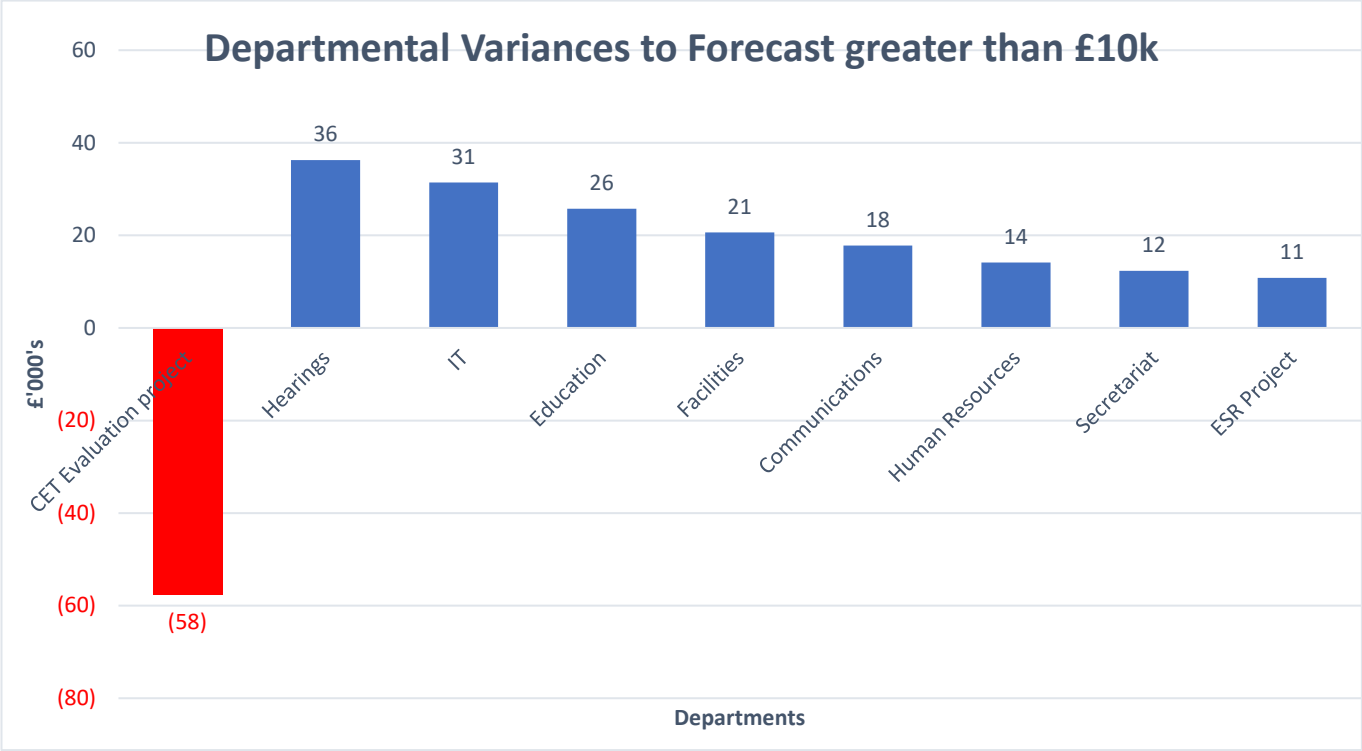


Graph 1



Graph 2

General Optical Council
Financial Performance Report for the 06 months ending 30 September 2021



Graph 3

Cash and Cash Equivalent Summary - 30 September 2021

	Actual £'000	Budget £'000	Variance £'000	Q1Forecast £'000	Variance £'000
Cash at Bank	1,272	439	833	776	496
Short term Investments	3,700	3,700	0	3,700	0
Working Capital	**4,972**	**4,139**	**833**	**4,476**	**496**
Investments	9,327	8,782	545	8,927	400
Total	**14,299**	**12,921**	**1,378**	**13,403**	**896**

Table 1

Analysis of expense variance -September	
Savings	£'000
Efficiency	0
Covid related savings	11
Covid related delays	0
Other savings	83
Staff vacancy gaps (excluding efficiency measures)	25
Other delays and timing	143
Revised plans / cancelations	13
Additional expenses	275
Additions	(127)
Others	(14)
Total Expense Variance	134

Table 2

Analysis of savings over past quarters					
Savings	Q1	Q2	Q3	Q4	Total
	£'000	£'000	£'000	£'000	£'000
Efficiency	29	0			29
Covid related savings	37	11			48
Other savings	112	83			195
Total Savings					272

Table 3

Headcount September 2021 (F T E's)

	Actual FTC Sep-21	Actual Perm. Sep-21	Actual Total Sep-21	Q1 Forecast Sep-21
Chief Executive Office	-	8.0	8.0	9.0
Strategy	1.0	8.3	9.3	10.3
Education	2.0	9.8	11.8	14.0
FTP	1.0	30.0	31.0	36.0
Resources	-	24.9	24.9	24.9
Change	1.0	-	1.0	1.0
Total Headcount	**5.0**	**81.0**	**86.0**	**95.2**

Table 4

General Optical Council
Financial Performance Report for the 06 months ending 30 September 2021

Table A
Income and Expenditure Accounts Including Project Expenditure

	April - September			April - September		
	Actual £'000	Budget £'000	Variance £'000	Actual £'000	Forecast £'000	Variance £'000
Income						
Registration	4,972	4,782	190	4,972	4,971	1
Dividend Income	152	98	54	152	109	43
Bank & Deposit Interest	0	5	(5)	0	3	(2)
Other Income	16	10	6	16	15	0
Total Income	**5,140**	**4,895**	**245**	**5,140**	**5,098**	**42**
Expenditure						
Staff Salaries Costs	2,233	2,512	279	2,233	2,244	11
Other Staff Costs	87	96	9	87	118	32
Staff Benefits	55	60	5	55	59	4
Members Costs	352	641	289	352	388	36
Case Examiners	22	38	16	22	32	10
Professional Fees	167	275	107	167	192	24
Finance Costs	70	44	(26)	70	70	(0)
Case Progression	381	311	(70)	381	368	(14)
Hearings	80	106	26	80	89	9
CET & Standards	187	157	(30)	187	131	(57)
Communication	18	17	(0)	18	21	3
Registration	6	6	0	6	6	0
IT Costs	224	311	87	224	254	30
Office Services	423	499	76	423	436	12
Other Costs	(1)	50	51	(1)	34	34
Depreciation & Amortisation	67	69	2	67	65	(2)
Total Expenditure	**4,371**	**5,193**	**822**	**4,371**	**4,505**	**134**
Surplus / Deficit	**769**	**(298)**	**1,066**	**769**	**593**	**176**
Unrealised Investment gains	503	135	369	503	217	286
Surplus / (Deficit)	**1,272**	**(163)**	**1,435**	**1,272**	**810**	**462**

General Optical Council
Financial Performance Report for the 06 months ending 30 September 2021

Table B
Income and Expenditure Accounts

	April - September			April - September		
	Actual £'000	Budget £'000	Variance £'000	Actual £'000	Forecast £'000	Variance £'000
Income						
Registration	4,972	4,782	190	4,972	4,971	1
Dividend Income	152	98	54	152	109	43
Bank & Deposit Interest	0	5	(5)	0	3	(2)
Other Income	16	10	6	16	15	0
Total Income	**5,140**	**4,895**	**245**	**5,140**	**5,098**	**42**
Expenditure						
Executive Office						
CEO's Office	119	166	47	119	119	1
Secretariat	298	357	58	298	311	12
Total Executive	**417**	**522**	**105**	417	430	13
Strategy						
Director of Strategy	59	70	12	59	61	2
Policy	67	91	24	67	67	(0)
Standards	22	84	62	22	27	5
Communications	88	111	23	88	106	18
Total Strategy	**236**	**356**	**120**	**236**	**261**	**25**
Education						
Director of Education	48	51	3	48	53	5
CET	148	183	35	148	152	5
Education	216	307	91	216	242	26
Total Education and Standards	**412**	**541**	**130**	**412**	**447**	**36**
FTP						
Director of FTP	57	55	(2)	57	57	(0)
Case Progression	823	767	(56)	823	821	(2)
Legal	176	186	10	176	183	7
Hearings	412	653	241	412	448	36
Total FTP	**1,468**	**1,662**	**194**	**1,468**	**1,508**	**40**

General Optical Council
Financial Performance Report for the 06 months ending 30 September 2021

Table B (Contd.)

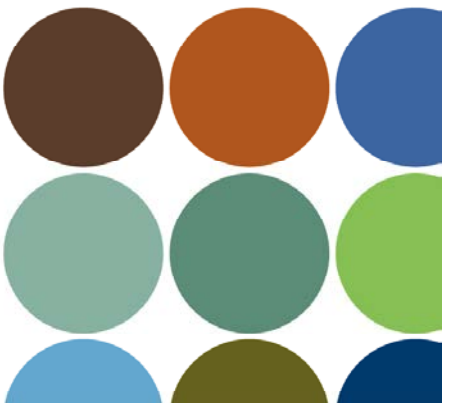
	April - September			April - September		
	Actual £'000	Budget £'000	Variance £'000	Actual £'000	Forecast £'000	Variance £'000
Resources						
Director of Resources	61	68	7	61	57	(4)
Facilities	474	538	64	474	495	21
Human Resources	204	232	28	204	218	14
Finance	195	191	(4)	195	200	5
IT	327	416	89	327	359	31
Registration	232	263	31	232	239	7
Total Resources	**1,493**	**1,707**	**214**	**1,493**	**1,567**	**74**
Depreciation	67	69	2	67	65	(2)
Total Expenditure	**4,093**	**4,858**	**765**	**4,093**	**4,279**	**185**
Surplus / (Deficit) before project expenditure	**1,047**	**38**	**1,009**	**1,047**	**820**	**227**
Project Expenditure						
CET Evaluation project	128	65	(63)	128	70	(58)
Education Strategic Review project	89	182	92	89	100	11
IT Strategy Implementation	55	88	34	55	48	(7)
GOC Refresh	5	0	(5)	5	8	3
CRM Amortisation	0	0	0	0	0	0
Total Project expenditure	**277**	**335**	**58**	**277**	**226**	**(51)**
Surplus / (Deficit) after project expenditure	**769**	**(298)**	**1,067**	**769**	**593**	**176**
Investment gains	503	135	369	503	217	286
Surplus / Deficit	**1,272**	**(163)**	**1,436**	**1,272**	**810**	**462**

General Optical Council
Financial Performance Report for the 06 months ending 30 September 2021

Balance Sheet as at 30 September 2021

	2021-22 30 September 2021 £'000	2020-21 31 March 2021 £'000	Variance £'000
Fixed Assets			
Refurbishment	627	664	(36)
Furniture & Equipment	132	148	(16)
IT Hardware	30	45	(15)
IT software	0	0	0
IT Software - Working Progress	176	163	13
Total Tangible Fixed Assets	**965**	**1,019**	**(54)**
Investment	9,327	8,860	467
Total Fixed Assets	**10,292**	**9,879**	**413**
Current Assets			
Debtors, Prepayments & Other Receivable	279	537	(258)
Short term deposits	3,700	7,700	(4,000)
Cash and monies at Bank	1,272	660	612
Total Current assets	**5,251**	**8,897**	**(3,646)**
Current Liabilities			
Creditors & Accruals	707	676	31
Income received in advance	4,675	9,004	(4,329)
Provision for rent	264	469	(205)
Total Current Liabilities	**5,645**	**10,149**	**(4,504)**
Current Assets less Current Liabilities	**(394)**	**(1,252)**	**858**
Total Assets less Current Liabilities	**9,898**	**8,627**	**1,271**
Long Term Liabilities	0	0	0
Total Assets less Total Liabilities	**9,898**	**8,627**	**1,271**
Reserves			
Legal Costs Reserve	700	700	0
Strategic Reserve	2,000	2,000	0
Covid -19 reserve	900	900	0
Infrastructure / dilapidations	500	500	0
Income & Expenditure	5,798	4,527	1,271
Total	**9,898**	**8,627**	**1,271**

Forecast Report for 2021/22 and 2022/23 October'21 Update



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2021-22 Q2 based Forecasts for 2021-22 and 2022-23			
	Budget	Forecast	Forecast
	Yr. 1 2021-22		Yr. 2 2022-23
	£'000	£'000	£'000
Income	9,750	10,033	10,409
Expenditure (BAU)	(9,750)	(9,086)	(9,961)
Surplus / (Deficit) before project expenditure	**0**	**947**	**448**
Project (Strategic) Expenditure	(676)	(817)	(1,127)
Surplus / (Deficit) after project expenditure	(676)	130	(679)
Unrealised Investment gains	269	359	457
Surplus / (Deficit)	**(407)**	**489**	**(222)**
Increase/(decrease) in income		3%	4%
Increase/(decrease) in BAU exp		(7%)	10%
Increase/ (decrease) in Projects		21%	38%

Table 1

Highlights

The latest forecast for the current year and Yr. 2 (next budget year) both show surpluses before project expenditure.

Prior to the pandemic our focus was on reducing costs and expenditure, often spending the bare minimum to ensure a breakeven position, which we successfully achieved in 2020-21. The change in our financial outlook means we can invest more in achieving our objectives and have identified areas where additional resources will improve operational performance and project delivery.. This is the cause of the cost increases in Year 2.

In-built efficiencies and lessons learned through remote working have kept expenditure levels low. The assumption is that registration fees remain frozen at current levels in Year two.

The Year two forecast will form foundation of the new 2022/23 budget which will be presented for approval in March 2022.

Income and Expenditure Accounts – 2021-22 Q2 +2Yr Forecast

	Year 1		Year 2
	2021-22		2022-23
	Approved Budget	Q2 Forecast	Oct'21 Forecast
	£'000	£'000	£'000
Income			
Registration	9,524	9,765	10,179
Dividend Income	196	242	200
Bank & Deposit Interest	10	0	10
Other Income	20	26	20
Total Income	**9,750**	**10,033**	**10,409**
Expenditure			
CEO's Office			
CEO	357	271	283
Secretariat	697	631	685
Total CEO's Office	**1,053**	**902**	**968**
Strategy			
Director of Strategy	141	118	0
Policy	237	213	325
Communications	223	221	209
Standards	128	86	96
Total Strategy	**728**	**638**	**631**
FTP			
Director of Casework & Resolution	112	115	120
Case Progression	1,515	1901	1,927
Legal	374	266	179
Hearings	1,325	973	1,172
Total FTP	**3,326**	**3,256**	**3,398**
Education			
Director of Education	110	113	126
Education	622	501	777
CET	330	316	254
	1,061	**930**	**1,157**

Income and Expenditure Accounts 2021-22 Q2+2 Yr. Forecast (Contd.)

	Year 1 2021-22		Year 2 2022-23
	Approved Budget	Q2 Forecast	Oct'21 Forecast
	£'000	£'000	£'000
Resources			
Director of Resources	135	123	153
Facilities	1,060	1002	1,049
Human Resources	471	465	494
Finance	440	429	488
IT	844	738	931
Registration	501	477	558
Total Resources	**3,451**	**3,234**	**3,673**
Depreciation & Amortisation	131	128	135
Total Expenditure	**9,750**	**9,088**	**9,961**
Surplus / (Deficit) before project expenditure	**(0)**	**945**	**448**
Project Expenditure			
CET Evaluation Project	128	184	14
Education Strategic Review project	256	202	143
IT Strategy Project	292	259	298
GOC Refresh project	0	172	519
Depreciation & Amortisation	0	0	154
Total Project expenditure	**676**	**817**	**1,127**
Surplus / (Deficit) after project expenditure	**(676)**	**128**	**(679)**
Unrealised Investment gains	269	359	457
Surplus / (Deficit)	**(407)**	**487**	**(222)**

Table 2

Movement in reserves

Our reserves ensure we are able to operate as a going concern in a range of different scenarios, and support achievement of our strategic plans. The figures below show a healthy surplus of reserves along with plans to use reserves productively through strategic projects (ref Table 3).

The strategic, Covid-19, and infrastructure/dilapidation reserves are all designated and currently maintained at maximum target level as per policy, re-filling any usage for project expenditure from general reserve at each year-end. Although general reserves are freely available funds, part of these are tied down in fixed assets, currently valued at £965k.

The Charity Commission recommends charities hold adequate reserves to carry on their activities in the event of financial difficulties, whilst spending on charitable activities. Reserves indicate the overall resilience to unplanned events.

Risks

Much of our reserves are held in long-term investments which may be volatile over short-term intervals. The reserves should support temporary fluctuations of the market value of investments (currently at £9.3m), ensuring the continuation of business plans without any interruption.

Movement in Reserves - Oct.'21 Forecast

	Year 1 2021-22 £'000	Year 2 2022-23 £'000	***Target as per Reserves policy***
Legal reserve	700	700	*£350k - £700k*
Strategic reserve	2,000	2,000	*£1m -£2m*
Covid -19 reserve	1,800	1,800	*£900k - £1,8m*
Infrastructure / dilapidations	1,250	1,250	*£250k - £1.25m*
General. Reserve	3,366	3,145	*£2.3m - £3.8m*
Total Reserve	9,116	8,894	*£4.80m - £9.55m*

Table 3

Assumptions

Income

- The number of fully qualified individual registrants will increase by 3% p.a. This is a net figure; OO will increase, DO will reduce and there will be retirement and other decreases. The trend is based on pre-covid stats.
- **Fee rates for Year 2 will not increase and remain at £360.**
- 90% of the new registrants will transfer from the student register**.**
- **Student fee income will be at £30, without increase.**

- Registrants changed to low income due to Covid will not change to the regular fee en masse. This is due to uncertainties of timing**.**
- There will be no further Covid related impacts on income.
- The rate of increase of Body Corporates will not change. There was a reducing trend pre-Covid, but an increase in 2020. Therefore, we are uncertain on future trends going forward.
- There will be no unusual shift due to retirement.
- The rate of new registrants will follow past trends.
- There will be no postponement of exams for new registrants.
- Investments will provide a total return of 5.2% p.a. with a 9.3% volatility level.
- Dividend income will be increased by 2% p.a.
- Fixed deposit interest rates will be similar to current rates.
- CET approver income will be similar to past trends.

Expenditure - assumptions

- There will be 4 directors: 3 permanent and 1 FTC (Change directorate).
- GOC refresh will not incur additional costs beyond those forecasted.
- Office rent will be maintained at Yr 1 level without any increase.
- IT developments will be carried out as planned.
- There will be no new strategic projects.
- There will be no large, fixed asset purchases beyond values forecasted.
- A hybrid work pattern will be maintained for staff, committees, and hearings.

PUBLIC
C56(21)

Council

Registrant Fees Rules and future fee strategy

Meeting: 8 December 2021 **Status:** For decision

Lead responsibility and paper author: Yeslin Gearty (Director of Resources)

Purpose

1. For Council to set the Registrant fee rules for 2022-23.

Recommendations

2. Council are asked to:
   - **agree** that we freeze fees for 2022-23 and continue the approach of raising fees in line with inflation over the medium term.
   - **consider** and **approve** the draft fee rules, as set out in **annex one**.

Strategic objective

3. This work contributes towards the achievement of all the GOC's strategic objectives as fees are our sole form of income.

Background

4. Council is required to set a budget each year in order to adequately manage the resources to run the business and deliver services in a sustainable way. At its meeting on 11 November 2020 (Paper ref C28(20)) Council approved the annual fee for 2021-22 and agreed to signal that the annual fee increases for the following two years should be modest and consistent with previous increases, which had been broadly in line with inflation (subject to annual review / approval).

5. In the previous five years we have met the objective of modest and consistent increases, amounting to a £10 increase per annum for the main registrant fee each year, with no increase at all last year.

6. Because of uncertainty over economic factors due to the impact of Covid-19 on the economy and our registrants, and in line with our usual approach of analysing our finances when developing fee proposals, last year we froze fees, with the main registrant fee remaining at £360. We also stated that we would consider a modest increase for 2022-23.

7. We have now completed our quarter two budget review and re-forecast. From this we conclude that our overall stable financial position, with projected surpluses even after

strategic project expenditure in four of the five years predicted and a healthy increased reserves position, combined with a low likelihood of registrant renewals reducing, mean that we are in a position to again recommend freezing our fees for the coming year.

8. We also considered a reduction in fees, but decided against, taking a cautious approach to maintaining healthy reserves reflecting Charity Commission guidance. We consider it prudent to continue on a level footing and allow for some potential fluctuations in both investment income and the overall value of our portfolio, by maintaining fees at their current level.

9. The recommendations are consistent with the assumptions underpinning our second quarter projections for 2021-22, 2022-23 and out-years, which were considered by the Audit Risk and Finance Committee (ARF) on 24 November 2021.

10. **At the 24 November meeting, ARF considered the Fees proposal for 2022-23 and recommend this to Council.**

Analysis

11. In recommending these fees, we have taken account of the following:
    - levels of inflation (including pay inflation);
    - the PSA's strong steer of ensuring that fees and fee increases are not unreasonable;
    - an expectation that we will deliver our core business within our income each year from 2022-23 onwards (breakeven or better);
    - relevant statutory requirements and wider public law considerations; and
    - legal advice in relation to the EU Directive to ensure that we are compliant in setting our fees for applicants wishing to apply from within the EEA or Switzerland. Whilst the UK has now left the EU and the transition period ended on 31 December 2020, the arrangements for Swiss nationals will be continued by four years. Fees for EEA based applicants have not changed; they follow the process that previously existed for non-EEA based applicants and pay the same fees.

12. The proposal is to not increase any registration fee. To follow previous increases and raise the main registration fee by £10; from £360 to £370, would represent a 2.75 per cent increase, which is below the rate of inflation (CPI 4.2% as of October 2021). Our reasoning includes consideration of the following:
    - The latest 5-year forecast shows a trend in increased surplus over the coming years, after a continuous increase in business-as-usual surplus for the first two quarters of 2021-22 demonstrating we can afford to manage our budget without a fee increase.
    - In-built efficiencies and lessons learned through remote working mean expenditure levels are lower than previous years and much of those savings from new ways of working are expected to continue.

- As shown in the separate finance paper, there is a healthy surplus of reserves, increasing with similar trends to the forecasted surplus (our reserves policy will be revised to address these trends in-line with our re-forecasted budget in Q4).
- Our review of reserves policy will ensure that our reserves and management of them appropriately reflects the need to provide additional financial resilience in the post pandemic environment.
- CPI, the main Government measure of annual inflation, has been between 0.3 - 4.2 per cent over the last 12 months (it dropped to 0.3 per cent in November 2020).
- Wage inflation is currently running at 4.9% (year on year 3-month average - ONS). Salary costs represent over 50% of the GOC's regular running costs. Our budget for next year will provide for an overall 5% increase with 3.5% reflecting an inflationary increase and 1.5% provided for performance related increases.
- The PSA have set a 1% increase in their fees to us from April 2022 on top of the 2.77% increase for 2021-22. The PSA levy a fee based on the number of registrants including students. For 2021-22 this was £88,215.00 and we will pay £89,083.00 for 2022-23.
- The number of low-income registrants is assumed to remain stable, noting that we will continue to maintain the qualifying threshold of £16,000 introduced for 2020-21, alongside the ongoing ability to apply to change to low-income at any point of the year.
- Again, the budget forecast includes assumptions on the above and this proposal being approved and implemented.

13. As we did last year, we also considered raising the main registration fee by £5, but decided against because of the lack of underlying need to seek to increase income given our current financial position and overall projected surplus. We hope that this freeze will again be welcomed by registrants and be recognised by representative bodies as a continued acknowledgement of the difficulties faced by their members during the pandemic and represents fair value, whilst allowing us to maintain a breakeven budget or better and provide a stable operating base, maintaining our reserves, in the event of future financial uncertainties.

14. In previous financial reports we made a number of assumptions around fee income reducing due to the effects of Covid-19 on optical professionals and businesses and included scenarios covering a variety of outcomes. The pessimistic assumptions for 2020-21 and the early stages of this year did not materialise and we have based future forecasts on a more stable position in relation to registrant retention, assuming overall growth of the register in line with year on year upward trends. The Financial Performance Report provides further background relating to our investments and assumptions on the income generated.

15. We therefore believe a zero increase is justified, affordable and the right thing to do in the current environment.

16. In line with our aim of modest and consistent fees for future years, any increases in fees for 2023-23 will be in line with inflation and should remain subject to annual review.

17. The fees are highlighted in the table below

Registrant Type	2021-22	2022-23
Fully Qualified & Body Corporate prompt payment fee	£360	£360
Fully Qualified & Body Corporate standard renewal fee	£360	£360
Student renewal fee	£30	£30
Application for Initial Registration or Restoration (not on student register) fee	£75	£75
Application for Initial Registration (transfer from student register) fee	£40	£40
Low-income discount	£100	£100

18. The Student application fees for initial registration and renewal were both increased by £5 two years ago. In 2020-21 we stated that we would not look to increase these in 2022-23.

19. We are developing our business plan for 2022-23 and have commenced the preparation of a full draft budget, which will be presented for consideration in March 2022. Even without an increase this year, the fee income generated by this proposal, along with savings from the impact of Covid-19 on working practices, efficiencies and anticipated investment returns are sufficient to cover business as usual expenditure, with judicious use of reserves for explicit investment in strategic projects.

Finance

20. There are no additional financial implications of this work.

Risks

21. The following risks are associated with the issue:

- The GOC is unable to deliver its strategic plans, programme of change, and business as usual either sufficiently quickly or effectively.
- There is an inherent risk in setting the fee level based on an outline budget as we are only seven months into the current financial year. As the full impact of trends and changes cannot be reflected fully in our financial performance for the year to date;
- There is risk in assuming investment income will provide a consistent annual return. This is in line with the remit of the Investment Manager but is based on long-term performance and could fluctuate year on year.

- Work around legislative reform may impact the way we charge registrants in future years, but this will require further detailed planning and consultation across stakeholders; and
- The end of the CET cycle results in higher than usual numbers of retirements, withdrawals and removals from the register for failure to meet CET requirements. Analysis of the 2019 cycle end, current CET data and notices received for number of retirements and withdrawals are within expected levels so far, all of which is incorporated into our planning.

Equality Impacts.

22. No equality impact has been undertaken as this is a continuation of current practice to raise fees broadly in line with inflation.

Devolved nations

23. There are no implications for the devolved nations.

Communications

External communications

24. Normal communications regarding fees will take place; including in our ‘News from Council’ and publication of the fees on the website.

Next steps

25. The 2022-26 strategy and associated Business Plan for 2022-23 will be presented for approval at the Council meeting in February 2022. Both plans will reflect the decisions taken here.

26. Financial reporting will continue to be considered by both ARF and Council quarterly including relevant forecasts.

Attachments

Annex one: Registration fee rules 2022-23

THE REGISTRATION FEES RULES 2022-2023

Each application falling within a category set out in the table below shall be accompanied by the fee shown for the period 1 April 2022 – 31 March 2023:

Applications for annual renewal of registration	22/23 Fee
Annual renewal fee Application for annual renewal of registration in the register of: • Optometrists • Dispensing opticians • Bodies corporate carrying on business as an optometrist or dispensing optician or both for the year commencing on 1 April 2022 and ending on 31 March 2023 received on or before 31 March 2023	£360
Low-income earners annual renewal fee[1] Application for annual renewal of registration in the register of: • Optometrists • Dispensing opticians for the year commencing 1 April 2022 and ending on 31 March 2023 applications received on or before 31 March 2023**.**	£260
Application for annual renewal in the register of student optometrists or the register or student dispensing opticians for the year commencing 1 September 2022 and ending on 31 August 2023 received on or before 31 August 2022.	£30

Applications for annual renewal of registration when entering, transferring or restoring to the register	22/23 Fee
Annual renewal fee for the period 1 April 2022 and ending on 31 March 2023, pro rata rate based on date of entry to the register of: • Optometrists • Dispensing opticians • Bodies corporate carrying on business as an optometrist or dispensing optician or both	£90.00 per quarter or part thereof

Applications for Registration	22/23 Fee
Initial application to be entered on the register of: • Optometrists • Dispensing opticians • Bodies corporate carrying on business as an optometrist or dispensing optician or both including low-income earners.	£75
Application for registration in the register of student optometrists or the register of student dispensing opticians for all or part of the year	£30

[1] a low-income earner is defined as an individual fully qualified applicant or registrant whose total individual income is estimated to be lower than £16,000 for the following year 1 April 2022 - 31 March 2023.

commencing 1 September 2022 and ending on 31 August 2023. No annual renewal fee will be charged for the year in which they are applying for registration.	
Application for entry of a specialty in the register of optometrists or the register of dispensing opticians.	£40

Applications for transfer of registration	**22/23 Fee**
Application for transfer between full registers for all or part of the year commencing on 1 April 2022 and ending on 31 March 2023.	£40
Application for transfer from the register of student optometrists to the register of optometrists or from the register of student dispensing opticians upon completion of a GOC accredited route to registration.	£40

Applications for restoration of registration	**22/23 Fee**
Initial application to be restored on the register of: • Optometrists • Dispensing opticians • Bodies corporate carrying on business as an optometrist or dispensing optician or both including low-income earners.	£75
Application for restoration to the register of student optometrists or the register of student dispensing opticians following removal or erasure from the registers for all or part of the year commencing on 1 September 2022 and ending on 31 August 2023. No annual renewal fee will be charged for the year in which they are applying for registration.	£30

Applications for Certificates of Current Professional Status	**22/23 Fee**
Application for a certificate of current professional status.	£25

Applications for assessment of qualifications gained from outside of the UK to gain entry to the register of dispensing opticians or optometrists	**22/23 Fee**
A scrutiny fee for processing documentation for applications for applicants qualified outside of the United Kingdom who wish to join either the register of optometrists or the register of dispensing opticians. A separate fee will be charged for each register applied to.	£125
For those that have passed the scrutiny stage and require an equivalency assessment, a fee will be charged for: Assessment of equivalency of qualifications and experience for applicants qualified outside of the United Kingdom who wish to join either the register of optometrists or the register of dispensing opticians. A separate fee will be charged for each register applied to.	£450
An interview fee for non-EEA applicants (this is the cost of a telephone interview between the applicant and GOC assessors	£200

Dr Anne Wright CBE
Chair of Council

Lesley Longstone
Registrar

Council Forward Plan 2022/2023

2022/2023			
Q4	**Q1**	**Q2**	**Q3**
• Statutory Committees report • CEO report • Chair report • Balanced Scorecard • Business Plan Assurance report Q3 • Q3 financial and performance reports • FtP Improvement Programme Update – continuous improvement • External Business Plan • Budget and Business Plan for 2022/23 • Council's Trustee Duty responsibilities and PSA regulatory responsibilities assessment review • Equality, Diversity and Inclusion: monitoring report • Public perceptions survey • Standards of Practice for individual registrants for consultation	• Statutory Committees report • CEO report • Chair report • Balanced Scorecard • Business Plan Assurance report Q4 • Q4 financial and performance reports • Education Annual Monitoring report • FTP Performance Review / Update and/or rules changes • PSA performance review • OCCS Annual report • Stakeholder survey •	• Statutory Committees report • CEO report • Chair report • Balanced Scorecard • Business Plan Assurance report Q1 • Q1 financial and performance reports • Annual report and financial statements for year ended 31 March 2020 • Equality, Diversity and Inclusion: monitoring report • H&S Annual report (JS) • Registrant survey	• Statutory Committees report • CEO report • Chair report • Balanced Scorecard • Business Plan Assurance report Q2 • Q2 financial and performance reports • Education Strategic Review • First Draft External Business Plan • Member fees