ANNEX ONE

Stakeholder responses to the GOC's Education Strategic Review concepts and principles consultation

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

ABDO and ABDO College

ABDO and ABDO College responds to the consultation as shown below:

Concept 1: Standards for Education Providers

Consultation question 1 - Do you agree or disagree with us further exploring the concept of new Education Standards in the way we describe above?

Agree.

Consultation question 2 - Please tell us more about your views on this concept, including any opportunities or risks you foresee.

In order for the profession to advance and evolve, there is clearly a need to revolutionise the way in which optical training is delivered in the future. Basic course content must be agreed to avoid disparity between programmes and different skill sets of registrants at entry-level. Moving into evidence-based practice and encouraging research into dispensing-related areas will be a priority for ABDO; it is on that skill set of understanding publications and an ability to critically evaluate research that we would strongly support and encourage a minimum standard of level 6 education by the regulator.

Delivery needs to involve a greater emphasis on clinical experience; however supervision must be assured in order to protect the patient. Learning outcomes need to be independently assessed to give the regulator robust and rigorous assurance prior to registration. It is essential that should new standards be introduced, the GOC adopt a consistent approach to ensure all institutes operate at the same level particularly when considering national frameworks.

Over a sustained period of time ABDO have ensured the QCA Level 6 award for the FBDO qualification has been maintained. We would be strictly opposed to a reduction in standards and would encourage the GOC to ensure the FBDO programme is a minimum requisite for registration of dispensing opticians.

Equally great care must be taken to ensure there is little impact financially to all parties during this transition period. Increased costs in the lead up and during implementation could have a detrimental effect on organisations, business and the student.

Exploring opportunities in such a way where eye care professionals develop clinically and in line with modern day practice requirements would be welcomed. It is clear that the current methods of practice relating to a dispensing optician are restrictive thus preventing evolution of activity in a professional sense. We would encourage the GOC to remove barriers that currently exist and incorporate more freedom to exercise professional knowledge in a practical sense.

Consultation question 3 – Do you agree or disagree with the concept of informing our education requirements by our professional standards?

Agree.

Consultation question 4 - Please tell us more about your views on this concept, including any opportunities or risks you foresee.

We are comfortable with this concept providing the GOC is confident that the current standards are fit for purpose. Clearly, should there be any foreseeable changes to business standards that may impact upon individual standards, alterations should be made at the earliest opportunity.

Professionalism needs to be at the very heart of optical education in order to serve patients well. Educational knowledge is irrelevant if the registrant cannot communicate effectively to the patient, the practice team and allied healthcare professionals where relevant. Mutual respect of practice colleagues needs to be taught at undergraduate level and enhanced through clinical experience.

The risks to this are lack of adequate supervision if early clinical experience is to be encouraged. The clinical outcome may be accurate but the patient experience may be somewhat lacking in terms of communication, respect, care and compassion.
Many of the Standards of Practice are deemed common sense rather than taught elements, more structure into the education system of teaching and assessing the SOP's would be welcomed.

Consultation question 5 - What are your views on the concept of system-wide learning outcomes for optometry and dispensing optician education and training, instead of an educational competency-based approach?

Learning outcomes would need to be carefully worded to ensure interpretation is the same across disciplines and institutions. There would need to be consideration for background knowledge as well as learning outcomes in order to avoid a 'teach- to-test' culture.

Additionally, there needs to be a fully staged approach so that students are assessed on aspects at the correct stage of their education.

Consultation question 6 - What do you see as the merits to removing the current link between CET and our education requirements, if any?

Whilst the current education links to CET enable registrants to keep updated in fields they may not see regularly, removing the rigid links between pre-qualification education competencies and post-registration education would make a continuing professional development (CPD) scheme possible, and would go some way to addressing the future pathways of optical registrants. This may also lead to a more holistic approach to patient –centred care.

Consultation question 7 - Do you envisage any disadvantages or risks in this approach, and if so what are they?

The inevitable consequence would be that there would be a difference in what the GOC considered was valid optical CPD, and the opinion of the practitioner. Basic clinical knowledge and skills may suffer if, for example, the registrant works in isolation with a restricted patient base. Also, there needs to be a compulsory requirement for

ensuring legislative changes reaches all registrants in a formal manner, such as the introduction of General Data Protection Regulation (GDPR) or Safeguarding for children and vulnerable adults which are regularly updated.

Consultation question 8 - What do you see as the key changes needed to the current content of optometry programmes and dispensing optician programmes to ensure our future requirements are fit for purpose?

From a dispensing optician/ contact lens optician perspective we would welcome the following;

- Practical refraction
- Enhanced low vision clinical experience
- Enhanced paediatric clinical experience
- Domiciliary patient experience
- Screening and interpretation of screening results
- MECS
- Post-surgery care
- Supervision skills
- Research skills

Consultation question 9 - Do you agree or disagree with the concept of embedding clinical elements of education and training progressively from the outset of programmes?

Agree.

Consultation question 10 - Tell us more about your views on this concept.

Giving the student exposure to patients (properly supervised) from the outset of a course helps to link the theoretical knowledge with practical application. It builds confidence in dealing with a variety of patients and therefore the student progresses faster as they can see the benefit to the patients of solving visual problems, embracing the latest technology and innovative ideas.

Most DO students, irrespective of how they train, work face-to-face with patients from very early on in their course. Hence they need to be aware of their own abilities and limitations from the start. They need to be able to link theory to practice and develop the clinical skills at the appropriate time on the programme.
Communication skills are acquired over a long period of time and work in clinical practice aids with consolidation of these vital skills.

Consultation question 11 - What do you foresee as being any positive or negative impacts on students, education providers, employers, patients and carers from taking a hybrid approach?

The main positive is the experience from the students prospective, learning about effective communication in a real environment. Students can see the ‘real job’ and how they can make a huge difference to patients. It would also be beneficial for students to experience different settings such as hospital placements, low vision centres and

paediatric specialist clinics. Employers benefit as they have a more useful member of staff at an earlier stage in their training. Patients and carers like to know they are helping when a student is training, as long as the work is properly checked and supervised.

Negatives would be adequate supervision as previously mentioned and who would hold responsibility over finding placements and ensuring that they were fit for purpose – the employer or the teaching institute? Would one practice location be adequate? We have found with our extensive experience of portfolio work that moving practices is often necessary in order to fulfil the variety of patient types required prior to registration. This would be extremely onerous in terms of auditing and applying rules of supervision, i.e a maximum of two trainees etc.

Consultation question 12 - Do you agree or disagree with the concept of a national registration examination?

Agree.

Consultation question 13 - What are the merits and risks of this concept?

Consistency is the greatest risk and this can only be achieved by an external awarding body delivering the same fair and rigorous assessment to all those seeking registration. Allowing internal assessments would encourage the 'teach to test' approach that will be detrimental to the profession. Appropriate assessments should be as true to real life practice as possible, approved and monitored by the GOC. Supervisors are checked and registered, logged hours are checked, practice changes are audited, and a portfolio of case records showcasing their experience also forms part of the Pre-Qualification Period. These checks and audit trail are currently also managed by the awarding body, on behalf of the GOC.
Appropriate assessments should be as true to real life practice as possible, approved and monitored by the GOC.

Historically, there used to be a nationally recognised exam via ABDO but the GOC then allowed Anglia to produce its own recognised qualification and at a lower level.

The nationally recognised examination ensures that all students achieve the same base level and should make the GOC's role of ensuring standards more easily achieved. There is still scope for education providers to innovate within that core knowledge and skills.

With apprenticeship programmes coming on board the profession will have to provide one single end-point- assessment provider for those programmes anyway.

Consultation question 14 - How feasible would it be to develop inter-professional and multi-disciplinary elements of study within optometry and dispensing optician education programmes?

We have to deliver registrants that have had exposure to the experts in their field. By showing mutual respect to colleagues within the profession and utilising their skills to teach different elements of the course, you are also then teaching the students to not

only show respect to team members but to work within their limits of competence and to refer when necessary.

The world of optics needs to become more patient-centred and less routine, by encompassing other areas of allied health, for example, nutrition, smoking cessation, hearing care, falls in the elderly, we can give our patients more tailored and rounded care.

Consultation question 15 - Tell us about any examples you know of already in other disciplines from within or outside the UK?

Consultation question 16 - What do you see as the strengths and weaknesses of retaining the current minimum duration as described above?

There will always be pressure from employers to reduce the time it takes to qualify and register. Reducing the duration will only serve to limit the knowledge, skills and experience of the registrant which will not serve patients well and create a multi- tiered level of professionals on registration. If a baseline registrant can be agreed then specialising in areas to suit interest and patient demand can be gained post-registration.

Consultation question 17 - What could be done differently in order to ensure students become competent, confident and safe beginners?

Encourage distance learning – the exposure to practice and real life scenarios on a daily basis brings all the knowledge to life and skills are practised repeatedly, hence a very high level of competence is achieved pre-registration.

As mentioned previously, the supervisor issue needs to be addressed and to link theory to practical skills acquisition at an earlier stage in the education programmes.

Consultation question 18 - What do you see as the opportunities for more flexibility between the education of different regulated and non-regulated optical professions?

As in nursing, the regulator may wish consider a minimum standard of education for optical assistants and consider registering them also. Whilst we see some merits in this approach, it is inevitable that the burden on both business and the individual will be costly and time consuming therefore we are reluctant to see such robust measures introduced.

Instead we believe a national agreement on career progression within optics would also be very useful in order to allow all programmes to be designed to recognise and apply APL immediately.

Consultation question 19 - What are the constraints and risks to this?

Getting fundamental agreement on APL in order to make the scheme attractive to all employers.

Career progression for dispensing opticians whilst the current two levels of education

exist.

Consultation question 20 - Are there any other principles and concepts we should consider at this stage in exploring future approaches to our quality assurance processes?

- Ensuring a Level 6 standard of education for Dispensing Opticians
- Ensuring patients at risk of not receiving the very best in eye care do so by extending the regulated function to encompass those who may be vulnerable, those who have a high prescription, safety spectacles and dispensing of special optical appliances.
- Visits (from the GOC) should be a sharing of best practice and not adversarial
- Visitors (GOC) should be better trained to understand different types of programme and innovation
- Quality assurance processes of the colleges & universities should be utilised and understood rather than asking for information “the GOC way.”

Consultation question 21 - Please tell us about any direct or indirect impact you can foresee from the concepts and principles we have set out in this public consultation on anyone with protected characteristics?

None identified.

ACLM, FMO and FODO

The ACLM, FMO and FODO respond to the consultation as shown below:

Concept 1: Standards for Education Providers

Consultation question 1 - Do you agree or disagree with us further exploring the concept of new Education Standards in the way we describe above?

Agree.

Consultation question 2 - Please tell us more about your views on this concept, including any opportunities or risks you foresee.

We support such exploration. In theory broader, higher level standards could encourage innovation and allow providers to be more agile in the face of changing demands. This "freedom within a framework" could encourage innovation in education provision and allow professional roles to evolve. The GOC should also take care not to measure what is already measured elsewhere, by the GOC or others.

As far as optometry is concerned, the GOC's Optometry Handbook[1] currently describes six 'areas/requirements' which must be met to achieve and maintain accreditation:

4.1 Public Protection
4.2 Student Experience
4.3 Student Assessment
4.4 Monitoring and Evaluation
4.5 Facilities and Resources
4.6 Professional Requirements

Public protection is also covered in Standards for Optometrists, DOs and Students[2] which should be taught as part of the new high-level education outcomes. Student experience is already measured by a number of other bodies, with feedback loops, so we are not sure that this is necessary.

Facilities and Resources in particular seems to us to be 'old world' and prescriptive. These could be removed completely or made more flexible so as to be more consistent with an outcomes-based approach.

Professional Requirements contains arbitrary patient contact minima – inputs, not demonstrated learning outcomes and old-style competencies rather than outcomes.

A set of standards that would be consistent with an outcomes-based approach could be, for example:

- Public Protection – emphasising ethics, patient safety, candour and concepts of supervision
- Assessment Methods
- Monitoring and Evaluation –

These would need to be written so that they cover all levels and types of practice and all professional groups.

The Optical Confederation would be supportive of standards that encouraged multi-disciplinary or inter-professional education and training where this was appropriate and higher education providers developing good relationships with employers as long as these were open and transparent. Any standards on course content should be consistent with an output-based approach. The ABDO in particular is concerned about any dilution of standards for dispensing optician training at this time when the profession needs to move up the clinical skills ladder. Other OC members support this aim of not throwing the baby out with the bathwater.

The risk with introducing higher level, less explicit standards is that it is harder to assess them consistently. Visitors will need to be highly skilled and the GOC will need to ensure that the assessment system they work within encourages appropriate and consistent interpretation of the standards. The experience of a visit by GOC Education visitors should feel and be welcomed, as far as possible, as a meeting with shared objectives (as opposed to a tick-box inspection). It should be an opportunity for the education institution to demonstrate and be challenged on what it is achieving and to share its thinking, including about challenges and innovation; and for visitors to share good practice and innovation from elsewhere.

Concept 2: Education Standards and Professionalism

Consultation question 3 – Do you agree or disagree with the concept of informing our education requirements by our professional standards?

Agree.

Consultation question 4 - Please tell us more about your views on this concept, including any opportunities or risks you foresee.

Education standards are those followed by institutions whereas standards for practice relate to individual registrants but there is an important symbiosis between the two. Higher level learning outcomes should be linked to standards of practice.

Concept 3: Learning Outcomes

Consultation question 5 - What are your views on the concept of system-wide learning outcomes for optometry and dispensing optician education and training, instead of an educational competency-based approach?

The OC is generally supportive of this idea but would like to see clarity about what this would mean in practice. A competency is a general statement that describes the knowledge, skills and behaviours required of a student or trainee at the point at which they successfully complete a programme of education and training. An outcome is very different to a competence. It is much more specific and would describe exactly what a student will be able to do in some measurable way.
There is no reason why competencies should not have accompanying defined and measurable outcomes.

Students should be expected to reach a certain level before seeing 'real patients' without direct supervision. In the case of dispensing students this already applies. In the case of optometry, with some modification. the current stage 1 optometry competencies are suitable for this.

In the cases of both optometrists and dispensing opticians moving into higher skills areas e.g. MECs and beyond, high level outcomes should also include intellectual skills such as the ability to understand clinical issues from first principles and to weigh evidence (maths/statistics).

This will be essential for future practitioners who will be faced with considerable technological change over the course of their careers. In many cases the professional roles will be less about carrying out tests and more about interpreting and explaining results, conditions and interactions in a way that patients will understand them. This will require good communication skills and an understanding of the underlying clinical concepts.

Concept 4: Links to Continuing Education and Training

Consultation question 6 - What do you see as the merits to removing the current link between CET and our education requirements, if any?

Consultation question 7 - Do you envisage any disadvantages or risks in this approach, and if so what are they?

If the learning outcomes are properly defined, linking CET to the standards for practice should be relatively straightforward particularly if the purpose of CET remains to maintain the level of competence demonstrated at point of registration.

There is another question entirely, which is about a continuing education framework which demonstrates that someone is now more than competent. Health Education England calls this 'care navigation', which is a tiered competency framework recognising three successive levels – essential, advanced and expert. This is a relatively new concept but interestingly in the HEE document 'Care Navigation: A competency framework' the point is made that this approach can lay the foundations for a career pathway framework for both clinical and non-clinical staff within primary and secondary care, and which we would be keen to explore further with the GOC as part of this strategic review.

Concept 5: Educational Content

Consultation question 8 - What do you see as the key changes needed to the current content of optometry programmes and dispensing optician programmes to ensure our future requirements are fit for purpose?

The Optical Confederation is not in favour of the GOC specifying curriculum content in any more detail than is required to deliver outcome-based high-level standards. Education providers should be empowered to develop course content in collaboration with the sector as a whole to deliver the learning standards/outcomes required and should be held rigorously to account for doing so.

Over-specification of inputs detail could restrict innovation and might not keep up with

changing practice and technology. We would be keen to discuss this further with the GOC as part of this review.

Concept 6: Enhanced clinical experience for students

Consultation question 9 - Do you agree or disagree with the concept of embedding clinical elements of education and training progressively from the outset of programmes?

Agree with caveats.

Consultation question 10 - Tell us more about your views on this concept.

Consultation question 11 - What do you foresee as being any positive or negative impacts on students, education providers, employers, patients and carers from taking a hybrid approach?

This is intuitively attractive and many in the sector are convinced that it will help students prepare for real practice and its pressures. Hands-on experience is generally considered to be a benefit for student clinicians. However, there is little hard evidence that more patient contact, of itself, leads to better optometry graduates although this model does seem to be proven in the training modules for dispensing opticians.

In the case of optometry what is clear is that the current patient contact minima are not evidence-based, encourage box-ticking and are provider resource-intensive (directing resource away from more valuable teaching activities). We need also be careful that 'real patient' contact at optometrist undergraduate level is not seen as a substitute for the acquisition of sound clinical knowledge and its application and demonstration. Available contact time and style of practice may not always offer the range of clinical, decision-making and communication challenges that students need to be prepared for. In many respects simulation may produce better-educated and safer clinicians[3].

The practical question of how time could be balanced to give good patient experience as well as provide the theoretical underpinnings is related to Concept 9 about course length and there can be practical challenges to supervising students across a series of short stints of clinical experience in different settings.
The OC members would be very keen to work further with the GOC on bottoming these issues.

3. Bokken L, Rethans J-J, Scherpbier A.J.J.A, van der Vleuten C.P.M., Strengths and Weaknesses of Simulated and Real Patients in the Teaching of Skills to Medical Students: A Review. Society for Simulation in Healthcare, 2008. Accessed at: http://www.ceesvandervleuten.com/application/files/9814/2979/9150/2008_Strengths_and_weaknesses_of_simulated_and_real_patients_in_the_teaching_of_skills_to_medical_students-_a_review.pdf

Concept 7: National registration examination

Consultation question 12 - Do you agree or disagree with the concept of a national registration examination?

There are a range of views within the Optical Confederation on this.

Consultation question 13 - What are the merits and risks of this concept?

We start from the position that there is not one national standardised examination at the moment. The University of Manchester, for instance, has a directly registrable MOptom which does not involve the College of Optometrists' scheme for registration.

There is of course a basic tension here which needs further inquiry and examination.

On the one hand a national examination can throttle innovation, because people might simply 'teach to the test'. On the other, and equally valid, a lack of standardisation, combined with more educational freedom for institutions, could lead to uneven quality of courses and different standards in examinations, which would in turn result in an undesirably inconsistent quality/preparedness of news professionals. Neither is desirable so a solution will have to be developed which combines freedom, flexibility and the facility easily to evolve with rigour in assessing learning outcomes which apply nationally to erasure the public and employers.

The Optical Confederation would welcome engaging further with the GOC, education providers and the College of Optometrists on this to see whether a safe way can be found that guarantees standards, whilst building in flexibility for institutions.

Currently we are agnostic as to assessment methodologies but we do believe that standards and learning outcomes should be demonstrable, fair and valid at a UK national level.

Concept 8: Multi-disciplinary education

Consultation question 14 - How feasible would it be to develop inter-professional and multi-disciplinary elements of study within optometry and dispensing optician education programmes?

Consultation question 15 - Tell us about any examples you know of already in other disciplines from within or outside the UK?

The Optical Confederation supports this concept. Optometrists and dispensing opticians will increasingly work in multi-disciplinary teams and so this will become more important especially as primary and community eye care expand and the traditional community/ secondary care boundary becomes more porous through training and technology and to meet expanding health public need.

A number of institutions will already have inter-professional learning embedded in their courses. Practical implementation might be more difficult for others but we do not see any of these issues are insuperable in the modern teaching environment and by partnerships between institutions and the health care sectors including our own.

Concept 9: Duration of education and training programmes

Consultation question 16 - What do you see as the strengths and weaknesses of retaining the current minimum duration as described above?

Consultation question 17 - What could be done differently in order to ensure students become competent, confident and safe beginners?

Whilst noting that the current 'standard' of three years + one year for optometrists and 2 years + 1 year for dispensing opticians are not "minimum durations" but rather the traditional length of a BSc programme of study plus pre-registration training in the case of optometry and 2 years full-time and 1 year pre-registration in the case of dispensing, the Optical Confederation does not yet have a consensus view on this issue.

In discussions on the call for evidence in 2017 some OC members argued for an extra year on the programme but some major employers were opposed, pointing out the impact of the extra year of fees and loans on students and poorer families might have in making optometry in particular a less appealing academic choice, and the potentially an increased risk of drop-outs.

There would also be the effect on supply of undergraduates in the year that no-one would graduate after such a change although this could be moderated in a variety of ways e.g. by introducing change gradually, institution by institution.

All of that said, one obvious way of increasing time spent studying without increasing the duration of the optometry course would be to change the basis of optometric education from a scientific degree to a clinical degree – thereby lengthening the course within the same three-year timespan.

Equally there may well be options to increase the amount of supervised training at an employer during the academic holidays although it might be hard for employers under current business models to provide irregular supervision for shorter periods at whatever time of year.

Again, all of this would suggest further discussion and consideration of options is required and OC members would be very happy to participate in this. This should not however prevent the GOC, as part of its review fieldwork, at least exploring the options for moving to a clinical rather than science degree at least for optometry.

Concept 10: UK educational routes to registration

Consultation question 18 - What do you see as the opportunities for more flexibility between the education of different regulated and non-regulated optical professions?
Consultation question 19 - What are the constraints and risks to this?

The Optical Confederation has no objections in principle to varying routes/entry points, indeed we would favour it. We need good clinicians entering the profession at any level and from the widest possible diversity of backgrounds reflecting the populations we serve.

However, whatever the entry point, admission and accredited prior learning and experience must focus on the ability to understanding optics and health care from first principles, the basic ability to weigh evidence (maths/statistics), and the interpersonal and team-working skills that will be required of anyone in a modern clinical practice.

Concept 11: Proportionate quality assurance

Consultation question 20 - Are there any other principles and concepts we should consider at this stage in exploring future approaches to our quality assurance processes?

The Optical Confederation agrees that the GOC should avoid duplicating other quality assurance processes. It should seek to ensure quality assurance links with outputs and is not just an input counting exercise. There should be a clear rationale for all data that are requested. In addition, quality assurance is a serious business which both we are academic institutions take seriously as part of our public protection roles. GOC visitors should therefore have done their homework fully before visits and focus on the important not the trivial which has sometimes seemed to be the case in the past.

Consultation question 21 - Please tell us about any direct or indirect impact you can foresee from the concepts and principles we have set out in this public consultation on anyone with protected characteristics?

AIO

AIO responds to the consultation as shown below:

Concept 1: Standards for Education Providers

Consultation question 1 - Do you agree or disagree with us further exploring the concept of new Education Standards in the way we describe above?
Agree.

Consultation question 2 - Please tell us more about your views on this concept, including any opportunities or risks you foresee.

Education must be able to evolve with the industry, as new technologies become available to practitioners, this must be reflected in teaching. As such it must be vital that as well as a comprehensive curriculum, those who teach clinical skills at Universities must be required to undertake a certain number of hours in clinical practice outside of the university clinics, almost *in lieu* or as part of the CET cycles required by other professionals.

Concept 2: Education Standards and Professionalism

Consultation question 3 – Do you agree or disagree with the concept of informing our education requirements by our professional standards?

Agree.

Consultation question 4 - Please tell us more about your views on this concept, including any opportunities or risks you foresee.

Students should be made aware of the implications of the Standards of Practice and what they entail.

Concept 3: Learning Outcomes

Consultation question 5 - What are your views on the concept of system-wide learning outcomes for optometry and dispensing optician education and training, instead of an educational competency-based approach?

This more flexible approach is a much better approach to education. There are many ways of meeting a patient's needs and performing various tests, and so students should be made aware that their clinical judgement is extremely important. If students are exposed to a variety of clinical approaches, all of which are acceptable, this encourages students to become more critical, and in a position to justify their methodology. This is key to retaining the clinical competence of the profession. Professionals should be actively encouraged to critically appraise what they are doing, and feel confident in the skills that they have.

Concept 4: Links to Continuing Education and Training

Consultation question 6 - What do you see as the merits to removing the current link between CET and our education requirements, if any?

CET is currently a largely tick-box based exercise and as such results in registrants doing the bare minimum for certain competencies which they may not enjoy/find interesting/know much about. As such the CET experience is not a positive task, and is perceived as an onerous task. This means that registrants are not keen to expand their knowledge base. A better approach would be to allow practitioners to expand their knowledge in specific areas, those which they either have more exposure to because of their job, or because they have an interest in that particular area.

Provided that all registrants qualify with the same basic skillset, specialisms which develop after years in practice will be very different from the basic education requirements, and this ought to be reflected in the way that continuing education is performed.

Consultation question 7 - Do you envisage any disadvantages or risks in this approach, and if so what are they?

The very core competencies should still be maintained. For instance an optometrist who does not undertake any continuing education in contact lenses, should still show a certain level of proficiency with the subject area should an emergency case present itself.

Concept 5: Educational Content

Consultation question 8 - What do you see as the key changes needed to the current content of optometry programmes and dispensing optician programmes to ensure our future requirements are fit for purpose?

Whilst technological advancements continue to appear in practice, practitioners should still be proficient in the original manual skills, if only to have a better understanding of what the skill entails (but also should the equipment not function etc., the registrant can still perform the skill manually).

Given the widespread nature of Minor Eye Conditions Schemes (MECS) etc., and that the content covered in this 'further qualification' is included in the basic training of optometrists, automatic accreditation should be incorporated into the undergraduate degree programme. Consideration for other such qualifications should be made also.

Students need to be made aware of the various aspects to primary eye care, and how those environments differ. A domiciliary eye exam is performed under very different conditions to an eye exam in a practice, and so registrants need to have a basic understanding / had exposure of these different environments before they qualify. Under the current system, an optometrist or dispensing optician can qualify having never performed a domiciliary examination or dispense, and there is no GOC-led guidance on ensuring that the optometrist or dispensing optician is suitably experienced to undertake this different role. The same can apply to other work settings, such as the hospital eye service, where examination structure is different again.

Specialisms should be encouraged amongst professionals, but awareness of these areas of specialism (binocular vision, contact lenses, glaucoma etc.) should exist so that students and newly-qualifieds can seek out those areas which they find of particular interest.

Students need a much greater awareness of business models to understand the varying approaches to eyecare in the industry. Concepts such as loss-leading, as well as KPI data like conversion rates and average transaction values are important as these are business pressure put upon pre-registration and newly qualified optometrists when they have had no previous exposure to them. As such, they are unprepared for these pressures and the transition from education to qualified practice is much more difficult. In line with this, students need to be made aware of the GOC's Business Standards, and what responsibilities a registrant has as an individual with regards to pressures put upon them by employers, such as bonus- driven conversion rate pressures.

Students need to also be made aware of how the profession develops, and so encouraged to engage with optometric and ophthalmological research. Some degree courses (such as psychology) require students to take part in at least one research project each academic year. This engages them with post-graduate and research students, but also shows students how advances are made in the profession. In terms of raising awareness to research this is important as well.

Concept 6: Enhanced clinical experience for students

Consultation question 9 - Do you agree or disagree with the concept of embedding clinical elements of education and training progressively from the outset of programmes?

Agree.

Consultation question 10 - Tell us more about your views on this concept.

This integrated approach is a much more robust way to develop student's communication skills, something which is not necessarily taught but acquired through continued exposure and experience. The large periods between academic years (often running from May to October) provides ample time for students to undertake compulsory experience and supervised practice periods in a variety of workplace settings, both to get a broad range of experiences but to also highlight any preferred places of work to the student themselves.

The hybrid approach can only work effectively however if there are strict rules and guidelines on student numbers. An academic or educational institution enrolling large numbers of students would need to clearly demonstrate how the large cohort would not be disadvantaged because of a saturation of students in the local vicinity. Students should be immersed into the workplace and so it should be avoided that students travel in groups to the same place of work.

Exposure to patients and clinical episodes from the beginning of the education process will lead to greater communication skills and competence.

Consultation question 11 - What do you foresee as being any positive or negative impacts on students, education providers, employers, patients and carers from taking a hybrid approach?

Students will qualify with a greater level of confidence, having grown accustomed to face-to-face interaction with 'real' patients over a number of years. Their communication and clinical skills will both benefit. They will also leave training with a greater awareness of the various places of work (independent, multiple, hospital, domiciliary etc) and hopefully have some inclination as to which they feel most suited to. These benefits will also work for the employer, as registrants will be much better prepared for the world of work, and have a better awareness of how businesses operate. Patients will experience more competent and proficient clinicians who have had a number of years developing their communication skills.

The problem may be that education establishments struggle to offer the range of workplaces for students to experience, particularly if the education establishment is not near to a particular workplace type. Also, large student intake numbers may make it physically impossible to offer placements to all students.

Concept 7: National registration examination

Consultation question 12 - Do you agree or disagree with the concept of a national registration examination?

Agree.

Consultation question 13 - What are the merits and risks of this concept?

Whilst The College of Optometrists's Scheme for Registration is in need of changes, the process itself is vital in ensuring that all newly qualified registrants are of the same standard and meet certain clinical benchmarks. Even with an integrated SfR within the undergraduate study, a set of examinations at the end of the process are vital in ensuring that a certain level of proficiency and knowledge has been achieved and maintained.

If an approach to flexible learning is to be adopted, the College's SfR would be fundamental in ensuring that all practitioners meet the same set of minimum standards for an optometrist, no matter where they learnt or how they learnt their skills.

Such a SfR should focus on basic proficiency, and rather than push students to attain a large number of patient episodes, a smaller number of cases with detailed write-up with justification by the student as to the process they took with the case would show a much deeper level of understanding. It also encourages a self- assessment approach and evidence based practice, both of which are key elements to continuing education.

Concept 8: Multi-disciplinary education

Consultation question 14 - How feasible would it be to develop inter-professional and multi-disciplinary elements of study within optometry and dispensing optician education programmes?

Again, this approach is possible provided there is not a large number of students enrolled in the course. Smaller courses are actually at an advantage, since it is easier to find other professional groups who can accommodate a small number of students, whereas expecting to find another institution capable of supporting excess of 100 students will be much more difficult. As such the GOC ought to place more emphasis on ensuring that academic institutions are able to provide an equal and detailed level of tuition to students, whether their cohort is 20 students or 200.

Consultation question 15 - Tell us about any examples you know of already in other disciplines from within or outside the UK?

Some European institutions (such as the Netherlands) require students to travel abroad to another country and experience optometry in that country, before reporting it back in a presentation to their peers. This would further encourage students and registrants to have an open mind as to how the profession works and be aware that professionals in other countries may have different approaches or techniques not seen in the UK which may be worth incorporating into practice nonetheless.

Concept 9: Duration of education and training programmes

Consultation question 16 - What do you see as the strengths and weaknesses of retaining the current minimum duration as described above?

As mentioned previously, there are huge periods of time between academic years which could be better utilised in expanding a student's experience of the optical profession. As such, rather than trying to race students through the course in a shorter period of time (which would ultimately be damaging to the profession), students have time to go over concepts learned and have further opportunities to practice skills.

Education models in other countries highlight the highly academic nature of the optometry programme. Some countries (such as North America) require a full degree before even embarking upon the Optometry course, and this results in both a more mature cohort who are actively driven study Optometry, as well as having a much greater understanding of basic science and physiology. Arguably this approach would be more beneficial to the optometry sector as a workforce of driven and motivated optometrists and dispensing opticians would be produced.

In Germany, the apprentice scheme for (dispensing) opticians means that qualified dispensing opticians have worked in practice for a number of years when they qualify and so have built up a greater level of understanding and communication skills. This could (potentially) be adapted for the optometry programme, whereby students are required to have worked in the optics sector for one year prior to enrolment into university (such as an optical assistant). This would provide students with a year's worth of patient exposure and communication skills, as well as showing a certain level of commitment and drive for the subject they are studying (as an alternative to the

North American approach of an entire foundation degree).

Consultation question 17 - What could be done differently in order to ensure students become competent, confident and safe beginners?

As stated above, students need a much greater exposure to 'real-life' practice and the various business types (independent, multiple, hospital, domiciliary etc). If this was encouraged as an entry requirement onto the programme, such as a year as an optical assistant, this would both give them the foundation communication skills, but also ensure that they are embarking on a career path that they enjoy.
Compulsory work placement through the summer holidays between academic years would also allow these skills and experiences to continue to flourish.

Concept 10: UK educational routes to registration

Consultation question 18 - What do you see as the opportunities for more flexibility between the education of different regulated and non-regulated optical professions?

There is currently a very good level of flexibility between professional levels, however this is not so apparent with non-regulated roles. Experience in non- regulated optical roles is very useful and should be considered in the Education Review. However, given that these roles are not regulated, it is very important that a set level of minimum knowledge/proficiency/competency is achieved in order for this experience to be used when transferring.

Consultation question 19 - What are the constraints and risks to this?

It must be ensured that using non-regulated roles *in lieu* of qualifications aren't used as a backdoor method to getting into a particular degree programme. For instance, it should not be permitted that students complete the dispensing optics degree and instantly enrol on the optometry degree. These are two very different professions, and whilst the role of an optometrist incorporates (to a certain extent) the role of a dispensing optician, to use one course as a foundation for the other actually undermines the whole role of a dispensing optician. If a dispensing optician wishes to transfer to optometry there ought to be a minimum term in practice (say 2 years) to discourage students failing to get onto the optometry programme using the dispensing optics degree as a foundation degree.

Work-based experience in non-regulated roles (such as optic assistant) should be considered as an alternative entry requirement for courses, however there needs to be a method of ensuring that there is a certain level of proficiency attained. Since these roles are not regulated, the actual abilities of someone employed in one of these roles can be highly variable.

Concept 11: Proportionate quality assurance

Consultation question 20 - Are there any other principles and concepts we should consider at this stage in exploring future approaches to our quality assurance processes?

N/A

Consultation question 21 - Please tell us about any direct or indirect impact you can foresee from the concepts and principles we have set out in this public consultation on anyone with protected characteristics?

N/A

Association of Optometrists (AOP)

The AOP responds to the consultation as shown below:

Concept 1: Standards for Education Providers

Consultation question 1 - Do you agree or disagree with us further exploring the concept of new Education Standards in the way we describe above?

Agree.

Consultation question 2 - Please tell us more about your views on this concept, including any opportunities or risks you foresee.

We agree that the GOC should further explore new high level Education Standards. We said in our response to the call for evidence that the current GOC requirements are too input driven. We think the proposed new Education Standards should be more focused on the achievement of learning outcomes. The requirements should encourage evidence-based learning, and be constructed in a way that allows education providers to meet the evolving learning needs of students in an agile and responsive way.

The GOC consultation paper suggests that the new Standards could cover the design and delivery of programmes, policies, procedures and course content, which are inputs rather than outputs. We think new Standards should avoid prescribing inputs as far as possible, although we acknowledge that some input requirements may be needed in order to ensure that education programmes are of adequate quality.

The current optometry accreditation and assurance standards[1] set out six sets of requirements for ongoing accreditation. The GOC could simplify these in a new set of Standards to be consistent with an outcomes-based approach and avoid unnecessary repetition. The current requirements cover:

4.1 Public Protection
4.2 Student Experience
4.3 Student Assessment
4.4 Monitoring and Evaluation
4.5 Facilities and Resources
4.6 Professional Requirements

Public protection is also covered in Standards for Optometrists, DOs and Students[2]. Student experience is already measured by a number of other bodies. Facilities and Resources is prescriptive and could be made less specific, as it is not consistent with an outcomes-based approach. Professional Requirements contains arbitrary patient contact minima and describes outcomes in terms of detailed competency statements rather than a higher-level approach.

A set of standards that would be consistent with an outcomes-based approach could be, for example:

- Public Protection – with emphasis on supervision of any patient contact, and the

inclusion of course content on ethics and patient safety
- Assessment Methods
- Monitoring and Evaluation

These would need to be constructed so as to cover all levels and types of practice and all professional groups.

High level Standards may be difficult to assess consistently. The GOC will need to put in place robust assessment and quality assurance mechanisms, including course visits, to ensure that the Standards are applied consistently by different education providers. Visitors will need to be highly skilled and the GOC will need to ensure that the assessment system encourages appropriate and consistent interpretation of the Standards. A visit by GOC education visitors should feel, as far as possible, like a collaborative partnership. It should be an opportunity for the education institution to share its thinking, including about innovation, and for the visitors to share their experience of good practice and innovation elsewhere.

We note that this change, and other potential changes discussed in the consultation paper such as enhanced clinical experience for students (concept 6), may have a range of cost and funding implications. We therefore think the GOC should involve education funding providers in any detailed redesign of the current education arrangements for the optical professions, and should assess the cost impact of changes on prospective registrants and on education providers. This should include consideration of the funding that universities receive for teaching optometry, the fees paid by university students and the salaries received by pre-registration students.

Concept 2: Education Standards and Professionalism

Consultation question 3 – Do you agree or disagree with the concept of informing our education requirements by our professional standards?

Don't know.

Consultation question 4 - Please tell us more about your views on this concept, including any opportunities or risks you foresee.

We agree in principle that the proposed new high-level Education Standards should be informed by the existing standards of practice for registrants. We have answered "don't know" to question 3 because we are unsure what "directly linking" the two sets of standards would mean in practice, given that the Education Standards apply to education providers rather than individual registrants.

The GOC's Standards of Practice for Optical Students reflect the current requirement for students to be registered with the GOC. We share the GOC's view that this is unnecessary. Linking education requirements to the professional standards that apply to optometrists and dispensing opticians would strengthen the case for removing the requirement for student registration.

Concept 3: Learning Outcomes

Consultation question 5 - What are your views on the concept of system-wide learning outcomes for optometry and dispensing optician education and training, instead of an educational competency-based approach?

We support the idea of focusing on higher level learning outcomes rather than the current competency based approach. As discussed in our response to question 1, we welcome a more outcome focused approach to the regulation of professional education. We think high-level outcomes should focus on intellectual skills, including the ability to think critically and independently, weigh evidence and understand concepts from first principles. This will allow practitioners to practise confidently in a variety of settings and adapt to changing technologies and service delivery in the course of their careers.

The existing competency framework for optometrists certainly needs to be changed. The current stage 1 competencies do not effectively describe the skill set, understanding and abilities required of a graduate entering a pre-registration placement. They are intended to be outcome based but set requirements out in too much detail, and may in fact demand too much of students at too early a stage. Students should be expected to reach a certain level before seeing 'real patients' without direct supervision in the pre-registration year (or any equivalent stage of learning in future). This could be achieved via a modified version of the stage 1 competencies. The stage 2 competencies to be demonstrated by the end of training would also benefit from review.

New outcome requirements should give educational providers the flexibility to meet changing demands and developments. The requirements should enable innovation while ensuring that common learning outcomes, including clinical and critical thinking skills, are embedded across course content – within and across different institutions.

In practical terms we are not sure how these learning outcomes would fit within the high level Education Standards that the GOC is proposing (concept 1). More explanation of this detail will be needed.

Concept 4: Links to Continuing Education and Training

Consultation question 6 - What do you see as the merits to removing the current link between CET and our education requirements, if any?

We support the removal of the link between CET and education requirements. The CET system overall needs to be reformed, as the GOC already accepts. It makes sense to focus the CET scheme on the Standards of Practice as this is the framework within which all registrants must practise. This is also consistent with setting education learning outcomes which are linked to the Standards of Practice, and would provide a common approach to learning requirements for registrants and students.

Removing the link to education requirements could also help the CET scheme to foster professional development amongst registrants. The continuous education requirements on registrants should build and develop new clinical skills, as well as maintaining and validating existing skills.

Consultation question 7 - Do you envisage any disadvantages or risks in this approach, and if so what are they?

We do not see any specific disadvantages to this approach. Its success will depend on how well the new CET scheme is designed and operated.

Concept 5: Educational Content

Consultation question 8 - What do you see as the key changes needed to the current content of optometry programmes and dispensing optician programmes to ensure our future requirements are fit for purpose?

Our response to the call for evidence argued that course content for optometry should cover core clinical and scientific skills, and enable the evaluation of evidence, critical thinking and self reflection. This is still our view.

The GOC has said that it is exploring certain cross-cutting aspects in advance of stakeholder consultation. Of the list of cross-cutting issues set out on page 20 of the consultation paper, we believe that the most important for the education of optometrists are:

• the skills of confident clinical decision-making and application of evidence-based practice;
• the need for professionals to communicate effectively with patients, carers, other professionals and the wider health system and optical sector; and
• monitoring and promoting public health.

We think the GOC should construct its future education requirements in a way that puts these skills and priorities at the centre of professional training for optometrists. It should avoid specifying curriculum content in any more detail than is required by outcome-based high-level standards. Education providers should be able to develop innovative course content in collaboration with the sector, as long as this is consistent with the GOC's education standards and learning outcomes. astonOverspecification could restrict innovation and might not keep up with changing practice and technology.

Concept 6: Enhanced clinical experience for students

Consultation question 9 - Do you agree or disagree with the concept of embedding clinical elements of education and training progressively from the outset of programmes?

Agree.

Consultation question 10 - Tell us more about your views on this concept.

We support an approach that would provide students with a more varied clinical experience in different modes of practice during their education. Working in different clinical environments should better prepare students for future changes in service delivery and different career paths. We would not support an approach that relied on experience of a limited range of clinical environments.

However, there are a number of practical factors to consider in any move to widen students' clinical experience in this way. Educational institutions would need to build relationships with a diverse range of employers, and would need to work closely with these employers to ensure that students are appropriately supervised, that they reflect on their practice and that learning from clinical experience is embedded. This in turn would have cost implications.

In our response to the call for evidence we noted that views differ as to whether there should be more patient contact in educational programmes. We note that education already includes patient contact, probably more than in the past. Clinical experience needs to be phased according to the level of experience of students and their journey towards registration. The same principle would need to apply to students receiving enhanced clinical experience in different modes of practice.

We also note that there is little evidence that more patient contact, of itself, leads to better university graduates. The current patient minima requirements are not evidence-based. They encourage box-ticking and are resource-intensive for providers, diverting resource from other valuable teaching activities. We must be careful that 'real patient' contact at undergraduate level is not seen as a panacea. It may not supply the range of clinical, decision-making and communication challenges that students need to be prepared for. Some real patient experience at undergraduate level is important but simulation has a number of advantages[3]. The GOC approach should not be prescriptive, but allow providers to design learning pathways which they can show meet the higher level learning objectives discussed in our response to concept 5.

Consultation question 11 - What do you foresee as being any positive or negative impacts on students, education providers, employers, patients and carers from taking a hybrid approach?

As discussed in our response to question 10, we support students receiving more diverse experience in different modes of practice. However, there is also an argument that students undergoing more and therefore shorter placements may gain less from the overall experience, since hosting organisations may have less of an incentive to invest time in students on shorter placements. Hosting organisations may also be unwilling to pay students for their time; this would of course not be welcomed by students who currently expect to receive a salary during their pre- registration placement.

As we discuss in our response to question 10, there will also be challenges for educational institutions in managing student experience in a greater range of clinical settings. This has the risk of adding pressures and costs to the overall programme. It may be difficult for providers to deliver much more clinical experience under the current funding structures.

Conversely, a hybrid approach which only exposed students to a limited range of clinical environments would not prepare students for the challenges they will face in their future careers.

Concept 7: National registration examination

Consultation question 12 - Do you agree or disagree with the concept of a national registration examination?

Disagree.

Consultation question 13 - What are the merits and risks of this concept?

The consultation paper discusses whether to "retain the principle" of a national standardised examination or assessment for registered roles. We note that at present there is not in fact a single common assessment route for optometrists joining the register. Manchester University already offers a degree which leads straight to registration, although the large majority of prospective registrants complete the Stage 2 assessment via the College of Optometrists.

We think it is clearly necessary to have common national standards for the registration of optical professionals, and robust, externally monitored verification that prospective registrants have all the necessary skills and experience, of the kind currently provided for the large majority of optometrists by the College of Optometrists' independent OSCE. That verification could take the form of an examination, but does not have to.

In principle it could be argued that any provider that can satisfy the GOC of its competence should be able to provide the final assessment before registration. However, this would not necessarily maintain public confidence that the training of optical professionals is subject to robust verification. A more fragmented approach to assessment at the registration stage could also have the unintended consequence of affecting the viability of the current assessment routes offered by established providers such as the College of Optometrists and ABDO. That in turn might have implications for the important wider work both bodies do for the optical sector.

There is a risk that a single national examination could encourage 'teaching to the test' and so work against the GOC's aim (which we support) of focusing on outcomes and promoting innovation in education. We therefore suggest that the way in which the GOC specifies and monitors any new national standard for registration should have the same focus on outcomes as the proposed new standards for education providers (concept 1).

Concept 8: Multi-disciplinary education

Consultation question 14 - How feasible would it be to develop inter-professional and multi-disciplinary elements of study within optometry and dispensing optician education programmes?

As we said in the AOP's response to the original call for evidence, we support the concept of a modular education model which would allow optometrists and DOs to benefit from joint study alongside other eye health (and other) professionals where there are genuine common elements to their training. Students should be taught to develop skills that will allow them to adapt to changing professional requirements during their career.

We agree with the comment in the GOC's consultation paper that the practical feasibility of developing education content on these lines will depend on the existing pattern of education provision in different providers. We note that it will also be affected by any changes flowing from the GOC's intention to review educational content (concept 5).

Consultation question 15 - Tell us about any examples you know of already in other disciplines from within or outside the UK?

Education providers will be best placed to give a comprehensive answer to this.

Concept 9: Duration of education and training programmes

Consultation question 16 - What do you see as the strengths and weaknesses of retaining the current minimum duration as described above?

We note that at present there is no formal minimum duration for the education and training of optometrists. Rather, there is a general assumption that a BSc will take at least three years to complete, and the subsequent pre-registration training will take around another year. We think this will remain appropriate for most students.

In practice we can see that it may be viable to deliver the required education and training in less time than the current four years. This could be attractive both to prospective registrants (who could benefit from a lower level of student debt) and to employers. However, the potential for this will depend on how far the current requirements may change as a result of the GOC's intention to review the content of education programmes leading to registration (concept 5), and the intention to introduce enhanced clinical experience for students (concept 6).

As with the concept of a single national examination (concept 7), the key thing will be to ensure that education and training produces professionals of the required standard – people who are rounded, mature and have the necessary clinical, critical thinking and communication skills. It may be challenging to give students the necessary experience to meet this standard in a shorter timeframe than at present. The academic ability of the student intake will also be a consideration here.

Consultation question 17 - What could be done differently in order to ensure students become competent, confident and safe beginners?

See response to question 16.

Concept 10: UK educational routes to registration

Consultation question 18 - What do you see as the opportunities for more flexibility between the education of different regulated and non-regulated optical professions?

In principle we support the concept that professional education should enable people to move between different optical roles. As we said in our response to the call for

evidence, we can see the value of having fewer divisions between professional groups, both in optics and in primary care more widely. Over time we think functions will become more important than titles, although the pace of change may be slow.

The opportunities for creating more flexibility between the education and training required for the regulated optical professions, like the scope for changing the duration of training, will be affected by the GOC's intention to review the content of education and training programmes leading to registration (concept 5) and to introduce enhanced clinical experience for students (concept 6). The GOC should bear this in mind when considering how the future education of the registered professions should develop.

The scope for enabling more flexibility between regulated and non-regulated professions may also be affected by the development of training for non-regulated roles. For instance, the new Optical Assistant level 2 apprenticeship standard in England could in time be supplemented by higher level apprenticeships, potentially including an apprenticeship for a more clinically-orientated 'clinical assistant' role. It will be important for the GOC's emerging thinking on this to keep pace with developments for non-registered roles.

Consultation question 19 - What are the constraints and risks to this?

There may be a tension between the GOC's intention to move to a more outcome-focused approach to education requirements (concept 3) and the aim of promoting flexibility between roles during education, unless an understanding of different optical roles is itself specified as one of the required outcomes of education and training. The scope to build links between different roles may also be limited by the differing practical and academic requirements of the training required for each role. For example, education and training that is predominantly vocational would be inappropriate in most cases for registration in an optometric role. The type of skill, knowledge and behaviours that allow clinicians to adapt to the demands of evolving technology, clinical decision making and changing service delivery are best suited to educational delivery with strong academic and scientific components.

We also note that the education and training requirements for each optical role should be proportionate and avoid unnecessary content, in the interests of students (who face cost burdens if courses are longer than necessary) and of employers.
This may limit the scope for education programmes to include interesting but non-essential material which builds links with the work of other professions.

Robust, consistent and accessible systems for the accreditation of prior learning will be particularly important. The GOC will need to take into account the various different non-registration optical training programmes and qualifications that exist across the UK nations.

Concept 11: Proportionate quality assurance

Consultation question 20 - Are there any other principles and concepts we should consider at this stage in exploring future approaches to our quality assurance processes?

We support the proposal that the GOC should develop a proportionate approach to approval and quality assurance. We think this should be based on careful consideration of the evidence, including the risks associated with quality assurance in this context. The GOC should also design its approach in a way that minimises unnecessary duplication, in accordance with the principles of good regulation.

Consultation question 21 - Please tell us about any direct or indirect impact you can foresee from the concepts and principles we have set out in this public consultation on anyone with protected characteristics?

1 Accreditation and Quality Assurance Handbook: Routes to Registration in Optometry, GOC, 2015 2 GOC Standards Framework, Standards for Optometrists and Dispensing Opticians and Standards for Optical Students, GOC, 2016
3 Bokken L, Rethans J-J, Scherpbier A.J.J.A, van der Vleuten C.P.M., Strengths and Weaknesses of Simulated and Real Patients in the Teaching of Skills to Medical Students: A Review. Society for Simulation in Healthcare, 2008.

Aston Optometry School, Aston University

Aston Optometry School of Aston University responds to the consultation as shown below:

Concept 1: Standards for Education Providers

Consultation question 1 - Do you agree or disagree with us further exploring the concept of new Education Standards in the way we describe above?

Agree.

Consultation question 2 - Please tell us more about your views on this concept, including any opportunities or risks you foresee.

In the light of projected changes to future optical practice it is sensible to reconsider Educational Standards in this way. Introducing new Education Standards would enable the profession to re-emphasise the central tenet of the GOC: patient safety. We would welcome increased focus from the GOC in ensuring that education providers are translating relevant contemporary scientific and pedagogical research into programmes, and drawing upon developments in educational practice.

Regarding a future requirement for education providers to collaborate with other programmes of health professional education, we broadly agree that inter- professional learning is an important element of a modern health care degree course. However, prior to implementation, the GOC need certainty and perhaps an evidence-base that other professions are willing and able to engage in these bilateral activities, and that there is a clear and explicit purpose/ rationale for this interaction.

With respect to the key statement that '*Insufficient clinical competence, confidence and professional willingness among optical professionals to undertake new roles…is seen to be linked to the content and structure of existing education and training,"* it is important that available empirical evidence, along with other factors in addition to education, which could contribute to problems in these areas, are explored. A lack of clinical competence amongst newer registrants is not apparent from a review of General Optical Council disciplinary and fitness to practise hearings between 2001 and 2011 (Forte, 2015), which highlighted a very small number of cases compared to the overall numbers of registrants, and revealed that the longest-registered practitioners were most likely to be involved in clinically- based hearings.

Universities currently engage well with external stakeholders e.g. we invite stakeholders from all parts of the sector to contribute to the delivery of our programmes. However, when considering the point '*developing active relationships with employers/service provider bodies'* we feel further clarity of the phrase '*active relationship*' is required to determine whether this is a valid concept.

In response to the Call for Evidence comments concerning '*new and different approaches to the delivery of education'*, UK HE institutions already adopt many innovative ways of delivering their course material. Examples from our own Optometry School include:

1. e-learning – a significant amount of material currently delivered at Aston Optometry School is via an e-learning platform (e.g. the Virtual Learning Environment, Blackboard), which, in turn, supports more interactive face-to-face teaching sessions. If used exclusively, however, there are potential risks associated with student disengagement (Maltby and Mackie, 2009), and perhaps with the security of examinations if delivered solely via an e-learning platform. A potential reduction in opportunities for peer interaction may also arise, which would be particularly concerning for a professional qualification such as optometry.

2. Blended learning – as defined by the Higher Education Academy (2017), blended learning is *'the combination of face-to-face with online activities in a seamless way'*. Clearly there are a range of ways in which this could be delivered, which sees a modification of the relative balance and emphasis of these activities. We already employ this approach; however, we would also support more diverse methods which may enable apprenticeship-style programmes.

3. Part-time – Opportunities for part-time learning would be welcomed as the modality would provide greater flexibility for learners, particularly for those with parental/ caring responsibilities; however, this could be challenging for education providers and regulators as it limits how responsive one can be to changes in the professions and the needs of our patients. Also, there are challenges surrounding credit validity over a 6 year (or more) period of time. One would need to ensure that the theoretical and clinical abilities obtained in the earlier stages of the programme remain valid in the latter stages of a part-time programme.

4. Earn-as-you-go etc. –if this terms refers to apprenticeships, then yes, this is a progressive method for programme delivery; however, restraints on funding via the Governments apprenticeship levy need to be considered.

Concept 2: Education Standards and Professionalism

Consultation question 3 – Do you agree or disagree with the concept of informing our education requirements by our professional standards?

Agree.

Consultation question 4 - Please tell us more about your views on this concept, including any opportunities or risks you foresee.

We agree that the Standards of Practice should form a central pillar of values for any future Education Standards, but these Education Standards should provide more detailed and tangible clinical outcomes against which students could be measured.

Concept 3: Learning Outcomes

Consultation question 5 - What are your views on the concept of system-wide learning outcomes for optometry and dispensing optician education and training, instead of an educational competency-based approach?

Although some elements of the current competency-based approach are rather

prescriptive and limit how flexible providers can be in the delivery and assessment of programmes, the granularity provided by the competencies, and the minimum requirement prescribed by the numbered patient episodes, ensures that the underpinning syllabus is covered and assessed in its entirety, and that students remain engaged in the course throughout its duration. Competencies and patient numbers also provide students with a transparent framework of clinical and academic benchmarks to work towards throughout their course. Ultimately, some framework must exist against which students can be assessed consistently across all UK Optometry Schools and other education providers.

Concept 4: Links to Continuing Education and Training

Consultation question 6 - What do you see as the merits to removing the current link between CET and our education requirements, if any?

Rather than removing any link, we believe the requirements for registered practitioners should be strengthened to ensure they remain up-to-date with all elements of clinical practice. Perhaps the emphasis should be to promote continuous development of clinical skills and knowledge acquisition through a professional CPD scheme. At present, the system is rather "tick box" and prescriptive- a more flexible system would allow registrants to undertake CPD activities relevant to their individual roles, promoting learning beyond the basic competencies and "upskilling" where appropriate.

Consultation question 7 - Do you envisage any disadvantages or risks in this approach, and if so what are they?

Such an approach would involve a significant change in mind set by registrants, with more personal planning of development activities and maintenance of CPD records. A broader framework of development areas (rather than many specific competencies) would enable registrants to plan their CPD and ensure that their activities are genuinely contributing to personal development. Part of this framework could involve maintenance of entry-level skills and knowledge, but with the overall emphasis on personal development (aligning with the concept of lifelong learning). Rather than a system of checking every registrant's points in each area, an audit-style system could be used whereby practitioners are required to maintain their own records and submit them upon request to the GOC.

Concept 5: Educational Content

Consultation question 8 - What do you see as the key changes needed to the current content of optometry programmes and dispensing optician programmes to ensure our future requirements are fit for purpose?

Before considering what changes might be required to current programmes, it is important to highlight that in recent years, the content and delivery of optometry programmes has changed substantially in response to mutable trends in practice; this is undertaken on an annual basis through adoption of critical reflective practice. For example, at Aston Optometry School:

- from their first week, undergraduate optometry students develop key clinical skills;
- professional values are interwoven throughout the degree programme;

- students learn how to use a goniolens and interpret the resultant clinical findings;
- contact lens teaching is at the vanguard of clinical practice where techniques are often taught before they are adopted by the profession;
- students are trained in first aid;
- virtual patient simulators have been developed to reinforce clinical understanding and decision making;
- students undertake specialist clinics in areas such as paediatrics, low vision, special educational needs, myopia, dry eye, medical retina;
- the use, interpretation and management of patients using optical coherence tomography (OCT) is embedded throughout the programme; and
- with increasing emphasis on professionalism, we have already rooted these attributes in the programme by creating core modules called 'Personal Professional Development' and 'Continuing Professional Development.'

Predicting the future is always challenging. However, there are projected changes to patient demographics e.g. an ageing population, which will impact the way optical services interact with patients.

Given the points outlined, above, we would consider the following additions:

- Enhance training in management of patients with additional needs (including SEN and acquired disorders such as dementia, stroke and other cognitive loss).
- Paediatrics is often underrepresented during the course of the current 4-year structure- an increased emphasis could be placed on this field.
- Provide exposure to domiciliary practice.
- Encourage genuine critical reflection and peer support/ mentoring as core elements of professional practice.
- Embed equality and diversity training throughout programmes.
- Promote development of students' management and leadership skills.
- Add emphasis on clinical governance to optimise standards of patient care.

Concept 6: Enhanced clinical experience for students

Consultation question 9 - Do you agree or disagree with the concept of embedding clinical elements of education and training progressively from the outset of programmes?

We feel the options of 'agree', 'disagree' or 'don't know' are insufficient to respond to Concept 6. The issues raised are far too complex and multifactorial. We therefore detail our thoughts in the following questions.

Consultation question 10 - Tell us more about your views on this concept.

We agree that embedding clinical experience throughout the road to registration is important. Indeed, this is something education providers already do as appropriate and in line with the experience of the student at each stage of their development. Moving forward, one could imagine '*practice experience*' to include, but not exclusively, the

use of patient simulators and peer-to-peer interactions in the early stages of training, leading to more integrated 'real-world' exposure to live patient episodes at the culmination of training. Importantly, to gain varied '*practice experience'* and mitigate a perceived risk of the main body of practice-based training taking place in one location in the fourth year, it would be essential for all students to experience multiple types of environment during placements. Given that there are over 3,500 optometry students in the UK alone, would this be feasible if placements become mandatory in all years of study? It is also worth remembering that there is considerable merit in developing these practical skills with peers (and associated peer review) in a pre-clinical university environment, which enables group work and therefore the development of teambuilding skills. Also, with multiple practice placements, it would be challenging to ensure equality of experience and standardised monitoring practices.

We do not support the notion that taking a more hybrid approach to undergraduate education would result in an inevitable move away from the current pre-registration period. The independent Scheme for Registration currently run by the College of Optometrists reassures the general public that despite a range of undergraduate courses, the profession can demonstrate consistency of standards at the point of registration.

Consultation question 11 - What do you foresee as being any positive or negative impacts on students, education providers, employers, patients and carers from taking a hybrid approach?

Students

The perception of using clinical skills from an early stage is appealing; however, this must be tensioned against the reality that many Year 1 students do not yet possess the necessary clinical and/ or theoretical capabilities. What may transpire is that students end up performing administrative/ non-clinical tasks, or being a passive observer on placements, which may isolate them in the external environment.

Again, perhaps a more appropriate model would be to ensure that early experiential learning takes place within well-supervised HE environments. Given the current funding model also requires students pay (albeit in a deferred way) for their degrees, too much time in industry could be perceived badly by students if they feel they are being exploited as free labour; clear guidelines would need to be established to mitigate this concern. Industrial practice experience may also be challenging for some students if their placements are located away from their home region; this may be particularly problematic for students with parental and/ or carer responsibilities, and those with limited financial resources.

Education providers

As outlined previously, we already undertake many of these proposals, but any changes to the current system must be demonstrably better that the current system for students and their patients. In practical terms, the reality of getting sufficient numbers of practical episodes in a range of high-quality external placements, would be extremely challenging to acquire, monitor and ensure equity of student experience both within and between HE institutions.

Employers

There are significant challenges for employers with this model in that they will

collectively have to accommodate placements for over 3,500 optometry students alone. To ensure a high-quality experience for the students, the financial and time cost to practices would be enormous and possibly prohibitive; impacting all staff members. Also, are staff suitably trained and qualified to educate and supervise undergraduate students? Would they all need to undertake formal training as now required by teaching staff employed in the HE sector?

Patients and carers

Additional checks will be necessary to ensure that patients and their carers consent to students with variable levels of experience performing clinical procedures or observing consultations. There are no benefits for patients and carers if students are practising unrefined clinical skills.

Concept 7: National registration examination

Consultation question 12 - Do you agree or disagree with the concept of a national registration examination?

Agree- the current Scheme for Registration is a perfect example of this standardised approach.

Consultation question 13 - What are the merits and risks of this concept?

Details regarding a possible new national registration examination have not been provided, making it impossible to judge the merits and risk of the proposed approach. Crucially, in order to protect the public, any new national registration examination must be as robust as the current scheme of assessments undertaken by pre-registration optometrists.

Concept 8: Multi-disciplinary education

Consultation question 14 - How feasible would it be to develop inter-professional and multi-disciplinary elements of study within optometry and dispensing optician education programmes?

It is clear that interprofessional learning (IPL) experience is becoming an increasingly important element of healthcare training (e.g. de Oliveira et al., 2018; Saunders et al., 1018). In the context of optometry, IPL provides a route to increase knowledge of the roles and responsibilities of other professionals; build interprofessional team working skills; broaden understanding of patient management; and, when working with medical professions, develop a greater understanding of the NHS. Furthermore, IPL may reduce the risk of patients who receive care from a range of professionals experiencing problems linked to poor communication and collaboration between healthcare providers (Olson and Bialocerkowski, 2014).

In practice, it is essential that there are clear ground rules so that each profession engaged in the process can demonstrate and measure meaningful learning outcomes. It has been recommended that health profession regulators jointly agree and publish a statement regarding the requirements of pre-qualification IPL (Barr et al., 2014). A recent mapping of outcomes for pre-qualification IPL (Steven et al., 2017) considered

the requirements of five UK health profession regulators (GMC; NMC; GPhC, GDC and HCPC), but did not include the GOC- it is essential that optometry is not left behind as progress is made nationally in this field. For optometry education providers to facilitate meaningful IPL, the profession must be recognised by other professions as a valuable collaborator- work is likely to be necessary above the level of individual education providers to achieve this.

Some undergraduate institutions may find IPL challenging if they do not deliver complementary healthcare courses and/ or have limited engagement with secondary care. Clearly, in any IPL arrangement it is crucial that both sets of professionals experience the challenges and opportunities of the corresponding profession. To that end, future IPL activities must ensure that optometry students are not merely passive observes of other professionals.

Consultation question 15 - Tell us about any examples you know of already in other disciplines from within or outside the UK?

Olson and Bialocerkowski (2014) report in a systematic review of pre-qualification IPL in allied health programmes many examples in the USA, Canada, UK and Ireland. Health professions included dentistry; diagnostic imaging; medicine; nursing; pharmacy and physical therapy. It has been argued that transferability of IPL activities and effectiveness across professions, institutions and countries cannot be assumed (Richards, 2003).

Concept 9: Duration of education and training programmes

Consultation question 16 - What do you see as the strengths and weaknesses of retaining the current minimum duration as described above?

The current format of most UK optometry degree programmes is 3 + 1 years, that is to say a 3 year BSc degree plus 1 year (normally) in practice as a pre-registration optometrist. Of course, other modalities also exist in the UK. A 4 year degree course (with an additional period/ year in pre-registration practice) would be a significant financial burden on trainees, potentially reducing how attractive the profession is to new, high-quality applicants, which, in the medium- to long-term, would be challenging for the profession. However, the additional year would enable education providers to augment their courses to reflect the changing nature of primary and secondary optometric practice. This approach would further strengthen the high standards of optometric education in the UK, and provide further opportunities for experiential learning prior to the pre-registration period.

Whilst shorter duration courses currently offered in the UK designed to upskill opticians are appropriate and useful, we do not subscribe to the notion of 2 year degrees for applicants fresh from tertiary education or without any prior optical qualification(s).

Consultation question 17 - What could be done differently in order to ensure students become competent, confident and safe beginners?

The current system ensures that entrants to the profession are safe to work. Challenges may occur when pre-registration students and newly qualified practitioners

are expected to see large numbers of patients each day, rather than building their patient numbers and confidence on a more gradual basis. The GOC could look to regulate working patterns of trainees and newly-qualified practitioners, perhaps by introducing a maximum number of patients per hour/ day, and/ or by requiring newly-qualified registrants to work in conjunction with a more experienced practitioner to avoid issues related to a lack of peer support.

Concept 10: UK educational routes to registration

Consultation question 18 - What do you see as the opportunities for more flexibility between the education of different regulated and non-regulated optical professions?

We believe that unnecessary constraints for progression should be minimised. Indeed, flexibility already exists in this regard e.g. the route for dispensing opticians to train as optometrists; APL; and other career progression opportunities. However, with this flexibility, it is important is ensure the candidate's aptitude remains a central pillar for progression from one programme/ discipline to another. Moreover, used in isolation, APL can be a blunt tool to gauge ability and thus enable progression.

Consultation question 19 - What are the constraints and risks to this?

Appropriate and detailed assessment tools (e.g. portfolios or structured interviews) would need to be used to consider individuals' prior learning (QAA, 2018) and whether it is suitable for entry onto programmes, or for recognition in terms of credits. For recognition involving the award of credit, skills and knowledge would need to be evidenced at the appropriate level, and align with the credit level descriptors detailed by the QAA. There is a risk in "group exemptions" where although the experiences of a group may be broadly similar, individuals' learning from it (and the exemptions to which they may be entitled) could differ.

Concept 11: Proportionate quality assurance

Consultation question 20 - Are there any other principles and concepts we should consider at this stage in exploring future approaches to our quality assurance processes?

- Ensure a consistent approach to quality assurance between education providers.
- The increasing number of education providers. Linked to the first point, above, continuation of this upward trend will by definition increase variability of training and, perhaps, will make it more difficult to reassure the general public that standards are upheld and consistent across all.

Consultation question 21 - Please tell us about any direct or indirect impact you can foresee from the concepts and principles we have set out in this public consultation on anyone with protected characteristics?

Given the proposed hybrid modality, equality and diversity policies would need to be as stringent in practice as in universities.

References

Barr H, Helme M, D'Avray L. (2014). Review of Inter-professional education in the United Kingdom 1997–2013: Centre for the Advancement of Inter-professional Education.

de Oliveira VF, Bittencourt MF, Navarro Pinto ÍF, Lucchetti ALG, da Silva Ezequiel O, Lucchetti G. (2018). Comparison of the Readiness for Interprofessional Learning and the rate of contact among students from nine different healthcare courses. Nurse Education Today. 63:64-68.

Forte JC. (2015). Survey of General Optical Council disciplinary and fitness to practise hearings: 2001-2011. DOptom thesis, Aston University http://publications.aston.ac.uk/28816/1/Forte_Josie_2016.pdf

Higher Education Academy (2017). Blended learning. Available online at: https://www.heacademy.ac.uk/knowledge-hub/blended-learning-0 (accessed 14/03/18).

Maltby A, Mackie S. (2009). Virtual learning environments – help or hindrance for the 'disengaged' student? ALT-J, Research in Learning Technology 17(1), 49–62

Olson R, Bialocerkowski A (2014). Interprofessional education in allied health: a systematic review. Medical Education 48: 236-246.

QAA (2018). UK Quality Code for Higher Education, Part B: Assuring and Enhancing Academic Quality. Available online at: http://www.qaa.ac.uk/assuring-standards-and-quality/the-quality- code/quality-code-part-b (accessed 14/03/18).

Richards LV. (2003). Evaluation in medical education: moving forward. Medical Education 37:1062– 3.

Saunders R, Dugmore H, Seaman K, Singer R, Lake F. (2018). Interprofessional learning in ambulatory care. Clin Teach. Feb 12. doi: 10.1111/tct.12764. [Epub ahead of print]

Steven K, Howden S, Mires G, Rowe I, Lafferty N, Arnold A, Strath A. (2017). Toward interprofessional learning and education: Mapping common outcomes for prequalifying healthcare professional programs in the United Kingdom, Medical
Teacher, 39:7, 720-744.

Cardiff University

Cardiff University responds to the consultation as shown below:

Concept 1: Standards for Education Providers

Consultation question 1 - Do you agree or disagree with us further exploring the concept of new Education Standards in the way we describe above?

We agree with the concept of exploring the modernisation and development of overarching Education Standards.

Consultation question 2 - Please tell us more about your views on this concept, including any opportunities or risks you foresee.

It would be helpful if the proposed new standards were scrutinised and discussed in a public consultation, with all stakeholders having the opportunity to be involved in their development. This would help ensure that the new requirements for education providers are achievable, driven by high level learning outcomes (Concept 3 – Learning outcomes), and supported by high quality educational research evidence. The providers of education will also be well placed to help develop methods of assessing how education providers meet the standards.

Concept 2: Education Standards and Professionalism

Consultation question 3 – Do you agree or disagree with the concept of informing our education requirements by our professional standards?

We agree that the professional Standards of Practice should inform curriculum design, teaching, learning, assessment and outcomes for optometrists and dispensing opticians.

Consultation question 4 - Please tell us more about your views on this concept, including any opportunities or risks you foresee.

We acknowledge that the GOC's 19 Standards of Practice relate to clinical care of patients. However, universities have wider and longer term educational aims besides the relatively short term objective of producing a competent newly qualified vocational practitioner. For example, education must facilitate development of strong scientific literacy and lifelong independent study skills, both of which are vital for future-proofing safe care for patients in a rapidly developing clinical world. Additionally, pure clinical teaching without an understanding of the fundamentals of pathology or vision science would mean that optometrists will not be at the forefront of research to enhance the profession or our understanding of diseases and treatments. Scientific understanding is not reflected in the current Standards of Practice, therefore there will be other principles which must underpin educational programmes and outcomes besides these standards. If the GOC expects the standards to overarch all the new educational requirements then a review of the professional standards would be needed.

Concept 3: Learning Outcomes

Consultation question 5 - What are your views on the concept of system-wide learning outcomes for optometry and dispensing optician education and training, instead of an educational competency-based approach?

We support the concept of high level learning outcomes to define what trainee practitioners must demonstrate they can do at a given stage of their training e.g. on graduation or at registration. The current input driven approach has resulted in a reductionist and rather mechanistic approach to assessment at times. There is potential for the GOC's quality assurance processes to be strengthened and more consistently applied in assessing students' attainment of broader learning outcomes, rather than assessing students' attainment of current Stage 1 and 2 competencies.

Any new learning outcomes should be sufficiently clear as to what range of clinical risk a newly qualified practitioner is expected to manage confidently and autonomously.Professionals who have a detailed understanding of different levels of patients' clinical risk should therefore be amongst those responsible for defining any new high level learning outcomes. This would include optometric educationists and advanced clinical practitioners who are experienced in teaching the diagnosis and management of ocular conditions across a range of disease complexity.

Dispensing opticians and optometrists should have different learning outcomes given their different professional skills and responsibilities.

We favour extending the discussion beyond defining learning outcomes, and consider in addition what would be needed to fully implement outcome-based education. This is now well established in other healthcare educational programmes such as medicine, and bases all curriculum and assessment-related decisions around defined learning outcomes (Davis et al. 2009; Harden 2009). If universities were to implement full outcome-based education, we recognise that the transition would be complex, could take years and could carry potential risk of failure if sustained additional funding were not available to education providers. Alternatively, if successful, outcome-based education would provide incentives and opportunities to innovate in teaching, learning and assessment, and would better allow providers to be responsive to changing future educational needs of the profession.

Davis, M.H. et al. 2009. Case studies in outcome-based education. Medical Teacher, 29:7, 717-722. doi: 10.1080/01421590701691429

Harden, R.M. 2009. Outcome-Based Education: the future is today. Medical Teacher, 29:7, 625-629. doi: 10.1080/01421590701729930

Concept 4: Links to Continuing Education and Training

Consultation question 6 - What do you see as the merits to removing the current link between CET and our education requirements, if any?

Consultation question 7 - Do you envisage any disadvantages or risks in this approach, and if so what are they?

We support the promotion of CPD rather than CET so that optometrists and dispensing opticians may grow as professionals throughout their careers. Current CET is set at entry level which does not provide an incentive for professional development.

The design would need to take into account practitioners who may be below an entry level standard in some clinical areas, so that they are adequately supported and their needs not overlooked.

If CPD were referenced to the current Standards of Practice, it is likely that these standards will not cover all areas that may be relevant for a practitioner's CPD needs (see response to Concept 2 – Educational standards and professionalism).

We note that the lack of career structure within both primary and secondary care clinical optometry could be a barrier to implementing effective CPD, with currently limited or no structured career development or increased remuneration for practitioners who take on extended roles and clinical risk.

Concept 5: Educational Content

Consultation question 8 - What do you see as the key changes needed to the current content of optometry programmes and dispensing optician programmes to ensure our future requirements are fit for purpose?

The entry level standard required of optometrists has not kept pace with changes in how optometrists contribute to eye healthcare. We agree that whereas the traditional optometry model was 'detect and refer' in regard to ocular disease, now the emphasis has evolved to 'diagnose and manage'. Curriculum design and delivery must reflect this.

Before curriculum content is decided, education providers will need to know:

- What are the new learning outcomes?
- What level of clinical risk should a newly qualified practitioner be competent and confident in taking on?

Notwithstanding the above, experience suggests that the following may be suitable to include or improve within an undergraduate programme:

- Clinical reasoning and clinical decision making studied throughout
- Evidence based practice including improved competence in statistical analysis and interpretation
- Self-directed study skills throughout
- Use of electronic patient records including e-referral
- Basic and clinical science relevant to therapeutic prescribing studied in more depth than currently e.g. pharmacology, microbiology, immunology, pathophysiology, systemic health
- Cataract pre and post-surgery management
- Minor eye conditions management
- Ocular hypertension and glaucoma suspect monitoring to the level of the College of Optometrists' professional certificate in glaucoma, currently studied at postgraduate level
- Low vision assessment to the level of the College of Optometrists' professional certificate in low vision, currently studied at postgraduate level

As we detail below for Concept 6, we support the development of an integrated curriculum with a spiral approach which reinforces basic and clinical science learning with clinical training from the start of Year 1.

Regarding use of technology in optometry, it must be noted that certain patients, for example vulnerable groups, will not be able to use some equipment such as autorefractors or ocular imaging tools. It is therefore essential that the highest standards of core skills such as refraction and ocular examination continue to be core in the optometry curriculum.

Independent prescribing (IP) for optometrists will be considered for both undergraduate and postgraduate education. The term 'therapeutic prescribing' is not used synonymously with 'independent prescribing'.

IP Undergraduate: it is imperative that students improve their knowledge of basic and clinical science relevant to therapeutic prescribing, and learn to diagnose and manage ocular conditions before they are permitted to prescribe therapeutic agents. Depending on the complexity and risk level of different ocular conditions, learning to manage them may require more or less clinical experience. For ocular conditions where more clinical experience is required, this may not be possible as part of undergraduate or pre-registration training. In common with other professions such as nursing and pharmacy, the GOC requires that optometrists need a minimum of 2 years' post registration experience before beginning the final part of current IP training. Therefore we do not support full independent prescribing rights for newly registered optometrists as the lack of clinical maturity and experience could pose a risk to patient safety. We do support use of therapeutic agents appropriate to a practitioner's level of experience in managing ocular conditions, which could include some agents being available for newly registered optometrists via other means than independent prescribing. If newly qualified optometrists were trained to be more competent and confident in managing, for example, patients with minor eye conditions, they may be more ready to use existing options for therapeutic agents such as current exemptions or pharmacy medicines where appropriate.

IP Postgraduate: we would strongly support an overhaul of the current pathway for qualified optometrists to train as independent prescribing optometrists. We advocate reducing the core curriculum of the taught elements to remove the theory of ocular disease diagnosis and management (currently anterior segment and glaucoma related conditions). The core IP curriculum could be streamlined to include only relevant basic and clinical science, plus legal, governance and other professional prescribing topics. The ocular disease elements would be more effectively studied separately in a dedicated study programme chosen by the student and relevant to their scope of practice e.g. the College of Optometrists' higher qualifications in glaucoma, or an equivalent nationally recognised qualification, not yet available, for anterior segment conditions. Ocular disease study programmes would need to include sufficient practical experience relative to the complexity and risk level of the ocular condition being diagnosed and managed.

Concept 6: Enhanced clinical experience for students

Consultation question 9 - Do you agree or disagree with the concept of embedding clinical elements of education and training progressively from the outset of programmes?

We agree with the concept of increasing clinical training in undergraduate optometry programmes. We consider this as separate from the concept of potentially removing the pre-registration period with the award of a registerable degree. Each of these concepts will be discussed in turn.

Consultation question 10 - Tell us more about your views on this concept.

1. Earlier clinical training – moving towards an integrated curriculum

We support the aim of increasing early clinical exposure and placements during undergraduate optometry training, provided that:

a) Additional funding is available. For a clinical placement to provide meaningful and genuine learning gain for students, the placement identification, organisation, quality assurance and enhancement, together with support for placement students, supervisors and tutors, will require comprehensive and expensive expertise from education providers (O'Keefe et al. 2012; Ledger and Kilminster 2014). It is highly unlikely that existing university finances will be sufficient to fund the additional time and resources needed for this high level of support.

b) Research is conducted into the feasibility of education providers finding sufficient hospital placement opportunities. It is our experience that access to suitable hospital placements for ocular disease diagnosis and management is extremely difficult in many parts of the UK – and it is these placements that are most needed to provide training for an enhanced clinical role for optometrists e.g. for independent prescribing or glaucoma related conditions (see response to Concept 5 – Educational Content). It would be helpful if early adopters could be evaluated so that good practice and problem areas could be shared, to avoid failure when upscaling hospital placements for large numbers of students. This would reduce the risk of this significant cross-institutional change.

c) The number and nature of placements is not prescriptive. Education providers must be able to choose how to offer their students placement experience in accordance with their curriculum design, local availability and students' requirements. Any additional placements should not destabilise existing circumstances where they are working well. For example, many students already undertake paid employment (effectively a form of 'self–sourced paid placement') in optometry practices during term or holiday time. If there is appropriate support in the practice and clear objectives that could be signed off, it may be appropriate to incorporate this work as part of students' experience.

d) Sufficient time is given to universities for the transitional period. Increasing external clinical placements within a new integrated curriculum could take a number of years for full implementation.

We appreciate the potential benefits of an optometry curriculum which integrates basic

and clinical science with clinical training, where the ratio of science to clinical training progressively changes over the course of the degree. For example, early on, more of students' time would be spent learning relevant science, whilst towards completion, students will be mainly engaged in clinical work. However, for long term educational benefit, it should be emphasised that relevant scientific theory must be continually revisited and reinforced as the degree progresses, and not left out altogether from later clinical training.

We recognise a truly integrated optometry curriculum incorporating a spiral approach, in which relevant sciences are learnt progressively across time and across different subjects, as a worthwhile aim (Brauer and Ferguson 2014).
Revisiting the underpinning science once a clinical viewpoint has been established promotes a deeper and symbiotic understanding of both scientific and clinical elements. Furthermore, a 'whole mechanism' scientific understanding of clinical work promotes clinical thinking and provides skills for adaptation which will serve to future-proof education in a constantly changing technological and clinical environment.

Brauer, D.G. and Ferguson, K.J. 2014. The integrated curriculum in medical education: AMEE Guide No. 96. *Medical Teacher*, 37:4, 312-322. doi: 10.3109/0142159X.2014.970998

Ledger, A. and Kilminster, S. 2014. Developing understandings of clinical placement learning in three professions: Work that is critical to care. *Medical Teacher*, 37:4, 360-365. doi: 10.3109/0142159X.2014.948830

O'Keefe, M. et al. 2012. Twelve tips for supporting student learning in multidisciplinary clinical placements. *Medical Teacher*, 34:11, 883-887. doi: 10.3109/0142159X.2012.700431

2. Registerable degree and the concept of a pre-registration period

We do not use the term 'registerable' synonymously with 'integrated' or 'hybrid'. We are not supporting mandatory introduction of a registerable degree at this time but believe that it should remain an option for universities as it is at present. We believe the priority for educators should be to develop an integrated curriculum with more placements as part of the degree. To do this well will be a significant challenge in itself. Our preference at this time would be to retain the pre- registration period, not only to avoid too much disruption and hence risk, but also because it takes heed of the medical model which is relevant given that optometrists are increasing their scope of advanced clinical practice (Concept 5 – Educational content). In the medical model, supervision is provided for trainee doctors and is well established as being necessary - it has stood the test of time through many decades of clinical learners and reorganisations of curricula. Whilst there is strong evidence that the introduction of an integrated curriculum with more placements earlier in the education process could achieve the changes the GOC is seeking, we have not found any evidence to support the view that the pre- registration year should be changed or that it is in any way a barrier to driving the changes that the GOC seeks to achieve.

Current strengths of the pre-registration period in optometry:

- Trainees are able to choose their preferred location for a pre- registration position.
- Pre-registration trainees are paid a salary.
- Some pre-registration trainees need longer than others to achieve the standard required to pass the Scheme for Registration (College of Optometrists

2018). Flexibility to support trainees of different abilities who need significantly longer to qualify (sometimes by a year or more) would be difficult or impossible within current university regulations.

Opportunities for improvement:

- Pre-registration students commonly work full time for their employer. If there were more options to work less than full time e.g. 0.7 or 0.8 FTE with the remainder as paid study leave, they could undertake structured study, possibly e-learning, with their university or other education provider. This would reinforce and further develop higher levels of clinical competence (Concept 5 – Educational content) and would be consistent with the spiral curriculum approach described above.

College of Optometrists. 2018. *Pre-registration trainee analysis report June 2014-August 2016* Available at: https://www.college-optometrists.org/qualifying/scheme-for-registration/scheme-for- registration-report.html [Accessed: 9 March 2018].

Consultation question 11 - What do you foresee as being any positive or negative impacts on students, education providers, employers, patients and carers from taking a hybrid approach?

We take 'hybrid' to mean embedding clinical placements earlier in the undergraduate programme.

Potential positives of earlier clinical placements

Students

- Promote professional identity and contextualise students' learning
- Improve communication skills
- Develop skills earlier, therefore more time to practise and adapt to real world scenarios
- Gain exposure to the NHS/ commercial balance of most optometric practice and through discussion with others and self-reflection, develop their understanding of patient-centred optometric practice

Employers

- More advanced and mature workplace skills demonstrated earlier in employees' careers

Patients and carers

- Service users' perspectives could inform and contribute to clinical training

All

- Learning gain from placement could be incorporated into ongoing development and quality improvement of curriculum

Potential negatives of clinical placements

Students

- Potentially vulnerable to any placement issues e.g. relationships with supervisor or other employees, or adapting to the hierarchy or culture of a workplace. Students may need to fit in their placements by working more during holidays.

Education providers

- Insufficient funding. Providers will need to fund students' travel and accommodation as well as the organisation and quality assurance of placements.
- Uncertainty of placement availability in UK primary and secondary care.

Employers

- May not be accustomed to managing and training inexperienced students who lack maturity or have undeveloped skills, whether interpersonal or clinical.

Patients and carers

- May be unwilling for inexperienced students to participate in their care.

All expectations may be unrealistic. Clinical placements alone will not improve care for patients. Very clear objectives for the placements must be set, and providers trained and supported.

Concept 7: National registration examination

Consultation question 12 - Do you agree or disagree with the concept of a national registration examination?

We strongly agree with the concept of a national registration exam for optometrists which is delivered separately from the education providers.

Consultation question 13 - What are the merits and risks of this concept?

Positives:
We consider a national registration examination to be a standardised, equitable and fair assessment which will uphold public confidence in the profession. Except for a very small number of MOptom students in one UK university, a national registration exam - the College of Optometrists' Scheme for Registration (SfR) - must be passed in order to qualify and register as an optometrist in the UK.

In the SfR, the number of trainees that need at least 3 attempts to pass the Stage 2 synoptic assessment of clinical competence (17% of the 2014-2016 cohort) or who take 3 or more attempts to pass the final OSCE (6% of the same cohort), indicate the benefit of including assessment of practical skills (College of Optometrists 2018). Given these statistics which are consistent with the previous year's analysis, we support retaining an element of practical assessment within a high stakes national licensing exam. We do not favour reducing a national licensing exam to an

assessment that assesses only applied knowledge e.g. a multiple choice written assessment based on clinical vignettes, although such assessments could have an important role at all stages of optometric education including the SfR, and could form part of a programme of assessment for national licensing.

We note that the SfR contains elements that can be regarded as additional to a strictly licensing function, namely the structured work-based assessment (Stage 1). In this stage, trainees receive individualised formative feedback from an external College of Optometrists assessor who works together with the trainee and supervisor to support trainees' progress. We support retaining the concept of work based assessment during the pre-registration period, whilst appreciating that the SfR should be able to innovate and optimise its processes in common with other providers.

Potential negatives:

- The possibility of duplication is present. It is important not to overburden students with unnecessary assessments; this could be addressed if all education providers have opportunities to contribute to a holistic assessment design.
- A new assessment will take time to calibrate against new or existing benchmarks; there could be unexpected pass or fail rates.
- High quality assessment design including standard setting, post assessment analysis and quality assurance requires significant time and resource (Ben-David 2000).

Ben-David, M.F. 2000. AMEE Guide No. 18: Standard setting in student assessment. *Medical Teacher*, 22:2, 120-130. doi: 10.1080/01421590078526

College of Optometrists. 2018. *Pre-registration trainee analysis report June 2014-August 2016* Available at: https://www.college-optometrists.org/qualifying/scheme-for-registration/scheme-for-registration-report.html [Accessed: 9 March 2018].

Concept 8: Multi-disciplinary education

Consultation question 14 - How feasible would it be to develop inter-professional and multi-disciplinary elements of study within optometry and dispensing optician education programmes?

Consultation question 15 - Tell us about any examples you know of already in other disciplines from within or outside the UK?

We agree with the principle of supporting optical practitioners in effective inter-disciplinary collaborative working. It is vital that students have appreciation of other professional roles within the ophthalmic sector and also within wider primary and secondary healthcare environments. Although we are supportive of the concept, we favour a non-prescriptive approach, in order to facilitate continued innovation.

Cardiff University has introduced interdisciplinary education in healthcare subjects, and success has been mixed to date. Initiatives have ranged from shared lectures, cross-discipline research projects, through to joint placement opportunities. For university-based cross-discipline lectures, it has proved difficult to provide material or support that is relevant to multiple disciplines, resulting in reduced student satisfaction, diluted

learning outcomes, and significant challenges for staff to manage the different expectations and prior experience all students. Student satisfaction is particularly low in students who already work in relevant practice- based employment, as they may find it difficult to appreciate any additional benefit from a university-organised initiative.

Cross-discipline "grand challenge" research is showing promise at integrating different disciplines, but this typically remains voluntary for students given the challenges involved with scheduling across different Schools and finding relevant subject areas. Cross-discipline placements (e.g. nursing alongside medicine) may be most likely to achieve the aims of developing a collaborative working environment, but this has been difficult in practice because students are typically at different stages of their programmes and are therefore given different levels of responsibility, making it difficult to truly collaborate at the undergraduate student level.

A successful collaboration between the Schools of Optometry and Pharmacy at Cardiff University, in which 2nd year pharmacy undergraduates attend placements at optometric practices, has resulted in positive student feedback. Practice-based interdisciplinary study may therefore provide opportunities for optometry. It is also relevant that most optometry undergraduate students work in optometric practice during their studies, or undertake summer placements and voluntary work with external providers; they then build upon this experience during their pre-registration year. All of these provide collaborative workplace opportunities. It would be useful if this existing experience could be captured and built upon as part of any revised undergraduate training programme, alongside additional opportunities that universities could provide.

Concept 9: Duration of education and training programmes

Consultation question 16 - What do you see as the strengths and weaknesses of retaining the current minimum duration as described above?

The proposed changes are extensive and will require a complete rethink of the curriculum. It will be possible to decide on the duration of training only once the learning outcomes and educational standards have been decided, and the new curriculum built. At that point, education providers will be able to consider programme length in relation to these factors, together with knowledge of their own students' likely abilities and requirements. Therefore, we would recommend that this question is considered only once institutions have had a chance to draft the new curriculum.

We do not support shortening the duration from the current three years plus pre-registration period since it is likely that additional content will need to be added to the curriculum (see response to Concept 5 – Educational content). Therefore any required or recommended minimum duration will be the same or longer than currently, and would principally be a function of the new learning outcomes.

Consultation question 17 - What could be done differently in order to ensure students become competent, confident and safe beginners?

Please refer to our responses to Concept 5 Educational content and Concept 6 Enhanced clinical experience for students.

Concept 10: UK educational routes to registration

Consultation question 18 - What do you see as the opportunities for more flexibility between the education of different regulated and non-regulated optical professions?

Consultation question 19 - What are the constraints and risks to this?

Widening access to optical education is an important strategic aim and value which education providers are already committed to exploring and implementing. There is a risk to this aim as the concepts proposed in this consultation with universities having more flexibility to set their own curriculum could make it difficult for a student to join a programme of study at any point other than the beginning. If a curriculum becomes less modular and adopts a more spiral approach, it may be much more difficult to award APL since some elements could be taught at several time points over the programme. Therefore, for example, it may be difficult for a dispensing optician to join in the second year of an optometry programme because an objective they need to cover is likely to be delivered across all years of the programme.

Concept 11: Proportionate quality assurance

Consultation question 20 - Are there any other principles and concepts we should consider at this stage in exploring future approaches to our quality assurance processes?

Professionals involved in developing and implementing future quality assurance processes should include those who have comprehensive understanding and current experience in clinical and educational practice relevant to any new learning outcomes. This will help ensure the appropriate level of scrutiny required to ensure patient safety, and assist the recognition and highlighting of areas of excellence and innovation in educational practice.

Setting up quality assurance processes should be integral to the education strategic review so that there is a) clarity over how education providers will be required to demonstrate that they are meeting any new education standards and b) assurance that the new education standards are assessable in practice.

Consultation question 21 - Please tell us about any direct or indirect impact you can foresee from the concepts and principles we have set out in this public consultation on anyone with protected characteristics?

Any requirement to attend clinical placements away from home could be difficult for some students who have health issues or disabilities, or are at an age where they are more likely to have family or caring responsibilities.

If students are required to pay an extra year of fees, this could be prohibitive for some.

College of Optometrists

The College of Optometrists responds to the consultation as shown below:

Concept 1: Standards for Education Providers

Consultation question 1 - Do you agree or disagree with us further exploring the concept of new Education Standards in the way we describe above?

Agree.

Consultation question 2 - Please tell us more about your views on this concept, including any opportunities or risks you foresee.

Key points

- Patient safety should underpin the development of standards
- Processes should be put in place to ensure students become clinicians who can practise safely and have the skills to continue developing throughout their careers
- Standards should be sufficiently detailed to enable institutions to understand what is required
- Some changes will require a significant increase in resources, for example small group work or clinical placements. Without these in place, some changes will not be feasible.
- We agree with the examples of standards. We believe the emphasis should be on patient safety – producing clinicians who can practise safely and know how to continue to develop. Unlike other health professionals, optometrists work independently from the outset in community practice, which is a risk that needs to be mitigated by the way they are trained.

The following are probably subsumed under assessment support functions but we would highlight the importance of:

- supporting students
- training education developers and teachers in good clinical curriculum and assessment development, teaching and assessment practice
- universities allowing optometry courses to use standard setting processes to set the pass mark for assessments (as opposed the university set pass mark) and a defined number of resit attempts. This would demonstrate that universities recognised that they were training students for working with the public and understood the importance of processes that related to patient safety.

We agree with taking an evidence-based approach to designing and delivering education and, by way of example, would suggest including in the standards: taking an integrated approach to teaching. This would remove the concept of having ‘done’ a module and, therefore, being able to forget it and move on, or teaching topics such as professionalism or communication as a separate module. This would be a spiral curriculum approach where students learn in a context relevant to optometric practice, and revisit topics at different stages and levels to reinforce understanding and develop skills and behaviours (also see comments in concept 2 below)

We recognise that many optometry schools are already taking the approaches set out above.

A risk might be that this would be a new way of working for many, so you may need to provide some guidance on what to do to fulfil these standards, while not being so prescriptive that you stifle innovation and difference. The GMC provides standards at an appropriate level of detail.

Another risk is that there will not be sufficient resource or funding to put these changes in place.

Consultation question 3 – Do you agree or disagree with the concept of informing our education requirements by our professional standards?

Agree with caveats

Consultation question 4 - Please tell us more about your views on this concept, including any opportunities or risks you foresee.

Key points

- The professional standards should strongly inform the education requirements but not dominate them
- Professionalism should be woven into all aspects of the curriculum so students understand that professionalism is an essential part of all areas of their work as a healthcare practitioner.

We agree that the professional standards should strongly inform the education requirements, but they should not be used as individual headings from which the requirements fall, as so much knowledge and skills would end up under *Conduct appropriate assessments, examinations, treatments and referrals under supervision.* There would also be overlap in many of the professionalism ones, for example: *Listen to patients and ensure that they are at the heart of the decisions made about their care, Communicate effectively with your patients and Show care and compassion for your patients*

It is vital to ensure that professionalism is woven into all aspects of the curriculum and not taught as a separate module, for example:

- thinking about the ethics related to drugs when learning about the use and supply of drugs and medicines
- communicating with patients in different ways, for example explaining what you are doing, what you have found and why, reassuring a patient about findings, establishing rapport and using appropriate listening and questioning skills to establish a history, or making decisions with a patient in different contexts.

This will ensure that students understand that professionalism is an essential element of all areas of their future practice as a healthcare practitioner.

The risk is that the format of the standards takes precedence, meaning that people try

to fit different topic areas against them rather than simply ensuring that they are covered and overtly raised during teaching and the links explained. Their importance has to be recognised, however, by embedding them into all aspects of the curriculum.

Consultation question 5 - What are your views on the concept of system-wide learning outcomes for optometry and dispensing optician education and training, instead of an educational competency-based approach?

Key points

- The learning outcomes should reflect the knowledge, skills and behaviours that an optometrist needs at the point of graduation or registration – what they need to know, be able to do, and how they should behave, and to give them the skills they need to continue to learn and develop throughout their careers.
- Learning outcomes should be sufficiently detailed to enable institutions to understand what is required, but not so prescriptive that they have no room to innovate.

We agree with a learning outcomes approach. The current competency framework is far too detailed. The learning outcomes should reflect the knowledge, skills and behaviours that an optometrist needs at the point of graduation or registration – that is what they need to know, be able to do and how they should behave. They need to be sufficiently detailed to enable institutions to reassure the public that all students have the knowledge, skills and behaviours they need to practise, but be flexible enough to allow institutions to take different approaches. Importantly, they should remove any possibility of students taking a tick box approach.

There is a risk in making them so high level that they apply to all programmes of learning for registration, as they will be meaningless. While they might cover the same overarching areas, learning outcomes must relate to what is expected of the different professions at the point of graduation or registration. They need to be sufficiently detailed to guide institutions about what is expected. While innovation and varied approaches are to be welcomed, all students need to emerge with the same core knowledge, skills and behaviours and at the same standard, so that the public and employers understand what they can expect. The GMC provides learning outcomes at an appropriate level of detail, as well as supplementary advice, which gives institutions clarity about what is expected.

Consultation question 6 - What do you see as the merits to removing the current link between CET and our education requirements, if any?

Key points

- The current system is not fit for purpose in a world where optometry practice is changing rapidly
- A system geared to what the optometrist actually does and that helps them improve in that area is needed
- Optometrists will need guidance on how to manage their own learning and processes that will help them do this effectively.

The current points based system appears good because it forces people to do at least six points a year and 36 points over a three-year period covering the whole competency framework. However, it encourages a race to the bottom for CET providers – for example not wanting to write challenging MCQs because others write easier ones and registrants will choose those. In addition, points from journals are easily obtained by those who are not optometrists because they are comprehension tests. Interactive points are also easily gained by sitting through a lecture and listening to questions, and those not trained as optometrists could probably contribute enough to a peer discussion to get through. There is also a danger that the current system sets 36 points as a goal rather than the minimum practitioners should aim for and potentially discourages some from undertaking further development once they have reached this level.

A system should have the flexibility to support those who want to develop further, particularly as we do not know what future practice will look like. A system geared to what the optometrist actually does and that helps them improve in that area would be considerably more meaningful. However, it would also be more challenging for optometrists. It would involve them in planning their learning, and reflecting on what they had learned and how to apply it to their practice, and building a portfolio to evidence their development.

This is crucial as optometrists already on the register will have to be able to adapt to fast changing practice for the rest of their careers and they will need guidance on how to manage their own learning and processes that will help them do this effectively.

Consultation question 7 - Do you envisage any disadvantages or risks in this approach, and if so what are they?

It will require a change of culture.

It is possible that some will take a risk and avoid doing much CET on the basis that, if a portfolio system were introduced, for example, it would be impossible to check everyone's portfolios.

Consultation question 8 - What do you see as the key changes needed to the current content of optometry programmes and dispensing optician programmes to ensure our future requirements are fit for purpose?

Key points

- The safety of patients is paramount and the education system should include core skills, knowledge and behaviours to support this.
- It is essential that students learn to direct their own learning from the beginning of their undergraduate course and begin to develop professional skills that will help them grow throughout their careers.
- Institutions will need the resources and funding to implement these changes.

The safety of patients is paramount and the education system should include the core skills, knowledge and behaviours to support this. This includes professional skills as well as clinical skills. These should be skills that the optometrist has a realistic chance of practising regularly in the early years of practice so that they have an opportunity to

consolidate them, preferably under supervision or with the help of a mentor, if that were feasible. For example, while we agree that some training in therapeutics, which includes the law, systemic health and general prescribing, would be useful for all optometrists, we do not believe that they should enter the register qualified as independent prescribers. This is because they will not have had enough opportunity to consolidate clinical decision-making skills, or their knowledge and skills in relation to diagnosing and treating diseases such as anterior eye disease, and because there would not be enough prescribing work for all optometrists to keep their prescribing skills up-to-date and remain safe to practise in this area.

Students should be well supported so that they emerge as competent, critical and reflective practitioners, confident in their abilities. This might mean more small group work, involving problem based learning (see comment about resources under Concept 1).

We believe that, as practice is likely to change rapidly, it is essential that students learn to direct their own learning from the beginning of their undergraduate course. If the profession wants to grow, students also need to begin to develop leadership, mentoring and evaluative skills.

Knowing that much of this is already in place in many optometry schools, we nevertheless suggest the following core skills, knowledge and behaviours should be included:

Basic and clinical science

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

Clinical and practical skills

- History taking
- Clinical assessment skills such as ocular examination, visual function, analysis of digital data, refraction (which will still be needed for some time and will always be needed for some groups, for example those with learning difficulties or dementia)
- Critical thinking and problem solving to underpin clinical decision making skills, including which tests to undertake, interpreting results, diagnosis, management, prescribing drugs appropriately
- Reflection skills
- An ability to write clearly and concisely and with the information the recipient needs – no more and no less. This is particularly important for referrals
- Communication skills: listening, explaining, and reassurance, involving patients in decision making
- Prescribing drugs appropriately but only in areas where they have the management expertise at registration. We believe it is very important that prescribing matches capability in terms of diagnosis and management and any higher level prescribing qualifications should be taken at the

appropriate time after registration when the optometrist has the requisite experience and capability to diagnose and treat particular diseases. This is because skills must be practised regularly to minimise patient safety issues
- Practical procedures that they need at the time of registration and continuing experience of doing them.

Professional skills

- Information management from keeping accurate records, to writing clear and concise referrals, and finding and verifying information
- Working in a multi-disciplinary team
- Understanding how to give and accept feedback, including negative feedback
- Working with patients
- Ethical principles and the law
- Equality and diversity
- Self-directed learning and reflection
- Clinical governance, including clinical audit to improve care.
- Understanding evidence and how to read a research paper critically
- Patient safety issues such as infection control and safeguarding.
- Healthy living
- Epidemiology and evidence based practice
- Leadership skills and the ability to teach others.

Institutions will need the resources and funding needed for small group work, if this is to be feasible

Consultation question 9 - Do you agree or disagree with the concept of embedding clinical elements of education and training progressively from the outset of programmes?

Agree that there should be enhanced clinical experience for students.

Consultation question 10 - Tell us more about your views on this concept.

Key points

- We support the concept of students spending structured time in a clinical setting with exposure to different types of patients to help them relate what they are learning in a classroom, clinic or laboratory setting to a real life environment
- We believe an independently assessed pre-registration period, including a mixture of assessments, is necessary
- The Scheme for Registration has already been adapted for new optometry schools and can be adapted further. The important point is that it is underpinned by sound assessment principles.

We support the concept of students spending time in a clinical setting with exposure to different types of patients. We believe this helps students to relate what they are learning in a classroom, clinic or laboratory setting to working with patients and to

develop the full range of clinical and professional skills they need at the point of registration. To ensure good quality, placements must be structured so students have clear objectives that match their level of attainment, and it must be an integral part of the curriculum. For example, students need to see patients that match the level of their skills – so in the early years, this will be low level, allowing them to get used to speaking to and dealing with patients and colleagues in a practice setting, rather than examining and treating patients. They should keep a reflective portfolio and discuss cases with their tutors.

We do not believe that the concept of early and increasing student placements at undergraduate level precludes a pre-registration period run by an independent organisation. We would argue strongly that the current Scheme for Registration (suitably revised), which is a national registration assessment programme involving work-based assessment, should be retained. It is crucial for demonstrating consistency of standards at the point of registration and for giving trainees a structure for a lengthy period in practice, which enables them to make the transition from the support of a university setting to full registration, where they may be the only optometrist in the practice.

Through the Scheme for Registration, the profession already has an assessment process which:

- Is delivered by a body independent of providers of undergraduate education and employers (but answerable to the GOC)
- Assesses students in their workplace on real patients
- Includes long assessments on simulated patients to cover important processes
- Uses a final assessment, in the form of an OSCE to sample across the skills needed for practice
- Prevents trainees who do not meet the standard set from entering the register and allows feedback to all institutions and employers about student performance in the workplace and the final assessment
- Has a large enough assessor and examiner body in place to deliver assessments and examinations across the UK throughout the year
- Has the added value of an infrastructure, including staff to develop and run the assessments, supported by IT, finance and communications teams
- Delivers a combination of assessments that are underpinned by clear information for trainees and clear guidance and training for supervisors, assessors and examiners
- Incorporates many quality assurance measures to make the workplace assessment as reliable as possible, and it sits towards the top of Miller's triangle in the shows how and does categories.

We believe this is an opportunity to adapt and develop the Scheme for Registration further to ensure it can continue to provide an independent assessment. The principles of good assessment that we apply could easily be adapted to a learning outcomes approach.

The Scheme is currently run:

- At the end of a three year BSc programme (four years in Scotland)

- Alongside MOptom programmes at the Universities of Aston, City and Ulster.

In addition, we have adapted the Scheme to fit the new methods of delivery at the Universities of Hertfordshire and Portsmouth and could continue to adapt it to fit with new methods of training, including a more flexible work-based assessment, which could be run either in conjunction with the undergraduate programme or at the end of it.

Consultation question 11 - What do you foresee as being any positive or negative impacts on students, education providers, employers, patients and carers from taking a hybrid approach?

This is a complex issue for optometry. Most optometry is delivered in High Street practices, which can be very small and have a limited number of patients. These practices are also primarily businesses. This can make it difficult to find enough practices locally willing to take on students and to be sure that they can see and obtain the appropriate learning experiences during the placements.

Experience of the major disease groups is mainly available in the Hospital Eye Service and we know that the Hospital Eye Departments are already inundated with medical students, ophthalmology trainees, nursing and orthoptic students and pre-registration optometry trainees. Funding is already an issue and this will increase significantly. However, we believe that this experience is important, not just in relation to experience of eye disease, but because it gives students a valuable insight into the issues of working in secondary care and of working as a part of a team with other professionals.

Clinical placements are essential. It is important to ensure that students have appropriate support and guidance during the placement as well as follow up by way of formative assessment. A negative impact would be if it did not work well and some did not actually get training during a placement or could not find a placement.
From the employer point of view, there is no doubt it would be an added burden on resources, so they would want funding. Supervision would have to be very close, at least initially. Supervisors would also need to understand what to expect from trainees at each placement and how to manage them, for example, a first year undergraduate on a placement would require more support and guidance than a third year undergraduate. It would also be wrong to assume that the same practice would take the same trainee back for placements over the full course of the degree. As undergraduate numbers continue to increase, any multiple placement programme needs to be able to expand to meet demand. As students paying fees, as opposed to trainees receiving a salary, the relationship between student and employer would change, with the student being in a position to demand more.

From an education provider point of view, providers would need significantly more resources to find placements, arrange contracts, ensure vetting and barring procedures were in place, as well as insurance, whistleblowing policies and safeguarding procedures. This would be in addition to planning the content, training the supervisors, providing assessments, putting feedback mechanisms in place for practices and students, and quality assuring the practices. This involves a layer of complexity that does not currently exist for the majority of providers. There will be a huge reputational risk for the providers if this element of the programme is sub-standard.

From a student perspective, our data shows that trainees like to study and practise close to their home and university. Assuming this trend continues, there will be considerable pressure on practices close to the universities to provide placements. Students who are unable to secure a placement near to home or their university will face higher costs in terms of accommodation, travel and cost of living each time they have to undertake a placement.

Patients and carers would have to give permission so would not have to have a student with them if they did not wish it.

Designing, arranging and assessing clinical placements requires significant resources and funding, and planning this will not be feasible without knowing whether these will be forthcoming.

Consultation question 12 - Do you agree or disagree with the concept of a national registration examination?

Agree with caveats.

Consultation question 13 - What are the merits and risks of this concept?

Key points

- This will ensure a common standard for those entering the register (currently achieved through the Scheme for Registration)
- It would be essential that the assessment was fair to candidates and demonstrated that they were prepared for practice in a way that was both valid and reliable, as well feasible in terms of costs and resources needed
- Assessment drives learning so this could stifle innovation

Who will pay for the national licensing assessment? There is no doubt that with an increasing number of schools being encouraged to provide innovative courses, an assessment that stands above them all will ensure a common standard for those entering the register.

It would be essential that the assessment was fair to candidates and demonstrated that they were prepared for practice in a way that was both valid and reliable, as well as feasible in terms of costs and resources needed. The exam must test the knowledge, skills and behaviours needed in practice to be valid. Being reliable means that students would pass or fail whenever or wherever they took it.

There is also the question of cost to consider. Who would pay for it?

As you point out, there is a danger that it would affect what was taught and what was learned at optometry school, thus impeding the very innovation that is hoped for in this review. It is well known that assessment drives learning. As a very high stakes assessment, it would affect how students approached their learning, and universities would not want the national assessment to show that their training was not as good as that of others.

We do not disagree with this concept, and we know that there are national licensing examinations in both optometry and medicine in other jurisdictions. We know, for example, that the US national licensing examination for medicine is very well put together and based on evidence about the best assessment methods. However, it is very resource intensive and costly.

We are also aware that the GMC has just agreed to put in place a medical licensing assessment but has been able to agree only on an applied knowledge test, which puts it on the knows how level of Miller's triangle. It seems a pity to go from a national assessment at the shows how and does levels, like the Scheme for Registration, to one at the knows how level.

Ensuring that those entering the register have reached an appropriate standard is, however, crucial for patient safety, so in the absence of a comprehensive work-based assessment run by an independent body, we would support this concept.

Consultation question 14 - How feasible would it be to develop inter-professional and multi-disciplinary elements of study within optometry and dispensing optician education programmes?

Key points

- It is important that different professionals working together trust and respect each other. Multi-disciplinary education is a way of helping this
- The purpose has to be very clear and the learning has to reflect the purpose in a demonstrable way.

Professionals have to work together and increasingly lines are becoming blurred between professions. It is important that different professionals, working together, trust and respect each other. Multi-disciplinary education is a way of helping this.
If multi-disciplinary learning is to be put in place, the purpose has to be very clear and the learning has to reflect this in a demonstrable way. Sometimes this can be difficult to achieve at undergraduate level because the institutions do not train the groups of professionals that will be working together in the future - optometrists and doctors and dispensing opticians, for example.

One approach could be shadowing other professionals to find out what life is like from the point of view of the other profession and/or discussions with other professionals that help to demonstrate the effect each profession can have on the other through their actions. This can aid mutual understanding.

Consultation question 15 - Tell us about any examples you know of already in other disciplines from within or outside the UK?

Griffith University in Australia has implemented a framework for inter-professional learning in the health professions. https://www.griffith.edu.au/health/griffith-health/health-ideas/programinterprofessional-education-scholarship
The Universities of Birmingham and Nottingham in the UK are carrying out a project, which looks at incorporating inter-professional education within pre-registration training

of health professions.

Consultation question 16 - What do you see as the strengths and weaknesses of retaining the current minimum duration as described above?

Key points

- Optometry schools are in a better position to answer this question
- It would mean an extra year's tuition fees for students
- A period of supervised practice is important in relation to patient safety.

Optometry schools are better placed to say whether they would be able to deliver a modernised education system, including significant placements within four years. However, this would mean an extra year's tuition fees.

Our data shows that the majority of trainees will successfully complete the Scheme for Registration in 18 months, without the added pressure of the academic content of the final year at university. If the programmes are fixed at four years and students must be fit for registration by that time, the element of flexibility for those who need a little longer, which currently exists within the Scheme for Registration, will be lost.

Consultation question 17 - What could be done differently in order to ensure students become competent, confident and safe beginners?

We believe that a period of practice under supervision is very important for public safety, particularly if the work becomes more clinical. This is particularly true in optometry as many optometrists work in High Street practices, where they are the only optometrist. Additionally, newly qualified professionals need someone to discuss their work with or to ask for help when they come across something about which they are unsure. A buddy or mentor system would provide this support. However, this would require resources and there may be implications for insurance.

Consultation question 18 - What do you see as the opportunities for more flexibility between the education of different regulated and non-regulated optical professions?

Key points

- Those with the right aptitude, attitude and interests should be able to move into and between optical roles
- A good selection system should be put in place, as it should also be for post A level or equivalent entry.

We agree that no unnecessary constraints should be put in the way of this concept. Those with the right aptitude, attitude and interests should be able to move into and between optical roles.

Consultation question 19 - What are the constraints and risks to this?

A good selection system should be put in place, as it should also be for post A level or equivalent entry.

There is a risk that students taking this route could have missed important background education that others had in a previous stage of education and training and processes should be in place to mitigate this.

Consultation question 20 - Are there any other principles and concepts we should consider at this stage in exploring future approaches to our quality assurance processes?

Key points

- A risk-based approach to quality assurance would seem sensible, together with using evidence about the most appropriate methods of clinical training and assessment as a benchmark
- As providers will be taking a new approach to course design and delivery, it might be sensible to work with them during the first years of delivery.

A risk-based approach to quality assurance would seem sensible, together with using evidence about the most appropriate methods of clinical training and assessment as a benchmark. However, there are risks inherent in the work of optometrists in the High Street, in that they work independently from the point of registration.

As providers will be taking a new approach to course design and delivery, it might be sensible to work with them during the first years of delivery – visiting to hold supportive discussions rather than inspecting. The GMC took this approach in 1993 when it introduced Tomorrow's Doctors, which involved new methods of course design and delivery for medical schools.

Consultation question 21 - Please tell us about any direct or indirect impact you can foresee from the concepts and principles we have set out in this public consultation on anyone with protected characteristics?

Key points

- Students may have to pay an extra year's fees at university, which may be prohibitive for some
- Students are also likely to incur additional costs if they are required to undertake multiple placements away from their home or university accommodation.

The main risk is that students may have to pay an extra year's fees at university, which may be prohibitive for some.

Students are also likely to incur additional costs if they are required to undertake multiple placements away from their home or university accommodation.

Federation of (Ophthalmic and Dispensing) Opticians (FODO)

FODO responds to the consultation as shown below:

Concept 1: Standards for Education Providers

Consultation question 1 - Do you agree or disagree with us further exploring the concept of new Education Standards in the way we describe above?

Agree.

There is widespread recognition, including by the GOC in this Education Strategic Review, that the roles of optometrists, dispensing opticians and contact lens opticians are already changing and will continue to change in the coming years. Demographic changes (an ageing population, resulting in increased demands for eye care) and the impact of new technology will all add to the pressures on the current eye care system.

Optical professionals and practices are well placed to respond to these growing and changing needs of patients. This will involve the majority of optical professionals moving up the clinical skills ladder and delivering a wider range of primary eye care services as standard, as well as perhaps smaller cohorts delivering or co-delivering services which were previously only offered in hospital eye departments or private clinics.

It will be essential therefore for the content and structure of education and training, and the standards underpinning the education of optical professionals, to support and enable the professions to respond to these needs.

Consultation question 2 - Please tell us more about your views on this concept, including any opportunities or risks you foresee.

Education standards need to be robust on outcomes but also flexible and adaptable on modes of delivery and able to be adjusted, without resource intensive reviews or system inertia, to meet the current and future needs of patients, professionals and optical businesses.

In order to achieve this, educational standards should concentrate on learning outcomes i.e. the professional knowledge and skills to be acquired and demonstrated by students.

As part of this approach, we believe that the GOC could safely be far less prescriptive about the learning process and inputs, focussing more on outcomes that need to be demonstrated and allowing educators to determine the most suitable teaching methods to achieve these, as in other areas of education and training. This would allow for the introduction of different teaching and learning formats, such as more time in practice interacting with patients and building inter- professional confidence and communication skills with fellow professionals. This could be combined with structured case studies to allow experiential learning across realistic scenarios.

The counterbalance to a more flexible educative approach, however, would be a rigorous assessment against the knowledge and skills demonstrated rather than, say, confirmation that a student had completed a certain number of patient episodes. Australia provides one such model; there may well be others. FODO would be keen to work with the GOC, educators and others to discuss how these goals could be achieved in the UK.

Concept 2: Education Standards and Professionalism

Consultation question 3 – Do you agree or disagree with the concept of informing our education requirements by our professional standards?

Agree.

Consultation question 4 - Please tell us more about your views on this concept, including any opportunities or risks you foresee.

It is entirely logical that education requirements should fully reflect professional standards and vice versa. However, there is a risk of one unduly dominating the other and distorting the results.

To avoid this, both should be informed by an assessment of the real world needs of patients and both should support practitioners and practices in delivering safe and effective eye health care in all settings.

Concept 3: Learning Outcomes

Consultation question 5 - What are your views on the concept of system-wide learning outcomes for optometry and dispensing optician education and training, instead of an educational competency-based approach?

We fully support the move to outcomes-based education. The challenge will be how best to assess and guarantee the outcomes across the board fairly, and at a national level.

Focusing on outcomes and standards achieved, rather than inputs, should liberate lecturers, institutions and supervisors to use their skills in making each student competent in a particular subject or skill areas as demonstrated by assessment, examination and OSCE, rather than measuring inputs.

We suggest that the levels of development and learning outcomes need to be agreed by the GOC with practitioners, employers and educators. This should include demonstrated core outcomes required for entry to the register combined with further skills development options to allow progression up or within the register. This approach would enable the creation of a single register for optical professionals and allow each professional the freedom to add to their core competences as they develop their career. We would welcome the opportunity to discuss further the detail of what should be included in these competences.

As noted in our response to Question 2, outcomes-based education and training is crucially dependent on the quality of the examinations/assessment systems. The

educators/academics, as the experts, should be allowed to determine the best way to teach skills and competences and should advise the GOC, the College and the ABDO of the best way to demonstrate the learning outcomes required.

The quid quo pro of the profession/academics deciding on the content and structure of courses is that students have to pass rigorous clinical examinations which are subject to external verification and audit.

An optometry or dispensing qualification from one institution should be no less rigorous or valid than the same qualification from another.

Concept 4: Links to Continuing Education and Training

Consultation question 6 - What do you see as the merits to removing the current link between CET and our education requirements, if any?

While an element of CET, ensuring that professionals maintain their essential core skills, will always remain important, it is our view that the current system of CET is now too restrictive for emerging roles.

The current system assumes that all skills are taught at an undergraduate level and does not allow for career development, progression or specialisation. In reality, over the course of their career, registrants will to need to maintain and update existing skills in response to developments in technology and new clinical approaches and many professionals will also want (or need) to gain additional skills or competencies to develop and advance within their changing professional roles.

We would therefore like to see the education system move to a modular approach, with the expectation that most registrants will extend their competences and scope of practice through further skills acquisition and CPD over the course of their careers.

As we have recognised in previous submissions, we appreciate that the focus to date has been on CET rather than CPD because this was all the four UK governments were prepared to part-fund for registrants who deliver GOS.

Nevertheless, with austerity making further significant funding for CET unlikely and the sector's ability now to recover the costs of upskilling through fees for services beyond GOS, the time has come to move to a full system of CPD to provide more flexibility for individuals, employers, commissioners and system planners to expand professional roles.

Consultation question 7 - Do you envisage any disadvantages or risks in this approach, and if so what are they?

This would be an important cultural shift away from the current system of CET which was aimed primarily at maintaining base-line skills.

To manage the risks of 'irrelevant' CPD being pursued whilst core needs are neglected, registrants could be required to set out in a portfolio why they have selected particular CPD; for example, to revise a core skill; employer requirement; to develop a new service; personal interest; changing practice/patient demographic; new technology; new clinical skills, etc.

The downside of a portfolio approach is that only a sample would be able to be reviewed in any one year perhaps a random sample combined with added focus on the newly-qualified, those taking on new non-traditional roles and those working in higher risk clinical practice.

It would also be important for the GOC register to have a means of recognising and informing the public about a registrant's enhanced skills where appropriate e.g. by an annotation or listing of approved qualifications in the register.

Concept 5: Educational Content

Consultation question 8 - What do you see as the key changes needed to the current content of optometry programmes and dispensing optician programmes to ensure our future requirements are fit for purpose?

As has already been said, the roles, and therefore skills required of optometrists and dispensing opticians are changing and can be expected to change in the future. For optometrists, some activities which to date have been treated as advanced or additional roles, such as MECs-level prescribing (Level 1[1]), are likely to become core. Optometrists are also likely to take on new roles in the future which have traditionally been the preserve of ophthalmologists (sometimes but not always under the supervision of or shared care arrangements with an ophthalmologist).

[1] Limited range of types of drugs prescribed within demonstrable competences

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

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

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

The likely expanded scope of practice for both optometrists and dispensing opticians means that new approaches (and attitudes) to education, training and CPD will be needed because it will no longer be practical or possible to teach the full range of skills and competences needed to deliver across the full range of primary eye care at undergraduate level (even if the pre-registration period is included or undergraduate degrees are lengthened significantly).

There is widespread agreement that optometry graduates should, as standard, be competent in the management of extended primary eye care services (i.e. the delivery

of GOS services in Scotland, MECs in England and WECs in Wales). This would also mean that Level 1 prescribing[2] (should be included in core competences. This would be short of the full scope of independent prescribing the breadth of which is currently acting as an inhibitor to individuals developing and maintaining their optical prescribing skills.

Refraction will continue to be a core skill for optometrists especially for specific patient groups such as people with learning disabilities or cognitive impairment. However, teaching refraction need not be lengthy or complicated or the primary focus of all optometric training. The supply and fitting of spectacles (i.e. dispensing) could instead become an optional module for optometrists who anticipate careers more in retail than therapeutic optics. It is of course essential that spectacle supply and fitting remains central to DO core training, and contact lens fitting to CLO training.

Communication skills, business management and public health are already covered on existing courses and training. However, all are likely to become increasingly important for all optical practitioners. They will increasingly need to communicate with a growing number of elderly and frail patients often with varying degrees of cognitive impairment and multiple long-term conditions. In these circumstances team-working and inter-professional communications (including effective handover and referrals) will also become key skills.

2. Limited range of types of drugs prescribed within demonstrable competences

Concept 6: Enhanced clinical experience for students

Consultation question 9 - Do you agree or disagree with the concept of embedding clinical elements of education and training progressively from the outset of programmes?

FODO fully supports proposals to combine academic study with clinical experience from the start for optical students – as is the case for other clinical professions.

Consultation question 10 - Tell us more about your views on this concept.

We believe that a key factor in improving optical education is early and ongoing exposure to other professionals working in day-to-day practice and with patients. Eye health is, when all is said and done, a people-focussed, caring profession. It is therefore at the coal-face and by watching good role models, delivering clinical skills in a business environment, that students will best learn what professionalism looks like and what the professional standards and expectations on them will be.
This needs to start early and continue throughout basic education, training and, for optometrists, their pre-registration period. This will also be a good way for students and their trainers to identify early whether or not patient-facing roles are going to be suitable for them.

To above will require closer partnerships between educational institutions and training practices, possibly along the Academies models. This would help increase the amount of patient contact throughout the course across the range of practice. Community, hospital and specialist placements, and placements with GP practices could provide

the variety needed and help students develop a wider range of professional and inter-professional skills.

At present a significant amount of optometry teaching is delivered by ophthalmologists. In our view much of this could and should be taught by experienced optometrists. However, there is a shortage of optometry professionals with the requisite combinations of clinical and teaching skills. This is compounded by the fact that some universities unrealistically demand lecturers with PhDs as a consequence of degree inflation.

We believe therefore that there is a strong case for creating a new accredited cadre of optometrist/optician educators/lecturers who could teach or supervise equally well in practice, clinic or academic settings. Using the Irvine Aitchison Memorial Fund legacy, we are funding a number of places on an Essential Skills in Medical Education (ESME) course for optometrist and DOs to test proof of concept, working with the College of Optometrists and the ABDO. Applications for places opened earlier this year and will go live in April 2018.

This new cadre of educators will fit well with what we believe will inevitably become the necessity for more ophthalmologist training also to move into community settings as services increasingly shift to primary care in line with patient expectations, technology, the squeeze on HES resources and NHS policy in all four UK countries.

Consultation question 11 - What do you foresee as being any positive or negative impacts on students, education providers, employers, patients and carers from taking a hybrid approach?

Such a hybrid system would need to be supported by employers to redesign operating systems, make training places available, and to enable existing high value staff with appropriate skills and the teaching qualification to spend a number of days each year out of the consulting room. These should not be insuperable obstacles as the pay-back could be significant in terms of skills dissemination throughout the business and professionals' commitment and motivation. Teaching options should, in our view, be explicitly encouraged as part of the career progression of individuals.

Concept 7: National registration examination

Consultation question 12 - Do you agree or disagree with the concept of a national registration examination?

We agree that there is a need for a consistent national qualifying process to reassure public and fellow professionals and that the bar for this should be set relatively high.

Consultation question 13 - What are the merits and risks of this concept?

The merits are as above in terms of reassuring the public and fellow professionals working in multi-disciplinary teams. Common standards for assessing educational outcomes will also reassure employers who are taking on newly qualified staff and independence from training institutions will rule out any or slippage of standards or biases in assessments based on prior knowledge of the students concerned.

The risks however are in costs, bureaucracy and inflexibility in moving with the times and engaging with the sector.

The solution may lie in greater stakeholder engagement in formulating the assessment processes and outcomes measures – e.g. a combination of academics, employers and providers as well as recent undergraduates and graduates - and the GOC could play a prime leadership role in facilitating such engagement including via its contracts with assessors.

Concept 8: Multi-disciplinary education

Consultation question 14 - How feasible would it be to develop inter-professional and multi-disciplinary elements of study within optometry and dispensing optician education programmes?

We believe that inter-professional and multi-disciplinary study should be part of education programmes, as eye health professionals increasingly move towards working in multi-disciplinary teams and across traditional primary/secondary care boundaries.

We recognise that some education providers may find it easier to develop multi-disciplinary relationships more quickly than others, based on the range of academic departments already within their own institutions. However, multi-disciplinary training should not be solely dependent on what is available within the academic environment. Different methods of education and training could also be introduced, including training alongside other health or social care professionals and in different environments. For example, increased clinical training could be delivered in hospitals, in community optical practices that provide primary and secondary eye care, or in GP practices or community health hubs as part of wider community clinical networks.

It would be important for the GOC to adopt a proportionate approach to recognition/accreditation and quality assurance of such training, depending on what the course is and who provides it. For example, the GOC should have the flexibility to accredit courses provided by other registered medical or health professional bodies, e.g. pharmacists or medical Royal Colleges, without necessarily putting them through a 'traditional' GOC assessment. The outcomes of the training - i.e. the demonstrated competences of practitioners - is what should count.

Consultation question 15 - Tell us about any examples you know of already in other disciplines from within or outside the UK?

Concept 9: Duration of education and training programmes

Consultation question 16 - What do you see as the strengths and weaknesses of retaining the current minimum duration as described above?

Whilst not advocating any change in the current duration of education and training for the reasons set out below, we do not believe that it is necessary to specify a minimum duration. The focus should be on supporting courses that can deliver agreed training outcomes, allowing for the development of new courses that may not necessarily follow

the traditional academic timetable.

Broadly, we support the duration of four years basic education and training for optometrists, and three for dispensing opticians as about right. However, optometry degrees need to cover a growing range of skills and competences and it is no longer realistic to expect the full range of skills and competences to be covered within the current format of a three-year optometry degree (plus a pre- registration training period). Added to which, if the sector wishes to see a different balance between undergraduate education and hands-on clinical work, then space will be needed for some degree of specialisation before qualification.

Whilst four-year degree (integrated or with further pre-registration training) already exist, we are not convinced that extending all degrees to four years would be the best or most viable solution. An additional year would put pressure on universities because it would require additional funding and additional teaching time. It may also be unattractive to students who would have to pay a fourth year of fees and could lead to higher levels of drop out. This is without the disruption to front-line services such a change could make in the short term and at a time of existing shortages in workforce supply.

Moreover, if much of the first year of study has to repeat much of the A level syllabus to make up for deficits in secondary education, a case could be made for entrance examinations or deferred admissions pending A level re-sits to ensure the undergraduates start at the correct level. We would wish to discuss this further with Optical Schools Council which time pressure have not allowed.

Whatever the answers to the above, as we argued in our previous evidence, we think there is a strong case for making optometry a clinical degree and increasing the length of the academic year as for other clinical disciplines. This could also bring additional government funding to universities via HEFCE etc.

However, one of the strengths of the current education and training systems is that they are flexible and numbers can be increased or reduced to meet patient needs, demographic change and service developments without bureaucratic process or overlong delays. It would be counterproductive if the move to a clinical degree brought optometry within government supply totals which continue to impede the progress of other professions and sectors. One option here might involve exploring different part-funding models with HEFCE including apprenticeship-type funding.

Either way we favour moving to a model which combines both core components with elective specialisms, with the expectation that a registrant would add to their competences over the course of their career according to their personal, clinical and employment ambitions and as business and employment opportunities become available or in prospect.

Consultation question 17 - What could be done differently in order to ensure students become competent, confident and safe beginners?

As we have said in response to question 10, a key factor in improvement will be early and ongoing exposure to other professionals working in day-to-day practice and to

patients. Ideally this would include exposure to multi-disciplinary working e.g. liaison with GPs and referrals to ophthalmology.

At entry stage, we believe that consideration should be given to students' ability to learn communication skills, their emotional intelligence and reflective learning as well as their academic and scientific ability. Students should be aware from the outset that clinical team working (including effective hand-over and inter- professional communications), and 'whole patient' understanding are core components of their future role.

At present each pre-registration student is assigned one supervisor. However, as the skills base widens, student DOs and pre-registration optometrists may well need more than one supervisor during their training to support them across both core competences and any specialism they may have chosen.

Other methods of learning for undergraduates should be encouraged, such as distance learning, webinars, and practice experience over the vacations.

We would also strongly suggest that the GOC should consider giving recognition, through the register to those who are competent to supervise pre-registration optometrists, and also to those who might want to expand their scope practice as optometrist/optical educators. (See response to Question 10).

Finally, as discussed in our previous submission, we suggest that it would be helpful to consider how ongoing support could be provided to those newly entered on the register via peer support groups and peer learning, to help embed their basic training and undergraduate learning, and for them to continue to develop these skills once they are registered for autonomous practice for the first time.

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

Concept 10: UK educational routes to registration

Consultation question 18 - What do you see as the opportunities for more flexibility between the education of different regulated and non-regulated optical professions?

At registration a professional should have demonstrated an agreed range of core clinical knowledge and applied professional skills and also perhaps a particular specialism (e.g. therapeutics, surgical, medical retina). Over the course of their career they will to need to maintain and update these skills in response to developments in technology and new clinical approaches. Many professionals will also want (or need) to gain additional skills or competencies to develop and advance in their profession.

Registrants should therefore be able to qualify under further specialist modules as part of the continuing professional development system or separately and have these

qualifications recognised in the GOC register. Both optometrists and dispensing opticians should be able to move up the skills ladder at a pace of their choice.

The same principle should apply to non-registrant ancillary staff. None of the above should prevent non-registrants from acquiring part of the range of skills of registrants and working in para-clinical optical roles either under the supervision of a registrant or autonomously depending on the function, training and experience.
This would provide greater flexibility in skill-mix, more satisfying professional roles for registrants and non-professional staff alike and more entry points (via prior learning) into the optical professions.

The above approach would enable the roles of optometrists and dispensing opticians and the wider workforce to change, evolve and be updated and developed over time. Rather than a particular function being reserved to a particular profession, the delivery of that function should only be restricted to those who are trained, competent and maintain their skills to deliver that function.

We would suggest that the right to use a protected title should depend on having a demonstrated a minimum set of core learning outcomes for each professional title or level. This would guarantee the right/duty to deliver or supervise protected functions in the interests of patient safety but would not mean the entirety of those functions could only be carried out by an individual with a protected title. This flexibility will be important as optometrists and opticians move up the clinical skills chain and operate more like other clinicians.

This newer approach would further create more attractive career paths and employment options and a pool of aspirant registrants with a broader range of skills, capabilities and backgrounds.

With sufficient training on offer, including from employers, the market would self-regulate by offering differential remuneration packages to attract the skills that are needed e.g. a shortage of particular skills would, all other things being equal, attract higher remuneration encouraging more individuals to acquire those skills and supply and demand to balance out.

Consultation question 19 - What are the constraints and risks to this?

It will be important to ensure that all training, including core skills, is not only properly assessed but also properly recognised in order to provide necessary assurance to the public, patients, other clinicians and commissioners.

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

The GMC and Academy of Medical Royal Colleges announced on 24 February 2017 their intention to undertake exploratory work to look at how to enhance the GMC's medical register by recording doctors' scope of practice. We would support something

similar, although proportionate to the optical professions, by the GOC.

Concept 11: Proportionate quality assurance

Consultation question 20 - Are there any other principles and concepts we should consider at this stage in exploring future approaches to our quality assurance processes?

We remain ambivalent about whether health regulators should accredit courses (even though most traditionally have) or whether meeting educational standards should be left to the university systems with the GOC focusing on ensuring rigorous testing and demonstration of learning outcomes before registrants are admitted to the register. Whatever happens in respect of this, we believe that there is significant scope for improvement in the current requirements imposed on undergraduate and preregistration education and how it is delivered and assessed.

If the focus is to shift more towards rigorously assessed learning outcomes, we would query the need for the GOC to set such detailed criteria for education providers to demonstrate.

We would also propose that the aim of GOC visits and assessments should be for accreditors to satisfy themselves that course content and work programmes deliver the totality of agreed learning outcomes for a high majority of average students over the duration of the course.

Consultation question 21 - Please tell us about any direct or indirect impact you can foresee from the concepts and principles we have set out in this public consultation on anyone with protected characteristics?

Our proposals above should make optometry, optics and ancillary roles more attractive and interesting career options for bright students and those seeking employment in both clinical and retail eye health roles. This, and a more modular approach to education, training and practice, should widen the pool of those entering the professions from less traditional backgrounds and lead to increased diversity amongst the practitioners of the future.

Glasgow Caledonian University

Glasgow Caledonian University responds to the consultation as shown below:

Concept 1: Standards for Education Providers

Consultation question 1 - Do you agree or disagree with us further exploring the concept of new Education Standards in the way we describe above?

Agree.

Consultation question 2 - Please tell us more about your views on this concept, including any opportunities or risks you foresee.

We welcome the move to a set of high-level Education Standards and away from the current prescriptive set of guidelines. This change will allow greater freedom to innovate in course design and delivery.

However, if the new Education Standards contain too much detail they might simply replace the constraints contained in the current Optometry Handbook for Education Providers rather than allow more flexibility in the regulatory regime.

Concept 2: Education Standards and Professionalism

Consultation question 3 – Do you agree or disagree with the concept of informing our education requirements by our professional standards?

Agree.

Consultation question 4 - Please tell us more about your views on this concept, including any opportunities or risks you foresee.

Professional standards are currently embedded throughout both of our academic programmes. However, it should be noted that our students are in training rather than full registrants of the GOC and this should be reflected in the expectation s made on them in terms of standards of practice and professionalism.

The university has long established procedure for dealing with students who transgress through a fitness-to-practise (FtP) regime. The GOC may want to consider delegating its role in this matter fully to the institutions. The FtP processes in place at the institution could be audited through annual report and during re- approval events.

Concept 3: Learning Outcomes

Consultation question 5 - What are your views on the concept of system-wide learning outcomes for optometry and dispensing optician education and training, instead of an educational competency-based approach?

We would welcome a move from an educational competency based system to one based on learning outcomes.

It will be challenging to develop a set of learning outcomes that can be measured

effectively. Undoubtedly, these outcomes should be underpinned by a comprehensive science base in optics, anatomy and physiology etc. Therefore, the learning outcomes should also include these elements. Furthermore, as undergraduate honours programmes, the outcomes must be appropriate to reflect the academic rigour for awards at this level.

Concept 4: Links to Continuing Education and Training

Consultation question 6 - What do you see as the merits to removing the current link between CET and our education requirements, if any?

It is clear that the link will have to be removed if the move from a competency based regime to one centred on outcomes goes ahead. We support the move to CPD in place of the current CET requirement.

Consultation question 7 - Do you envisage any disadvantages or risks in this approach, and if so what are they?

Any disadvantages and risks would be highly dependent on the CPD requirements adopted.

Concept 5: Educational Content

Consultation question 8 - What do you see as the key changes needed to the current content of optometry programmes and dispensing optician programmes to ensure our future requirements are fit for purpose?

We favour an educational model where every graduate has the same core skills and can, if required, acquire additional and specialisation skills throughout their career. This is similar to medical training with common basic and subsequent specialist training.

What should the core level of optometric education be? We think that the basic, common core level should be IP: providing graduates with the essential knowledge to operate independently and diagnose and manage conditions within their sphere of experience and competence. At the point of entering the professional register, the range of conditions that may be managed by a typical optometrist may not be very different from today's entry level but the graduate is equipped with sufficient pharmaceutical knowledge to take on increased responsibilities commensurate with their clinical experience.

Further specialisation can then be provided either formally via post-graduate training or informally via hospital placements and peer-to-peer training and shadowing.

To implement this, it would require key changes to the current content of optometry programmes. The new structure/content needs to enable future optometrists to meet the demands of a fast developing profession (new technologies will affect how ocular disease is detected, monitored, and managed), by providing them with solid foundations on a much wider range of basic aspects than is currently the case (optics, physiology, anatomy, pharmacology). We envisage this to be akin to medical training before specialisation. Such a solid grounding will enable graduates to adapt to future changes in clinical practice.

Concept 6: Enhanced clinical experience for students

Consultation question 9 - Do you agree or disagree with the concept of embedding clinical elements of education and training progressively from the outset of programmes?

Agree.

Consultation question 10 - Tell us more about your views on this concept.

We believe this would give students an early insight into their chosen career. This exposure would also strengthen their professional identity.

Consultation question 11 - What do you foresee as being any positive or negative impacts on students, education providers, employers, patients and carers from taking a hybrid approach?

It is important that the core clinical teaching continues to be carried out in a university based clinic to provide appropriate and consistent supervision and monitor the quality of provision. Practice based education could then supplement rather than replace this core clinical teaching.

It would be difficult to maintain a consistent student experience during the practice based elements. There is a danger that employers may not be engage with the process due to commercial pressures.

Concept 7: National registration examination

Consultation question 12 - Do you agree or disagree with the concept of a national registration examination?

Agree.

Consultation question 13 - What are the merits and risks of this concept?

This approach would protect patient safety. The examination should be as robust and rigorous as the current scheme for registration.

Concept 8: Multi-disciplinary education

Consultation question 14 - How feasible would it be to develop inter-professional and multi-disciplinary elements of study within optometry and dispensing optician education programmes?

Inter-professional education (IPE) is an important element in the training of most healthcare professionals. GCU currently delivers IPE between optometrists, orthoptists and dispensing opticians on our three programmes. Undoubtedly our students benefit from this experience and have a much deeper understanding of each other roles upon graduation. We anticipate increasing both the amount of IPE and the range of professions involved.

Consultation question 15 - Tell us about any examples you know of already in other disciplines from within or outside the UK?

The health school at GCU currently offer an IPE framework across the health professions. We anticipate that our programmes will make use of this provision when they next undergo review. This will allow our students to experience IPE with a multitude of other health professions.

Concept 9: Duration of education and training programmes

Consultation question 16 - What do you see as the strengths and weaknesses of retaining the current minimum duration as described above?

The undergraduate honours degree in Scotland is 4 years in length. We support keeping this duration so that students can develop their skills and academic rigour be maintained.

Consultation question 17 - What could be done differently in order to ensure students become competent, confident and safe beginners?

We believe the current system delivers competent, confident safe beginners.

Concept 10: UK educational routes to registration

Consultation question 18 - What do you see as the opportunities for more flexibility between the education of different regulated and non-regulated optical professions?

We would encourage the introduction of more flexibility in allowing individuals to move between professions. In particular a route from orthoptics to optometry and ophthalmic dispensing and vice versa would be a welcome addition.

Consultation question 19 - What are the constraints and risks to this?

If properly designed and monitored the pathways would not represent any particular risk.

Concept 11: Proportionate quality assurance

Consultation question 20 - Are there any other principles and concepts we should consider at this stage in exploring future approaches to our quality assurance processes?

We have been encouraged by the openness and willingness to listen that the GOC has exhibited during its recent consultations. We hope that this approach continues in its role as regulator.

As with all UK universities, we have elaborate internal quality processes and procedures. We would encourage the GOC to make use of these processes where possible to avoid duplication of effort. One approach may be to make use of the

internal monitoring documentation and approval processes rather than insisting on those of the GOC. This would require flexibility and a degree of trust.

Consultation question 21 - Please tell us about any direct or indirect impact you can foresee from the concepts and principles we have set out in this public consultation on anyone with protected characteristics?

We do not anticipate any impact of the review on those with protected characteristics.

Local Optical Committee Support Unit (LOCSU)

LOCSU responds to the consultation as shown below: Explanation of Response

As LOCSU does not represent individuals it is not appropriate for us to complete the full set of consultation questions. However, as an optical sector body we would still like to contribute to it by addressing some key points.

LOCSU Response

Our overarching point is that optical education programmes must make sufficient provision for students to confidently perform services falling outside of core primary care (General Ophthalmic Services). As the Government and NHS's out of hospital care plans develop, newly registered optometrists and dispensing opticians can expect to play greater roles than they have historically in providing extended primary care services to the public. These services will include, but not be limited to, minor eye conditions, glaucoma and cataract monitoring, learning disabilities, low vision, and paediatrics. All training required will reflect the requirements within NICE.

In general, there is much to support in the ESR consultation. From our perspective, we think that the GOC should ensure due credence is given to the following areas:

1. Learning outcomes for the future: education programmes should focus on the desired outcome of confident, holistically trained students able to deliver upon qualifying a wide range of services to the public. In our view optical practice narrowly delivered in silos is coming to an end: newly qualified optical professionals should be taught in such ways to reflect this. Technology is a large part of this: the optical sector is utilising technology at an exponential rate. Practice in ten years' time will be significantly altered to that of today. When learning about current technology and equipment, students should be appraised of likely technologies that they will be using in the future. The recently published 'Foresight Report illustrates this in details': http://www.opticalconfederation.org.uk/downloads/foresightsummary- reportweb.pdf While of course new technologies cannot be absolutely predicted, it is important that students are given the best possible insight into the future and understand underlying principles and how to evaluate evidence base so that they have the skills to appraise and utilise new technology as it evolves. By developing forward- thinking education programmes, optical professionals will benefit from future- proofing and be ready to meet the optical landscape of the decades ahead.

2. Evidence based learning: education programmes should assess successful extended primary care services across the country and embed the lessons of these into education programmes. Successes, as well as challenges, should be considered to ensure that students have practical examples to utilise in their development.

3. Role flexibility and multi-disciplinary approaches: we believe that there is a greater role for optometrists to take on some of the current skillsets of ophthalmologists, and for dispensing opticians in turn to play a greater role in areas currently within the remit of optometrists. For optometrists, this may mean greater involvement in community monitoring (allowing ophthalmologists to focus on more complex issues); for dispensing opticians, a greater role in the treatment of some minor eye conditions.

Indeed, this is already happening—but there is further scope for development. While there is still much work needed to identify details and accreditation standards including quality assurance, in principle and in practice we think there is much to be said for breaking down some of the historical barriers between the professions. Such a recalibration, we believe, would lead to more rewarding and patient-centred roles for all optical professionals. Clearly, however, it will be essential to avoid duplication as far as possible.

4. Professional institutions: LOCs and local eye health networks are bodies referred to in statute required to represent their local contractors and performers for the benefit of all. For LOCs to do this effectively, they need regular influxes of fresh ideas and energy that recent qualified optical professionals can provide. We think that education programmes should encourage students at an early stage to think about the ways they could both benefit their local optical communities and broaden their personal professional expertise by considering potential roles to complement clinical competencies. Inter-institutional relationships between the optical professions would also be fostered by this approach.

5. Contracts and regulation: there is a significant level of clinical governance that newly qualified practitioners will be expected to adhere to when delivering both core primary care services (GOS) and, in particular, extended primary care services. It would be to students' benefit if this was explored at a pre-qualifying stage to give them the best grounding for post-qualification requirements, to include knowledge of policies and procedures. A basic understanding of the requirements of the NHS Standard Contract and accompanying legislative requirements would be a good way to achieve this.

The Optical Consumer Complaints Service (OCCS)

The OCCS responds to the consultation as shown below:

Concept 1: Standards for Education Providers

Consultation question 1 - Do you agree or disagree with us further exploring the concept of new Education Standards in the way we describe above?

Agree.

Consultation question 2 - Please tell us more about your views on this concept, including any opportunities or risks you foresee.

This timely review sets out a framework that should liberate the optical education sector to evolve and innovate at a time when both optics and UK Education is undergoing change on a scale and at a pace we have not seen before. The technical and socio economic drivers of change will continue to move apace and concepts and principles set out in this review and critical to ensure the most effective mechanism by which we create a profession fit for the future. Other healthcare profession are already embracing and delivering many of the concepts outlined in the document and this should give us great assurance that they framework is appropriate.

Liberating providers from the outdated handbook should be accelerated ahead of the broader programme to encourage nimble innovative and technologically advanced education providers to deliver programmes that align with the digitally savvy Generation Z student cohort.

The encouragement to co create and co deliver programmes with employers and front line practitioners will facilitate, as we see in other healthcare programmes, a collaborative approach to skills development and sign off. Many new medical degree courses are heavily skewed to clinical competence sign off by front line clinicians not academics and we believe this will create a more consumer focussed profession-given the significantly higher risk associated with medical training we should be confident we can create a safe framework to expose undergraduates to patients much earlier in their training than is currently the case. It cannot be right that the current situation where an optometry graduate can turn up at their pre-reg practice having never undertaken a single patient episode outside a university environment. We should be bold and ambitious on how far we push this patient contact further and earlier into the system.

The OCCS deals with many customer concerns (1400 in 16/17) the vast majority of which have a lack of communication skills at their heart. It is imperative that as a sector we embed customer led behaviours as deeply and early as possible in the development our future workforce. Indeed as technology will replace many of the professional data gathering functions, the ultimate rasion d'etre of the clinician will be to impart advice and to counsel the patient.

Concept 2: Education Standards and Professionalism

Consultation question 3 – Do you agree or disagree with the concept of informing our education requirements by our professional standards?

Agree.

Consultation question 4 - Please tell us more about your views on this concept, including any opportunities or risks you foresee.

Having delivered a number of CET sessions predicated on the new standards, the OCCS see them as a pragmatic framework for registrants to abide by. It is entirely sensible that if compliance with the standards is the measure of clinical competence by which registrants are judged, then it is entirely sensible that the education system is built on that framework.

There is a secondary benefit in that it underpins the importance and validity of the Standards.

Concept 3: Learning Outcomes

Consultation question 5 - What are your views on the concept of system-wide learning outcomes for optometry and dispensing optician education and training, instead of an educational competency-based approach?

The OCCS supports this approach as it will facilitate and enable improved all round confident competent practitioners. The historical competency approach can be somewhat transactional and technocratic with a resulting process focus. Based on our insights a shift to a consumer lead mindset in the optical professionals would also be hugely beneficial in the future.

By exposing students to both the commercial and expectation of paying consumers early will equip them far more effectively for their future careers.

The current system of a standard final PQE should be retained as this appears to be effective in ensuring public safety through technical competence (OCCS reiterate we see very few issues of clinical incompetence). The safety net of a standard PQE should enable us to be more expansive in how we allow undergraduate education to be agile and develop to meet evolving needs over time. Being provocative….From a consumer perspective: “Who cares how we get them there as long as we get them to common standard?”

Concept 4: Links to Continuing Education and Training

Consultation question 6 - What do you see as the merits to removing the current link between CET and our education requirements, if any?

As both users and providers we find the current system is simple to access, easy to understand and administer-although the website is in need of an update as it could be more intuitive and user friendly.

The CET system provides the regulator with a framework by which it can drive activity in key areas (16-19 period and requirement to undertake CET around Practice

Standards) and the ability to use enhanced points allocation to drive registrants to particular modality of learning such as highly effective peer review or peer group discussion.

Consultation question 7 - Do you envisage any disadvantages or risks in this approach, and if so what are they?

Risk in implementing significant change in this area is that we may lose the positive engagement we currently have around CET.

Concept 5: Educational Content

Consultation question 8 - What do you see as the key changes needed to the current content of optometry programmes and dispensing optician programmes to ensure our future requirements are fit for purpose?

Much of our view here is covered in section 2.

Increased and earlier exposure to dealing with real fee paying customers will be essential to develop the soft skills required to be successful in the future. As technology replaces much of the data collection and diagnostic functions of our roles this will be increasingly important.

Front line clinicians must be engaged to work in partnership with education providers to co deliver clinical experience and sign off clinical competence-they are much better placed to do so than a university environment.

Increased co learning with aligned clinical groups & increased HES exposure to facilitate multi-disciplinary working.

Concept 6: Enhanced clinical experience for students

Consultation question 9 - Do you agree or disagree with the concept of embedding clinical elements of education and training progressively from the outset of programmes?

Agree.

Consultation question 10 - Tell us more about your views on this concept.

As set out in previous answers we see this as the most critical step change to enhance the effectiveness of optical education. It requires a step change in regulation but also a mindset change in educators and the profession itself. The idea of 'opting in' to supervision that pervades optometry would be an anathema to other medical disciplines this will need to change and the expectation to supervise students and taking responsibility for their activity must be embedded as a core expectation of all clinicians. This goes to the heart of 'what it means to be a professional'.

Consultation question 11 - What do you foresee as being any positive or negative impacts on students, education providers, employers, patients and carers from taking a hybrid approach?

As long as we design effective systems of governance (as other sectors have done) guidelines to 'pre select' patients early in the process then the risks are minimal are will be balanced by producing more rounded competent confident practitioners. In a world where third year medical students can catheterise /take bloods and assist in surgical procedures the risks in high street optometry are minimal by comparison.

Existing system can leave some undergraduates woefully under prepared for life in high street practice and ill equipped to manage ever increasing public and consumer expectations.

Concept 7: National registration examination

Consultation question 12 - Do you agree or disagree with the concept of a national registration examination?

We do not provide a response on this aspect.

Consultation question 13 - What are the merits and risks of this concept? We do not

provide a response on this aspect.

Concept 8: Multi-disciplinary education

Consultation question 14 - How feasible would it be to develop inter-professional and multi-disciplinary elements of study within optometry and dispensing optician education programmes?

Core elements of a syllabus such as anatomy and physiology could easily be taught in conjunction with other cohorts.

Consultation question 15 - Tell us about any examples you know of already in other disciplines from within or outside the UK?

Teesside University use common modules across nursing/physiotherapy and paramedic cohorts.

Concept 9: Duration of education and training programmes

Consultation question 16 - What do you see as the strengths and weaknesses of retaining the current minimum duration as described above?

We should avoid extension of the current programme. Current political discourse reflects concerns that will increase around cost of education. 3+1 works. Three years of acquiring student debt then one year earning will be more attractive to prospective entrants than 4+0. Graduate apprenticeships (earn while you learn) could be an emerging concept that we may need to embrace in the future. This could encourage

students from diverse backgrounds and those with commercial acumen as well as the ability to excel at the clinical and technical aspects of the education framework.

Consultation question 17 - What could be done differently in order to ensure students become competent, confident and safe beginners?

See previous answers.

Earlier exposure to 'real patients' in 'real' optometric settings (high street or hospital locations) with clinical competence sign off by front line practitioners will create a more effective workforce - more resilient and better able to meet demands of optical consumers. Introduction of minimum clinical episodes before entering a Pre reg year followed by increased levels of minimum episodes during the year will help including a requirement for significant Contact Lenses experience.

Concept 10: UK educational routes to registration

Consultation question 18 - What do you see as the opportunities for more flexibility between the education of different regulated and non-regulated optical professions?

Based on our experience, the OCCS would be comfortable with the concept of creating a career ladder to allow progression as focus must be on producing regulated and nonregulated healthcare professionals who have the required skills to meet the needs and expectations of patients.

Consultation question 19 - What are the constraints and risks to this?

Require effective governance and mapping of skills and transferability of skillset.

Concept 11: Proportionate quality assurance

Consultation question 20 - Are there any other principles and concepts we should consider at this stage in exploring future approaches to our quality assurance processes?

No.

Consultation question 21 - Please tell us about any direct or indirect impact you can foresee from the concepts and principles we have set out in this public consultation on anyone with protected characteristics?

None.

Optometry Northern Ireland

Optometry Northern Ireland responds to the consultation as shown below:

Concept 1: Standards for Education Providers

Consultation question 1 - Do you agree or disagree with us further exploring the concept of new Education Standards in the way we describe above?

Agree.

Consultation question 2 - Please tell us more about your views on this concept, including any opportunities or risks you foresee.

All accreditation and registration organisations have a duty to periodically review their standards. However, it is important that an evidence-based approach is taken and that the notion of 'education' as oppose to 'training' is maintained. Undertaking a Bachelors degree in Science to gain an education in the science of the visual system and optometry as a discipline is inherently distinct from a 'training' programme designed to deliver specific functions. We would not want to see 'optometric education' become a 'training scheme' and consider that optometrists require degree level education. While, the route to registration may contain a mixture of education and training, the former must underpin the latter and we strongly support the idea that optometrists require degree level education.

To our knowledge the optometry undergraduate degree which is currently in place in UK universities delivers a curriculum that includes many of the features highlighted by the GOC. This includes an evidence-based approach to delivering education; undertaking regular programme reviews to ensure current concepts, evolution of scope of practice and skills, and technological innovations are included in programmes. A common feature across programmes is the existence of modules specifically designed to be flexible and responsive to changing evidence, technology and service needs. The recognition by the GOC of the value of inter- disciplinary collaboration is welcomed, but the enhancement of such training opportunities needs to be balanced by ensuring core optometric content is not lost and that training doesn't become generic. The danger in inter-disciplinary learning experiences is that they become 'tick box' or are seen as less relevant by learners if the relevance to the learner's specific discipline isn't clearly signposted. While we welcome interdisciplinary learning that amplifies and enhances the skills and knowledge of undergraduates, programmes should be free to do this where it provides a truly enhanced value and we would suggest that this issue does not receive excessive attention.

The value of active relationships with employers and service providers also needs to be balanced with ensuring the quality and scope of undergraduate provision is not skewed to meet the needs of specific areas of the optical sector, but ensures graduates are able to work across all areas of the discipline and, often, in more than one area during the duration of their career. The graduate should not be pigeon-holed into one specific area of practice early on in their career, thus limiting options later. ONI would encourage the development of business and management skills amongst their staff, but we would argue that this should not come before robust undergraduate

clinical education and training. The ability of optometrists to work across sectors (primary care - multiple and/or independent practice, industry, academia, secondary/tertiary care, charitable sector etc.) is something that should be nurtured for cross-fertilisation of ideas, best practice and life-long learning.

Concept 2: Education Standards and Professionalism

Consultation question 3 – Do you agree or disagree with the concept of informing our education requirements by our professional standards?

Disagree.

Consultation question 4 - Please tell us more about your views on this concept, including any opportunities or risks you foresee.

ONI considers that this concept is misjudged and that includes an evidence-based approach to delivering education is paramount. ONI considers that this concept does not wholly reflect this. We would agree with the notion of using the professional standards to inform the development of new education requirements and we appreciate the importance of the standards for professional practice, but they include relatively little emphasis on knowledge and application of a critical approach to new knowledge, evidence and/or technology. It is our view that the professional standards should inform but not be strongly linked to education requirements. However, we do agree that the current competency frameworks applied to optometric education require revision; if indeed they are retained. For example, the current stage 1 and 2 competency frameworks show a considerable amount of overlap, and, in contrast to areas of overlap, there are skills, knowledge and behaviours that the current framework fails to capture/assess. We believe that assessment of knowledge and the safe application of knowledge must be a central component in the education of potential optometrists and that competency-based frameworks also have a role in evaluating learning outcomes on the route to registration.

Concept 3: Learning Outcomes

Consultation question 5 - What are your views on the concept of system-wide learning outcomes for optometry and dispensing optician education and training, instead of an educational competency-based approach?

The application of a learning outcome framework to optometric training is a reasonable approach. Ensuring students have demonstrated attainment of learning outcomes is a key component of current programmes and is a well recognised method to attain consistent outcomes at the desired level. However, if not robustly applied, outcomes based learning/assessment frameworks can result in superficial approaches to teaching and this approach must be balanced with the retention of a core curriculum.

ONI considers that, ensuring that the education of optometry students is ‘clinically focused and experientially based’ is important, but needs to be balanced with a strong and deep understanding of the basic, unchanging, science of the visual system and visual processing, such that, whatever the future of optometric practice and eye care holds, optometry graduates understand the nature of the visual system and how it works, how diseases and conditions which impair normal visual function act on the

anatomy and physiology of the visual (and systemic) system, and how to maximize each patient's visual performance. We consider that this is the key role of optometrists and requires an underpinning knowledge that is honed and focused by clinical experience. The science needs to be in place for the clinical experience to be sustained and meaningful.

Assessing whether students have met learning outcomes relating to "new and emerging technology" and "demographic needs and patient expectations" are also valuable, but even more valuable is to assess whether they are able to be responsive to and apply scientific and critical thinking to any new (as yet unknown) technology, service models or cultural developments. We strongly agree that the inclusion of research activity and critical thinking within the undergraduate programme is essential to nurture and assess students' ability in this area and 'future-proof' them for optometric practice.

Finally, if a learning outcome based framework is developed for optometry and dispensing optics, the two distinct professions will require different learning outcomes but we do recognise that there may be some overlap. Optometry encapsulates dispensing optics and goes much further in breadth of knowledge; the demands of the degree are currently reflected in the admission requirements for undergraduates and this should continue to be the case.

Concept 4: Links to Continuing Education and Training

Consultation question 6 - What do you see as the merits to removing the current link between CET and our education requirements, if any?

ONI consider that CET should also use a learning outcomes-based approach.

Consultation question 7 - Do you envisage any disadvantages or risks in this approach, and if so what are they?

Concept 5: Educational Content

Consultation question 8 - What do you see as the key changes needed to the current content of optometry programmes and dispensing optician programmes to ensure our future requirements are fit for purpose?

ONI are not sure that there is clear evidence that changes are needed to the current content of optometry programmes to ensure future requirements are fit for purpose. We understand that the Call for Evidence Summary Report has gathered opinion about a changing eye care landscape which we do not contend. This may require optical providers to change the mode and scope of services they deliver, but we are not convinced that there is the evidence that graduates with a BSc/MOptom in Optometry are not suitably equipped to contribute to these new and evolving models of care.

GOC-registered optometrists, educated and trained in the current system, contribute strongly and successfully to many enhanced schemes and extended roles in Northern Ireland and across the UK. Governance structures around such positions do, however, vary widely across the UK. For example, some require clinicians to have formal additional qualifications (such as College of Optometrists' accredited Professional Certificates), while others do not have any such requirements. This indicates that

current education and training provided by universities appropriately prepares students for practice in areas outside core optometry.

It is our opinion that high quality undergraduate programmes already incorporate evidence-informed teaching across the curriculum and, in addition to the core and vitally important modules which cover the science of the visual system, optics and optical materials, ocular (and systemic) pathology and clinical practice, include flexible, dynamic modules designed to house cutting edge topics. ONI consider current that optometric education content is appropriate for entry level practice and could be argued to educate optometry graduates in skills which are over-looked and under-utilised in many primary care settings (see below).

We argue that post-graduate qualifications are a key and under-used resource which should have a stronger profile in optometric careers. We consider that post- graduate qualifications are a key component of a primary care optometrist's potential career progression.

All high quality undergraduate programmes currently deliver content which ensures graduates have the ability to deliver core-level 'enhanced services' which currently operate in the community, e.g. repeat pressures schemes, preoperative cataract assessment. To date, we are aware that this basic knowledge and skill has often not been recognised and optimally utilised by commissioners and eye care providers, with the risk (or perception) that postgraduation optometrists lose skills and confidence in some areas. In many UK locations, when 'enhanced service' schemes are introduced lack of trust in optometrists' basic core skills and/or lack of confidence by optometrists who have not been required to utilise these core skills since registration leads to requirements for further training; often without clear rationale.

To future-proof optometry education and training, an increasing emphasis (contrary to many new/evolving undergraduate programmes) will need to be placed on the ability of graduates to utilise primary research as an evidence base for practice, applying this in conjunction with sound clinical skills and taking a problem-solving approach to clinical care. The pace of change in treatment and technologies relating to optometry is accelerating. We cannot 'second guess' what optometrists of the future will need to know but equipping graduates with skills in critical analysis of research outcomes and published data will be invaluable for their ability to respond to change and apply an evidence-based approach to their future practice. This will become increasingly important with increased Optometric involvement in extended-roles and comanagement of eye disease, particularly for practitioners working in isolation. A greater emphasis on ophthalmic public health and increasing interdisciplinary working will also help address this. Mandating competency in specific enhanced skills at undergraduate level is likely to mean that curricula become outdated more rapidly. It would seem sensible, therefore, for such specialised functions, e.g. independent prescribing, to continue to be optional, post- graduate training. Post-graduate training is more flexible and nimble in responding to changing service and delivery needs. Post-graduate training not only enhances clinical service provision, as needed, but provides valuable lifelong learning opportunities for practitioners, which aligns with modern educational theory and practice. A 'commitment to lifelong learning' is stressed in research presented by the GOC in their consultation document (p. 3-4, Patterns and Trends Research Collaborate Research 2017). The value and success of post-

graduate training is also enhanced by the participant's experience of clinical practice and their maturity, which brings considerable added value to the training and outcomes.

While the impact of technology on practice and its implications for traditional manual skills must be acknowledged, we need to deliver clinicians confident to harness technological developments as they arise for best assessment of eye care, rather than put technology itself at the heart of a programme. Additionally, automated approaches are not appropriate for a significant, vulnerable minority of patients (the elderly, the very young, those with physical/communication/intellectual disability etc.). For example, it is important that core skills such as retinoscopy are maintained and assessed as the most appropriate (sometimes the only) method by which to assess refractive errors.

Concept 6: Enhanced clinical experience for students

Consultation question 9 - Do you agree or disagree with the concept of embedding clinical elements of education and training progressively from the outset of programmes?

Unsure – the answer is dependent on how this would be implemented.

Consultation question 10 - Tell us more about your views on this concept.

ONI considers that clinical elements of education and training are currently embedded progressively from the outset of high quality optometry degrees. Most, if not all, optometry undergraduate programmes commence practical clinical experience in their university eye clinics during the first year of the programme. We understand that this exposure to clinical practice is increased throughout the programme and involves both in-house and placement activity. We would think that the former provides opportunity for closely supervised learning in the clinical arena using a variety of patient interaction opportunities involving a range of patients.

Consultation question 11 - What do you foresee as being any positive or negative impacts on students, education providers, employers, patients and carers from taking a hybrid approach?

Positive:

- Students enjoy varied clinical experience as long as it is well supported and they don't feel out of their depth.
- Students could have experience of working with a variety of other professionals.
- Such an approach could ensure students are not confined to working for a multiple from the outset and dilute the opportunity for multiples to gather workforce. Students will understand the role of the optometrist at an earlier stage of their career.
- Employers may be pleased to utilize students on placement such as pre-screening

Negative:

- To provide a variety of clinical experiences will require more resources and buy in from NHS and other providers of eye care services. In an increasingly pressurised NHS landscape, this would be extremely challenging.
- Students may have onus on them personally to find and facilitate placements. This will disadvantage some students who are less well connected, less resourceful or who have less ability to travel. They will also question why they are being asked to do this when they are paying significant fees to the University and may think the Universities should be in a position to fully fund and facilitate such placements.
- Having a variety of placements may actually disadvantage student development: currently a longer-term single supervisor can identify and nurture areas for improvement; but a shorter-term placement may mean less ownership of the supervisory role and leave the student with knowledge and experience gaps.
- The hybrid approach will likely make it more difficult to deliver equity of experience for students.
- If a placement is not available this might impact on degree/training completion time for student.
- If only certain optical provider can provide placements a narrow minded view of the profession the student may develop
- Placement supervisors may show less interest in students in the early stages of their education/training as they are of less worth to the practice/business (e.g. Can't complete sight tests under supervision)
- Students may end up shadowing qualified practitioners too much rather than gaining the hands-on experience if placement comes too early in the degree
- Patient/carer consent for student placement needs to be considered

Concept 7: National registration examination

Consultation question 12 - Do you agree or disagree with the concept of a national registration examination?

Agree.

Consultation question 13 - What are the merits and risks of this concept?

ONI consider that the current College of Optometrists Scheme for Registration (SfR) following the undergraduate degree is a suitable to route to registration. The independent nature of the scheme and the quality of the governance applied by the College is very beneficial. We recognise the value of graduates being able to choose the type of practice in which they undertake the clinical placement during the SfR period; the inclusion of multiple, hospital, independent and mixed placements should be maintained.

ONI feel that there is significant value in a common national standard for the

registration of an optometrist.

Concept 8: Multi-disciplinary education

Consultation question 14 - How feasible would it be to develop inter-professional and multi-disciplinary elements of study within optometry and dispensing optician education programmes?

Inter-professional and multidisciplinary elements of study are already components of undergraduate optometry programmes in the UK. While there may be scope to increase these components, this must be done to truly enhance learning, not just as part of a 'tick-box' exercise. The opportunities for post-graduate inter-professional learning should be explored by the GOC. This may not be so easily resourced or developed but has the potential to be more relevant and impactful than inter-disciplinary learning at undergraduate level. However, ONI would encourage increased opportunities to build on trust and communication between professional groups and this would potentially be a valuable outcome of the Education Strategic Review.

Consultation question 15 - Tell us about any examples you know of already in other disciplines from within or outside the UK?

ONI is aware that Ulster University currently runs joint teaching sessions with Pharmacy undergraduates.

Concept 9: Duration of education and training programmes

Consultation question 16 - What do you see as the strengths and weaknesses of retaining the current minimum duration as described above?

ONI see benefit in maintaining the minimum four-year period. Shortening the current minimum duration would risk the depth and scope of the education and training provided and the maturity and readiness of those entering the register.

Consultation question 17 - What could be done differently in order to ensure students become competent, confident and safe beginners?

ONI would have the opinion that the ability of graduates is strongly related to the quality of the students taken into the undergraduate programmes. The College of Optometrists have clearly identified a relationship between the strong and weak performance in the SfR and the class of degree obtained. According to colleagues at Ulster University, this can be extrapolated back to the tariff on entry to undergraduate study; with those entering with higher tariffs having better degree outcomes. It follows that the quality of graduates and registrants (i.e. how competent, safe and confident they are as entrants to the register) would be improved by safeguarding the quality of entrants to undergraduate optometry programmes. This can be monitored and maintained through evaluation of the tariff points of those entering the programme.

The GOC have a role in exploring how universities are able to take increasing numbers of undergraduate optometry students without appreciable increases in resources and the effect this has on the quality of the intake in terms of tariff scores and the

subsequent quality of the graduates. There is only so much 'added value' which even the best of optometry programmes can add. Maintenance of high entrance tariffs and academically able undergraduates is only possible if optometry is seen by high-achieving students as a profession worth studying towards for four years. To align with such expectations, the professional landscape into which these graduates emerge must reflect such aspirations; including appropriate remuneration, working environments where optometrists can freely exercise clinical and professional judgement and opportunity for post-registration career progression and development.

The GOC could also ask current/recent pre-registration supervisors and employers which graduates they want to employ and why. Where are these graduates being educated and how do these education providers differ from the providers that employers/supervisors prefer not to employ. This is a controversial and potentially painful approach, but could be informative.

The idea of embedding clinical experience within undergraduate programmes has great merit and most institutions have an in-house public eye/optometry clinic which allows students access to supervised patient experiences both for eye examinations and ophthalmic dispensing before they graduate. The quality, diversity and validity of these experiences and the supervisory arrangements are, in our experience, key to developing "competent, confident and safe" beginners.
Public access clinics, properly run and delivered in a teaching context, encourage a flexible, responsive and professional approach and are key to producing graduates that are fit for purpose.

Close supervision, delivered by experienced optometrists (and other eye care professionals) within the framework of a teaching clinic, provides opportunity for the safe development of clinical skills. This close interaction between supervisors and students in a real clinical setting is also a powerful method through which the 'softer' skills relating to professionalism, communication and the interface between commerce and clinic can be learnt and reflected on. Many graduates are *"competent, confident and safe beginners"*, but they need to recognise their limitations and be comfortable in asking for help and advice. Universities may have a greater responsibility than they currently deliver in maintaining a relationship with graduates throughout the early years of their training. Such a relationship may be valuable in allowing a means of asking for help or for signposting to organisations which are a strong, but perhaps underused, resource for newly qualified optometrists, i.e. College of Optometrists and the Association of Optometrists.

Concept 10: UK educational routes to registration

Consultation question 18 - What do you see as the opportunities for more flexibility between the education of different regulated and non-regulated optical professions?

The route from dispensing optician to optometrist is currently well-defined and available, as is the route from optometrist to Independent Prescriber optometrist. We do not see an advantage in modifying these well-trodden and apparently successful routes. Individuals in non-regulated roles are also able to apply to undertake training to qualify as a dispensing optician, optometrist or contact lens optician. It is clearly important for the profession that entrance criteria to these education programmes are

maintained for all applicants for the reasons discussed above (e.g. in 17). There are no barriers to individuals moving from optical assistant, to dispensing optician to optometrist etc. if they have the proven ability to meet the entrance criteria of the relevant education programmes and there are Foundation degrees offered by many institutions which may be an appropriate route for such progression.

Consultation question 19 - What are the constraints and risks to this?

In a dynamic eye care landscape, the best way to ensure this is to maintain the quality of those entering the regulated eye care professions and the quality and rigour of the education they undertake such that professionals are equipped to deliver excellent eye care; meeting the needs of patients in a variety of settings and responding to changes in technology, working environments, funding structures and patient need. In the interests of public safety, this may restrict flexibility of movement from non-regulated roles to regulated roles.

Concept 11: Proportionate quality assurance

Consultation question 20 - Are there any other principles and concepts we should consider at this stage in exploring future approaches to our quality assurance processes?

ONI would like to see the GOC enforce future quality assurance processes consistently across all institutions.

Consultation question 21 - Please tell us about any direct or indirect impact you can foresee from the concepts and principles we have set out in this public consultation on anyone with protected characteristics?

A possible impact on those with protected characteristics may be the change to a hybrid course that requires clinical placement. Equality and diversity measures would need to be as stringent in the placement as in University policies.

Optometry Schools Council

The Optometry Schools Council responds to the consultation as shown below:

Concept 1: Standards for Education Providers

Consultation question 1 - Do you agree or disagree with us further exploring the concept of new Education Standards in the way we describe above?

Agree (majority).

All accreditation and registration organisations have a duty to review their standards periodically. In the light of projected changes to future optometry and optical practice it is sensible to review Education Standards. Introducing new Education Standards would enable the profession to reemphasise the priority of patient care and safety as the primary focus in education, and in the development of the professions and their scopes of practice.

There is a risk however that setting high- level Education Standards will render such standards difficult to both demonstrate and evaluate.

Consultation question 2 - Please tell us more about your views on this concept, including any opportunities or risks you foresee.

There is a fundamental question to be addressed as to whether Education Standards set by the regulator are for the sole purpose of assuring quality of education, or whether they are intended to drive educational provision in a particular direction. The latter seems to be an explicit goal here and therefore we must be careful that the premise for, and nature of, proposed change is valid. While agreeing with the principle of exploring new Education Standards, we are concerned that there are already assumptions in the consultation document about what these should achieve and which, at the very least, require further and full discussion with education providers.

For example: With respect to the key statement that *'Insufficient clinical competence, confidence and professional willingness among optical professionals to undertake new roles…is seen to be linked to the content and structure of existing education and training,"* it is important that available empirical evidence is presented, and that other factors that may contribute to problems in these areas are also identified. A lack of clinical competence amongst newer registrants is not apparent from a review of GOC disciplinary and fitness-to-practise hearings between 2001 and 2011 (Forte, 2015), which highlighted a very small number of cases compared to the overall numbers of registrants, and revealed that the longest-registered practitioners were most likely to be involved in investigation relating to clinical competence. We do not know to what extent the limitation of practitioners' competence, confidence and willingness to undertake new roles is a reflection of their working environment rather than of their education and training.

Forte JC. (2015). Survey of General Optical Council disciplinary and fitness to practise hearings: 2001-2011. DOptom thesis, Aston University http://publications.aston.ac.uk/28816/1/Forte_Josie_2016.pdf

The consultation document also states: “If we were to introduce new Education Standards … we might direct them more strongly towards encouraging and engendering innovation, variety and flexibility in the way programmes leading to registration with us are delivered and continue to evolve.” This implies, incorrectly, that innovation and flexibility has somehow been held back by existing Education Standards. This is not the case - existing optometry programmes, accredited under existing GOC standards, already demonstrate a variety of routes to registration, and varied approaches to delivery including e-learning and blended learning.

Universities, by nature, seek opportunities for innovation, variety and flexibility. The desire for *“modular and flexible learning models … part-time and earn-as-you-go etc.”* is one that most if not all universities would be willing to explore, but what matters is that any such developments must deliver degree-level education.
Optometry programmes are not, and must not become, training programmes. Good practice must be supported by good theory, and teaching must be supported by research. Degree programmes in optometry must continue to provide a strong scientific foundation for clinical practice, and students admitted to such programmes must be capable of succeeding at this level.

Embedded in the desire for part-time and earn-as-you-go approaches, there is often the notion that all we have to do is to give everyone the opportunity to undertake study, in whatever form it can be made most accessible, without regard to how the intellectual demands of the programme, alongside the demands of family-life and working-life, limit the viability of this approach. A serious risk in driving universities to offer flexible, part-time, earn-as-you-go, pic’n’mix programmes, is that while some very able students will navigate their way through such programmes successfully, many others will find the demands overwhelming and will withdraw or fail.

In relation to the criteria and features outlined in the consultation document, we are sympathetic to the spirit of many of these aims, but these too seem to imply that education providers are not already active in such areas. What we see, across optometry schools generally, is the existence of modules specifically designed to be flexible and responsive to changing evidence, technology and service needs.

The value of active relationships with employers and service providers also needs to be balanced with ensuring the quality and scope of undergraduate provision is not skewed to meet the needs of specific areas of the optical sector, but ensures that graduates are able to work across all areas of the discipline and, often, in more than one area during their career. Naturally, employers may want to encourage the development of business and management skills amongst their staff, but we would argue that this should not be prioritised over a solid foundation of clinical education and training. The ability of optometrists to work across sectors (primary care practice – corporate and/or independent, optical industry, academia, secondary/tertiary care, charitable sector etc.) is something that should be nurtured for cross-fertilisation of ideas, best practice and life-long learning.

Concept 2: Education Standards and Professionalism

Consultation question 3 – Do you agree or disagree with the concept of informing our education requirements by our professional standards?

Optometry schools are divided on this question, over all three responses (agree, disagree, don't know).

Consultation question 4 - Please tell us more about your views on this concept, including any opportunities or risks you foresee.

Once again the incorrect assumption is implied, that professional practice standards do not already permeate the education and training that students receive. Schools generally are of the view that the standards of knowledge, skills, and behaviour expected of students on optometry programmes are well-informed by an understanding of professional standards. We note that the majority of academic staff in optometry schools are themselves GOC-registered optometrists who are familiar with professional standards and their importance in student education. Overall, the view of the optometry schools is that professional standards should continue to inform education standards, but need not necessarily be strongly linked to them.

There is a distinct difference between standards of knowledge and skills on the one hand, and standards of behaviour on the other, and this distinction needs to be recognised and maintained. Students (and qualified practitioners) may achieve requisite standards of knowledge and skill but fall short in their behaviour, or vice-versa.

Standards of knowledge and skill are encompassed by the competency frameworks; the prevailing view in the optometry schools is that these require revision, which should include a reconsideration of whether it is in fact meaningful to apply the concept of competence to students (pre-registrants) who, by definition, are not yet competent to enter unsupervised practice. We believe that assessment of knowledge and the safe application of knowledge must be central in the education of optometrists, and that competency-based frameworks have a role in evaluating learning outcomes on the route to registration. The revision of the competency framework to better capture higher-level knowledge, skills and experience would be welcomed.

With regard to standards of behaviour we note that education providers generally have their own standards and procedures for fitness-to-study / fitness-to-practise, but these may differ significantly between institutions, and there are no clear criteria from the GOC as to what should be regarded as unprofessional behaviour at university, under what circumstances should a student's behaviour be referred to the GOC, and what sort of behaviour or circumstances (e.g. mental health issues) should cast doubt on fitness-to-study, etc. If the profession wishes to ensure that high standards of professionalism are not only promoted but also required through the stages of optometry education, pre-registration and post-registration practice, then the regulator must make it clear to the education providers and their prospective students what is required, so that this may be communicated and applied consistently across all institutions.

Concept 3: Learning Outcomes

Consultation question 5 - What are your views on the concept of system-wide learning outcomes for optometry and dispensing optician education and training, instead of an educational competency-based approach?

The principle behind this concept appears to be the degree to which the GOC should continue to be prescriptive about educational requirements, through detailed specification of competencies, as opposed to outcomes focused, which suggests a loose & more flexible approach under which providers would be expected to address broad outcomes rather than specific competencies. Examples of such outcomes include: clinical practice techniques and the application of relevant, new and emerging technology, demographic needs and patient expectations, safety and professionalism, and new and evolving service delivery/business models.

First, we note that most if not all of the broad outcome 'themes' mentioned here are already addressed in optometry programmes. As with so much of the current review, we detect here signs of the GOC being urged to direct change in a way that not only betrays a lack of understanding of what optometry education currently delivers, but seems determined to shift emphasis towards a view of what is (or will become) desirable in practice / business at operational level, as opposed to what is necessary in programmes delivering science, health and psychology-based graduate-level education to provide the profession of optometry with the sound intellectual foundation it requires.

Although some elements of the current competency-based approach are rather prescriptive, and limit how flexible providers can be in the delivery and assessment of programmes, the granularity provided by the competencies and the minimum requirement prescribed by the numbered patient episodes ensures that the underpinning syllabus is covered and assessed in its entirety, and that students remain engaged in the course throughout its duration. Competencies provide students with a transparent framework of clinical and academic benchmarks to work towards throughout their course. Ultimately, some framework must exist against which students can be assessed consistently across all education providers.

An outcomes-based approach is fine provided such outcomes can be appropriately quantified. There are risks in encouraging a free-for-all approach to professional education. How will this be scrutinised, and quality and consistency assured? Indeed, the pendulum appears to have swung full circle - a competency-based approach was introduced for the very reason that outcomes are so difficult to assess in a snapshot-type evaluation.

One significant risk of an outcomes-based approach is that it results in an over-reliance on the integrity of the education provider. Another is that education providers may come under pressure to mould their programmes to meet the business and training needs of employers or other stakeholders, rather than to achieve the fundamental educational standards required by the accrediting body. If there is to be a move in this direction then the 'high-level' outcomes must also focus on intellectual skills, including the ability to weigh evidence and develop understanding from first principles. This will be essential for optometrists already faced with an unprecedented

pace of technological change - to avoid becoming ‘button pushers’ or mere technicians, optometrists must understand underlying concepts and principles.

If not applied robustly, outcomes-based learning and assessment frameworks can result in superficial approaches to teaching, so this approach would need to be balanced with the retention of a core curriculum. Ensuring that the education of optometry students is ‘clinically focused and experientially based’ is important, but needs to be balanced with a strong and deep understanding of fundamental principles and the basic science of the visual system and visual processing. This fundamental scientific knowledge needs to be in place for clinical experience to be sustained and meaningful, and to enable clinicians to develop throughout the course of their careers. We also contend that elements such as research awareness, critical thinking, public health awareness, and the ability to analyse and interpret data are essential parts of any optometry curriculum.

Finally, if a learning outcome based framework is developed for optometry and dispensing optics, the different professions will require different learning outcomes (although there may be overlap). Optometry encapsulates optics and ophthalmic dispensing but goes much further in breadth of knowledge - the demands of optometry degree programmes are reflected in the current admission requirements for undergraduates.

We need good theory for good practice, and education for professional responsibility and development, rather than training for operational convenience.

Concept 4: Links to Continuing Education and Training

Consultation question 6 - What do you see as the merits to removing the current link between CET and our education requirements, if any?

As the consultation document indicates, the removal of the current link is an implication of moving away from a competency framework towards loosely-specified ‘outcomes’ (Concept 3). Given that we have expressed our concerns about this approach, we prefer to view the question of continuing education more broadly than in terms of competency- based CET.

Regardless of the approach that may be taken in response to Concept 3, we favour Continuing Professional Development (CPD) as opposed to entry level CET linked explicitly to educational competencies. CPD might, for example, include recognition of professional development activity such as university MSc or DOpt qualifications, College of Optometrists higher certificates and diplomas, training in important new and emerging technologies, etc. We believe that the requirements for registered optometrists should be strengthened to ensure they remain up-to-date with elements of clinical practice that are particularly relevant to their roles, and (as is the case with postgraduate and professional higher qualifications) should encourage optometrists to develop their scope of practice, rather than just maintaining the minimum standard for entry-level professional practice.

Consultation question 7 - Do you envisage any disadvantages or risks in this approach, and if so what are they?

There are some challenges for CPD. It may result in losing the ability to evaluate whether most members of the profession are actually maintaining their basic skill levels, unless the CPD scheme retains some base-level minimum level of achievement that applies to all.

Because of differing modes of practice it may be difficult to make certain elements of education and training compulsory and to set generic outcomes, because these may not be relevant to everyone.

A move to CPD would require a significant change in mind set by registrants, with more personal planning of development activities and maintenance of records of activity.

Concept 5: Educational Content

Consultation question 8 - What do you see as the key changes needed to the current content of optometry programmes and dispensing optician programmes to ensure our future requirements are fit for purpose?

The call for evidence identified likely future healthcare needs for the population, and the optometry schools agree unanimously that changes in education should focus principally on enhancing the knowledge and skills of optometrists to enable the profession to expand its scope of practice in health-related areas.

We are, however, concerned that there may be an incorrect implication in this concept that radical revision of optometry programmes is required for future 'fitness', as though universities have failed to provide optometry graduates with the skill-sets to adopt, with additional training where necessary, novel and evolving approaches to patient care. We have no seen evidence to support a view that significant change is needed to the current content of optometry programmes to ensure that future requirements are fit for purpose? Also, does this imply that the GOC proposes to specify what is required in the content of optometry programmes henceforth? This would be the opposite of an outcomes-based approach.

It is our contention that most, if not all, undergraduate programmes already incorporate evidenceinformed teaching across the curriculum and, in addition to the core and essential modules covering the science of the visual system, optics and optical materials, ocular and systemic anatomy and physiology, ocular disease, and clinical practice, we include content such as ocular imaging, disease prevention, and public health.

Our experience of delivering undergraduate and post-graduate teaching is that optometry programme content is not only appropriate for entry-level practice, but also educates students in areas routinely overlooked and under-utilised in primary care settings, including visual impairment and rehabilitation, children's vision, binocular vision and orthoptics, and patients with learning disabilities and special needs. Such areas are not always considered when there is talk of the increased role of optometry in healthcare, but we think they should be.

Undergraduate optometry programmes currently deliver content which provides

graduates with knowledge and skills to deliver core-level 'enhanced services' in the community, e.g. repeat-measures schemes and pre- and post-operative cataract assessment. To date, this basic knowledge and skill has often not been recognised and optimally utilised by commissioners and eye care providers with the risk (or perception) that, post-graduation, optometrists lose skills and confidence in some areas. In many UK locations, when 'enhanced service' schemes are introduced, lack of trust in optometrists' basic core skills and/or lack of confidence by optometrists who have not been required to utilise these core skills since registration leads to requirements for further training, often without a clear rationale.

To help future-proof optometry education and training, more emphasis will need to be placed on the ability of graduates to utilise primary research as an evidence- base for practice, applying this in conjunction with sound clinical skills and taking a problem-solving approach to clinical care. This will become increasingly important with increased involvement of optometrists in extended roles and comanagement of eye disease. A greater emphasis on ophthalmic public health and increasing interdisciplinary working will also help address this.

Mandating competency in specific enhanced skills at undergraduate level is likely to mean that curricula become outdated more rapidly. It would seem sensible, therefore, for such specialised functions, e.g. independent prescribing, to continue to be optional, post-graduate training. Postgraduate training is more flexible and nimble in responding to changing service and delivery needs. Post-graduate training not only enhances clinical service provision as needed, but provides valuable life-long learning opportunities for practitioners, which aligns with modern educational theory and practice. A 'commitment to lifelong learning' is stressed in research presented by the GOC in their consultation document (p.3-4, Patterns and Trends 2017). The value and success of post-graduate training is also enhanced by the participant's experience of clinical practice and their maturity, which brings considerable added value to the training and outcomes.

While the impact of technology on practice must be acknowledged, we need to educate clinicians who will feel confident to harness technological developments as they arise, rather than putting technology itself at the heart of our programmes.
There is a view in the optometry schools that the emphasis on changes in technology in this review of education is somewhat excessive and misguided. Technology changes quickly, underlying concepts and principles do not. We should build educational programmes on fundamental scientific concepts and principles, and the methods that arise from their application, and not on the basis of throwing out these established methods to make way for ad hoc training on the latest technology. Practitioners who qualify with a solid understanding of concepts and principles will adopt and adapt to new technologies with ease as they develop, as has generally been the case. Additionally, automated approaches to refraction are not appropriate for a significant, vulnerable minority of patients (the elderly, the very young, those with physical or communication or intellectual disability etc.). For this reason, it is essential that core skills such as retinoscopy and manual subjective refraction are maintained and assessed as the most appropriate (sometimes the only) method by which to assess refractive errors, at least for the foreseeable future.

Concept 6: Enhanced clinical experience for students

Consultation question 9 - Do you agree or disagree with the concept of embedding clinical elements of education and training progressively from the outset of programmes?

The overall consensus in the optometry schools is that this issue is too complex and multifactorial, and its implications are too significant, to be reduced to a question of agreement or disagreement. The prevailing view is succinctly expressed by one school as follows: "it is hard to disagree with the statement above, but we disagree with some of the ideas presented in the context of posing this question, hence we have identified 'disagree' as our response."

Consultation question 10 - Tell us more about your views on this concept.

It is already the case that optometry programmes combine academic study with clinical experience from the start, but that early experience is generally not in a real practice setting. It is therefore important to be clear that the 'hybrid approach' and 'clinical elements' referred to in this concept do not refer to the various forms of in- house clinical experience that education providers do or could provide but, rather, are specifically concerned with the desire that students should gain more of their undergraduate education in real practices. At present many students work in practice at weekends or in holiday periods, and thus gain some valuable practice experience, but this is generally not integrated with their university-based experience.

We broadly agree that opportunities for students to gain more real practice experience integrated into their educational programmes should be beneficial, though we do not think that every aspect of such an approach is necessarily ideal. Where we particularly disagree with this concept is on the feasibility of achieving it at scale, and also that a natural and inevitable implication of this approach is a move away from the pre-registration period to a position where the education providers take responsibility for the entire student journey up to the point of registration.

In order to gain sufficiently varied practice experience to mitigate the perceived limitations of the main body of practice-based education taking place in one location immediately prior to registration, it would be essential for all students to experience different types of practice environment during their university programme. Given that the total number of UK optometry students is probably in excess of 3500 (all programme stages), how feasible would it be to provide meaningful placements for all students? Who will provide opportunities for students to learn 'clinical elements of education and training' in practice, who would supervise it, what would it cost, and who would pay for it? We pose these questions not as rejection of the principle but to highlight the scale of the challenge.

The consultation document states "it would most likely necessitate education and training institutions building active, innovative and ongoing relationships with a range of eye health service providers - such as independent and multiple community optometry practices, domiciliary care providers, community ophthalmology-led services, and hospital eye services, as well as where relevant continuing to develop their university eye clinics." We particularly would like optometry students to have more experience of

working in healthcare settings but, as a profession sitting largely outside the NHS, formalising such clinical experience with NHS providers could be exceedingly difficult, in addition to the fact that placements in NHS settings would probably be in short supply compared to the number of optometry students. Naturally therefore the education providers would need to look mainly to the large 'multiples' who currently provide the majority of pre- registration positions for graduates. It is already apparent, however, that there is a reluctance on the part of some employers and practice owners to take students for clinical placements when their knowledge and clinical skills are at an early stage of development, because this is perceived by the practice as involving more cost than benefit. Students, by definition, must develop their clinical skills under supervision, and a hybrid approach to educate can only work if those with supervisory responsibility in the practice environment can be relied upon to think and act as educators, not as employers.

We acknowledge that for students in the earliest stages of optometry programmes it may be feasible to develop an approach that formalises the modest amount of practice experience that some already gain through part-time employment, and to extend this to all students, so that it can be properly integrated into the students' education. Such an approach would foster cooperation between education provider, employer and student and might work to the advantage of all parties. Ideally, then, a continuation of such a relationship forward to the later stages of the students' education would seem like a natural progression. However, when the requirement of these later stages is that students spend most or all of their time in practice, as is the case currently with the pre-registration period, then serious feasibility issues arise and risks increase.

We do not support the view expressed in the consultation document that "a consequence of taking a more hybrid approach would be to move away from the notion of the 'pre-registration year', where that applies, and that education providers would take on responsibility for the entirety of the student journey".

First, this is not by any means an inevitable consequence, as 'hybrid' arrangements to share elements of education between practice and university could apply at some stages of optometry programmes but not others. An all-or-nothing approach is not necessary and there is no reason, in principle, why a pre-registration period following graduation from university should not continue to exist.

Second, the implications of education providers 'taking on responsibility' for that part of the students' educational journey is that they (the providers) would become responsible for a variety of aspects, which would include: a) finding placements for students for extended periods of many months of clinical practice, b) managing the three-way relationships between themselves, their students and the supervising practices, including undertaking quality assurance of the supervision provided and students' experiences, and resolving any difficulties or disputes, c) training and accrediting practice-based supervisors, and overseeing the assessment of students' progress, d) managing final assessments for the purpose of registration – unless this continues to be handled externally and independently (see Concept 7). Education providers in optometry are simply not resourced adequately to handle the additional workload and responsibility that this entails.

In addition, aside from resources, we perceive a major risk in this model relating to understanding and fulfilment of roles. Under the current pre-registration arrangement, students are employed and their employer is responsible for providing the clinical education and practice experience they need at that stage. Much of what we have heard over the period of this consultation, however, suggests that many employers see this responsibility as more cost than benefit and that, rather than continuing to take responsibility for students' education, they would like the education providers to supply students already registered and 'practice-ready'. As this would be impossible to achieve without involving students in extended periods under supervision in practice, the 'hybrid approach' would then require these same employers to work with the education providers but, instead of having authority and seeing themselves as employers, they would need to behave as educators working under the authority of the providers responsible for the educational programmes. We would like to think that this could be achieved, to the mutual advantage of all parties, but we see little in the way of evidence that the major employers would be willing to play a full part as educators in such a model.

In summary, we have grave concerns about vigorous promotion of a hybrid approach to optometry education, and we urge the GOC not to consider driving education in this direction without engaging fully in joint discussions with current education providers, employers/placement providers, and the College of Optometrists (which manages the current Scheme for Registration) to fully evaluate the feasibility and viability of the idea.

Consultation question 11 - What do you foresee as being any positive or negative impacts on students, education providers, employers, patients and carers from taking a hybrid approach?

Some of our views on this are captured in our response to the previous question.

Further to this, potential positive impacts include: students gain insight into professional practice and the working environment, and learn relevant skills sooner and more persistently; education providers and employers develop better cooperation and mutual understanding with opportunities for shared working and collaboration; all parties including patients and carers benefit from opportunities to improve optometry education and its primary purpose which is improved patient care. Further positive impact of a hybrid approach implemented in the form of an apprenticeship model of education could be benefit to students who could 'earn-as- they-learn', with improved opportunities for career progression within the professions, and prospects for part-time study.

On the other hand, potential negative impacts include: the hybrid approach only gains employer support in the context of apprenticeship models of education, and employers are unwilling to commit to playing a full part in optometry education unless they can also control the 'release' of their employees/students to undertake academic study.

The idea of apprenticeship models in optometry/optical education would itself warrant further discussion between GOC, education providers and employers.

Concept 7: National registration examination

Consultation question 12 - Do you agree or disagree with the concept of a national registration examination?

Agree (majority).

Consultation question 13 - What are the merits and risks of this concept?

We support the view, in the consultation document, that "a standardised examination or assessment could maintain a national benchmark for equivalence that overarches a potentially more varied range of approved education programmes". Although consistency of standards across education providers should be accounted for by institutional quality assurance mechanisms including external examiner procedures, there is broad agreement across optometry schools that a national registration examination that is independent of the education providers is in the public interest.

However, in order to protect the public, any new national registration examination must be at least as robust as the current scheme of assessments undertaken by pre-registration optometrists under the auspices of the College of Optometrists. Assessment of practical abilities and clinical expertise is costly and difficult. If replaced by only a knowledge-based assessment, this would be inadequate as an examination to permit registration.

Overall, we consider that the Scheme for Registration currently managed by the College of Optometrists already meets the requirement of providing an independent assessment framework, with well-established and high-quality governance already in place. A distinct advantage of the College continuing to act in this capacity is that, as the professional body it is well-placed to understand the standards required for professional practice and how they should be assessed. Also, it is independent of the optometry programme providers. We see no obvious advantage in replacing this arrangement.

Concept 8: Multi-disciplinary education

Consultation question 14 - How feasible would it be to develop inter-professional and multi-disciplinary elements of study within optometry and dispensing optician education programmes?

It is clear that interprofessional learning (IPL) is becoming an increasingly important element of healthcare training (e.g. de Oliveira et al., 2018; Saunders et al., 2018). In the context of optometry, IPL provides a route to increase knowledge of the roles and responsibilities of other professionals; build interprofessional team working skills; broaden understanding of patient management; and, when working with medical professions, develop a greater understanding of the NHS. Furthermore, IPL may reduce the risk of patients who receive care from a range of professionals experiencing problems linked to poor communication and collaboration between healthcare providers (Olson and Bialocerkowski, 2014).

de Oliveira VF, Bittencourt MF, Navarro Pinto ÍF, Lucchetti ALG, da Silva Ezequiel O, Lucchetti G. (2018). Comparison of the Readiness for Interprofessional Learning and the rate of contact among

students from nine different healthcare courses. Nurse Education Today. 63:6468. Olson R, Bialocerkowski A (2014). Interprofessional education in allied health: a systematic review. Medical Education 48: 236-246.

Saunders R, Dugmore H, Seaman K, Singer R, Lake F. (2018). Interprofessional learning in ambulatory care. Clin Teach. Feb 12. doi: 10.1111/tct.12764. [Epub ahead of print]

Inter-professional and multidisciplinary elements of study are already components of most if not all optometry programmes. While there may be scope to increase these components, this must be done to genuinely enhance learning, not just as part of a 'tick-box' exercise. For optometry education providers to facilitate meaningful IPL, the profession must be recognised by other professions as a valuable collaborator- work is likely to be necessary above the level of individual education providers to achieve this. For example, it has been recommended that health profession regulators jointly agree and publish a statement regarding the requirements of prequalification IPL (Barr et al., 2014). A recent mapping of outcomes for pre-qualification IPL (Steven et al., 2017) considered the requirements of five UK health profession regulators (GMC; NMC; GPhC, GDC and HCPC), but did not include the GOC- it is essential that optometry is not left behind as progress is made nationally in this field.

Barr H, Helme M, D'Avray L. (2014). Review of Inter-professional education in the United Kingdom 1997–2013: Centre for the Advancement of Inter-professional Education.

Steven K, Howden S, Mires G, Rowe I, Lafferty N, Arnold A, Strath A. (2017). Toward interprofessional learning and education: Mapping common outcomes for prequalifying healthcare professional programs in the United Kingdom, Medical Teacher, 39:7, 720-744, DOI: 10.1080/0142159X.2017.1309372

A caveat to this however is, once again, the need to recognise limitations on what can be expected and achieved within optometry programmes due to lack of funding and time.

Consultation question 15 - Tell us about any examples you know of already in other disciplines from within or outside the UK?

Olson and Bialocerkowski (2014, op.cit.) report in a systematic review of pre-qualification IPL in allied health programmes many examples in the USA, Canada, UK and Ireland. Health professions included dentistry, diagnostic imaging; medicine; nursing; pharmacy and physical therapy.

Examples of current practice in UK optometry schools includes involvement of orthoptists and ophthalmologists in optometry teaching, and joint teaching sessions involving optometry and pharmacy students. In some schools, optometry and pharmacy students sit as patients for each other in practical assessments, and optometry and medical students visit local optometry practices together. In many schools there is potential to extend the range of professions involved to include, for example, nursing, midwifery, physiotherapy, radiography and occupational therapy but, as mentioned previously, while opportunities for increased interprofessional learning may be available, such experiences must be meaningful and relevant, rather than merely a 'tick-box' exercise. It has been argued, for example, that transferability of IPL activities and effectiveness across professions, institutions and countries cannot be assumed (Richards, 2003).

Richards LV. (2003). Evaluation in medical education: moving forward. Medical Education 37:1062– 3.

Concept 9: Duration of education and training programmes

Consultation question 16 - What do you see as the strengths and weaknesses of retaining the current minimum duration as described above?

There is no 'current minimum' for optometry programmes. It happens that BSc programmes have a 3 year duration in most cases, and the College Scheme for Registration is at least 1 year, so the 'standard' minimum duration is 4 years to registration. Under current arrangements, however, there is nothing to stop a provider attempting shorter or longer durations.
We sense that there is a drive towards provision of shorter programmes which seems to come, in some cases, from prospective students who would like the opportunity to study for an optometry degree in shorter time and at lower cost. We also, however, see some employers wishing to reduce the time that students spend in education. The motivation for this is not entirely clear, except perhaps in the context of the apprenticeship model of education, where there is an obvious incentive for employers to minimise the cost of supporting their employees through education.

A significant strength of the current standard minimum 4 years is that it creates a level playing field where students base their decisions upon educational quality rather than on the financial incentives of short programmes. We see a benefit in maintaining a standard minimum four-year period for the majority of students. Exceptions might be made for programmes that are specifically designed for students with relevant prior qualifications; the obvious example being the existing BSc Optometry (Career Progression) Programme for Dispensing Opticians at the University of Bradford. Aside from such exceptions, however, we consider that shortening the minimum duration would risk the depth and scope of the education and training provided, and the maturity and readiness of those entering the register. Furthermore, optometry degree programmes are demanding, and a significant minority of existing students struggle to complete them successfully. In general, students need time to consolidate their learning, and to gain life experience as well as clinical experience.

Following from the points above, some optometry education providers would favour an increase in programme duration to at least 4 years + 1 year of full-time pre- registration practice-based experience. This is on the basis that future changes in optometry scope of practice, already recognised in the previous stage of the current consultation, will require students to study a wider range of subjects up to a higher level, and to gain as much practice-based experience as possible, in order to be ready to deliver what is required for practice in the near future. It takes time and additional curriculum content to develop students to higher-levels of knowledge and skill, but there is little or no scope to achieve this within existing standard 3 year degree programmes. On the other hand, there is no sound justification for removing basic science and clinical methods from the curriculum (which is what we have heard suggested) in order to make for higher-level skills.

A strength of increasing the length of the degree programme would be the opportunity to enable higher standards and a broader knowledge base to be achieved prior to registration. A weakness is that would increase the financial burden on all students, and the time commitment may deter other students regardless of financial

considerations. We note, however, that 4 year degree programmes are commonly recognised as being necessary in other health-related professions.

Consultation question 17 - What could be done differently in order to ensure students become competent, confident and safe beginners?

In our view, the first requirement to meet the criteria for students to become competent, confident, and safe is that the minimum standard required for registration as an optometrist must continue to be at the level of a BSc Hons degree, plus a requisite amount of experience in clinical practice, with demonstration of clinical competence at the point of registration.
The current system ensures that entrants to the profession are safe to work. Challenges may occur when pre-registration students and newly qualified practitioners are expected to see large numbers of patients each day, rather than building their patient numbers and confidence on a more gradual basis. The GOC could look to regulate working patterns of trainees and newly qualified practitioners, perhaps by introducing a maximum number of patients per hour/ day, and/ or by requiring newly-qualified registrants to work in conjunction with a more experienced practitioner to avoid issues related to a lack of peer support.

It is our experience that a fundamental requirement to ensure that students become competent, confident and safe in practice is to assure the quality of students entering optometry programmes. All education providers seek to 'add value' in helping to develop students from positions of inexperience and relative weakness to become competent and confident practitioners, and part of this involves giving opportunities to students who do not necessarily appear to be academically strong but who show potential. Whatever criteria are used to select students, however, all education providers have a clear sense of 'what good looks like', in terms of prior qualifications, experience and attitudes. To protect the profession and, thereby, the public we need to give priority to the quality of students entering optometry programmes. Currently we face significant challenges in that increase in the number of accredited optometry programmes has run in parallel with decrease in number of applicants to study optometry, to such an extent that the total number of applicants nationally now barely exceeds (if indeed it still exceeds) the total number of university places. In addition there is a lack of diversity in this diminishing pool of applicants. A consequence of this is that universities now have no choice but to admit students that they would not have admitted in the past, and not only is there a significant 'tail' in most optometry schools of students who repeatedly fail exams and assessments, there are also more issues relating to fitness-to-study and professionalism. There is a need for more awareness and understanding of the importance of applicant numbers and applicant quality to the future of the profession.

Concept 10: UK educational routes to registration

Consultation question 18 - What do you see as the opportunities for more flexibility between the education of different regulated and non-regulated optical professions?

In terms of opportunities for career progression, a key driver here appears to be the desire of employers to introduce degree level apprenticeships. We are in favour of unnecessary constraints being minimised to enable those with ability to progress

between professions. Indeed, some flexibility already exists in this regard, with availability of career progression opportunities, recognition of accredited prior learning (APL/APEL), etc. However, APL can be a blunt tool to enable progression.

The route from dispensing optician to optometrist is currently well-defined and available, as is the route from optometrist to Independent Prescriber optometrist. We do not see an advantage in modifying these well-established and apparently successful routes. Individuals in non-regulated roles are also able to apply to undertake training to qualify as a dispensing optician, contact lens optician or optometrist. It is clearly important for the profession that entry criteria to these education programmes are maintained for all applicants for the reasons discussed above (e.g. in Q17). There are no barriers to individuals moving from optical assistant to dispensing optician to optometrist, etc., if they have the proven ability to meet the entrance criteria of the relevant education programmes. Foundation degrees offered by many institutions may be an appropriate route for such progression.

In this vein, any non-regulated experience must have valid evidence of achievement at the appropriate level and in the necessary domains of activity. We agree with the principle of allowing various routes/entry points but each one must have focus on intellectual ability and achievement. As discussed above (Concept 9), aptitude and attitude are the appropriate criteria to enable students to progress from one programme to another.

Consultation question 19 - What are the constraints and risks to this?

We do not see any major risk to the principle of encouraging career progression in present circumstances – the risk to standards, and to the public, arises when the boundaries between professions become blurred.

The GOC must retain the distinction between optical assistants, (dispensing) opticians, and optometrists. These must not be viewed merely as different stages along an operational skillbased continuum, but as distinct professions having major differences in their intellectual and scientific foundations, scopes of practice and professional motivation.

A potential risk for the future, if there are to be successful new hybrid approaches including apprenticeship models, is that the overarching authority of the accredited education providers must be assured. We would hope that any such arrangements could be seen as opportunities for cooperation and collaboration between education providers, employers and professional bodies for the benefit of the profession, but this ideal may not always be realised in practice.

Concept 11: Proportionate quality assurance

Consultation question 20 - Are there any other principles and concepts we should consider at this stage in exploring future approaches to our quality assurance processes?

We urge the GOC to attend to the need for a more consistent approach to quality assurance across education providers. In recent years we have seen apparent differences in the expectations and requirements in relation to staffing and resourcing, for new

providers compared to those with established programmes, and differences in the application of accreditation conditions and recommendations between established providers. We would also ask that consideration is given to the need for and use of information. Submission of onerous amounts of detailed information on programme provision, student outcomes, student experience, etc., is acceptable if the data are used in a meaningful and proportionate manner, but if data are not to be used then they should not be requested. There should be a clear rationale for all data requested and, where possible, the GOC should not duplicate other quality assurance processes if the data and outcomes from these can be used to inform the accreditation process.

A significant concern to be considered at this stage relates to the growth in the number of providers, and the possibility that the outcome of this review may be that the GOC may accept, or even encourage, different providers offering different models of optometry education within a relatively open-ended outcomes-based framework. With increased variability comes increased difficulty in validation and quality assurance - the stakes, and the risks, become much higher.

Consultation question 21 - Please tell us about any direct or indirect impact you can foresee from the concepts and principles we have set out in this public consultation on anyone with protected characteristics?

A possible impact on those with protected characteristics may be a consequence of a change to a hybrid course involving clinical placement. Equality and diversity policies would need to be as stringent in practice as in university.

Optometry Scotland

Optometry Scotland responds to the consultation as shown below:

Concept 1: Standards for Education Providers

Consultation question 1 - Do you agree or disagree with us further exploring the concept of new Education Standards in the way we describe above?

Agree.

Consultation question 2 - Please tell us more about your views on this concept, including any opportunities or risks you foresee.

The role of optometrists, dispensing opticians and contact lens opticians is changing and this approach would allow training institutions to respond to change quickly.

Training institutions must have the ability to adapt quickly whenever there is new technology and innovation in eyecare. The GOC should allow this agility by being less prescriptive with regard to course content, standing back from competencies and allowing an outcome based approach.

Patient safety is fundamental. There must be quality assurance which is proportionate to the level of risk. If QA is inadequate there is a risk that we could see a dumbing down of the courses and variation in students graduating from different universities. We would want to see an improvement in the standard of graduates in regard to what they could actually do, as a result of these changes. Some training establishments will find it more difficult to adapt and it could take some time for change to occur. The profession and ophthalmology will need to be supportive and step up to the challenge of providing clinical experience in placements. This could be problematic.

Concept 2: Education Standards and Professionalism

Consultation question 3 – Do you agree or disagree with the concept of informing our education requirements by our professional standards?

Agree.

Consultation question 4 - Please tell us more about your views on this concept, including any opportunities or risks you foresee.

The standards should be embedded in to all aspects of the curriculum so that professionalism is inculcated from the outset and students are set up for their working life.

Concept 3: Learning Outcomes

Consultation question 5 - What are your views on the concept of system-wide learning outcomes for optometry and dispensing optician education and training, instead of an educational competency-based approach?

We agree with a learning outcomes approach. System wide learning outcomes will require detail of what a student will be able to do rather than the knowledge or skill they will have. This will be important as technology advances and students will have to both understand and interpret increasing amounts of information. It will allow training institutions to be more flexible and innovate as technology and best practise changes.

Concept 4: Links to Continuing Education and Training

Consultation question 6 - What do you see as the merits to removing the current link between CET and our education requirements, if any?

The current CET system is not set up for career long development. It will have to change if the system is to demonstrate that someone has progressed beyond the standard for qualification. If undergraduate training changes to problem based learning then it makes sense that CET follows suit.

Consultation question 7 - Do you envisage any disadvantages or risks in this approach, and if so what are they?

Concept 5: Educational Content

Consultation question 8 - What do you see as the key changes needed to the current content of optometry programmes and dispensing optician programmes to ensure our future requirements are fit for purpose?

There must be an expectation of self-directed learning as an undergraduate which continues throughout the clinician's career. Clinicians who qualified some time ago will need to adapt to this change which some may find challenging.

- Education content has to reflect the changing role of optometrists and dispensing
- opticians and include new technologies
- Opticians in Scotland are considered to be the 'first port of call 'for any eye problem and GP's rarely deal with any eye issues. Optometrists now have to be able to deal with and prescribe appropriately for patients who would previously have been seen in a GP setting. With this and new technologies that are now available it is important to ensure that undergraduate training equips students for this expectation
- As optometrists expand their scope of practice, dispensing opticians and contact lens opticians will need to expand their own clinical skills contact
- The training methodology should be joined up between dispensing opticians, lens opticians and optometrists
- Students need to develop better critical appraisal and problem solving skills and have more exposure to clinical experience in both optometry practices and the hospital eye service. Most importantly, they will need to develop a mind-set whereby lifelong learning is the norm. Blended learning with a patient centred approach would allow students to develop these skills. They should have exposure to multi-disciplinary teams and be capable of working within a healthcare team.

- Good communication skills and the ability to make decisions based on interpretation of results qualification as
- The undergraduate course should include IP and get the students as close to that possible

Theoretical learning needs to be enhanced by practical experience. This helps students grasp the concepts of any theoretical knowledge. Clinical placements in optical practices and hospital departments are key.

It would be sensible for universities to look at the evidence of what is happening in each of the four nations and structure their courses accordingly.

Concept 6: Enhanced clinical experience for students

Consultation question 9 - Do you agree or disagree with the concept of embedding clinical elements of education and training progressively from the outset of programmes?

Agree.

Consultation question 10 - Tell us more about your views on this concept.

Consultation question 11 - What do you foresee as being any positive or negative impacts on students, education providers, employers, patients and carers from taking a hybrid approach?

- It is vital for students to gain as much clinical decision-making experience as possible
- Theoretical learning can be enhanced by clinical experience. Students would benefit by having much more time with patients as this experience will allow them to grasp the concepts which they have previously only learnt in theory
- Students would also benefit from spending time in a hospital situation working alongside ophthalmology
- In Scotland we have 'teach and treat' clinics run by NES for post graduate optometrists. One of these centres is situated beside an A and E department and because of its location optometrists at this clinic get to see a lot of acute presentations which have been referred over from A and E. This type experience would be extremely beneficial to students and it would be good if clinics like this were available for undergraduates. This sort of experience would set students up much better to deal with the different types of situation that present in practice and learn communication skills with real patients. Working with ophthalmology would expose students to a 'medics' attitude to risk.
- There will be an issue finding placements for students, this will rely on the support of optometry practices who can provide the required learning experiences
- In regard to ophthalmology clinics, they are already under pressure to train other professional groups and may not be able to fulfil the demand for teaching of undergraduates
- Employers would face the challenge of providing close supervision in the early stages of the course during placements. There would also be the need to coordinate placements as more students came through the programmes

- It will be crucial that there is quality assurance on clinical placements for this to work well
- There should be an ongoing robust record of the student's placement progress which is an easily auditable record reviewed by lecturing staff. This should be supported by a mandatory mentor programme which ensures the quality and consistency of the mentor.

Ultimately employers and patients will benefit from more rounded graduates arriving at the pre-registration stage who will have better abilities to deal with the challenges that face them in practice.

Concept 7: National registration examination

Consultation question 12 - Do you agree or disagree with the concept of a national registration examination?

Agree.

Consultation question 13 - What are the merits and risks of this concept?

On balance we believe it necessary to retain a registration exam. There needs to be a basic registration that allows optometrists to practise UK wide which is standardised and avoids the potential of inconsistency in what new professionals can actually do.

The question for Scotland is whether the country requires its own exam in recognition of the extra skills which are required to work in Scotland. We believe that any student coming through this proposed new training regime should be fit for purpose to work in Scotland when qualification is based on outcomes. As more enhanced services and shared care happens elsewhere in the UK the profession is becoming more aligned across the four nations.

Another question to ask would be; could other providers e.g. NES provide this exam and who would pay for it?

Concept 8: Multi-disciplinary education

Consultation question 14 - How feasible would it be to develop inter-professional and multi-disciplinary elements of study within optometry and dispensing optician education programmes?

Optometry Scotland supports this concept. Optometry and dispensing optician students will increasingly form part of a multi-disciplinary team and would benefit from shared learning with many other health and social care professionals. There are many opportunities e.g. learning pharmacology alongside pharmacists, safeguarding and social work issues alongside social workers as well as learning with junior medics.

Consultation question 15 - Tell us about any examples you know of already in other disciplines from within or outside the UK?

Concept 9: Duration of education and training programmes

Consultation question 16 - What do you see as the strengths and weaknesses of retaining the current minimum duration as described above?

The optometry course in Scotland is 4 years and we believe that this presents the opportunity for students to graduate IP ready. The course should allow time for as much clinical experience as possible. One possible option would be to consider a change from a science degree to a clinical degree. This would extend the course but across the same timeframe.

Consultation question 17 - What could be done differently in order to ensure students become competent, confident and safe beginners?

Problem based learning and clinical experience and placements will allow students to become competent and confident beginners.

Concept 10: UK educational routes to registration

Consultation question 18 - What do you see as the opportunities for more flexibility between the education of different regulated and non-regulated optical professions?

- We believe that there should be varying routes in to optometry and dispensing
- Entrance qualifications should include experience and accredited prior learning and access courses should be available to allow career progression. Admission should be focused on an ability to understand the fundamentals of eye health and optics, good communication skills and the ability to work as part of a team
- Interviews for under-graduate courses should be part of this process in order to identify the right people for the right training
- Any prior learning accreditation or experience must be considered to allow movement between the different roles

Consultation question 19 - What are the constraints and risks to this?

Accreditation of experience and structured education for unqualified staff would increase flexibility and improve access to a career ladder.

Concept 11: Proportionate quality assurance

Consultation question 20 - Are there any other principles and concepts we should consider at this stage in exploring future approaches to our quality assurance processes?

QA must be fair and proportionate focusing on outputs rather than inputs.

Consultation question 21 - Please tell us about any direct or indirect impact you can foresee from the concepts and principles we have set out in this public consultation on anyone with protected characteristics?

Optometry Wales

Optometry Wales responds to the consultation as shown below:

Concept 1: Standards for Education Providers

Consultation question 1 - Do you agree or disagree with us further exploring the concept of new Education Standards in the way we describe above?

Agree.

Consultation question 2 - Please tell us more about your views on this concept, including any opportunities or risks you foresee.

Moving to the system described gives the opportunity to allow education to be provided more flexibly. OW would recommend an increased level of clinical experience and improved clinical decision making skills from newly qualified optometrists, and this could be strengthened by moving to new education standards.

Increasingly in Wales, as more services are moved to community settings, Optometrists core skill sets may need to diversify. The education standards should consider how they may be written to allow students to specialise in areas of interest early in their education, whilst maintaining those core skills required to be an Optometrist.

Summary of views:
- In Wales, Government Policy in relation to eye care is focussed upon moving services where appropriate to the community setting and funding for higher qualification course fees has been recurrent over the last 2 financial years. This highlights the need for optometrists to be able to diversify into specialist roles from early in their career, to be able to keep pace with the changing landscape in Wales
- Any change to the way that Education is delivered and the workforce is regulated should of course always be with Patient Safety as its foundation

We would draw attention to the importance of:
- Supporting students (postgraduate and undergraduate)
- Optometry Departments to use standard setting processes to set the pass mark for students (as opposed to the Universities set pass marks.
- We are aware that some proposed changes might require significant investment in terms of financial and capacity resources for example, small group work and clinical placements. Without funding this could impact the number of optometrists coming into the profession, which would be detrimental to eye care delivery in Wales.

We do agree that taking an evidence based approach to designing and delivering education and using the approach that some universities are already taking (an integrated approach to teaching) which we believe reinforces understanding and develops skill sets over time in a more effective way than simply doing a module and then moving on to the next topic. We caveat this with the fact that this will be a very new way of working for many and there will need to be a supportive infrastructure built around this.

Concept 2: Education Standards and Professionalism

Consultation question 3 – Do you agree or disagree with the concept of informing our education requirements by our professional standards?

Agree.

Consultation question 4 - Please tell us more about your views on this concept, including any opportunities or risks you foresee.

Summary of views:
- We believe that professionalism should underpin the infrastructure of how these changes will be delivered. We do not believe that Professionalism should be taught as a standalone module, but integrated into all teaching.
- Students will be required to adhere to the standards for practice on qualification, so embedding them in their education will ensure that they are familiar with them and familiar with how they will affect their practice. This should increase the level of professionalism on entry into the profession.

Concept 3: Learning Outcomes

Consultation question 5 - What are your views on the concept of system-wide learning outcomes for optometry and dispensing optician education and training, instead of an educational competency-based approach?

Summary of views:
- Learning outcomes should reflect the knowledge, skills and behaviours that the profession(s) need at the point of either graduation or registration. We strongly believe that learning outcomes should be sufficiently detailed, but not too prescriptive. It would be important that the outcomes provide education providers with the flexibility to take different approaches and move away from delivering education as a tick box exercise.
- The risk within this is ensuring that outcomes are sufficient to ensure uniform high standards for education, delivered in a variety of different ways and settings, including Optometrists who are educated abroad.

Concept 4: Links to Continuing Education and Training

Consultation question 6 - What do you see as the merits to removing the current link between CET and our education requirements, if any?

We believe that the current system could be significantly improved for use in a landscape of a devolved government such as Wales. Optometry practice is changing rapidly and the competency based approach can be restrictive in terms of what is recognised as CET, and how it is registered.

Moving to use of the professional standards would be a good step forward, however the process of approval of CET and what is required of registrants could also be improved, and this would be assisted by moving away from competency's towards standards of practice.

OW would support a system where guidance is available to help individuals manage their own learning and the infrastructure to allow this to happen. We see benefits in the point's based approach in maintaining a minimum standard, but would encourage flexibility in the system to allow recording and crediting of other methods of learning that are not prior accredited or are about expanding standards, not simply maintaining them.

We would encourage a system of greater flexibility to support those who do want to develop further but wish to practice only to their core skills and to support those that do –68% of the profession in Wales who responded to a a recent survey indicated that studying for higher qualifications related directly to job satisfaction. We acknowledge that this will involve more individual time spent on reflection which might be challenging as a new way of working.

Consultation question 7 - Do you envisage any disadvantages or risks in this approach, and if so what are they?

Knowing where you stand with CET is important to the whole profession. None of the profession yet have protected time for education, which is a significant barrier to a more sophisticated or onerous system. Any system which is more onerous to manage or more punitive would be detrimental, unless protected time was also introduced.

Currently this will be a significant change in practice at a time when many CET providers are reducing their offers of free CET. This highlights the need to ensure ease of delivery of CET for providers, as a significant change in requirements, combined with a reduction in CET availability may mean access to CET is more difficult for practitioners.

Wales is highly rural, and CET availability in rural areas is usually minimal. It is important that distance based approaches to learning remain an option.

Concept 5: Educational Content

Consultation question 8 - What do you see as the key changes needed to the current content of optometry programmes and dispensing optician programmes to ensure our future requirements are fit for purpose?

Summary of Views:
- A focus on clinical decision making and professionalism.
- Increased clinical experience starting early in the students education.
- core skills, knowledge and behaviours must focus upon the safety of the patient and supporting the profession(s) in knowing this - It would be helpful for optometrists to be WECS accredited on entry into the profession, including having the clinical experience and confidence to deliver EHEW services.
- Self-directed learning because of the changing and rapid changing nature of the profession
- An acknowledgement that universities require significant investment in terms of resources and planning new curricula
- We believe that further attention must be paid to developing future leaders within the profession, coaching and mentoring skills

Concept 6: Enhanced clinical experience for students

Consultation question 9 - Do you agree or disagree with the concept of embedding clinical elements of education and training progressively from the outset of programmes?

Agree.

Consultation question 10 - Tell us more about your views on this concept.

We support the concept of students spending structured time on clinical placements.

Experience in Wales shows that Pre registration optometrists who delver EHEW under supervision during their pre reg year are much more ready to provide EHEW on qualification than their counterparts who do not. This emphasises the importance of clinical learning and experience.

We believe and support an independent pre-registration period.

In Wales we have worked with School of Medicine in Cardiff to deliver visits to community practices for 2nd year medics who are accompanied by 2nd year students from the School of Optometry in Cardiff. Formal feedback and evaluation suggests that these students benefitted from having spent some time simply observing what the typical routine of an optometrist in the community is.

Consultation question 11 - What do you foresee as being any positive or negative impacts on students, education providers, employers, patients and carers from taking a hybrid approach?

A hybrid approach presents difficulties for the profession in Wales because the majority of care is delivered in high street practices having to deliver a retail service. Clinical placements will be required in this environment if they are to be of benefit. We believe that they should be provided throughout an optometrist's education.

The negative aspects are that a structure and funding will be required to enable educators to provide placements in conjunction with the profession.

There are benefits to this too. Employers and students will be introduced to a variety of modes of practice from large busy city centre practices to rural part time practices. In Wales we need this variety to cater for a large rural population. The current system of pre-registration training really only caters for medium to large practices.

This will allow students to see what are of the profession hey wish to work in once qualified, and allows a professional relationship to develop between potential employers and students.

There are benefits to patients, as a greater level of clinical experience will bring with it superior clinical decision making and professionals with more confidence in themselves. There are benefits to the workforce in Wales, as experiencing more rural practices may

encourage students to consider rural locations once qualified and looking for employment.

Most independent practices are small and have limited patient numbers, with a significant number of welsh practices, part time. This makes it difficult for practice owners to take on students and to be sure they can see and obtain the appropriate learning experiences. Whilst we believe that clinical placements are essential, they are difficult to obtain at undergraduate and postgraduate levels. The current funding of pre- registration places in particular is woefully underfunded and resource hungry making it almost prohibitive.

Concept 7: National registration examination

Consultation question 12 - Do you agree or disagree with the concept of a national registration examination?

Consultation question 13 - What are the merits and risks of this concept?

There are associated risks of cost, the concept might also affect what was taught and learned at undergraduate level.

There are associated merits of consistency with a common standard for all.

Concept 8: Multi-disciplinary education

Consultation question 14 - How feasible would it be to develop inter-professional and multi-disciplinary elements of study within optometry and dispensing optician education programmes?

We already use a multi-disciplinary approach in the national, accredited services in Wales like the Low Vision Service Wales and the Eye Health Examination Wales Service but the purpose for the delivery of multi-disciplinary education must be clear and the learning will need to reflect the purpose.

Consultation question 15 - Tell us about any examples you know of already in other disciplines from within or outside the UK?

Not known.

Concept 9: Duration of education and training programmes

Consultation question 16 - What do you see as the strengths and weaknesses of retaining the current minimum duration as described above?

We would support the maintenance of a 3+1 or 4 year (direct to registration) course. Moving to a longer duration course would potentially cause a workforce shortage in as there would be a year with no optometry graduates in the year of the changeover. There is no evidenced need to extend the course significantly, unless what are currently considered higher qualifications are added to the degree. If these are, then they should not be options that may extend the course for some students, but would enable others to stick with the core degree.

Moving to a clinical rather than science based degree may help with the overall course length and also the multi-disciplinary training.

Optometry Schools are in a better position to address this but it does mean an additional year's extra tuition fees for students. We believe that a period of supervised practice is important for confidence and patient safety.

Consultation question 17 - What could be done differently in order to ensure students become competent, confident and safe beginners?

Early clinical experience throughout and the reassurance and stability of being able to ask questions and seek re-assurances is essential. This is currently delivered by the Pre-Registration period. A mentor or buddy system could be co-ordinated but this would have cost and resource implications. In some, rural, community practices there might only be one, newly qualified, optometrist.

Concept 10: UK educational routes to registration

Consultation question 18 - What do you see as the opportunities for more flexibility between the education of different regulated and non-regulated optical professions?

We would argue that those with the right aptitude, skills and interests should be able to move between and into optical roles

Consultation question 19 - What are the constraints and risks to this?

There is a risk, that would need to be mitigated, that students taking this route could have missed the important background education that others have had.

Having said this, it is essential for the workforce in wales that people are able to move between roles, and come to those roles from different backgrounds. In particular, in rural areas a career progression from school leaver may be a preferred route to developing a local workforce, rather than relying on university leavers moving to, or back to, a rural area.

Concept 11: Proportionate quality assurance

Consultation question 20 - Are there any other principles and concepts we should consider at this stage in exploring future approaches to our quality assurance processes?

Work with providers closely following implementation to provide support.

Consultation question 21 - Please tell us about any direct or indirect impact you can foresee from the concepts and principles we have set out in this public consultation on anyone with protected characteristics?

- Additional course fees
- Multiple placements away from home will incur additional cost and will not make optometry an attractive career option.

Peter Black

Peter Black responds to the consultation as shown below:

Concept 1: Standards for Education Providers

Consultation question 1 - Do you agree or disagree with us further exploring the concept of new Education Standards in the way we describe above?

Agree with reservations.

Consultation question 2 - Please tell us more about your views on this concept, including any opportunities or risks you foresee.

There appears to be a general consensus amongst optical and optometric educational institutions that the process of accreditation and GOC visits amounts to micromanagement when universities and colleges have robust systems for self- regulation of a course's level, content and assessment. Other regulators are involved in the regulation of non-university training courses (OfQual, OfSTED etc) and to some extent there is duplication of regulation and inspection that could and should be eliminated by the GOC relying on the reports prepared for other internal or external quality control agencies.

The concept of high level educational standards is appealing but would not be borne out if the items listed were all included in the regulation of future programmes as the list remains comprehensive and largely proscriptive.
At its heart optical education is simple building steadily on the competencies of the dispensing optician (DO), through contact lens optician (CLO), to optometrist (OO) and then therapeutic optometrist (TO).

A DO should be able to dispense spectacles to every form of patient, dealing with the most complex and difficult cases without recourse to another professional as they should be the ultimately knowledgeable practitioner with regard to ophthalmic dispensing save for a DO with more experience.

DOs should also be able to: explain to patients the consequences, correction and treatment of common eye conditions and disease; recognise the symptoms of sight threatening emergencies and refer; diagnose and offer first line treatments for common low level ocular conditions; carry out and supervise pre-screening; advise on contact lenses and their insertion, removal and aftercare; remove a lens in an emergency; provide general direction on the supply of contact lenses to non- restricted patients; supervise trainee dispensing opticians and optical assistants to dispense optical appliances to restricted groups and others. DOs can legally refract but not prescribe.

In simple terms a CLO does everything a DO does plus they fit contact lenses of every type and use a slit lamp bio-microscope and other equipment to assess the health of the anterior eye and adnexa, monitoring and / or referring as appropriate. CLOs supervise Trainee CLOs and DOs.

In simple terms an Optom does everything a DO / CLO does plus they can detect and diagnose internal eye disease, referring as appropriate, and prescribe spectacles.

TOs can additionally manage and treat eye conditions and independently prescribe drugs relevant to optometric practice.

However in practice many optoms no longer fit contact lenses, and most optoms and CLOs have lost their dispensing skills unless they take supervision of others very seriously. Optometrists are often unwilling to see young children or carry out orthoptics despite being qualified to do so which appears wrong and has recently attracted criticism from the retinoblastoma charity.

Concept 2: Education Standards and Professionalism

Consultation question 3 – Do you agree or disagree with the concept of informing our education requirements by our professional standards?

Agree with reservations.

Consultation question 4 - Please tell us more about your views on this concept, including any opportunities or risks you foresee.

Currently qualified registrant Standard 5 does not apply to students, however whilst CET is clearly not appropriate reflecting on practice and reviewing literature and evidence clearly are – in fact they are best learned at the undergraduate level. Currently diploma level DOs are not properly equipped to review academic research and it could be argued that the profession needs to move to be a graduate profession. The method of learning for the best CET – peer discussion, and discussion workshops is also a vital means of learning to reflect and should form part of undergraduate programmes to consolidate learning.

For undergraduate programmes to follow current standards of practice properly they would need to be extended in some way to include a number of business topics such as health and safety, equality discrimination and inclusion, law, team work etc. When I qualified as a DO (full time in Glasgow in 1989) all these topics were in the syllabus – and they are more important than the inner workings of some of the optical instruments or some of the aspects of physical optics.

Concept 3: Learning Outcomes

Consultation question 5 - What are your views on the concept of system-wide learning outcomes for optometry and dispensing optician education and training, instead of an educational competency-based approach?

Whilst I agree with this I have some concerns as to what it means. In general terms most educationalists consider competencies to indicate that a practitioners has been assessed as competent in a particular practical skill, whereas a learning outcome is that they have been assessed as having the theoretical knowledge. It should not be lost on the GOC that for quite a number of competency areas an optometrist is required to have “an ability to” whereas a dispensing optician might have an identically worded competency except that it is “an understanding of” and is therefore a learning outcome rather than a competency.

For example dispensing competency 3.1 (An understanding of the use of instruments

used in the examination of the eye and related structures, and the implications of results) is very similar to optometrist competency 3.1 (The ability to use techniques in ocular examination and to understand the implications of the findings in terms of subsequent examination techniques). Whilst a DO is capable of using almost every piece of ophthalmic equipment used in practice including for example a fundus camera, it is clear that a DO is not in a position to interpret the results and as such sometimes an identical "understanding of" will not confer the same occupational skill levels as "an ability to". That said it should be incumbent upon the GOC and educators to properly accredit prior academic and experiential learning of DOs who want to progress to optometry and currently this doesn't really happen.

There is also the issue of risk. Examining the internal eye, or rather failing to do it properly, is clearly a riskier business than say refraction. To convert a DO from an understanding of internal eye examination to a practical ability to carry out this task is a very involved process of acquiring new diagnostic skills, an understanding of systemic disease, pharmacology etc that could take the equivalent of a year's full time study plus months of supervised practice.

On the other hand ABDO Exams have demonstrated by employing optoms to train DOs in refraction and examine in the subject in Malaysia that it takes minimal effort to convert "an understanding of" into an ability to carry out practical refraction, including history and symptoms etc to the same standard as an optometrist. It can be achieved in 4 or 5 days training and a couple of dozen additional patient episodes under supervision combined with studying a suitable text on the subject. For optoms to be GPs of the eyes, they need to be able to elect not to do refraction, and similarly DOs should be able to refract patients who require spectacles but get their eye health care elsewhere. This would also remove barriers to Low Vision Practice currently associated with referral protocols and waiting times where by the time a patients gets to the top of the list they have to be referred back for an up to date refraction.

The risk of a patient going blind needs to be taken seriously and therefore competency assessment is essential for techniques to check for sight threatening eye disease. On the other hand the ability to refract is self-correcting – opticians who are not competent get more retests and soon learn. Indeed it has always been that way regardless of what examiners may think. Experienced practitioners have always seen newly qualified optometrists adept in the science of refraction having to adapt their methods in order to accommodate the art. There is no risk to this process, save for some patient inconvenience that a few pairs of spectacles have to remade at the practice's expense while the refracting optician learns their craft.

Concept 4: Links to Continuing Education and Training

Consultation question 6 - What do you see as the merits to removing the current link between CET and our education requirements, if any?

I don't see any merits. The purpose of our CET scheme is NOT to ensure that practitioners remain at the same standard as they were when they qualified but to develop to reflect the standard of today's courses so that CET ensures experienced practitioners have to engage in the new topics that are added to the syllabus. Standards of practice is a case in point – practitioners have had to embrace new concepts of consent, data protection, safeguarding etc and move with the times. Equally they must keep up to date

with new diagnostic equipment, contact lens and spectacle related innovations and changes to scope of practice and can't just rely on standards of practice / professional conduct. If DOs move to refract, or Optoms move to do enhanced services as standard then there will be a lot of learning to mandate.

Consultation question 7 - Do you envisage any disadvantages or risks in this approach, and if so what are they?

By comparison with the CPD Certified system used by other professions the current GOC CET system is easy to run for providers, cost effective for all parties and easy for registrants to keep on top of. The downside of the current CET system is that it fails to reward inter-professional development and education that is so valuable to the benefit of patients. There should be an ability to register attendance at a non-CET accredited event at say a rate of 1 point for 2 hours and the suitability of the training should be decided by the registrant who should be required to reflect (perhaps more extensively than normal) on their experience. In my experience having attended events with sight loss rehab workers, pharmacists, nurses, orthoptists etc, as well as lectures from ophthalmologists that are strictly beyond a dispensing optician I have learned more from these sessions than normal CET and it helps me deal with patients and train and supervise others. Even a session with architects and planners on accessibility was useful as you can see how badly some opticians' practices are designed from the perspective of visually impaired patients and those with hearing impairment as businesses seem only to think of wheelchairs when they think of accessibility.

Whist we need a grown up approach to allowing people to get CPD with other professionals and explore areas of interest competencies are important in providing structure and moving the profession forward. For example it is only since Standards of Practice in April 2016 and the inclusion of consent for the first time that this topic has really been talked about. It is staggering that Gillick v West Norfolk was in 1984 and yet in my experience as someone who delivers CET on Gillick Competency around 80% of registrants are incompetent in this regard and would deny service to a competent child unnecessarily.

If as standard 5 requires we are going to get opticians to take into account research, reflect on their practice etc then we need to equip them with the skills. DOs who do not do a degree have until recently never been required to conduct a literature review or interpret quantitative scientific data. Whilst there is no intention to lose Standards of Practice as a competency from CET, I believe it is important other competencies are retained. For example technology will pose challenges that the profession will need to gear up for and rather than use accredited courses area by area we should take an approach similar to medicine where practitioners decides for themselves whether they are competent to carry out a new procedure or technique having had training from manufacturers, read learned journals, consulted with colleagues etc. If technology like insulin monitoring contact lens come to bear then it should be up to CLOs and Optoms to gear themselves up not wait years for an accredited course. The pathfinders will then train the rest – but it has to start somewhere and currently this often starts outside of optics despite optics being more highly qualified and competent to deliver.

Concept 5: Educational Content

Consultation question 8 - What do you see as the key changes needed to the current content of optometry programmes and dispensing optician programmes to ensure our future requirements are fit for purpose?

The world of eyes is changing. There are forecast to be 4 million people living with sight loss in the UK by 2050 according to RNIB estimates. Myopia is reaching epidemic proportions. Patients who were once told nothing could be done are routinely undergoing treatments such as intravitreal injection. Refraction can be done accurately by machine for 95% of patients and is less important as a diagnostic tool but remains essential for the sale of optical appliances including to those with low vision. Patients with low vision represent a vastly underserved community. Optical practices are increasingly involved in medical care. Sight loss rehabilitation services are, like the rest of social care, experiencing unprecedented demand. Orthoptists are neglecting their core activity of school vision screening and treating children with binocular vision problems (mainly because screening is not mandated and is being cut from budgets to become a postcode lottery), yet move into optometric type roles under supervision ophthalmologists without it being within their competency etc and preventing them from having transferrable skills and practicing in their own right.

In short the eye care sector is fragmented and to a large extent dysfunctional. Patients are passed from pillar to post in a system that revolves round perverse incentives, protectionism and professional jealousies, rather than the patients. Patients should be at the centre with the eye health care system revolving around them to help them live their lives, and nowhere is this less evident than for patients who lose their sight later in life.

The GOC has started to move in this regard for example mandating DOs do five low vision case records in their portfolio. However there is no compulsion on their employers to stock magnifiers to enable this to happen easily and low vision services are the least commissioned of all enhanced services. Some employers buy magnifiers for their pre-reg optoms and trainee DOs to give to patients so they can tick the box and complete their case records but it doesn't help the 2 million people living with sight loss.

Broadly the content of current programmes remains entirely appropriate providing students get the appropriate practical / clinical experience.

Concept 6: Enhanced clinical experience for students

Consultation question 9 - Do you agree or disagree with the concept of embedding clinical elements of education and training progressively from the outset of programmes?

Agree absolutely.

Consultation question 10 - Tell us more about your views on this concept.

The way most dispensing opticians are trained via a mixed / blended learning approach (involving 96 correspondence papers, 12 weeks at college, 1,600 supervised hours, hundreds of prescribed supervised tasks and 51 cases records) over 3 years is a proven

cost effective way of ensuring the right number of practitioners can be employed where they are needed in the country. By way of contrast optometry suffers regional shortages in areas away from training institutes. A blended learning approach, regardless of where the educational institute is located, helps employers retain professionals in the practice where they need them rather than see them return to their home town / location of study at the end of their pre-reg year. It is too be welcomed in optometry.

Consultation question 11 - What do you foresee as being any positive or negative impacts on students, education providers, employers, patients and carers from taking a hybrid approach?

This type of course is ideal for being formally classed as an apprenticeship and attracting funding via the apprenticeship levy and is therefore cost effective for both students and employers. Current models for dispensing are usually paid for by the employer at rates considerably lower than standard university course tariffs which benefits both the student and the employer.

There is scope to employ different methods of assessment of knowledge and practical skills – in practice by supervisor and / or external assessor, written coursework, practical and theory exams, project and presentation work etc.

The skills of supervisors both in terms of supervision and teaching need to be of a consistent and high quality for this model to work, and the ability of the student to study, research and reflect independently are also key to a positive outcome.

In practice assessment is a resource intensive system that could have cost implications and also recruitment issues regarding assessors. An answer is to train supervisors as tutor practitioners and for universities to pay supervisors to help students through their studies.

Concept 7: National registration examination

Consultation question 12 - Do you agree or disagree with the concept of a national registration examination?

Agree providing standards aren't dropped.

Consultation question 13 - What are the merits and risks of this concept?

Currently for dispensing opticians there are two levels of qualification that offer a route to registration one at level 5 and another at level 6. Some people who qualify at level 6 after 3 years achieve a level 5 qualification equivalent to the ARU FDSc after 2 years yet rightly cannot register with it. It is not helpful to have this confusion and a national standard exam, providing the qualification remained at level 6, would be welcomed. There is an argument, given the increased requirement to review literature and research, practice according to the evidence base and reflect on one's practice that dispensing opticians would be better qualified at a level 6 BSc rather than a level 6 professional diploma to facilitate better critical thinking skills.

For optometry the College Scheme for Registration remains the route to registration for 99% of graduates. Proliferation of routes to registration would increase costs to the regulator and create difficulties for employers both in terms of supporting students and recognising employment potential.

In reality if there are to be different means of education ranging from full time traditional programmes to work based apprenticeships then final practical examinations with in practice assessment remains the only viable way of ensuring programmes and practitioners are comparable.

In a sense, providing the examination / assessment system is robust, the GOC shouldn't be concerned about the content of the course, its length etc, providing it is of a certain level and standard. The course would live or die by the result students achieve in their final examinations and assessment and / or apprenticeship end point assessment and the quality of new registrants would therefore be assured.

Concept 8: Multi-disciplinary education

Consultation question 14 - How feasible would it be to develop inter-professional and multi-disciplinary elements of study within optometry and dispensing optician education programmes?

The Foresight Report predicted the likely demise of dispensing opticians by 2030, and other types of practitioner are under even more threat. As well as multidisciplinary teams across inter-professional boundaries there is also a need for multidisciplinary individuals who can utilise different types of skills to make life easier for patients whilst also securing their own future into the bargain as the world changes. For example orthoptists are evolving into all sorts of roles, prescribing drugs, managing glaucoma etc. It should be easier for them to qualify as optometrists than it currently is without having to give up work. Dispensing opticians should equally be able to gain easy access to optometry courses with proper accreditation of prior learning and perhaps CET.

Equally dispensing opticians are highly suited to become sight loss rehabilitation workers having already got the required people skills and knowledge of eye conditions and low vision.

It would help to get eyes up the public health and healthcare agenda if all eye related professions had one regulator – perhaps the GOC should become the General Eye Care Council? It would also help if the different disciplines were all taught under one roof.

Consultation question 15 - Tell us about any examples you know of already in other disciplines from within or outside the UK?

This would be entirely feasible for places like the University of Central Lancashire (UCLan) Preston, where the whole ethos is based around placing the patient at the heart of healthcare with practitioners orbiting at varying degrees of proximity depending on the patient's needs rather than the needs of the health system. This would be helped by vision science being placed within a medical school / faculty where possible rather than science.

In large universities there is scope to co-educate opticians, pharmacists, physician associates, medics, nurses, rehab workers, Eye Clinic Liaison Officers, occupational health professional and social workers who all have involvement with eye health. This would be challenging but is not an insurmountable problem. The common thread is sight loss, since accessibility, EDI, and the practical matter of serving patients with sight loss affects every type of practitioner. Similarly the GOC's own research shows that patients could attend half a dozen different places if they woke up with an eye problem, yet the place that is likely to do the best job, the opticians, is bottom of the list.

To do this at undergraduate level would also require it to be available for existing registrants in the form of CPD / CET. Having personally attended events with pharmacists and orthoptists in the past I am convinced of the value of multidisciplinary CET / CPD, however as a CET provider myself I have been surprised by the difficulty and expense of getting accredited CET registered as Certified CPD for other professions. It would be very useful if the GOC could negotiate that CET containing say binocular vision could be approved for orthoptists cheaply, or everyday eye conditions could be approved for pharmacists, GPs, physician associates etc to facilitate inter-professional networking and learning.

Concept 9: Duration of education and training programmes

Consultation question 16 - What do you see as the strengths and weaknesses of retaining the current minimum duration as described above?

The most important aspect is not duration as such but total learning hours / experience. The government has expressed a wish that degrees could be compressed from 3 years to 2 years by increasing the academic year from around 32 weeks to around 47.

This is likely to appeal to non-standard students (which account for most dispensing opticians and also DOs and other mature students studying optometry) who recognise the financial benefit (over £25,000 according to the government) of fast track qualifications.

Currently there is a push to increase scope of standard practice which would necessitate either a longer course or removing course content to be replaced with new content such as enhanced optical services for optometrists, refraction for dispensing opticians, and MECS for CLOs. Longer courses are rebutted by the universities and employers because it robs them of year of graduates of optometry which is an issue for recruitment needs as well as disrupting the whole pre-reg supervision and exam / assessment network. It would necessitate 2 cohorts of student sitting exams in one year – half to the old syllabus, and half to the new one which would likely result in issues of unfavourable comparison of one cohort against the other unless other fundamentals changed.

In other disciplines, such as medicine programmes that moved from 7 to 5 year fast track have not experienced such problems whereas pharmacy did experience shortages when it increased the length of its course in some universities. Because of the need to improve supervision of restricted dispensing and the move to more enhanced optical services employers are recruiting record numbers of DOs and optoms at the moment and would not relish disruption of this. That said if course duration increasing was accompanied by a simultaneous move towards blended learning / apprenticeships and students being useful in practice from early in their course it could very easily produce an increase in capacity if

careful thought through.

Consultation question 17 - What could be done differently in order to ensure students become competent, confident and safe beginners?

More supervised practice earlier on in the course, combined with better supervision, elevating supervisors to tutor practitioner status recognised by the educational institution and / or awarding body would be ideal and already happens in newer medical, dental and other healthcare courses such as physician associate. Allow similar practitioners to supervise e.g. IP optoms to supervise IP students not only ophthalmologists. Moving the scientific underpinning away from physical optics towards biomedical science for optometry and optics would also be helpful. Key triage skills of history and symptoms, differential diagnosis of red / pink eyes and presenting symptoms of sight threatening emergencies should be taught at the earliest opportunity within the course to negate the most substantial risks associated with optics and optometry. Critical thinking skills, reflective practice, discussion of case studies and compilation of case records should happen early on. Standards of practice should be assessed early on to ensure competence in aspects such as record keeping, safeguarding, consent etc, however this should not be seen as a final assessment – it is important that Standards from both the foundation and the capstone to courses and sometimes it is felt these competencies, and communications skills, are assessed too early in programmes. Currently DOs get one practice visit and assessment quite late in their training. It would be better for the equipment and level of supervision to be checked early on in the training, with some form of basic assessment at that time, plus advice on portfolio. A second visit in second year with portfolio audit and advice and further assessment. Final year assessment visit and final guidance on supervision, tasks and case records.

Optometry and optics could take a leaf out of the typical MBA book. A case study discussion approach pioneered by Harvard business school and the subject of a number of books is a good way of consolidating learning, can be conducted between supervisor and learner, or groups of learners, face to face or virtually with tutor supervision / intervention as appropriate. On an MBA an online discussion topic / case scenario would be posted with recommended relating reading which could be anything from a short company report / research paper to a full text book. Each student posts their individual answers of a specified length between a stated minimum and maximum length. Sometimes further reading is then suggested by the tutor (especially if there hadn't been any reading at the outset) and students are then requested to review every other response and make comments to provoke discussion and further exploration of the subject. Students are marked on their original answer, but mainly on the quality of the discussion, their analysis of other answers, their reflection on their original answer and any change of position, and communication skills when in disagreement or explaining complex concepts etc.

Another tactic employed by universities such as UCLan which have been innovative in offering for example Medicine degrees to students with much lower than the usual 4 A* grades at A Level. They do this by accepting only existing graduates in biomedical type subjects. Optometry courses could be developed as Masters degrees to only be open to existing graduates such as dispensing opticians or orthoptists and other healthcare practitioners who are already registered and conversant in sight threatening eye conditions, emergency referral protocols, duty of care etc.

Concept 10: UK educational routes to registration

Consultation question 18 - What do you see as the opportunities for more flexibility between the education of different regulated and non-regulated optical professions?

Many people fall into optics starting as optical assistants and finding they love it then find it easy in practical terms to begin training as a dispensing optician. Some would wish to then train as an optometrist but find they can't afford to give up work and balance life with children etc so are unable to realise their ambitions. Even the fast track course requires moving to Bradford and incurring significant debt.

Blended learning courses while in employment remove all those barriers and discriminatory aspects and enable employers to retain ambitious trustworthy employees; and employees to stay in work with an employer they like, in a convenient location, while studying. Potentially courses could be redesigned with stepwise career progression and career changes in mind. Some of the best practitioners have done other things first – I have worked with optometrists who have previously done other things – optical technician, dispensing optician, contact lens optician, pharmacist, orthoptist, ophthalmic nurse – and rate them amongst the best optometrists. Likewise dual qualified practitioners bring special skill sets that lessen the need for multidisciplinary teams in some practice environments – orthoptist/optician; optometrist/ ophthalmologist; optician/ sight loss rehab officer – are all combinations that provide a level of understanding of the health system and patient needs that are highly valued by patients.

To embed professionalism in lower level courses it is worth considering following colleagues in dentistry or pharmacy and ensuring all colleagues engaged in regulated activities such as pre-screening, dispensing, teaching contact lenses are qualified at levels 2, 3 or 4 to protect the public and formalise the career ladder.

Registration at this level is considered unnecessary by employers adding bureaucracy and cost for no benefit that is not already conferred by training and qualification and supervision by (or general direction of) a registrant.

Consultation question 19 - What are the constraints and risks to this?

Looking around at other subjects and educators there should not be any constraints that cannot be overcome. Some will worry that allowing lesser mortals onto higher level courses may lower standards, however providing assessment is robust and consistent this is not an issue.

Concept 11: Proportionate quality assurance

Consultation question 20 - Are there any other principles and concepts we should consider at this stage in exploring future approaches to our quality assurance processes?

Optics and optometry are fundamentally low risk professions. Quality hinges on improving supervision and ensuring the final assessment process is robust. All educators already have robust quality control procedures either through the university itself or via OfQual / OfSted / internal exam boards / external examiners etc.

Consultation question 21 - Please tell us about any direct or indirect impact you can foresee from the concepts and principles we have set out in this public consultation on anyone with protected characteristics?

The move towards blended learning formats that enable people to stay in work, career progression courses and accreditation of prior learning all serve to improve access to education for older workers and those, mainly women, who have children or other caring responsibilities.

Professional Standards Authority for Health and Social Care (PSA)

The PSA responds to the consultation as shown below:

Concept 1: Standards for Education Providers

Consultation question 1 - Do you agree or disagree with us further exploring the concept of new Education Standards in the way we describe above?

Agree.

Consultation question 2 - Please tell us more about your views on this concept, including any opportunities or risks you foresee.

We agree with the proposal to move towards a set of high-level overarching education standards. This should allow education providers the flexibility to innovate and develop programmes of education and training which meet the evolving needs of the optical workforce. This is in line with Right-touch reform in which we highlighted that the regulators' approach to assuring education and training should be: 'sufficiently flexible to allow a risk-based approach to assuring different professional groups and to meet future challenges'[2].

One risk may be the potential for inconsistency between education providers, therefore the GOC will need to be confident that it can continue to assure the quality and safety of those joining the optical register, regardless of where they are qualifying from.

We are also supportive of the criteria and features which the GOC has highlighted for potential inclusion in the new standards. In particular we welcome the reference to collaboration with other programmes of health professional education and developing active relationships with employers and service providers to respond to patient needs and expectations and relevant workforce requirements. These reflect some of the areas of best practice which we highlighted in Right-touch reform.

[2] Professional Standards Authority 2017, *Right-touch reform.* [Online] Available at: https://www.professionalstandards.org.uk/docs/default-source/publications/thought-paper/right-touch- reform-2017.pdf?sfvrsn=2e517320_5 [Accessed: 15/03/2018]

Concept 2: Education Standards and Professionalism

Consultation question 3 – Do you agree or disagree with the concept of informing our education requirements by our professional standards?

Agree.

Consultation question 4 - Please tell us more about your views on this concept, including any opportunities or risks you foresee.

We are supportive of the GOC using its standards for professionals to inform its new education requirements. This is in line with our Standards of Good Regulation[3]. It should help to ensure that the standards for professionals are well understood at an early stage

and should help to embed these requirements when students qualify and join the register.

[3] Professional Standards Authority 2016, *Standards of Good Regulation.* [Online] Available at: https://www.professionalstandards.org.uk/publications/detail/standards-of-good-regulation [Accessed: 15/03/2018]

Concept 3: Learning Outcomes

Consultation question 5 - What are your views on the concept of system-wide learning outcomes for optometry and dispensing optician education and training, instead of an educational competency-based approach?

We are supportive of the GOC's move towards an outcomes rather than input based approach. This should allow training providers the flexibility to ensure that courses remain up to date and relevant to new and emerging elements of practice and technologies, whilst still allowing the GOC to remain assured that those qualifying are competent to join the register.

Concept 4: Links to Continuing Education and Training

Consultation question 6 - What do you see as the merits to removing the current link between CET and our education requirements, if any?

We are supportive of the proposals to remove the link between Continuing Education and Training (CET) and the GOC's requirements for initial education and training and instead moving to a system where registrants are required to demonstrate that their practice remains in line with their core Standards of Practice for Optometrists and Dispensing Opticians. A move of this nature would be in line with the position we outlined in our 2012 paper on continuing fitness to practise in which we state that: 'the primary role of continuing fitness to practise should be that of reaffirming that registrants continue to meet the regulators' core standards'[4].

Whilst this consultation is not on CET we would recommend that when reviewing their approach in this area the GOC ensure that it has a clear picture of the different risks of practice for the different groups on their register to enable them to develop a proportionate and tailored approach to continuing fitness to practise or CET for each professional group.

[4] Professional Standards Authority 2012, *An approach to assuring continuing fitness to practise based on right-touch regulation principles* [Online]. Available at: https://www.professionalstandards.org.uk/docs/default-source/publications/policy-advice/continuing-fitness-to-practise-based-on-right-touch-regulation-2012.pdf?sfvrsn=68c67f20_6 [Accessed: 15/03/2018]

Consultation question 7 - Do you envisage any disadvantages or risks in this approach, and if so what are they?

As outlined above we are supportive of this approach. Whilst it will be important that initial education and training and CET remain broadly aligned, if both are based around the Standards of Practice then this should be the case. However, as noted above this approach will also allow flexibility for the GOC to tailor CET requirements to the specific context and risks of each professional group which it regulates and to encourage training and development beyond the initial level.

Concept 5: Educational Content

Consultation question 8 - What do you see as the key changes needed to the current content of optometry programmes and dispensing optician programmes to ensure our future requirements are fit for purpose?

Whilst we do not have the specific expertise to comment on changes that might be required to the content of optometry and dispensing optician programmes, we note that the GOC's proposals address many of the issues and challenges that we identified in Right-touch reform. These include the trend towards multidisciplinary working and increasing impact of technology on practice.

It is positive that the research which the GOC has commissioned to support its proposals is forward looking and includes the trend towards evidence based practice, team working, a patient centred approach to delivering care and a commitment to career long learning and development.

Concept 6: Enhanced clinical experience for students

Consultation question 9 - Do you agree or disagree with the concept of embedding clinical elements of education and training progressively from the outset of programmes?

No view.

Consultation question 10 - Tell us more about your views on this concept. No view.

Consultation question 11 - What do you foresee as being any positive or negative impacts on students, education providers, employers, patients and carers from taking a hybrid approach?

No view.

Concept 7: National registration examination

Consultation question 12 - Do you agree or disagree with the concept of a national registration examination?

No view.

Consultation question 13 - What are the merits and risks of this concept? No view.

Concept 8: Multi-disciplinary education

Consultation question 14 - How feasible would it be to develop inter-professional and multi-disciplinary elements of study within optometry and dispensing optician education programmes?

We welcome consideration of this issue by the GOC. As we noted in Right-touch reform, there is growing recognition of the value of interprofessional learning to ensure shared

values and an aligned approach to ensuring patient safety across professional groups. Organisations such as the Centre for the Advancement of Interprofessional Education (CAIPE)[5] have produced guidance for organisations on ways in which closer alignment between professional courses can be achieved. We do recognise that this may be more challenging for professions where training takes place outside of an NHS environment.

[5] The Centre for the Advancement of Interprofessional Education. Available at: https://www.caipe.org/

Consultation question 15 - Tell us about any examples you know of already in other disciplines from within or outside the UK?

We are aware that some of the other professional regulators have done work in this area. For example, the Health and Care Professions Council has made interprofessional education a requirement within their standards of education and training. Additionally, the NMC have recently committed to align with the Royal Pharmaceutical Society's approach to prescribing as part of their commitment to interprofessional learning and a multi-professional approach to prescribing proficiency.

Concept 9: Duration of education and training programmes

Consultation question 16 - What do you see as the strengths and weaknesses of retaining the current minimum duration as described above?

No view.

Consultation question 17 - What could be done differently in order to ensure students become competent, confident and safe beginners?

No view.

Concept 10: UK educational routes to registration

Consultation question 18 - What do you see as the opportunities for more flexibility between the education of different regulated and non-regulated optical professions?

We are supportive of encouraging flexibility of entry into different optical professional roles and allowing individuals to move more easily between professional groups. This might allow a wider range of people to gain access to the profession and allow professionals a more flexible career path within the optical professions.

Consultation question 19 - What are the constraints and risks to this?

It will be important for the GOC to be assured that such training adequately manages any risks to patient safety and is consistent with other models of education in ensuring that individuals are competent and qualified. As noted in the consultation document it will also be important to ensure that equivalence is maintained with non-UK qualifications that the GOC recognise to allow mobility of professionals.

Concept 11: Proportionate quality assurance

Consultation question 20 - Are there any other principles and concepts we should consider at this stage in exploring future approaches to our quality assurance processes?

We are very supportive of a proportionate approach to the quality assurance of education and training. As we noted in Right-touch reform, there are a number of organisations involved in quality assurance of health professional education and training, some with overlapping requirements. Whilst the regulator plays an important role in checking education and training to ensure that those qualifying from recognised courses are competent to join the register, there is also the need to shape procedures so that they are targeted at areas of risk and do not become an unnecessary burden on education and training providers.

We know that most of the UK professional regulators have already made some progress in trying to use information and data gathered by other bodies as part of their quality assurance processes. We welcome the GOC's stated intention to explore taking a more risk-based and evidence led approach, seeking to avoid unnecessary duplication with other regulatory or quality assurance approaches.

Consultation question 21 - Please tell us about any direct or indirect impact you can foresee from the concepts and principles we have set out in this public consultation on anyone with protected characteristics?

There is a potential that GOC proposals around flexibility to move between regulated and non-regulated optical professions could improve access to optical professions for some individuals with protected characteristics.

Royal College of Opthalmologists

The Royal College of Ophthalmologists responds to the consultation as shown below:

Concept 1: Standards for Education Providers

Consultation question 1 - Do you agree or disagree with us further exploring the concept of new Education Standards in the way we describe above?

Agree.

Consultation question 2 - Please tell us more about your views on this concept, including any opportunities or risks you foresee.

Moving to a set of higher level standards that providers must provide evidence of meeting, would provide greater flexibility and reflect the approach used by other professional regulators, including the GMC. The robustness of this approach to quality assurance will depend on how well the evidence is audited, assessed and reported.

Concept 2: Education Standards and Professionalism

Consultation question 3 – Do you agree or disagree with the concept of informing our education requirements by our professional standards?

Agree.

Consultation question 4 - Please tell us more about your views on this concept, including any opportunities or risks you foresee.

We agree that professional standards should inform education requirements. The purpose of education should be to produce professionals who are fit to practise, including the appropriate standards of professionalism.

Concept 3: Learning Outcomes

Consultation question 5 - What are your views on the concept of system-wide learning outcomes for optometry and dispensing optician education and training, instead of an educational competency-based approach?

We support the adoption of a learning-outcomes-based approach which would provide greater flexibility in how education is delivered in response to changing need.

Concept 4: Links to Continuing Education and Training

Consultation question 6 - What do you see as the merits to removing the current link between CET and our education requirements, if any?

If replacing the link between CET and education requirements with the Standards of Practice encourages professional development, this is to be welcomed.

Consultation question 7 - Do you envisage any disadvantages or risks in this approach, and if so what are they?

Concept 5: Educational Content

Consultation question 8 - What do you see as the key changes needed to the current content of optometry programmes and dispensing optician programmes to ensure our future requirements are fit for purpose?

To identify necessary changes to training content, further clarity is needed about the future role of these professions and the skills and knowledge they will require. While increasing the use of enhanced optical roles within hospital eye services is an important opportunity to address capacity issues, the extent to which we can rely on this is currently unclear. It depends on a range of factors such as hospital units' capacity to upskill staff, availability of suitable staff, having the leadership to develop new roles, patient expectations and physical space.

The RCOphth remains engaged with exploring the future role of optometrists and dispensing within the hospital eye service and open to continued discussion about this.

Concept 6: Enhanced clinical experience for students

Consultation question 9 - Do you agree or disagree with the concept of embedding clinical elements of education and training progressively from the outset of programmes?

Agree.

Consultation question 10 - Tell us more about your views on this concept.

Enhancing clinical experience is to be welcomed as a way of preparing students for practice. Gaining more varied experience of a range of eye conditions can significantly improve the quality of examination, detection and referral to hospital eye services. Hospital services can provide valuable clinical experience and we would encourage educators to identify opportunities for students with local eye units.

Consultation question 11 - What do you foresee as being any positive or negative impacts on students, education providers, employers, patients and carers from taking a hybrid approach?

Concept 7: National registration examination

Consultation question 12 - Do you agree or disagree with the concept of a national registration examination?

Consultation question 13 - What are the merits and risks of this concept?

Concept 8: Multi-disciplinary education

Consultation question 14 - How feasible would it be to develop inter-professional and multi-disciplinary elements of study within optometry and dispensing optician education programmes?

Consultation question 15 - Tell us about any examples you know of already in other disciplines from within or outside the UK?

Concept 9: Duration of education and training programmes

Consultation question 16 - What do you see as the strengths and weaknesses of retaining the current minimum duration as described above?

Consultation question 17 - What could be done differently in order to ensure students become competent, confident and safe beginners?

Concept 10: UK educational routes to registration

Consultation question 18 - What do you see as the opportunities for more flexibility between the education of different regulated and non-regulated optical professions?

Providing optical professionals with greater flexibility to move between professions could provide an opportunity to bring previous experience into new and developing roles.

Consultation question 19 - What are the constraints and risks to this?

There will need to be systems in place to effectively assess transferable skills and experience.

Concept 11: Proportionate quality assurance

Consultation question 20 - Are there any other principles and concepts we should consider at this stage in exploring future approaches to our quality assurance processes?

Consultation question 21 - Please tell us about any direct or indirect impact you can foresee from the concepts and principles we have set out in this public consultation on anyone with protected characteristics?

School of Optometry and Vision Science, University of Bradford

The School of Optometry and Vision Science, University of Bradford, responds to the consultation as shown below:

Concept 1: Standards for Education Providers

Consultation question 1 - Do you agree or disagree with us further exploring the concept of new Education Standards in the way we describe above?

Agree.

Consultation question 2 - Please tell us more about your views on this concept, including any opportunities or risks you foresee.

In principle, we agree that there could be value in developing and agreeing new education standards.

In our view, the standards expected of providers, which are currently set out in the Education Handbooks, are not overly-prescriptive. In support of this, under the current standards, we have seen significant innovation in course design and development. For example, the Career Progression course at the University of Bradford provides a route for Dispensing Opticians and Contact Lens Opticians to train as Optometrists via an accelerated route, with appropriate accreditation of prior learning. There has also been the development of registrable (or 'hybrid') Optometry programmes under current regulations. Accordingly, we don't see that current GOC requirements for Education Providers are stifling change.

We are not, however, opposed to the principle of setting new education standards. On the contrary, we believe that providers would welcome greater clarity on the expectations of the regulator. We suggest that if new education standards are to be developed, they should be informed by evidence gathered from jurisdictions where overarching education standards have already been set.

Concept 2: Education Standards and Professionalism

Consultation question 3 – Do you agree or disagree with the concept of informing our education requirements by our professional standards?

Agree.

Consultation question 4 - Please tell us more about your views on this concept, including any opportunities or risks you foresee.

We agree with the principle that existing professional standards should be used to inform any new overarching Education Standards. This approach does, however, rely on the assumption that the existing professional standards are effective, proportionate and robust. Accordingly, we would support an evidence-based review of the effectiveness of existing professional standards, before new Education Standards are developed.

Concept 3: Learning Outcomes

Consultation question 5 - What are your views on the concept of system-wide learning outcomes for optometry and dispensing optician education and training, instead of an educational competency-based approach?

We agree that it may be desirable for learning outcomes set by the regulator to be high-level so as to achieve an outcome-focussed approach. This has the advantage of enabling providers to adopt an innovative approach to designing programmes.

Nevertheless, the implementation of this approach must guarantee patient safety and consistently high standards of clinical competence and professionalism amongst registrants. We have identified two types of risk associated with a move from a competency-based to high-level, learning outcome approach.

Firstly, the current competency-based system affords employers, patients and pre-registration supervisors a degree of assurance that all pre-registration Optometrists have achieved a standard level of clinical competence. Any replacement of the current competency-based system would need to provide the same assurances. While pre-registration Optometrists work under supervision, it is possible that removing the standard baseline of clinical competence for pre-registration Optometrists could increase the risk of harm to the public.

A common criticism of current competency-based system is that it is overly-prescriptive. We can see some areas where 'higher-level' learning outcomes could replace specific competencies. For example, we may consider replacing individual competencies in direct and indirect ophthalmoscopy with a single learning outcome which requires students to become proficient in the examination of the retina and other internal ocular structures. On the whole, however, our view is that the existing competencies are not overly-prescriptive in terms of either outcomes, or the methods required to achieve competencies. Given that there are considerable differences between the programmes offered by current providers, the competency-based system does include provision for flexibility.

Secondly, there is a substantial risk that there will be a lack of agreement amongst training providers and the regulator of what constitutes acceptable evidence that a high- level learning outcome has been met. There may be considerable difficulty in ensuring that such a high-level approach is applied fairly and consistently across different training providers. This is particularly important given that there is already substantial variation in the mode of delivery across providers. An associated risk is a lack of consistency in the standards of clinical competence and professionalism achieved by students training at different providers.

In sum, our position is that switching from a competency to high-level, learning outcome based approach may have some advantages, but it also carries significant risks. To mitigate those risks, we suggest that evidence should be gathered from the other health professional regulators that have already moved from a competency-based to high-level learning outcome focussed approach.

Concept 4: Links to Continuing Education and Training

Consultation question 6 - What do you see as the merits to removing the current link between CET and our education requirements, if any?

We agree with the principle of removing the link between CET and education requirements. Current practices require registrants to demonstrate those competencies which are used to assess student optometrists at the point of entry to the register. While this ensures that minimum levels are being maintained, there is limited scope for rewarding professional development. That those registrants who pursue higher qualifications (e.g. Independent Prescribing, Professional Certificates) are not automatically recognised by the current CET system (i.e. these qualifications do not count towards the minimum number of CET points required per cycle) does not incentivise professional development.

Removing the link between the 'entry-level' competencies and CET would enable Dispensing Opticians and Optometrists to receive credit for undertaking continuing professional development and advancement. For example, the Common Competency Framework, agreed by the Royal College of Ophthalmologists, College of Optometrists, Royal College of Nursing and British and Irish Orthoptics Society in glaucoma, medical retina and acute eye care has driven professional and clinical advancement in allied health professionals. Developments of this type are not, however, pinned to entry-level competencies and not automatically credited with CET points.

Consultation question 7 - Do you envisage any disadvantages or risks in this approach, and if so what are they?

One advantage of the current system is that registrants are required to meet a minimum standard across all areas of practice. While registrants may develop particular areas of interest or specialism, and appropriately direct more CPD towards these areas, we believe that it is desirable to retain a minimum standard across all fundamental areas of practice. This can be considered as an alternative to the concept of revalidation.

It has been proposed that a CPD scheme would be more appropriate for the profession than the existing CET scheme. Disconnecting CET/CPD from requirements intended for the education and assessment of students provides an opportunity for advances in training and knowledge, rather than, as now, ensuring that minimum levels are being maintained.

Concept 5: Educational Content

Consultation question 8 - What do you see as the key changes needed to the current content of optometry programmes and dispensing optician programmes to ensure our future requirements are fit for purpose?

Optometry programmes regularly undertake curriculum reviews to take account of technological advancement and changes in clinical practice. For example, on our Optometry programme, first year students are now introduced to optical coherence tomography (OCT), with a view to developing skills in the interpretation of retinal and anterior eye scans in subsequent years of training. Certain aspects of the programme, particularly those relating to diagnosis and management of ocular disease, require annual review in order to ensure that teaching reflects current clinical guidelines. In our view, prescribed step changes in course content are not required; programme content

continually evolves in light of the latest research and professional standards.

In our view, it would be difficult for a regulator to encourage and engender innovation, variety and flexibility amongst providers, whilst adopting a prescriptive approach to course content.

Concept 6: Enhanced clinical experience for students

Consultation question 9 - Do you agree or disagree with the concept of embedding clinical elements of education and training progressively from the outset of programmes?

Agree.

Consultation question 10 - Tell us more about your views on this concept.

Clinical elements of education and training are already embedded from the outset of Optometry programmes. Our programme has been specifically designed to provide training on the clinical skills required of Optometrists from Semester 1 of Year 1.

Specifically, Year 1 students undertake clinical training in objective and subjective refraction (Module: Refraction and Refractive Error), Indirect Ophthalmoscopy (Module: Ocular Health Assessment) and the principles of professionalism and ethical practice (Module: Evidence-Based Practice and Professionalism). Students learn, practice and are assessed upon these clinical skills by working on fellow students who act as volunteer patients. All Year 1 students are introduced to the eye clinic environment and are required to act as volunteer patients for students in later years of the programme. In order to pass Year 1, and proceed to Year 2 of our programme, students are required to demonstrate a satisfactory level of achievement in specific areas of clinical practice.

We believe that the principle of embedding clinical training from the outset is not unique to our programme. We suspect that all other training providers use a similar approach.

Consultation question 11 - What do you foresee as being any positive or negative impacts on students, education providers, employers, patients and carers from taking a hybrid approach?

We wish to respond directly to the following aspect of this concept:

"A consequence of taking a more hybrid approach would be to move away from the notion of the 'pre-registration year', where that applies, and that education providers would take on responsibility for the entirety of the student journey, with the awarding of an academic qualification that could lead to registration with us at the end."

Firstly, we support the principle of considering new and innovative approaches to Optometry programme delivery. Our view is that there should be a variety of approaches to programme design. This will likely include 'hybrid' programmes and perhaps newer models (e.g. blended learning), but also the more commonly implemented model of 3 years (BSc(Hons)) + 1 year pre-registration.

The principle of requiring, rather than allowing, education programmes to adopt a

'hybrid' model appears to be at odds with that of encouraging providers to be *"proactive and innovative in how they are designed and delivered".*

The major difference between the 3 + 1 model and a 'hybrid' approach lies in a shift in responsibility for delivering training to the point of registration from two providers to a single provider. We do not see that this change in programme organisation offers any advantage in terms of the overall goal of embedding clinical training from the outset of the programme. Specifically, given that in both models patient encounters are typically scheduled from Year 3 of the programme onwards, it is unclear how a 'hybrid' approach would offer any advantage in terms of embedding clinical training from Year 1 of the programme over the more commonly implemented 3 (BSc) + 1 (Pre-Reg) model. There is limited scope for incorporating significant, and therefore meaningful, patient encounters in earlier stages of training because the knowledge and clinical ability of students is not sufficiently developed.

We are unable to identify any differences in the impact on the health and safety of the general public of the 3 + 1 and 'hybrid' models.

One advantage of the 3 + 1 model is that students are employees, rather than students, for the pre-registration year. This affords the employer the opportunity to mould students in their own image, and develop their ability to practice as a healthcare clinician in a commercial environment, throughout the final year of training. While this may be considerably less important for other healthcare professions (e.g. Nursing) where most work takes places in a NHS hospital setting, it is critical for Optometry- the vast majority of registrants work under the auspices of a retail business, rather than a NHS facility.

Under a 'hybrid' approach, students would begin work after graduation as registered optometrists, rather than pre-registration student optometrists, perhaps with limited previous work experience. This may disadvantage employers who, under the 3 + 1 model, expect registered optometrists to be equipped with at least 1 year of experience of working as an optometrist (albeit at pre-registration level) in a commercial business environment.

On a related point, students currently benefit from periods of time working as optical assistants (or similar), typically at weekends, or over the summer months. This work is often linked to applications for pre-registration positions. Students apply for these jobs independently of the University and, as a result, are required to develop transferable skills (e.g. job applications, CV writing, interview technique). If clinical placements (i.e. in place of the pre-registration year) were arranged for students by the University, students would miss out on this valuable life experience.

Moving from the 3 + 1 model to that of a 'hybrid', registrable programme delivered by a single education provider will have a considerable financial impact on students. Specifically, students would be liable for an additional year of higher education fees (£9000), and, most likely, forfeit the salary normally paid to pre-registration optometrists (approximately £13000-14000). It is, therefore, incumbent upon the regulator and profession to demonstrate that this cost is justified by the educational advantages offered by a 'hybrid' approach. Our view is that, currently, these advantages are not sufficiently clear. Further, it is possible that the £20000+ financial turn-around could deter prospective students from considering a career as an optometrist.

Requiring training providers to assume responsibility for the full educational journey to the point of registration carries very significant resource implications. Providers would be required to co-ordinate multiple, appropriate placements for a large number of students. This may be particularly challenging in certain geographical regions, and place additional travel burden upon students. Further, a substantial number of additional staff would be required to both co-ordinate and quality assure clinical placements. Universities would need to develop robust, but flexible, approaches to ensuring consistency and fairness in the student experience across this large number of placements. Further, it would be difficult for individual providers to match the scale of resource and wealth of assessment experience which is currently offered by the College of Optometrists as part of their Scheme for Registration.

While concerns about resource implications are not, of course, insurmountable barriers to adopting a 'hybrid' approach, the impact of this demand on resources must be proportionately considered alongside the educational advantages which the 'hybrid' approach may offer over the 3 + 1 model. In our view, those educational advantages are currently not sufficiently clear to justify the resource impact.

Concept 7: National registration examination

Consultation question 12 - Do you agree or disagree with the concept of a national registration examination?

Agree.

Consultation question 13 - What are the merits and risks of this concept?

We believe that, in order to ensure that high and consistent standards are demonstrated by new registrants, independent assessment at the point of entry to the register is essential. We see many merits in a national registration examination and believe that it should be retained. While some may view it as duplicative, in the interests of ensuring standards and the safety of the public, we don't believe it is now, or will turn out to be, disproportionate.

In our view, abolishing the principle of a national examination at the point of registration, delivered by an independent provider, would jeopardise patient safety.

With a growing list of providers, different modes of delivery (3 + 1 model, 'hybrid' model) and the likelihood of further developments in course design, we see, more than ever, a need for a national registration examination. In our view, this is the only method of ensuring that the public can be assured that they will receive a consistent standard of care and professionalism across the UK.

The College of Optometrists is well placed to act as the independent body to deliver this national examination at the point of registration. The College have considerable experience of designing and delivering assessments to assess the fitness to practice of prospective registrants. We recognise that the Scheme for Registration has undergone considerable development by the College and represents a major step change from the previous format of Professional Qualifying Exams. If the Scheme for Registration were to continue, our view is that continual review of this process is required to ensure that the Scheme is an appropriate national registration examination.

We also recognise that co-ordinating a national registration examination could be delivered by other groups. For example, it may be that a panel is convened, which includes representatives from each provider, to decide upon the content and structure of the national registration examination.

Concept 8: Multi-disciplinary education

Consultation question 14 - How feasible would it be to develop inter-professional and multi-disciplinary elements of study within optometry and dispensing optician education programmes?

Multi-disciplinary teaching may be seen as desirable, but must be implemented proportionately. Optometrists work mainly with Dispensing Opticians and Ophthalmologists, our view is that this is where efforts around multi-disciplinary education should be focussed. Given that, in England and Wales, the majority of Optometric work sits outside of the NHS, there is limited scope for Optometrists to interact with other healthcare professionals (e.g. Dentists, Physiotherapists, Midwives, Nurses).

As described in response to Concept 6, Optometry programmes are focussed upon delivering clinically-relevant education from Year 1 of the programme. Accordingly there is limited scope for substantial and, therefore, meaningful multi-disciplinary education. For example, shared teaching sessions (e.g. on basic science, or ethical principles) is one method of promoting multi-disciplinary education. The content of these sessions, however, is, by necessity, generic and not directly relevant to the clinical aspects of Optometry. It is very challenging to ensure that this shared learning material is relevant and useful to the different student groups.

An important pedagogical principle is that learning activities are framed in a discipline-specific context. For example, a session on ethical principles for Optometry students should be centred upon clinical situations which occur in Optometric practice (e.g. considering the ethical principles of informing the DVLA of a patient who fails to meet the driving standard). This enhances the authenticity of the learning activity, and embeds a sense of professionalism within students. It is difficult to reconcile this discipline-specific principle with that of multi-disciplinary education.

We recognise that there are generic skills which are common to all healthcare professionals. There are, however, substantial differences in how these skills are developed and applied to clinical practice in different professions. In our view, it is easy to underestimate the challenges associated with effective delivery of training in multi-disciplinary learning environments.

Consultation question 15 - Tell us about any examples you know of already in other disciplines from within or outside the UK?

Student Optometrists undertake hospital placements, both in their final year of a BSc, and in their pre-registration year. These placements enable students to develop experience of multi-disciplinary working with Ophthalmologists, Orthoptists and Ophthalmic Nurses.

Optometrists work closely alongside Dispensing Opticians. This inter-professional working

is cultivated at University level; student Optometrists are taught and supervised by dispensing opticians in lectures, labs and clinical teaching sessions. This important relationship between Optometrists and Dispensing Opticians is then developed during the pre-registration year when working in practice.

In our programme, final year students undertake a key module on ocular disease which has considerable (i.e. at least 75%) input from ophthalmologists and hospital optometrists. These sessions give our students first-hand experience of how colleagues work in hospital eye clinics, and how these professionals would like Optometrists to interact with them (e.g. what makes an effective referral?).

We would be receptive to learning of successful examples of other forms of multi-disciplinary education from optometry programmes in the UK or overseas.

Concept 9: Duration of education and training programmes

Consultation question 16 - What do you see as the strengths and weaknesses of retaining the current minimum duration as described above?

In our view, the minimum duration of training should be determined by the length of time required to acquire the necessary skills and clinical experience to join the register. While the regulator may wish to indicate their expectations of typical duration, we do not feel it necessary to prescribe a minimum duration. Rather, the focus should be on ensuring that the required outcomes of optometric training are met by both providers and students.

We support the principle of considering new approaches to Optometry programme delivery. Our view is that there should be a variety of approaches to programme design. This will likely include 'hybrid' programmes, the 3 + 1 model and new designs (e.g. blended learning) which providers propose in the future.

Both the 'hybrid' and 3 (BSc) + 1 (Pre-Reg) model agree that 4 years is the minimum duration of training before a student is ready to join the register. We have not identified any impact in terms of patient safety of academic qualifications (i.e. BSc(Hons) Optometry/MOptom) being awarded either after 3 years (after which a pre-registration period follows before joining the register) or after 4 years (under the 'hybrid' model).

As outlined in response to concept 6, the 'hybrid' model places students at a clear financial disadvantage. Currently, students may choose between providers who offer the 3 + 1 model and those that offer the 'hybrid' model. If, however, the regulator and profession move to requiring (rather than allowing) providers to adopt this 'hybrid' model, the advantages of this mode of delivery over the alternative 3 + 1 model must be clearly articulated. In our view, the advantages of moving from a 3 + 1 model to a 'hybrid' model are not yet sufficiently clear to justify mandatory conversion to this model.

One option to reduce course duration would be to move towards a model where degree programmes are taught over a greater number of weeks per year, but for fewer years. In our view, this would be hugely detrimental to the ability of Universities to deliver high quality research. We believe that such a step could be a significant backward step for UK optometry, since research forms the basis of an academic discipline and associated profession. Another disadvantage of shorter, but more intensive, programmes is that

academic staff would have less time to develop high quality and innovative approaches to teaching. Further, it remains to be determined if shortening the duration of training would have a detrimental impact on the quality of the student learning experience, and the standards of professionalism and clinical competence achieved by students. In sum, our view is that a move in the direction of shorter, more intensive, training programmes in Optometry carries significant risk for the profession, students and the public, and would therefore require careful consideration to ensure that these risks are mitigated.

Consultation question 17 - What could be done differently in order to ensure students become competent, confident and safe beginners?

As described in response to Concept 3, the current competency-based system affords employers (and pre-registration supervisors) a degree of assurance that students have achieved a standard level of clinical competence before beginning their pre-registration year. Any replacement of the current competency-based system would need to provide the same assurances.

In our view, a national examination delivered by an independent body at the point of registration is the only route to ensuring that consistent and high standards are maintained amongst new registrants. This function is currently fulfilled by the College of Optometrists Scheme for Registration.

Concept 10: UK educational routes to registration

Consultation question 18 - What do you see as the opportunities for more flexibility between the education of different regulated and non-regulated optical professions?

Our School identified an opportunity for flexibility between Dispensing Opticians, Contact Lens Opticians and Optometrists some time ago. As a result, we are accredited to provide a 'Career Progression' course which is specifically intended to provide a route for Dispensing Opticians and Contact Lens Opticians to train as Optometrists, taking appropriate account of accredited prior learning.

Similarly, a clear route for progression from Optometrist to IP Optometrist is well established and offered by several providers.

Consultation question 19 - What are the constraints and risks to this?

There are no specific barriers to individuals with a background in non-regulated optical roles (e.g. optical assistants) training as either Dispensing Opticians or Optometrists. Providers already consider evidence of this type of work experience favourably when reviewing admission applications.

Nevertheless, the academic component (e.g. education qualifications) of admission requirements is needed to ensure that prospective students have the necessary educational foundation and experience to study for a University degree-level qualification in either optometry or ophthalmic dispensing.

Where a provider offers more than one programme (e.g. ophthalmic dispensing and optometry), inter-disciplinary learning is already implemented (e.g. joint lectures on

optics). For providers who offer one programme only (i.e. the majority), it is difficult to see how inter-disciplinary teaching could be realised in practice.

Concept 11: Proportionate quality assurance

Consultation question 20 - Are there any other principles and concepts we should consider at this stage in exploring future approaches to our quality assurance processes?

Consultation question 21 - Please tell us about any direct or indirect impact you can foresee from the concepts and principles we have set out in this public consultation on anyone with protected characteristics?

SeeAbility

SeeAbility responds to the consultation as shown below:

Concept 1: Standards for Education Providers

Consultation question 1 - Do you agree or disagree with us further exploring the concept of new Education Standards in the way we describe above?

Agree.

Consultation question 2 - Please tell us more about your views on this concept, including any opportunities or risks you foresee.

SeeAbility has collected substantial evidence of the difficulties experienced by people with learning disabilities, particularly with more complex needs, in accessing sight tests. The education review is a chance to tackle this in the undergraduate curriculum so the workforce is more adept at seeing and treating people with more complex needs and recognizing when they are unable to best meet the needs of a person. We support the closer link to professional standards in the curriculum.

Currently barriers include:

- Uncertainties among people with learning disabilities and carers that the sight test will be accessible and also regarding which optometric service would be best suited.
- There is low public awareness of availability of domiciliary eye care services.
- Difficulties in providing a sight test where the needs of the patient with learning disabilities were not identified before the appointment.
- Communication difficulties
- Inappropriate or inadequate testing methods
- Inadequate feedback of sight test results
- Time restraints preventing best practice
- Difficulties in dispensing suitable spectacles

We would therefore expect any high level education standards to address these issues. The workforce should be prepared to support the 1.5 million people with learning disabilities in the UK (a growing population) with their eye care needs given the exceptionally high risk of sight problems experienced by this population.

A recent study of over 1000 adults found visual impairment the most common comorbidity (experienced by 47% of those tested) and research has also persistently demonstrated a vast breadth of ocular disorders and high refractive error, as well as cerebral visual impairment. .

In our view, no optometrist or dispensing optician should be graduating from their course without being aware of these facts.

There will be an increasing need for optical professionals to be aware of their obligations to provide reasonable adjustments, and accessible information, as well as having a proper

understanding of consent and capacity issues.

SeeAbility would also like to see the curriculum for undergraduate optometry students provide a mandatory requirement to perform an eye examination on a patient with learning disabilities or dementia or another communication difficulty as part of their learning outcomes.

For dispensing opticians training should focus on specialist frames, communication with people with disabilities including some Makaton/BSL and aiding patients with spectacle adaption – particularly as people with learning disabilities will usually need much stronger prescriptions. This would benefit many 'mainstream' patients as well. There is a real need for greater knowledge of facial shapes, necessitating frame adaption for facial asymmetry due to natural changes to faces due to race/disability, and low vision due given statistics and growing number of older people.

However given the rising complexity of people's needs, it is very likely that more formalised professional specialisms will be needed in the eye care of people with more severe learning disabilities, as well as other complex needs, and we would hope in time there will be suitable services and pathways nationally in the community that would enable optometrists and dispensing opticians to specialize in the provision of these services. People could search for those with specialisms and competencies in supporting people with more complex needs on the GOC register. We also believe that regulations should be changed so that rules that ensure spectacle dispensing is by a qualified professional extends to people with learning disabilities, and that this move should be supported by the General Optical Council.

Concept 2: Education Standards and Professionalism

Consultation question 3 – Do you agree or disagree with the concept of informing our education requirements by our professional standards?

Agree.

Consultation question 4 - Please tell us more about your views on this concept, including any opportunities or risks you foresee.

This appears to be a good idea, as reflected in our answer to Question 1.

Concept 3: Learning Outcomes

Consultation question 5 - What are your views on the concept of system-wide learning outcomes for optometry and dispensing optician education and training, instead of an educational competency-based approach?

There is a need always to ensure appropriate safeguards are in place but we support a move away from a 'tick box' competency approach which might be soon forgotten, to more blended learning.

It would be helpful to have more examples or descriptions about what a learning outcome may be. As highlighted in Question 1 we believe no one should be graduating without knowing that those with learning disabilities are a high risk group, the types of ocular disorders that will be a feature of this group, and without being able to show they are able and willing to make adjustments to their approach or seek appropriate advice or referral if they believe the patient needs a more experienced practitioner.

Concept 4: Links to Continuing Education and Training

Consultation question 6 - What do you see as the merits to removing the current link between CET and our education requirements, if any?

SeeAbility is a CET provider, and we support the moves towards more strongly encouraging professional development in accordance with Standards.

Consultation question 7 - Do you envisage any disadvantages or risks in this approach, and if so what are they?

It would appear that aligning professional development with standards would provide additional safeguards and reassurance to more vulnerable groups.

Concept 5: Educational Content

Consultation question 8 - What do you see as the key changes needed to the current content of optometry programmes and dispensing optician programmes to ensure our future requirements are fit for purpose?

Please see our response to Question 1.

Concept 6: Enhanced clinical experience for students

Consultation question 9 - Do you agree or disagree with the concept of embedding clinical elements of education and training progressively from the outset of programmes?

Agree.

Consultation question 10 - Tell us more about your views on this concept.

We agree a more blended approach moving away from the pre-registration year would help students gain more experience in a range of settings. We would be happy to work with universities to offer placements with our clinical team in supporting sight tests in special schools.

We would also like to see students gain more experience in domiciliary care, as presently there is no specific accreditation or training programme specific to this workforce, other than that offered once someone is working within domiciliary eye care. For example a Complex Needs specialism as referenced above could become a pre-requisite to provision of domiciliary services.

Consultation question 11 - What do you foresee as being any positive or negative impacts on students, education providers, employers, patients and carers from taking a hybrid approach?

Concept 7: National registration examination

Consultation question 12 - Do you agree or disagree with the concept of a national registration examination?

Agree.

Consultation question 13 - What are the merits and risks of this concept?

Providing there is the examination which will cover the needs of those with complex needs/communication difficulties for both optometrists and dispensing opticians and that this significant cohort of the population is not overlooked in any final examination.

Concept 8: Multi-disciplinary education

Consultation question 14 - How feasible would it be to develop inter-professional and multi-disciplinary elements of study within optometry and dispensing optician education programmes?

We hope that there will be increased opportunities for multidisciplinary education and training, and collaboration, so that optometrists and dispensing opticians can work more closely with orthoptists and ophthalmologists in delivering pathways of eye care for people with learning disabilities.

There is certainly an argument for dispensing opticians to be formally trained in areas of clinical assessment - for example measurement of visual acuity, visual fields and history taking.

There are two areas of practice which need sufficient focus across all disciplines in order to support people with learning disabilities.

- An understanding that autorefraction is not viable on many children or adults with learning disabilities, and can be very unsuccessful due to abnormal head/eye posture and poor fixation. The instrumentation relies on steady central fixation. Research is now showing that retinoscopy is the only accurate tool for diagnosing early signs of keratoconus which can then be treated through corneal cross linking. This opportunity will be lost if the keratoconus has progressed because it has not been picked up at a sight test.
- Understanding the prevalence of and impact of problems with the processing of vision, that relate to the brain, rather than the structure of the eye. While formal diagnosis of Cerebral Visual Impairment needs the input of ophthalmology, it is important that optometrists and dispensing opticians are suitably informed of the impact that CVI will have on the way the patient 'sees'.

Consultation question 15 - Tell us about any examples you know of already in other disciplines from within or outside the UK?

Concept 9: Duration of education and training programmes

Consultation question 16 - What do you see as the strengths and weaknesses of retaining the current minimum duration as described above?

Consultation question 17 - What could be done differently in order to ensure students become competent, confident and safe beginners?

Concept 10: UK educational routes to registration

Consultation question 18 - What do you see as the opportunities for more flexibility between the education of different regulated and non-regulated optical professions?

Consultation question 19 - What are the constraints and risks to this?

Please see our comments about the needs of more vulnerable groups and our call for national programmes of eye care and more regulation protection for those with learning disabilities, eg. For spectacle dispensing to be through dispensing opticians. Although outside the regulatory scope of the GOC there is much overlap in the curriculum for orthoptists and optometrists/dispensing opticians and conversion courses between these professions would be a major positive development to support both complex needs and paediatric eyecare being more holistic.

Concept 11: Proportionate quality assurance

Consultation question 20 - Are there any other principles and concepts we should consider at this stage in exploring future approaches to our quality assurance processes?

Consultation question 21 - Please tell us about any direct or indirect impact you can foresee from the concepts and principles we have set out in this public consultation on anyone with protected characteristics?

We would hope that those being admitted to courses a value base that respects disability rights and that discriminatory judgments should never be made in terms of whether it is 'worth' someone having a sight test or having spectacles if they have profound or complex needs. It is really important to embed the attitude that even if someone cannot work, drive or read, their eyesight will be crucial and they can be supported to have a sight test, benefit from glasses and be supported to get used to glasses.

Simon Webster

Simon Webster responds to the consultation as shown below:

Comments made on Concept 5, Question 8 only Concept 5:

Educational Content

Consultation question 8 - What do you see as the key changes needed to the current content of optometry programmes and dispensing optician programmes to ensure our future requirements are fit for purpose?

1) Skill provision for public benefit is best defined by determining competencies required and gearing training towards those ends, rather than narrow professional groups defining their own 'turf'. Professional distinctions between dispensing opticians, optometrists, contact lens opticians and orthoptists should be extinguished to develop an occupational grouping based on acquiring progressive skills below the level of ophthalmologist ('Occupations Allied to Ophthalmology'- OAO). This will provide a more a flexible workforce, with a wider skill base, suitable for both private and public practice. Trainees would work their way up through different competencies to make themselves better available to meet progressive skill requirements and will not be held back by narrow vested interests of small, specialist professional groups.

2) Training and education is fit for purpose- criticisms have been made in recent times of the provision of university education, both in this country and overseas (see Wolf, 2017 and Caplan, 2018). Whilst universities can provide good quality skill enhancement, they have been accusations of 'credentialing' or 'signalling', in other words, overeducating for the job in hand. This can already be seen in some overseas optometric courses which require intending optometrists to complete a general university science degree prior to committing to a further undergraduate degree in optometry. Also, the OCANZ (Optometry Council of Australia and New Zealand) accreditation procedure required for UK optometrists wishing to work in Australia and New Zealand is an example of a credentialist barrier which does little more than train the same person to do the same job (although in a different country). In any review of education, the GOC should guard against 'credentialing'.

The plethora of optometry courses now available is suggestive that too many optometrists are being trained for the needs of society. The GOC makes the claim it cannot interfere with the establishment of new courses. However, in its remit for public protection, it is clearly in the public interest that both a sufficient, but not an excess of, optometrists are trained. Whilst it cannot interfere with establishment of such schools, it can and should express an opinion publically if it is felt too many optometrists are being trained. The public are not protected if excess numbers drive down both student standards and the professional skills of the available optometric pool.

National standards (if adopted) imply a common occupationally-based education. Economies of scale in the academic (theoretical) part of training can be made. The ABDO have established expertise in distance learning, and modern teaching/learning platforms, such as MOOC's (Massive Open Online Courses), can provide the necessary theoretical base to optometric studies without the expense of full-time attendance at a university. Full-time university attendance will need to be retained for clinical/practical training.

3) Resource efficient- there is anecdotal evidence of a significant dropout rate amongst optometry students before registration. Interestingly, Caplan (2018) makes the connection that '..as credentials proliferate, so do failed attempts to acquire them. Any respected verdict on the value of education must account for these academic bankruptcies'.

Whilst the impact of 'dropouts' does not disadvantage the training universities, it is a poor use of human resources, detrimental to students and bad for optometry generally. Prior to seeking entry to an optometric school, all reasonable attempts should be made to see that students are adequately screened for suitability before investing their money, effort, emotional and academic energies in committing to something that may not, ultimately, be suitable for them (as individuals are screened before entry to the armed forces, for example).

References

Caplan, B. (2018) 'The world might be better off without college for everyone', The Atlantic, Jan/Feb 2018.
Wolf, A. (2017) 'Degrees of failure: why it is time to consider how we run our universities', Prospect, 4th July 2017.

Specsavers Professional Leadership Council (PLC)

Specsavers Professional Leadership Council (PLC) responds to the consultation as shown below:

Concept 1: Standards for Education Providers

Consultation question 1 - Do you agree or disagree with us further exploring the concept of new Education Standards in the way we describe above?

Agree.

This demonstrates that the GOC has reflected on the evidence derived from the earlier consultation and has developed the thinking in this direction in a positive way, which supports innovation and moves away from the current, potentially restrictive approach.

In particular, this should focus on outcomes rather than process.

Consultation question 2 - Please tell us more about your views on this concept, including any opportunities or risks you foresee.

Opportunities

- High level education standards increase the potential for agility of academic institutions and for the profession to respond to change. This needs to be considered in partnership with the principle of CET transitioning to CPD in order to be meaningful.
- Universities need to be enabled to balance the internal/institutional and external/stakeholder specific demands on their curricular provision. Knowledge and skills of students could be nurtured not only from research informed curricula but just as importantly, through evidence based practice.
- Active relationships with employers and service provider organisations should help allow curricula to remain relevant to the changing demands placed on the workforce and to clinical service provision as it evolves. In novel courses that recognise situated clinical experience and remote learning, the learning objectives and assessment criteria should be clearly defined to mentors and employers whilst the transition from student to autonomous professional could and should be clearly demarcated by the taking on of responsibility as well as a national common final assessment.
- The GOC's system and procedures for review of educational programmes leading to registration should be transparent and where established on the basis of logic rather than evidence, should be reasoned and substantiated. The GOC should offer both *formative* and *summative* communications so to remove any guesswork and enable providers to work towards delivering what their regulator requires of them.

Risks

- The GOC needs to be more agile to facilitate this. Cycles of change within academic institutions tend to be annual, and 3-5 yearly. If this is not aligned with the regulator oversight activity, then any ideas of agility get undermined.

- Novel courses proposing registerable degrees could lead to huge variation of GOC category registrants.
- Must be seen to be making a positive impact for the benefit of the public and the

sustainability of the registrant professions. Cannot justify introducing change for change's sake

- The implications for existing registrant must also be taken into account.

Concept 2: Education Standards and Professionalism

Consultation question 3 – Do you agree or disagree with the concept of informing our education requirements by our professional standards?

Agree.

When the education requirements are informed by the professional standards then a more high level approach is possible.

Consultation question 4 - Please tell us more about your views on this concept, including any opportunities or risks you foresee.

Much like the core competencies, the current standards of practice don't seem to be equally weighted if considered individually but perhaps they should be considered as a package because the themes need to be interwoven. The detail of how education providers would be expected to respond to future changes in those standards would need to be described.

Standards should be used to unshackle universities and stimulate educational development to create registrants that resilient, resourceful, empowered, applying reasoning and reflection in order to broaden skills in problem solving. There is a risk of a closed feedback loop developing where the currently established standard inform the curricula and in time (and in turn) standards end up being defined and limited by what registrants have been trained to do. It is therefore important that the standards remain under independent and dynamic review.

Concept 3: Learning Outcomes

Consultation question 5 - What are your views on the concept of system-wide learning outcomes for optometry and dispensing optician education and training, instead of an educational competency-based approach?

Learning outcomes approach for educational courses leading to registration for optometrists and dispensing opticians should be high level and using the appropriate SEEC credit level descriptors for higher education (2016).

The outcomes should (as proposed above as part of concept 3), include technological considerations, population demographics, interdisciplinary working methods and clinical service delivery and sustainable business models.

The implications for the whole workforce and not just undergraduates will need to be managed and supported. The pace of change could be rapid and destabilising if the implications for the whole workforce are not considered.

Concept 4: Links to Continuing Education and Training

Consultation question 6 - What do you see as the merits to removing the current link between CET and our education requirements, if any?

Entry level registration requirements should not be the limit of learning for registrants, yet this has been an unintended outcome of the CET system. A system of CPD should be implemented for maintenance of registration, in order to nurture the GOC's ambition for lifelong learning and professional development or registrants. In particular, emerging roles mean are not effectively supported by the current approach.

Consultation question 7 - Do you envisage any disadvantages or risks in this approach, and if so what are they?

Compulsory CET has been in place long enough now that all stakeholders understand it and work with it. The risks arise if the link to CET is removed without an alternative, well-reasoned and well-understood CPD system in place for registrants.

CPD however will be essential in order for the whole profession to progress for the benefit of patients. The current CET system which is pegged to entry level competencies does not allow for recognition of further professional development and skills and has more of the potential to be stifling therefore a greater risk at this point in time.

Concept 5: Educational Content

Consultation question 8 - What do you see as the key changes needed to the current content of optometry programmes and dispensing optician programmes to ensure our future requirements are fit for purpose?

As the roles of optometrists and dispensing opticians evolve, so too will their skill requirements, and content needs to be carefully reviewed to ensure that any 'nice to have' content can justify its position in a curricula where space for the 'need to have' will be at a premium. Some topics that may have previously considered to be advanced will become core and likewise some areas currently included, may turn out to be of niche interest and therefore once the basics are secured, their further development can be safely deferred to post-graduate development.

Perhaps it is not so much the theoretical content that needs to change but the way that it is applied to the learning process that requires revision. Learners still need to know theory and to learn in in a constructive, experiential manner, in a logical order however it should be leant by systematically applying context and done so within functioning services.

That said relevant topics for Optometrists include:

- Visual anatomy physiology perception and ocular pathology
- Sytemic anatomy, physiology and pathology for conditions with visual morbidity or where optometrists can play a significant role in public health for systemic conditions in the style of a Healthy living Optician
- Visual optics, properties of light energy, light filters and optics of instrumentation
- Epidemiology and natural history disease progression as well as refractive development.
- Evidence based practice and evaluating evidence through critical thinking.

- Complex problem-solving and cognitive flexibility
- Px-centred service orientation/Efficient and sustainable service delivery
- Co-ordinating with others/People management/ Emotional intelligence
- Creativity
- Negotiation

Many of these skills get used in the final year research project/dissertation but anecdotal reports suggest some universities are removing this from curriculum.

The students need to learn from academics who know what the clinical professional realities are in a variety of settings to create optometrists working in sustainable services, and from clinicians who understand the evidence basis for professional guidelines and can mentor students into developing their clinical reasoning skills.

Concept 6: Enhanced clinical experience for students

Consultation question 9 - Do you agree or disagree with the concept of embedding clinical elements of education and training progressively from the outset of programmes?

Agree.

Specsavers PLC fully supports this approach and the summary you have provided here has much to commend it. There will need to be clarity when defining 'clinical training' so that it cannot be assumed this is wholly or significantly covered through the existing approach of patient simulation and learning on the real eyes of fellow students from the start. A further aspect that is currently absent, is learning about care systems which should be learnt in a variety of contexts and from a variety of sources to compare and contrast the positives with the negatives.

Consultation question 10 - Tell us more about your views on this concept.

As we commented in our response to the 'call for evidence', students must learn alongside those who are immersed in the treatment and care of patients. In optometry in particular, best practice is evolving rapidly and it is essential that training occurs alongside where the optometrist in practice is delivering this patient care. High quality placements must become a central part of the undergraduate programme. Blended learning programmes have great potential to support this new immersive approach to clinical education.

The current system of pre-registration periods demarcates the transition from student (with no responsibility) to trainee (with responsibility) very clearly and is a transformative experience for graduates. Any introduction to the workplace early on should include both observational but also interactive learning with increasing onus and responsibility. It has been suggested that some medics who have had earlier and continuous exposure to hospital placements in the new medical degrees have been more reluctant to take on responsibility in their Foundation year after graduating, and this would be an undesirable outcome if it were to result from the educational review. However, it has also been noted that those who qualified through one of the medical schools with a Problem Based Learning (PBL) curriculum, reported feeling better prepared in many areas when compared with those from other medical school types.

Consultation question 11 - What do you foresee as being any positive or negative impacts on students, education providers, employers, patients and carers from taking a hybrid approach?

A number of key changes would be required not only from educational institutions but also from the whole workforce and all stakeholders. A continuum of mentoring would be very useful but is currently absent beyond the pre-registration period.

To engage and mobilise the industry to participate, a sustainable financial model facilitating any earlier placements in the workplace is needed. The expertise of the scheme providers (College of Optometrists and the ABDO) who have a wide network of trained and experienced supervisors / assessors across the UK would be able to add value here.

Concept 7: National registration examination

Consultation question 12 - Do you agree or disagree with the concept of a national registration examination?

Agree.

In the absence of evidence to say registrable degrees could all be quality assured as being equivalent to each other, we believe a national registration examination should remain in place.

Consultation question 13 - What are the merits and risks of this concept?

Absence of the national examination would mean an absence of quality assurance and equivalence of graduate practitioners at the point of entry to the register.
Any national examination should be constructively aligned with the job that the professional would be expected to perform not just a written exam (exam for the sake of having an exam) which is unrelated to the skills used in the day-job. As a result, it will be important for those tasked with delivering a national examination (the College of Optometrists and the ABDO) to ensure that these remain dynamic and able to reflect the changing demands on optometry and ophthalmic dispensing.

Concept 8: Multi-disciplinary education

Consultation question 14 - How feasible would it be to develop inter-professional and multi-disciplinary elements of study within optometry and dispensing optician education programmes?

The feasibility would probably vary as per the description under concept 8. Some educational institutions will naturally be able to implement forms of interdisciplinary learning because they already have cohorts of students for a range of health professions whilst other would need to proactively develop them to fill a requirement. The key to feasibility is not to be prescriptive as regards the *how* but to identify the end goal for the just-safe registrant on entry, based on the job that they need to be doing to help academic institutions work on the relevant assessed learning objectives.

Consultation question 15 - Tell us about any examples you know of already in other disciplines from within or outside the UK?

The examples we are most familiar with in the UK are those that already take place within funded NHS settings for medics, nurses, allied health professionals such as orthoptists, dieticians, physiotherapists OTs and podiatrists etc., who all learn in a multidisciplinary setting where a substantial funding tariff for placements is provided and the ethos is integrated into the standards and expectations put upon the professions.

Concept 9: Duration of education and training programmes

Consultation question 16 - What do you see as the strengths and weaknesses of retaining the current minimum duration as described above?

Any change to the duration would need to be well justified either by using more intensive course timetables throughout the year, or by implementing something like apprenticeships (which would naturally take longer but reduce the loss of income during the learning process). The learning outcomes that need to be achieved to create the relevant and well-rounded professional should shape these but it would not be desirable to create longer courses undergraduate that cause learners to incur further debt.

Consultation question 17 - What could be done differently in order to ensure students become competent, confident and safe beginners?

The things that could be done differently to create competent, confident and safe should not be considered as being led by nominal duration. The answer to this question lies in what the end product in terms of the professional should look like. Competent confident safe professionals should have sound underpinning evidence- based knowledge, problem solving skills, flexible and adaptable communication skills, team working and independent self-reliance ability all nurtured by role models and mentors they can identify with. So the consideration is how to expose them to relevant relearning activities that will get them to that point as safe beginners in a reasonable time. And the concept of a safe beginner is the starting point to a continuum of ongoing development and ethos of lifelong learning.

Concept 10: UK educational routes to registration

Consultation question 18 - What do you see as the opportunities for more flexibility between the education of different regulated and non-regulated optical professions?

Any APEL that maps assessed learning outcomes and relevant portfolios of experience makes sense and in some respects is already in place. Some of the barriers that currently exist are in the funding limitations for people who are entering their second degrees or for candidates whose academic ability or basic scientific qualifications at level 3 (A-level/BTEC/Access/Foundation year 0 etc) is not on par with any competitors for the same place at a learning institution.

Any approach which encourages non-regulated colleagues to develop and expand their skills has to be welcomed as this provides both a skilled support staff to participate in delivery of services to patients, and potentially enables those individuals to progress into training leading to registrant roles.

Consultation question 19 - What are the constraints and risks to this?

Unless a UK-wide overhaul of education in eye care is made, which would require all eye care disciplines to be involved including those who end up being ophthalmic nurses, nurse practitioners, orthoptists and ophthalmologists based on learning together and progressing based purely on aptitude, there is no radical gain to be made here. In the meantime if the role of the dispensing optician is threatened in its current form then educational development needs to be put into place to allow that groups of professionals to meet eye health needs in another way even if they cannot meet APEL for optometry.

Concept 11: Proportionate quality assurance

Consultation question 20 - Are there any other principles and concepts we should consider at this stage in exploring future approaches to our quality assurance processes?

It would not make sense for there to be any duplication in quality assurance processes if they exist elsewhere in the academic system but from a regulatory perspective, educational development underpinning the optical professions on this register needs to be facilitated rather than hampered or slowed down.

Consultation question 21 - Please tell us about any direct or indirect impact you can foresee from the concepts and principles we have set out in this public consultation on anyone with protected characteristics?

Through modernising training for optometrists, dispensing opticians and the wider eye health team, the creation of fulfilling and interesting job roles is assured. This in turn should create more opportunity and draw more potential candidates into the workforce which benefits both those individuals and the people whose needs they meet. Flexible learning models will go some way to reducing barriers to those who might currently be deterred from pursuing a career in eye health.

Tim Hunter

Tim Hunter responds to the consultation as shown below:

Concept 1: Standards for Education Providers

Consultation question 1 - Do you agree or disagree with us further exploring the concept of new Education Standards in the way we describe above?

Agree.

Consultation question 2 - Please tell us more about your views on this concept, including any opportunities or risks you foresee.

It seems reasonable to explore this. However I would be concerned that we could see a further increase in the variation in quality of delivery by the various educational organisations delivery Optometry qualifications. We already have some degree providers where it is quite clear they provide a better clinical training than others, I would want reassurance that the new approach would increase quality of clinical training and not reduce it. There is also a risk that regional variation would increase to reflect the different approaches towards optometric care delivery across the UK. I think it would require an impressive amount of foresight to deliver an educational structure that would prepare graduate optometrists for all the enhanced roles that will exist in the future. I think many of these roles will require post graduate qualifications and that the undergraduate programme should deliver capable clinicians with a strong clinical base and clinical management abilities who would be able to access those postgraduate routes to enhanced roles. It is difficult to comment in any detail without more detail from the GOC on this area.

Concept 2: Education Standards and Professionalism

Consultation question 3 – Do you agree or disagree with the concept of informing our education requirements by our professional standards?

Agree.

Consultation question 4 - Please tell us more about your views on this concept, including any opportunities or risks you foresee.

The GOC and the profession would need to make sure that the professional standards and values, central to optical practice, reflect the increasing range of roles that optometrists, dispensing opticians and others are going to be expected to provide in our changing healthcare service.

Concept 3: Learning Outcomes

Consultation question 5 - What are your views on the concept of system-wide learning outcomes for optometry and dispensing optician education and training, instead of an educational competency-based approach?

I would be concerned that a more flexible model could lead to a significant variation in the quality of optometrists coming out of the various training establishments and their ability to meet the challenges of the future eye healthcare needs of our patients. There would need to be core skills and abilities that all optometrists should have which would not be subject to flexible delivery. Whilst a flexibility in programme would be attractive to the course providers it would require a very tight monitoring to ensure consistency in standards of graduating optometrists. I am not sure how it benefits the profession or our patients.

Concept 4: Links to Continuing Education and Training

Consultation question 6 - What do you see as the merits to removing the current link between CET and our education requirements, if any?

Not sure, as ever the devil is in the detail. Continuing education and training involves maintaining knowledge and skills but by its nature also allows practitioners to gain new knowledge and skills. CPD is more about the latter and I would worry about those who need the former more.

Consultation question 7 - Do you envisage any disadvantages or risks in this approach, and if so what are they?

I think it would take a while for CPD to bed in and without some mandatory components as in the present CET structure, we could find ourselves as practitioners cherry picking areas we feel comfortable learning about and not filling in the gaps in our knowledge in areas we are less enamoured with as has happened in the past. I think the gradual move to more critical assessment of provision and content by the GOC as well as the requirement to undertake a specific range of CET has been positive for the development of the profession and I would not want to see that lost in any change.

Concept 5: Educational Content

Consultation question 8 - What do you see as the key changes needed to the current content of optometry programmes and dispensing optician programmes to ensure our future requirements are fit for purpose?

I think we can always improve on our clinical training and the range of clinical experience our undergraduates are exposed to. I think the large course numbers at some universities has diluted the amount of time given to practical training and it shows in the skill set of some graduates. I am still shocked by how poor some graduate optometrists are at clinical management. Personally I also feel that there continues to be a significant disconnect between some University lecturers and the real world of optometry, which is not healthy for the clinical training of undergraduates. Whilst we need to build in much more content on the expanding roles that many optometrists are now providing or could provide, we need to ensure that the core skills of refraction and prescribing (which is still our legally protected function and the reason we still continue to exist as a profession) are maintained.

Concept 6: Enhanced clinical experience for students

Consultation question 9 - Do you agree or disagree with the concept of embedding clinical elements of education and training progressively from the outset of programmes?

Agree.

Consultation question 10 - Tell us more about your views on this concept.

I agree up to a point. I think it could enhance the undergraduate course. It could winnow out the students who are not aware of the realities of clinical practice, as happens in the orthoptic degree, where students are in clinical placements within the first few weeks and there is a significant drop out of students who realise it is not for them. It would give students a much more realistic view of the nature of optometric community practice and hopefully exposure to a broad range of practices (not just the big multiples). However I would be concerned about difficulties in gaining access to HES experience, this is a problem in terms of regional variation in both capacity and optometric involvement in the HES in some areas. I would be concerned that the providers of optometric education with a large student intake would struggle to provide their students with the same level of experience as those with smaller and more manageable numbers. Looking at orthoptic courses they have 50 to 60 students to place not 100+. I would be utterly opposed to the idea of a hybrid course replacing the pre-registration year as I do not feel that a hybrid course would effectively duplicate the benefits of the pre- registration year of supervised practice. It has been said that the pre-registration year is the hardest and most important year of any optometrists career and that is very much because it builds on the theoretical and very basic clinical skills and clinical experience that the universities provide. It has its flaws but I would need a lot more evidence to consider getting rid of it.

Consultation question 11 - What do you foresee as being any positive or negative impacts on students, education providers, employers, patients and carers from taking a hybrid approach?

See above.

Concept 7: National registration examination

Consultation question 12 - Do you agree or disagree with the concept of a national registration examination?

Disagree.

Consultation question 13 - What are the merits and risks of this concept?

I would be extremely concerned about reducing the barrier to registration, unless I was convinced that this new process was robust enough to winnow out the graduates who are not safe to practice. I absolutely agree that there should be a total separation between registration and degree as I am afraid that I do not trust the education providers to separate their economic imperative to graduate students from the need to maintain standards in the profession and protect the public. This has become much more of a

problem in recent years. I am also not convinced that the education providers would be able to provide sufficient practical and clinical experience to replace the pre-registration year. Every pre-registration optometrist is personally supervised and mentored by a practising optometrist during the PRP, I do not see how this level of supervision could be provided to 100+ students on an undergraduate course. I think everyone acknowledges that their optometry degree is the start of the learning process and that the pre-registration year is the key to developing the skills and increasing knowledge to be a safe and competent practitioner.

Concept 8: Multi-disciplinary education

Consultation question 14 - How feasible would it be to develop inter-professional and multi-disciplinary elements of study within optometry and dispensing optician education programmes?

I have no idea. I think it would depend on existing relationships and availability of other health course provision in the specific education providers. I would be concerned that it should not be just a programme filler and a way to pad out the course but should add to our ability to provide safer care for patients. I am unclear how we could make it work for the benefit of the profession.

Consultation question 15 - Tell us about any examples you know of already in other disciplines from within or outside the UK?

I have no examples to share. Unless you count the fiasco at Glasgow when they tried to run an orthoptic degree alongside their optometry degree and were unable to provide appropriate orthoptic training.

Concept 9: Duration of education and training programmes

Consultation question 16 - What do you see as the strengths and weaknesses of retaining the current minimum duration as described above?

I have no particular issue with course duration either minimum or maximum length as long as it delivers graduates with knowledge and skills to provide appropriate and safe care for their patients. I suspect that anything less than two years of very concentrated work would be regarded as insufficient for the needs of the profession and the public. I would also be concerned that a move to more distance learning components would be counter to the desire to provide more clinical training and experience.

Consultation question 17 - What could be done differently in order to ensure students become competent, confident and safe beginners?

I think that we need smaller undergraduate courses, which would make it more practical for undergraduates to gain more clinical work and experience. Students would also benefit from more real world experience of a range of optometric providers, in a variety of environments and more real world practitioners involved in teaching and training. I would personally suggest looking at the separation of the research role from clinical training, which I think means research orientated rather than clinically capable optometrists end up teaching (often grudgingly) in our optometry departments.

Concept 10: UK educational routes to registration

Consultation question 18 - What do you see as the opportunities for more flexibility between the education of different regulated and non-regulated optical professions?

I think there is definitely room for a more coherent approach to the transition for dispensing opticians into optometry, as happens in some undergraduate courses at present. I would think something similar would be appropriate for optical assistants. There is definitely room to improve the training and examination of IP optometrists, which is incredibly variable at present.

Consultation question 19 - What are the constraints and risks to this?

I think it would be important to make sure there are consistent standards for the transition between the different optical groups across the education providers.

Concept 11: Proportionate quality assurance

Consultation question 20 - Are there any other principles and concepts we should consider at this stage in exploring future approaches to our quality assurance processes?

Not sure.

Consultation question 21 - Please tell us about any direct or indirect impact you can foresee from the concepts and principles we have set out in this public consultation on anyone with protected characteristics?

Not aware of any.

Ulster University

Ulster University responds to the consultation as shown below:

Concept 1: Standards for Education Providers

Consultation question 1 - Do you agree or disagree with us further exploring the concept of new Education Standards in the way we describe above?

Agree.

Consultation question 2 - Please tell us more about your views on this concept, including any opportunities or risks you foresee.

All accreditation and registration organisations have a duty to periodically review their standards. However, it is important that an evidence-based approach is taken and that the notion of 'education' as oppose to 'training' is maintained. Undertaking a Bachelors degree in Science to gain an education in the science of the visual system and optometry as a discipline is inherently distinct from a 'training' programme designed to deliver specific functions. While, the route to registration may contain a mixture of education and training, the former must underpin the latter if we accept that optometrists require degree level education.

To our knowledge the optometry undergraduate degree which members of the Ulster academic staff have taught on, and/or examined for, currently delivers a curriculum that includes many of the features highlighted by the GOC. This includes an evidence-based approach to delivering education; undertaking regular programme reviews to ensure current concepts, evolution of scope of practice and skills, and technological innovations are included in programmes. A common feature across programmes is the existence of modules specifically designed to be flexible and responsive to changing evidence, technology and service needs.

The recognition by the GOC of the value of inter-disciplinary collaboration is welcomed, but the enhancement of such training opportunities needs to be balanced by ensuring core optometric content is not lost and that training doesn't become generic. The danger in inter-disciplinary learning experiences is that they become 'tick box' or are seen as less relevant by learners if the relevance to the learner's specific discipline isn't clearly signposted. Our experience is that students engage best when they see the direct relevance to their working practices of content, e.g. ethical scenarios based on optometric cases, rather than generic health care roles. The challenges in providing high quality inter-disciplinary learning experiences should not be underestimated. While we welcome interdisciplinary learning that amplifies and enhances the skills and knowledge of undergraduates, programmes should be free to do this where it provides a truly enhanced value.

The value of active relationships with employers and service providers also needs to be balanced with ensuring the quality and scope of undergraduate provision is not skewed to meet the needs of specific areas of the optical sector, but ensures graduates are able to work across all areas of the discipline and, often, in more than one area during the duration of their career. Naturally, employers may want to encourage the development of business and management skills amongst their staff, but we would argue that this should

not come before robust undergraduate clinical education and training. The ability of optometrists to work across sectors (primary care - multiple and/or independent practice, industry, academia, secondary/tertiary care, charitable sector etc.) is something that should be nurtured for cross- fertilisation of ideas, best practice and life-long learning. We, in common with other University programmes, actively seek meaningful stakeholder engagement and opinion from all areas of optometric practice, and this, in conjunction with other considerations, forms part of programme evolution.

Concept 2: Education Standards and Professionalism

Consultation question 3 – Do you agree or disagree with the concept of informing our education requirements by our professional standards?

Disagree.

Consultation question 4 - Please tell us more about your views on this concept, including any opportunities or risks you foresee.

It is difficult to 'disagree' with the notion of using the professional standards to inform the development of new education requirements. However, the text relating to this question highlights the impetus to make a 'strong link' between the professional standards and the new education standards and this is less appealing. We appreciate the importance of the standards for professional practice, but they include relatively little emphasis on knowledge and application of a critical approach to new knowledge, evidence and/or technology. It is our view that the professional standards should inform but not be strongly linked to education requirements. However, we do agree that the current competency frameworks applied to optometric education require revision; if indeed they are retained. For example, the current stage 1 and 2 competency frameworks show a considerable amount of overlap, and, in contrast to areas of overlap, there are skills, knowledge and behaviours that the current framework fails to capture/assess. We believe that assessment of knowledge and the safe application of knowledge must be a central component in the education of potential optometrists and that competency-based frameworks also have a role in evaluating learning outcomes on the route to registration. The SOLO taxonomy and Dreyfus models of competency frameworks are recognised as useful paradigms on which to develop skills assessment in medicine and the allied health professions. The revision of the competency framework to better capture higher-level knowledge, skills and experience would be welcomed.

Concept 3: Learning Outcomes

Consultation question 5 - What are your views on the concept of system-wide learning outcomes for optometry and dispensing optician education and training, instead of an educational competency-based approach?

The application of a learning outcome framework to optometric training is a reasonable approach. Ensuring students have demonstrated attainment of learning outcomes is a key component of current programmes and is a well recognised method to attain consistent outcomes at the desired level. However, if not robustly applied, outcomes based learning/assessment frameworks can result in superficial approaches to teaching and this approach must be balanced with the retention of a core curriculum.

The example of the College of Optometrists' Professional Certificates, which detail specific learning outcomes that all providers must meet, may be a useful paradigm; different providers take differing approaches to content delivery and assessment, but the same outcomes are achieved.

Some of the examples given in the consultation are less welcome. In our experience ensuring that the education of optometry students is 'clinically focused and experientially based' is important, but needs to be balanced with a strong and deep understanding of the basic, unchanging, science of the visual system and visual processing, such that, whatever the future of optometric practice and eye care holds, optometry graduates understand the nature of the visual system and how it works, how diseases and conditions which impair normal visual function act on the anatomy and physiology of the visual (and systemic) system, and how to maximize each patient's visual performance. The latter is the key role of optometrists and requires an underpinning knowledge that is honed and focused by clinical experience. The science needs to be in place for the clinical experience to be sustained and meaningful.

Assessing whether students have met learning outcomes relating to "new and emerging technology" and "demographic needs and patient expectations" are also valuable, but even more valuable is to assess whether they are able to be responsive to and apply scientific and critical thinking to any new (as yet unknown) technology, service models or cultural developments. We contend that the inclusion of research activity and critical thinking within the undergraduate programme is essential to nurture and assess students' ability in this area and 'future-proof' them for optometric practice.

Finally, if a learning outcome based framework is developed for optometry and dispensing optics, the two distinct professions will require different learning outcomes (although there may be some overlap). Optometry encapsulates dispensing optics and goes much further in breadth of knowledge; the demands of the degree are reflected in the admission requirements for undergraduates.

Concept 4: Links to Continuing Education and Training

Consultation question 6 - What do you see as the merits to removing the current link between CET and our education requirements, if any?

It is our understanding that the proposal is not to remove the link between CET and education requirements, rather that as the educational requirements move to a learning outcomes-based approach, CET might also use learning outcomes as a basis for its framework. This appears to be a sensible approach if education requirements move towards a learning outcomes-based approach.

Consultation question 7 - Do you envisage any disadvantages or risks in this approach, and if so what are they?

We suggest that CET providers and CET participants know what 'good' CET looks and feels like. We imagine that CET providers will continue to be able to deliver 'good' CET and align it with whatever framework the GOC establishes. Ongoing development of skills and knowledge and skills 'refreshment' throughout optometric careers should be further supported, encouraged and resourced. In this way, moving toward broader ways to capture continuing professional development (CPD), rather than a relatively narrow prescription of points, may be beneficial in the future. It may be difficult to set generic learning outcomes for CET for all qualified practitioners, given the wide range of clinical skills optometrists

require depending on their mode of practice.

Concept 5: Educational Content

Consultation question 8 - What do you see as the key changes needed to the current content of optometry programmes and dispensing optician programmes to ensure our future requirements are fit for purpose?

What is the evidence that changes are needed to the current content of optometry programmes to ensure future requirements are fit for purpose? The Call for Evidence Summary Report has gathered opinion about a changing eye care landscape which we do not contend. This may require optical providers to change the mode and scope of services they deliver, but where is the evidence that graduates with a BSc/MOptom in Optometry are not suitably equipped to contribute to these new and evolving models of care?

GOC-registered optometrists, educated and trained in the current system, contribute strongly and successfully to many enhanced schemes and extended roles across the UK. Governance structures around such positions do, however, vary widely across the UK. For example, some require clinicians to have formal additional qualifications (such as College of Optometrists' accredited Professional Certificates), while others do not have any such requirements. This indicates that current education and training provided by universities appropriately prepares students for practice in areas outside core optometry.

It is our contention that high quality undergraduate programmes already incorporate evidence-informed teaching across the curriculum and, in addition to the core and vitally important modules which cover the science of the visual system, optics and optical materials, ocular (and systemic) pathology and clinical practice, include flexible, dynamic modules designed to house cutting edge topics. Our experience of delivering undergraduate and post-graduate teaching is that optometric education content is appropriate for entry level practice (and could be argued to educate optometry graduates in skills which are over-looked and under-utilised in many primary care settings, see below).

We argue that post-graduate qualifications are a key and under-used resource which should have a stronger profile in optometric careers.

All high quality undergraduate programmes currently deliver content which ensures graduates have the ability to deliver core-level 'enhanced services' which currently operate in the community, e.g. repeat pressures schemes, preoperative cataract assessment. To date, this basic knowledge and skill has often not been recognised and optimally utilised by commissioners and eye care providers, with the risk (or perception) that post-graduation optometrists lose skills and confidence in some areas. In many UK locations, when 'enhanced service' schemes are introduced lack of trust in optometrists' basic core skills and/or lack of confidence by optometrists who have not been required to utilise these core skills since registration leads to requirements for further training; often without clear rationale.

To future-proof optometry education and training, an increasing emphasis (contrary to many new/evolving undergraduate programmes) will need to be placed on the ability of graduates to utilise primary research as an evidence-base for practice, applying this in conjunction with sound clinical skills and taking a problem-solving approach to clinical

care. The pace of change in treatment and technologies relating to optometry is accelerating. We cannot 'second guess' what optometrists of the future will need to know but equipping graduates with skills in critical analysis of research outcomes and published data will be invaluable for their ability to respond to change and apply an evidence-based approach to their future practice. This will become increasingly important with increased Optometric involvement in extended-roles and co-management of eye disease, particularly for practitioners working in isolation. A greater emphasis on ophthalmic public health and increasing inter-disciplinary working will also help address this. Mandating competency in specific enhanced skills at undergraduate level is likely to mean that curricula become outdated more rapidly. It would seem sensible, therefore, for such specialised functions, e.g. independent prescribing, to continue to be optional, post- graduate training. Post-graduate training is more flexible and nimble in responding to changing service and delivery needs. Post-graduate training not only enhances clinical service provision, as needed, but provides valuable life-long learning opportunities for practitioners, which aligns with modern educational theory and practice. A 'commitment to lifelong learning' is stressed in research presented by the GOC in their consultation document (p. 3-4, Patterns and Trends Research Collaborate Research 2017). The value and success of postgraduate training is also enhanced by the participant's experience of clinical practice and their maturity, which brings considerable added value to the training and outcomes.

While the impact of technology on practice and its implications for traditional manual skills must be acknowledged, we need to deliver clinicians confident to harness technological developments as they arise for best assessment of eye care, rather than put technology itself at the heart of a programme. Additionally, automated approaches are not appropriate for a significant, vulnerable minority of patients (the elderly, the very young, those with physical/communication/intellectual disability etc.). For example, it is important that core skills such as retinoscopy are maintained and assessed as the most appropriate (sometimes the only) method by which to assess refractive errors.

Concept 6: Enhanced clinical experience for students

Consultation question 9 - Do you agree or disagree with the concept of embedding clinical elements of education and training progressively from the outset of programmes?

Disagree.

Consultation question 10 - Tell us more about your views on this concept.

It is hard to disagree with the statement above, but we disagree with some of the ideas presented in the context of posing this question, hence we have identified 'disagree' as our response above.

Clinical elements of education and training are currently embedded progressively from the outset of high quality optometry degrees. Most, if not all, optometry undergraduate programmes commence practical clinical experience in their university eye clinics during the first year of the programme. This exposure to clinical practice is increased throughout the programme and involves both in-house and placement activity. The former provides opportunity for closely supervised learning in the clinical arena using a variety of patient interaction opportunities involving a range of patients; fellow students, healthy volunteers across a range of ages, volunteers with known ocular/systemic conditions, secondary care

patients and those seeking primary eye care (i.e. ‘real patients’). Many students also undertake placements during the summer period between second and third year. These non-compulsory placements are a private arrangement between student and provider and are not quality controlled by the universities. Such placements are usually with one of the large eye care providers and students report that they provide useful insight clinical practice. There may be scope, in collaboration with eye care providers, to extend and enhance the opportunities for learning these placements provide. However, while such opportunities sound attractive, university regulations may prohibit or restrict any compulsory student engagement in placement activity during the summer and, as such, close consultation with university regulators will need to be undertaken before such avenues are considered.

The GOC recognises ‘variation in the extent and range of clinical experience being provided to students by different education providers’ (Consultation on the Education Strategic Review, December 2017). If this is indeed the case the GOC perhaps requires more strict criteria of what constitutes patient experience if they desire consistent quality across programmes? The Education Strategic Review provides the opportunity to describe and apply a more consistent approach across providers, with recognition of the resource implications in relation to providing clinical experience.

The Education Strategic Review has raised the idea of a move away from the ‘pre-registration year’ and for education providers to take on responsibility for the entirety of the student journey. This concept has significant resource and quality assurance implications.

Firstly, in terms of resources: The GOC are aware that the HEFCE funding for training in undergraduate optometry is significantly lower than other clinical programmes such as medicine and dentistry. If the GOC call for an increased level of clinical work in an extended undergraduate programme, funding will need to be increased beyond the current HEFCE tariff, at least for part of the programme.

Currently, optometry programmes offer clinical training and experience within their undergraduate programmes which goes above and beyond the resources that HEFCE supply. Institutions have been stretched to provide this clinical experience, but have consistently done so, in line with GOC requirements. Resourcing further clinical experience within the undergraduate programme within the current funding model will be a huge challenge, unless it occurs as part of a Integrated Masters in Optometry in collaboration with the College’s Scheme for Registration.

“Collaborative working with a range of eye health service providers” is an exciting aspiration, but one which imposes further cost implications for universities if these collaborations are not restricted to large multiple optical companies. Universities already pay significant monies to NHS Trusts/services in order to provide training opportunities for undergraduate optometrists. Extending such training opportunities to other settings will incur further costs, which the universities are not in a position to meet. The large optical bodies are likely to be more receptive to collaborative opportunities, and hence, the risk is that a more limited range of experience based on multiple practice situations is offered to students, rather than the rich and diverse experience envisaged by the GOC. This would be entirely counter to the aspirations presented in the Consultation document (p22): “If we were to develop a more hybrid approach, it would most likely necessitate education and

training institutions building active, innovative and ongoing relationships with a range of eye health service providers - such as independent and multiple community optometry practices, domiciliary care providers, community ophthalmology-led services, and hospital eye services, as well as where relevant continuing to develop their university eye clinics."

In relation to quality assurance: If universities 'host' the pre-registration year within degree and "award an academic qualification that could lead to registration" with the GOC at the end of the degree, issues around quality assurance must be considered. Higher education institutions are businesses, as well as educational establishments, and performance indicators such as 'number of good degrees', 'retention and progression figures' are increasingly used to internally and externally judge and determine sustainability of programmes. The introduction and application of the Teaching Excellence Framework (TEF) should be considered as an increasingly important driver for education providers in the coming years. The current model of an independent Scheme for Registration is immune from such pressures and hence, a presents a consistent, accountable and rigorous approach to the end-stages of the route to registration. Perhaps a solution would be that the College of Optometrists (possibly in partnership with universities) devises a pre- registration year which incorporates rotation of students across different clinical environments, e.g. in three or four-month placement durations)? There would be several practical challenges to such a suggestion including difficulties for students having to relocate multiple times (particularly difficult for students with families, raising significant equality and diversity issues) and challenges for providers of clinical placements in having to adapt to a new staff member every 3-4 months.

In the context of the TEF and the University providers as business organisations, we would urge the GOC to consider within their Education Strategic Review, how best to maintain or enhance the quality of the students enrolled into optometry programmes. The attraction of good quality undergraduates is an important element in achieving a workforce which meets and exceeds the professional standards for practice. The GOC has previously collected information on student entry 'tariffs' but we are not aware that these data have been effectively used to ensure providers don't extend recruitment to gain additional fee-paying students, without maintaining the high tariffs we would contend are required to ensure high quality graduates. With an ageing population and the increased need for basic and enhanced (primary and secondary) eye care services, there is potential for the role of optometrists to be increased and even more valuable than it currently is. It should be a profession that is attracting bright and motivated students. However, it will only attract high quality students (and future optometrists) if optometry is seen as a profession and career worth training for four years to enter. This will not be the case if the number of students continues to escalate. This does not promote quality amongst applicants; it is already apparent that the increasing intake has driven down entry standards (see UNISTATS/KIS published data) and this will consequently be reflected in the calibre of those entering the profession. If the GOC are truly seeking individuals who are receptive to and able to adapt to change such as technology, patient demographics and clinical treatments, then it is in the patient and public interest that this issue is addressed. One method by which to mitigate optometry programmes stretching their intake without maintaining quality would be to mandate entry tariffs more rigorously and/or restrict intake dependent on the quality/quantity of patient experiences available to undergraduate students at individual institutions.

The concern over a growing number of weak students/graduates is evident and likely to be the cause of some of the concern highlighted by the response to the GOC's Call for Evidence. Institutions are putting pressure on courses to take more students with no increase in the resources required to provide high quality training (including real patient experience) and optical companies looking for willing (cheap?) workers are encouraging institutions to develop new courses. These larger or new courses will need to lower entrance standards to fill places but once enrolled, none will want to fail students. This may not lead to unemployed optometrists, but it is likely to lead to lower standards in the profession as salaries decrease and quality also drops. This is not in the public interest.

Consultation question 11 - What do you foresee as being any positive or negative impacts on students, education providers, employers, patients and carers from taking a hybrid approach?

Positive:
• Students enjoy varied clinical experience as long as it is well supported and they don't feel out of their depth.
• Students could have experience of working with a variety of other professionals.
• Such an approach could ensure students are not confined to working for a multiple from the outset and dilute the opportunity for multiples to gather workforce. Students will understand the role of the optometrist at an earlier stage of their career.
• Employers may be pleased to utilise students on placement in some clinical skills such as pre-screening

Negative:
• To provide a variety of clinical experiences will require more resources and buy in from NHS and other providers of eye care services. In an increasingly pressurised NHS landscape, this would be extremely challenging.
• Students may have more onus on them personally to find and facilitate placements. This will disadvantage some students who are less well connected, less resourceful or who have less ability to travel. They will also question why they are being asked to do this when they are paying significant fees to the University and may think the Universities should be in a position to fully fund and facilitate such placements.
• Having a variety of placements may actually disadvantage student development: currently a longer-term single supervisor can identify and nurture areas for improvement; but a shorter-term placement may mean less ownership of the supervisory role and leave the student with knowledge and experience gaps.
• The hybrid approach will likely make it more difficult to deliver equity of experience for students.
• If a placement is not available this might impact on degree/training completion time for student.
• If only certain optical providers can provide placements the student may develop a narrow minded view of the profession
• Placement supervisors may show less interest in students in the early stages of their education/training as they are of less worth to the practice/business (e.g. Can't complete sight tests under supervision)
• Students may end up shadowing qualified practitioners too much rather than gaining the hands-on experience if placement comes early in the degree
• Patient/carer consent for student placement needs to be considered

Concept 7: National registration examination

Consultation question 12 - Do you agree or disagree with the concept of a national registration examination?

Agree.

Consultation question 13 - What are the merits and risks of this concept?

We would like to continue to work with the College of Optometrists to utilise the SfR in the route to registration. The independent nature of the scheme and the quality of the governance applied by the College is very beneficial. We recognise the value of graduates being able to choose the type of practice in which they undertake the clinical placement during the SfR period; the inclusion of multiple, hospital, independent and mixed placements should be maintained.

In the event that the delivery of this direct clinical experience deviates from the current format of the SfR, we still feel that there is significant value in a common national standard for the registration of an optometrist.

Concept 8: Multi-disciplinary education

Consultation question 14 - How feasible would it be to develop inter-professional and multi-disciplinary elements of study within optometry and dispensing optician education programmes?

Inter-professional and multidisciplinary elements of study are already components of our undergraduate optometry programme. While there may be scope to increase these components, this must be done to truly enhance learning, not just as part of a 'tick-box' exercise. The opportunities for post- graduate inter-professional learning should be explored by the GOC. This may not be so easily resourced or developed but has the potential to be more relevant and impactful than inter-disciplinary learning at undergraduate level. If a blended learning, part-time and/or learn-as- you-go system of education were introduced it would be extremely challenging to incorporate such inter-professional and multidisciplinary elements. However, increased opportunities to build on trust and communication between professional groups would be a valuable outcome of the Education Strategic Review.

Consultation question 15 - Tell us about any examples you know of already in other disciplines from within or outside the UK?

Ulster University currently runs joint teaching sessions with Pharmacy undergraduates, and, as part of the Faculty of Life and Health Sciences, could extend these experiences to other healthcare professions (nursing, physiotherapy, speech and language therapy, occupational therapy and in the near future, medicine). Whilst increased inter-disciplinary learning is achievable at Ulster, the proviso is that such experiences must be meaningful and relevant, rather than a 'tick-box' exercise.

Concept 9: Duration of education and training programmes

Consultation question 16 - What do you see as the strengths and weaknesses of retaining the current minimum duration as described above?

We see benefit in maintaining the minimum four-year period. Shortening the current minimum duration would risk the depth and scope of the education and training provided and the maturity and readiness of those entering the register.

Consultation question 17 - What could be done differently in order to ensure students become competent, confident and safe beginners?

It is our experience that the ability of graduates is strongly related to the quality of the students taken into the undergraduate programmes. The College of Optometrists have clearly identified a relationship between the strong and weak performance in the SfR and the class of degree obtained. This can be extrapolated back to the tariff on entry to undergraduate study; with those entering with higher tariffs having better degree outcomes. It follows that the quality of graduates and registrants (i.e. how competent, safe and confident they are as entrants to the register) would be improved by safeguarding the quality of entrants to undergraduate optometry programmes. This can be monitored and maintained through evaluation of the tariff points of those entering the programme.

The GOC have a role in exploring how universities are able to take increasing numbers of undergraduate optometry students without appreciable increases in resources and the effect this has on the quality of the intake in terms of tariff scores and the subsequent quality of the graduates. There is only so much 'added value' which even the best of optometry programmes can add. Maintenance of high entrance tariffs and academically able undergraduates is only possible if optometry is seen by high-achieving students as a profession worth studying towards for four years. To align with such expectations, the professional landscape into which these graduates emerge must reflect such aspirations; including appropriate remuneration, working environments where optometrists can freely exercise clinical and professional judgement and opportunity for post-registration career progression and development.

The GOC could also ask current/recent pre-registration supervisors and employers which graduates they want to employ and why. Where are these graduates being educated and how do these education providers differ from the providers that employers/supervisors prefer not to employ. This is a controversial and potentially painful approach, but could be informative.

The idea of embedding clinical experience within undergraduate programmes has great merit and most institutions have an in-house public eye/optometry clinic which allows students access to supervised patient experiences both for eye examinations and ophthalmic dispensing before they graduate. The quality, diversity and validity of these experiences and the supervisory arrangements are, in our experience, key to developing "competent, confident and safe" beginners. The utilisation of 'patient simulation' or 'surrogate' patients should be considered as an adjunct to 'real' patient experience. Surrogate patients do not provide for the development of effective communication skills and students soon learn not to take these interactions as seriously as the experiences they have with patients actually seeking and requiring an eye examination. Neither can

‘surrogate’ patient experiences equip graduates to learn to deal with whatever ‘walks through the door’. Public access clinics, properly run and delivered in a teaching context, encourage a flexible, responsive and professional approach and are key to producing graduates that are fit for purpose.

Close supervision (we would recommend 1 supervisor: 2 students/patients for primary eye care clinics), delivered by experienced optometrists (and other eye care professionals) within the framework of a teaching clinic, provides opportunity for the safe development of clinical skills. This close interaction between supervisors and students in a real clinical setting is also a powerful method through which the ‘softer’ skills relating to professionalism, communication and the interface between commerce and clinic can be learnt and reflected on.

Many graduates are “competent, confident and safe beginners”, but they need to recognise their limitations and be comfortable in asking for help and advice. Universities may have a greater responsibility than they currently deliver in maintaining a relationship with graduates throughout the early years of their training. Such a relationship may be valuable in allowing a means of asking for help or for signposting to organisations which are a strong, but perhaps underused, resource for newly qualified optometrists, i.e. College of Optometrists and the Association of Optometrists.

Concept 10: UK educational routes to registration

Consultation question 18 - What do you see as the opportunities for more flexibility between the education of different regulated and non-regulated optical professions?

While universities may acknowledge any recommendations that the GOC issue on accreditation of prior learning through practical experience in non-registered roles, individual institutions establish and apply their own criteria for accreditation of prior learning. It is unlikely that practical experience in delivering services as an optical assistant, for example, would qualify a potential undergraduate optometry student for exemptions.

The route from dispensing optician to optometrist is currently well-defined and available, as is the route from optometrist to Independent Prescriber optometrist. We do not see an advantage in modifying these well-trodden and apparently successful routes. Individuals in non-regulated roles are also able to apply to undertake training to qualify as a dispensing optician, optometrist or contact lens optician. It is clearly important for the profession that entrance criteria to these education programmes are maintained for all applicants for the reasons discussed above (e.g. in 17). There are no barriers to individuals moving from optical assistant, to dispensing optician to optometrist etc. if they have the proven ability to meet the entrance criteria of the relevant education programmes and there are Foundation degrees offered by many institutions which may be an appropriate route for such progression.

Consultation question 19 - What are the constraints and risks to this?

As noted above, the GOC wants to “ensure students become competent, confident and safe beginners”. In a dynamic eye care landscape, the best way to ensure this is to maintain the quality of those entering the regulated eye care professions and the quality

and rigour of the education they undertake such that professionals are equipped to deliver excellent eye care; meeting the needs of patients in a variety of settings and responding to changes in technology, working environments, funding structures and patient need. In the interests of public safety, this may restrict flexibility of movement from non-regulated roles to regulated roles.

Where is the pressure for such flexible paths from non-regulated into regulated roles articulated, and by whom?

Concept 11: Proportionate quality assurance

Consultation question 20 - Are there any other principles and concepts we should consider at this stage in exploring future approaches to our quality assurance processes?

We would like to urge the GOC to ensure future quality assurance processes are consistent across institutions and that information submitted by institutions for QA purposes are either utilised, or that they are no longer requested. The presentation of onerous amounts of detailed information on course provision, student outcomes, student experiences etc. is acceptable if these data are used in a meaningful and proportionate way by the GOC. We would also request a consistent approach to the application, and implementation, of conditions and recommendations to course providers.

Communication between education providers and the GOC has been slow and unsatisfactory over recent years. We have seen some improvement in recent months, but would like to encourage the GOC, during this Education Strategic Review, to ensure the framework and resources are in place for meaningful and responsive dialogue to be the norm.

Consultation question 21 - Please tell us about any direct or indirect impact you can foresee from the concepts and principles we have set out in this public consultation on anyone with protected characteristics?

A possible impact on those with protected characteristics may be the change to a hybrid course that requires clinical placement. Equality and diversity measures would need to be as stringent in the placement as in University policies.

University of Manchester

The University of Manchester responds to the consultation as shown below:

Concept 1: Standards for Education Providers

Consultation question 1 - Do you agree or disagree with us further exploring the concept of new Education Standards in the way we describe above?

Agree.

Consultation question 2 - Please tell us more about your views on this concept, including any opportunities or risks you foresee.

All providers of qualifications leading to registration as an optometrist are currently subject to the same standards - laid out in the Optometry Handbook (2015). With modification we think it would be possible to describe a set of standards which would apply to both optometry and dispensing optics. Distinct high level learning outcomes would then be specified for each profession. The current optometry standards are:

- Public protection
- Student experience
- Student assessment
- Monitoring and evaluation
- Facilities and resources
- Professional requirements

Any new set of 'High level standards' should not contain in detail:

- Public protection: As this is covered in standards of practice for optometrists/dispensing opticians/optical students.
- Student experience: As this is covered by other directives and metrics (e.g. internal institutional frameworks and the National Student Survey)

Any new set of standards should modify:

- Facilities and resources: Specifying this in detail is not consistent with an output based approach. However, a level of evidence based specification would be required to safeguard standards.
- Professional requirements: The current patient minima required before graduation are arbitrary and not evidence based. Providers of the undergraduate element of the pathway to registration should be free to use any mix of learning experiences they can evidence are appropriate to reach the specified learning outcomes.

Any new set of standards might consider:

- Inter-Professional Education (IPE): Optometrists and Dispensing Opticians are increasingly working in teams with other healthcare professionals and it would not be unreasonable to expect IPE to be a feature of routes to registration. Consideration would need to be given as to how feasible this might be for institutions that do not provide training in other disciplines.

- Employers: The link between training institutions and employers should be strong. It is important that training institutions are mindful of the requirements of

those receiving their graduates. Employers should be in a position to inform but not dictate the content of programmes and outcomes from them.

- Course content: Specifying this in minutiae is not consistent with an outcomes based approach (however see response to concept 5)

Higher level standards give providers greater room for innovation and allow them to be more agile in the face of change. A danger will be that higher level standards may be harder for the GOC to appraise. Visitor panels will need to be highly skilled and experienced if they are to fairly and consistently judge providers against them.

Concept 2: Education Standards and Professionalism

Consultation question 3 – Do you agree or disagree with the concept of informing our education requirements by our professional standards?

Don't know.

Consultation question 4 - Please tell us more about your views on this concept, including any opportunities or risks you foresee.

Education standards, as described in concept 1, are 'for all education and training providers'. But the standards for optometrist and dispensing opticians apply to individual registrants. We assume that what is meant here is that one or more of the education standards will cite or include the standards for optometrists/dispensing opticians/students. It seems unnecessary to do this in any detail as both students and staff will be subject to the individual standards anyway.

Concept 3: Learning Outcomes

Consultation question 5 - What are your views on the concept of system-wide learning outcomes for optometry and dispensing optician education and training, instead of an educational competency-based approach?

The current competency model is outcomes based – it describes the skills an optometrist is expected to have at the end of undergraduate training (Stage 1 Competencies) and upon registration (Stage 2 competencies). From our perspective the problems with the current model are:

i) Detailed inputs are described as well as outputs (e.g. students must see 18 primary care episodes on 1:1 basis, they must have 12 contact lens episodes on 1:2 basis etc.)
ii) The outputs described at undergraduate level (Stage 1 competencies) are detailed (not 'high level outcomes') and arguably too advanced for undergraduates (e.g. 'ability to make an appropriate management plan, including the ability to make appropriate referrals, for each patient and to involve the patient in the decision making process). A paper submitted to the GOC in the last call for evidence (Holmes and Myint, 2017) sets out evidence based recommendations for changing the current stage 1 competencies and setting them at an appropriate level on Miller's pyramid. The same Delphi method approach used by Holmes and Myint (2017) could

be used to generate evidence based outcomes for the point of registration for optometrists/dispensing opticians and post registration specialities.

We believe that any high level outcomes must not only focus on practical clinical skills but must also contain requirements for academic and intellectual skills. Some examples are given below.

a) The ability to weigh evidence: including a sound grasp of statistics, experimental design and an ability to critically appraise papers in academic journals. Without these skills we do not believe that graduates can 'provide or recommend examinations, treatments, drugs or optical devices that are clinically justified and in the best interests of the patient' (Standards of Practice for Optometrists and Dispensing Opticians). We should follow the lead of the General Medical Council who specify that doctors are 'scholar, scientist, practitioner and professional' 1.

The British Medical Association states:

'Every person that becomes a patient expects the doctor looking after their care to be not only an expert in diagnosis and treatment and in empathic communication with them, but also to have an up to date working knowledge of the causes and treatments of disease. They expect the doctor to be able to be able to weigh scientific evidence that is relevant to their condition, and to recommend the best treatment for them. In order to do this it is in the patient's best interest to be able to understand the evidence presented from research in their sphere of practice' 2

We would argue that the word 'doctor' could be substituted for 'optometrist or dispensing optician'.

ii) Pure sciences: There should be outcomes related to understanding of pure science (e.g. optics, anatomy, neuroscience). We would argue that it is only possible to study applied science once students have a firm understanding of the science that they are applying. Understanding from first principles enables optometrists and dispensing opticians to properly appraise evidence for treatments. For example it would be difficult to appraise a product claiming to affect enzymes in the tear film if a practitioner had no understanding of what an enzyme is. As technology progresses there is an increasing need to understand from first principles. For example, the widespread use of OCT, now makes detailed knowledge of the retinal layers essential to clinical practice. Maintaining and requiring outcomes related to the pure sciences/first principles will ensure graduates are prepared for future practice and technological changes.

It is important that the GOC bear in mind the level of funding received by universities (HEFCE Band B) when considering the number and level of learning outcomes.

1.GMC (2015) Outcomes for Graduates:
https://www.gmcuk.org/education/undergraduate/undergrad_outcomes.asp 2.BMA (2015)
Every Doctor a Scientist:
https://www.bma.org.uk/advice/career/applying-for-a-job/every-doctor-a-scientist-and-a-scholar

Concept 4: Links to Continuing Education and Training

Consultation question 6 - What do you see as the merits to removing the current link between CET and our education requirements, if any?

Consultation question 7 - Do you envisage any disadvantages or risks in this approach, and if so what are they?

We would welcome the removal of the link between the current GOC stage 2 core competencies and CET. We think it is sensible that CET is linked to the Standards of Practice. Once registered, practitioners should be required to maintain competence in the areas within which they practise. As professionals and as per the standards of practice ('not practising beyond your competence') they should be trusted to seek further training and experience if they move back into an area which they have not had recent experience in.

Concept 5: Educational Content

Consultation question 8 - What do you see as the key changes needed to the current content of optometry programmes and dispensing optician programmes to ensure our future requirements are fit for purpose?

Detailed specification of curriculum content is not consistent with an outcomes based approach. It may also hinder innovation and lead to a loss of agility in the face of change. Content, however, will be informed by the high level learning outcomes prescribed by the GOC. We have made the argument in concept 4 that the ability to weigh evidence and an understanding of first principles is essential for safe practise now and in the future. These should not be jettisoned in order to 'make room' on programmes. Changes in content should be primarily led by providers in partnership with employers and other stakeholders (patients, CCGs etc.). Many of the changes will be driven by local environments. For example in Greater Manchester we are working with the Greater Manchester Health and Social Care Partnership to ensure our graduates are ready to practise in the devolved area.

Concept 6: Enhanced clinical experience for students

Consultation question 9 - Do you agree or disagree with the concept of embedding clinical elements of education and training progressively from the outset of programmes?

Disagree.

Consultation question 10 - Tell us more about your views on this concept.

Consultation question 11 - What do you foresee as being any positive or negative impacts on students, education providers, employers, patients and carers from taking a hybrid approach?

We note that the current Optometry Handbook (2015) does not prevent a provider from embedding clinical experience from the start. Some providers already do this with 'real patients' from year 1 and others use volunteers and introduce 'real patients' at a later date.

We disagree with this concept in that we do not think that it should be a requirement for all routes to registration. It should be incumbent on providers to demonstrate that students are achieving the learning outcomes, but the mix of methods used should not be dictated. At undergraduate level there should be some exposure to 'real patients' but the very real benefits of simulation should not be overlooked 3. It is harder to realise the benefits of simulation and other learning activities with the heavy administrative burden of tracking and monitoring the current patient minima and competency requirements at undergraduate level.

We think that any route to registration must contain substantial and varied experience in real clinical practice. Currently, for most students, this takes place in the postgraduate 'pre-reg' year administered by the College of Optometrists. In order to progress to the pre reg year undergraduate students must demonstrate that they have achieved the stage 1 competencies. As explained in concept 3 we believe that these should be modified. But a standard should remain in place that students must reach before seeing 'real patients' if the clinical experience currently gained in the pre reg is fragmented across a longer undergraduate programme.

We think that it is important that the substantial clinical placements mandated on the route to registration (whether a 'pre reg' year or another model) are viewed as periods of education in their own right and not only clinical experience to consolidate existing knowledge. At present little formal training in teaching and learning is required of clinical teachers (e.g. no requirement to undertake CET in this area) and there is no facility for expertise to be acknowledged on the register. Requiring increased training in teaching and learning for clinical teachers will have benefits for both students and the public.

3.Bokken, L., Rethans, JJ., Scherpbier, A.J.J.A and van der Vleuten, C.P.M., (2008) Strengths and Weaknesses of Simulated and Real Patients in the Teaching of Skills to Medical Students: A Review, Simulation in Healthcare, 3(3), 161-169.

Concept 7: National registration examination

Consultation question 12 - Do you agree or disagree with the concept of a national registration examination?

Disagree.

Consultation question 13 - What are the merits and risks of this concept?

It is not true to say that there is currently 'a principle of a national standardised examination…. to enter the GOC register'. The University of Manchester has a directly registrable MSci Optometry degree – these students do not do the College of Optometrists' pre-registration scheme.

The current Optometry Handbook (2015) allows for any provider to construct a pathway to full registration and submit this to the GOC for approval. We believe that providers who can demonstrate that they meet the prescribed GOC requirements should continue to be able to do this.

Concept 8: Multi-disciplinary education

Consultation question 14 - How feasible would it be to develop inter-professional and multi-disciplinary elements of study within optometry and dispensing optician education programmes?

Consultation question 15 - Tell us about any examples you know of already in other disciplines from within or outside the UK?

Optometrists increasingly work as part of multidisciplinary teams. We are continuing to build multidisciplinary education into our curriculum. At the University of Manchester there are established programmes in almost all healthcare disciplines and support for multidisciplinary learning. The GOC should be mindful that these opportunities might be less available at some institutions.

Concept 9: Duration of education and training programmes

Consultation question 16 - What do you see as the strengths and weaknesses of retaining the current minimum duration as described above?

Consultation question 17 - What could be done differently in order to ensure students become competent, confident and safe beginners?

It is not true to say that there is a 'current minimum duration' for education and training. The standard 4 years which currently exists is a product of the fact that a Bachelor's degree happens to take 3 years and the College scheme 1 year. The length of degrees has recently been discussed by government and could be shortened.

We consider that qualifications leading to full registration as an optometrist must be at level 7 of the QAA framework. Level 7 specifies outcomes which are consistent with an independent, critically thinking professional (e.g. with the skills to weigh evidence). The level of the qualification is more important than the length of the course. However, we tend towards the view that although the appropriate learning outcomes are feasible in the current 4 year model the curriculum is a full one. We would be supportive of longer courses (perhaps 4-5 years as with Pharmacy and Dentistry). But we are mindful that there are consequences for student finance and debt in increasing course length.

Concept 10: UK educational routes to registration

Consultation question 18 - What do you see as the opportunities for more flexibility between the education of different regulated and non-regulated optical professions?

Consultation question 19 - What are the constraints and risks to this?

As set out in our responses to the other concepts we are of the view that to maintain patient safety and trust qualifications that allow access to the register must be QAA level 7 – that is they must equip students with scientific and intellectual skills in addition to clinical skills. Any pathway to full registration as an optometrist must contain substantial academic elements (see response to concept 3). We do not think that routes to registration as an

optometrist that are wholly or mainly vocational will deliver the appropriate outcomes.

Concept 11: Proportionate quality assurance

Consultation question 20 - Are there any other principles and concepts we should consider at this stage in exploring future approaches to our quality assurance processes?

We would suggest two principles:

i) The GOC should seek not to duplicate other processes (e.g. institutional) where they exist and are also satisfactory for regulatory purposes
ii)) Visitor panels should contain individuals with substantial knowledge of pedagogy in addition to clinical practice

Consultation question 21 - Please tell us about any direct or indirect impact you can foresee from the concepts and principles we have set out in this public consultation on anyone with protected characteristics?

University of the West of England (UWE)

UWE responds to the consultation as shown below:

Concept 1: Standards for Education Providers

Consultation question 1 - Do you agree or disagree with us further exploring the concept of new Education Standards in the way we describe above?

Don't know.

Consultation question 2 - Please tell us more about your views on this concept, including any opportunities or risks you foresee.

We would welcome new Education Standards that would incorporate flexible learning outcomes rather than a rigid competency based framework. However, we are unclear as to what a 'high-level' standard might mean, and would welcome greater granularity with the concept. Encouraging innovation and flexibility within a degree programme would be desired, and as a new provider, this is something we have sought to include already. Collaboration with other health professions and stakeholders is logical, as Optometry becomes more included into a wider health partnership. However, it is important to keep a separation between educational provision and stakeholders as there is the risk for a large conflict of interest. We would require more information regarding how regularly the outcomes would be assessed and re-assessed so that institutions do not become overburdened with bureaucracy.

Concept 2: Education Standards and Professionalism

Consultation question 3 – Do you agree or disagree with the concept of informing our education requirements by our professional standards?

Agree.

Consultation question 4 - Please tell us more about your views on this concept, including any opportunities or risks you foresee.

We agree that any new Education Standard should link to the current Standards of Practice and the practice standard inform the education that students receive.
However, if the Standards of Practice were to also change, this would need to be looked at as a separate entity.

Concept 3: Learning Outcomes

Consultation question 5 - What are your views on the concept of system-wide learning outcomes for optometry and dispensing optician education and training, instead of an educational competency-based approach?

We wholeheartedly welcome a move to a less prescriptive and more flexible approach to initial education. Utilising a small number of higher-order descriptive learning outcomes will allow institutions to deliver education in a manner that best fits their setting and abilities. An outcomes-based approach to healthcare education allows institutions to tailor training to the

variety of methods that students may learn.

Concept 4: Links to Continuing Education and Training

Consultation question 6 - What do you see as the merits to removing the current link between CET and our education requirements, if any?

The merit to removing the link between CET and educational requirements is that rather than maintain a minimum educational standard, registrants are encouraged to professionally develop. There currently is little motivation for registrants to attain more than the minimum required – many view the CET framework as a necessity to maintain statutory registration rather than a way to improve their own practice. We would welcome CET becoming more aligned with professional development.

Consultation question 7 - Do you envisage any disadvantages or risks in this approach, and if so what are they?

The disadvantage to this approach is that some registrants may disengage as they are unmotivated to change or improve their current forms of practice.

Concept 5: Educational Content

Consultation question 8 - What do you see as the key changes needed to the current content of optometry programmes and dispensing optician programmes to ensure our future requirements are fit for purpose?

As a future new provider of optometry education, we have worked hard to incorporate changes to the current content of programmes delivered elsewhere. These changes include more clinical exposure in a variety of settings, more clinical training and the inclusion of preparation for students to take on extended roles. We have also worked hard to create a programme that is multi-disciplinary where optometry students are integrating with other students in other healthcare courses. There is a large emphasis on communication training, where our students will follow the models of communication education delivered in programmes such as Paramedic Science, Occupational Therapy and Physician Associates. We feel it is vital that optometry education is flexible enough to change for all future requirements of the role.

Concept 6: Enhanced clinical experience for students

Consultation question 9 - Do you agree or disagree with the concept of embedding clinical elements of education and training progressively from the outset of programmes?

Don’t Know.

Consultation question 10 - Tell us more about your views on this concept.

We feel that the notion of moving away from a pre-registration year and moving towards a registrable degree could be a risky proposition and we do not feel able to agree or disagree with the notion without knowing all the details about alternatives.

With the programme that we have created, we are currently working hard to build

relationships with a range of eye health service providers for our students to be able to attend placement exposure periods – small periods of time where students will not be performing much in the way of clinical tasks. This in itself is a massive undertaking and is not easy. Having to provide and administer practice-based training for the entirety of the student journey would be a logistical impossibility. The danger with a HE institution administering a work-based assessment programme that would lead to registration is that students become a customer translating their fees into their automatic ability to register - rather than being subject to the checks and balances required to ensure patient safety. However, registrable degrees are currently being delivered by many other healthcare programmes successfully; the difference being that Optometry as a profession is more autonomous and independent than many other healthcare professions and hence they are regulated in a different manner.

Consultation question 11 - What do you foresee as being any positive or negative impacts on students, education providers, employers, patients and carers from taking a hybrid approach?

The negative impacts of a hybrid approach include the following:

Students – Having to pay a university fee for another year. Not having autonomy over where their work-based training is, and having a different experience to their peers (leading to dissatisfaction and decreased NSS). Being considered as an undergraduate for an extra year and with a larger number of patients.

Education Providers – The requirement for a much larger team of staff to implement the practice-based training. Increased audits, increased travelling. The risks of not having enough practice providers, and having to train providers to be unvarying in the experience they provide for students. HE institutions will have to employ legal teams to have processes in place to deal with potential patient complaints and litigation.

Employers – Having to provide a different form of work-based education as a type of placement rather than an employment contract will be complicated and bureaucratic and might dissuade them from taking part. They will also have to align themselves to a particular HE institution rather than being able to take pre- registration students from any HE institution, thus significantly decreasing the pool of future employees. Students will not likely have the same work ethic as a pre- registration student who is earning a salary.

Patient and Carers – Patient safety is most at risk when a HE institution in partnership with practice providers, rather than a separate professional body, is administering work-based assessments. Patients will have to spend longer in an eye-care setting, and potentially will have to undergo more tests or treatments.

The positive impacts of a hybrid approach include the following:

Students – Not having to hunt for their own pre-registration place in amongst stiff competition.

Education Provider – An extra year of fees and being able to have control over the entire education process.

Employers – Potentially not having to pay a salary for a pre-registration student. Patient and Carers – None that we can foresee.

Concept 7: National registration examination

Consultation question 12 - Do you agree or disagree with the concept of a national registration examination?

Don't Know.

Consultation question 13 - What are the merits and risks of this concept?

The current scheme for registration by the College of Optometrists is already independent of HE institutions so forms a National Standardised Examination. We do not know how creating a national registration examination would either be different to this, or if it is of any worth.

Concept 8: Multi-disciplinary education

Consultation question 14 - How feasible would it be to develop inter-professional and multi-disciplinary elements of study within optometry and dispensing optician education programmes?

Inter-professional and multi-disciplinary elements of study are very feasible for our institution as it is currently practised in most healthcare and other programmes. However, we recognise that other HE institutions are different and might struggle with this. Our vision is to integrate optometry students in with other healthcare and science students so that they are able to be taught generalised subjects (eg anatomy and physiology) together and to be included in all wider participation of health care simulations (eg trauma days). We also encourage teaching from experts in other disciplines to give optometry students a different perspective.

Consultation question 15 - Tell us about any examples you know of already in other disciplines from within or outside the UK?

UWE already fosters a multi-disciplinary approach to all its healthcare courses.

Concept 9: Duration of education and training programmes

Consultation question 16 - What do you see as the strengths and weaknesses of retaining the current minimum duration as described above?

The strength of maintaining a minimum duration of 4 years is to ensure all the vital foundations of optical education are in place and built upon and students have enough time to become clinically competent. It is impossible to ensure that students have the best knowledge and clinical ability in a time frame that is less than this.
There is an importance to having a four year course for students who have just left school – this time is vitally important for them to properly mature into adults capable of clinical decision-making.

The weakness of having a minimum of 4 years is that employers do have to wait for future employees, however, as mentioned above, this wait is justified.

Consultation question 17 - What could be done differently in order to ensure students become competent, confident and safe beginners?

Students could follow a Medicine/ Dentistry model of much longer academic years to shorten the overall experience– however, as mentioned above, the time off for the full 4 year duration is really vital for maturity of students who have just left school.

Concept 10: UK educational routes to registration

Consultation question 18 - What do you see as the opportunities for more flexibility between the education of different regulated and non-regulated optical professions?

The opportunities for more flexibility between different regulated and non-regulated optical professions means that individuals could move between professions more easily and with less time spent in education, which could be beneficial for patients and service delivery.

Consultation question 19 - What are the constraints and risks to this?

The constraints to the above however, is that the education of these roles might not be as rounded as those who have completed full courses in each. The risk, as ever, is always to patient safety.

Concept 11: Proportionate quality assurance

Consultation question 20 - Are there any other principles and concepts we should consider at this stage in exploring future approaches to our quality assurance processes?

In addition to the concepts and principles already mentioned in the document, we would encourage the exploration of a faster and more efficient quality assurance process. This would entail having faster response times to all enquiries, a faster and more efficient method to disseminate information to committees and councils and a more efficient way to present findings. As a new provider, we would also encourage more clarity from the outset about timescales, document requirements and a shared understanding of the process, together with a more transparent and direct method for responding to enquiries. We would also welcome a review into the usefulness of the current handbook, with more direct and tailored regulations.

Consultation question 21 - Please tell us about any direct or indirect impact you can foresee from the concepts and principles we have set out in this public consultation on anyone with protected characteristics?

We cannot predict if there will be any direct or indirect impact on anyone with protected characteristics from this public consultation. The needs of those with protected characteristics must be taken into account both from a patient point of view, and from a student point of view. Having a four year degree may well impact on those planning for life changing events such as marriage and pregnancy, and for older students.

Welsh Government

The Welsh Government responds to the consultation as shown below:

Concept 1: Standards for Education Providers

Consultation question 1 - Do you agree or disagree with us further exploring the concept of new Education Standards in the way we describe above?

Agree.

Consultation question 2 - Please tell us more about your views on this concept, including any opportunities or risks you foresee.

The evolving model of delivery of eye care with a shift of services from secondary to primary care means that the way we teach our undergraduates needs to be aligned. There are significant opportunities to develop models of learning interactively and in collaboration with other programmes of health education/

It is imperative that the models of eye care in all of the nations of the UK are considered when developing education services. One of the risks is that courses and developments do not take into consideration the changes that have already taken place across the four nations and are not bold enough in their goals to ensure that all practitioners are working towards the top of their licence in line with the principles of prudent healthcare.

Concept 2: Education Standards and Professionalism

Consultation question 3 – Do you agree or disagree with the concept of informing our education requirements by our professional standards?

Agree.

Consultation question 4 - Please tell us more about your views on this concept, including any opportunities or risks you foresee.

It is important that the professional standards are embedded in education and training at the earliest opportunity.

Concept 3: Learning Outcomes

Consultation question 5 - What are your views on the concept of system-wide learning outcomes for optometry and dispensing optician education and training, instead of an educational competency-based approach?

Welsh government would support a move towards an outcomes based system.

Concept 4: Links to Continuing Education and Training

Consultation question 6 - What do you see as the merits to removing the current link between CET and our education requirements, if any?

Welsh government supports the concept of encouraging continued professional

development. In lines with the principles of prudent healthcare we would like to see all practitioners working at the top of their licence and doing only what they can do. Continued professional development would allow this concept to develop and evolve.

Consultation question 7 - Do you envisage any disadvantages or risks in this approach, and if so what are they?

There would appear to be greater risks in continuing with a CET system that could be restrictive and unintentionally discourage training and development beyond the level of initial education and training- this would not fit with the policies of Welsh Government.

Concept 5: Educational Content

Consultation question 8 - What do you see as the key changes needed to the current content of optometry programmes and dispensing optician programmes to ensure our future requirements are fit for purpose?

In Wales we have the Eye Health Examination Wales Service and Low Vision Service Wales. Optometrists are trained and accredited through the Wales Postgraduate Education Centre to undertake these enhanced services/examinations. We believe that this training now forms the baseline of standards in Wales and the content of the postgraduate training needs to be incorporated into undergraduate training.

Together with this there needs to be an increased emphasis and exposure to clinical scenarios which may require a longer period of time at undergraduate/preregistration level.

Concept 6: Enhanced clinical experience for students

Consultation question 9 - Do you agree or disagree with the concept of embedding clinical elements of education and training progressively from the outset of programmes?

Agree.

Consultation question 10 - Tell us more about your views on this concept.

As per previous responses continued clinical exposure ensures that undergraduates are coming into the workforce with the skills that are required to manage patients effectively and safely.

Consultation question 11 - What do you foresee as being any positive or negative impacts on students, education providers, employers, patients and carers from taking a hybrid approach?

See previous commnets.

Concept 7: National registration examination

Consultation question 12 - Do you agree or disagree with the concept of a national registration examination?

Agree.

Consultation question 13 - What are the merits and risks of this concept? Welsh

Government would expect consistency across all contractor professionals.

Concept 8: Multi-disciplinary education

Consultation question 14 - How feasible would it be to develop inter-professional and multi-disciplinary elements of study within optometry and dispensing optician education programmes?

We would consider this as an essential part of the education of undergraduates. Postgraduate multidisciplinary events are essential to the delivery of eye care pathways and as such should be embedded at an early stage in the curriculum.

Consultation question 15 - Tell us about any examples you know of already in other disciplines from within or outside the UK?

In Wales primary care clusters have developed. A Cluster is a grouping of GPs working with other health and care professionals to plan and provide services locally. Clusters are determined by individual NHS Wales Local Health Boards (LHB's).

There are 64 cluster networks across Wales, serving populations between 30 and 50 thousand patients.

All contractor professions play an important role within clusters and provide strong links with secondary care.

A fully integrated primary care model is essential for the development of furture pathways.

Concept 9: Duration of education and training programmes

Consultation question 16 - What do you see as the strengths and weaknesses of retaining the current minimum duration as described above?

No further observations from the above dialogue.

Consultation question 17 - What could be done differently in order to ensure students become competent, confident and safe beginners?

A review of the relevance of current course material as we move towards a more clinically based system. Are some of the academic modules fit for purpose in a modern eye care service?

Concept 10: UK educational routes to registration

Consultation question 18 - What do you see as the opportunities for more flexibility between the education of different regulated and non-regulated optical professions?

Poor eye health is a common and growing issue. Currently nearly 100,000 people in Wales are living with sight loss. By 2020, this is predicted to increase by 22 per cent and double by 2050 . Over 50% of sight loss can be prevented through early identification and intervention . The demand for eye care services means that the workforce must keep pace with the demand for services. A flexible well trained workforce is needed to future proof eye care services and as such flexibility between education of different regulated and non regulated optical professions is to be encouraged.

Consultation question 19 - What are the constraints and risks to this?

Quality assurance must be guaranteed .

Concept 11: Proportionate quality assurance

Consultation question 20 - Are there any other principles and concepts we should consider at this stage in exploring future approaches to our quality assurance processes?

Consultation question 21 - Please tell us about any direct or indirect impact you can foresee from the concepts and principles we have set out in this public consultation on anyone with protected characteristics?

Worshipful Company of Spectacle Makers

WCSM responds to the consultation as shown below:

Concept 1: Standards for Education Providers

Consultation question 1 - Do you agree or disagree with us further exploring the concept of new Education Standards in the way we describe above?

Agree.

Consultation question 2 - Please tell us more about your views on this concept, including any opportunities or risks you foresee.

Increased use of technology (including OCT and auto-diagnostic equipment) and changes in the educational landscape (student funding and Government approved apprenticeships) are already making significant changes in how optical professionals learn and do their jobs. Given its duty of care for patient safety, the GOC is right to review its approach to standards of education.

There are certainly opportunities to allow innovation among education providers and enable those entering regulated professions to have a wider knowledge base, to benefit from greater exposure to clinical decision making whilst still in a protected environment and, for talented individuals who may have found difficulty in funding a three year full time course, to choose a route to registration which better suits their needs.

1) A “free for all” approach with maximum flexibility and no common framework could risk a clear understanding outside the optical world of what is required of registrants, and, at worst, potentially increase risk for patients. Education providers should have freedom to decide who they accept for training and how they teach as long as there is created no doubt among patients or health authorities about the capability of registrants to deliver excellent standards of patient care in practice. This argues for maintenance of some form of agreed common standard, such as exists in the Scheme of Registration and Dispensing Opticians’ pre-qualifying period portfolios and final qualifying examination, though mechanisms for assessing that standard will develop over time.

2) A rush to qualify individuals too quickly. The important issue is not setting a fixed duration for any course of education but ensuring that a professional will have sufficient time and exposure to clinical work to develop their knowledge and skills to the point where they can practise safely. Some individuals will be quick to learn; others will take more time. The demands of an ageing population and shortages of registrants in some areas of the country could encourage providers and employers to push for a faster result but the GOC’s watchword must be ensuring patient safety.

3) Timing – there is no indication of the timecale for adopting new ways of working proposed by the consultation and there is a risk that the GOC could be left behind by the changes already happening within universities and training institutions. The consultation document encourages progression, for example, but the GOC’s policy on Accreditation of Prior Learning is still not in place.

In fact, there is a strong argument for professional developments to be driven by the professions and universities themselves, with the regulator overseeing common standards, noting that the transition period from one system to another is the point at which most attention will be needed.

4) Further change is inevitable so a single review will not be the end of the story. Education Standards and their regulation will need to be flexible enough to adapt to changes in the professions. This means that those responsible for maintaining the standards must themselves be ahead of the game and actively involved.

Concept 2: Education Standards and Professionalism

Consultation question 3 – Do you agree or disagree with the concept of informing our education requirements by our professional standards?

Agree.

Consultation question 4 - Please tell us more about your views on this concept, including any opportunities or risks you foresee.

Those in education need to have a clear understanding right from the beginning of the standards which will be expected of them in practice. Professional standards themselves may, of course, need further development – for example, thinking about accountability for the work of an inter-disciplinary team or appropriate delegation of responsibilities to support staff. Maintaining quality systems in practice to reduce the risk of errors is expected to be an increasing need within eye health as the scope of work expands.

The GOC professional standards are generic and do not, and should not, address clinical practice standards. Additional emphasis should be given to the role of the profession in promoting high standards of clinical practice.

Concept 3: Learning Outcomes

Consultation question 5 - What are your views on the concept of system-wide learning outcomes for optometry and dispensing optician education and training, instead of an educational competency-based approach?

Students need to know why, as well as how – it is not a case of one or the other. Patient care demands that those who qualify will have shown both that they have sufficient understanding of conditions presented to them in practice and that they know how to deal with them.

We would argue that there must be sufficient consistency across different education providers to maintain confidence in the sector – it would not be acceptable for an individual achieving a higher level Apprenticeship as a Dispensing Optician to have worked to different standards, and not have the same level of professional competence, as someone achieving the FBDO diploma through a more traditional blended learning course, for example.

Competencies could be linked clearly to defined and measurable outcomes. The work done by the College of Optometrists and the Royal College of Ophthalmologists on competencies provided a model for how inter-disciplinary discussions could help the sector and we would support some recognised standards at each professional level, starting with optical assistants who are increasingly taking on more clinical roles.

Concept 4: Links to Continuing Education and Training

Consultation question 6 - What do you see as the merits to removing the current link between CET and our education requirements, if any?

Consultation question 7 - Do you envisage any disadvantages or risks in this approach, and if so what are they?

There is an inevitable cost within the sector but many see the need to move to system of continuing professional development (CPD), as is seen in other professions, rather than the tick-box approach to CET which is evident today. Attendance at 100% Optical or Optrafair shows many examples of registrants sitting in one place for a whole day just to achieve a set number of hours' CET, without linking that knowledge to their own practice needs or their own clinical competencies.

Areas of professional development should go beyond basic education requirements. Recognition should be given to training in which individuals learn about expanding capability through technology, developing quality standards (as mentioned above) and management training for supervision of professional support staff as their roles increase, as well as peer reviews and continuing study in areas of clinical practice where change is happening fast and registrants need to be able to keep up to date.

In most professional environments, practitioners are asked to maintain their own records and provide an annual Declaration to the professional body or regulator, rather than having each element of their ongoing training checked. It is vital that all registrants do not see their formal training as an end to their learning, but only the beginning.

Concept 5: Educational Content

Consultation question 8 - What do you see as the key changes needed to the current content of optometry programmes and dispensing optician programmes to ensure our future requirements are fit for purpose?

Population change would argue for more attention on eye care for the vulnerable – paediatrics, low vision and domiciliary work are areas of considerable growth. As mentioned above, registrants in future will need to draw upon management skills to manage teams effectively, delegate appropriately, manage and mitigate against risk and maintain quality. It would be helpful to give students access to training to develop the business skills and understanding of healthcare economics and systems that many will need to manage clinics or practices but the GOC's concern should be about outcomes and the ability of registrants to deliver patient care, rather than enforcing particular areas of content.

We would refer to The College of Optometrists and the Association of British Dispensing Opticians for their views.

Concept 6: Enhanced clinical experience for students

Consultation question 9 - Do you agree or disagree with the concept of embedding clinical elements of education and training progressively from the outset of programmes?

Consultation question 10 - Tell us more about your views on this concept.

Consultation question 11 - What do you foresee as being any positive or negative impacts on students, education providers, employers, patients and carers from taking a hybrid approach?

We agree in principle but there are many factors to be taken into account and there is no clear solution which improves on the current arrangements for clinical placements and portfolios of evidence for student optometrists and dispensing opticians.

1) Students entering optical training vary greatly in maturity and communications skills and the differences may increase as younger entrants come through apprenticeship programmes. There is a clear need for all those who will work with patients to have face to face experience, but they must be properly prepared and supervised – and the quality and approach of supervisors themselves will vary. As mentioned before, students will need to know something of why, as well as how, so an immediate introduction to clinical practice without foundation would be inadvisable, not least because we want patients to recognise the people they meet in practice as professionals.

2) There are economic factors to take into account. Ideally there would be opportunities with different employers and in different locations to give students a breadth of clinical experience but this may just not be feasible. Employers also need to be willing to accept the responsibility of supervision and introduce students appropriately to clinical situations. Some may not be able to do so because of a shortage of resources in a busy practice; some employers could seek to take advantage of students to undertake work which goes outside the expectations for that placement. It seems unlikely that the sector could support placements for all would-be dispensing opticians and optometrists in every year of their training, nor could anyone guarantee that the experience of all students would be positive, and, importantly, consistent. This is particularly true in the case of optometry students gaining clinical experience of ocular pathology in hospital clinics, something which will become more important as more care is transferred from the secondary to primary sectors.

3) Peer reviews within current programmes are undoubtedly a good start and artificial intelligence may help in developing simulation equipment and/or exercises for students to be able to recognise and diagnose conditions and test both their knowledge and their ability to communicate with others.

Concept 7: National registration examination

Consultation question 12 - Do you agree or disagree with the concept of a national registration examination?

Consultation question 13 - What are the merits and risks of this concept?

Throughout WCSM's history, we have been concerned to maintain standards. It is unacceptable to the public or to those funding health care provision to have different standards within a single profession. There must be a single recognised level of minimum knowledge and competence for registrants (and, we would argue, some form of measurement of competence for those below registrant level supporting clinical work too) but forms of assessment have developed and an "examination" may not be the best description for an assessment which gives the necessary appropriate assurance.

Our experience is that many of those leaving school now and approaching an examination concentrate on "passing the exam". Many expect answers to be given to them during their training, rather than exploring and learning for themselves and this would be contrary to the vision we have of optical professionals who continue to advance their own learning and development and embrace debate and changes in ideas, equipment and therapies for the benefit of their patients.

Registrant professionals must be able to do, as well as know, and all currently have to demonstrate experience within a clinical framework, under suitable supervision. We would support a recognised definition of professional capability to start practice (such as the College of Optometrists' Scheme of Registration) and would encourage the GOC to consider different approaches to assessment by different education providers but there must be consistent standards in order to protect patients and give assurance to employers. There will always be some students who will "fail" and we should not be afraid of that.

Concept 8: Multi-disciplinary education

Consultation question 14 - How feasible would it be to develop inter-professional and multi-disciplinary elements of study within optometry and dispensing optician education programmes?

Consultation question 15 - Tell us about any examples you know of already in other disciplines from within or outside the UK?

This sounds great in theory but may be difficult to deliver in practice. It would dependon other disciplines being convinced of the benefits of working with optometry and dispensing optics and having the time and resources to dedicate to inter-disciplinary training. Given the current pressures within the National Health Service and with different regulators overseeing the standards of professionals working in medicine, eye health and associated health and social care services, it seems unlikely that sufficient time and energy could be devoted to making this happen but common teaching of subjects common to optometry and other health care professions should be encouraged. Optometry and orthoptics would be an example.

We support wholeheartedly the continuing growth in understanding of professional competencies and recognition of the value of team working in eye health. There is a higher level of respect now for the work of optometrists and dispensing opticians by medical professionals and that is greatly to be encouraged. Basic first aid training for optical professionals would be very useful as would providing hospital experience within

optometry programmes.

The GOC could make a good start by giving approval for mutual recognition of prior learning for some elements of study common to higher level optical assistants, student dispensing opticians, ophthalmic nurses, orthoptists and optometrists. This has been delayed for too long and is an unnecessary barrier for those interested in moving between eye health professions.

Concept 9: Duration of education and training programmes

Consultation question 16 - What do you see as the strengths and weaknesses of retaining the current minimum duration as described above?

Consultation question 17 - What could be done differently in order to ensure students become competent, confident and safe beginners?

The GOC should not be most concerned about the exact duration of courses, but with the capability of those who are educated and their ability to deliver safe and effective patient care.

There will be potential conflict between those who want to shorten courses, for financial reasons or to fill gaps in the workforce, and those who believe that a minimum amount of time is needed to develop professional capability and maturity and gain sufficient experience before taking on individual clinical responsibility.
Further discussion will be needed.

Concept 10: UK educational routes to registration

Consultation question 18 - What do you see as the opportunities for more flexibility between the education of different regulated and non-regulated optical professions?

Consultation question 19 - What are the constraints and risks to this?

See comments above on the need for an effective policy on accreditation of prior learning which would release the current blockages between orthoptists wanting to become dispensing opticians or optometrists and non-regulated staff who have taken Level 4 qualifications wanting to progress to courses leading to regulated profession.

The individual capability, communications skills and emotional intelligence of candidates who wish to move and progress will be a major factor and it may be that education providers may increase their requirements for submission of detailed portfolios of evidence and interviews before admission to courses, which would incur more resource. It should be the responsibility of the education provider to make decisions as to entry standards and exemptions and teaching methods; the responsibility of the regulator is to ensure that providers enable their students to reach the same standards of knowledge and competency irrespective of the method of entry.

The expansion of clear competency frameworks which show what is expected at each professional level, from a non-registrant member of staff, through a clinical assistant or technician role and lower or higher level apprenticeships to registered professions, and

the increase in expectations at each stage, would be helpful to show individuals how they might progress. Again, the work done by the College of Optometrists and Royal College of Ophthalmologists provides a good model for what could be done.

There is a risk involved in requiring greater supervision at lower levels, as mentioned above, and in maintaining standards, but we do not believe these are insuperable and progression should be more vigorously supported by the GOC.

Concept 11: Proportionate quality assurance

Consultation question 20 - Are there any other principles and concepts we should consider at this stage in exploring future approaches to our quality assurance processes?

No comment.

Consultation question 21 - Please tell us about any direct or indirect impact you can foresee from the concepts and principles we have set out in this public consultation on anyone with protected characteristics?

We believe that optical education providers and employers are keen to attract talented people of all backgrounds into optical professions. No further comment.