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

**AGENDA**

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

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

**Date of next meeting – Wednesday 16 March 2022**

# Impact Assessment Screening Tool

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|---|---|
| **Name of policy or process:** | **Education Strategic Review (ESR)** |
| **Purpose of policy or process:** | To update our requirements for GOC approved qualifications for specialist entry to the GOC register in Additional Supply (AS), Supplementary Prescribing (SP) and/or Independent Prescribing (IP) categories. |
| **Team/Department:** | Education |
| **Date:** | October 2021 |
| **Screen undertaken by:** | Simran Bhogal (ESR Project Manager) |
| **Approved by:** | Leonie Milliner (Director of Education) |
| **Date approved:** | November 2021 |

This impact assessment screening tool is in two sections.

Section one considers the impacts of the Education Strategic Review (ESR) as a GOC project using a standard screening GOC-tool. Second two considers the impacts, costs, benefits and risks of our proposals to update our requirements for GOC approved qualifications for specialist entry to the GOC register.

In section two we assess impact of our proposals and whether they are proportionate, targeted and transparent. We also assess the likely effect of our proposals on each category of stakeholder and on the GOC.

Section two also includes an assessment of whether any of our proposals raise any particular equality and diversity issues. Alongside this consultation we are undertaking a Equality Impact Assessment which will be published in December 2021.

This impact assessment screening builds on and should be read in conjunction with our previous impact assessments, including the draft impact assessments we published in November 2019 and in July 2020, associated ESR research and reports published on our website along with our proposals and associated impact assessment approved by GOC Council in February 2021 (the ESR deliverables; Outcomes for Registration; Standards for Approved Qualifications and Quality Assurance and Enhancement Method).

It also draws upon evidence of impact gained through engagement with stakeholders and our Expert Advisory Groups (EAGs) and will be further developed as we receive feedback gained through consultation and from our externally commissioned equality impact assessments (commissioned 2021).

Assessing impact and likely effect on stakeholders is an iterative process. As such this is a live document. We will continue to seek information from stakeholders and to review and update our current assessment in light of the further evidence we gather.

## Impact Assessment Screening Section One: ESR Project

| A) Impacts | High Risk | Medium Risk | | Low Risk | ? or N/A |
|---|---|---|---|---|---|
| 1. Reserves | It is likely that reserves may be required | It is possible that reserves may be required | | No impact on the reserves / not used | |
| 2. Budget | No budget has been allocated or agreed, but will be required. | Budget has not been allocated, but is agreed to be transferred shortly | Budget has been allocated, but more may be required (including in future years) | Budget has been allocated and it is unlikely more will be required | |
| 3. Legislation, Guidelines or Regulations | Not sure of the relevant legislation | Aware of all the legislation but not yet included within project/process | Aware of the legislation, it is included in the process/project, but we are not yet compliant | Aware of all the legislation, it is included in the project/process, and we are compliant | |
| 4. Future legislation changes | Legislation is due to be changed within the next 12 months | Legislation is due to be changed within the next 24 months | Legislation may be changed at some point in the near future | There are no plans for legislation to be changed | |
| 5. Reputation & Media | This topic has high media focus at present or in last 12 months | This topic has growing focus in the media in the last 12 months | This topic has little focus in the media in the last 12 months | This topic has very little or no focus in the media in the last 12 months | |
| 6. Resources (people & equipment) | Requires new resource | Likely to complete with current resource, or by sharing resource | Likely to complete with current resource | Able to complete with current resource | |
| 7. Sustainability | Less than 5 people are aware of the process/project, and it is not recorded centrally nor fully | Less than 5 people are aware of the project/process, but it is recorded centrally and fully | More than 5 people are aware of the process/project, but it is not fully recorded and/or centrally | More than 5 people are aware of the process/ project and it is clearly recorded centrally | |
| | No plans are in place for training, and/or no date set for completion of training | Training material not created, but training plan and owner identified and completion dates set | Training material and plan created, owner identified and completion dates set | Training completed and recorded with HR | |
| 8. Communication (Comms) / Raising Awareness | No comms plan is in place, and no owner or timeline identified | External comms plan is in place (including all relevant stakeholders) but not completed, an owner and completion dates are identified | Internal comms plan is in place (for all relevant levels and departments) but not completed, and owner and completion dates are identified | Both internal and external comms plan is in place and completed, owner and completion dates are identified | |
| | Not sure if needs to be published in Welsh | Must be published in Welsh, Comms Team aware. | | Does not need to be published in Welsh. | |

Please put commentary below about your Impacts ratings above:

**Budget**: The project's five-year financial forecasts and one-year budget include foreseeable costs, including approved use of reserves for development, consultation and associated project research costs, as well as additional approval and quality assurance activity required to support potential providers and existing providers prepare new qualifications or adapt existing qualifications to meet the proposed outcomes and standards for speciality registration.

**Legislation, guidelines and regulations**: Advice from the GOC's legal team has informed the preparation of these proposals in relation to our duties to approve qualifications under the Act. Where increased scope necessitates an enhanced or changed approach to skill development the high-level nature of the outcomes together with the requirement for providers to maintain the currency of approved qualifications through local responsiveness to stakeholder need will provide assurance. Where changed or increased scope also necessitates a change of GOC policy, rules or legislation, we would undertake a separate policy or legislative change exercise, including full stakeholder consultation before making any change. Nothing in these proposals changes scope as currently defined in legislation or GOC policy in relation to scope.

**Future legislation changes**: We expect DHSC to consult on changes to our legislation in 2022 or 2023. We will assess the impact of potential legislative change upon the ESR deliverables when further detail is available.

**Reputation and media**: The proposals to update our requirements for GOC approved qualifications leading to speciality registration in Additional Supply, Supplementary Prescribing and/or Independent Prescribing or as a contact lens optician continues to attract press and stakeholder attention, which has been amplified due to the negative impact of Covid-19 on higher and further education and ongoing issues with workforce supply/ progression in Independent Prescribing. Coverage in the broader media is likely to be very limited due to the positioning of optics in relation to other allied-healthcare professions.

We have taken a consultative and open approach to communicating with our stakeholders about our proposals. Our Expert Advisory Groups (EAGs) include staff and members from professional associations and representative organisations in optics and we continue to meet with stakeholders on a regular basis, including those in each devolved administration.

**Resources (people and equipment)**: Subject to a decision by Council in December 2021, we anticipate completing this element of the ESR workstream (for post-registration qualifications) within agreed timescales and cost tolerances.

| B) Information Governance | High Risk | Medium Risk | | Low Risk | ? or N/A |
|---|---|---|---|---|---|
| 1. What data is involved? | Sensitive personal data | Personal data | Private / closed business data | Confidential / open business data | |
| 2. Will the data be anonymised? | No | Sometimes, in shared documents | Yes, immediately, and the original retained | Yes, immediately, and the original deleted. | |
| 3. Will someone be identifiable from the data? | Yes | Yes, but their name is already in the public domain(SMT/Council) | Not from this data alone, but possibly when data is merged with other source | No – all anonymised and cannot be merged with other information | |
| 4. Is **all** of the data collected going to be used? | No, maybe in future | Yes, but this is the first time we collect and use it | Yes, but it hasn't previously been used in full before | Yes, already being used in full | X |
| 5. What is the volume of data handled per year? | Large – over 4,000 records | Medium – between 1,000-3,999 records | | Less than 1,000 records | |
| 6. Do you have consent from data subjects? | No | Possibly, it is explained on our website (About Us) | Yes, explicitly obtained, not always recorded | Yes, explicitly obtained and recorded/or part of statutory duty/contractual | |
| 7. Do you know how long the data will be held? | No – it is not yet on retention schedule | Yes – it is on retention schedule | Yes – but it is not on the retention schedule | On retention schedule **and** the relevant employees are aware | |
| 8. Where and in what format would the data be held? (delete as appropriate) | Paper; at home/off site; new IT system or provider; Survey Monkey; personal laptop | Paper; Archive room; office storage (locked) | GOC shared drive; personal drive | Other IT system (in use); online portal; CRM; Scanned in & held on H: drive team/dept folder | |
| 9. Is it on the information asset register? | No | Not yet, I've submitted to Information Asset Owner (IAO) | Yes, but it has not been reviewed by IAO | Yes, and has been reviewed by IAO **and** approved by Gov. dept. | |
| 10. Will data be shared or disclosed with third parties? | Yes, but no agreements are in place | Yes, agreement in place | Possibly under Freedom of Information Act | No, all internal use | |
| 11. Will data be handled by anyone outside the EU? | Yes | - | - | No | |
| 12. Will personal or identifiable data be published? | Yes – not yet approved by Compliance | Yes- been agreed with Compliance | No, personal and identifiable data will be redacted | None - no personal or identifiable data will be published | |

Please put commentary below about reasons for Information Governance ratings:

**What data is involved/will the date be anonymised?** During consultations personal data will be stored on our consultation platform (identifiable details like email address, place of work and a range of protected characteristics). We will only publish responses where individuals have consented to having their response published.

**Will someone be identifiable from the data?** Yes, respondents to consultations will be identifiable as their information will be linked to their own named record in Citizen Space. However, if we take statistics from Citizen Space for evaluation and monitoring purposes and publish these or disseminate them more widely than within the GOC, respondents will not be identifiable and information will be redacted.

**What is the volume of data handled per year?** The volume of data held on our consultation platform will not exceed 1,000 records.

| C) Human Rights, Equality and Inclusion | High Risk | Medium Risk | Medium Risk | Low Risk | ? or N/A |
|---|---|---|---|---|---|
| Main audience/policy user | Public | | | Registrants, employees, or members | |
| Participation in a process (right to be treated fairly, right for freedom of expression) | Yes, the policy, process or activity restricts an individual's inclusion, interaction or participation in a process. | | | No, the policy, process or activity does not restrict an individual's inclusion, interaction or participation in a process. | |
| The policy, process or activity includes decision-making which gives outcomes for individuals (right to a fair trial, right to be treated fairly) | Yes, the decision is made by one person, who may or may not review all cases | Yes, the decision is made by one person, who reviews all cases | Yes, the decision is made by an panel which is randomly selected; which may or may not review all cases. | Yes, the decision is made by a representative panel (specifically selected).<br><br>No, no decisions are required. | |
| | There is limited decision criteria; decisions are made on personal view | There is some set decision criteria; decisions are made on 'case-by-case' consideration. | There is clear decision criteria, but no form to record the decision. | There is clear decision criteria and a form to record the decision. | |
| | There is no internal review or independent appeal process | There is a way to appeal independently, but there is no internal review process. | There is an internal review process, but there is no way to appeal independently | There is a clear process to appeal or submit a grievance to have the outcome internally reviewed and independently reviewed | |
| | The decision-makers have not received EDI & unconscious bias training, and there are no plans for this in the next 3 months. | The decision-makers are due to receive EDI & unconscious bias training in the next 3 months, which is booked. | The decision-makers are not involved before receiving EDI & unconscious bias training. | The decision-makers have received EDI & unconscious bias training within the last 12 months, which is recorded. | |
| Training for all involved | Less than 50% of those involved have received EDI training in the last 12 months; and there is no further training planned | Over 50% of those involved have received EDI training, and the training are booked in for all others involved in the next 3 months. | | Over 80% of those involved have received EDI training in the last 12 months, which is recorded. | |

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| Alternative forms – electronic / written available? | No alternative formats available – just one option | Yes, primarily internet/computer-based but paper versions can be used | | Alternative formats available and users can discuss and complete with the team. | |
| Venue where activity takes place | Building accessibility not considered | Building accessibility sometimes considered | | Building accessibility always considered | |
| | Non-accessible building; | Partially accessible buildings; | Accessible buildings, although not all sites have been surveyed | All accessible buildings and sites have been surveyed | X |
| Attendance | Short notice of dates/places to attend | Medium notice (5-14 days)of dates/places to attend | | Planned well in advance | |
| | Change in arrangements is very often | Change in arrangements is quite often | | Change in arrangements is rare | |
| | Only can attend in person | Mostly required to attend in person | | Able to attend remotely | |
| | Unequal attendance / involvement of attendees | Unequal attendance/ involvement of attendees, but this is monitored and managed. | | Attendance/involvement is equal, and monitored per attendee. | |
| | No religious holidays considered; only Christian holidays considered | Main UK religious holidays considered | Main UK religious holidays considered. | Religious holidays considered, and ability to be flexible (on dates, or flexible expectations if no alternative dates). | |
| Associated costs | Potential expenses are not included in our expenses policy | Certain people, evidencing their need, can claim for potential expenses, case by case decisions | | Most users can claim for potential expenses, and this is included in our expenses policy; freepost available. | |
| Fair for individual's needs | Contact not listed to discuss reasonable adjustments, employees not aware of reasonable adjustment advisors. | Most employees know who to contact with queries about reasonable adjustments | | Contact listed for reasonable adjustment discussion | |
| Consultation and Inclusion | No consultation; consultation with internal employees only | Consultation with employees and members | Consultation with employees, members, and wider groups | Consultation with policy users, employees, members and wider groups. | |

## Impact Assessment Screening Section Two: ESR Deliverables (for post registration speciality qualifications)

## Step 1: Scoping the IA

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|---|---|
| **Name of the policy/function:** | **Education Strategic Review** |
| **Assessor:** | Simran Bhogal (ESR Project Manager) |
| **Date IA started:** | 2016 |
| **Date IA completed:** | October 2021 |
| **Date of next IA review:** | March 2022 |
| **Purpose of IA:** | To assess the key impacts of our proposals to update our requirements for GOC approved qualifications for specialist entry to the GOC register in Additional Supply (AS), Supplementary Prescribing (SP) and/or Independent Prescribing (IP) categories. |
| **Approver:** | Leonie Milliner, Director of Education |
| **Date approved:** | November 2021 |

*Q1. Screening Assessment*

- Has a screening assessment been used to identify the potential relevant risks and impacts? Tick all that have been completed:
  - ☐ Impacts
  - ☐ Information Governance (Privacy)
  - ☐ Human Rights, Equality & Inclusion
  - ☐ None have been completed

*Q2. About the policy, process or project*

- What are the main aims, purpose and outcomes of the policy or project?
- You should be clear about the policy proposal: what do you hope to achieve by it? Who will benefit from it?

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|---|
| **Aim:** To assess the key impacts of our proposals to update our requirements for GOC approved qualifications for specialist entry to the GOC register in Additional Supply (AS), Supplementary Prescribing (SP) and/or Independent Prescribing (IP) categories. |
| **Purpose and Outcome**: Following the launch of the Education Strategic Review in March 2016, in July 2019 Council gave steers on the ESR proposals. This included the introduction of an integrated form of optical education, combining academic study with professional and clinical experience for specialist entry to the GOC register in Contact Lens Optician, Additional Supply, Supplementary Prescribing and/or Independent Prescribing categories. Two Expert Advisory Groups (EAGs) for therapeutic/Independent Prescribing and Contact Lens Opticians were tasked with advising on the development and drafting of the new, proposed, Outcomes for Registration, Standards for Approved Qualifications for specialist entry to the GOC register in Contact Lens Optician, Additional |

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| Supply, Supplementary Prescribing and/or Independent Prescribing categories, and an updated quality assurance process to be held in common for both Contact Lens Optician and Independent Prescribing approved qualifications.<br><br>The outcomes and standards for approved qualifications for specialist entry to the GOC register (in the Additional Supply, Supplementary Prescribing and/or Independent Prescribing categories) will replace our 'Handbook for Optometry Specialist Registration in Therapeutic Prescribing' published July 2008 and the 'Competency Framework for Independent Prescribing' published in 2011 including the list of required core-competences, the numerical requirements for trainees' practical experiences, education policies and guidance contained within the handbooks, and our policies on supervision and recognition of prior learning, published separately.<br><br>Together, these documents mitigate the key risk that our current requirements become out of date. They have been drafted to ensure the post-registration qualifications we approve are responsive to a rapidly changing landscape in the commissioning of eye-care services in each of the devolved nations and so that the skills and abilities of our registrants remain up to date. |
| **Who will benefit:** Patients and the public; registrants; employers: other healthcare professionals, local/national workforce training/commissioning bodies and the NHS; GOC staff, EVPs and committees: providers of GOC approved and provisionally approved qualifications and their trainees. |

*Q3. Activities or areas of risk or impact of the policy or process*

- Which aspects/activities of the policy are particularly relevant to impact or risk? At this stage you do not have to list possible impacts, just identify the areas.

| **Key proposals** |
|---|
| a. Candidates will acquire a single qualification approved by the GOC leading to specialist entry to the GOC register in Additional Supply, Supplementary Prescribing and/or Independent Prescribing categories. |
| b. The approved qualification will be either an academic award or a regulated qualification at a minimum of Regulated Qualification Framework (RQF) (or equivalent) Level 7. |
| c. There will be no proposed minimum/maximum or recommended time or credit volume for an approved qualification or specified location or duration of clinical experience, other than the requirement that an approved qualification leading to specialist entry to the GOC register in Additional Supply, Supplementary Prescribing and/or Independent Prescribing categories must integrate approximately 90 hours of learning and experience in practice. |
| d. For qualifications in Additional Supply, Supplementary Prescribing and/or Independent Prescribing the supervision of a trainee's learning and experience in practice must be co-ordinated by an appropriately trained and qualified registered healthcare professional |

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| with independent prescribing rights (called a Designated Prescribing Practitioner or DPP) and be an active prescriber competent in the clinical area(s) they will be supervising the trainee in, have the relevant core competencies and be trained and supported to carry out their role effectively. |
| e. The provider of the approved qualification must, in the design, delivery and assessment of an approved qualification, involve and be informed by feedback from a range of stakeholders including patients, employers, trainees, supervisors, members of the eye-care team and other healthcare professionals. |
| f. An outcomes-based approach is used to specify knowledge, skills and behaviours using an established competence and assessment hierarchy known as 'Miller's Pyramid of Clinical Competence' (knows: knows how: show how & does), mapped to relevant external prescribing frameworks, including the draft Royal Pharmaceutical Society's (RPS) Competency Framework for all Prescribers (2021). |
| g. Providers of approved qualifications are responsible for the measurement (assessment) of students' achievement of the outcomes at the required level (on Miller's Pyramid) leading to an award of an approved qualification. |
| h. Providers of approved qualifications will be responsible for recruiting and selecting trainees onto an programme leading to an award of an approved qualification. Recognition of prior learning can be deployed to assist the progression of trainees whose progress to specialist registration has stalled, and the requirement for optometrist independent prescribing trainees to have been registered for at least two years prior to commencing clinical experience/ hospital placements has been removed. |
| j. At the point of retention, registrants in the Additional Supply, Supplementary Prescribing and/or Independent Prescribing categories will no longer need to supply details of prescribing decisions undertaken in the previous twelve months. |

*Q4. Gathering the evidence*

- List below available data and research that will be used to determine impact of the policy, project or process.
- Consider each part of the process or policy and identify where risks or implications might be found for: 1) Impacts; 2) Information Governance and Privacy implications; and 3) Human Rights, Equality and Inclusion.

| **Available evidence – used to scope and identify impact** |
|---|
| **Research and consultation:**<br>• Call for evidence (report June 2017)<br>• Research to learn from other professions/overseas (Nov 2017)<br>• System leaders' roundtable (Nov 2017)<br>• Consultation on concepts/principles (report April 2018)<br>• Research with newly qualified/employers (June 2018)<br>• Development of standards/learning outcomes with Committees, Expert Advisory Group other external stakeholder groups (summer 2018)<br>• Consultation on draft Education Standards and Learning Outcomes (November |

2018-Feburary 2019)
- Education Visitor Panel and Advisory Panel feedback (Jan-Dec 2020)
- Expert review and input from the Quality Assurance Agency (April-June 2020 and Oct-Nov 2020)
- Roundtable on funding (March 2020)
- Consultation on draft Outcomes for Registration, Standards for Approved Qualifications and Quality Assurance and Enhancement Method for optometry & dispensing optics (August 2020 – October 2020)
- QAA RQF Levels Research Report (November 2020)
- Expert Advisory Groups developmental activity and feedback (September 2019 – May 2021).
- Commissioned literature review undertaken by University of Surrey for IP/AS/SP (June 2021)
- Commissioned EDI Impact Assessment (Oct 2021)
- Consultation on draft Outcomes for Registration, Standards for Approved Qualifications and Quality Assurance and Enhancement Method for AS, SP & IP (July 2021 – Sept 2021)

*Q5. Evidence gaps*

- Do you require further information to gauge the probability and/or extent of impact?
- Make sure you consider:
    1) Impacts;
    2) Information Governance and Privacy implications; and
    3) Human Rights, Equality and Inclusion implications.

**If yes, note them here:**

We have undertaken extensive activity to gauge the extent of impact of the ESR. We continue to work with stakeholders to gather evidence of probability or extent of impact, and will review and update this impact assessment in light of new information

*Q6. Involvement and Consultation*

**Consultation has taken place, who with, when and how:**

A patient and public consultation was held for 12 weeks from July 2021-September 2021 and included an online survey hosted via our Citizen Space platform (with quantitative and qualitative questions), online focus groups with optical patients and interviews with a range of stakeholders conducted and analysed by our independent research partner.

**Summary of the feedback from consultation:**

Consultation responses were independently analysed by our research partner, Enventure Research, and a consultation report prepared by Enventure Research to be published on our website.

**Link to any written record of the consultation to be published alongside this assessment:**

Our response to Enventure Research's report and updated proposals once approved by Council will be published on our website.

## Step 2: Assess impact and opportunity to promote best practice

- Using the evidence you have gathered what, if any, impacts can be identified? Please document your findings and the strand(s) affected.
- What can be done to remove or reduce any impact identified?
- Consider each part of the process or policy and identify where risks might be found for equality, human rights and information governance and privacy.
- Ensure any gaps found in Q5 are recorded as actions and considerations below.

### Impact assessment methodology

The following categories or groups of stakeholders will potentially be impacted by our proposals:

- GOC
- Patients and members of the public
- Providers and potential providers of GOC approved speciality qualifications
- Supervisors / DPPs/ DMPs
- Trainees studying GOC approved speciality qualifications
- Representative organisations, professional bodies, employers and other stakeholders.

The impact assessment in step 2:

- Identifies the proposals that address the need for change;
- Includes a qualitative discussion of the costs, benefits and risks associated with each key proposal; and
- Makes an initial estimate of the costs and benefits and summarises mitigating actions or counter measures to the extent that it is possible or proportionate to do so.

### Assessment of costs, benefits, opportunities and risks

Our assessment of costs, benefits and risks of our key proposals will inform rather than determine our decision. There are two reasons for this. First, fulfilling our statutory duties involves taking account of issues that fall outside of a narrow consideration of costs and benefits. Second, it will only be possible to precisely quantify all the costs and benefits once providers of approved qualifications begin to adapt their existing qualifications to meet the new outcomes and standards and providers of qualifications applying for approval begin their application process. The magnitude and nature of costs will vary according to the qualification design decisions made by each provider. We have described the costs and benefits qualitatively and described who bears the costs (in broad terms). Where we have included an assessment of cost we have provided information about our key assumptions and the evidence used to inform our assessment of best estimate and likely range. As stated above, we continue to seek evidence of anticipated costs and to receive information that would enable us to quantify these costs. Benefits are harder to quantify as they tend to be more uncertain and are often spread across many stakeholders.

## Evidence and options

The 2017 concepts and principles report, subsequent roundtable and 2018-19 consultation considered the evidence base for change and sought feedback on options. This evidence base and options were described in various reports published on our website and informed the 2019 steer for an integrated approach to qualification approval, with candidates acquiring a single GOC-approved qualification (rather than two as at present) leading specialist entry to the GOC register in Additional Supply, Supplementary Prescribing and/or Independent Prescribing categories, supported by an outcome-orientated approach to specifying the required knowledge, skills and behaviour required for specialist annotation. This approach to post-registration qualification approval was considered the most appropriate, given the urgent need to ensure the GOC's standards and requirements continued to equip future professionals to meet service needs and patient demand as they evolve and, wherever they practise in the UK, continue to protect the public.

## Final Options

Because of the iterative approach taken to development of the proposals, including taking steers at key points, the two options available at this stage are:
Option 1. Continue with the current (2008) 'Handbook for Optometry Specialist Registration in Therapeutic Prescribing,' and the (2011) 'Competency Framework for Independent Prescribing,' the (2007) and related education policies and guidance.
Option 2. Require all GOC approved qualifications leading to specialist entry to meet the proposed outcomes and standards to the timescale outlined in the QA&E Method.

## Costs and benefits of option 1

The benefits of option 1 are defined as zero; the additional costs as low/ medium. This is the counterfactual against which option 2 is appraised. The analysis of cost, benefit and risks of option 1 is outlined below.

## Costs and benefits of option 2

The analysis of costs, benefits and risks of option 2 is outlined below.

## Summary

| | Additional cost: ongoing | Additional cost: one off | Benefit | Wider impact | Proport-ionate | Targeted | Transparent |
|---|---|---|---|---|---|---|---|
| **Option 1** | Low-Medium | None | None | Weaknesses, risks and opportunities of current system not addressed | No | No | In part |
| **Option 2** | Low-Medium | Medium | Higher standards of post-registration education | Proposed requirements reflect contemporary optical practice and patient/ workforce needs | Yes | Yes | Yes |

**Option 1 (counterfactual)**

Under this option we continue with the current quality assurance handbooks for approved qualifications leading to specialist entry in the GOC register including our current list of core competencies, supervision and numerical requirements for trainees' practical experiences.

Costs There are potential additional costs of retaining the current quality assurance handbooks from addressing failure due to the inadequacy of our requirements (provider failure and fitness to practice cases)

Benefits There are no additional benefits of retaining the current quality assurance handbooks. However, any uncertainty, risks or cost related to updating our requirements for qualification approval are avoided.

Wider impacts As discussed in previous impact assessments, associated ESR research and reports published on our website, there are a number of weakness in our current system:

- Continuing public, registrant and student confidence in our ability to set and maintain high standards for entry to specialty registration categories (as an Additional Supply, Supplementary Prescriber and/or Independent Prescriber) given how long ago they were written;
- Prescriptive list of competences limits innovation and responsiveness to changing patient and service-user needs, and extended roles; given need to consult;
- For trainees in Independent Prescribing, numerical requirements and 2-year time bar for clinical supervision by a consultant ophthalmologist within the hospital eye service restrict placement opportunities and limits workforce development/ progression;
- For trainees and their employers, limited choice (in price and quality) of GOC approved 'stage two' final qualifying qualifications leading to speciality registration; and for trainees in Independent Prescribing, lack of availability of placements limits progression.
- The current system does not promote achievement of earlier, better quality direct patient contact, inter-professional education and more varied clinical experience, which would better prepare trainees for advanced or specialised roles; and
- Limited engagement of stakeholders, including patients, service-users and commissioners in the design and delivery of GOC approved qualifications for entry to specialty registration categories.

Risks The risks of option 1 are as follows:

a. We fail in our overarching statutory responsibility to promote and maintain high standards of professional education and public confidence in the professions because our requirements for qualification approval for entry to specialty registration categories are out of date and unfit for purpose.
b. Risk of challenge to GOC qualification approval decisions from trainees, providers, potential providers and sector bodies if grounds for approval depart from current (but out of date) Quality Assurance Handbook and related requirements.

c. Risk we would not be able to take action if a qualification we approve meets our requirements but nevertheless fails to prepare trainees to meet employer, patient and service user needs, putting future patients at risk of inadequate care.
d. Risk our requirements and processes do not reflect modern methods for statutory regulators in setting education and training benchmarks for qualification approval and do not reflect contemporary optical practice or meet patient or service-user needs, thereby bringing the profession and its education into disrepute.

Summary Our current requirements for qualification approval for entry to specialty registration categories do not address the risks, potential for enhanced roles for optical professionals within service redesign or the challenges of meeting an increased demand for eye-health care given our aging population. Requiring trainees to acquire two GOC approved qualifications either sequentially or simultaneously for entry to the specialty registration categories is unnecessarily burdensome and provides few benefits. An outcomes-orientated approach to specifying the future knowledge, skills and behaviours of an Additional Supply, Supplementary Prescribers and/or Independent Prescriber at the point of specialty registration is required, better aligned with regulatory systems for qualification approval deployed by other healthcare regulators and in line with GOC's new requirements for pre-registration qualifications.

| | |
|---|---|
| **Costs** | Potential high additional costs addressing failures because of the inadequacy of our requirements (provider failure and fitness to practice cases) |
| **Benefits** | No additional benefits |
| **Wider impacts** | Weaknesses of current system not addressed by retaining current requirements for qualification approval for entry to specialty registration categories |
| **Proportionate** | Current requirements do not reflect contemporary optical practice or meet patient or service-user needs, address the risk of the GOC not meeting its statutory objectives or its strategic aim of being a world class regulator |
| **Targeted** | No- current requirements are not targeted satisfactorily on areas of greatest risk |
| **Transparent** | In part. A list of GOC approved qualifications is published on our website. Current requirements are complex, frequently poorly expressed and open to interpretation, and at risk of being out of date. |

**Option 2 (Our proposals)**

Under this option we would require all GOC approved qualifications for entry to specialty registration categories (as a Additional Supply, Supplementary Prescriber and/or Independent Prescriber) to meet the proposed outcomes and standards to the timescale outlined in the QA&E method.

Costs There will be additional costs to GOC of this option of:

- An on-going cost of increased approval and quality assurance support (1 new FT permanent A&QA post and 1 x FT QA project, policy & research manager – in budget);
- A one-off cost for drafting and seeking feedback on frameworks and SOPs to support implementation (from reserves – already agreed); and
- An on-going cost of thematic and sample-based reviews (which may be externally contracted – in budget).

There may be additional costs to providers/potential providers of approved qualifications for:

- A one-off cost in designing and preparing new qualifications for GOC approval; *or*
- A one-off cost in adapting existing GOC approved qualifications to meet the proposed outcomes and standards to the timescale outlined in the QA&E Method;
- An on-going cost in integrating learning and experience in practice within the approved qualification, stakeholder engagement and enhanced teaching and assessment quality control to meet the new requirements; and
- For one provider (the College of Optometrists) a one-off and ongoing cost of Ofqual registration (if desired).

There may be additional costs to trainees:

- For current Independent Prescribing trainees whose progression has stalled, and who wish to transfer (potentially with advance standing/RPL) into the new, integrated approved AS, SP & IP qualifications, an additional fee may be payable to the provider (the amount will vary according to type and location of approved qualification and any local workforce support/ funding that may be available);
- For some trainees, there may be additional costs and expenses for periods of learning and experience in practice;
- For trainees who wish to gain a GOC approved qualification for entry to a specialty registration category (as a Contact Lens Optician or Additional Supply, Supplementary Prescribers and/or Independent Prescribers) at the same time, or shortly after gaining an approved qualification in dispensing optics or optometry, there may be additional fees, and costs and expenses for periods of learning and experience in practice (the amount will vary according to type and location of approved qualification and any local workforce support/ funding that may be available).

There may be additional costs to local/national workforce training/commissioning bodies:

- There may be increased fees payable to the provider by those commissioning/ purchasing training (the amount will vary according to type and location of approved qualification and any local workforce support/ funding that may be available).

There may be additional costs to patient and public representative organisations, employers and other stakeholders:

- A one-off cost in working with providers in qualification design;
- An on-going cost in working with providers in qualification delivery and assessment, review and feedback; and
- An on-going cost to employers in offering short periods of learning and experience in practice (for which trainees may or may not be remunerated) and associated supervision.

Benefits The potential benefits to the GOC are:

- Patients and public would benefit from this option. Updated standards for for entry to specialty registration categories (as an Additional Supply, Supplementary Prescriber and/or Independent Prescriber) leading to improved patient safety;
- Patient, public, registrant and trainee confidence in our ability to maintain and monitor high standards for qualification approval for specialty registration will increase;
- Qualifications we approve will be more responsive to local, regional and national patient, service-user and broader stakeholder requirements and therefore more current, and better aligned with GOC's new requirements for pre-registration qualifications;
- This option, with its refreshed quality assurance and approval process, will give greater assurance that our requirements are being met and risks managed appropriately; and
- This option, with its outcomes-orientated approach, focuses more on the development of professional capability, critical thinking, research-informed clinical reasoning and decision-making vital to responding effectively to changing patient and service user needs, evidence-based practice and new models of delivery.

The potential benefits to providers/potential providers of approved qualifications are:

- Additional opportunities for current providers of pre-registration approved qualifications to offer to trainees at the same time a GOC approved qualification leading to entry to specialty registration;
- Greater flexibility in compliance and responsiveness in qualification design and delivery;
- All providers will be placed under the same obligations to maintain standards, which will safeguard standards and ensure a level playing-field in the sector;
- Simplification of our requirements for qualification approval with a more transparent and proportionate framework for quality assurance and approval focused on risk reduction;
- Some providers may, depending on qualification design, benefit from additional funding council or local/national workforce training/commissioning bodies support of L7 qualification; and
- Providers (Awarding Organisations) offering an Ofqual-regulated L7 qualification may choose a candidate registration fee and/or centre approval business model.

The potential benefits to trainees:

- Greater choice of approved qualifications leading to entry to the register with earlier and better-quality learning and experience in practice and inter-professional learning;

- This option requires providers to give students' accurate information about qualification at application, including the provider's intended curriculum and assessment approach, RQF level and the total costs/ fees that will be incurred; and
- This option, for most students and their employers, removes the necessity for up-front payment of examination or assessment fees for a stage 2, 'registerable' qualification (and associated membership fees) and instead gives the potential, depending on provider's qualification design, for fees/maintenance to be supported by student loans.

The potential benefits to local/national workforce training/commissioning bodies of:

- Better alignment of commissioning (funding) post registration speciality qualifications, particularly independent prescribing qualifications, with approved qualifications leading to entry to the register;
- Greater responsiveness to devolved administration workforce development needs, with potentially a better-skilled workforce, particularly in therapeutic prescribing qualifications.

The potential benefits to patient and public representative organisations, employers and other stakeholders;

- Patients, public and employers would benefit from this option as a result of updated requirements for specialty registration leading to improved patient safety;
- Patient, public, registrant and trainee confidence in our ability to maintain and monitor high standards for post-registration qualification approval will increase;
- Qualifications we approve will enable stakeholders to inform and be involved in post-registration qualification design, delivery, assessment, quality control and review;
- Qualifications we approve will be more responsive to local, regional and national patient and service-user needs and stakeholder requirements and so entrants to specialty registration categories (as an Additional Supply, Supplementary Prescriber and/or Independent Prescriber) will be better-prepared to work in enhanced roles in dynamic, multi-professional settings and engage in up -to-date, effective and research informed practice for the benefit of patients;
- This option, for eligible employers, removes the necessity for employers to support trainees' course, examination or assessment fees for two approved qualifications (gained either sequentially or simultaneously) required for entry to a specialty registration category; and
- Employers and trainees will have a greater choice of qualifications for entry to specialty registration categories (as an Additional Supply, Supplementary Prescriber and/or Independent Prescriber).

<u>Wider impacts</u> As discussed in previous impact assessments, associated ESR research and reports published on our website, there are a number of impacts, positive and negative:

- We are conscious of the potential negative impact on a professional association (the College of Optometrists) offering market-leading GOC approved 'registrable' post-registration qualifications due to increased market competition, and are continuing dialogue with the College;

- This option specifies a minimum RQF level for qualifications we approve with potential impact on trainees recruitment, selection and widening participation;
- Provider vulnerability due to covid-19 with potential negative impact on local/ regional workforce supply (and potential to meet future patient and service-user needs).

Balanced by:

- Entrants to specialty registration categories better prepared to meet patient needs, especially in the softer skills, clinical reasoning and decision-making, underpinned by consistently applied academic standards at relevant RQF level;
- Qualifications better aligned with other healthcare disciplines and funding mechanisms, leading to closer collaboration in assessment, interprofessional learning and multi-disciplinary working, potentially a positive impact on cost through shared resource, economies of scale and increased resilience in the sector;
- In this option, replacing the prescriptive list of competences and patient episodes with an outcomes-based approach to specifying the knowledge, skills and behaviours expected will build registrants' skill and capability for new and evolving roles to meet workforce development needs;
- In this option, flexibility in qualification design enables greater responsiveness by providers to trainees with different preferences and from diverse backgrounds;
- A potential positive impact in the enhanced influence and attractiveness of professional associations as Awarding Organisations offering GOC approved qualifications.

Risks The risks of option 2 are as follows:

a. We fail in our overarching statutory responsibility to promote and maintain high standards of professional education and public confidence in the professions because our requirements for qualification approval become out of date and are unfit for purpose. *Mitigation*: planned and budgeted longitudinal research will provide the data we need to measure and review the effectiveness of our outcomes and standards on registrants' competence, confidence and capability, providing the evidence for potential adjustment at regular intervals (subject to consultation);
b. Risk that current providers and potential providers do not adequately prepare qualifications to meet the outcomes and standards necessary for GOC approval; qualifications fail to recruit; fail to thrive, or providers decide to withdraw their qualifications. *Mitigation:* for existing providers, we will work with each provider individually to support transition at a pace that works for them; for new providers the risk-based staged approach to qualification approval decision now includes interrogation of providers' business and delivery plans to ensure qualifications only progress if we are confident they will thrive and risks managed;
c. Risk of challenge to GOC qualification approval decisions from trainees, providers, potential providers and sector bodies if grounds for approval depart from proposed outcomes and standards. *Mitigation*: the proposed outcomes and standards are now far clearer, proportionate to the risks posed and less open to interpretation than current requirements, reducing the risk an approval decision does not logically follow from evidence of compliance.
d. Risk that employers fail to engage with providers in qualification design and delivery. *Mitigation:* Ongoing engagement with employers' representative bodies and national

commissioners supplemented by our requirement in the standards that providers similarly engage with employers, local/national workforce training/ commissioning bodies and NHS commissioners;

e. Risk that proposals create a regulatory bar, preventing providers, trainees or optical practices access to existing funding streams. *Mitigation:* Ongoing engagement with devolved administrations and local/national workforce training/ commissioning bodies and NHS commissioners to identify and resolve regulatory bars preventing access to existing (or new) funding streams.

Summary This option would enable us to address the risks, problems and potential opportunities with our current requirements for post-registration speciality qualifications. It will provide us with contemporary and up-to-date requirements for post-registration qualification approval that in turn will mean providers will better prepare entrants to specialist post-registration categories for enhanced or extended roles within service redesign, meeting the challenges of increased demand for eye-health care given our aging population. Requiring trainees to only acquire a single GOC approved qualifications for entry to specialty registration simplifies our regulatory framework and introduces greater trainee and employer choice. An outcomes-orientated approach to specifying the future knowledge, skills and behaviours of a future Additional Supply, Supplementary Prescriber and/or Independent Prescriber at the point of registration better aligns with other healthcare regulatory systems for qualification approval and post-registration specialty annotation.

| | |
|---|---|
| **Costs** | Medium additional one-off costs for providers<br>Potentially low to medium additional on-going costs for providers<br>Potentially further course fees for current trainees whose progression is stalled to transfer to new, integrated qualifications (depending on recognition of prior learning & qualification design)<br>Potentially lower course fees for new trainees |
| **Benefits** | Updated standards of post-registration specialist education<br>Greater assurance providers meet required standards<br>Better preparedness of future registrants for enhanced/ extended roles<br>Improved progression for trainees (in particular, for independent prescribing, with move from DMP to DPP and greater flexibility for clinical experience) |
| **Wider impacts** | Weaknesses of current system addressed by proposed updated requirements for post-registration qualification approval |
| **Proportionate** | Proposed requirements reflect contemporary optical practice and future patient/ workforce needs, addresses the risk that GOC may not meet its statutory objectives or its strategic aim of being a world class regulator. |
| **Targeted** | Proposed requirements target areas of greatest risk |
| **Transparent** | A list of GOC approved qualifications will be published on our website.<br>Proposed requirements are straightforward, simple to understand, not at risk of wide interpretation and are up to date. |

## Step 3: Monitoring and review

*Q6. What monitoring mechanisms do you have in place to assess the actual impact of your policy?*

**Longitudinal Research**

We believe that it is extremely important to measure the impact of our proposed changes on the competence, confidence and capacity of future registrants. We intend to commission a longitudinal research project to provide the empirical data required to measure the effectiveness of the new qualifications we approve and adjust our outcomes and standards as required (subject to consultation).

**Impact Measurement**

We will also measure the impact of our proposed changes through:

- Implementation timescales and data;
- Repeat consultations and surveys: newly qualified and employers; providers; representative and membership bodies;
- Risk reviews as part of our Annual Monitoring process.

**CPD impact**

The Director of Education also leads our work to review our CET system. From January 2022 we will be introducing our new requirements for Continuing Professional Development. The ESR Project Team continues to work closely with CPD Project Board to share pertinent information about skill gaps in the transition from optical students to fully-qualified registrants and onto specialty registration, which could impact the 'additional requirements' domain for registrants (or sub-set of registrants) in any given cycle.

**International Registration impact**

We continue to work closely with Registration team on impacts of ESR and Brexit on international registrants.

**Financial Impact**

Our outline impact assessment published as part of our ESR consultation gave some consideration of financial impacts of our proposals, in particular the financial impact for future providers of GOC approved qualifications (a mix of Further (FE) and Higher Education (HE) providers and private membership-based organisations) across the UK; on students and placement providers/ employers, drawing upon the outcome of our funding roundtable held on 13 March 2020 and its subsequent report 'Further and Higher Education Funding of Optometrists and Dispensing Opticians' published on our website. As stated above, we continue to seek evidence of anticipated costs and to receive information that would enable us to quantify them more precisely.

**Equality Impact Assessment**

We have commissioned Fraser Consulting to undertake an Equality, Diversity and Inclusion (EDI) assessment of the impact of our proposals with reference to each of the protected characteristics as defined by the Equality Act (2010) across each of the four

nations. Clare Fraser is an experienced equality and diversity consultant with a range of clients across the public and private sectors, and her report will be published on our website. This EDI assessment will focus on EDI impacts (positive and negative) on trainees and providers of GOC approved qualifications using qualitative and quantitative data analysis and will be undertake alongside the public consultation.

Please provide a review date to complete an update on this assessment.

**Date: November 2021 and annually thereafter**

# Optometrist therapeutic prescribing:

# A rapid review of the literature

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**Abbreviations**

AC - Advanced Clinical

A&E – Accident and Emergency

AMED - Allied and Complementary Medicine Database

APCOS – Acute Primary Care Ophthalmology Service

AOS - Acute Ophthalmic Service

AS - Additional Supply

CoO – College of Optometrists

CFA – Common Final Assessment

COM-B – Capability, Opportunity, Motivation, and Behaviour model

CPD – Continuing Professional Development

CUES - COVID-19 Urgent Eyecare Service

DMP – Designated Medical Prescriber

DTC – Drug Therapeutic Committees

GPhC – General Pharmaceutical Council

GP – General Practitioner

GOC – General Optical Council

GOS – General Ophthalmic Service

GRRS – Glaucoma Referral Refinement Scheme

HCPC – Health and Care Professions Council

HEI – Higher Education Institutions

HES – Hospital Eye Service

IP – Independent Prescribing

IPs – Independent Prescribers

IPOS – Independent Prescribing Optometrist Service

MCQ – Multiple Choice Questions

MDT – multidisciplinary team support

MECS - Minor Eye Conditions Service

NHS – National Health Service

NMC – Nursing and Midwifery Council

NMP – Non-medical prescribing

NMPs – Non-medical prescribers

OHT – Ocular Hypertension

OSCE – Objective Structured Clinical Examinations

OTP – Optometrist therapeutic prescribing

PEARS - Primary Eye-care Assessment and Referral Service

PRISMA – Preferred Reporting Items

RCO – Royal College of Ophthalmologist

RPL – Recognition of Prior Learning

RPS – Royal Pharmaceutical Society

SP – Supplementary Prescribing

SPIDER – Sample, Phenomenon of Interest, Design, Evaluation, Research Type

TDF – Theoretical Domains Framework

UG – Undergraduate

UK – United Kingdom

## 1 Executive summary

*Background:* Optometrists in the UK can undertake training that entitles them to prescribe a range of medicines for patients with eye conditions. This training, and registration as an Optometrist therapeutic prescriber, is overseen by the General Optical Council (GOC).

*Aim:* This rapid review was commissioned by the GOC with the aim to identify known barriers and facilitators to implementing non-medical prescribing that impact on Optometrist therapeutic prescribing, related to additional supply, independent and supplementary prescribing. An additional aim was to identify literature on the scope of Optometrist therapeutic prescribing.

*Methods:* This rapid review comprises:

1. A review of systematic reviews to identify common barriers and facilitators to non-medical prescribing across all relevant professions,
2. A review evidence on Optometrist therapeutic prescribing (OTP) and additional supply to identify scope of OTP, state of current evidence base and barriers and facilitators to OTP
3. Conversations with key informants to identify key challenges and facilitators to OTP

*Data:* A total of 13 systematic reviews were included in the review of systematic reviews, 11 articles (8 empirical and 3 reviews) were included in the review of OTP and 8 conversations were held with key informants involved in OTP across England, Northern Ireland, Wales and Scotland.

*Findings*: A range of barriers and facilitators were found to impact on non-medical prescribing in the following stages: i) preparatory stage ii) training iii) early transition and iv) sustainment and development. This included the extent of organisational readiness, leadership, preparation of the infrastructure to support NMP (such as policy, access to prescription pads and a prescribing budget), practitioner readiness, continued support and professional development. Limited evaluative research evidence was available on OTP, with a lack of information about the current scope of OTP practice or service delivery. Challenges to OTP included a) limited practitioner skills and motivation, b) access to clinical practice training, c) limited organisational support and d) a lack of external/local policies to facilitate prescribing. Many of these barriers remained unchanged over the past decade and were also reported by key informants. A number of further challenges raised by key informants included: a need for greater strategic visioning and commissioning of OTP services; better alignment with governance, clinical and educational standards applied to other non-medical prescribing professions; preparation

of optometrists for the prescribing role (including undergraduate training); improvements to supervised practice; and greater support for transition and long-term sustainability of OTP. Innovative approaches to service commissioning and support for OPT taken in some of the devolved nations were reported to have reduced many barriers to implementation. Key informant conversations reiterated the important position of OTPs in meeting the needs of patients with acute and non-acute ocular conditions, providing accessible care and reducing burden on general practice and acute services.

*Discussion and conclusion:* The limited evidence base on OTP indicates that i) it has a positive impact within enhanced services in community and acute settings and ii) barriers and facilitators are similar to those experienced by other non-medical prescribing professions. Key differences were identified in the way that OTP is governed at national and organisation level compared to other NMP professions, however the justification for these differences were unclear. There are potential benefits to be gained from a greater alignment with NMP prescribing competencies, educational and governance standards and frameworks for advanced practice career development. Bottlenecks in accessing practice placements and a lack of integration and feedback between educational and practice components were a particular concern for key informants. Solutions to reduce barriers to the uptake and use of OTP were evident in some of the devolved nations, such as: improving strategic vision, pro-OTP leadership, and service commissioning to facilitate novel OTP roles, training costs and infrastructure support. There is potential to improve the sustainability of OTP and facilitate the development of novel and innovative OTP-led roles by greater recognition and support of OTP scope of practice. The recommendations of this review are timely given the role of non-medical prescribing in improving service capacity to meet increasing demand for medication.

## 2 Background

The 1999 Crown Report[1] recommended extension of independent prescribing (IP) responsibilities to a number of non-medical professional groups. In the UK, registered optometrists were already using a restricted range of prescription-only medicines in professional practice, under exemptions listed in the Medicines Act (1968), to support diagnostic procedures and management of common ocular conditions posing limited risk to sight. Examples include topical antibiotics for bacterial conjunctivitis, and pupil dilators such as cyclopentolate hydrochloride. In 2005, necessary changes were enacted to various relevant legislation to implement the recommendations of the Crown Report, followed by further amendments in 2008[2]. This created additional prescribing roles outlined in Table 1[3]. Introduction of these prescribing rights was intended to supplement existing shared care models for management of sight-threatening ocular disease[4].

Optometrists who wish to become independent prescribers (referred to in this report as Optometrist Therapeutic Prescribing) must have a minimum of 2 years in practice prior to undertaking the three stages of IP training. Stage one comprises completion of an ocular therapeutic course at one of the five approved UK universities. Secondly, a clinical placement comprising 24 x three-hour clinical sessions under the supervision of an ophthalmologist based in secondary care must be undertaken within two years of completing the theoretical component. The final step is successful completion of the Common Final Therapeutics Assessment (TCFA) via the College of Optometrists (GOC)[2]. Optometrists are awarded the dual qualification of independent and supplementary prescriber, with requirement for yearly renewal with GOC and a detailed log of prescribing activity. When qualified, optometrists should work within their scope of practice and acknowledge limitations of their practice[2].

Evidence suggests that there is consensus regarding barriers and facilitators to implementation of non-medical prescribing, which are known to commonly occur during i) preparation for the role ii) early integration and iii) on-going sustainment. Given the dearth of evidence exploring optometrist IP, this review will therefore consolidate the wider body of literature exploring non-medical prescribing and then map this against knowledge related to Optometrist Therapeutic Prescribing (OTP).

## 3 Aim

This rapid review addresses the following questions:

a) What are the known barriers and facilitators to implementation of non-medical prescribing that impact on Optometrist therapeutic prescribing, related to additional supply, independent and supplementary prescribing?

b) What is the scope of Optometrist therapeutic prescribing?

## 4 Objectives

1. Undertake a review of systematic reviews to identify common barriers and facilitators to non-medical prescribing across all relevant professions.
2. Review evidence on Optometrist therapeutic prescribing (OTP) and additional supply to identify scope of OTP, state of current evidence base and barriers and facilitators to OTP.
3. Undertake conversations with key informants, to identify key challenges and facilitators to OTP.

## 5 Methods

### 5.1. Review of systematic reviews of barriers and facilitators to non-medical prescribing

Adopting a rapid review[5] a narrative synthesis was conducted on the topic of barriers and facilitators experienced by non-medical prescribers including nurses, pharmacists, and optometrists.

#### 5.1.1 Search strategy

A systematic search of literature reviews of barriers and facilitators to non-medical prescribing was conducted in March-April 2021, using search terms developed according to the Sample, Phenomenon of Interest, Design, Evaluation, Research Type (SPIDER) tool[6]. These were tested based on abbreviations of words related to non-medical prescribing by nurses, pharmacists, optometrists, and other relevant professional groups. Wild card and Boolean Search Operators were used. Search strings included keyword terms, such as (non-medical prescrib*) plus (optometr*, nurs*, pharmacist*) plus (e.g., meta-synthesis, meta-analysis). Search terms, and full example search string are available in Appendix 1. Databases included EBSCO (MEDLINE, CINAHL), OVID (EMBASE) and ProQuest (British Nursing Index, Nursing & Allied Health). Publications were searched from January 2010 to March 2021. Retrieved citations were downloaded to EndNote V.X9 software and duplicates removed.

#### 5.1.2 Screening and eligibility

Two reviewers (JE, SvE) independently appraised titles and abstracts for eligibility in relation to the inclusion criteria shown in Table 2. Full texts of the remaining reviews were screened independently by all members of the research team (NC, KS, MC, JE, & SvE) using the Joanna Briggs Institute Critical Appraisal Checklist for Systematic Reviews and Research Syntheses[7]. All reviewers confirmed the eligibility of the identified reviews. Any disagreements about possible inclusion were resolved during group discussions. Reference list hand searching supplemented database searching. An overview of the selection process and search results are available in Figure 1.

5.1.3 Data extraction

Data extraction was conducted by one researcher (SvE) resulting in a bespoke table adapted from recommended templates[8]. The table included the basic outline of the evidence under study such as aims, study design, sample size (number of papers included), time frame, model of prescribing (independent/supplementary), profession (nurses/pharmacists/mixed), and care setting. To help contextualise barriers and facilitators, main findings were included (see Appendix2). Data extraction was iterative and involved repeated review and update between subsequent stages of analysis[9].

5.1.4 Data analysis and assessment

Data analysis followed a four stage, iterative process[10] (see Table 3).

Barriers and facilitators to implementation of non-medical prescribing, identified from the review of systematic reviews, were grouped under the following stages: i) preparatory stage ii) training iii) early transition and iv) sustainment and development (see Appendix 3).

**5.2. Review of literature on optometry prescribing and scope of practice**

5.2.1 Search strategy, screening, and eligibility

A secondary systematic search of literature on optometrist therapeutic prescribing and medicines administration/supply/optimisation conducted in the United Kingdom between 2010 and 2021 was undertaken in April 2021, using inclusion/exclusion criteria shown in Table 4. The search was designed to capture any literature relevant to IP in optometry, including primary and secondary research, non-empirical reviews, and reports. Search terms were developed following the PICO format and tested based on truncations of words related to prescribing, medicines optimisation, administration and/or supply, optometrists, and optometry. Wild card and Boolean Search Operators were used to capture relevant studies. Search strings, examples of which are shown in Appendix4, were adapted for 4 databases including MEDLINE, EMBASE, CINAHL and AHMED.

Identified citation records from electronic database searches were exported into EndNote V.X9. Screening followed a three-step process as shown in Figure 2 PRISMA to select studies according to inclusion/exclusion criteria. Titles were initially reviewed to identify and exclude non-NMP relevant literature (n=201), abstracts were then screened (n=28) and full texts of those appearing relevant sought (n=14). Reference list hand searching was additionally completed to maximise inclusion.

5.2.2 Data extraction and synthesis

Study data were extracted to a bespoke table designed to capture information on key study characteristics including study aim, design, setting, sample, main findings and - where evident- barriers and facilitators to implementation.

**5.3. Conversations with key informants**

Using established contacts and networks, and a snowballing technique, contact was made with leaders and key informants involved in OTP across England, Northern Ireland, Wales and Scotland (n=13). Conversations (n=8) were held with to gain insight into the evolvement of OTP and opinions on key enablers and challenges.

Additional relevant literature, including that recommended by informants, were used to further inform the review.

Handwritten notes made on informal conversations were analysed to identify key barriers, enablers, and suggestions for optimising OTP.

**5.4 Data analysis and synthesis**

Barriers and facilitators to implementation of non-medical prescribing, identified from the review of systematic reviews, were grouped under the following stages: i) preparation for the role ii) training iii) early integration and iv) sustainment and development. Using a process of framework analysis[11], these key barriers and facilitators were mapped against knowledge relating to OTP from the literature review and conversations with key informants in order to identify key issues and challenges and inform recommendations. This synthesis provides the basis of the discussion and recommendations.

Findings from each section are reported separately and then the overall synthesis is discussed.

## 6 Results

### 6.1 Review of systematic review of barriers and facilitators to non-medical prescribing

#### 6.1.1 Search outcome

In total 3,474 total records were identified from initial database searches using MEDLINE (n=865), CINAHL (n=410), EMBASE (n=1,148), British Nursing Index (n=603) and Nursing & Allied Health (n=448). After duplicate removal (n=955) and exclusion of articles by title (n=2,337) and abstract (n=131), 51 full text articles were reviewed by the research team. A further 41 were excluded for reasons shown in PRISMA Figure 1, leaving 10 full text articles eligible for inclusion. Hand searching reference lists generated 3 more reviews fulfilling inclusion criteria; in total 13 systematic reviews were included.

#### 6.1.2 Study characteristics

Thirteen articles fulfilled the inclusion criteria and were reviewed. This included: 9 systematic reviews using mixed methods [12-20], 3 systematic reviews focused on studies using qualitative methods[21-23], and 1 review included quantitative studies only[24] .Statistical meta-analysis was not possible due to the heterogeneity between studies[15, 20, 24] .Instead, findings were presented in a narrative form[13, 15, 16, 24], with qualitative data being analysed thematically [13, 14, 16-18, 20, 21] .In two of the reviews a meta-synthesis was conducted[19, 22] .One systematic review conducted a meta-ethnography[23] and one used framework analysis to synthesise the data [12]. All systematic reviews were international and included studies from the UK, apart from one systematic review[14] which focused on the UK only.

Studies addressed community (n=4), primary care (n=11), secondary care (n=9) and tertiary care (n=3). Participants included independent prescribers (n=13) and supplementary prescribers (n=9). Non-medical prescribing professions included: pharmacists (n=8), nurses (n=9), physiotherapists (n=2), podiatrists (n=2), radiographers (n=1).

#### 6.1.3 Thematic synthesis findings

Several factors were identified that can inhibit or facilitate the uptake and implementation of NMP (see Appendix 3). For the most part, it appeared that NMP was largely acceptable to both service users and health care professionals. However, barriers are consistently reported and a lack of strategic planning to support wider scale implementation of NMP identified [14, 18, 23]. The implications of this are discussed in more detail below.

**Theme i) Preparatory stage**

a) Organisational readiness

Following approval of legislative frameworks and the appropriate regulatory body, optimising organisation readiness is key to supporting successful implementation of NMP. Having an up to date NMP policy; pro-NMP leadership, buy-in at a senior level and a supportive inter-professional climate were all factors reported to contribute to a conducive environment for NMP implementation

*Local policy and infrastructure to support prescribing*

In additional to professional registration, Trust policy and ratification of NMP, for each profession, must be in place within the organisation to enable NMP[14, 19]. For example, scope of prescribing is agreed by Drugs and Therapeutic committees and a prescribing budget identified[18 14]. Delays in registration of newly qualified NMPs were known to occur, particularly if they were the first NMP in the trust and there was, for example, no trust NMP policy in place[18 20]. Additionally, delays could occur where the infrastructure was not in place to provide access to prescription pads[17-19, 22] or access to medical records[18 13-15, 17, 18, 20]. Practicalities, such as space and time to engage in prescribing also needed to be considered[18 15, 17-19]. Pharmacist NMPs had concerns about not having access to private consultation rooms (i.e., lack of privacy[15]). They also reported issues regarding accessing confidential medical records and the necessity of being able to record prescribing actions in patients' medical notes within a community pharmacy setting [15].

NHS trusts had their own drug formularies, which imposed limits on which medications could be prescribed [14, 18, 19, 22, 23 14]. These formularies required updating and regular review to ensure they were fit for purpose for NMP use[18, 21]. In addition, some trusts required individual prescribers to have a personal formulary, which is an agreed list of medicines that they could prescribe [14, 19]. This could be useful in defining scope of practice but could also be a barrier if too restrictive and time consuming to adapt when NMPs want to expand their prescribing remit[18].

*Leadership, support, and strategic vision*

Strong pro-NMP leadership facilitated the development of NMP within an organisation [14, 19]. A lack of strategic vision for NMP[14 23] hampered innovative NMP-led service development and resulted in a perceived lack of need for NMP within an organisation[17]. Thus, it was important that stakeholders recognised the demand for NMP[17], that they had positive attitudes towards NMP and could see the

benefits associated with NMP in relevant roles [15, 18, 21, 22]. Funding to optimise the workforce could improve the supportive climate for NMP[15, 17].

A lack of management and Multi-disciplinary Team (MDT) support[12 17 19, 21]hindered the uptake of NMP, together lack of regular clinical supervision[21] and mentoring support [17]. Formal support mechanisms, including (clinical) supervision and feedback on NMP practice, were viewed as helpful [13, 21]. Support for NMP by doctors and MDT was crucial to facilitate NMP uptake and implementation from pre-training through to post-training [15-17, 19-22].

A lack of clarity regarding NMP roles often led to ambiguity, particularly regarding professional and legal boundaries of the role[14, 18, 19, 21, 22]. This was made worse by poor communication networks with NMPs expressing the need for better communication within MDTs [12, 14]. Furthermore, NMP often had to deal with role dissonance which manifested itself as a lack of acceptance, opposition, resistance, and professional rivalry, mostly from doctors [13-22, 24], but also from other pharmacists[17]. Some of the reviews used the word 'conflict' in this context[16, 20].

b) Practitioner readiness

Aspects highlighted as important to practitioner readiness included: practitioner selection, expectations, and motivation. It was recognised as beneficial that managers and HEI course providers select appropriate practitioners to undertake the prescribing programme, based on clearly defined criteria [18]. In addition, it was important that candidates had realistic expectations about what the NMP programme provided to avoid misunderstanding about the generic nature of NMP programmes that were multi-professional[12, 18]. However, variation in the content of NMP prescribing programmes[21], particularly in relation to pharmacology[12, 18, 22], and adherence to selection procedures were reported[18] .

Motivation to undertake NMP training included: an increased sense of autonomy [14, 18, 19], the desire to make better use of professional skills and expertise[22]. In addition, practitioners felt that it helped with their professional development [22] and that it increased their clinical competence, for example by improving their pharmacological knowledge[12, 19, 22]. Training as an NMP also provided practitioners with professional satisfaction[14, 15, 17-19, 21, 22]. Deterrents to undertaking NMP training were the added responsibility that came with prescribing[12, 17] together with a lack of financial renumeration[14, 18, 19]. The time and cost related to completing course prerequisites[18], combined with a lack of funding available for training[14, 18] made it less attractive for practitioners to train as NMPs.

**Theme ii) Training**

Feedback on the prescribing programme has highlighted inadequacies, according to the views of some NMPs[12, 13, 17, 21, 22]. Mainly, it was considered that applied pharmacology within courses was not adequate to compensate for the lack of grounding in pharmacology and bioscience at undergraduate level, particularly for nurses and physiotherapists [12, 19, 20, 22, 23 18]. Other shortfalls included preparation for assessment, physical examination, therapeutics, and diagnostic skills training[12, 15, 17, 21-24]. While some of the shortfalls mentioned may relate to poor pre-course selection, preparation and expectations, there were reports of disparity across NMP courses including duration, content, and relevance[21].

A multifaceted mixed methods approach was found to work well when undertaking training for the prescribing role[12]. For example, pedagogical methods, such as podcasts and virtual patients, facilitated history taking and developed diagnostic skills[12] . Repetition of key concepts and the opportunity to apply knowledge in the workplace further helped to consolidate NMP abilities acquired through training[12] .

Practitioners often had difficulty identifying an appropriate person to act as a designated medical prescriber (DMP), which in turn could prevent candidates from undertaking the training [12, 18]. Both peer and professional support were reported as lacking[14], and DMP supervision was patchy and sometimes poor quality[20] . Additionally, the course was reported to be challenging in terms of time and course commitments[14, 17].

**Theme iii) Early transition**

Transitioning to the prescribing role was commonly reported as a time of vulnerability where newly qualified NMPs needed to build confidence in prescribing[12, 13, 16, 17, 19, 20, 22, 23] . Some studies reported poor knowledge of pharmacology and therapeutics, and a need for CPD on pharmacology and drug interactions[16, 22] . At this time, continuing support and supervision from MDTs, management, and peers, appeared to be crucial, however was sometimes lacking [12, 17, 18] , leading to feelings of isolation, in particular for newly qualified NMPs[17].

The experience of prescribing was key for developing expertise, competence, and capability [12, 16, 19, 22]. NMPs who experienced a delay in putting their skills into practice and starting to prescribe resulted in a loss of confidence. At times, delays occurred due to local or national administrative processes required to obtain professional registration and authorisation to prescribe[18].

Newly qualified NMPs reported being fearful of making mistakes[12, 13, 17, 19, 20, 23 18], suggesting that they experienced a 'blame culture' within their workplace[19]. The anxiety associated with making mistakes was linked with increased accountability[12, 19], fear of liability[15, 18, 20]and litigation, particularly with respect to the perceived lack of legal protection practitioners had when working as an NMP[13, 18, 23]. This was further exacerbated by the excessive workload NMPs often had, which in turn was viewed as a risk factor when making difficult prescribing decisions [14, 17, 19] . Conversely, having appropriate clinic time meant that practitioners had enough time to assess and make appropriate prescribing decisions[13]. However, this was often not possible due to time pressures experienced in busy clinics[12, 16, 19] .

An additional area that newly qualified NMPs found challenging was establishing boundaries and expectations with colleagues and patients as to what they could prescribe[13, 16, 23]. A team approach to prescribing with support and encouragement from management, MDT, and doctors built NMPs confidence[12, 14, 17, 18, 22] and helped them to resist pressure from patients to prescribe[12, 16]. Peer support post- training [12, 13, 16, 18], including a buddy system and regular multidisciplinary continued professional development (CPD), was also found to have a positive impact on maintaining evidence-based medicines use[18].

**Theme iv) Sustainment and development**

Although benefits of NMP were clear, e.g., it provided improved access to healthcare [15, 17, 20, 21, 24] and better quality of care [20, 21] , there were still issues with developing and maximising NMP roles.

A lack of access to ongoing CPD to update and extend prescribing knowledge and remit was considered a barrier in the development and sustainability of NMP[12, 14, 19, 23] . This included the ability to keep up to date with evidence-based practice, including pharmacology, as well as regular updates on prescribing policy[12]. CPD that was offered to NMPs often lacked structure, with some NMPs not being able to access formal CPD and others turning to colleagues and peers for support[12, 23]. This was of particular importance in the context of expanding NMPs formulary[22]. NMPs who had completed specialist training were found to prescribe more items, from a wider range of medications [12].

The importance of governance and support for audit of prescribing practice was raised as a means to ensure transparency, accountability and safety of prescribing within areas of competence[18, 21]. Audit was also flagged as an important means to gather evidence on the cost-effectiveness NMP[18].

## 6.2 Review of literature on optometrist prescribing and additional supply

### 6.2.1 Study characteristics

Eleven articles including 8 empirical studies and 3 narrative reviews fulfilled inclusion criteria and were reviewed (see Table 4 and Appendix 5). However, due to the paucity of empirical studies identified, a relevant study outside published the review time was additionally included[25]. Empirical studies therefore included 7 quantitative studies, 1 qualitative study and 1 mixed-methods study. Quantitative designs included audits[26-28], national surveys[25, 29, 30], and 1 diagnostic agreement study [31]. Qualitative and mixed method studies employing interviews[32, 33], with the latter additionally employing focus groups and surveys [33].

Studies addressed community (n=3), acute eye hospital (n=2) and mixed community/hospital (n=4) optometry. Participants included optometrist independent prescribers (n=7 studies), non-prescribers (n=4), and relevant stakeholders including GPs, commissioners, and patients (n=2).

### 6.2.2 Focus of studies

Broadly categorised, studies focused on:

1. Auditing IP optometry service delivery [26-28]
2. Exploring views on extended prescribing [25, 30] and non-prescribing roles [33]
3. Describing prescribing practices [29, 31]
4. Identifying barriers and facilitators to OTP implementation [32].

### 6.2.3 IP service delivery

There was a lack of large UK national surveys which precluded overall estimate of IP adoption by the optometrist profession or enabled overview of the pattern of OTP service delivery. The literature was biased to community based optometry, with the majority of studies focusing on acute and/or chronic community/primary care ophthalmology services [26-29, 32], and fewer reporting optometrist IPs working in acute eye hospital services [29-32]. This is in contrast to Rumney's 2019 narrative reporting a bias in England to hospital uptake[34]. Estimates for Scotland (with analysis restricted to community-based optometrists proving eye examinations under the GOS) however suggested uptake of around 34%. Although overall studies reported an increase in the number of supplementary eye examinations undertaken within the community by optometrists since the 2012 Health & Social Care Act, there was no analysis indicating whether IP has facilitated/aided transfer of care to the community, although one study comparing pre-post lockdown figures estimated IP optometrist workload had increased by 20% following Covid-19. Studies looking at referrals from community optometrists to hospital eye

services reported a stable rate of around 4%, indicating 96% of patients could be independently managed to care completion by optometrist IPs, with one study asking optometrist IPs about referral patterns indicating that 20/39 qualified IPs (51%) believed they referred patients onwards less frequently post-IP [29].

### 6.2.4 Scope of IP practice

Data on scope of practice was restricted to prescribing frequency, drugs prescribed, independent case management (as above), referral sources, with some limited data on conditions managed by IPs. Loeffler found 87% of OTPs prescribed on a daily/weekly basis, amounting to prescription issue every 2 days, and a median of 10 prescriptions each month [29]. However, only 33% (n=18/54) of optometrists reported using a prescription pad to prescribe, with 33% (n=18/54) and 24% (n=13/54) indicating they requested prescribed medicines via a GP/ophthalmologist or used a written order. Asked their intentions to use IP to specialise in specific clinical areas, 75% (n=50) stated that they intended to or already had used IP to specialise in primary care conditions, with 61% (n=41/67) indicating glaucoma specialism. Although 40% of this sample of IPs (n=16) indicated that IP enabled them to manage conditions that they could not formerly address [29], there was no other data indicating how IP expanded scope of practice. One study presented clinical diagnostic agreement data for optometrists with standard reference to consultant ophthalmologist diagnosis/management, and although it addressed agreement in prescribing management, it did not provide finer details on prescribing or medicines management decisions related to IP skills [31]. However, the study identified 19 conditions which were considered as independently manageable by optometrist IPs.

### 6.2.5 Barriers and facilitators to optometrist IP implementation

Three empirical studies provided evidence of barriers and facilitators to OTP implementation including 2 cross-sectional surveys [25, 29] and 1 qualitative study [32]. Both surveys were conducted over a decade ago, either pre-legislation (and hence recruiting non-prescribers) [25], or in 2011 during early national adoption [29]. The latter recruited a mix of qualified OTPs (n=39) and those in part-training (n=21). IP pertained predominantly to community (independent and/or multiple practice) based optometrists (around 50%) with 20% [29] and 31% hospital based [32]. Studies collected data from Scottish, English and Welsh [29] and English and Welsh OTPs [32], with none reporting data from Northern Ireland. With only the recent study (set in England and Wales) focusing specifically on identifying factors to inform future implementation the contemporary empirical evidence base for implementation and its challenges is extremely limited.

Nevertheless, Spillane et al (2021)[35] and Loffler et al (2011)[36] identified a range of barriers to OTP, with some common challenges to implementation persisting over the review decade. Broadly categorised, barriers related to a) practitioner skills and motivation, b) training, c) organisational support and d) external/local policies.

a) Practitioner skills and motivation

IP was reported to be essential to hospital optometrist roles, proffered increased job satisfaction, enhanced professionalism and improved clinical autonomy and patient management [32]. Prior clinical experience and communication skills were deemed essential requisites, both to reinforce prescribing (and non-prescribing decisions), for patient treatment adherence and for holistic management [32]. Motivational deterrents to undertaking IP included lack of fair remuneration [25, 32] (a greater concern for independent optometrists, $p<0.001$[25]), a perception of increased workload (how workload increased was not fully elucidated), difficulty securing funding, fear of litigation, lack of time for training and costs incurred [25].

b) Training

From Loffler et al.'s 2011 survey (n=60 optometrists), satisfaction ratings for various components of OTP training were in general high, with 75% believing training was relevant and helpful to practice. However, 25% indicated they did not have adequate exposure to relevant clinical conditions/number of patients during training or had less opportunity for discussion of prescribing decisions with ophthalmologists. The main barriers to training were identified as difficulty finding a hospital clinical placement and the length of time it took for placement completion (38% took 6 months to 1 year).

c) Organisational support

Optometrists reported three main challenges to development of competence and prescribing scope of practice post NMP qualification: limited clinical caseload exposure, lack of availability of learning support and the constraints of College of Optometry practice guidelines [32]. In general, greater confidence was expressed by hospital optometrists, or those with access to support and/or IP peers, than those in community and/or independent settings. The latter reported isolation and less access to support channels. While College of Optometry clinical guidelines were a facilitator to early prescribing, they were perceived as draconian, outdated and at conflict with organisational clinical guidelines by more experienced optometrists. Overall, optometrists expressed strong desire for greater organisational input for continued professional development, including updates and targeted

educational events. Optometrists overall perceived the scope of prescribing practice as well as the utilisation of optometry IP in services was constrained by this lack of development opportunities.

d) External/local policies

Key policy/contractual limitations were a major barrier limiting the use and scope of community OTP with up to 50% of optometrists lacking access to prescription pads [29]. This required community OTPs to rely on private prescription issue in England (incurring patient costs) and/or GP referral for accessing medicines needs. Although OTP could in theory streamline and offset identified bottlenecks in medicines pathways for locally commissioned enhanced optometric services (as described by Baker et al (2016)), this lack of contractual agreement severely limited the ability to enact and engage in prescribing activities and hence develop and enhance services. It also restricted access to certain medicines which impeded equitable medicines access for community patients.

6.2.6 Summary of main findings

Overall, the review found a relative paucity of empirical work carried out on OTP within the past decade, with a tendency to small scale, local audit, and lack of national evaluation. As a result, there is limited knowledge and understanding about the current scope of OTP practice, its service delivery, and the challenges for national implementation. However, there was some evidence to suggest that barriers to implementation arise in four main areas including a) practitioner skills and motivation, b) training, c) organisational support and d) external/local policies, and that many are prevalent and unchanged over the past decade.

### 6.3 Conversations with key informants

There was agreement that Optometrists have a key role in supporting current government policy and transforming services to provide care that is safe and accessible close to home[37]. It was acknowledged that the knowledge and skills of optometrists mean that they are well placed to meet the needs of patients who present with acute and non-acute stable ophthalmology conditions, compared to services previously provided by general practitioners.

Discussion around the history and development of the General Optical Council provided an insight into some of the challenges experienced by the regulator over the past few decades. A number of difficulties arose from the historical association with the Royal College of Ophthalmologists. Concerns

were expressed about the GOC regulatory framework, comprising four professional groups, which currently bear little resemblance to original registration, and frustration regarding an apparent reluctance to modernise this aspect of the register by improving recognition of current practice, and associated nomenclature

There was evidence of some top-down resistance (at least initially) to OTP and a lack of support for autonomous practice from the Royal College of Ophthalmologists. Overall, there appeared to be a sense of resistance to change and a belief that OTP was somehow different to non-medical prescribing by the other professional groups e.g. nurse, pharmacists, and allied health professionals, although the basis for this understanding was not clear.

Conversations with the key informants focussed on a number of issues including: i) Strategic vision and commissioning for OTP services; ii) OTP preparation; iii) Supervised practice; iv) Undergraduate training; v) Early transition; vi) Long-term sustainability

6.3.1 Strategic vision and commissioning for OTP services

A lack of evidence exploring the benefits of OTP for patients and services limited understanding and appreciation of the value and potential scope of OTP in both primary and secondary care. This was thought to be hindered by the lack of recognition for different roles/ titles for OTP use within GOC and commissioned services. Despite the lack of evidence, and similarly to other professional groups of NMPs it was noted that OTP is more than just issuing a prescription. Eye conditions need to be considered holistically and this requires experience, knowledge, and skill. There also needs to be wider recognition of other decision making that requires prescribing skills, e.g., decision not to prescribe, deprescribing, and medicines optimisation activities. There were mixed views regarding how optometrists might align with HEE framework for Advanced Clinical Practice, and the potential opportunities this could offer to further extend optometrist scope of practice in new and innovative areas of practice.

OTP led services were reported to be very popular by GPs who were able to ensure access to care for patients within 36 hours. Patients prefer care that is provided closer to home, and commissioners value the fact that OTP is cheaper (90% of tariff cost) and helps reduce waiting lists.

Despite the popularity of OTP led services, different approaches to commissioning were evident across the devolved nations. The extent of commissioned services across the devolved nations varied, resulting in a wide range of service models. In England for example, service commissioning was patchy,

and lacked joined up thinking. Services had to adapt and follow the money over time. Examples of long-running and well established multi-disciplinary services were discussed, with reports of multiple NMPs working in teams providing services that had been responsive to Covid-19 challenges. The complexity of funding in England was highlighted and a need for local commissioners to be innovative, which had in some cases led to funding being drawn down from acute service budgets in the first instance.

In contrast, in Scotland and Wales, a strategic drive to invest in OTP models of care has resulted in OTP services as first contact, diverting patients from GP and from acute services. There is a current drive to support all primary care based optometrists to undertake IP training. Consequently, the Scottish government has allocated funds for IP training courses and placements, but not backfill. Similarly, in Wales there are commissioned IPOS (independent prescribing optometrist service (enhanced services)), to deal with a backlog of patients waiting to be seen with eye conditions. However, it was evident that are still some issues regarding spread and availability of OTPs who tend to be concentrated in urban rather than rural locations, leaving gaps in rural service provision. This is part of a shift from secondary to primary care optometry services in Wales called 'Transforming eye care in Wales', which has opened more opportunity for optometrist independent prescribing roles. More recently during 2021 a cohort of Optometrist IPs had been commissioned to undertake the theoretical component of the training by Health Education England, and commissioned practice placements in Northern Ireland were in the process of being introduced. Wales has similarly put in measures to increase the number of available placements.

Despite positive comments regarding OTP, concerns were expressed about ophthalmologists who appeared to be protecting their role and its potential erosion by OTP. Challenges were noted around the commercial aspects of Optometrist practice, many of whom were employed or self-employed in High Street Opticians, plus a lack of critical cases in primary care.

*6.3.2 Pre-course requisites*

Current guidance states that those wishing to undertake OTP must have a minimum of two years post-registration experience. Informants agreed that current undergraduate Optometrist curriculum and preparation is limited in its clinical component. There was agreement regarding a general desire to improve UG role preparation where, similarly to nurses, optometrists would be more 'prescribing ready' at initial registration or, that OTP became embedded into undergraduate preparation and initial registration.

*6.3.3 OTP preparation*

Mixed views on the adequacy of preparation for the OTP role were expressed amongst the key informants. Pre-course expectations regarding the role were felt to be adequate by course providers, but concerns were raised regarding how 'prescribing ready' OTPs were on qualification, and an apparent lack of awareness regarding the wider aspects of the NMP role e.g. prescription pad safety, and governance aspects of the OTP role.

Higher Education Institutes reported good success rates on the taught aspect of OTP preparation, which comprised blended learning, and commonly 45 credits at master's level. Assessments were reported to have a strong clinical focus e.g. MCQ, OSCEs, case scenarios, computer-based exams. In contrast to other NMPs there was no provision to assess numeracy @ 100% and or requirement to obtain 80% in a pharmacology-based exam. Upon completion of the practice element one course provider explained how OTPs can apply for Registered Prior Learning of clinical placement 15 credits so students can exit with a post-graduate certificate.

Current preparation for the OTP role is however fragmented and there is poor alignment between OTP standards, competencies and learning outcomes for OTP. Additionally, there is poor alignment between current OTP competencies and the RPS prescribing competency framework[38] which has been adopted by all other NMP professional groups.

The theoretical aspect of OTP is currently delivered only to optometrists, resulting in a lack of interprofessional learning compared to other NMP programmes, the majority of which are taught together. However, it was not clear if the different registration process for OTP meant that training needed to be separate as well. In contrast to other NMP programmes theoretical and practice-based components of OTP training are separate, leading to a potential disconnect between theory and practice, delays in obtaining practice hours and course completion. The disjointed approach and lack of joined up thinking between HEI providers and practice means no one person or organisation has oversite of the OTP preparation journey, with little opportunity for students or ophthalmologists undertaking the supervisory role to provide feedback, and or address any issues that may arise.

*6.3.4 Supervised practice*

Clinical placements, organised only at the point of completion of the theoretical component, are quite separate, and unaudited, resulting in a lack of quality assurance and there are no links between HEIs and placement providers. There is an over reliance on hospital-based systems to provide placements

for supervised practice. The prescriptive nature of clinical hours, where Ophthalmologists, in secondary care, are the only people who can provide this, has resulted in a large backlog of people waiting (>2,000) to undertake this aspect, and hence a delay in people registering as IPs. Additionally, there is a cost to students for OTP supervised practice placements many of whom are required to self-fund. As noted above, this is in contrast to other professional groups who routinely undertake supervised practice within their home organisation.

Suggestions to overcome the backlog included, aligning with other professional groups who have recently enabled any NMP to take on the role of practice assessor/ supervisors. The use of telometry was also suggested as way of addressing the need to develop clinical skills using a tablet device or split lamp linked up to Ophthalmologists, which was reported to has been successfully used in practice during the current pandemic.

*6.3.5 Early transition*

Completion of OTP training and registration is a lengthy process sometimes with more than 2 years between the taught element, supervised practice and the final exam. This resulted in long gaps before OTPs were in a position to prescribe, leading to potential deskilling, lack of prescribing confidence and implementation. The level of available support from HEIs, and practice supervisors to OTPs during this time was not clear. As with other NMPs, it was evident that a team approach enabled peer support and opportunities for multi-professional learning.

Initial governance procedures in some of the devolved nations were discussed and appeared robust in nature. However, the extent to which these are in place, particularly when providing a non-commissioned service, across the UK needs further exploration. Implementation of the OTP role was much easier when part of a commissioned service, providing access to prescription pads and a prescribing budget e.g. in NI, Wales and Scotland. In England where commissioned services are patchy, a lack of prescribing budget and pad were reported to hinder OTP practice, although the proportion of OTPs that this affects was not clear. There were mixed reports on the scope and frequency of prescribing practice, with some OTPs prescribing infrequently, for a narrow range of products, whereas others were quite prolific and prescribed across the formulary. Reasons for this variation in terms of scope and frequency are unknown and would benefit from further exploration.

There were mixed reports regarding the amount and type of formal and informal support for OTPs in practice. The majority of OTPs work in isolation, and concerns were raised about a lack of peer support and clinical supervision. Examples of good practice were mentioned including peer to peer support, a

'Whats App' group and regional OTP events. A lack of remuneration and or increased banding in recognition of IP status was reported and the approach to managing this inconsistent across the UK, with particular challenges noted in Wales.

*6.3.6 Long term sustainability*

There was agreement regarding the importance that OTP develops in a way that is responsive to wider changes in the NHS, patient needs and to manage long term sustainability. Examples of long-running services, where NMP was integral were discussed. Wider benefits of having an embedded service were highlighted including enhanced relationships in the local landscape, and improved referral systems in and out of the service. Similarly, the ability of commissioned services to adapt and continue during the pandemic, ensuring stable access to services for patients, provided further confirmation of a successful OTP commissioned service.

Frustrations were expressed regarding the regulatory requirement to record every prescribing decision, regardless of whether a prescription is issued, and for it to be available for inspection as an audit by the regulator that has no current mechanism to manage this process. A lack of CPD relevant to current practice and or NMP was also found to be frustrating. Knowledge and awareness of the various types of support available to other NMPs however appeared limited, and or how OTPs might engage with the wider body of NMPs across the UK through national NMP events and/ or the Association for Prescribers.

## 7 Discussion

This rapid review has systematically explored the evidence of barriers and facilitators to non- medical prescribing across all professions, including optometrist therapeutic prescribing along with conversations with key informants to identify key challenges and potential solutions. Given that non-medical prescribing is likely to be increasingly important for services to overcome predicted workforce deficits and inadequacies, this review is timely and of significant importance.

The results suggest a lack of joined up thinking which appears to have hampered advancement and improvement in relation to many aspects of the preparation, education and use of the prescribing role by OTPs. Evidence reporting benefits of OTP is limited but indicates that that OTP-led community services are able to manage the vast majority of the case load (96%) independently, with few referrals being made from these services to acute care[36]. There is evidence of isolation between OTPs and other professional groups who are NMPs. 'Silo' thinking, resulting in a lack of shared learning,

threatens to hamper the development of novel and advanced roles for OTP that are occurring in other NMP professions to meet the increasing demand for medication.

**Organisational level**

Issues were identified at a national/GOC level in terms of recognition of OTP scope and the leadership and support of developing innovative OTP roles. Concerns about role erosion and examples of resistance to NMP, in particular from the medical profession, have been long noted as a barrier to the acceptance and implementation of NMP [13-15, 19-22]. Indications from this review are that similar resistance exists with regards to OTP. Gaining acceptance and approval for OTP from key stakeholders and leaders is a crucial step towards uptake within an organisation and is also essential for supporting the implementation and individual development of NMPs throughout each stage. Negative views and concerns about NMP are known to dissipate once colleagues gain experience of working alongside NMPs, understand the benefits and have opportunity to develop a trusting relationship[39].

Discussion of advanced practice within optometry services was lacking, particularly non-clinical components such as leadership and research[40] . In other professions, the development of roles and agreement of competencies for advanced practice have coincided with the development of prescribing, and more recently the HEE ACP framework, providing[40] a backbone to career development and clinical pathways e.g., paramedics and physiotherapists. The alignment of prescribing with advanced clinical practice career development is a strong motivator for paramedics undertaking prescribing training[41].

Delays in organisational preparation to provide the infrastructure required to support NMP, such as access to a prescribing budget, prescribing pads and access to medical records were barriers experienced by OTPs [35, 36, 42]. Similar barriers reported by other NMPs [13-15, 17-20, 22]. Such problems are usually overcome once the first NMPs have become established in an organisation, however problems of accessing patient medical records and agreements to prescribe across primary care networks have been persistent barriers in community services[43]. A strategic approach to commissioning, as reported by key informants, can help facilitate the development and longevity of innovative service models, within which IP is key to providing care.

**Practitioner readiness**

Barriers and facilitators to undertaking NMP reported by optometrists are similar to those reported by other NMPs, in particular lack of remuneration, lack of funding and the time required to complete

NMP training[35, 36, 42] . Motivation to undertake NMP training, as reported by other NMPs, is primarily to gain the autonomy of practice to be able to improve patient care (e.g., by reducing waiting time and improving the quality of care [14, 18, 19, 22]. Where barriers are in place, as is the case with OTP access to prescribing pads or budget[35, 36, 42], the motivation to undertake training is reduced. A common secondary motivation is to improve job satisfaction and professional status [14, 19, 22]. These motivational aspects often win out over deterrents, such as lack of renumeration, time and effort to complete the course[14, 19, 21]. There is little information on the uptake of OTP but was reported as 34% in one study[44]. It is likely that barriers to OTP and additional complications such as payments for clinical practice placements, can act as deterrents that need to be addressed to promote uptake and implementation of the OTP role[35, 42] .

**OTP role preparation**

*Pre-course requisites*

There were mixed opinions regarding current guidance which states that those wishing to undertake OTP must have a minimum of two years post-registration experience. There is a lack of consensus within other regulators who have adopted different approaches to supporting uptake of the IP role. For example, recent regulatory changes have increased accessibility to independent/supplementary prescribing training for nurses as the requirement for post registration experience has been reduced from 3 to 1 years[45, 46]. Original policy supporting prescribing by allied health professionals, such as physiotherapist, podiatrists and paramedics [47, 48] however, recommended that only clinicians working at a highly skilled and specialist level, in a relevant clinical/service area should progress to independent prescribing, with at least 2-3 years post registration experience prior to undertaking the prescribing programme.

*OTP preparation*

Preparation for OTP is very different to all other groups of NMPs. OTP prescribing training is for example divided into three distinct stages (academic modules, practice-based learning, and final exam). This is in contrast with prescribing programmes for other NMPs who simultaneously undertake the taught component along with the required period of supervised practice. Practice-based learning which is integral to the prescribing programme is a Health and Care Professionals Council (HCPC) requirement [49] central to which is the integration of theory and practice[49]. Separation of these components may prevent consolidated learning in practice; a positive educational process that enable students to translate theory into practice. There is also a lack of alignment between prescribing standards set out by the GOC and those in the RPS Competency Framework for all Prescribers, adopted

by all the other professional groups who undertake NMP training[38]. This makes it difficult to compare OTP prescribing competencies with those of other NMPs in the UK. The taught component of OTP is uni-professional, and hence there is missed opportunity for multi-professional learning for OTPs and a lack of awareness amongst OTP HEI course providers of how other NMP programmes work. This prevents shared understanding of best practice in NMP education. By training together, NMPs from different professions gain mutual understanding of their professional roles, which can enhance communication and working across boundaries.

The restriction of practice-based learning to an acute ophthalmic care setting under the supervision of an ophthalmologist was reported to problematic in terms of availability and accessibility, creating a bottleneck in the availability of clinical placements. For those working in community settings, it was argued that low frequency of relevant clinical cases required to complete supervised practice could create further delays. The problem of a shortage of relevant clinical placements and problems accessing practice supervisors is not isolated to OTP and has been reported by other NMPs. Recent regulatory changes have allowed suitably qualified NMPs to undertake the role of practice assessor [45, 49, 50] , a role that previously could only be undertaken by a medical doctor or dentist, known as 'designated medical practitioner' (DMP). However, there was significant concern that limited availability of DMPs in some areas was acting as a barrier to those wishing to access training[51-53]. The growing workforce of experienced NMPs and a desire to make best use of their skills led to the regulatory changes outlined above[45].

It was found that there were few effective 'feedback loops' through which OTP course providers and practice-based educators could learn from student experiences, preparation for the prescribing role, or outcomes/success in practice or quality assure clinical placements., This is similarly in contrast to the HCPC, whose standards for prescribing set out the need for regular and effective collaboration between education providers and practice education providers.

There is a lack of clear justification for the differences between OTP educational and clinical standards for prescribing training and those of other NMP professions. From the little feedback that exists on OTP learning experiences, a quarter reported a lack of clinical exposure and support from practice educators[36] . Delays in initiating prescribing are known to reduce confidence[18] . The extended time between educational and practice components for OTPs may reduce confidence in prescribing practice and thereby reduce use of the qualification. Financial barriers deterring OTPs from undertaking practice placements also need to be considered.

**Early transition**

The extent to which NMPs use their qualification in practice is one indicator of the success of NMP implementation. However, it is important to capture the range of ways that prescribing knowledge can be used in addition to issuing prescriptions. For example, to acknowledge benefits of providing advice or information to patients on medication and deprescribing inappropriate medicine, and the longer-term cost implications of these actions[54]. Once qualified, the rate at which NMPs issue prescriptions, as highlighted by key informants, is known to vary enormously depending on the role and setting in which they work[43]. Those working in urgent and emergency services such as A&E and walk-in-centres tend to prescribe more frequently than NMPs in mental health, community nursing. Prescribing rates by OTPs[36] appear to be in line with average prescribing rates of other NMPs, which fall between 1-10 items per week. However, Loeffler et al.'s finding that 33% were referring patients to a GP for a prescription or using written orders suggests that barriers may be preventing greater use of prescribing, as found by Spillane et al 2021[35] .

**Ongoing sustainment and development**

Problems faced by OTPs over the long term include isolation, poor access to clinical supervision and CPD to support development of the prescribing role. These issues, as discussed by key informants, can be resolved, by schemes such as buddying [18], peer support [12, 13, 16, 18]and pan organisational provision for CPD[12, 14, 18, 19, 23] opportunities, and improved awareness of generic NMP study days and conferences, and support offered by the Association for Prescribers. Long term sustainability could be facilitated by more strategic approaches to service commissioning for OTP services, including robust service evaluation, to avoid instability, with services 'chasing the money' to survive.

## 7.,1 Limitations

This rapid review would have benefited from the input of a wider range of key informants including patients, OTP students, practicing OTP prescribers and ophthalmologists supervisors. As this was a rapid review, there was no assessment of the quality of included articles, however the review of NMP literature excluded reviews that did not follow a systematic process which is an indicator of quality. Furthermore, the timescale of literature included in these reviews reflects historical issues throughout the progression of NMP, some of which have since been addressed, such as provision of preparatory education on physical assessment and diagnosis prior to entering NMP programmes. The impact of changes, such as recent regulatory changes to NMP the practice supervision and assessment, have yet to be assessed. Literature on non-medical prescribing outside of the UK was excluded, limiting the international relevance of this review.

## 8 Further Research

The review indicates a number of issues related to OTP that may warrant further investigation. We recommend:

1) Evaluation on the uptake, use and impact of OTP on patient care and service delivery.
2) Exploration of the wider benefits of improved knowledge gained from OTP training on quality of care, safety and services provided by optometrist independent prescribers. This work should feed into commissioners and service leaders to inform future service development.
3) Evaluation of patient and carer views.
4) Evaluation of the appropriateness and effectiveness of OTP preparation.
5) Research into the medicines management activities of OTPs e.g. deprescribing, decision not to prescribe. This would help improve understanding regarding the true value of OTP with respect to patient outcomes and efficiency of care processes.
6) Research into the cost effectiveness of OTP.

## 9 Recommendations

These recommendations are designed to support OTP implementation by addressing reported challenges and building on good practice.

It is recommended that:

1. There is a need for review and alignment of current GOC standards for prescribing with those of other regulatory bodies i.e., HCPC, Nursing and Midwifery Council (NMC) and General Pharmaceutical Council (GPhC) and adoption of the RPS Competency Framework for all Prescribers.

2. Current professional preparation programmes are reviewed with respect to improving the integration of basic pharmacology within this provision and potential to revise existing pre-course requisites for Optometrists to have acquired 2 years post-registration experience prior to undertaking preparation for the OTP role.

3. There is a need to establish robust systems to capture data on OTP involvement in medicines management activities to support ongoing evaluation and clinical audit.

4. The use of the ACP framework to support Optometrist advanced clinical practice is reviewed in more detail with a view to providing guidance for clinicians with respect to developing innovative service models in primary and secondary care.

5. Those involved in OTP preparation should reconsider opportunities for shared learning with other groups of professionals undertaking NMP training.

6. There is a need to review current arrangements and provision for practice placements and consider alignment with recent changes adopted by other regulatory bodies and the newly introduced Competency Framework for Designated Prescribing Practitioners[55].

7. A national UK evaluation is required in order better understand uptake, scope and implementation of OTP and its impact on team configuration, costs and patient experience.

8. There is a need to review current governance arrangements, practical challenges associated with accessing prescribing budgets for non-commissioned services, and provision of CPD and support for OTPs who work in different practice settings.

## 10 Conclusion

This rapid review has identified similar barriers and facilitators that impact on the uptake and use of non-medical prescribing and optometrist therapeutic prescribing across different stages, from initial preparation through to long-term sustainability. A review of relevant literature on OTP, together with input from key informants, has highlighted key challenges along with potential solutions. While research evidence is limited, OTP has been positively received. There is however clear scope to further extend it OTP in order that its potential is fully realised.

A lack of joined up thinking appears to have hampered advancement in relation to many aspects of the preparation, education and use of the prescribing role by OTPs. Future development of OTP would benefit from greater strategic oversight and alignment with educational and governance procedures in place for other NMPs. Arrangements for practice placements require review to address bottlenecks in course completion and the impact this has on prescribing practice. Acknowledgement and support for novel and advanced roles for OTP may facilitate role development in line with other NMP professions. These changes are timely given the role of non-medical prescribing in improving service capacity to meet increasing demand for medication, especially considering current and predicted workforce deficits in primary and secondary care, particularly ophthalmology.

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## Tables

### Table 1: Additional prescribing roles

| Prescribing role | Role description | Training requirements | Prescribing access (As Prescription-Only Medicine) |
|---|---|---|---|
| Additional supply | Write orders for, and supply in an emergency, a range of drugs in addition to those which can be ordered or supplied by a normal optometrist according to CoO Formulary | 2 years post-registration experience<br>Taught educational course<br>Clinical placement hours (6 x 3-hour sessions)<br>Pass CoO Common Final Assessment | Acetylcysteine<br>Atropine Sulfate<br>Azelastine Hydrochloride<br>Diclofenac Sodium<br>Emedastine<br>Homatropine Hydrobromide<br>Ketotifen<br>Lodoxamide<br>Nedocromil Sodium<br>Olopatadine<br>Pilocarpine<br>Sodium Cromoglicate |
| Independent and supplementary prescribing (includes additional supply) | Take responsibility for clinical assessment of<br>patient, establish diagnosis and determine clinical management required (including prescribing where necessary) | 2 years post-registration experience<br>Taught educational course<br>Clinical placement hours (24 x 3-hour sessions)<br>Pass CoO Common Final Assessment | Any licensed, non-controlled medicine for ocular conditions, affecting the eye and adnexa, within the recognised area of expertise and competence of the optometrist. Drugs requiring injection excepted. |

**Table 2: Inclusion and exclusion criteria barriers and facilitators non-medical prescribing review of systematic reviews**

| Inclusion Criteria | Exclusion Criteria |
|---|---|
| ► Systematic reviews (with meta-analyses or meta-synthesis) | ► Literature and scoping reviews without documented transparent and replicable process |
| ► Qualitative, quantitative, and mixed methods systematic reviews | ► Primary research |
| ► Reviews addressing NMP (this includes NMIP by legislated non-doctor health care professionals, reviews addressing supplementary and/or collaborative models of prescribing) | |
| ►Reviews addressing NMP in primary/ community/secondary/mixed primary and secondary care | |
| ► Reviews presenting empirical evidence of barriers and/or facilitators to NMP implementation | |
| ► Peer reviewed, full text articles published between 01 January 2010 and 25 March 2021 | ► Abstracts, conference reports |
| ► Reviews published in English | ► Reviews published in non-English language |

**Table 3: Four stage, iterative process of data analysis**

| |
|---|
| **Stage 1:** In-depth reading and familiarisation with individual systematic reviews and data extraction.<br>**Stage 2:** Inductive line-by-line coding by one reviewer (SvE). Using NVivo 11 the reviewer created a codebook which included an overview of all the individual codes.<br>**Stage 3:** The individual codes were discussed with the full research team (NC, KS, MC, & JE). Wherever there was any lack of clarity or consensus about the naming of a code or the interpretation of a concept, this was discussed and where appropriate the coding was revised accordingly. Further to these discussions the reviewer (SvE) grouped the codes into descriptive themes. This codebook created in NVivo was applied to all papers.<br>**Stage 4:** Descriptive themes were organised into analytical themes (see Appendix 3). |

**Table 4: Inclusion criteria optometrist prescribing and additional supply review**

| Inclusion Criteria |
| --- |
| ►Primary and secondary empirical studies, abstracts, conference reports, literature reviews, reports |
| ►Studies employing any quantitative, qualitative or mixed methods design |
| ►Studies addressing non-medical prescribing (including supplementary and independent prescribing), medicines administration and/or supply undertaken by legislated optometrists |
| ►Studies addressing IP in any healthcare setting |
| ► Full text articles published between January 2010 and March 2021 in the English language |
| ►Studies undertaken in the United Kingdom |

**Figures**

**Figure 1: PRISMA flowchart of paper selection process for barriers and facilitators in non-medical prescribing review of systematic reviews**

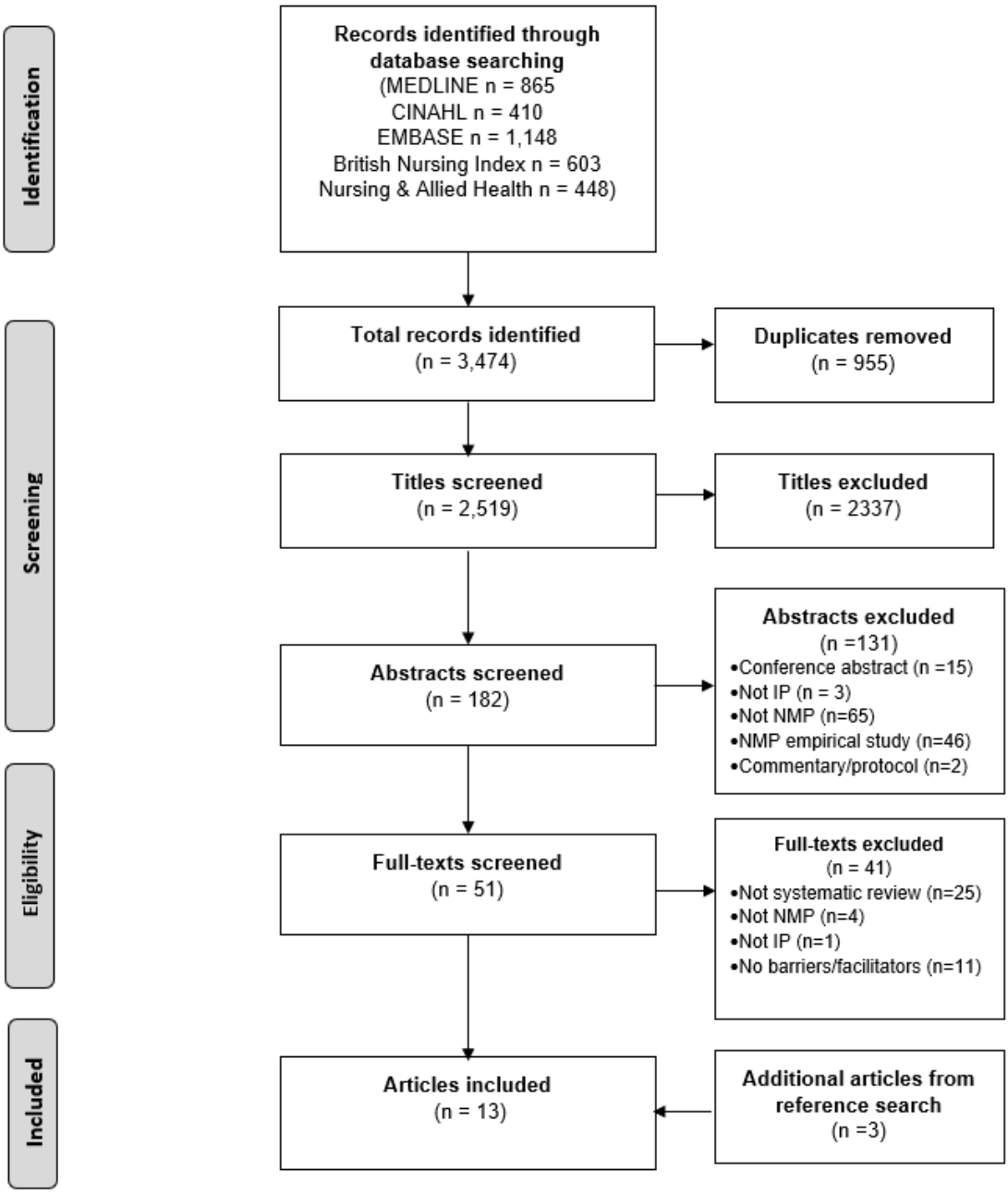
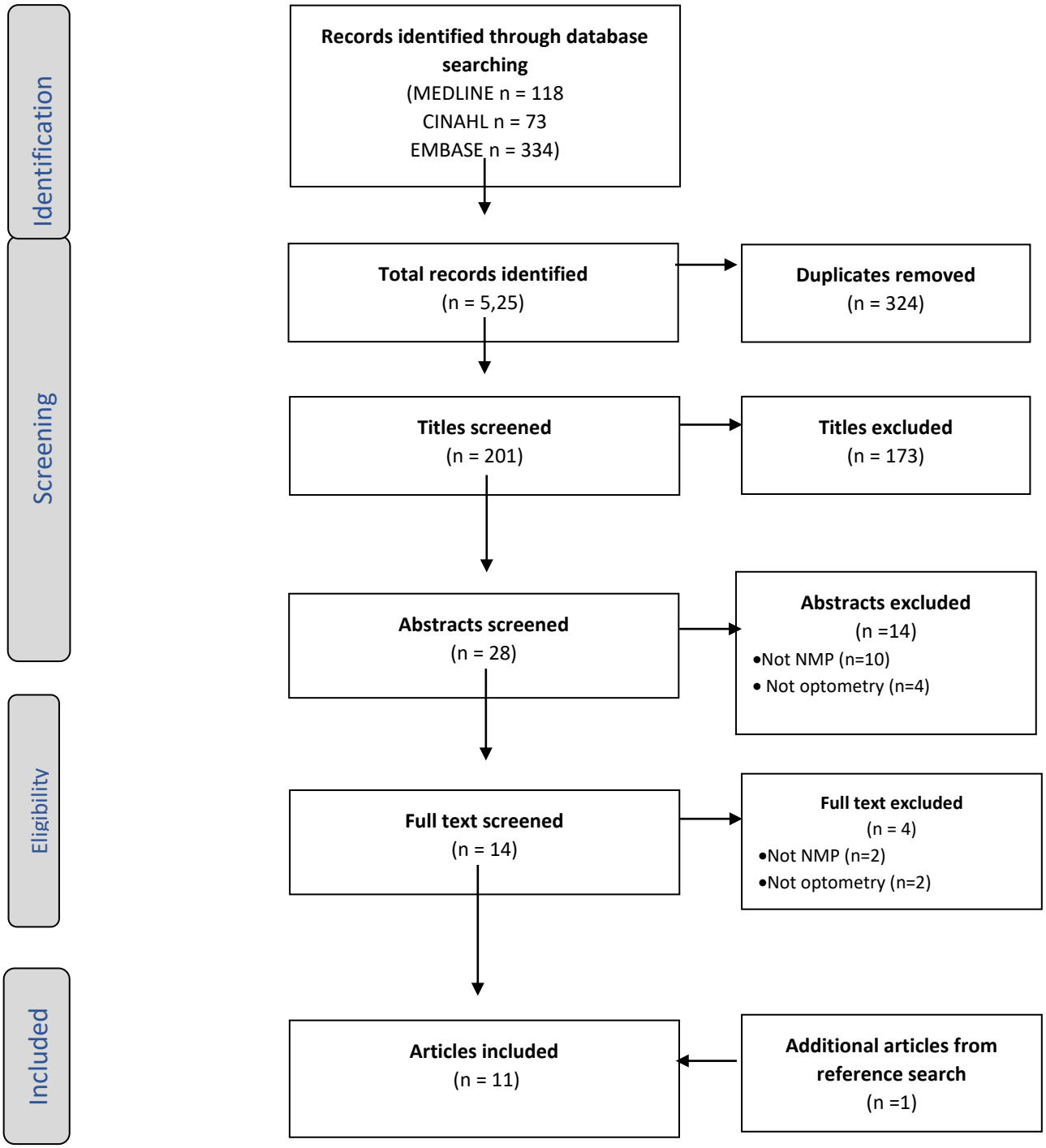


**Figure 2: PRISMA flowchart of paper selection process for optometrist prescribing and additional supply review**



## Appendices

### Appendix 1: Example search string for barriers and facilitators to non-medical prescribing

| | EBSCO host; CINAHL | |
|---|---|---|
| 1 | AB prescrib* OR TI prescrib* | 154,192 |
| 2 | AB independent prescrib* OR TI independent prescrib* | 510 |
| 3 | AB non-medical prescrib* OR TI non-medical prescrib* | 173 |
| 4 | AB patient group direction* OR TI patient group direction* | 260 |
| 5 | AB exemption* OR TI exemption* | 3,593 |
| 6 | AB medicine* exemption* OR TI medicine* exemption* | 20 |
| 7 | AB medicine* endorsement* OR TI medicine* endorsement* | 41 |
| 8 | AB standing order* OR TI standing order* | 884 |
| 9 | AB medicine* administration* OR TI AB medicine* administration* | 3,297 |
| 10 | AB medicine* supply OR TI medicine* supply | 904 |
| 11 | AB medicine* optimisation OR TI medicine* optimisation | 268 |
| 12 | AB medicine* management OR TI medicine* management | 5,024 |
| 13 | AB medication administration OR TI medication administration | 8,004 |
| 14 | AB prescribing right* OR TI prescribing right* | 152 |
| 15 | AB prescribing authority OR TI prescribing authority | 205 |
| 16 | OR/1-15 | 162,670 |
| 17 | AB nurs* OR TI nurs* | 462,694 |
| 18 | AB physiotherap* OR TI physiotherap* | 26,750 |
| 19 | AB physical therap* OR TI physical therap* | 30,633 |
| 20 | AB pharmacist* OR TI pharmacist* | 34,605 |
| 21 | AB (podiatr* OR chiropod*) OR TI (podiatr* OR chiropod*) | 3,293 |
| 22 | AB radiographer* OR TI radiographer* | 1,764 |
| 23 | AB (dietician* OR dietician*) OR TI (dietician* OR dietician*) | 1,770 |
| 24 | AB paramedic* OR TI paramedic* | 8,019 |
| 25 | AB optometr* OR TI optometr* | 4,888 |
| 26 | OR/17-26 | 560,565 |
| 27 | 16 AND 26 | 14,369 |
| 28 | AB nurse N3 prescrib* OR TI nurse N3 prescrib* | 1,599 |
| 29 | AB pharmacist N3 prescrib* OR TI pharmacist N3 prescrib* | 1,261 |
| 30 | AB physiotherap* N3 prescrib* OR TI physiotherap* N3 prescrib* | 162 |
| 31 | AB paramedic* N3 prescrib* OR TI paramedic* N3 prescrib* | 10 |
| 32 | AB podiatr* N3 prescrib* OR TI podiatr* N3 prescrib* | 23 |
| 33 | AB dietician* N3 prescrib* OR TI dietician* N3 prescrib* | 6 |
| 34 | AB dietitian* N3 prescrib* OR TI AB dietitian* N3 prescrib* | 32 |
| 35 | AB radiograph* N3 prescrib* OR TI radiograph* N3 prescrib* | 97 |
| 36 | AB optometr* N3 prescrib* OR TI optometr* N3 prescrib* | 62 |
| 37 | OR/20-28 | 3,148 |
| 38 | 19 OR 29 | 14,483 |
| 39 | (MM "Systematic Reviews as Topic") | 8,923 |
| 40 | AB systematic review* OR TI systematic review* | 207,733 |
| 41 | AB scoping review* OR TI scoping review* | 8,579 |
| 42 | AB realist review* OR TI realist review* | 472 |
| 43 | AB "literature review*" OR TI "literature review" | 358,083 |
| 44 | AB "rapid review*" OR TI "rapid review" | 3,135 |
| 45 | AB meta-synthesis OR TI meta-synthesis | 1,002 |
| 47 | AB metasynthesis OR TI metasynthesis | 361 |
| 39 | AB "qualitative review*" OR TI "qualitative review*" | 7,633 |

## Appendix 2: Summary of barriers and facilitators to non-medical prescribing

| Authors | Aims/objectives | Number of papers included | Time frame | Model of prescribing | NMP profession | Care setting | Main findings |
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| Abuzour (2018) | To explore whether McLellan et al.'s (2012) theory of expertise development model - true competence in prescribing demands expertise, regardless of the simplicity of the task at hand-<br>is applicable to iNMP and to assess the factors underpinning expertise development reported in the literature. | 34 | 2006-2016 | Independent prescribing | Pharmacists & nurses | Primary, secondary, & tertiary care | Focused on transition of prescribing into practice.<br><br>Knowledge, pre-registration education, experience, support and confidence were some of the intrinsic and extrinsic factors influencing IPs.<br><br>Difficulty in transferring theory to practice due to lack of basic pharmacology and bioscience content in pre-registration nursing rather than the prescribing programme.<br><br>Students saw interventions using virtual learning or learning in practice as more useful with long-term benefits.<br><br>IPs were able to develop their expertise when integrating their competencies in a workplace context with support from colleagues and adherence to guidelines. |

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| Chater (2020) | To identify what evidence exists regarding the influences of NMPs antimicrobial prescribing behaviour and analyse the operationalisation of the identified drivers of behaviour using the Theoretical Domains Framework (TDF). | 8 | All relevant papers published up to July 2019 | Independent prescribing | Mixed | Not specified | Review aimed to identify what evidence exists regarding the influences on NMP's antimicrobial prescribing behaviour and analyse the operationalisation of the identified drivers of behaviour using the Theoretical Domains Framework (TDF).<br><br>Key issues centred around strategies for managing challenges experienced during consultations, managing patient concerns, peer support and wider public awareness of antimicrobial resistance. The two most common TDF domains highlighted as influences on prescribing behaviour, represented in all studies, were social influences and beliefs about consequences. |
| Cleary (2017) | To identify and summarize qualitative research that focussed on mental health nurse prescribing, synthesize findings, and outline key themes discerned. | 12 | Not specified | Independent & supplementary prescribing | Mental health nurses | Not specified | Three general themes were identified: (i) patient-centred care; (ii) professional role; and (iii) professional support. Nurse prescribers embrace a patient-centred approach, providing timely and effective medication management. Adequate education and continuing professional development inclusive of clinical supervision enable competency development in nurse prescribing, supportive professional relationships, and patient safety. |
| Darvishpour (2014) | This review aims to combine and interpret existing literature reviews and systematic studies to obtain new insights on nurse prescription. | 11 | No time limitation used | Independent & supplementary prescribing | Nurses | Primary & secondary care | Eight themes were identified: leading countries in prescribing (i.e., the UK), positive views on nurse NMP, features (i.e., prescribing patterns, areas of nurse prescribing, confidence in prescribing and quality and safety of practice), infrastructures, benefits (i.e. for health system, patients and nurses), disadvantages (additional work, safety concerns), facilitators (educational factors, managerial factors, organisational factors) and barriers (legal limitations, executive factors, humanistic factors, educational deficiencies and, research weaknesses) of nursing prescription. |

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| Djerbib (2018) | The aim of this review is to discover and understand the factors that influence prescribing decisions made by iNMP nurses in primary care. | 10 | 1994 - July 2016 | Independent & supplementary prescribing | Nurses | Primary care | A total of 14 common descriptive themes were identified across the papers included in the review. These were further analysed and gave rise to three interpretative themes: perception of confidence, perception of risk and impact on the patient. Appropriate education and training are pivotal in improving prescribers' competence, reducing risk and preventing harm to patients. |
| Graham-Clarke (2017) | The aim of this review is to evaluate the use of, as well as facilitators, and barriers of independent non-medical prescribing in primary and secondary care in the UK. | 42 | 2006 - 26 March 2017 | Independent prescribing | Mixed | Primary & secondary care | This systematic review & thematic synthesis focused on b & f's of NMP - please note that the authors argued that each theme and subtheme could act as a barrier or facilitator depending on the circumstances:<br>a. Where there was a lack of understanding on NMP role, or lack of trust in the individual NMP, then the factors were more inclined to be barriers.<br>b. For example, medical professionals were less likely to support NMP where there was a lack of clarity about who took responsibility for the prescribing practice.<br>c. Because of budgetary constraints factors may become barriers, such as the use of restrictive formularies as a cost saving measure.<br>d. Themes and subthemes do not stand in isolation, but are interdependent on each other |
| Jebara (2018) | The aims of this systematic review are to: (1) critically appraise, synthesize and present the available evidence on the views and experiences of stakeholders on pharmacist prescribing and (2) present the perceived facilitators and barriers for its global implementation. | 65 | No date limit until November 2017 | Independent & supplementary prescribing | Pharmacists | Primary care, community, & secondary care | The main benefits were ease of patient access to healthcare services, improved patient outcomes, better use of pharmacists' skills and knowledge, improved pharmacist job satisfaction, and reduced physician workload. The main barriers were pharmacists' skills (clinical examination and diagnostic skills), resources (workforce, access to medical records, space, time), physicians and organisational support, funding, legal aspects (accountability, conflict of interest), pharmacy practice recognition. |

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| McIntosh (2016) | To critically appraise, synthesize and present evidence on the influences on prescribing decision-making among supplementary and independent NMPs in the United Kingdom. | 3 | 2003 - June 2013 | Independent & supplementary prescribing | Mixed | Primary care | Regarding prescribing decision-making, complex influences were evident such as experience in the role, the use of evidence-based guidelines and peer support and encouragement from doctors; these helped NMPs to feel more knowledgeable and confident about their prescribing decisions. Opposing influences included prioritisation of experience and concern about complications over evidence base, and peer conflict. |
| Mills (2020) | To explore the views, opinions, and attitudes of pharmacists and graduates towards non-medical prescribing. | 14 | January 2003 - September 2017 | Independent & supplementary prescribing | Pharmacists | Primary care & community setting | NMP was considered a natural extension to the role of a pharmacist despite difficulties in completing the required training. The ability to then prescribe was dependent on funding and access to medical records, time, and support staff. Pharmacists experienced professional rivalry with both support and resistance from members of the primary care team. The provision of training was frequently referred to as unsatisfactory. Pharmacists were motivated to prescribe, deriving increased job satisfaction and a sense of professionalism; however, they often felt underprepared for the reality of unsupervised practice. Furthermore, pharmacists reported a cautious approach with a fear of making errors frequently discussed. |
| Noblet (2017) | To explore the factors that affect the implementation or utilisation of independent non-medical prescribing (iNMP)? | 43 | 2001-2011 | Independent prescribing | Mixed | Primary, secondary, & specialist care | Qualitative studies identified barriers and facilitators to non-medical prescribing in political/ organisational factors; whether a formulary is used; education and support; personal and professional factors among the medical profession, other professions, and service users; and financial factors. Quantitative studies confirmed these factors. |

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| Nuttall (2018) | To develop an understanding of the existing theoretical perspectives around nurse prescribing and to identify any gaps in knowledge which would support further research into the lived experience of the nurse prescriber in the primary care setting. | 37 | 1999-24 April 2015 | Independent & supplementary prescribing | Nurses | Primary care | Nine themes were identified: patient-centred care; benefits to the service; the need for knowledge (particularly pharmaceutical); professional accountability and boundary-setting; safety consciousness; barriers to effective prescribing (e.g., lack of access to training, lack of support); role-preservation; power-shifts and interprofessional relationships and culture of prescribing. |
| Poh (2018) | To synthesize the best available evidence on the safety and effectiveness of pharmacist prescribing on patient outcomes in patients who present to hospital. | 15 | Until 24 January 2017 (from database inception?) | Independent & supplementary prescribing | Pharmacists | Secondary care | This review explored the impact of pharmacist NMP on patient outcomes in a hospital setting.<br><br>It provided low to moderate evidence that pharmacists could prescribe to the same standards as doctors. Pharmacists were better at adhering to dosing guidelines when prescribing by protocol and made significantly fewer prescribing errors when charting patients' usual medications on admission to hospital. |
| Stenner (2018) | To systematically review physiotherapy and podiatrist prescribing and medicines management activity, including evidence of impact on patient care, levels of knowledge and attitudes towards extended medicine's role. | 21 | January 1985 - May 2016 (physiotherapy) + January 1968 - May 2016 (podiatry) | Independent & supplementary prescribing | Physiotherapists & Podiatrists | Primary & secondary care | This review focused on physiotherapist and podiatrist NMP.<br><br>No studies were identified that specifically evaluated prescribing by physiotherapists or podiatrists and no studies relating specifically to podiatry met the inclusion criteria.<br><br>Four main themes were identified in the data relating to physiotherapy: 1. Extent of involvement in medicines advice or administration; 2. Knowledge levels and training needs relating to role in medicines management or advice; 3. Attitudes towards physiotherapist prescribing or extended medicines role; 4. Care outcomes and costs. |

**Appendix 3: Overview of barriers and facilitators to non-medical prescribing**

| Analytical themes | Barriers | Facilitators |
|---|---|---|
| 1a. Preparatory stage -<br><br>Organisational readiness | • No local legislation and policies in place (Noblett 2017; Stenner 2018)<br>• Administrative processes are long and arduous and can lead to delay in practicing (Noblett 2017)<br>• Restrictive formularies are used as a cost saving measure (Graham-Clarke 2018)<br>• Lack of agreement regarding budgetary arrangements (Noblett 2017)<br>• No access to prescription pads (Darvishpour 2014; Mills 2020; Noblett 2017; Nuttall 2018)<br>• No access to medical records (Chater 2020; Graham-Clarke 2017; Jebara 2018; Mills 2020; Noblett 2017; Stenner 2018)<br><br>1. Lack of space and time to prescribe (Jebara 2018; Mills 2020; Noblett 2017; Nuttall 2018):<br>2. No access to private consultation rooms (Jebara 2018)<br>3. Issues with confidentiality regarding accessing patients' medical records (Jebara 2018)<br><br>• Formulary limitations making scope of what NMPs can prescribe too restrictive (Darvishpour 2014; Djerbib 2018; Graham-Clarke 2017; Noblett 2017; Nuttal 2018)<br>• Lack of strategic vision (Djerbib 2018; Graham Clarke 2017; Noblett 2017)<br>• Perceived lack of need for NMP (Mills 2020)<br>• Lack of management and MDT support (Abuzour 2017; Cleary 2017; Mills 2020; Nuttall 2018) | • Clear local NMP policies, guidelines, and protocols in place (Chater 2020; Djerbib 2018; Graham-Clarke 2017; McIntosh, 2016; Noblett 2017; Nuttall 2018; Poh 2018)<br>• Scope of prescribing agreed by Drug Therapeutic committees and a prescribing budget identified (Noblett 2017; Graham-Clarke 2017)<br>• Regular review and updates of policies and formularies (Cleary 2017; Noblett 2017)<br>• A strong pro-NMP leadership (Graham-Clarke 2017; Nuttall 2018)<br>• MDT and doctors understand and appreciate NMP (Cleary 2017; Graham-Clarke 2017)<br>• Acceptance and positive attitudes towards NMP (Cleary 2017; Darvishpour 2014; Jebara 2018; Noblett 2017)<br>• Funding to optimise the workforce (Darvishpour 2014; Jebara 2018; Mills 2020)<br>• Formal support mechanisms, including (clinical) supervision in place (Chater 2020; Cleary 2017; Nuttall 2018)<br>• MDT and doctors support NMP (Cleary 2017; Darvishpour 2014; Jebara 2018; McIntosh 2016; Mills 2020; Nuttall 2018; Stenner 2018) |

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| | • Lack of regular (clinical) supervision (Cleary 2017)<br>• Lack of mentoring support (Mills 2020)<br>• Ambiguity around NMP roles led to lack of clarity regarding professional and legal boundaries (Darvishpour 2014; Cleary 2017; Graham-Clarke 2018; Nuttall 2018)<br>• Poor communication networks (Abuzour 2017; Graham-Clarke 2017)<br>• Role dissonance from doctors (Chater 2020; Cleary 2017; Darvishpour 2014; Graham-Clarke 2017; Jebara 2018; McIntosh 2016; Mills 2020; Noblett 2017; Nuttall 2018, Poh 2018; Stenner 2018) and from colleagues (Mills 2020) | |
| 1b. Preparatory stage -<br><br>Practitioner readiness | • Inadequate pre-training knowledge of pharmacology and numeracy (Abuzour 2018; Noblett 2017)<br>• Added responsibility is perceived as a deterrent (Abuzour 2018; Mills 2020)<br>• Lack of financial renumeration (Cleary 2017; Graham- Clarke 2017; Noblett 2017; Nuttall 2018)<br>• Time and cost of completing course prerequisites (Noblett 2017)<br>• Lack of funding for training (Graham-Clarke 2018; Noblett 2017) | • An increased sense of autonomy (Darvishpour 2014; Graham-Clarke 2018; Noblett 2017; Nuttall 2018)<br>• Making better use of existing skills and expertise practitioners (Darvishpour 2014)<br>• Helps with professional development and increases clinical competence (Abuzour 2017; Darvishpour 2014; Graham-Clarke 2018; Nuttall 2018)<br>• Professional satisfaction (Cleary 2017; Darvishpour 2014; Graham-Clarke 2018; Jebara 2018; Mills 2020; Noblet 2017; Nuttall 2018) |
| 2. Training | • NMP training is inadequate (Chater 2020; Cleary 2017; Darvishpour 2014; Mills 2020), due to lack of:<br>1. Applied pharmacology (Abuzour 2018; Darvishpour 2014; Djerbib 2018; Noblet 2017; Nuttall 2018; Stenner 2018)<br>2. Bioscience (Abuzour 2018)<br>3. Advanced clinical activities training (Abuzour 2018; Darvishpour 2014; Cleary 2017; Djerbib 2018; Jebara 2018; Mills 2020; Poh 2018) | • Multi-faceted mixed methods approach to teaching students how to prescribe (Abuzour 2018)<br>• Pedagogical methods (e.g., podcasts and virtual patients) (Abuzour 2018)<br>• Identify learning needs of students, e.g., repetition of key concepts and applying knowledge in the workplace (Abuzour 2018) |

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| | • Difficulty finding DMPs and/or mentors (Abuzour 2018; Noblett 2017)<br>• Lack of peer and professional support during training (Graham-Clarke 2018)<br>• Lack of quality supervision during training (Stenner 2018)<br>• Time and course commitments make completing NMP training challenging (Graham-Clarke 2017; Mills 2020) | |
| 3. Transition – post-training | • Lack of confidence (Abuzour 2018; Chater 2020; Darvishpour 2014; Djerbib 2018; Graham-Clarke 2017; McIntosh 2016; Nuttall 2018; Stenner 2018)<br>• Delay in obtaining authorisation to practice as NMP after qualifying can mean that practitioners lose confidence<br>• Fearful of making mistakes (Abuzour 2017; Chater 2020; Djerbib 2018; Mills 2020; Noblett 2017; Nuttall 2018; Stenner 2018)<br>• Anxiety is associated with (increased) accountability (Abuzour 2017; Nuttall 2018)<br>• Fear of liability (Jebara 2018; Noblett 2017; Stenner 2018) and litigation (Chater 2020; Djerbib 2018; Noblett 2017)<br>• Lack of legal protection (Chater 2020; Djerbib 2018; Noblett 2017)<br>• Time pressure and excessive workload (Abuzour 2018; Graham-Clarke 2018; Mills 2020; Nuttall 2018)<br>• Lack of support by management and MDT (Abuzour 2018; Graham-Clarke 2018; Noblett 2017)<br>• Lack of peer support (Noblett 2017)<br>• No adequate supervision post-training (Noblett 2017)<br>• Feelings of isolation (due to lack of support) (Mills 2020) | • Increasing expertise, competence, and capability by gaining experience of prescribing (Abuzour 2018; Darvishpour 2014; McIntosh 2016; Nuttall 2018)<br>• Having enough time to make prescribing decisions (Chater 2020)<br>• A team approach to prescribing (Abuzour 2018; McIntosh 2016)<br>• Adequate support from management (Graham-Clarke 2017), MDT and doctors helped build NMPs' confidence (Abuzour 2018; Darvishpour 2014; Noblett 2017)<br>• Peer support post-training (Abuzour 2018; Chater 2020; McIntosh 2016; Noblett 2017) |

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| | • Problems with setting boundaries with patients (Chater 2020; Djerbib 2018; McIntosh) | |
| 4. Development and sustainability | • Difficulty accessing formal CPD (Abuzour 2018; Djerbib 2018; Graham-Clarke 2018; Nuttall 2018)<br>• Lack of structure in CPD (Abuzour 2017; Djerbib 2018)<br>• Need for adequate and up-to-date knowledge not met (Abuzour 2018; P 2020; Nuttall 2018) | NMP has lots of benefits:<br>• Improved access to healthcare (Cleary 2017; Jebara 2018; Darvishpour 2014; Mills 2020; Poh 2018; Stenner 2018)<br>• Better quality of care (Darvishpour 2014; Cleary 2017; Stenner 2018)<br>• NMPs who had completed specialist training prescribed more items from a wider range of medications (Abuzour 2017) |

## Appendix 4: Example search string for OTP

| | EBSCO host; MEDLINE/CINAHL | |
|---|---|---|
| 1 | (MM "Family Practice") | 42, 101 |
| 2 | (MM "Primary Health Care") | 51,956 |
| 3 | (MM "Physicians, Family") | 11,166 |
| 4 | (MH "Community Health Nursing") | 19,631 |
| 5 | (MH "Community Health Workers") | 5,455 |
| 6 | (MH "Community Health Services") | 31,960 |
| 7 | (MH "Community Health Centers") | 117, 681 |
| 8 | TI (community N1 health) OR AB (community N1 health) | 41, 115 |
| 9 | TI (community N1 care) OR AB (community N1 care) | 13,480 |
| 10 | TI (community N1 clinic) or AB (community N1 clinic) | 3,944 |
| 11 | TI (primary N1 health) OR AB (primary N1 health) | 28,106 |
| 12 | TI (primary N1 care) OR AB (primary N1 care) | 137,751 |
| 13 | TI (general N1 practice*) OR (AB general N1 practice*) | 45,372 |
| 14 | TI (general N1 practitioner*) OR AB (general N1 practitioner*) | 53,331 |
| 15 | TI (family N1 practice*) OR AB (family N1 practice*) | 10,889 |
| 16 | TI (family N1 practitioner*) OR AB (family N1 practitioner*) | 2,941 |
| 17 | TI (gp N1 practice*) OR AB (gp N1 practice*) | 2,042 |
| 18 | TI (gp N1 service*) OR AB (gp N1 service*) | 428 |
| 18 | TI (gp N1 clinic*) OR AB (gp N1 clinic*) | 336 |
| 19 | (MM "Secondary Care") | 373 |
| 20 | TI (secondary care) OR AB (secondary care) | 12,642 |
| 21 | TI hospital* OR AB hospital* | 1,314,737 |
| 22 | TI acute care OR AB acute care | 39,857 |
| 23 | TI outpatient* clinic* OR AB outpatient* clinic* | 44,771 |
| 24 | TI ambulatory care OR AB ambulatory care | 14,090 |
| 25 | TI outpatient service* OR AB outpatient service* | 8,357 |
| 26 | TI outpatient care OR AB outpatient care | 16,227 |
| 27 | TI health centre* OR AB health centre* | 41,779 |
| 28 | TI health center* OR AB health center* | 17,060 |
| 29 | TI walk in centre* OR AB walk in centre* | 173 |
| 30 | TI residential care OR AB residential care | 5,783 |
| 31 | TI day centre* OR AB day centre* | 2,032 |
| 32 | TI long term care OR AB long term care | 29,507 |
| 33 | OR/1-32 | 518,224 |
| 34 | TI prescrib* OR AB prescrib* | 151, 614 |
| 35 | TI independent prescrib* OR AB independent prescrib* | 501 |
| 36 | TI non-medical prescrib* OR AB non-medical prescrib* | 205 |
| 37 | TI supplementary prescrib* OR AB supplementary prescrib* | 123 |
| 39 | TI dependent prescrib* OR AB dependent prescrib* | 239 |
| 39 | TI collaborative prescrib* OR AB collaborative prescrib* | 97 |
| 40 | OR/34-41 | 155,308 |
| 41 | TI nurs* OR AB nurs* | 979,276 |
| 42 | TI physiotherap* OR AB physiotherap* | 26,282 |
| 43 | TI physical therap* OR AB physical therap* | 30,126 |
| 44 | TI pharmacist* OR AB pharmacist* | 34,045 |
| 45 | TI (podiatr* OR chiropod*) OR AB (podiatr* OR chiropod*) | 3,264 |
| 46 | TI radiographer* OR AB radiographer* | 1,730 |
| 47 | TI (dietician* OR dietician*) OR AB (dietician* OR dietician*) | 1,733 |
| 48 | TI paramedic* OR AB paramedic* | 7,872 |

## Appendix 5 Summary of barriers and facilitators to OTP

| Author | Title | Aim | Design | Setting | Sample | Findings | Barriers/ facilitators |
|---|---|---|---|---|---|---|---|
| Ansari 2021 England | *Acute Community Ophthalmology Services Provided by Independent Prescribing Optometrists Supporting Hospital Eye Services during the COVID-19 Outbreak. Journal of Optometry 2021* | Describe re-organisation of emergency eye services in Kent. | Audit pre/post Covid-19 | Acute Primary Care Ophthalmology Service (APCOS) | n=1032 cases seen by APCOS January-June 2020. | Transfer of referral/ care from hospital to community with introduction of Acute primary Care Ophthalmology services (with optometrist IP). | No barriers/facilitators or data relevant to implementation |
| Baker 2016 England | *Multi-stakeholder perspectives of locally commissioned enhanced optometric services* | To explore views of stakeholders regarding operation of community-based enhanced optometric services (including IP). | Qualitative study using mixed methods | Minor eye conditions scheme (MECS) and glaucoma referral refinement scheme (GRRS) provided by accredited community (non-IP) optometrists. | 189 patients<br>25 community optometrists (non-IP)<br>4 glaucoma specialist hospital optometrists (non-IP)<br>5 ophthalmologists<br>6 GPs<br>4 commissioners. | Inability to prescribe resulted in re-referral to GP, multiple consultations. Service pathway bottle necks, lack of service streamlining. Suggested PGDs may overcome. | entified clinical/service need for prescribing, and service gap |
| El-Abiary 2020 Scotland | *Assessing the effect of Independent Prescribing for community optometrists and referral rates to Hospital Eye Services in Scotland* | Determine distribution of IP optometrists and associated hospital referral rates across Scotland. Assess impact of IP on referral rates into Hospital Eye Service since 2010. | Audit | Service data on community optometry visits and outpatient hospital attendances 2010-2019 | 278 /1189 (23.4%) community optometrist IPs in Scotland | • 23% optometrists hold IP<br>• Strong positive correlation between location of IP optometrists and population served.<br>• No association between number of IPs and referral to Hospital Eye | • Uptake of IP higher in population dense areas; limited uptake in rural areas |

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| | | | | | | Services, i.e. no impact of IP on referral rates. | |
| Golash 2021<br>England | *Specialised Independent Prescribing Optometrists Delivering a Community Shared-Care Glaucoma Service: A Pilot Study* | Contribution of IP to stable glaucoma and ocular hypertension (OHT) | Retrospective service audit | Community Ophthalmology Team - shared care scheme run by specialised IP optometrists for stable glaucoma and ocular hypertension (OHT) | N=2 optometrist IP<br>N=80 patients (157 eyes) | • Community follow-up of stable glaucoma and ocular hypertension by IP optometrists was safe, with stability of disease maintained and few referrals back to HES | • IP enabled independent care episode completion<br>• No barriers or facilitators |
| Harper 2015<br>UK wide | *Scope of practice of optometrists working in the UK Hospital Eye Service: a national survey* | Describe results of national survey on scope of practice of UK hospital optometry. | Cross-sectional survey – hospital eye service optometrists | 70 hospital eye service units/departments (N = 60, 86% in England), | N=67/70 (96%) HES stated included optometrists in extended roles.<br>N=32 (48%) in IP roles | 83% used GP prescriptions<br>48% used IP formulary<br>14% used PGD<br>8% requested via GP<br>1 (<2%) SP | • Availability of medical support underpins extended role activity; 33% clinics always require medical input.<br>• Calls for national qualifications in specialist areas of practice |
| Loffler 2011<br>UK wide | *Therapeutic prescribing for optometrists: an initial perspective prescribing for optometrists: an initial perspective* | Describe impact of the IP by therapeutic optometrists on practice. | Cross-sectional survey (1 HEI) | 32 (53%) community<br>20% hospital<br>27% mixed community/hospital. | n=60 optometrists who had completed theoretical training for IP qualification. | 47 (78%) completed clinical placement;<br>39 (65%) passed common final assessment.<br>92% improved confidence with diagnosis & management.<br>75% regarded IP helpful for practice (rating ≥8 scale 1-10.<br>93% would recommend IP.<br>87% prescribing at least weekly | 70% prescribed via GP, ophthalmologists, or OTC.<br>50% no access to FP10. |

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| | | | | | | (median 10/month). | |
| Needle 2009 UK wide | *A survey of the scope of therapeutic practice by UK optometrists and their attitudes to an extended prescribing role* | Investigate clinical practices in ocular disease management within UK optometrists, elicit views on extended prescribing roles. | Cross-sectional survey | 90% community. | N= 1288 members of the College of Optometrists. | 8% respondents in training for extended prescribing role (additional supply or supplementary prescribing) | Describes conditions treated with IP, prescribing rates, views about training, confidence levels, patient satisfaction. 51% referring less patients to secondary care; 41% reported no noticeable difference in referring behaviour |
| Rough 2017 | *The challenges of rural optometry and how independent prescribing has helped* | Narrative on role of IP in rural optometry | Narrative | | | | Describes one optometrist's experience of IP and use in rural community optometry in Scotland. No barriers and facilitators. |
| Rumney 2019 | *Optometry and independent prescribing* | Describes the pathway to independent prescribing, both professionally and individually. | Narrative – discusses education/training for IP, clinical placement, governance and barriers and argument for NOT including IP as undergraduate training. | | | | Piecemeal CCG-led approach to commissioning affected IP optometry. English DH resisting change by GOS and national contract – promotes local developments to formalise optometric skills. IP underutilised and cannot find a way to include NHS prescribing to IP qualified optometrists. |
| Spillane 2021 | *Factors influencing the prescribing behaviour of independent prescriber optometrists: a qualitative study using the Theoretical Domains Framework* | Identify barriers and facilitators using TDF, map to COM-B to identify behaviour change techniques for intervention | Qualitative: interviews | Hospital (n = 6) Community (n = 10) | 16 optometrist IP | Used TDF imp framework to analyse data; 8 key themes identified facilitating behaviours for implementation. | •**Organisational readiness**<br>- MDT Support<br>- Lack contract with hospital (i.e. for prescribing) led to GP referral for medicines<br>- England and NI – IPs issue private prescriptions – cost to patient<br>- No access to prescribing budget |

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| | | | | | | | - Good relationships<br>- Role clarity/ identity<br>**•Practitioner selection/ preparation**<br>- Communication skills<br>- Clinical experience<br>- Lack of motivation/ remuneration<br>- Job satisfaction<br>**•Transition support**<br>- GOC guidelines barrier<br>**•Sustainability**<br>- Increased workload |
| Todd 2020 | *Agreement in clinical decision-making between independent prescribing optometrists and consultant ophthalmologists in an emergency eye department* | Test concordance between 4 IP optometrists and 9 consultant ophthalmologists for diagnosis and management | Prospective diagnostic agreement study | Eye hospital | 321 patient presentations | Percentage-agreement between all IP optometrists and the staged reference standard per diagnosis was 82.0% | Agreement between IP optometrists and ophthalmologists was: 'almost perfect' for diagnosis (K = 0.882 ± 0.018), 'substantial' for prescribing decision (K = 0.745 ± 0.034) and 'almost perfect' for onward management (0.822 ± 0.032). |

| Proposed Outcomes for Specialty Registration (AS, SP and/or IP)<br>Expert Advisory Group Response to Delphi Verification Exercise (November 2021) | | |
|---|---|---|
| **Original Outcome (2021 Consultation)** | **Delphi Recommendation** | **IP Expert Advisory Group View** |
| O1.1 Works collaboratively as part of a wider multidisciplinary eye care team to ensure that the transfer and continuity of care (within and across all care settings) is developed and not compromised. (RPS-10.1) (IP) (SP) (AS) [Does] | Remove the words "eye care". | Delphi recommendation accepted. |
| O1.3 Undertakes the consultation in an appropriate setting, taking account of confidentiality, consent, dignity and respect in line with regulatory practice and contractual requirements. (RPS-1.1/1.2) (IP) (SP) (AS) [Does] | After "regulatory practice" insert "legislation". | Delphi recommendation accepted. |
| O2.1 Demonstrates good consultation skills and builds rapport with the patient/carer. (RPS-1.5) (IP) (SP) (AS) [Does] | Merge O2.1 and O2.3 to create: "Explores the patient/carers understanding of a consultation; demonstrates appropriate consultation skills based on the patient's individual requirements; builds rapport with the patient/carer, and aims for a satisfactory outcome for the patient/carer and prescriber. (IP) (SP) (AS) [DOES] (RPS-1.5/3.6) | Delphi recommendation rejected and original outcome kept. |
| O2.3 Explores the patient's/carer's understanding of a consultation and aims for a satisfactory outcome for the patient/carer and prescriber. (RPS-3.6) (IP) (SP) (AS) [Does] | | |
| O2.5 Makes prescribing decisions based on the needs of patients and not the prescriber's personal preferences. (RPS-8.4) (IP) (SP) (AS) [Shows how] | Change Miller's Pyramid of Competence level to "Does". | Delphi recommendation rejected and Miller's "Shows how" level kept. |
| O2.8 Builds a relationship which encourages appropriate prescribing and not the expectation that a prescription will | After "relationship" insert "with the patient," and after "that a prescription will" insert "always". | Delphi recommendation accepted. |

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| be supplied. (RPS-3.5) (IP) (SP) (AS) [Shows how] | | |
| O2.10 Guides the patient/carer on how to identify reliable sources of information about their medicines and treatment. (RPS-5.3) (IP) (SP) (AS) [Does] | Change Miller's Pyramid of Competence level to "Shows how". | Delphi recommendation accepted. |
| O3.5 Requests and interprets appropriate investigations necessary to inform treatment options. (RPS-1.10) (IP) (SP) [Knows how] | Change Miller's Pyramid of Competence level to "Does". | Delphi recommendation rejected but Miller's level changed to "Shows how". |
| O4.8 Stays up-to-date in own area of practice and applies the principles of evidence-based practice. (RPS 2.8) (IP) (SP) (AS) [Does] | Change Miller's Pyramid of Competence level to "Shows how". | Delphi recommendation accepted. |
| O5.3 Prescribes unlicensed and off-label medicines where legally permitted, and unlicensed medicines only if satisfied that an alternative licensed medicine would not meet the patient's clinical needs. (RPS-4.11) (IP) (SP) (AS) [Shows how] | After "where legally permitted, and" insert "in the patient's best interest, and". | Delphi recommendation accepted. |
| O6.2 Recognises, minimises risk and manages potential misuse of medicines using appropriate processes. (RPS-4.7) (IP) (SP) (AS) [Shows how] | Delete "minimises risk" and after "potential misuse of medicines" add "by patients". | Delphi recommendation to delete "minimises risk" accepted. Recommendation to add "by patients" not accepted. |
| O7.2 Supports the learning and development of others with their prescribing practice and learning journey, by engaging in mentoring, leadership and workforce development. (RPS-9.6) (IP) (SP) (AS) [Does] | Change Miller's Pyramid of Competence level to "Shows how". | Delphi recommendation accepted. |

General Optical Council

## Expert Advisory Group – Independent Prescribing Optometry

| Name | Organisation | Sector |
|---|---|---|
| Leonie Milliner | GOC/Director of Education | Chair |
| Prof. Gunter Loffler | Glasgow Caledonian University | Programme lead |
| Laura Sweeney | Glasgow Caledonian University | Lecturer in vision sciences |
| Colin Davidson | University of Hertfordshire | Programme lead, IP |
| Dr Nik Sheen | Cardiff University/HEIW/WOPEC | Education/NHS Wales, CET provider |
| Dr Julie McClelland | Ulster University | Senior lecturer |
| Dr Doina Gherghel | Aston University | Senior lecturer |
| Professor Barbara Ryan | University of Cardiff | Director of Postgraduate taught programmes |
| Sally Gosling | College of Optometrists | Professional body, CET provider |
| Prof. Lizzy Ostler | College of Optometrists | Director of Education |
| Dr Joy Myint | University of Herfordshire | Head of Optometry and Director of Studies (Optometry) |
| Angela Whitaker | Cardiff University | Postgraduate Taught Senior Lecturer |
| Sarah Canning | Moorfields Eye Hospital | NHS – Head of Optometry |
| Dr Hannah Bartlett | Aston University | Associate Pro-Vice Chancellor for Diversity & Inclusion |
| Dr Michelle Hennelly | City University | MSc Programme Director |
| Josie Forte | Specsavers/FODO/GOC | Companies Committee/ employer/Council lead, CET provider |
| Dr Ruth Edwards | Aston University | Head of Pharmacy Practice and Senior Teaching Fellow |
| Indie Grewal | BCLA | President, BCLA |
| Melanie Corbett-Wood | Rcophth | Education Chair, Rcophth |
| Melanie Hingorani | Moorfields | Consultant Ophthalmologist |
| Kevin Wallace | AOP | Special Advisor |

| | | |
|---|---|---|
| Jane Harris | NHS Education for Scotland (NES) | Programme Director |
| Dr Siew Yeoh | Moorfields | GP in practice |
| Daniel Todd | Manchester University Hospitals | Specialist Optometrist |
| Dr Kathryn Morrison | NHS Education for Scotland (NES) | Programme Director, Optometry |
| Dr Lesley Rousselet | NHS Education for Scotland (NES) | Programme Director, Optometry |
| David O'Sullivan | Welsh Government | Chief Optometry Advisor |
| Poonam Sharma | NHS | Clinical Advisor, Optometry |
| Raymond Curran | Health and Social Care Board, Northern Ireland | Head of Ophthalmic Services |
| Fiona North | Health and Social Care Board, Northern Ireland | Optometric Advisor |
| Mike Galvin | General Optical Council | GOC Council |
| Kiki Soteri | Specsavers | Head of Optometry Development |
| Nicholas Rumney | BBR Optometry | Managing Director |

### Expert Advisory Group – Contact Lens Opticians

| Name | Organisation | Sector |
|---|---|---|
| Leonie Milliner | GOC/Director of Education | Chair |
| Christopher Simons | CANDI | Head of School |
| Dean Dunning | Bradford College | Programme Leader |
| Jo Underwood | ABDO College | Principal |
| Dr Holly Price | Anglia Ruskin University | Senior Lecturer |
| Thomas Finney | Anglia Ruskin University | Lecturer, Practitioner |
| Dr Michelle Hennelly | City University | MSc Programme Director |
| Cheryl Donnelly | ALCON | International Head of Professional Affairs |
| Indie Grewal | BCLA | President |
| Rosemary Bailey | Formerly ABDO | Former Chief Examiner |
| Alexandra Webster | ABDO | Head of CPD |

| | | |
|---|---|---|
| Mark Chandler | ABDO | Head of Examinations and Registration |
| Andrew Price | ABDO | Fellow |
| David Hewlett | FODO | Director for Leadership, Transformation and Strategic Partnerships |
| Luke Stevens Burt | BCLA | Chief Executive |
| Claire Mallon | University of Manchester | Lecturer in Optometry |
| Simon Rodwell | Association of Contact Lens Manufacturers Ltd (ACLM) | Secretary General |
| Helen Thompson | Boots Opticians | Division Contact Lens Lead |
| Jeet Saimbi | Scrivens Opticians | Professional Services Director |
| Andrew Symons | Specsavers | Contact Lens Business Manager |
| Poonam Sharma | NHS | Clinical Advisor, Optometry |
| Glenn Tomison | General Optical Council | GOC |
| Jeanette Brook | Specsavers | Dispensing Optician |

**GENERAL OPTICAL COUNCIL**
**DRAFT Minutes of the Education Committee breakout session**
**held on Monday 22 November 2021 at 10:00 hours via Microsoft Teams**

| | |
|---|---|
| Present: | Mike Galvin (Chair), Geraldine McBride, Mary Wright, Andrew Logan and Neil Retallic. |
| | |
| GOC Attendees: | Leonie Milliner and Nadia Denton (Governance Officer) *Minutes.* |

| | |
|---|---|
| | **Welcome and Apologies** |
| 1. | The Chair welcomed the members of the group to the breakout session |
| | |
| 2. | Hilary Tompsett and Imran Jawaid were absent. |
| | |
| | **Declaration of Interests** |
| 3. | It was noted that Andrew Logan (Education Committee) declared a new interest as an External Examiner at the University of Sheffield. |
| | |
| 4. | The Education Committee were asked to:<br><br>• advise Council on proposals to update requirements for GOC approved qualifications leading to specialist entry to the GOC register, in additional supply (AS), supplementary prescribing (SP) and independent prescribing (IP) categories.<br>• note the outcome of the public consultation (Enventure Research consultation report); EDI impact assessment (Fraser Consulting); the impact assessment screening; literature review report (University of Surrey) and the outcome of the Delphi verification of the proposed outcomes (University of Hertfordshire)<br>• note the progress of Expert Advisory Groups (EAGs) for Contact Lens Opticians as set out in the 'Analysis' section of this paper. |
| | |
| 5. | It was noted that to be awarded qualifications leading to specialist entry to the GOC register, there was an overarching frame and structure organised into 7 categories:<br><br>1. Uphold professional standards<br>2. Person centred care<br>3. Established and manages patient options<br>4. Prescribing practice<br>5. Ethics and standards<br>6. Manages risk<br>7. Leaning and development |
| | |
| 6. | In discussion the following points were noted:<br><br>**<u>Providers</u>**<br>• the GOC Director of Education reported to the committee that if the proposals are approved by Council, the next step will be to develop an evidence framework (similar to the evidence framework developed for optometry and dispensing optics). The evidence framework will describe the range and type of evidence |

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|---|---|
| | providers might like to consider submitting to GOC as part of the proposed Quality Assurance and Enhancement Method to evidence that the standards and outcomes are met.<br>• the GOC has run a couple of sessions for IP providers to make them aware of the proposals;<br>• it was recommended that a staged approach to the provider roll out should be considered as it might be ambitious to change the training programmes all at once as the committee was concerned that some providers could not meet a single changeover date<br>• when asked what provider's plans for adaptation to the new requirements might be, the GOC Director of Education reported that all providers had been asked in this year's annual monitoring for an early indication of their plans for adaptation and to indicate which academic year they are aiming at recruiting their first cohort into; and that the GOC will work at provider's pace and will be cognizant of their circumstances;<br>• whilst GOC establishes requirements for qualification approval, the committee commented that it also should have a role in encouraging the sharing of good practice amongst providers; the GOC Director of Education then outlined the role of the GOC-commissioned knowledge hub (SPOKE) as a vehicle for sharing best pracrice. The panel also indicated that up to now the GOC had focussed on dealing with failure (i.e. non-compliance). It needed to take the lead in promoting best practice.<br>• The committee noted that advice and guidance will be given to providers by the GOC on draft applications for adaptation or new qualification approval prior to submitting their formal application so that informal feedback can be given and providers get an idea about whether they are roughly on the right track or not;<br>• the committee expressed concerned that a risk was that some students on some optometry programmes may not be ready for IP practice at the point of graduation. In discussion it was agreed and confirmed that the proposals are written so that approved qualifications in optometry and IP are two separate and distinct qualifications. It would be a provider's decision as to whether a whole or part of a cohort of optometrists would be admitted and allowed to progress onto an IP, AS or SP qualifications at the same time. Trainees will get two certificates and potentially pay two sets of fees;<br>• providers will need to provide data on progression and attainment and the GOC will, as part of it annual monitoring, decide what data it collects and for what purpose. This will be an important part of measuring the success of the changes.<br>• it was commented that it would be possible but unlikely that a commercial organisation could apply to Ofqual to become an awarding organisation to deliver a level 7 qualification, and then apply o GOC for qualification approval, but the economic and business case from a commercial perspective may preclude this; as an alternative, a commercial organisation could acquire degree awarding powers from the OfS/ Privy Council, however, it was commented that such a proposition would also be highly unlikely given the difficulty for commercial organisations to achieve degree-awarding powers.<br>• providers may have challenges if DPPs are unable to provide an adequate amount of supervision to trainees within the required timeframes; and<br>• it was noted that September 2023 was likely to be that date that most providers would begin admitting trainees into IP qualifications that meet the new proposals but noted that providers could agree pace of transition with the GOC. |
| 7. | **<u>Role of the DPP</u>**<br>• providers will be responsible for deciding who is a suitable DPP either upon application or admission. The RPS competency framework will be the key tool that providers will use to assess whether a DPP is appropriate or not. The Optometry sector may wish to create their own competency framework to assess DPPs in the future; |

| | |
|---|---|
| | • the provider will have input into the trainee's selection of the DPP and the Education Visitor panel members will scrutinise the provider's quality controls in assessing the suitability of the DPP;<br>• it is expected that DPPs will be supported by their employers to undertake the responsibilities of the role;<br>• the role of the DPP is a voluntary role and would need to be kept under review to determine if employees were being pressured to take up the role as DPP or if there were commercial pressure or conflicts of interest around discharging the responsibilities of a DPP, or that registrants might be pressured into acting as a DPP to support the commercial aims of their employers;<br>• there is an issue around the protection of DPP's time to supervise in context of commercial pressure on supervisors. This is a safeguarding issue that needs to be considered in terms of number of students a DPP is allowed to train;<br>• DPPs will need to have sufficient time in practice to carry out supervision in the context of commercial pressures. This may need to be considered in the framing of the role. Stresses placed upon the DPP in their role will impact the quality of the training that the student will receive;<br>• It was noted although the proposals contained a number of controls around the relationship between the DPP, provider and trainee; and that assurance will be gained by through EVPs scrutiny, including evidence of stakeholder feedback as well as attrition and attainment rates in relation to whether students are meeting outcomes, providers would need support to identify, train, and support DPPs and build the capacity of the profession in all parts of the UK to undertake the role of the DPP. |
| | |
| 8. | **<u>Other Points</u>**<br>• it was suggested that it was worth looking at how optometrists and their employers might be able to gain funding;<br>• it is understood that Health Education England are looking to boost the capacity in IP in the optometry sector;<br>• not in natural DNA of Optometrists to supervise in same way for other clinical practitioners. This habit needs to be fostered earlier on in training programmes so that it is part of the eco-system; and<br>• whilst a member of the Royal College of Ophthalmologists have a member of the GOC's EAG and involved in shaping early drafts of the proposals, it was noted that they had not submitted a formal response to consultation. |
| | |
| 9. | **ACTION Director of Education to an have urgent conversation with Royal College of Ophthalmologists to ensure they are up to speed with the proposals.** |
| | |

**GENERAL OPTICAL COUNCIL**
**DRAFT Minutes of the Standards Committee breakout session**
**held on Monday 22 November 2021 at 10:00 hours via Microsoft Teams**

| | |
|---|---|
| Present: | Glenn Tomison (Chair), Joy Myint and Marcus Weaver. |
| | |
| GOC Attendees: | Lesley Longstone (Chief Executive Officer and Registrar), Marcus Dye (Director of Strategy), Ben Pearson (Project & Policy Support Executive), Simran Bhogal (ESR Manager) and Ivon Sergey (Governance Officer) *Minutes.* |

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| | **Welcome and Apologies** |
| 1. | The Chair welcomed the members of the group to the breakout session |
| | |
| 2. | Apologies were received from Paula Baines, Cecilia Fenerty and Nigel Best. |
| | |
| | **Declaration of Interests** |
| 3. | Joy Myint declare a conflict of interest as she runs the IP programme and was a member of the IP EAG. |
| | |
| 4. | The Standards Committee were asked to:<br><br>• advise Council on proposals to update requirements for GOC approved qualifications leading to specialist entry to the GOC register, in additional supply (AS), supplementary prescribing (SP) and independent prescribing (IP) categories.<br>• note the outcome of the public consultation (Enventure Research consultation report); EDI impact assessment (Fraser Consulting); the impact assessment screening; literature review report (University of Surrey) and the outcome of the Delphi verification of the proposed outcomes (University of Hertfordshire)<br>• note the progress of Expert Advisory Groups (EAGs) for Contact Lens Opticians as set out in the 'Analysis' section of this paper. |
| | |
| 5. | It was noted that to be awarded qualifications leading to specialist entry to the GOC register, there was an overarching frame and structure organised into 7 categories:<br><br>1. Uphold professional standards<br>2. Person centred care<br>3. Established and manages patient options<br>4. Prescribing practice<br>5. Ethics and standards<br>6. Manages risk<br>7. Leaning and development |
| | |
| 6. | The group considered the overarching statements, criteria for each of the seven categories and discussed each IP proposal. Some categories had fewer outcomes than others. It was noted that approved qualifications for specialist entry in additional supply categories would need to meet the outcomes indicated with Additional supply (AS). |

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| 7. | It was noted that the outcomes incorporated the updated Royal Pharmaceutical Society's Framework for all Prescribers. All outcomes had also been through the Delphi process and the Expert Advisory Group. |
| | |
| 8. | It was discussed that additional supply (AS) and independent prescribing (IP) categories were in different levels and whether there was a danger in (AS) masquerading as (IP). Each of the criteria levels differed, and there were a couple of criterions which did not relate to (AS). It was noted that (AS) and (IP) having to undertake the same outcomes except for one or two could potentially cause confusion but there was nothing that could be done as this was part of the legislation. |
| | |
| 9. | Colleagues in Scotland were looking to integrate (AS) and there was a concern whether this would lead to confusion to public perception. It was noted that as long as registrants had the appropriate designation, if patients were looking for a particular service there was a website to point them to individuals who could provide them with that service. |
| | |
| 10. | There were concerns that some registrants had difficulties getting placements, particularly in hospital settings, which was a noted blockage in the system. These proposals should assist those who were unable to progress due to placement availability. The issue of remote placements and the inability for supervisors to intervene was also discussed. |
| | |
| 11. | Additional mentoring schemes needed to support Designated Prescribing Practitioner's (DPP's) training. |
| | |
| 12. | It was agreed that the quality assurance aspect of the work read very well and there was broad support for the proposal. The group approved the updated requirements which would go to Council for approval. |
| | |

**PUBLIC**
**C51(21)**

**COUNCIL**

## Health and Safety Policy Update

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

**Lead responsibility:** Yeslin Gearty (Director of Resources)
**Paper Author(s):** Jacob Sanchez (Facilities Manager)
**Council Lead(s):** there is no Council lead for this work

### Purpose

1. To enable Council to note the updated Health and Safety compliance audit

### Recommendations

2. Council is asked to note the contents of the report

### Strategic objective

3. This work is included in our 2021/22 Business Plan.

4. This work forms part of Business as Usual whilst also contributing towards the achievement of the following strategic objective:
    - Building a culture of continuous improvement

### Background

5. The annual audit was undertaken on 17 May 2021 reviewing the existing Health & Safety Management System in line with a wide range of industry standard guidance on safe practices.

6. This year the visit was conducted in-situ observing all guidance recommended by the UK Government and measures implemented in line with that guidance, for the safety of all parties involved.

### Analysis

7. A full, independent, health and safety audit was carried by Stallard Kane Associates Ltd. on 17 May 2021 and the report received on 6 June.

8. The objective of the audit was: to review the organisation's existing health & safety management system and its effectiveness; identify the hazards and risks to the organisation, its employees and any third parties; and make recommendations for action required to improve the health, safety and welfare standards and levels of compliance with relevant legislation and industry standards. In particular, the audit focussed on the measures being taken to control the spread of Covid-19 and

considered the company's return to work program appropriate and on schedule in accordance with the government guidelines at this time.

9. The overall rating of the audit was positive and increased by 11 points from the previous year to 94.26%, reaching a Silver standard. In the executive summary it was mentioned, "…*the General Optical Council are responsible for maintenance, upkeep and management of their demised areas within the first floor, which has been completed to an excellent standard*."

10. There were no high priority actions identified and only three medium priority actions as follows:

- Firefighting equipment, extinguishers and automatic systems should be inspected at least annually by a competent person. Some fire extinguishers were missed during the 2020 maintenance visit, which was unsupervised due to covid restrictions.
    - Service providers rectified the issue on 02/07/2021.
- For staff driving to third-party locations on GOC business, ensure driving licence checks are completed electronically using the DVLA system at least annually, and that their own vehicles have been taxed and insured.
- For staff driving to third party locations on GOC business, ensure that a driving policy is in place and that this made available to all drivers of organisation vehicles.
    - The points relating to driving are in development (a policy is in draft and will be subject to our consultation process). This was de-prioritised due to Covid restrictions and was considered as low risk because GOC employees or workers very infrequently drive during the course of their employment and largely not at all during the last 18 months or so. The new policy work is planned for completion during Q1 2022-23 and will reinforce existing control measures within our current policy for business related journeys where driving is required.

11. There was one action proposed as goodwill advice:

- The subcontractor's Control of Substances Hazardous to Health (COSHH) assessments were noted to be out of date. Liaise with the cleaning contractor to ensure that COSHH assessments are available for all currently used hazardous substances, that these are reviewed annually (ensuring the site folder is updated) and communicated to all their employees who are exposed to them.
    - Some of the updates for cleaning products had been missed due to Covid related absence. Our cleaning contractor produced updated COSHH sheets for their products on 02/08/2021.

12. The full report is set out at Annex one.

## Finance

13. The budget has been reviewed and approved for the associated costs.

## Risks

14. No additional or imminent risks were identified but recommendations were made to strengthen the current measures in place.

## Equality Impacts

15. No adverse effects were identified but additional driving checks may help to identify staff that may require additional assistance.

## Devolved nations

16. N/A

## Other Impacts

17. N/A

## Communications

### External communications

18. None required in this instance.

### Internal communications

19. The Health and Safety page on IRIS is up to date and contains the current H&S Policy, GOC H&S statement of intent, H&S booklet as well as relevant forms for staff to easily access.

## Next steps

## Attachments

**Annex one:** The General Optical Council - H&S Compliance Survey May 2021

# Compliance Survey

## The General Optical Council

## May 2021

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# Executive Summary

This audit was undertaken at the organisation's site at 10 Old Bailey, EC4M 7NG on 17/05/2021, in order to carry out a full review of the organisations existing Health & Safety Management System in line with a wide range of industry standard guidance on safe practices. For example; HSG65 - Managing for Health & Safety.

The objective of the audit was to review the organisation's entire Health & Safety Management System. Also, to identify hazards and risks to the organisation as well as its employees, visitors etc. make recommendations for action required to improve the health, safety and welfare standards and levels of compliance with relevant legislation and industry standards.

The General Optical Council maintain an excellent set of offices on the first floor of 10 Old Bailey, London. The building is managed by a third-party management organisation, who are responsible for communal areas and plant, such as the lifts, the electrical systems, the water systems, fire alarms and some of the reception and security personnel. However, the General Optical Council are responsible for maintenance, upkeep and management of their demised areas within the first floor, which has been completed to an excellent standard. A number of small gaps have been identified and these should be resolved at the earliest opportunity.

Recommendations for improvement have been identified, many of which require only a commitment of time and effort. Recommendations are detailed in the "Hazard Identifiers and Action list" on the following page. The actions requiring attention have been categorised in separate Action Plans, following a RAG System (Red, Amber, Green, with a final table of "Goodwill Advice" – each having guided timescales for completion, based on the level of priority.

This allows you to easily identify the higher priority actions which require urgent attention.

Following the Action Plans is the main body of the report detailing all findings and recommendations as a result of the Audit.

Your overall score for this Health & Safety Compliance Audit is 94.26% which is a Silver standard.

Jonathan Ely
Health and Safety Advisor
Stallard Kane Associates Limited

# Hazard Identifiers & Action List

| | |
|---|---|
| **HIGH PRIORITY** | Deficiencies should be addressed within 1 month or time specified |
| **MEDIUM PRIORITY** | Deficiencies should be addressed within 3 months |
| **LOW PRIORITY** | Deficiencies should be addressed within 6 months |
| **GOODWILL ADVICE** | Recommendations should be considered |

## Action Plan - Medium Priority

| Item No. | Section | Action to eliminate or reduce risk | Target Date | Completion Date | Completion Signature |
|---|---|---|---|---|---|
| **M1** | Fire Management | As discussed, firefighting equipment, extinguishers and automatic systems should be inspected at least annually by a competent person. A number if extinguishers were noted to be overdue their annual inspection. Ensure that all extinguishers are inspected to ensure that they remain operational. | 23/08/2021 | 2.7.21 | |
| **M2** | Driving Risk Management | For staff driving to third-party locations on GOC business, ensure driving licence checks are completed electronically using the DVLA system at least annually, and that their own vehicles have been taxed and insured. | 23/08/2021 | Re-scheduled for Q1 2022 | |
| **M3** | Driving Risk Management | For staff driving to third party locations on GOC business, ensure that a driving policy is in place and that this made available to all drivers of organisation vehicles. We can assist with this if required. | 23/08/2021 | 2.8.21 | |

## Action Plan - Goodwill Advice

| Item No. | Section | Action to eliminate or reduce risk | Target Date | Completion Date | Completion Signature |
|---|---|---|---|---|---|
| **G1** | Control of Hazardous Substances (COSHH) | The subcontractor's COSHH assessments were noted to be out of date. Liaise with the cleaning contractor to ensure that COSHH assessments are available for all currently used hazardous substances, that these are reviewed annually (ensuring the site folder is updated) and communicated to all their employees who are exposed to them. | 23/08/2021 | | |

*Note that completion of any of the above requirements does not necessarily imply compliance with current Building, Local Authority, Fire, Environmental, Health and Safety or other Legislation. It is your duty to ensure that you comply with all aspects of current legislation.*

# Health & Safety Compliance Survey

| Name of Client: | Name and Position of Person Seen: | Number of Employees: | Date of Survey: |
|---|---|---|---|
| The General Optical Council | Jakob Sanchez, Facilities Manager | 90 | 17/05/2021 |
| **Name of Surveyor:**<br>Jonathan Ely | **Marking Guide:**<br>• N/A - Not Applicable<br>• 0 - Fails to Meet Requirements<br>• 1 - Low Level of Compliance<br>• 2 - Medium Level of Compliance<br>• 3 - High Level of Compliance<br>• 4 - Fully Meets Requirements | | |

| Section | Remarks | Score | Action Recommended | Compliant? |
|---|---|---|---|---|
| **COVID-19 Control Measures** | | | | |
| Has a Covid-19 risk assessment been developed for the organisation/site and has it been communicated to the relevant staff? | A suitable and sufficient Covid-19 risk assessment has been completed for the organisation/site and has been communicated to all the relevant staff. It is displayed in the kitchenette. | 4 | No further action required. | Yes |
| Have suitable measures been implemented to reduce the transmission of Covid-19, such as social distancing, signage, enhanced cleaning procedures and increased hygiene, sanitation and washing facilities? | At the time of the inspection, there were suitable and sufficient control measures implemented to reduce the transmission of Covid-19. These included social distancing, enhanced cleaning procedures and increased hygiene and washing facilities. | 4 | No further action required. | Yes |

| | | | | |
|---|---|---|---|---|
| **COVID-19 Control Measures** | | | | |
| Have the Covid-19 control measures, guidance and advice been adequately communicated to all staff? | Covid-19 control measures, guidance and advice have all been suitably communicated to staff via signage, toolbox talks and briefings. | 4 | No further action required. | Yes |
| **Specific Risk Management** | | | | |
| Are risk assessments in place for workers under the age of 18 (young Workers)? | There are no young workers employed within the organisation. | N/A | No further actions are required. | N/A |
| Does the organisation employ anyone with a disability? | There are employees with disabilities that might affect their work and risk assessments have been undertaken and communicated. | 4 | Continue with good practice. | Yes |
| Does the organisation employ any new or expectant mothers? | There are new or expected mothers and risk assessments have been undertaken and communicated. | 4 | Continue with good practice. | Yes |
| Does the organisation employ non-English-speaking employees? | There are non-English speaking employees, procedures are in place and have been communicated | 4 | Continue with good practice. | Yes |
| Is lone working carried out in the organisation? | Lone work is carried out on several operations in the organisation, is assessed and a method of communication is in place and documented. High risk activities are avoided. | 4 | Continue with good practice. | Yes |

| | | | | |
|---|---|---|---|---|
| **Liability Insurance** | | | | |
| Is an in date, organisation liability Insurance certificate displayed? | The employer's liability insurance certificate is in date and displayed in a prominent position. | 4 | Continue with good practice. | Yes |
| What insurance organisation does the organisation use? | The organisation use Hiscox as their employer's liability insurance provider. | 4 | No further actions are required. | Yes |
| **Safety Policy Management** | | | | |
| Does the organisation have a Health and Safety Policy? | There is a signed and dated health and safety policy available. | 4 | Continue with good practice. | Yes |
| Is there a Health and Safety Statement of Intent in place? | There is a signed and dated health and safety statement of intent available. | 4 | Continue with good practice. | Yes |
| Does the organisation issue Health and Safety Booklets? | Health and safety booklets are issued to employees and the acknowledgment sheet is complete. | 4 | Continue with good practice. | Yes |
| Has the nominated person or director for health and safety had any formal training in H&S? | The director(s) and/or nominated person(s) for health and safety have undertaken NEBOSH qualifications. | 4 | Continue with good practice. | Yes |

| | | | | |
|---|---|---|---|---|
| **Risk Assessments** | | | | |
| Have suitable and sufficient risk assessments been carried out for all tasks and activities? | There are risk assessments in place to cover all significant risks. | 4 | Continue with good practice. | Yes |
| Have the findings of the risk assessments been explained to employees? | Risk assessments have been communicated to employees and signed as acknowledgement. | 4 | Continue with good practice. | Yes |
| **Safe Working Practices** | | | | |
| Does the organisation develop safe operating procedures, safe systems of work or safe working practices? | The type of work carried out by the organisation does not require safe systems of work to be developed. | N/A | No further actions are required. | N/A |
| Have safe operating procedures, safe systems of work or safe working practices been explained to employees? | The type of work carried out by the organisation does not require safe systems of work to be developed. | N/A | No further actions are required. | N/A |
| **Mains Supply Services and Gases** | | | | |
| Has the organisation had an electrical fixed mains inspection carried out? | A fixed mains inspection has been carried out and is in date. This is understood to have been completed in July 2020. | 4 | Continue with good practice. | Yes |
| Are mains gas appliances serviced annually? | There are no mains gas appliances used. All gas appliances are under the control of the managing agent. | N/A | No further actions are required. | N/A |
| Does the organisation use Liquid Petroleum Gas (LPG) and other bottled gas? | There is no LPG, or any other cylinder/bottled gas used. | N/A | No further actions are required. | N/A |

| | | | | |
|---|---|---|---|---|
| **Mains Supply Services and Gases** | | | | |
| Does the organisation use compressors and pressure systems? | There are no compressors and/or pressure systems used. | N/A | No further actions are required. | N/A |
| Is there bulk oil or fuel storage on site? Over 201L requires a double bunded container. Over 3500L requires a double bunded container and a relevant risk assessment covering the location in line with the Oil storage regulations for businesses? | There is no bulk oil or fuel storage on site. | N/A | Continue good practice | N/A |
| **Contractors and Sub-contractors** | | | | |
| Has a formal process of approving contractors / sub-contractors been adopted? | Health and safety information is obtained formally from contractors / sub-contractors, held on record and an approved contractor / sub-contractor register is updated. | 4 | Continue with good practice. | Yes |
| Is the Health and Safety performance of contractors audited? | Contractor / sub-contractor performance is audited and recorded. Several have Safe Contractor status. | 4 | Continue with good practice. | Yes |
| **Machinery and Equipment** | | | | |
| Are statutory inspections in place for all machinery and lifting appliances? | The organisation do not own work equipment or machinery requiring statutory inspections as they are not required. Lifts and other equipment are managed by the managing agent. | N/A | No further actions are required. | N/A |
| Are ladders, steps and other access equipment placed in a register and inspected? | There is no access equipment used by the Organisation. | N/A | No further actions are required. | N/A |

| Machinery and Equipment | | | | |
|---|---|---|---|---|
| Is all machinery and equipment sufficiently guarded / does the organisation recognise that they need to have the correct guarding in place before every use? | The Organisation does not have any machinery or equipment that requires guarding to be in place. Lifts and other equipment are managed by the managing agent. | N/A | No further actions required. | N/A |
| Are routine (pre use) equipment checks carried out and recorded? | There is no work equipment and machinery used deemed as requiring recorded checks. Lifts and other equipment are managed by the managing agent. | N/A | No further actions are required. | N/A |
| Is a documented planned maintenance scheme in operation? | There is no machinery used requiring planned maintenance. Lifts and other equipment are managed by the managing agent. | N/A | No further actions are required. | N/A |
| Are employees trained in the safe use of all machinery and equipment? | The organisation does not use any machinery or equipment. Lifts and other equipment are managed by the managing agent. | N/A | No further actions are required. | N/A |
| Is there a program of Portable Appliance Testing (PAT) in place? | PAT has been completed to portable electrical appliances and records held. | 4 | Continue with good practice. | Yes |
| Are local exhaust ventilation systems (LEVs) subject to thorough inspections by competent persons? | There are no LEV systems installed at the premises. | N/A | No further actions are required. | N/A |
| Does the organisation use abrasive wheels (grinding/cutting wheels)? | The organisation does not use abrasive wheels. | N/A | No further actions required. | N/A |

| Environmental Management | | | | |
|---|---|---|---|---|
| Does the organisation have an environmental policy statement? | There is a signed and dated environmental statement of intent available. | 4 | Continue with good practice. | Yes |
| Are waste transfer notes available? | Non-hazardous waste is not moved from the premises/site. | N/A | No further actions are required. | N/A |
| Is the organisation a hazardous waste producer? | The organisation is not classed as a hazardous waste producer. | N/A | No further actions are required at present. | N/A |
| Does the organisation have a current waste carriers license? | The organisation does not transfer any waste. | N/A | No further actions are required. | N/A |
| Does the organisation have a spills kit available? | The organisation do not use any hazardous substances that require a spill kit. | N/A | No further actions are required. | N/A |
| Has the nominated person received any environmental training? | Due to the scope of works undertaken by the organisation, formal environmental training is not deemed as necessary. | N/A | No further actions are required. | N/A |

| Accident and Incident Management | | | | |
|---|---|---|---|---|
| Does the organisation have an accident book or other means of recording accident information? | There is a means for recording accidents available, all accident entries are kept separate in a secure location. | 4 | Continue with good practice. | Yes |
| Do accident trends and significant accidents get investigated? | There are not any accident trends to review but significant accidents have been investigated. | 4 | No further actions are required. | Yes |
| Does the organisation have a near miss or incident reporting procedure in place? | There is a formal process in place for recording near misses, they are recorded, actioned and findings are communicated back to employees. | 4 | Continue with good practice. | Yes |
| Has the organisation had any enforcement actions over the last year? | The organisation has not been issued with any enforcement action in the past year. | N/A | No further actions are required. | N/A |
| Have accidents been recorded and reported, where necessary to the enforcing authority, in accordance with RIDDOR in the last 12 months? | The organisation are fully aware of the requirements for reporting accidents and incidents under RIDDOR but there has been no requirement to do so. | N/A | No further actions are required. | N/A |

| | | | | |
|---|---|---|---|---|
| **Health and Safety Communication** | | | | |
| Is induction training undertaken? | A recorded induction is completed with new starters and held on file. | 4 | Continue with good practice. | Yes |
| Are toolbox talks or safety briefings carried out? | Other methods of communication are used in the organisation. A central website maintains all necessary documentation and communication, and urgent communiques can be dispatched via emails. | 4 | No further actions are required. | Yes |
| Does the organisation have external Human Resources Support? | HR is covered in house. | N/A | No further actions are required. | N/A |
| **Occupational Health** | | | | |
| Are employment medical questionnaires issued? | Medical questionnaires are issued to new starters and reviewed periodically for all employees. The organisation is aware of members of staff with medical conditions. | 4 | Continue with good practice. | Yes |
| Are employees who use RPE as part of their role, face fit tested? | It is not deemed a requirement for employees to wear RPE as part of their role. Therefore, face fit testing is not required. | N/A | No further actions are required. | N/A |
| Is a program of occupational health surveillance in place for employees who are exposed to asbestos, noise, vibration, dust, welding fumes, paints, thinners and oils? | Following risk assessment, occupational health surveillance is not deemed necessary. | N/A | No further actions are required. | N/A |

| | | | | |
|---|---|---|---|---|
| **Asbestos Management in Non-Domestic Premises** | | | | |
| Are asbestos surveys commissioned or made available on transient sites prior to starting intrusive works? | The organisation does not carry out intrusive works off site. | N/A | No further actions are required. | N/A |
| **Traffic Management** | | | | |
| Are designated protected pedestrian routes available in areas where people and mobile plant operate? | The organisation do not have any areas where mobile plant / vehicles operate in the vicinity of pedestrians | N/A | No further actions are required. | N/A |
| Does the organisation have a documented traffic management plan in place? | There is no requirement for such a plan in the organisation. | N/A | No further actions are required. | N/A |
| Are relevant employees trained in vehicle / plant marshalling / banksman? | This is not required due to the nature of the business / premises. | N/A | No further actions are required. | N/A |
| **Additional Observations** | | | | |
| Is smoking in the workplace controlled and specific covered areas designated? | Smoking is not allowed anywhere on site, in line with the Organisation's no smoking policy. | 4 | No further actions are required. | Yes |
| Has a legionella risk assessment been conducted? | Yes, a legionella, leptospirosis risk assessment has been complete and actioned. A copy has been provided to the Building Manager as proof of compliance and ongoing checks are undertaken by the Facilities Team. | 4 | Continue with good practice | Yes |

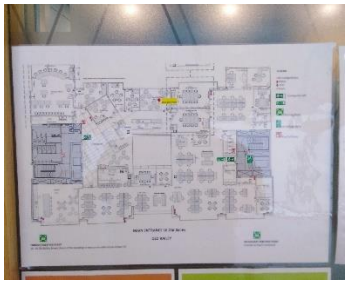
| Additional Comments: |
| --- |
| Nil |

| Overall Mark | |
| --- | --- |
| **Possible Score:** | 244 |
| **Actual Score:** | 230 |
| **Percentage:** | 94.26% |

# Appendix One - Photographs

| Section | Evidence |
|---|---|
| **Section:** COVID-19 Control Measures<br>**Question:** Has a Covid-19 risk assessment been developed for the organisation/site and has it been communicated to the relevant staff? | <br>Covid risk assessments displayed within the kitchenette |
| **Section:** COVID-19 Control Measures<br>**Question:** Have suitable measures been implemented to reduce the transmission of Covid-19, such as social distancing, signage, enhanced cleaning procedures and increased hygiene, sanitation and washing facilities? | <br>Wipes and gels available in various locations around the premises |
| **Section:** Machinery and Equipment<br>**Question:** Are statutory inspections in place for all machinery and lifting appliances? | <br>All common area plant and machinery is managed by the managing agent. |
| **Section:** Occupational Health<br>**Question:** Has a mental wellbeing and physical first aid risk assessment been conducted and actioned? | <br>Risk assessment conducted and actioned. Lists of first aiders available on posters. |

| Section | Evidence |
|---|---|
| **Section:** Occupational Health<br>**Question:** Are adequate mental first aiders and physical first aiders available? | <br>Trained personnel available, with lists available in prominent locations |
| **Section:** Occupational Health<br>**Question:** Are notices displayed indicating locations of first aiders and the first aid boxes? | <br>First aid signage available in prominent locations |
| **Section:** Occupational Health<br>**Question:** Are first aid boxes available and inspected once a month to replace any used or out of date items? | <br>First aid equipment available throughout the premises |
| **Section:** Fire Management<br>**Question:** Are fire plans available for the premise? | <br>Fire evacuation plans available in various locations |
| **Section:** Fire Management<br>**Question:** Are escape routes and assembly points adequately signed? | <br>Illuminated running man signage available throughout the premises |

| Section | Evidence |
| --- | --- |
| **Section:** Fire Management<br>**Question:** Where premises are occupied by more than one occupant have fire emergency procedures been shared between all occupants? |  <br>Fire plans and fire procedures are available through shared sites, as controlled by the managing agent. |
| **Section:** Safety Signage<br>**Question:** Is a copy of the latest health and safety Law poster displayed and contact details completed? | <br>Health & Safety Law Signage available within the kitchenette |

## Council Forward Plan 2022/2023

| 2022/2023 | | | |
|---|---|---|---|
| **Q4** | **Q1** | **Q2** | **Q3** |
| • Statutory Committees report<br>• CEO report<br>• Chair report<br>• Balanced Scorecard<br>• Business Plan Assurance report Q3<br>• Q3 financial and performance reports<br>• FtP Improvement Programme Update – continuous improvement<br>• External Business Plan<br>• Budget and Business Plan for 2022/23<br>• Council's Trustee Duty responsibilities and PSA regulatory responsibilities assessment review<br>• Equality, Diversity and Inclusion: monitoring report<br>• Public perceptions survey<br>• Standards of Practice for individual registrants for consultation | • Statutory Committees report<br>• CEO report<br>• Chair report<br>• Balanced Scorecard<br>• Business Plan Assurance report Q4<br>• Q4 financial and performance reports<br>• Education Annual Monitoring report<br>• FTP Performance Review / Update and/or rules changes<br>• PSA performance review<br>• OCCS Annual report<br>• Stakeholder survey<br>• | • Statutory Committees report<br>• CEO report<br>• Chair report<br>• Balanced Scorecard<br>• Business Plan Assurance report Q1<br>• Q1 financial and performance reports<br>• Annual report and financial statements for year ended 31 March 2020<br>• Equality, Diversity and Inclusion: monitoring report<br>• H&S Annual report (JS)<br>• Registrant survey | • Statutory Committees report<br>• CEO report<br>• Chair report<br>• Balanced Scorecard<br>• Business Plan Assurance report Q2<br>• Q2 financial and performance reports<br>• Education Strategic Review<br>• First Draft External Business Plan<br>• Member fees |