First meeting in 2022 of the Council held in PUBLIC
on Wednesday 16 March 2022 at 10:00am via Microsoft Teams videoconference

AGENDA

					Page No.	
1.	**Welcome and Apologies**		Oral	Chair	-	10:00am (5 mins)
2.	**Declaration of Interests**		C01(22)	Chair	3 – 5	
3.	**Minutes, Actions and Matters Arising**					10:05am (5 mins)
	3.1	**Minutes – 8 December 2021** For approval	C02(22)	Chair	6 - 12	
	3.2	**Updated Actions** For noting	C03(22)		13	
	3.2	**Matters Arising**				
4.	**Chair's report** For noting		C04(22)	Chair	14 – 15	10:10am (10 mins)
5.	**Chief Executive and Registrar's report** For noting		C05(22)	Chief Executive /Registrar	16 – 28	10:20am (10 mins)
	STRATEGIC					
6.	**Education Strategic Review – Post-Registration CLO Specialty Qualifications** For approval		C06(22)	Director of Strategy	28 – 263	10:30am (45 mins)
7.	**Budget and Business Plan for 2022/2023** For approval		C07(22)	Chief Executive /Registrar	264 – 286	11:15am (30 mins)
11:45am BREAK (15 mins)						
	ASSURANCE					
8.	**Balanced Scorecard** For noting		C08(22)	Interim Head of Secretariat	287 – 288	12:00noon (15 mins)
9.	**Business Plan Assurance Report Q3** For noting		C09(22)	Interim Head of Secretariat	289 – 291	12:15pm (15 mins)

10.	**Finance performance report for the period ending 31 December 2021 and Q3 Forecast of 2021/22**	C10(22)	Director of Corporate Services	292- 312	12:30pm (15 mins)
11.	**External Audit of Fitness to Practice Decision Making 2020/2021** For noting	C11(22)	Director of Regulatory Operations	313 - 448	12:45pm (20 mins)
	OPERATIONAL				
12.	**Members Fees Policy and Review for 2022/23** For approval	C12(22)	Interim Head of Secretariat	449 – 469	1:05pm (20 mins)
13.	**Data Policies** For approval	C13(22)	Interim Head of Secretariat	470 – 486	1:25pm (20 mins)
14.	**Council forward Plan** For noting	C14(22)	Interim Head of Secretariat	487 – 488	1:45pm (5 mins)
15.	**Any Other Business** (Items must be notified to the Chair 24 hours before the meeting)		Chair		1:50pm
	Meeting Close				1:55pm

Date of next meeting – Wednesday 29 June 2022

GENERAL OPTICAL COUNCIL – REGISTER OF INTEREST 2021/22 (UPDATED 08 March 2022)

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

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

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

General Optical Council

GENERAL OPTICAL COUNCIL

DRAFT minutes of Council held in public on Wednesday 8 December 2021 at 10:00 hours via Microsoft Teams

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

GOC Attendees: Marcus Dye (Interim Director of Strategy), Yeslin Gearty (Director of Resources), Philipsia Greenway (Director of Change), Lesley Longstone (Chief Executive and Registrar), Sarah Martyn (Interim Head of Secretariat), Leonie Milliner (Director of Education) and Dionne Spence (Director of Casework and Regulation)

External Attendees: Matt Thurman (Eventure Research)

	Welcome and Apologies
1.	The Chair opened the meeting and welcomed external attendees and staff to the meeting. She then reminded the meeting of the housekeeping rules.
	Declaration of Interests C45(21)
2.	There were no new declarations and Council noted the register of interest.
3.	Glenn Tomison, Josie Forte and Roshni Samra have an interest in item 6 *Education and Training Requirements for GOC-Approved Qualifications in Additional Supply, Supplementary Prescribing and/or Independent Prescribing Categories.*
4.	All registrant Council members have a declaration of interest in item 23 *Registrant Fees Rules and Future Fee Strategy.*
	Minutes of Previous Meetings C46(21)
5.	Council **approved** the minutes of the meeting held on 22 September 2021 as an accurate record of the meeting.
	Updated Actions C47(21)
6.	Council noted progress on the actions since the last meeting.
	Matters Arising
7.	There were no matters arising.
	Chief Executive and Registrar's report C48(21)
8.	The Chief Executive and Registrar provided an update to her report as follows: • Congratulations were given the Director of Education on her appointment as Chief Executive and Registrar, effective from 3 January 2022, which created a gap in the Senior Management Team. The Director of Regulatory Strategy role would be advertised shortly. • The outcome of the KPMG report had not yet been shared with regulators even though it was due by the end of the year. Several options were expected to be presented to Ministers with a smaller number shared for consultation. • Thanks were given to Lizzy Ostler at the College of Optometrists for leading the collaborative work on, and to all those who had contributed to, the indicative guidance.

	• The three-year CET cycle was coming to an end and although the numbers were still changing, currently completions for optometrists was 5% lower and for dispensing opticians 8% lower than the equivalent period for the previous three-year cycle. Reminder letters would continue to be sent and there would be someone available to deal with any queries over the Christmas and New Year period. • The new website had gone live. The next step was to release the new version of MyGOC in 2022. • The new *Speaking up Guidance* for registrants had been launched. • The latest staff engagement survey had concluded at the end of November and the headline responses looked positive; though it was clear there was still more work to be done. One of the strong messages that had come across was positivity regarding the work around anti-racism. • There had been a good response to the recent Council Associate recruitment campaign, which had been positioned as a development opportunity for learning more about boards and committees. • There had been conversations with the Northern Council for Technical Education who had been awarded the contract to develop an Optical Care Services T level which would allow for progression routes from school or college. The GOC had been invited, and agreed, to take part in the Technical Education Advisory Meeting.
9.	In response to a question about the CET cycle being moved away from the Christmas and New Year period, Council noted that this was something that could be considered in future as part of legislative reform but that any change would also affect alignment with the annual renewal cycle.
10.	In response to a question regarding higher education funding of optical education Council noted that as yet, there were no identified additional funding streams. Conversations were more difficult in England because of commissioning arrangements and the Government's delayed response to the Auger review, but were taking place in the devolved nations.
11.	Council noted the report.
	Chair's Report C49(21)
12.	The Chair also congratulated the Director of Education on her appointment as Chief Executive and Registrar.
13.	The Council Associate role had attracted very wide ranging and interesting applications but the pilot was only for two individuals in the first instance. Thought was being given to how interested registrants could be engaged with in other ways.
14.	The Chair had undertaken many internal and external meetings, including attending meetings of the anti-racism group and several black history events, which she commended. There had also been events for disability month.
15.	Council **noted** the report.
	STRATEGIC
	Matt Thurman (Eventure Research) joined the meeting.
	Education and Training Requirements for GOC-Approved Qualifications in Additional Supply, Supplementary Prescribing and/or Independent Prescribing Categories C50(21)
16.	The Director of Education opened the item by reminding Council that the deadline for the open consultation on updated requirements for Contact Lens Optician qualifications was 20 December 2021. Council were asked to consider the recommendations in paragraph two of the covering paper and the supporting annexes, in particular annex one; the proposed, updated requirements for GOC-Approved Qualifications in Additional Supply, Supplementary Prescribing and/or Independent Prescribing categories. Advice from the statutory committees (Education Committee and Standards Committee) on the proposals was also included to inform Council's consideration of the proposals. It was noted that this workstream formed the third strand of the Education Strategic Review, and that an Expert Advisory Group had met nine times since October 2020 to consider the proposals. Thanks were given to all those who had been involved in the journey to this point.

	10:26 hours - Frank Munro entered the meeting.
17.	Eventure Research then set out the key findings from the consultation, which had resulted in 55 responses over a 12-week period. Council noted: • 76% of respondents agreed with the proposal to replace the Quality Assurance Handbook and related policies with the three new documents. • On the whole, positive feedback was received on: - changing to a single qualification from two GOC-approved qualifications; - removing current, highly specific requirements for clinical experience; - the proposal for a qualified designated prescribing practitioner (DPP); - the proposal for a requirement for providers to seek feedback from stakeholders; - the proposal for the use of an outcomes-based approach; - the proposal for that providers to be responsible for the assessment of approved qualifications; - the proposal for recognition of prior learning and the removal of two-year registration requirement; and - the proposal to remove the requirement to supply details of prescribing decisions. • The majority of survey respondents reported no positive or negative impacts of the proposals in relation to protected characteristics.
18.	In further discussion, Council noted the following: • The recommendations were welcomed and all those involved were to be congratulated on the progress of the work. • A lot of detailed work had taken place, including a large number of Education Advisory Group (EAGs) meetings to shape the proposals. • This new approach would provide an excellent opportunity for training and career progression. • It would be interesting to see whether there was consistency of approach for independent practitioner training. • There would be some challenges with the removal of requirements for hospital placements, but on the whole this was considered a positive move. • The move to a designated prescribing practitioner would enable non-medical prescribing practitioners, including optometrists, to fulfil this role and free up pressure on hospital-based ophthalmologists. • It was good to see the proposal for clinical experience align to other non-medical prescribing programmes; this was warmly welcomed. • The single qualification to enter the register would open up opportunities to align independent prescribing qualifications for optometrists with those of other non-medical prescribing programmes; this too was warmly welcomed. • The £60k from reserves was believed to be sufficient for the information hub, but it was suggested that any further requests would be considered positively. • It was important to engage with commissioners, medicine management groups and other groups with access to prescribing budgets early on. In England there would shortly be 42 integrated care systems, which would each require engagement. • It was noted that holding an independent prescribing qualification did not mean that a practitioner could manage glaucoma or other complex cases. • This development would be welcomed in Scotland where there was a bottleneck in hospital placements. • There was a need to obtain assurances from providers that the full range of experience could be obtained in different settings. This reflected the changing landscape and burden of different diseases, particularly where an optometrist was considered the first port of call. It was noted that 80% of people with acute eye conditions were now being managed in the community. • There are a range of issues the GOC will need to consider in the future including support for providers as they adapt existing courses to meet the new requirements, at the pace required. • Upskilling of the profession, as these proposals would lead to, was welcomed. • There was a need to continue the open dialogue with stakeholders going forward. • There were some concerns around the practicalities of the implementation, as universities had suffered over the last two years. Council questioned whether they would have the capacity to adapt existing approved IP qualifications as well as adapting qualifications in optometry/

	dispensing optics, particularly if this was required to be rolled out by September 2023. This meant that the courses would have need to be adapted by the summer of 2022 followed by marketing of the courses.
19.	In response to Council's observations, the Director of Education made the following points: • If the £60k proved insufficient for the knowledge hub, Council would be asked to approve further funding. • A key risk for GOC moving forward was the aged nature of our current quality assurance handbooks and competence framework, and reliance on a single supplier for final part of the route to qualification. • Providers' engagement with commissioners and other such groups would be undertaken in a co-operative way and assurance provided via the EVPs/quality assurance and enhancement method in accordance with proposals. • Guidance to providers could be provided by the proposed knowledge hub. • The Act at present only permitted GOC to approve qualifications for optometrists in the additional supply (AS), supplementary prescribing (SP) and independent prescribing (IP) categories. Post-registration qualification approval in other post-graduate specialisms is an area of interest for HEE and maybe considered as part of the DHSC's legislative reform programme. • Training and support for designated prescribing practitioners should align with the published RPS competence framework for designated prescribing practitioners. • In relation to adaptation of existing approved prescribing qualifications, current providers had been engaged in the development of the proposals as members of the EAG and in a dedicated webinar and had been engaged in the development of timescales for adaptation. • A future workstream is a longitudinal-cohort-based study which is anticipated to provide data to inform for future adjustments to requirements for qualification approval for the future.
20.	The Director of Education advised that thus far the consultation on new requirements for Contact Lens Opticians had had a low response and requested that stakeholders and Council members responded to the consultation before 13 December 2021.
21.	Council: • received advice from Education Committee and Standards Committee 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. • noted 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); • approved the proposed updated requirements (full copies attached at annex one): Outcomes for Approved Qualifications for Specialist Entry to the GOC Register; Standards for Approved Qualifications for Specialist Entry to the GOC Register and Quality Assurance and Enhancement Method for Specialist Entry to the GOC Register • approved use of reserves of up to £60,000 of over a period of three years (2022 - 2025) to facilitate a cross-sector knowledge-led collaboration and information exchange central to the successful implementation of proposals in annex one; and • delegated to the Chief Executive and Registrar authority to approve final scheme design, budget, contract specifications and tender process in accordance with the Scheme of Delegation for Financial Management and Contracts and Procurement Policy (should the proposals be approved by Council).
	11:41 hours - Matt Thurman (Eventure Research) left the meeting. Council took a break and returned at 11:57 hours.
	ASSURANCE
	Health and Safety Report C51(21
22.	The Director of Resources introduced the report, which covered the survey conducted in May 2021.

23.	Council noted DSE surveys were conducted on a rolling basis. The welfare of staff working at home was monitored and equipment was provided as well as services such as physiotherapy. The Executive confirmed that the report covered 10 Old Bailey rather than staff working at home.
24.	It was suggested that Council receive a report showing a more rounded view of health and safety in future, including performance against relevant KPIs and key risks. This should include the risk to people's eyesight for being on screens all day. Council noted that the Audit, Risk and Finance Committee (ARC) reviewed a serious incident report that included any RIDDOR reports and other compliance activity. There was a separate risk covering Covid infections. It was agreed that consideration would be given to how the compliance information regarding health and safety should be presented to Council.
25.	The Chair of ARC and the Director of Resources would give consideration to the flow of information to Council around managing risk of infection in the office. The Director of Resources advised that the GOC had been ahead of the curve around Covid. Daily taskforce meetings had been held in the lockdown until such time that the threat had alleviated. There were recommended Covid instructions implemented in the office, which had been updated each time government guidelines changed. It was noted that the Covid taskforce had met the previous week to discuss the new variant which had led to the GOC taking a cautious approach.
	ACTION: the Chair of ARC and the Director of Resources would give consideration to the flow of information around health and safety to Council around managing the risk of infection in the office to provide a more holistic view.
26.	Council noted the report.
	First draft Budget and Business Plan for 2022/2023 C52(21)
27.	Council noted that the budget and business plan presented was midway through a five-year strategy. Individual teams had looked at their business activity over the coming year and had aligned them with their current financial forecast for 2022-23. Their planned activities had then been cross referenced to the five-year strategy to identify work that had slipped as well as forecast. Work around the legislative reform had been delayed by the Department of Health and Social Care (DHSC) which would not now be launched before late 2022. There had also been some additional unplanned activities which were now anticipated to continue into year 3. The intended review of business regulation would start with a call for evidence but would now be implemented in year 4 with only proposals and strategy being completed in year 3. The CPD programme would be launched over the next year and there would on-going work in relation to the ESR including implementation of decisions made at this Council meeting.
28.	In terms of budget Council would be asked to approve a balanced budget, or better, whilst more detailed work took place, including costing out the additional pieces of work that had been committed to. There may also be some additional funding required for the change programme.
29.	It was suggested that regulatory reform, which was a high risk area, could require additional investment in unplanned activity. Council noted that regulatory reform would be highlighted in the final business plan, by which time more might be known about the outcome of the KPMG report. Clearly, dependent on the outcome of this review, the GOC may have to completely shift its focus and there would likely be an additional call on resources. This was a risk that needed watching, but any significant activity for the GOC was likely to arise in year 2023-24 rather than next year. This would need to be clearly set out in the business plan.
30.	Council: • noted that the draft business plan supports the current five-year strategic plan; • noted that the final budget will be on the basis of a balanced budget or better; • provided comments on the draft
	11:10 - 11:25 hours – Council took a break.
	Balanced Scorecard C53(21)

31.	Council noted that staff engagement was shown as a downward arrow on the basis of the "pulse survey", which fluctuated throughout the year. The staff survey, which looked at engagement annually had been received since the papers had been produced and was very positive, showing an upward trend.
32.	Council **noted** the balanced scorecard.
	Business Plan 2021/2022 – Q2 Progress C54(21)
33.	The format of the report was welcomed but it was suggested that the font size of this (and the risk register) should be increased to meet the policy on minimum font size.
34.	The increased number of FtP cases received was noted and linking into a previous conversation regarding organisational resilience there was a question as to whether additional resources were needed to support the 50% caseload increase. The Director Casework and Resolution advised that although there was a 50% increase in receipts, many of them would not make it through the system. However, the structure was being reviewed to ensure that the skills are in the right place and that staff can be moved across when additional resource were required. Staff were being recruited at admin levels and developed as part of succession planning.
35.	Council **noted** the Q2 progress of the internal operational business plan 2020/2021.
	Finance Performance reports for the period ending 31 September 2021 and Quarter 2 Forecast of 2021/2022 and 2022/2023 C55(21)
36.	Council noted the continuing surplus which was largely due to savings from the remote ways of working, efficiencies in work methodology and delays in operations. There had also been gains from the portfolio investments. Future work will include reviewing the reserves and investment policies in line with Chairty Commission guidelines. Council also noted that savings and the current financial position had continued along the same trajectory and had slightly improved since the end of September 2021.
37.	Council noted: • the financial performance for the six months ending 30 September 2021 in Annex one • the Q2 forecast for the current year 2021-22 in Annex two, and • the latest forecast for 2022/23 under Q2 forecast year 2 in Annex two.
	OPERATIONAL
	Registrant Fees Rules and Future Fee Strategy C56 (21)
38.	The Director of Resources advised that the recommendation to freeze fees for the coming year was due to feasibility and economic issues. ARC had looked at the proposal on 24 November alongside the five-year projection and agreed to recommend that Council approve the proposal. It was noted that a small increase had been considered but the financial benefit was neither appropriate nor necessary in the current circumstances.
39.	The Director of Resources agreed to look at the wording of any announcement in terms of manging expectations for fee levels in future years.
	Action: the Director of Resources agreed to look at the wording of any announcement in terms of manging expectations for fee levels in future years.
40.	Council: • agreed that fees would be frozen for 2022-23 and that the approach of raising fees in line with inflation would be continued over the medium term.
	• considered and approved the draft fee rules, as set out in annex one.
	Council Forward Plan C57(21)
41.	Council **noted** the report.
	Any Other Business

	Chief Executive and Registrar
42.	The Chair thanked the outgoing Chief Executive and Registrar for her outstanding leadership of the GOC.
43.	The Chief Executive and Registrar responded by thanking Council, staff, and the Senior Management Team (SMT), noting that the job could not have done without them.
44.	Thanks were given to the members of the public who attended.
	Meeting closed: 12:42 hours
	Next meeting: 16 March 2022

PUBLIC
C03(22)

COUNCIL

Actions arising from Public Council meetings

Meeting Date: **16 March 2022** **Status:** **For noting.**

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

Purpose

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

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

Part 1: Action Points from the Council meeting held on 8 December 2021

Reference	By	Description	Deadline	Notes
C25(21) (8 December 2021)	Chair of ARC / Director of Resources	To give consideration to the flow of information around health and safety to Council around managing the risk of infection in the office to provide a more holistic view.	April 2022	**Ongoing**
C39(21) (8 December 2021)	Director of Resources	To consider the wording of any announcement in terms of manging expectations for fee levels in future years.		**On-going:** As indicated previously, our intention remains for modest and consistent fees for future years, any increases in fees for 2023-23 will be in line with inflation and will remain subject to annual review.

Part 2: Action points from previous meetings which remain outstanding

C36(21) (22 September 2021)	Secretariat	To circulate a request for information on personal characteristics to Council.	March 2022	**COMPLETED:** We originally advised that this would be sent out with the Council skills audit. This did not happen due to resourcing issues but has since been sent out.

Part 3: Action points previously outstanding but now completed.

There are no actions outstanding from previous meetings.

General Optical Council

PUBLIC COUNCIL

Report from the Chair of Council

Meeting: 16 March 2022 **Status:** For noting

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

Introduction

1. This report covers my principal activities since the last Council meeting on 8 December 2021.

2. This will be Leonie's first Council meeting as Chief Executive and Registrar. I would like to place on record on behalf of Council our appreciation for her former achievements as Director of Education and wish her the absolute best in her new role.

Management

3. I have had regular catch-up meetings with the Chief Executive and Registrar as well as briefings from members of the Senior Management Team (SMT), Leadership Team and Secretariat on a range of priorities.

4. I have held regular catch-up meetings with individual SMT members.

5. I have attended some activities of the GOC Equality, Diversity and Inclusion networks including Black History Month, LGBTQ+ History Month, and events to mark International Women's Day. I attended a presentation by the charity Ambitious About Autism and a follow up meeting (15 December 2021).

Council and Committees

6. I have chaired a meeting of the Nominations Committee (01 February 2022). I attended meetings of the Remuneration Committee (16 February 2022), and the Audit and Risk Committee (20 January 2022 and 03 March 2022).

7. I have held regular catch-up meetings with the Council Senior Member Glenn Tomison as well as occasional meetings with individual Council members.

8. I chaired the Appointment Panel for the Council Associate Campaign. I am delighted to welcome our new Council Associates Rukaiya Anwar and Harry Singh to their first Public Council meeting. We received a strong response to the Recruitment Campaign from our registrants and thank all those who put themselves forward.

9. I attended a meeting with the statutory Committee Chairs to discuss the Advisory Panel and Statutory Committees going forward (09 February 2022).

10. I attended the Audit, Risk and Finance Committee Development Session (10 February 2022).

11. I chaired the Council Strategy and Development Session (14 February 2022).

Stakeholders

12. My ongoing induction programme has included further introductory meetings with sector bodies and stakeholders. These included the NHS Education for Scotland (NES) with Karen Reid, CEO and David Garbutt, Chair (14 March 2022) and a follow up meeting with Health Education England (HEE) with Navina Evans and Sir David Behan (08 February 2022). I have also met with Association of British Dispensing Opticians (ABDO), on the 28 February 2022 with President Jo Holmes and Head of Strategy Alistair Bridge to brief them about the Council Associate programme, and was joined for the meeting by Leonie Milliner. An introductory meeting with the OSC is currently scheduled for 16 March.

13. I participated in the HEE Long-Term Strategic Framework Programme - Second Deliberative Event (09 December 2021). The third and final session is to take place later this month.

14. I attended the Department of Health and Social Care (DHSC) introductory meeting for Leonie Milliner as new CEO with Mark Bennett and Gavin Larner (10 March 2022).

PUBLIC
C05(22)

COUNCIL

Chief Executive and Registrar's Report

Meeting: 16 March 2022 **Status:** For noting

Lead responsibility and paper author: Leonie Milliner (Chief Executive and Registrar)

Council Lead(s): Dr Anne Wright CBE

Purpose

1. To provide Council with an update on stakeholder and other meetings attended by the Chief Executive and Registrar and activities not reported elsewhere on the agenda.

Recommendations

2. Council is asked to note the Chief Executive and Registrar's report.

Strategic objective

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

Background

4. The last report to Council was provided at the December 2021 meeting.

Analysis

5. As this is my first report as Chief Executive and Registrar, I would like to extend my thanks to our Chair and Council, members and committees, our capable and committed staff team and the wider stakeholder community for the warmth of my welcome and for the constructive and insightful support I have received in my first two months in post. I look forward to building on the GOC's strong track record as the independent regulator for the optical sector working across all nations of the UK to the benefit of patients and the public we serve.

6. I would also like to formally welcome our two new Council Associates, Rukaiya Anwar and Harry Singh Bhakar, to their first meeting of Council.

7. Steve Brooker will join GOC on 23 May 2022 as the Director of Regulatory Strategy, leading our Education, Policy, Standards and Communications and

Engagement functions. This is the final appointment to our reshaped Senior Management Team (SMT) as part of our wider change programme to ensure successful delivery of our 'Fit for the Future' five-year strategic plan. Steve Brooker is currently Head, Policy Development and Research at the Legal Services Board (LSB) where his key responsibilities include strategy and business planning, policy development, the LSB's research programme and statutory oversight of the Legal Ombudsman and Solicitors Disciplinary Tribunal. I would like to thank Marcus Dye, Acting Director of Regulatory Strategy, for so ably managing the Strategy Directorate during this transitional period on an interim basis.

8. On 19 January I received a confidential summary of KPMG's report to DHSC.

9. On 18 February I received a copy of a letter from the Chief Optometric Advisor in Scotland to the Community Eyecare Sector in Scotland describing the Scottish Government's changes to its General Ophthalmic Services, Community Glaucoma Service and Low Vision Service. The letter also described the Scottish Government's intention to support NES Education Scotland's work with universities in Scotland as they adapt their GOC approved qualifications to meet the GOC's new education and training requirements.

10. Following the UK Government's announcement on removing the requirement for health and care professionals to be vaccinated in order to be deployed in Care Quality Commission (CQC) regulated healthcare settings in England, we published a news release on our website outlining that we will continue to promote the message that our registrants should be vaccinated in all settings in which care is delivered and that they should encourage other patient-facing colleagues and support staff to do the same.

11. We, together with optical sector professional and representative bodies, will also be writing to all registrants, in all UK nations, the week commencing 7 March highlighting their personal and professional responsibilities under our standards, encouraging them to be vaccinated and providing links to support materials for those who are still considering vaccination.

Education

12. In January 2022, all programme providers responded to our annual monitoring return, in which they reflect on key changes, events and risks to their programmes. This feeds into our routine quality assurance of providers' ability to meet GOC education requirements and informs an annual sector report which will be presented to Council in June 2022.

13. As part of this annual monitoring return, providers were also asked for their plans on adapting to the new optometry and dispensing optics education and training requirements, published March 2021. Following this, meetings are

taking place with each provider to discuss their plans in more detail and offer advice on the requirements. A provider workshop also took place in January 2022 where we discussed our quality assurance documentation and processes for the adaptation of approved qualifications to the new education and training requirements.

14. Education quality assurance visits are continuing as planned, with most continuing in a virtual format. On-site visits are taking place as required, for example, where facilities need to be reviewed or for exam observations. Since December 2021, one on-site visit has taken place, and two are scheduled to take place shortly.

15. Two providers remain under our Serious Concerns Review (SCR), with visits scheduled for March and April 2022. The status of the SCR for both providers will be reviewed as part of these visits and the outcome reports will be published on our website.

16. Following approval of the updated education and training requirements for approved qualifications in additional supply (AS), supplemental prescribing (SP) and independent prescribing (IP) in December 2021, a Technical Advisory Group (TAG) meeting is scheduled to take place on 27 April to review the proposed evidence framework, forms and quality assurance documents developed to support providers' adaptation of their existing approved qualifications in therapeutic prescribing to meet the new requirements.

17. A Sector Strategic Implementation Steering Group (SSISG) meeting is due to take place on the March, with updates due from each of the workstream leads.

Registration

18. Annual renewal for fully qualified registrants and body corporates opened on 25 January. As usual, the closing date for renewal applications is 31 March. Renewal rates are in line with previous years and as of 8 March 69% of individuals had completed the process and paid, along with 76% of body corporates.

19. The final CET cycle closed on 31 December 2021; 716 of registrants did not meet their points requirement. This means that 97% of our registrants successfully completed the CET cycle for 2019 to 2021 (98% for the last cycle.) Of those not meeting the requirement, 171 registrants withdrew or retired from the register. From the remaining 545 registrants, around 200 have lodged disputes relating to their CET points total or have made an application for consideration under our CET exceptions policy. My review of applications for consideration under our CET exceptions policy, supported very ably by Lesley Longstone and Allison Siveyer, has been completed and applicants will be notified from 9 March 2022 in line with the end of the renewal cycle and in sufficient time to allow for removals at the beginning of April.

Casework and Resolution

20. We have received over 400 new concerns this year to date - an increase of 28% on whole of last year - while achieving a conversion rate of less than 25%, improving on the benefits obtained through our streamlined triage process and greater early collaboration with the Optical Consumer Complaints Service.

21. The public consultation on our review of our approach to illegal practice has closed and has received some very constructive responses which we are currently working through. We aim to publish our revised strategy in Spring 2022.

22. We continue to make positive strides in reducing the length of time it takes us to resolve investigations and are currently achieving a rolling closed case median of 90 weeks for all substantive decisions.

23. We will shortly be launching our FtP Improvement Programme 2.0, documenting the programme of change and continuous improvement we will be undertaking between now and 2025. A key deliverable of this will be an integrated case management system to support a more streamlined and efficient customer led fitness to practise process.

Strategy

24. We published new guides to CPD and launched the CPD scheme on 1 January 2022. This included delivery of two CPD webinars for registrants and approvers on 14 December and 7 February – registrant webinars available to view on our website. The next webinar is planned for March.

25. We held three student welcome webinars online during January and February. These new online webinars are available for all students to attend and introduce the GOC, its regulatory functions and expectations of students. A recording of the webinar will be sent to all student registrants and is available to view on GOC YouTube.

26. The directorate has been making preparations to launch a call for evidence on potential reform of areas of the Opticians Act not covered by proposals already made the DHSC. It has also begun pre-consultation engagement on a review of the Standards of Practice for Optometrists and Dispensing Opticians, Standards for Optical Students and Standards for Optical Businesses. This included presentations and engagement on both areas with the GOC advisory panel and statutory committees, and some engagement with sector organisations on the former. The call for evidence launch will be timed to follow the current DHSC consultation on regulated professions, to which the GOC is also producing a response. A consultation on reform of the standards is

planned for the beginning of 2023.

27. We have begun recruitment for a new Head of Communications position to bolster our communications function as part of the GOC Refresh project.

Corporate Services

28. The Finance team have been working on the completion of our 2022/23 budget five-year forecast including reserves and cashflow, which is presented for Council's consideration as part of the meeting papers.

29. Human Resources have been busily occupied with the considerable recruitment activity that has been a feature of the last three months. Our current headcount has increased to 92 as we expand our workforce to deliver our GOC Refresh programme and strategic projects for the coming year.

30. Following the removal of almost all Covid-19 restrictions the office is available for all staff to utilise and we are encouraging teams and individuals who are comfortable to attend the office for induction, team meetings, collaborative work, for a quiet space to work and indeed, for a change of scene. Control measures remain in place to reduce the risk of transmission and to help keep everyone safe. Staff may not attend the office if they have tested positive and/or have COVID-19 symptoms and staff must wear a mask when not sat at their desk. A full description of controls measures and risk assessment forms for staff and visitors are available on our internal intranet site, IRIS.

Equality, Diversity, and Inclusion

31. We continue to actively recruit for a new EDI manager following the departure of our former EDI partner.

32. Our Staff Wellbeing and Engagement Group (SWEG) continues to offer support to colleagues impacted by the ongoing conflict in Ukraine, and conscious that staff may have friends or relatives from either side of the conflict, on 1 March we held an all-staff virtual coffee break to allow colleagues to come together and reflect. A further event is being planned by SWEG.

33. On 25 February, I was delighted to attend an inter-regulatory lunchtime event co-led by our EmbRace and LGBTQ+ staff networks to mark the end of LGBTQ+ month; a screening of the BAFTA nominated short film 'Black Cop,' along with an enlightening QandA with the Director.

34. This month our WOMEN network is planning a series of events to mark International Women's Day on 8 March and Women's History Month, 1-31 March.

Governance

35. Two Council Associates were welcomed at the beginning of January 2022 and inductions sessions completed with Council and SMT.

36. Recruitment has just finished for independent lay members for the Audit, Risk and Finance Committee and the Remuneration Committee.

Change

37. Recruitment of the change team continues with 75% of vacancies now filled. With the Head of Programmes now in post, the focus is ensuring timely delivery of change programme alongside facilitation of capability organisation across the organisation.

38. Stage 2 of the organisational redesign is underway with visioning and development of options for directorate structures. Initial discussion with teams on business processes is complete with options for informal discussion expected early April. Arrangements are being made to include the incoming Director of Regulatory Strategy in options analysis for the strategy directorate organisational design.

External stakeholder engagement

39. Since the last Council meeting, in my former role as Director of Education I attended the following meetings:
    - 7 December 2021: I participated in the Alconversation 2021 Panel which was broadcast live and available to view online.
    - 9 December 2021: I attended the Quality Assurance Agency for Higher Education (QAA)'s Advisory Committee on Degree Awarding Powers (ACDAP).
    - 10 December 202: I attended the Optical Suppliers Association Christmas lunch at the Bloomsbury Hotel.
    - 13 December 2021: GOC's Head of Education and I met Kiki Soteri (GOC Education Visitor) to discuss the registration of internationally trained optometrists in the context of the new education and training requirements.
    - 14 December 2021: I chaired the CPD Registrants' Webinar.
    - 15 December 2021: with Lesley Longstone I attended a meeting with Ambitious about Autism (AaA) to discuss AoA's internship programme.

40. In addition, since the last Council meeting and before her retirement on 2 January 2022, Lesley Longstone, Chief Executive held the following meetings:
    - 14 December 2021: Quarterly meeting with Mark Bennett, Director of Workforce, Department of Health and Social Care (DHSC).
    - 16 December 2021: Lucy Smith DG Strategy and Change, Department for Environment, Food and Rural Affairs (DEFRA).

41. Since my appointment on 2 January 2022, I have attended the following eternal meetings and engagements:

- 11 January 2022: Lizzy Ostler, Director of Education at College of Optometrists to discuss clinical learning in practice, SPOKE and other ESR-related developments.
- 13 January 2022: Ian Humphreys, Chief Executive at the College of Optometrists to discuss the GOC's new CPD Scheme.
- 18 January 2022: I met Maree Todd MSP, Minister for Public Health, Women's Health and Sport, Mike Stewart and Janet Pooley (Scottish Government) to discuss the GOC's new education and training requirements for approved qualifications in independent prescribing and other the development of optometry education in Scotland.
- 19 January 2022: I joined an update meeting for Professional, Statutory and Regulatory Bodies (PSRBs) with the Office for Students (OfS) outlining its current consultations.
- 21 January 2022: I joined a joint meeting of the Optometry and Dispensing Optician Expert Advisory Groups.
- 26 January: I attended and presented at the GOC Education Providers' Forum, which focused on adaptation to the GOC's new education and training requirements for approved qualifications.
- 27 January 2022: I attended the Quality Assurance Agency for Higher Education (QAA)'s Advisory Committee on Degree Awarding Powers (ACDAP).
- 27 January 2022: I had an introductory meeting with Hugh Simpson, Chief Executive, Architects Registration Board.
- 31 January 2022: I met Mark Bennett, Director of Workforce, Department of Health and Social Care (DHSC) to discuss developments in relation to Covid-19 and the government's vaccination programme in England.
- 02 February 2022: I attended the Chief Executives of Health and Social Care Regulators (CEORB) to discuss the government's vaccination programme in England.
- 03 February 2022: I joined the Contact Lens Optician Expert Advisory Group post-consultation meeting.
- 01 February 2022: I attended Nominations Committee.
- 04 February 2022: I joined a lunch meeting with Maurice Cheng, Chief Executive of the Institute of Osteopathy.
- 4 February 2022 and 4 March 2022 I attended the Chiropractic, Optical, Pharmacy, Osteopathic and Dental Regulatory Bodies Co-operation Pod (COPOD) meeting, organised by the General Osteopathic Council (GOsC).
- 08 February 2022: I held an introductory meeting with Alan Clamp, Chief Executive of the Professional Standards Authority (PSA).
- 08 February 2022: I joined the Chair, Dr Wright in a meeting the Health Education England (HEE) Chief Executive, Dr Navina Evans, and Chair, Sir David Behan.

- 10 February 2022: Quarterly meeting with Ian Humphreys, Chief Executive, College of Optometrists.
- 25 February 2022: I attended the Chief Executives of Health and Social Care Regulators (CEORB) meeting organised by the General Dental Council (GDC).
- 16 February 2022: I attended a Remuneration Committee meeting.
- 24 February 2022: I attended an Advisory Panel meeting and a meeting of Education Committee.
- 28 February 2022: The Chair and I joined a discussion with the Association of British Dispensing Opticians (ABDO) about the development of GOC's Council Associate initiative.
- 01 March 2022: I chaired the Optical Sector CEO meeting.
- 02 March 2022: I attended a meeting with Joanne Pearson from HR Business Solutions.
- 02 March 2022: I attended a meeting with the Optometry Schools' Council to discuss to discuss the registration of internationally trained optometrists in the context of the new education and training requirements.
- 20 January 2022 and 03 March 2022: I attended the Audit, Finance and Risk Committee meeting and on 10 February 2022 I joined the Committee for their annual development session.
- 07 March 2022: To mark International Women's week I gave a talk to the General Dental Council (GDC) Gender Equality Together (GET) network.
    - 10 March 2022: The Chair and I attended an introductory meeting with Mark Bennett and Gavin Larner Workforce Directorate, Department of Health and Social Care (DHSC).
    - 11 March 2022: I joined a health regulators' meeting with Health Education England (HEE).
    - 14 March 2022: The Chair and I had an introductory meeting with Karen Reid, CEO and David Garbutt, Chair from NHS Education for Scotland (NES).

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

Finance

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

Risks

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

Equality Impacts

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

Devolved nations

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

Other Impacts

47. No other impacts have been identified.

Communications

External communications

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

Internal communications

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

Next steps

50. There are no further steps required.

Attachment

Annex one - Directors' Stakeholder Meetings

Meetings/visits since last Council meeting

Philipsia Greenway **Director of Change**	**Marcus Dye** **Director of Regulatory Strategy (Acting)**	**Dionne Spence** **Director of Regulatory Operations**	**Yeslin Gearty** **Director of Corporate Services**
Jo Sanford NHS projects network – to discuss healthcare project and change community and initial plans for formally setting up the Healthcare Project and Change Association (hosted under HFMA) to provide the profession function on a more sustainable basis	**6 x Weekly UK Advisors Meeting with:** • Raymond Curran – Head of Ophthalmic Services, Health and Social Care Board Northern Ireland • Janet Pooley – Chief Optometric Advisor to Scottish Government • David O'Sullivan - Chief Optometric advisor to Welsh Government • Daniel Hardiman McCartney – The College of Optometrists	**21/01/22 Witness to Harm - project meeting** Dr Louise Wallace, *Professor of Psychology and Health, Open University* Dr Ros Searle, *Chair - HRM and Organisational Psychology, Glasgow* Sara Ryan, *researcher, Manchester Metropolitan University* Francesca Ribenfors, *researcher, Manchester Metropolitan University* Gemma Hughes, *primary healthcare investigator, University of Oxford*	11/01/22 Ashley Norman – Director TIAA (internal auditors)
15th Feb: initial inter – regulatory project network inception meeting to bring together project professionals across the regulatory sphere to share best practice, tools and support where appropriate	**2 x Monthly UK-REACH STAG Project Board meetings (December and February)** – Government commissioned research into impact of Covid-19 on diagnosis and treatment of ethnic minorities	**17/01/22 Amazon UK** Gaon Hart, *Head of Public Policy* Jeremy Opperer, *Principal, Product Trust and Regulatory Affairs* Marta Mathew, *Corporate Counsel* Yara Fadayel, *Corporate Counsel* Paer Stenmark, *Principal Manager, Customer Trust*	08/02/22 Adam Halsey – Partner, Charlotte Williams – senior manager hayesmacintyre (external auditors)
	13/01/2022 ABDO Board Meeting – to present on regulatory reform	**13/12/21 Defence Stakeholder Group**	14/01/21 Michael Scott – business development manager,

Philipsia Greenway **Director of Change**	**Marcus Dye** **Director of Regulatory Strategy (Acting)**	**Dionne Spence** **Director of Regulatory Operations**	**Yeslin Gearty** **Director of Corporate Services**
		Representation from AOP, ABDO, FODO, BLM Law, Hempsons, William Graham Law, Kingsley Napley and CMS	Dun and Bradsteet
	18/01/2022: Meeting with Maree Todd MSP, Minister for Public Health, Women's Health and Sport, Mike Stewart and Janet Pooley (Scottish Government) to discuss the GOC's new education and training requirements for approved qualifications in independent prescribing and other the development of optometry education in Scotland.	**09/12/21 TIAA** Kelly Reid, *Principal Internal Auditor*	08/12/21 Katie Faramarzie – relationship manager Lloyds Bank
	21/01/2022 Chaired Optometrist and Dispensing Optician Expert Advisory Group meeting	**09/12/21 Association of Optometrists** Ella Franci, *Director of Legal and Regulatory Services* Cassandra Dighton, *Head of Professional Discipline*	25/01/22 Gary Cattermole – partner The Survey Initiative
	25/01/2022 Student welcome event	**21/01/21 FtP Directors** *Monthly inter-regulatory meeting between all healthcare regulators to*	11/01/22 Peter Fairchild – consultant QCG Ltd

Philipsia Greenway Director of Change	Marcus Dye Director of Regulatory Strategy (Acting)	Dionne Spence Director of Regulatory Operations	Yeslin Gearty Director of Corporate Services
		share good practice and highlight new challenges	
	26/01/2022 GOC Education Provider event	**26/01/22 Primary Care Stakeholder Forum** Lead: Ursula Montgomery, *Interim Director of Primary Care, NHS England*	
	26/01/2022 Health and Social Care Regulators forum – meeting of health and social care CEOs	**10/02/22 GOC student welcome event**	
	03/02/2022: Chaired the Contact Lens Optician Expert Advisory Group post-consultation meeting	**09/02/22 Civica (software solutions – CMS)** Lead – Michael Hill, *iCasework*	
	08/02/2022 Alongside Head of Policy, meeting with Edward Dean Butler, Chairman of SuperVista AG	**24/02/22 Multi Agency Safeguarding Meeting** Local Authority Designated Officer Social Services Local Constabulary School ABDO College	
	08/02/2022 Student welcome event	**25/02/22 OCCS Quarterly Review** Jennie Jones, *Head of Complaints* Richard Edwards, *Consultant Clinical Advisor*	
	23/02/2022 NHS England Primary Care stakeholders meeting	**24/02/22 GOC Advisory Panel**	
	24/02/2022 GOC Advisory Panel meeting	27/01/22 Association of Chief Executives EDI Forum	

Philipsia Greenway Director of Change	Marcus Dye Director of Regulatory Strategy (Acting)	Dionne Spence Director of Regulatory Operations	Yeslin Gearty Director of Corporate Services
	24/02/2022 GOC Companies Committee meeting	07/02/22 Tom Scott, Executive Director, FtP - NMC	
	24/02/2022 GOC Standards Committee meeting		
	01/03/2022 Student welcome event		
	03/03/2022 The College of Optometrists' workforce project roundtable alongside optical sector representative bodies		

PUBLIC
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Council

Education Strategic Review – Post-Registration Speciality Qualifications

Meeting: 16 March 2022 **Status:** For decision

Lead responsibility: Marcus Dye (Acting Director of Regulatory Strategy)
Paper Author(s): Ben Pearson (Acting Education Manager – Policy, Projects & Research), Samara Morgan (Head of Education (maternity cover)), Simran Bhogal (Project Manager – Change), Leonie Milliner (Chief Executive and Registrar)
Council Lead(s): Dr Josie Forte

Purpose

1. To consider proposals to update our requirements for GOC approved qualifications leading to specialist entry to the GOC register as a Contact Lens Optician.

Recommendations

2. Council is asked to:
   - Receive **advice** from Education Committee and Standards Committee on our proposals to update our requirements for GOC approved qualifications leading to specialist entry to the GOC register as a Contact Lens Optician;
   - **Note** the outcome of the public consultation (Enventure Research consultation report); EDI impact assessment (Fraser Consulting); the impact assessment screening; and the outcome of the Delphi verification of the proposed outcomes (University of Hertfordshire);
   - **Approve** the proposed updated requirements (full copies attached at annex one):
     - Outcomes for Approved Qualifications for Specialist Entry to the GOC Register
     - Standards for Approved Qualifications for Specialist Entry to the GOC Register
     - Quality Assurance and Enhancement Method for Specialist Entry to the GOC Register; and
   - **Approve** recommendations made by the Sector Partnership for Optical Knowledge and Education (SPOKE) relating to the indicators (as amended in annex seven) contained within the Clinical Practice category of Outcomes for Dispensing Optics and Optometry as part of the GOC's "Requirements for Approved Qualifications in Optometry and Dispensing Optics" document, approved separately by Council on 10 February 2021.

Strategic objective

3. This work contributes towards the achievement of the following strategic objective: World class regulatory practice. This work is included in our 2021/22 Business Plan.

Background

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

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

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

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

8. In August 2019 the terms of reference and project plan for the development of the ESR post-registration speciality qualifications deliverables were approved by our Senior Management Team (SMT). The intention was to replicate (at pace) the drafting, research and consultation process undertaken for the pre-registration qualifications for dispensing opticians and optometrists, with leadership from two dedicated Expert Advisory Groups (EAGs), one for therapeutic/independent (TP/IP) prescribing and one for contact lens opticians (CLOs). The CLO EAG has now met ten times between September 2020 and January 2022. A list of IP and CLO EAG members is provided at annex eight.

9. The current requirements for specialty CLO qualification approval (quality assurance handbooks and related competence frameworks) were published in 2007 and 2011 respectively and are at significant risk of being no longer fit for purpose. The proposal is to replace the 'Visit handbook guidelines for the approval of training institutions and providers of schemes for registration for United Kingdom trained Contact Lens Opticians' published July 2007 and the 'Contact Lens Specialty Core Competencies' published in 2011, including the list of required core competencies, 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 with updated requirements for approved qualifications for specialist entry to the GOC register (as a CLO) at annex one.

10. In September 2021 we launched a 15-week public consultation seeking views on our proposals to update our requirements for GOC approved qualifications leading to specialist entry to the GOC register as a contact lens optician, specifically;

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

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

12. In addition, we commissioned the University of Hertfordshire to verify the proposed CLO outcomes using the established and tested Delphi method. The purpose of deploying the Delphi method was to test (verify) the veracity of the outcomes and the allocation of level (Miller's pyramid). Council received a verbal update on the University of Manchester and University of Hertfordshire's findings from the first round of the Delphi Method to verify the Outcomes for Registration for optometry and dispensing optics at its meeting in December 2020, and so the Council will be familiar with the use of the Delphi method to provide an additional level of assurance regarding the accurate allocation of Miller's pyramid level and description of expected knowledge skills and behaviours for specialty registration.

13. In early February 2022, following the close of the consultation, the CLO Expert Advisory Group met to consider the feedback gained from the consultation, Delphi verification, EDI Impact assessment and synthesised the results to further develop

the CLO proposals ready for consideration by the Advisory Panel in late February 2022, and by Council in March 2022 (see annex one).

14. In August 2021, the GOC commissioned SPOKE to establish a Knowledge Hub/Information Exchange to facilitate knowledge-led collaborations within the optical sector to meet our updated requirements for qualification approval. SPOKE is led by the College of Optometrists in a partnership arrangement with the Association of British Dispensing Opticians (ABDO), the Optometry Schools Council (OSC) and Opticians Academic Schools Council (OASC).

15. SPOKE's first project was to develop sector-led co-produced indicative guidance to sit alongside the Outcomes for Registration in the 'Requirements for Approved Qualifications in Optometry and Dispensing Optics.' The purpose of the indicative guidance is to provide a more granular level of detail to support providers as they begin to adapt their existing approved qualifications to meet the new outcomes for registration, with reference to the clinical practice outcomes. SPOKE worked rapidly in autumn 2021 with colleagues across the sector to prepare and publish its guidance, which was reported to Council in December 2021. The indicative guidance document is located at annex six.

Council decision; advice from statutory committees

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

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

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

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

20. On 24 February 2022 the Education Committee and Standards Committee met to discuss the proposals (attached at annex one) and in addition, the Registration Committee and Companies Committee also discussed the proposals. Written advice to Council from the committees is included in annex nine.

Analysis

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

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

23. The key proposals in annex one are:

    a. Candidates will acquire a qualification approved by the GOC leading to specialist entry to the GOC register as a contact lens optician.

    b. The approved qualification will be either an academic award or a regulated qualification at a minimum of Regulated Qualification Framework (RQF) (or equivalent) level 6.

    c. There will be no proposed minimum/maximum or recommended time or credit volume for an approved qualification or specified location or duration of clinical experience, other than the requirement that an approved qualification leading to

specialist entry to the GOC register as a contact lens optician must integrate approximately 225 hours of learning and experience in practice.

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

e. An outcomes-based approach is used to specify knowledge, skills and behaviours using an established competence and assessment hierarchy known as 'Miller's Pyramid of Clinical Competence' (knows; knows how; shows how; and does).

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

g. Providers of approved qualifications will be responsible for recruiting and selecting trainees onto a programme leading to an award of an approved qualification. Recognition of prior learning can be deployed to assist the progression of trainees whose progress to specialist registration has stalled.

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

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

26. Our prime intention is to ensure the qualifications we approve are far more responsive to local, regional and national patient, service-user and broader stakeholder requirements and are therefore more current, and aligned with our new requirements for pre-registration qualifications, leading to improved patient care. We also want to ensure continuing patient and public confidence in our ability to maintain and monitor high standards for qualification approval through our refreshed quality

assurance and approval process and give greater assurance that our requirements are being met and risks managed appropriately.

27. The proposals mitigate the key risk that our current requirements for post-registration qualification approval; (the core competencies, requirements for trainee's practical experiences and supervision, education policies and guidance) become out of date and are even less fit for purpose than they currently are.

Consultation

28. The 15-week public consultation seeking views and evidence of impact of our proposals launched on 20 September 2021 and closed on 3 January 2022 was broadly supportive of our proposals. We received 29 responses from a variety of stakeholders, including providers of approved qualifications, individual registrants, students, patients and service users, businesses, professional associations/representative bodies and national commissioners, and held focus groups and interviews with stakeholders from across the sector and all nations of the UK. A description of the research methodology for this can be found in Enventure Research' consultation report located at annex two. For information on the consultation, including copies of the consultation documents, please see the accompanying documentation on the GOC consultation hub.

Delphi Verification, Equality, Diversity, Inclusion Impact Assessment (EQIA)

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

30. **Verification of Outcomes for Approved Qualifications for Specialist Entry to the GOC Register as a contact lens optician**. We commissioned the University of Hertfordshire to verify the outcomes. The purpose of the verification is to test the veracity of the outcomes and the allocation of level (Miller's triangle) through use of the Delphi method. The Delphi method involves gathering a consensus of expert opinion and has been applied to the development of competency frameworks and curricula for optometric and medical subspecialties (Clancy et al. 2009; Hay et al. 2007; Myint et al. 2010; Stewart et al. 1999). It involves a series of rounds to gather opinion anonymously. The advantage of the Delphi technique is that participants can express views without being influenced by others, most particularly to facilitate consensus on borderline outcomes. The CLO EAG on 13 September 2021 received the final report from the University of Hertfordshire on their findings. The outcome of the EAG's review of the University of Hertfordshire recommendations for adjustments to the outcomes is described in annex five. Additional EAG amendments have been made to the CLO outcomes since this EAG in September 2021 and February 2022.

31. **Equality, Diversity, Inclusion Impact Assessment (EQIA)**. We commissioned Fraser Consulting to undertake an EDI assessment of the impact of our proposals

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

Key responses: summary of feedback

32. We have reflected on the feedback provided by stakeholders, public consultation and impact assessment and identified the following in relation to each of our proposals where the Education Committee, Standards Committee, Registration Committee and Companies Committee were invited to provide further advice (see annex nine), to ensure that the qualifications we approve in the future are fit for purpose and transitional arrangements are realistic.

33. In relation to proposal a; '*Candidates will acquire a qualification approved by the GOC leading to specialist entry to the GOC register as a contact lens optician*, there was broad agreement that this is a logical step to simplify and streamline the route to specialty registration, this proposal is clear and self-explanatory.'

34. In relation to proposal b; *'The approved qualification will be either an academic award or a regulated qualification at a minimum of Regulated Qualification Framework (RQF) (or equivalent) level 6.',* most respondents agreed that the qualification should be at a minimum of RQF level 6, as this level is reflective of the level of knowledge required of contact lens opticians in practice. One respondent suggested that level 6 is appropriate and brings the CLO qualification in line with the dispensing optician qualification (also at level 6). Respondents stressed that even though both qualifications sit at level 6, the contact lens expertise obtained through the contact lens qualification is more in-depth. However, regarding this proposal it is also suggested increasing the level of the qualification to a level 7 would increase the recognition and standing of the CLO role, particularly amongst the public and patients. It is felt that in recent years the level of responsibility and accountability of CLOs has increased and therefore the qualification should reflect this. Respondents did recognise achieving a level 7 qualification would be difficult, structuring the qualification, gaining relevant experience, and length of study would prove difficult to bring to fruition and the increased academic content would not be proportional to the practical role of CLOs, this may deter dispensing opticians from taking the qualification.

35. In relation to proposal c: '*There will be no proposed minimum/maximum or recommended time or credit volume for an approved qualification or specified location or duration of clinical experience, other than the requirement that an approved qualification leading to specialist entry to the GOC register as a contact lens optician must integrate approximately 225 hours of learning and experience in practice.',* this proposal was received positively, the removal of specified location and

duration requirement, allows for increased flexibility for trainees and employers. Trainees no longer need to struggle to achieve a specific number of hours and instead could sit their examinations when they felt ready to do so. Fraser Consulting's Equality Impact Assessment (EQIA) showed lower CLO Specialty participation by females and registrants aged 35-44. People in this age group are more likely to have responsibility for childcare. The removal of the minimum/maximum time or credit volume could positively affect and encourage participation by females aged 35-44. However, participants did express concern and unease about the removal of a minimum time requirement for clinical experience during CLO qualification training – in particular the use of the word 'approximately' to describe suggested number of hours of learning and experience. The Standards Committee also questioned the use of the word 'approximately' as insufficiently precise and suggested whether 'minimum' would be a better alternative. The Education Committee suggested greater clarity and an explanation requiring approval if less than 225 hours of learning and experience is proposed by the provider.

36. In relation to proposal d: '*The provider of the approved qualification must, in the design, delivery and assessment of an approved qualification, involve and be informed by feedback from a range of stakeholders including patients, employers, trainees, supervisors, members of the eye-care team and other healthcare professionals.*', this proposal was respected and viewed as very important aspect of the provision of a training course. Some respondents explained it was their expectation that multiple stakeholders would be involved during design, delivery and assessment of a training course and welcomed this proposal. Gaining feedback from the wider team and other healthcare professionals was viewed as compulsory due to increased multi-disciplinary working within practice and across healthcare. Respondents feel that feedback should be fairly weighted and not weighted towards large employers and that measures should be in place to ensure feedback is balanced. Fraser Consulting's EQIA highlights participation by those who use and care about optical services and whose feedback should enable an increased understanding of the patient experience and how to respond to diverse needs, including those members of the public who have the poorest health. This proposal demonstrates taking steps to meet the needs of protected groups, improving access to services, and reducing differences in healthcare inequalities. The value and importance of patient input into the process is important to ensure public understanding.

37. In relation to proposal e: '*An outcomes-based approach to specify knowledge, skills and behaviours using 'Miller's Pyramid of Clinical Competence' (knows: knows how: show how & does).',* this proposal was received in a positive manner as a logical choice given that Miller's Pyramid of Clinical Competence is already used for the dispensing optics qualification and in other education/healthcare professions. This approach also ensures consistency for those optical professionals who choose to continue education and training. One respondent felt the use of Miller's pyramid in

assessment would help focus trainees more on the application of their learning in a practical setting. Fraser Consulting's EQIA suggests that an outcomes-based approach puts the patient first and should support the advancement of equality and elimination of discrimination with regards to the wider public health.'

38. In relation to proposal f: '*Providers of approved qualifications are responsible for the measurement (assessment) of students' achievement of the outcomes at the required level (on Miller's Pyramid) leading to an award of an approved qualification.',* some respondents echoed concerns about the consistency and varying standards of qualification, without the level of consistency provided by the current system of assessment, achieving the qualification may vary from provider to provider. Some participants felt that the potential for varying standards of assessment could result in a multi-tiered system of qualifications across the country, which could result in placing patients at risk if CLOs are not all qualified to the same standard. It was suggested by some respondents the current system of assessment is not consistent and therefore this proposal is justified and issues of relating to inconsistency of assessment could be overcome by careful regulation from the GOC. The proposed new quality assurance and enhancement method will ensure providers are held accountable by the GOC for the maintenance of standards in assessment and open up opportunities for trainees and their employers to choose between providers, increasing flexibility for trainees, their employers and commissioners/ statutory education and training bodies.'

39. Proposal g: '*Providers of approved qualifications will be responsible for recruiting and selecting trainees onto a programme leading to an award of an approved qualification. Recognition of prior learning can be deployed to assist the progression of trainees whose progress to specialist registration has stalled*.', this proposal was viewed logical and respondents were in agreement, however most respondents thought this proposal was already in place. The recognition of prior learning was welcomed as a positive change, increasing flexibility and assisting the progression of trainees whose specialist registration had stalled e.g., due to the pandemic, illness, caring responsibilities, childcare. One respondent also thought recognition of prior learning made the qualification more accessible for those who may have studied abroad. There were some questions raised about how prior learning would be measured and verified to ensure a fair approach is taken.'

Arrangements for existing providers of GOC-approved CLO qualifications

40. Our proposals include a commitment to working with each provider of GOC-approved CLO qualifications to understand at what pace providers will wish to adapt their existing qualifications or develop new qualifications to meet the updated requirements included in annex one. If the proposals are approved by Council in March 2022, we anticipate most providers will begin to adapt their existing CLO qualifications from July 2022 and that most providers will work towards admitting trainees to approved qualifications that meet the updated outcomes and standards by Sept 2023. Some providers may, in consultation with the GOC, agree an earlier or

later start date. Separate arrangements will be made with the Association of British Dispensing Opticians (ABDO) to ensure that for trainees who graduate from qualifications approved before 2022, their route to specialist entry to the GOC register is maintained.

Indicative Guidance Recommendations - Sector Partnership for Optical Knowledge and Education (SPOKE)

41. GOC made a commitment to present the indicative document prior to finalisation to the Optometry and Dispensing Optics EAGs to seek their views; the document was presented to the joint EAG on 21 January where it was well received by the EAG and is located at annex six. At this meeting SPOKE presented suggested amendments to the indicative document relating to the indicators contained within the Clinical Practice category of Outcomes for Dispensing Optics and Optometry as part of the GOC's "Requirements for Approved Qualifications in Optometry and Dispensing Optics" document. The table of amendments includes the outcome criterion and original indicator provision, followed by the recommendation by SPOKE, EAG advice and further invited stakeholder feedback, followed by the final indicator. The table is located at annex seven.

Finance

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

Risks

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

52. Failure to support the culture change necessary for successful implementation risks poor quality qualification redesign that fail to meet our proposed standards and outcomes, fail to recruit, and fail to thrive, with resulting instability in the sector and consequential workforce supply issues.

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

Equality Impacts

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

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

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

Devolved nations

57. The proposed education and training requirements for GOC approved qualifications leading to specialist entry to the GOC Register as a contact lens optician will apply to providers across the United Kingdom.

58. Consideration of specific impacts upon providers, employers and relevant stakeholders in each devolved nation was included in the brief for the externally commissioned impact assessments and public consultation, the results of which have informed the development of the proposals and impact assessment post-consultation.

Communications

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

Next steps

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

If the proposals are approved by Council in March 2022, we anticipate most providers will begin to adapt their existing CLO qualifications in 2022 and that most providers will work towards admitting trainees to approved qualifications that meet the updated outcomes and standards by Sept 2023. Some providers may, in consultation with the GOC, agree an earlier or later start date.

Attachments

Annex one:	Proposed Education and Training Requirements for GOC-Approved Qualifications for Specialist Entry to the GOC Register as a contact lens optician
Annex two:	Enventure Research CLO Consultation Report
Annex three:	Fraser Consulting EDI impact assessment
Annex four:	CLO Outline Impact Assessment
Annex five:	CLO Outcomes Delphi Verification Exercise Report
Annex six:	SPOKE Indicative Guidance Document
Annex seven:	Proposed amendments to Clinical Practice Indicators by SPOKE and GOC Stakeholders
Annex eight:	EAG membership
Annex nine:	Advice from Education Committee, Standards Committee, Registration Committee, and Companies Committee.

Education and Training Requirements for GOC-Approved Qualifications for Specialist Entry to the GOC Register as a Contact Lens Optician

Draft for Council, March 2022

Introduction

This document describes our requirements for approval of qualifications for specialist entry to the GOC register as a contact lens optician. It is divided into the following sections:

- **Section 1: Outcomes for Approved Qualifications for Specialist Entry to the GOC Register as a Contact Lens Optician** ('outcomes for approved qualifications') describes the expected knowledge, skills and behaviours a dispensing optician must have for the award of an approved qualification for specialist entry to the GOC register as a contact lens optician.
- **Section 2: Standards for Approved Qualifications for Specialist Entry to the GOC Register as a Contact Lens Optician** ('standards for approved qualifications') describes the expected context for the delivery and assessment of the outcomes leading to an award of an approved qualification for specialist entry to the GOC register as a contact lens optician.
- **Section 3: Quality Assurance and Enhancement Method for Specialist Entry to the GOC Register as a Contact Lens Optician** describes how we will gather evidence to decide in accordance with our duties under the Opticians Act 1989 ('the Act') whether a qualification for specialist entry to the GOC register as a contact lens optician meets our outcomes for approved qualifications and standards for approved qualifications. This method statement is common to qualifications for specialist entry to the GOC register.

What do these documents replace?

Together, the outcomes and standards for approved qualifications for specialist entry to the GOC register as a contact lens optician replace our 'Visit handbook guidelines for the approval of training institutions and providers of schemes for registration for United Kingdom trained Contact Lens Opticians' published July 2007 and the 'Contact Lens Speciality Core Competencies' published in 2011, including the list of required core competences, the numerical requirements for trainees' practical experiences, education policies and guidance contained within the handbooks, and our policies on supervision and recognition of prior learning, published separately.

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

What have we consulted on previously?

These proposals are based on our analysis of the responses to our Call for Evidence, Concepts and Principles Consultation in 2017-2018, feedback from our 2018-2019 consultation on proposals stemming from the Education Strategic Review (ESR) and associated research and our public consultations held in July-September 2020 and October 2021-January 2022. For more information, please see the GOC's consultation hub.

Pre-registration qualifications

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

How have we developed our proposals?

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

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

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

Arrangements for current providers of GOC-approved and provisionally qualifications

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

We anticipate most providers will work towards admitting trainees to approved qualifications that meet the outcomes and standards from July 2022.

Separate arrangements will be made with the Association of British Dispensing Opticians (ABDO) to ensure that for trainees who graduate from qualifications approved before 2022, their route to specialist entry to the GOC register is maintained.

Section 1: Outcomes for Approved Qualifications for Specialist Entry to the GOC Register as a Contact Lens Optician

Introduction

The outcomes for approved qualifications for specialist entry to the GOC register as a contact lens optician describe the expected knowledge, skills and behaviours a dispensing optician must have to be awarded an approved qualification for specialist entry to the GOC register as a contact lens optician.

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

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

The outcomes are organised into six categories:

1. Uphold professional standards
2. Person centred care
3. Ocular examination
4. Verification and identification
5. Contact lens fitting and aftercare
6. Learning and development

Each category includes an overarching statement and outcomes which must be met if a trainee is to be awarded the approved qualification. Each outcome is described using a level based on an established competence and assessment hierarchy known as 'Miller's Pyramid of Clinical Competence'[2] (knows; knows how; shows how; and does). We have provided a note on Miller's Pyramid on page 9 of this document.

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

[1] Act gives GOC powers to approve' 'qualifications[2] Miller, G.E. (1990) The assessment of clinical skills/competence/performance. Acad

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

Outcomes for Approved Qualifications Leading to Specialist Entry to the GOC Register as a Contact Lens Optician

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

1. Uphold professional standards

Contact lens opticians establish relationships with others based on professional understanding and respect; acting as part of a multidisciplinary team they ensure that continuity of care across care settings is not compromised.

O1.1 Establishes relationships with other professionals based on understanding, trust and respect for each other's roles in relation to contact lens and other care, and works collaboratively to ensure the delivery, transfer and continuity of care is assured and not compromised [Knows How]

O1.2 Undertakes a patient consultation in an appropriate setting, taking account of confidentiality and understands the issues involved in obtaining valid consent and maintaining dignity and respect in accordance with regulatory standards and contractual requirements. [Knows How]

O1.3 Introduces self and role to the patient/carer and confirms patient/carer identity. [Shows how]

2. Person centred care

Contact lens opticians must have a patient centred approach, be adaptive and work collaboratively with others in the best interests of the patient. They must understand their role appreciating uncertainty, ambiguity and limits to their knowledge and the process of contact lens fitting as part of a multidisciplinary approach to a patient's ocular health.

O2.1 Assesses the communication needs of the patient/carer and adapts consultation appropriately (e.g. for language, age, capacity, physical or sensory impairments). [Knows how]

O2.2 Works with the patient/carer in partnership to make informed choices, aiming for the optimal outcome for the patient which meets the professional aims of the practitioner. [Knows how]

O2.3 Identifies, recommends and fits contact lenses to achieve vision correction and/or eye health goals, including explaining where patient expectations cannot be met and/or when contact lenses cannot be fitted. [Does]

O2.4 Explains to the patient the potential risks and benefits of contact lens wear and any management options/treatment, including the importance of hygiene regimes, wearing compliance and when to seek further advice. [Does]

O2.5 Encourages patients to take responsibility for their ocular health and to respond to contact lens and other health conditions appropriately. [Shows how]

O2.6 Works within scope of practice and recognises when to refer or seek guidance from another member of the healthcare team or a specialist. [Knows how]

3. Ocular examination

Contact lens opticians must conduct a detailed examination of the anterior eye and related structures using appropriate instrumentation and clinical techniques they have learned. They must apply their knowledge to understand the implications of their findings and identify appropriate clinical responses including diagnosis, clinical management, contact lens fitting or referral within scope of practice.

O3.1 Demonstrate knowledge of appropriate instrumentation and technology for detailed inspection of the anterior segment of the eye, related ocular adnexa and tear film. This should include methods of illumination, filters, other instrument attributes and related use of diagnostic stains. [Knows how]

O3.2 Assesses the anterior segment, related ocular adnexa and tear film in a systematic sequence. [Does]

O3.3 Assesses the curvature and regularity of the cornea and any other dimensions required for contact lens fitting. [Does]

O3.4 Evaluates results using evidence-based knowledge to make differential diagnoses and inform an appropriate management plan including referral within scope of practice when appropriate. [Does]

O3.5 Has acquired knowledge of common systemic conditions and their ocular impacts and contact lens implications. [Knows]

O3.6 Recognises the signs and symptoms associated with relevant ocular conditions, (including, but not exclusively, anterior eye disease, dry eye, red eye and foreign body), differentiates normal from abnormal findings, manages the conditions appropriately and refers where necessary. [Shows How]

O3.7 Recognises the signs, symptoms and contact lens implications of non-systemic (ocular) pathological conditions. [Knows]

O3.8 Manages contact lens induced complications for all types of contact lenses. [Shows how]

O3.9 Uses appropriate grading scales, imaging and other available technological information and creates and maintains accurate and contemporaneous records of all patient advice and management decisions in line with relevant legislation. [Does]

4. Verification and identification

Contact lens opticians exercise personal responsibility by checking lenses applying the methods and techniques they have learned to verify that they are correct as per contact lens specifications.

O4.1 Understands how to assess using the appropriate instruments, the dimensional measurement and other features of contact lenses to identify where possible and enable their replication. [Knows how]

O4.2 Understands how contact lens parameters are measured to International Organisation for Standardisation (ISO) standards of tolerance. [Knows how]

O4.3 Recognises and differentiates between the design features of contact lenses. [Shows how]

5. Contact lens fitting and aftercare

Contact lens opticians take a shared approach to evidence-based decision-making (sometimes in complex and unpredictable contexts) by assessing patients' planned use / clinical needs and recommending an appropriate lens to achieve desired outcomes, managing the fitting and aftercare of patients with contact lenses and adapting the management plan where necessary.

O5.1 Takes a comprehensive history eliciting any information relevant to the fitting, aftercare and use of contact lenses. [Does]

O5.2 Interprets and investigates appropriately the presenting symptoms of the patient. [Does]

O5.3 Interprets relevant patient records to ensure knowledge of the patient's ocular and contact lens history and management to date. [Shows how]

O5.4 Interprets relevant patient information (i.e. spectacle prescription, history and any relevant information supplied by any other health care practitioners) and clinical findings to assess the indications and contraindications for contact lens fitting. [Shows how]

O5.5 Discusses contact lens options and makes appropriate recommendations allowing patients to make an informed choice; selects and fits the most appropriate contact lens and parameters for the planned use and clinical needs of the patient. [Does]

O5.6 Assesses the fitting of a contact lens (soft, rigid and new modalities/materials where applicable) using a variety of techniques; adjusts lens parameters where appropriate. [Does]

O5.7 Issues unambiguous and complete contact lens specifications which meet legal requirements. [Shows how]

O5.8 Instructs the patient in contact lens handling (i.e. hygiene, insertion and removal, etc) and how to wear and care for the lenses including appropriate action to take in an emergency. [Shows how]

O5.9 Demonstrates a routine contact lens aftercare consultation in compliance with the requirements of the Opticians' Act. [Does]

O5.10 Investigates, identifies and manages any contact lens adaptation or aftercare issues. [Shows how]

O5.11 Informs patients of the importance of continuing contact lens aftercare and regular eye examinations and provide information on arranging aftercare and relevant emergency procedures. [Shows how]

O5.12 Selects and fits the most appropriate complex/specialist contact lens for the planned use and clinical needs of the patient (e.g. refractive management, therapeutic, prosthetic and cosmetic contact lenses); manages the ongoing contact lens care of own patients. [Shows how]

O5.13 Recognises the signs and symptoms of sight threatening conditions/ocular emergencies requiring immediate treatment and manages them appropriately. [Shows how]

O5.14 Understands and applies relevant local protocols and professional guidance on the urgency of referrals e.g. The College of Optometrists' clinical management guidelines. [Knows how]

6. Learning and development

Contact lens opticians must maintain their clinical and contact lens knowledge and skills appropriate to their scope of practice; they must work within their areas of expertise and competence to achieve desired patient outcomes.

O6.1 Understands common ocular conditions, presenting symptoms and urgency e.g. glaucoma, retinal detachment and age-related macular degeneration (AMD) in the context of contact lens practice. [Knows]

O6.2 Understands the principles and maintains knowledge of evidence relating to myopia management. [Knows how]

O6.3 Demonstrates knowledge of refractive techniques including the principles of binocular vision management in the context of contact lens practice. [Shows how]

O6.4 Understands the range of lenses available including soft, rigid and new materials/modalities. [Knows]

O6.5 Understands the clinical application of all contact lens types e.g. optical, therapeutic, protective, diagnostic, prosthetic and cosmetic. [Knows]

O6.6 Understands and safely applies knowledge of the drugs and staining agents used in clinical practice, including any relevant risks and side effects. [Knows how]

O6.7 Understands the various forms of ocular surface diseases (e.g. dry eye) and maintains knowledge of available management options. [Knows how]

O6.8 Implements infection prevention and control in optical practice. [Does]

O6.9 Understands the methods of disinfection of contact lenses / contact lens containers including awareness of the different solutions used in contact lens practice, their constituents, the importance of maintaining sterility and common pathogens. [Knows how]

O6.10 Applies current legislation to contact lens practice and understands the relevant legislation surrounding the use of common ocular drugs. [Shows how]

O6.11 Evaluates advances in contact lens practice, the evidence behind management strategies and any emerging safety concerns. [Knows]

O6.12 Demonstrates a reflective approach to learning and own development of contact lens practice to ensure continued alignment with current best practice. [Shows how]

O6.13 Understands continuing education and professional requirements (e.g. continuing professional development (CPD)) within contact lens practice. [Knows]

[ENDS]

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

Knows Knowledge that may be applied in the future.
(Assessments may include essays, unseen examinations, practical reports, essays, oral examinations and multiple-choice questions (MCQs), etc.)

Knows how Knows how to apply knowledge and skills in a defined context or situation.
(Assessments may include essays, oral examinations, unseen examinations, short answer questions, multi-format MCQs (single best answer, extended matching questions), practical simulations, portfolios, workbooks and poster presentations, etc.)

Shows how Applies knowledge, skill and behaviour in a simulated environment or in real life repeatedly and reliably.
(Assessments may include objective structured clinical examinations (OSCEs), simulated patient assessments, oral and poster presentations, designing, conducting and reporting an experiment, dispensing tests and taking a patient history, unseen examinations involving patient cases, etc.)

Does Acting independently and consistently in a complex situation of an everyday or familiar context repeatedly and reliably.
(Assessments may include OSCEs, simulated patient assessments and observed practice, case-based assessments, portfolios, sustained research project (thesis, poster and oral presentation) etc.)

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

Section 2: Standards for Approved Qualifications for Specialist Entry to the GOC Register as a Contact Lens Optician

Introduction

The standards for approved qualifications for specialist entry to the GOC register as a contact lens optician describe the expected context for the delivery and assessment of the outcomes leading to an award of an approved qualification for specialist entry to the GOC register as a contact lens optician.

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

GOC-approved qualifications[4] will prepare trainees to meet these outcomes for specialist entry to the GOC register. We expect to see evidence that the outcomes are met and for this reason a minimum duration or credit volume is not provided.

The standards are organised under five categories:

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

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

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

Standards for Approved Qualifications for Specialist Entry to the GOC Register as a Contact Lens Optician

1. Public and patient safety

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

Criteria to meet this standard:

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

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

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

S1.4 Upon admission (and at regular intervals thereafter) trainees must be informed it is an offence not to be registered as a dispensing optician with the GOC at all times whilst studying on a programme leading to an approved qualification as a contact lens optician.

2. Selection and admission of trainees

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

Criteria to meet this standard:

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

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

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

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

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

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

S2.5 Recognition of prior learning must be supported by effective and robust policies and systems. These must ensure that trainees admitted at a point other than the start of a programme have the potential to meet the outcomes for award of the approved qualification. Prior learning must be recognised in accordance with guidance issued by The Quality Assurance Agency for Higher Education (QAA) and/or Ofqual / Scottish Qualifications Authority (SQA) / Qualifications Wales / Department for the Economy in Northern Ireland and must not exempt trainees from summative assessments leading to the award of the approved qualification.

S2.6 Trainees upon application must have identified a suitably experienced and qualified supervisor who has agreed to supervise their clinical experience in practice. The trainee's supervisor must be a contact lens optician (with a minimum of two years' specialist registration) or optometrist (with a minimum of two years' registration with current experience of contact lens practice). (See also standard 4.)

3. Assessment of outcomes and curriculum design

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

Criteria to meet this standard:

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

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

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

S3.4 'The approved qualification must provide experience of working with patients (such as patients with disabilities, children, their carers, etc); inter-professional learning (IPL); and team work and preparation for entry into the workplace in a variety of settings (real and simulated) such as *clinical practice, community, manufacturing, research, domiciliary and hospital settings* (for example, Harden's ladder of integration). This experience must increase in volume and complexity as students progress through a programme.

S3.5 The outcomes must be assessed using a range of methods and all final, summative assessments must be passed. This means that compensation, trailing and extended re-sit opportunities within and between modules where outcomes are assessed is not permitted. Summative assessments directly related to the outcomes demonstrating unsafe practice must result in failure of the assessment.

S3.6 Assessment (including lowest pass) criteria, choice and design of assessment items (diagnostic, formative and summative) leading to the award of an approved qualification must ensure safe and effective practice and be appropriate for a qualification leading to specialist entry to the GOC register as a contact lens optician.

S3.7 Assessment (including lowest pass) criteria must be explicit and set using an appropriate and tested standard-setting process. This includes assessments which occur during learning and experience in practice.

S3.8 Assessments must appropriately balance validity, reliability, robustness, fairness and transparency, ensure equity of treatment for trainees, reflect best practice and be routinely monitored, developed and quality-controlled. This includes assessments which might occur during clinical experience.

S3.9 Appropriate reasonable adjustments must be put in place to ensure that trainees with a disability are not disadvantaged in engaging with the teaching and learning process and in demonstrating their achievement of the outcomes.

S3.10 There must be policies and systems in place to plan, monitor and record each trainee's achievement of outcomes leading to award of the approved qualification.

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

S3.11 The approved qualification must be listed on one of the national frameworks for higher education qualifications for UK degree-awarding bodies (The Framework for Higher Education Qualifications of Degree-Awarding Bodies in England, Wales and Northern Ireland (FHEQ) and the Framework for Qualifications of Higher Education Institutions in Scotland (FQHEIS)), or be a qualification regulated by Qfqual, SQA or Qualifications Wales. Approved qualifications leading to specialist entry to the GOC register as a contact lens optician must be at a minimum Regulated Qualification Framework (RQF), FHEQ or Credit and Qualifications Framework Wales (CQFW) level 6 or Scottish Credit and Qualifications Framework (SCQF) / FQHEIS level 10.

S3.12 There must be a range of teaching and learning methods to deliver the outcomes that integrates scientific, professional and clinical theories and practices in a variety of settings and uses a range of procedures, drawing upon the strengths and opportunities of context in which the qualification is offered.

S3.13 The approved qualification must integrate clinical experience (a minimum of at least 30 days / 225 hours) to enable the development of trainees' clinical experience to meet the outcomes. This must be under the supervision of a contact lens optician (with a minimum of two years' specialist registration) or optometrist (with a minimum of two years' registration and current experience of contact lens practice) and include active involvement in the fitting and aftercare of a wide range of lens materials, designs and wearing modalities as well as management of complications arising from contact lens wear. (See also standard 4.)

S3.14 The outcomes must be delivered and assessed in an environment that places study in an academic, clinical and professional context which is informed by research and provides opportunities for trainees to develop as learners.

S3.15 Outcomes delivered and assessed during clinical experience must be clearly identified, included within the assessment strategy and fully integrated within the programme leading to the award of an approved qualification.

S3.16 The choice of outcomes to be taught and assessed during periods of clinical experience and the choice and design of assessment items must be informed by feedback from a variety of sources, such as patients, employers, trainees, supervisors, members of the eye-care team and other healthcare professionals.

S3.17 Assessment (if undertaken) of outcomes during learning and experience in practice must be carried out by an appropriately trained and qualified GOC registrant or other statutorily registered healthcare professional who is competent to measure students' achievement of outcomes at the required level (Miller's Pyramid)

S3.18 The collection and analysis of equality and diversity data must inform curriculum design, delivery and assessment of the approved qualification. This analysis must include trainees' progression by protected characteristic. In addition, the principles of equality, diversity and inclusion must be embedded in curriculum design and assessment, and used to enhance trainees' experience of studying on a programme leading to an approved qualification.

S3.19 Trainees must receive regular and timely feedback to improve their performance, including on their performance in assessments and in periods of clinical experience.

S3.20 As part of the approved qualification, trainees must meet regularly with their supervisor to discuss and document their progress as learners.

4. Management, monitoring and review of approved qualifications

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

Criteria to meet this standard:

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

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

S4.3 The provider of the approved qualification must be able to accurately describe its corporate form, its governance and lines of accountability in relation to its award of the approved qualification.

S4.4 The provider must have a named point of contact for the approved qualification.

S4.5 There must be agreements in place between the trainee, their supervisor and the approved qualification provider that describe their respective roles and responsibilities during periods of clinical experience. These must be regularly reviewed and supported by management plans, systems and policies which prioritise patient safety.

S4.6 The provider of the approved qualification may be owned by a consortium of organisations or some other combination of separately constituted bodies. Howsoever constituted, the relationship between the constituent organisations and the ownership of the provider responsible for the award of the approved qualification must be clear.

S4.7 There must be agreements in place between the different organisations/people (if any) that contribute to the delivery and assessment of the outcomes, including during periods of learning in practice. Agreements must define the role and responsibility of each organisation/person, be regularly reviewed and supported by management plans, systems and policies that ensure the delivery and assessment of the outcomes meet these standards.

S4.8 A trainee's supervisor (who must be either a contact lens optician or optometrist) must be trained and supported to carry out their role effectively.

S4.9 A trainee may be supervised by no more than two supervisors at any time, one of whom must assume primary responsibility for the trainee's supervision.

S4.10 The approved qualification must be systematically reviewed, monitored and evaluated across learning environments using best available evidence, and action taken to address any concerns identified. Evidence should demonstrate as a minimum:

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

This will ensure that:

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

S4.11 There must be policies and systems in place for:

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

S4.12 Trainees, and anyone who supervises trainees, must be able to provide feedback on progress and raise concerns. Responses to feedback and concerns raised must be recorded and evidenced.

S4.13 Complaints must be considered in accordance with the good practice advice on handling complaints issued by the Office for the Independent Adjudicator for Higher Education in England and Wales (or equivalent).

S4.14 There must be an effective mechanism to identify risks to the quality of the delivery and assessment of the approved qualification and to identify areas requiring attention or development.

S4.15 There must be systems and policies in place to ensure that the GOC is notified of any major events and/or changes to the delivery of the approved qualification, assessment and quality control, its organisation, resourcing and constitution, including responses to relevant regulatory body reviews.

5. Leadership, resources and capacity

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

Criteria to meet this standard:

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

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

- an appropriately qualified and experienced programme leader, supported to succeed in their role;
- sufficient staff responsible for the delivery and assessment of the outcomes, including GOC registrants and other suitably qualified healthcare professionals benchmarked to comparable provision[6]; and
- sufficient supervision of trainee learning in practice by GOC registrants who are appropriately trained and supported in their role.

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

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

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

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

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

[6] Providers must regularly benchmark their student:staff ratio (SSR) to comparable providers (alongside seeking trainee and stakeholder feedback) to determine if their SSR provides an appropriate level of resource for the teaching and assessment of the outcomes leading to the award of an approved qualification.

Section 3: Quality Assurance and Enhancement Method for Specialist Entry to the GOC Register as a Contact Lens Optician

Introduction

Our quality assurance and enhancement method describes how we will gather evidence to decide in accordance with the Act whether a qualification for specialist entry to the GOC register as a contact lens optician meets the outcomes for approved qualifications and standards for approved qualifications. This method statement is common to all qualifications for specialist entry to the GOC register.

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

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

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

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

The method is organised in seven sections:

1. Legal basis for quality assurance and enhancement
2. Quality assurance and enhancement – definitions
3. Geographic scope
4. Arrangements for current (2021) providers of approved and provisionally approved qualifications
5. Approval of new qualifications (from March 2022)
6. Periodic review, annual return, thematic and sample-based review
7. Scope of evidence
8. Decision-making

Quality Assurance and Enhancement Method

1. Legal basis for quality assurance and enhancement

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

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

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

2. Quality assurance and enhancement – definitions

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

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

3. Geographic scope

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

4. Arrangements for current (2022) providers of approved and provisionally approved qualifications

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

We anticipate most providers will work towards admitting trainees to approved qualifications that meet the outcomes and standards from July 2022.

Separate arrangements will be made with ABDO to ensure that the route to specialist entry to the GOC register is maintained for trainees who graduate from qualifications approved before 2022.

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

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

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

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

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

During the transitional phase, the 'Visit Handbook Guidelines for the Approval of: [A] Training Institutions; and [B] Providers of Schemes for Registration for United Kingdom Trained Contact Lens Opticians' (2007), including the list of required core competences, the numerical requirements for trainees' practical experiences, education policies and guidance contained within the handbooks, and our policies on supervision and recognition of prior learning will apply to all existing (2021) GOC-approved and provisionally approved qualifications during the teach out or migration phase.

5. Approval of new qualifications (from March 2022)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A decision by Council as to whether to approve the qualification will rely upon its consideration of the evidence gathered during stages 1 to 5 and will be informed by the advice of the Education Visitors. If the decision of Council is to *approve* the qualification (with or without conditions), the decision will specify the date from which the qualification is approved (normally the date of the examination Board for the first graduating cohort of trainees). The duration of the qualification's approval may be limited if necessary, according to its risk profile.

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

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

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

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

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

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

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

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

We will publish the specification for a thematic review from time to time, which will be based on the criteria contained in the standards, together with the timeframe for participation.

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

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

7. Scope of evidence

Demonstrating that the outcomes and standards are met should not be unnecessarily onerous, and guidance is given below on the type of evidence a

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

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

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

In relation to the outcomes:

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

In relation to the standards:

- Information about the provider, its ownership, corporate form, organisation, leadership and lines of responsibility, evidence of the contractual relationships underpinning the delivery and assessment of the award of the

approved qualification, service/local level agreements, agreements between stakeholders / placement providers, management plans.

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

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

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

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

8. Decision-making

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

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

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

Date of approval

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

Standard conditions

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

Conditions, recommendations and requests for information

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

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

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

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

Notifications of changes and events

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

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

Serious concerns review

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

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

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

Withdrawal

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

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

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

Appeal

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

ENDS

Education and training requirements for GOC-approved qualifications for specialist entry to the GOC register as a Contact Lens Optician

Consultation report

General Optical Council

January 2022

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Executive Summary

Introduction

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

Once an optometrist or dispensing optician is registered with the GOC, they may wish to practice in areas of specialist skill and knowledge, which requires additional training and qualification. Once specialist training is completed and their competence assessed, practitioners then register their specialty with the GOC. Continuing its strategic review of optical education and training, the GOC has reviewed the contact lens optician specialty qualification that it approves for dispensing opticians.

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

- Outcomes for Approved Qualifications for Specialist Entry to the GOC Register as a Contact Lens Optician
- Standards for Approved Qualifications for Specialist Entry to the GOC Register as a Contact Lens Optician
- Quality Assurance and Enhancement Method for Specialist Entry to the GOC Register as a Contact Lens Optician

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

Methodology

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

- An online consultation survey, delivered by the GOC via the Citizen Space platform, which received 29 responses over a 15 week period
- Online focus groups with GOC registrants, delivered by Enventure Research
- Online focus groups with optical patients, delivered by Enventure Research

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

Key findings

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

Consultation survey response

Consultation survey respondents answered a series of questions in relation to the three proposed documents that will replace the current handbook, competencies and guidance.

Outcomes for Approved Qualifications for Specialist Entry to the GOC Register as a Contact Lens Optician

- 79% of respondents thought this document would have a positive impact on the expected knowledge, skill and behaviour of future contact lens opticians
- 10% thought it would have a negative impact, and 10% that it would have no impact
- 33% thought there was something missing from this document or that should be changed. This included suggested changes to the level of assessment assigned to specific outcomes, wording, or technical details

Standards for Approved Qualifications for Specialist Entry to the GOC Register as a Contact Lens Optician

- 72% of respondents thought this document would have a positive impact on the expected knowledge, skill and behaviour of future contact lens opticians
- 10% thought it would have a negative impact, and 17% that it would have no impact
- 38% thought there was something missing from this document or that should be changed. This included further suggestions to change the wording of the document in some areas to better align it with the Standards for the Dispensing Optician qualification, and references to the removal of the minimum time requirement for clinical experience

Quality Assurance and Enhancement Method for Approved Qualifications for Specialist Entry to the GOC Register as a Contact Lens Optician

- Just 10% thought there was something missing from this document or that should be changed
- Of the two responses provided, one referenced the need for providers to have access to relevant paperwork before implementing the new qualification, and the other highlighted support for the document and its emphasis on stakeholder engagement

Replacing the quality assurance handbook and related policies

- 66% of respondents agreed with the proposal to replace the handbooks and related policies for contact lens opticians with the proposed three new documents (Outcomes, Standards, Quality Assurance and Enhancement Method). 14% disagreed with this proposal, and another 21% neither agreed nor disagreed
- Comments provided included:
    - The proposals provide more ways to qualify
    - The proposals will help to ensure contact lens opticians will practise safely and respond to the changing nature of clinical practice
    - The documents are well-considered, robust and detailed
    - The proposals are welcomed and timely
    - Some concerns about the rationale for the proposals and potential inconsistency
    - Concern about the removal of minimum duration requirements for the qualification
    - The proposals offer little change from the current system

Impact of proposals

- The majority of survey respondents reported no positive or negative impacts of the proposals on certain individuals or groups
- Very small numbers reported that the proposals may benefit certain groups, including pregnancy and maternity (4 respondents), disability (3 responses), gender reassignment (2 responses), and religion or belief (2 responses)
- Explanations provided related to there being no perceived barriers for any groups or individuals, and increased flexibility for registrants to complete the qualification which would help those who may become ill or who may take a career break to have children, and those with family commitments
- 48% of respondents thought that the proposed changes will positively impact other individuals or groups, and 24% thought the changes would negatively impact other individuals or groups
- Explanations provided included:
    - Positive impact on maintaining or reducing the cost of training
    - Negative impact on the potential lowering of pay for contact lens opticians, and the reduction of standards posing a risk to the public

Registrant focus group feedback

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

Academic award or regulated qualification

- Most participants agreed that this was an appropriate level of qualification which recognises the knowledge and skill required from contact lens opticians
- Some thought it could be set at a higher level to exceed the dispensing optician qualification, but it was accepted this may not be possible or practical

Removing the duration and location requirements for clinical experience

- This change was viewed by some participants as providing increased flexibility for trainees and employers due to the current difficulties experienced when arranging clinical experience, often alongside dispensing optician duties
- This proposal could be seen to represent a move towards true learning and away from ‘box-ticking’
- A number of participants expressed concerns about removing the minimum time requirements for clinical experience and the ambiguity of the word ‘approximately’ in reference to the 225 hours
- It was suggested this proposal may pose the risk of trainees not gaining enough clinical experience, which could impact standards in the profession and patient safety

Providers must involve feedback from stakeholders

- This proposal was viewed by the majority of participants as an expected aspect of the provision of a training course, with clear benefits to including feedback from all relevant stakeholders, and was therefore viewed in a positive light
- Some participants highlighted the importance of ensuring feedback from stakeholders is fairly weighted to avoid anyone having an unfair say in the design, delivery and assessment of the qualification
- A smaller number of participants questioned the relevance of gaining feedback from all the stakeholders listed in the proposal, particularly patients and other healthcare professionals

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

- Feedback for this proposal was generally positive, as participants felt adopting Miller's Pyramid was a logical choice as it was already used for the dispensing optician qualification and in other healthcare professions
- This approach was also perceived to be easy to understand, providing consistency across optometry qualifications and flexibility for providers
- Some participants felt that the assessment should focus more on 'shows how' and 'does' than 'knows' and 'knows how', explaining that the demonstration of clinical skills is crucial

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

- Concerns were expressed about how consistency would be maintained in the assessment of this qualification if it was the responsibility of providers
- However, it was also discussed that this could be overcome by careful regulation from the GOC
- Some participants highlighted potential benefits of this proposal, such as increased accessibility and improved standards

Providers are responsible for recruiting trainees to course programmes, recognition of prior learning

- Participants were in agreement with the proposal for providers having responsibility for the recruitment of trainees, explaining that this seemed logical and that they already assumed this was the case
- The proposal to recognise prior learning to assist the progression of trainees whose progress to specialist registration has stalled was generally viewed as a positive change, as it would make the process more flexible for those who may have to take time away from work, those who struggle to find clinical experience, and those who have begun their education outside the UK
- Some questioned how prior learning would be measured to ensure the approach was fair

Outcomes for Approved Qualifications

- Each outcome from the Outcomes for Approved Qualifications document was reviewed by registrant focus group participants. Generally, participants were supportive of the outcomes, explaining that they were reasonable, realistic, and achievable
- Most suggestions from participants for changes focused on changing the level of assessment on Miller's Pyramid (often increasing it, but in some cases decreasing it)

Patient focus group feedback

The following summarises feedback from two patient focus group discussions. Participants were members of the public who currently used contact lenses at least once a week.

- Patient participants discussed their reasons for deciding to try contact lenses, which were a mixture of aesthetic reasons (not liking how they looked wearing glasses) and practical reasons (not being able to wear glasses when playing sports)
- When discussing their experiences of wearing contact lenses, some participants reported some teething issues when first starting to wear them, and others reported problems with dry and irritated eyes. However, in general, experiences of wearing contact lenses were positive, and most participants said they would recommend wearing them to others
- Some participants said they would recommend wearing contact lenses to others, but with the caveat of ensuring they take care of their eye health and do not over-wear their lenses
- Reported experiences of visiting an opticians for contact lenses were positive

- Although there was little awareness of how optical professionals are regulated, there was an assumption that they are required to be suitably qualified to provide services
- Most participants felt the information they received during their contact lens appointment, such as how to care for, clean and store their lenses, was of a high standard
- There was some awareness amongst participants of the different roles within an optical practice, but most were not clear on what each role was responsible for
- Most participants were unaware of the specific contact lens optician role, but explained that they could see benefits to having this role in an optical practice, such as patients receiving a better standard of specialised care, and being able to more easily see a practitioner who can meet their eye care needs
- Generally, participants said they would be happy to see a contact lens optician, as they assumed they would be adequately trained and knowledgeable, and some suggested that they may receive a better level of service due to the specialist role
- However, some participants explained they would prefer to see an optometrist, typically if a patient had more complex eye health needs
- Some participants felt that it would be beneficial for patients to receive more information about the role of contact lens opticians as it could provide more clarity, allowing patients to understand what a contact lens optician is qualified to do

1. About this consultation

1.1 Background

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

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

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

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

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

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

1.1.7 Once an optometrist or dispensing optician is registered with the GOC, they may wish to practice in areas of specialist skill and knowledge, which requires additional training and qualification. Once specialist training is completed and their competence assessed, practitioners then register their specialty with the GOC. Continuing its strategic review of optical education and training, the GOC has reviewed the Contact Lens Optician specialty qualification that it approves for dispensing opticians.

1.1.8 To ensure that the current requirements for approved specialist qualifications do not cause increased risk by becoming out of date, and to ensure the qualifications the GOC approves in the future respond to the way the optical sector is changing, the GOC plans to replace the current handbook, competencies, and guidance ('Visit Handbook Guidelines for the Approval of: A) Training Institutions; and B) Providers for Schemes for Registration for United Kingdom Contact Lens Opticians' (2007) and the 'Contact Lens Speciality Core Competencies' (2011) including the list of required core competencies, numerical requirements for trainees' practical experiences, education policies and guidance contained within the handbooks, and policies on supervision and recognition of prior learning) with three new documents:

- Outcomes for Approved Qualifications for Specialist Entry to the GOC Register as a Contact Lens Optician
- Standards for Approved Qualifications for Specialist Entry to the GOC Register as a Contact Lens Optician
- Quality Assurance and Enhancement Method for Specialist Entry to the GOC Register as a Contact Lens Optician

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

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

1.2 The documents for consultation

1.2.1 The consultation sought views on replacing the current handbook, competencies, and guidance with:

- Proposed '**Outcomes for Approved Qualifications for Specialist Entry to the GOC Register as a Contact Lens Optician'**, which describes the expected knowledge, skills and behaviours a dispensing optician must have for the award of an approved qualification for specialist entry to the GOC register as a contact lens optician.

- Proposed '**Standards for Approved Qualifications for Specialist Entry to the GOC Register as a Contact Lens Optician'**, which describes the expected context for the delivery and assessment of the outcomes leading to an award of an approved qualification for specialist entry to the GOC register as a contact lens optician.

- Proposed '**Quality Assurance and Enhancement Method for Specialist Entry to the GOC Register as a Contact Lens Optician'**, which describes how the GOC will gather evidence to decide in accordance with the Opticians Act 1989 whether a qualification for specialist entry to the GOC register as a contact lens optician meets the outcomes for approved qualifications and standards for approved qualifications.

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

1.2.3 In preparing these documents, the GOC has utilised analysis of responses to its Call for Evidence, Concepts and Principles Consultation 2017-2018, feedback from the 2018-2019 consultation on proposals stemming from the ESR and associated research, a public consultation held in July-September 2020, the advice provided by an Expert Advisory Group (EAG) and feedback from a

range of stakeholder groups including Education Visitors, an Advisory Panel (including Education and Standards Committee), the optical sector, and sight-loss charities.

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

1.3 Key proposals

1.3.1 The three new documents set out a number of key proposals that will change the education and training requirements for GOC-approved qualifications for specialist entry to the GOC register as a contact lens optician. These proposals are summarised below:

a. Candidates will acquire a qualification approved by the GOC leading to specialist entry to the GOC register as a contact lens optician.

b. The approved qualification will be either an academic award or a regulated qualification at a minimum of Regulated Qualification Framework (RQF) (or equivalent) level 6.

c. There will be no proposed minimum/maximum or recommended time or credit volume for an approved qualification or specified location or duration of clinical experience, other than the requirement that an approved qualification leading to specialist entry to the GOC register as a contact lens optician must integrate approximately 225 hours of learning and experience in practice.

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

e. An outcomes-based approach is used to specify knowledge, skills and behaviours using an established competence and assessment hierarchy known as ‘Miller’s Pyramid of Clinical Competence’ (knows; knows how; shows how; and does).

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

g. Providers of approved qualifications will be responsible for recruiting and selecting trainees onto a programme leading to an award of an approved qualification. Recognition of prior learning can be deployed to assist the progression of trainees whose progress to specialist registration has stalled.

2. Methodology

2.1 Overview

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

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

2.2 Online consultation survey

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

2.2.2 The online survey was managed and promoted by the GOC and hosted online via the Citizen Space platform. The consultation ran for 15 weeks from 20 September 2021 to 3 January 2022. During this time, 29 responses were received.

2.2.3 The majority of responses were from individuals (21) and the rest (8) were from organisations. ***Figure 1*** below shows that, of individual responses, 10 came from contact lens opticians.

Figure 1 – Individual respondent type
Base: All individual respondents (21)

Individual respondent type	Number	%
Contact lens optician	10	48%
Dispensing optician	4	19%
Optometrist	3	14%
Trainee contact lens optician	2	10%
Optometry student	1	5%
Dispensing optician student	1	5%

2.2.4 As shown in ***Figure 2***, of the 8 organisational responses received to the consultation survey, three came from optical professional bodies, two came from providers of GOC-approved qualifications, one came from a current CET/CPD provider, and one came from an optical defence/representative body.

Figure 2 – Organisation respondent type
Base: All organisational respondents (8)

Organisation respondent type	Number	%
Optical professional body	3	38%
Provider of GOC-approved qualification(s)	2	25%
Current CET or CPD provider	1	13%
Optical defence/representative body	1	13%

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

- ABDO
- Association of Optometrists (AOP)
- British Contact Lens Association
- FODO - The Association for Eye Care Providers
- Ramesh Lasik and laser centre

2.2.6 Health Education England also submitted a response to the consultation outside the survey and also gave their consent to being identified.

2.3 Qualitative consultation activity

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

Online focus groups with registrants

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

- Contact lens opticians
- Trainee contact lens opticians
- Dispensing opticians
- Optometry students
- Dispensing optician students

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

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

2.3.5 In total, 24 registrants took part in the focus groups. The qualitative consultation activity with registrants took place in November 2021.

Online focus groups with patients

2.3.6 Two focus groups were conducted with optical patients who currently used contact lenses at least once a week to explore a range of topics relevant to the consultation, such as experiences of wearing contact lenses, experiences of visiting an optical practice for contact lenses, and awareness and understanding of the contact lens optician role.

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

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

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

3. Reading this report

3.1 Interpreting survey data

Interpreting percentages

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

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

3.1.2 For each survey question, the results are shown at an overall level (including all consultation survey responses), and split between individual and organisation responses. Due to the overall sample size of 29, with 21 responses from individuals and 8 from organisations, no direct comparisons between the two respondent types have been made. The results displayed in the charts are therefore indicative only.

Combining response options

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

Open-end responses

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

3.2 Interpreting qualitative feedback

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

registrants or the public. Qualitative findings are collected by speaking in much greater depth to a smaller number of individuals.

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

3.3 Terminology and clarifications

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

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

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

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

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

4. Consultation survey response

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

4.1 Outcomes for Approved Qualifications for Specialist Entry to the GOC Register as a Contact Lens Optician

Document summary

4.1.1 The proposed 'Outcomes for Approved Qualifications for Specialist Entry to the GOC Register as a Contact Lens Optician' describe the expected knowledge, skills and behaviours dispensing optician must have to be awarded an approved qualification for specialist entry to the GOC register as a contact lens optician.

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

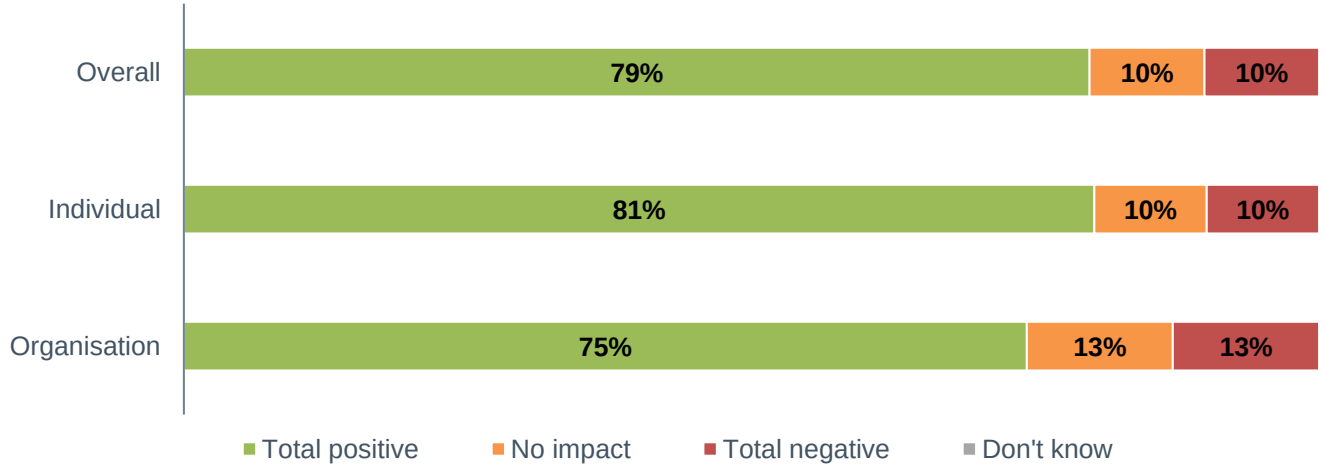
1. Uphold professional standards
2. Person centred care
3. Ocular examination
4. Verification and identification
5. Contact lens fitting and aftercare
6. Learning and development

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

Consultation survey response

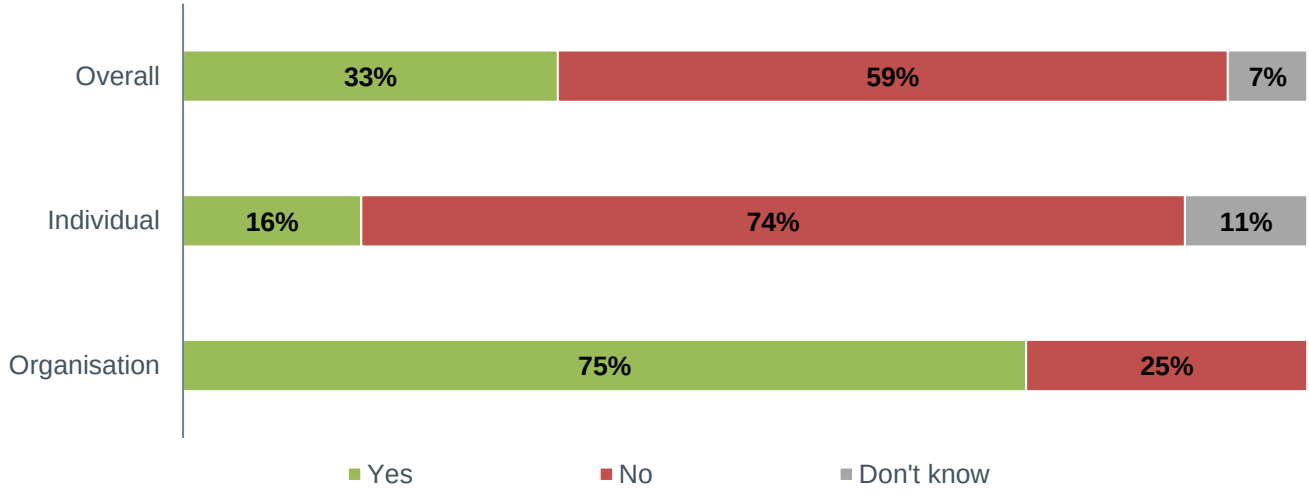
4.1.4 As shown in ***Figure 3***, the majority of respondents thought introducing the proposed 'Outcomes for Approved Qualifications for Specialist Entry to the GOC Register as a Contact Lens Optician' would have a positive impact on the expected knowledge, skill and behaviour of future contact lens opticians (79%).

Figure 3 – What impact, if any, will introducing the proposed 'Outcomes for Approved Qualifications for Specialist Entry to the GOC Register as a Contact Lens Optician' have on the expected knowledge, skill and behaviour of future contact lens opticians?
Base: Overall (29); Individual (21); Organisation (8)



4.1.5 As can be seen in ***Figure 4***, a third of respondents (9) felt that there was something missing or that should be changed in the criteria in the 'Outcomes for Approved Qualifications for Specialist Entry to the GOC Register as a Contact Lens Optician' (33%).

Figure 4 – Is there anything in the criteria in the 'Outcomes for Approved Qualifications for Specialist Entry to the GOC Register as a Contact Lens Optician' that is missing or should be changed?
Base: Overall (29); Individual (21); Organisation (8)



4.1.6 Respondents were asked to explain their answer, thinking about what is missing or should be changed. In total, 10 responses were provided. Most focused on the specific wording and technical details used in the Outcomes document, or questioned how certain outcomes may be assessed in reality. Some of these suggestions included changing the level of assessment criteria on Miller's Pyramid for certain outcomes. Examples are shown below from the British Contact Lens Association, ABDO, a registered optometrist, and a provider of GOC qualifications. These comments can be found in full in **Appendix B**.

> *O3.4 – Would this mean that students are diagnosing and managing ocular diseases? How is this different from an optometrist? The scope of conditions ought to be defined*
> *O3.6 – How is this different from an optometrist who needs far more practical training and a 4 year degree?*
> *O5.6 – remove *new modalities/materials where applicable' – just keep to soft and rigid? A variety of modalities/materials clearly exist, perhaps there is little need to include this in the wording.*
>
> British Contact Lens Association

> *O2.2 'Good outcome' should be amended to 'best outcome'. Although the best outcome may not be achieved it should still be the initial aim.*
> *O2.3 Consider changing the term 'eye health goals' to 'eye health needs'.*
>
> ABDO

> *While we generally support the outcomes, we believe that achieving or assessing these may be challenging due to the way they have been phrased. For example:*
> *O1.1 – Difficult to achieve this outcome (understanding, trust, and respect separately and ensure all are met) with other roles for Contact Lens care but also ensure these are met for other care, separately as well as in combination. This implies 35 different elements need to*

be achieved to meet this single outcome. Additionally, there is some ambiguity over how to evidence this in clinical practice.

Optical defence/representative body

O4.3 in line with 04.1 and O4.2 I suggest this will be better assessed as 'knows how' instead of 'show how'

Optometrist

*05.6 – remove *new modalities/materials where applicable' – just keep to soft and rigid? Obviously a variety of modalities/materials exist but no need to have this wording included?*
O5.12 – should this be knows rather than shows how?
O5.14 Obviously we do not know/can't test on all the local protocols? Understands and applies, where relevant, local protocols and professional guidance on the urgency of referrals e.g. The College of Optometrists' clinical management guidelines.

Provider of GOC approved qualification(s)

4.1.7 The Association of Optometrists explained that it would like further information about how the Outcomes will be reviewed on a regular basis in the future to ensure they remain up to date.

We agree with the use of the Miller's learning hierarchy to structure the outcomes for CLOs in order to align these with the education requirements for all the other frameworks leading to GOC optical registration. It would be helpful for the GOC to explain its proposed approach for the future review and update of the outcomes for CLO registration. The optometry therapeutics learning outcomes will need review every 5 years when the RPS framework, which it is mapped to, is revised. Whilst the outcomes for CLOs are not similarly mapped to another framework, there may be benefit in constructing a similar schedule for review in order to ensure the outcomes are kept up to date.

Association of Optometrists

4.2 Standards for Approved Qualifications for Specialist Entry to the GOC Register as a Contact Lens Optician

Document summary

The 'Standards for Approved Qualifications for Specialist Entry to the GOC Register as a Contact Lens Optician' describe the expected context for the delivery and assessment of the outcomes leading to an award of an approved qualification for specialist entry to the GOC register as a contact lens optician.

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

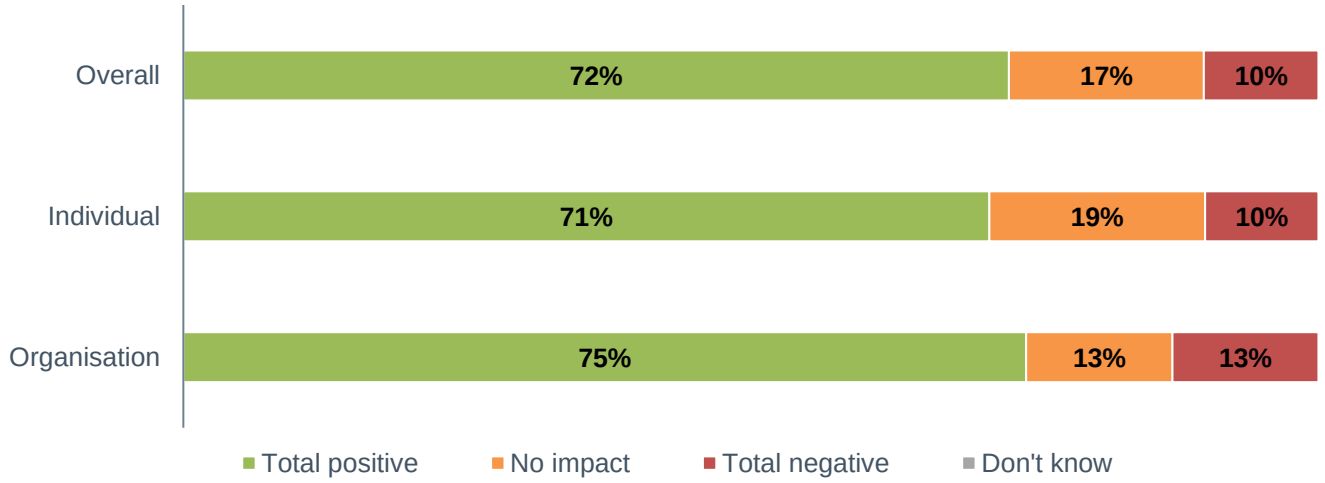
1. Public and patient safety
2. Selection and admission of trainees
3. Assessment of outcomes and curriculum design
4. Management, monitoring and review of approved qualifications
5. Leadership, resources and capacity

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

Consultation survey response

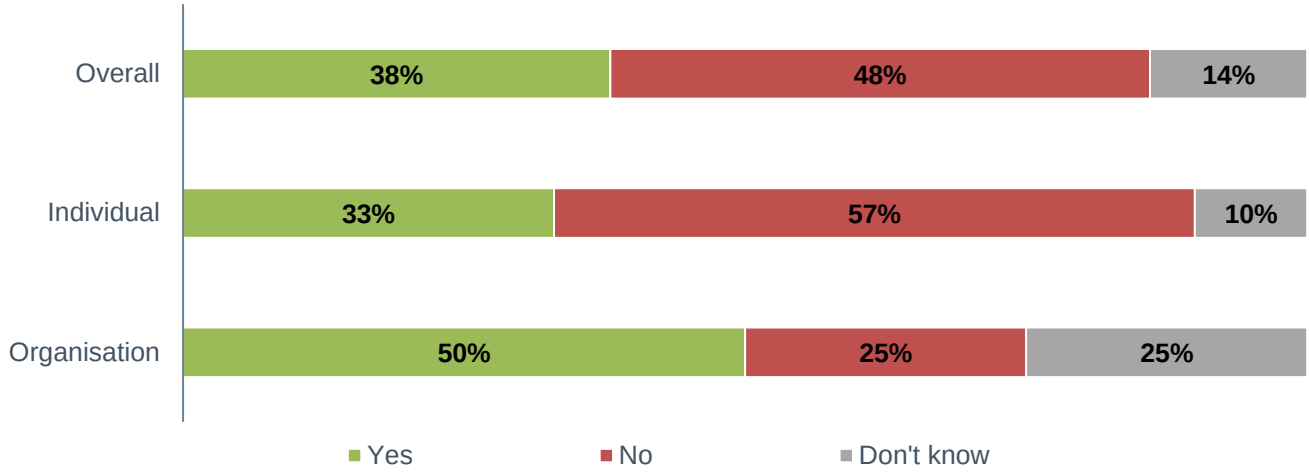
4.2.1 ***Figure 5*** shows the majority of respondents felt that introducing the proposed 'Standards for Approved Qualifications for Specialist Entry to the GOC Register as a Contact Lens Optician' would have a positive impact on the expected knowledge, skill and behaviour of future contact lens opticians (72%).

Figure 5 – What impact, if any, will introducing the proposed 'Standards for Approved Qualifications for Specialist Entry to the GOC Register as a Contact Lens Optician' have on the expected knowledge, skill and behaviour of future contact lens opticians?
Base: Overall (29); Individual (21); Organisation (8)



4.2.2 Almost two in five respondents thought there was something in the 'Standards for Approved Qualifications for Specialist Entry to the GOC Register as a Contact Lens Optician' that was missing or should be changed (38%), as shown in ***Figure 6***.

Figure 6 – Is there anything in 'Standards for Approved Qualifications for Specialist Entry to the GOC Register as a Contact Lens Optician' that is missing or should be changed?
Base: Overall (29); Individual (21); Organisation (8)



4.2.3 Respondents were asked to explain their answer, thinking about what is missing or should be changed. In total, 11 responses were provided. ABDO provided a number of suggestions for possible changes to the Standards to align them with the Standards for Approved Qualifications for Dispensing Opticians and Optometrists. An excerpt is provided below, and can be found in full in **Appendix B**.

> *Below are some suggested changes that will enable the Standards for Approved Qualifications for Specialist Entry to the GOC Register as a contact lens optician' to be aligned to the associated Standards for Approved Qualifications for Dispensing Opticians and Optometrists. These have been highlighted as there is no current understanding of why they are different:*
> *S3.2 Should be amended to say ....'The component parts should be linked into a cohesive programme of academic study, clinical experience and professional practice (for example, Harden's spiral curriculum)….'*
> *S3.3 It should be considered that although the current process to become a DO requires the trainee to*
> *S5.2 Should be amended to include the following from the Standards for Approved Qualifications for Dispensing Opticians and Optometrists:*
> ** sufficient staff responsible for the delivery and assessment of the outcomes, including GOC registrants and other suitably qualified healthcare professionals;*
> ** sufficient supervision of trainee learning in practice by GOC registrants who are appropriately trained and supported in their role*
>
> ABDO

4.2.4 The British Contact Lens Association explained that they were generally satisfied with the Standards, but felt that the process of including patient views (S3.14) should be clarified.

> *Overall, no issues, we are pleased to see stringent standards, and a wide variety of stakeholders including service users, supervisors, etc. However, one specific comment:*

S3.14 – Patient views should, of course, be taken into consideration, however we suggest rephrasing this point to make clear the exact role of the patient's involvement.

British Contact Lens Association

4.2.5 Two responses related to the removal of the minimum time requirement for clinical experience during training, suggesting that there should be a greater level of time spent with real patients.

There should be a minimum and required time frame and hours experiences prior to qualification. It is essential trainees are allowed to see and manage the impact of fitting and aftercare of patients over a period of time. Issues do not manifest themselves within several hours of face to face contact - it is usually months even years.

Contact lens optician

Possible longer supervised practical time with real patients.

Contact lens optician

4.2.6 Other explanations included a concern that they could find no mention of record keeping in the Standards, that the Standards may be too onerous, and that setting the qualification at RQF level 6 may be too low.

No mention specifically of record keeping, but one would assume this is covered by evidence

Dispensing optician

They are very long and onerous. Many of these are standard requirements for any further or higher education provider

Optometrist

If optometry is moving to level 7 then why is a Contact lens optician course staying at level 6? This seems to suggest a possible two tier CL patient experience.

Dispensing optician

4.3 Quality Assurance and Enhancement Method for Specialist Entry to the GOC Register as a Contact Lens Optician

Document summary

The 'Quality Assurance and Enhancement Method for Specialist Entry to the GOC Register as a Contact Lens Optician' describes how the GOC will gather evidence to decide in accordance with the Act whether a qualification for specialist entry to the GOC register as a contact lens optician meets the outcomes for approved qualifications and standards for approved qualifications. This method statement is common to all qualifications for specialist entry to the GOC register.

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

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

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

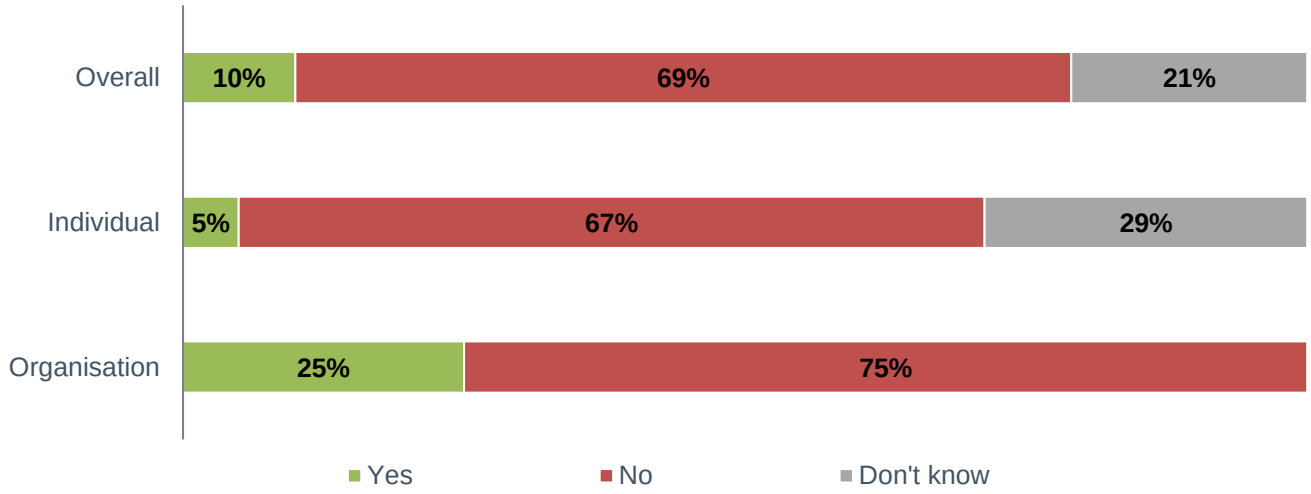
The method is organised in eight sections:

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

Consultation survey response

4.3.1 Just three respondents thought there was something in the 'Quality Assurance and Enhancement Method for Specialist Entry to the GOC Register as a Contact Lens Optician' that was missing or should be changed (10%) , as shown in ***Figure 7***.

Figure 7 – Is there anything in 'Quality Assurance and Enhancement Method for Specialist Entry to the GOC Register as a Contact Lens Optician' that is missing or should be changed?
Base: Overall (29); Individuals (21); Organisations (8)



4.3.2 Respondents were asked to explain their answer, thinking about what is missing or should be changed by providing a free-text comment. One explanation was provided by the British Contact Lens Association, presented below:

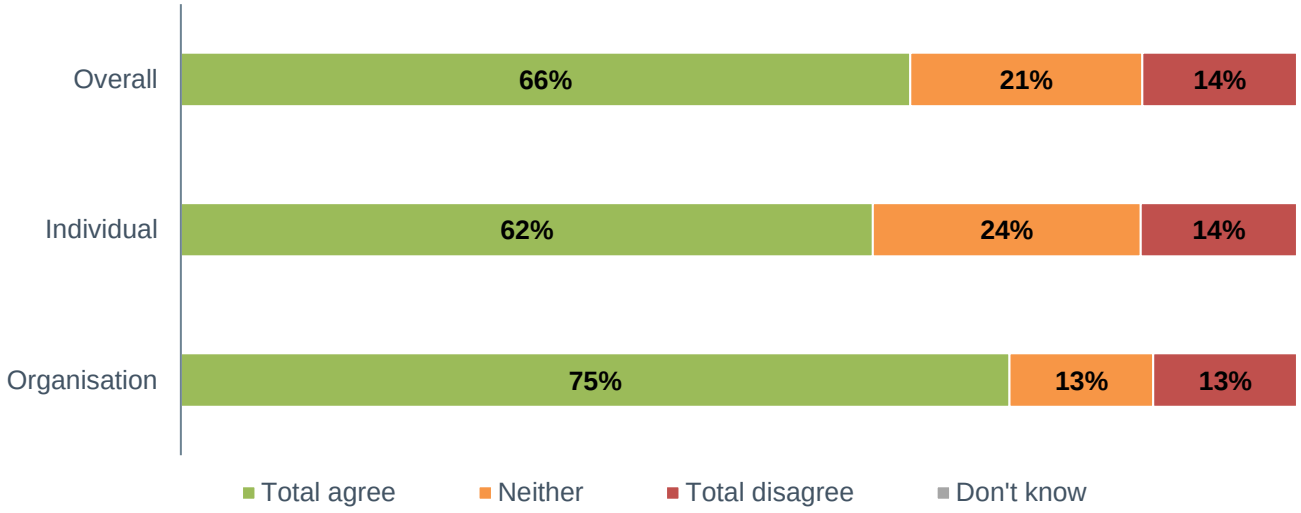
> *It was highlighted that indicative content is drafted after the outcomes have been approved, which could have a negative impact on quality assurance. It would be helpful for institutions to have access to the relevant paperwork before implementing the new rules.*
>
> British Contact Lens Association

4.4 Replacing the Quality Assurance Handbooks

Consultation survey response

4.4.1 Two thirds of respondents agreed with the proposal to replace the handbook for contact lens opticians and related policies with the three documents (66%). A further 21% neither agreed nor disagreed, and 14% disagreed, as shown in ***Figure 8***.

Figure 8 – To what extent do you agree with our proposal to replace our handbook for contact lens opticians and related policies with the proposed 'Outcomes for Approved Qualifications for Specialist Entry to the GOC Register as a Contact Lens Optician', 'Standards for Approved Qualifications for Specialist Entry to the GOC Register as a Contact Lens Optician' and 'Quality Assurance and Enhancement Method for Specialist Entry to the GOC Register as a Contact Lens Optician'?
Base: Overall (29); Individuals (21); Organisations (8)



4.4.2 Respondents were asked to explain their answer by providing a free-text response. In total, 13 responses were provided. It is encouraging to note that a number of responses explained that the replacement of the current handbooks with the three new documents, and the changes proposed within them, were positive. Some comments explained that the changes provided more ways to qualify, ensured that future contact lens opticians would practise safely, and that the documents were well-considered, robust and detailed.

More ways to qualify

Trainee contact lens optician

I believe these documents and their contents cover all aspects to ensure the development of future contact lens opticians in a safe and monitored environment as well as ensuring public safety

Dispensing optician

I feel the enclosed documents are a robust and detailed explanation of how the qualification is changing, setting out evidence to reassure any approved qualifications will not be dumbed down. That institutions offering the new qualification will be rigorously checked not only along their development but at periodic points after as well. That there is support for both the trainee and supervisor, as well as protection for the patient or service user.

Contact lens optician

More complete. Provides more detail and is inclusive.

Contact lens optician

4.4.3 FODO provided a positive explanation, stating that the proposal to introduce the three new documents was responding well to the changing nature of clinical practice.

Clinical practice is evolving all the time and what was once clinically appropriate such as RGP lenses for all patients has largely been superseded by new technologies. Reviewing these standards, when the ESR is about to be implemented, is wise and will ensure up-to-date standards of education and training for CLOs to meet the changing needs of patients and new modalities of wear. FODO has been closely involved in the development of these standards, which we support. We would like to congratulate the GOC on the open and inclusive way they have been developed and the GOC's openness to new ideas and challenge.

FODO - The Association for Eye Care Providers

4.4.4 Some explanations expressed concerns, including a lack of clear rationale for the introduction of any changes, and that the proposals may result in inconsistency in levels of training and the potential for self-certification by multiples.

It is important to make pertinent changes but my main area of concern is that by not having just 1 recognised qualification but from multiple sources there may be inconsistency in the level of training. A positive may be that the costs will fall as they don't seem good value for money. I also have concerns about multiples effectively self-certifying their employees.

Contact lens optician

The scope of practice is being changed without a clear rationale

Provider of GOC approved qualification(s)

4.4.5 The Association of Optometrists, whilst supportive of the proposals as a logical step forward, also raised a concern about the removal of the minimum duration requirements for the qualification, which they saw as a risk associated with increased flexibility that could be managed by the GOC's quality assurance process.

The current CLO education requirements are 14 years old and it's right for these to be updated as a logical step following the agreement of new education requirements in February 2021 for entry to the register as an optometrist and dispensing optician, and more recently to the framework for optometrist prescribers. This will bring the design of the CLO requirements into alignment with these other frameworks, moving to less prescriptive requirements for providers, with outcomes framed using the Miller's triangle hierarchy, and a common risk based approach to quality assurance and approval. As a result however the CLO requirements will also suffer from the same delivery risks that inevitably flow from the use of a high level flexible set of requirements, and these will need to be mitigated through the GOC's quality assurance and approval process.

The new CLO education requirements do not provide any minimum duration requirements for the qualification to be completed, save for the inclusion of 225 of learning experience in practice. This is a reasonable move given similar changes to the other optical education frameworks. However, the GOC should monitor CLO course duration and resourcing as part of its approval and assurance process - to mitigate the risk of overly short course lengths compromising the overall quality of learning.

4.4.6 The Association of Optometrists also highlighted their support for the inclusion of outcomes related to the management of conditions such as glaucoma, retinal detachment, AMD, and myopia, and provided advice on how this could be improved and made clearer in the documents.

> *We welcome the inclusion of outcomes 6.2 about urgency of glaucoma, retinal detachment and AMD (knows) and 6.3 on the principles of myopia management (knows how) for CLOs. It should be beneficial for CLOs to have basic knowledge about symptoms of these eye conditions - to give them an understanding about relative urgency in service delivery, and a knowledge of myopia management principles will also be useful. Within the learning framework these outcomes should logically focus on developing knowledge rather than practice, as these are not part of the current CLO competencies or directly related to CLO practice. It is important that the distinction between knowledge and practice is clear. The GOC should ensure that CLOs are not exposed to professional risks as a result of pressure from employers to work in areas covered by outcomes 6.2 and 6.3 which they're not appropriately skilled in. This could be done via the standards for optical businesses and through CPD. It would also be useful for the GOC to clarify whether the requirement for the CLO qualification to be at RQF level 6 has any impact on those registrants who have previously gained their dispensing optician registration as a level 5 qualification.*
>
> Association of Optometrists

4.4.7 Two responses stated that the documents offered little change from the current system, with the exception of moving to an outcomes based approach.

> *There seems to be little change only a move from competency to learning outcomes.*
>
> Dispensing optician

> *There seems little real change apart from the competency to learning outcomes practice.*
>
> Provider of GOC approved qualification(s)

4.4.8 Respondents were asked to comment if they had anything else to say about the education and training of future contact lens opticians. Some respondents took the opportunity to express their support for the consultation and the proposed changes set out for the education and training of future contact lens opticians.

> *I'm excited to see the evolvement of the CLO qualification, making it accessible to more people, who may not be able to be away from home weeks at a time. I hope it will encourage more DO to take up the speciality qualification, and for employers to see the benefit academically without as much impact financially.*
>
> Contact lens optician

> *There is always room for keeping up to date with clinical knowledge and OCT scans and use of IT in practice and CPD onwards and upwards it doesn't do to say we know it all.*
>
> Contact lens optician

> *It is good the GOC is consulting on these proposed changes and there must be clear and documented ongoing dialog with those that have responded before any changes are approved.*
>
> Provider of GOC approved qualification(s)

4.4.9 Some responses reiterated queries or concerns, or made suggestions for how the proposals could be changed or improved.

> *We recommend a requirement or recommendation towards a minimum period over which learning takes place to ensure there is enough time for reflection etc. In addition, we strongly recommend the use of a separate (final) examination body i.e. not the provider.*
>
> British Contact Lens Association

> *The GOC might reconsider whether the date for the commencement of approval of new qualifications (1 December 2021 – Section 3 of the consultation) is achievable, given that the consultation closes on 20 December. It is not clear that this leaves sufficient time to analyse responses, check and then implement any changes.*
>
> FODO - The Association for Eye Care Providers

> *Make it easier for organisation to register.*
>
> Trainee contact lens optician

> *I believe the future should include the ability for contact lens opticians to work towards either full IP or a version like AS.*
>
> Trainee contact lens optician

> *I propose the supervisor should be CLO rather than OO due to knowledge and experience of the CLO's.*
>
> Contact lens optician

> *I have never worked in a practice with a radiuscope. I have never need to replicate a contact lens in 30 years of lens fitting. I see no reason for verification and being able to replicate a lens as something that is relevant to modern day practice.*
>
> Contact lens optician

> *Is there a need for two levels of qualification?*
>
> Contact lens optician

4.4.10 Several comments related to setting the qualification at RQF level six, questioning why it was not set at level seven in order to be higher than the dispensing optician qualification, and to better recognise the contact lens optician role and specialism.

> *CLO's should be recognised as level 7 qualification. It is a specialism and the depth of knowledge required is much deeper than optometrist level; yet CLO's are not considered equal and are often treated with disrespect by optometrists.*
>
> Contact lens optician

> *I do not understand the rationale for having DO and CLO at the same minimum qualifying level. If all DOs are to be level 6 minimum how can CL be also at level 6? If the CL specialism is at the same level, is it possible that the CL may be seen less attractive to both prospective students and employers?*
>
> Dispensing optician

> *The minimum level 6 qualification mandate in line with Dispensing opticians also a level 6 seems at odds with the perception of a higher skill level. the uplift of optometry to level 7*

suggests a two tier contact lens practitioner in a practice. We are unsure as to the possible impact this might have on prospective CLOs and employers.

Provider of GOC approved qualification(s)

4.4.11 The Association of Optometrists emphasised the importance of contact lens opticians in the optical workforce.

CLOs are an important part of the optical workforce and an education model which allows appropriate workforce capacity is essential. As well as traditional roles in community optics CLOs, as well as dispensing opticians, are increasingly becoming involved in the delivery of enhanced primary care optical services such as for minor eye conditions and low vision. The AOP currently has over 150 dispensing optician members and a designated position to represent DO members on our Council.

Association of Optometrists

4.5 Impact of proposals

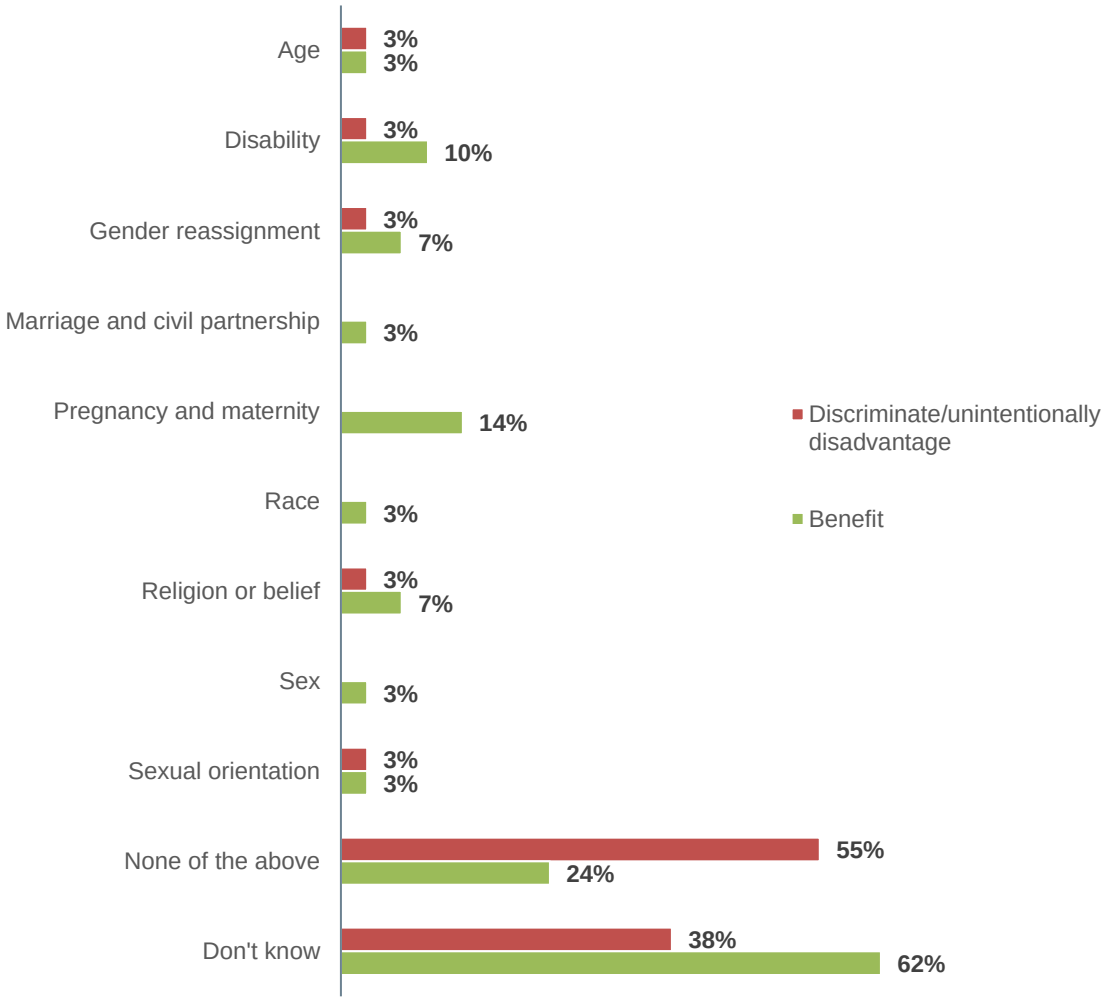
Consultation survey response

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

4.5.2 As shown in ***Figure 9***, over half of respondents said that the proposals would not discriminate against or unintentionally disadvantage any of the groups or individuals listed (55%). A further 38% answered that they did not know whether the proposals would discriminate or unintentionally disadvantage any groups.

4.5.3 A quarter of respondents said that the proposals would not benefit any of the groups listed (24%), but the majority said they did not know if there would be any benefit (62%). Only small proportions of respondents thought the proposals may benefit certain groups or individuals, including pregnancy and maternity (4 respondents), disability (3 respondents), gender reassignment (2 respondents), and religion or belief (2 respondents).

Figure 9 – Do you think our proposals will have a negative or positive impact on certain individuals or groups who share any of the protected characteristics listed below?
Base: All respondents (29)



4.5.4 Respondents were asked to describe how the proposals may discriminate or unintentionally disadvantage the individuals or groups they had identified, with three responses provided. All responses were positive, with two highlighting that they did not perceive any barriers for any individuals or groups, and that the proposals would allow access for all those interesting in pursuing this qualification.

> *I think everyone that wishes to obtain entry onto the specialist register as a contact lens optician can only benefit from the structure and assurance they will be offered by these proposals, as they will ensure a high standard of learning across all groups of individuals.*
>
> Dispensing optician

> *I do not see any barriers.*
>
> Contact lens optician

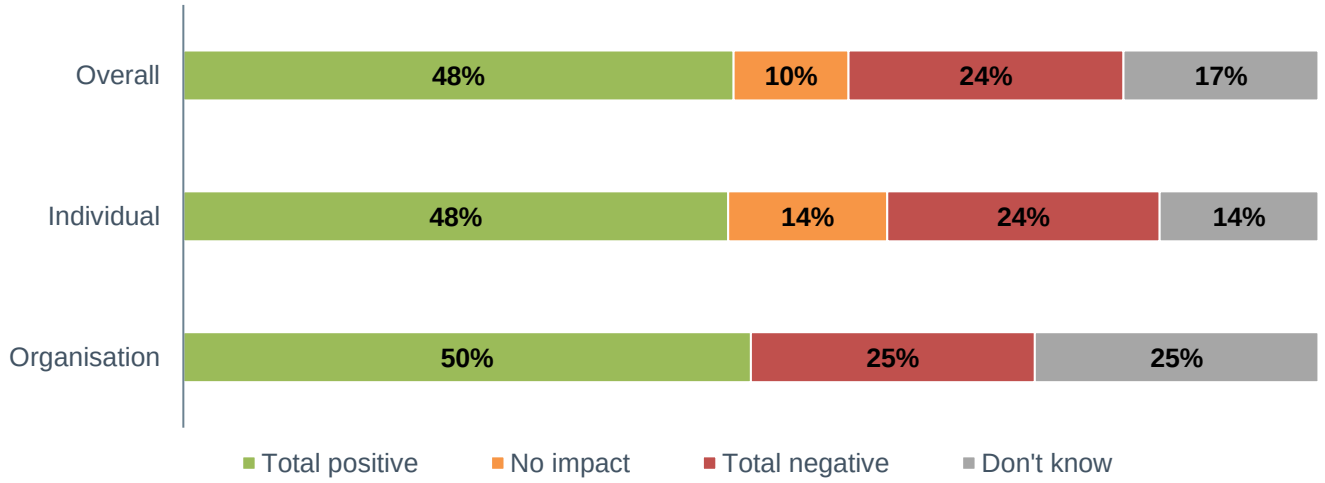
4.5.5 A respondent highlighted a number of benefits to certain groups, including the increased flexibility for registrants to complete the qualification which would help those who may become ill or who may take a career break to have children and those with family commitments.

> *All three marked; if there is no cut of time to complete the qualification, it gives room for anyone who may have to time out unexpectedly, be it for a flare up of a chronic illness, for urgent childcare or pregnancy, or for surgery. With potential multiple places offering the new qualification, block releases may be closer to individuals home, negating the need to be away overnight, or even giving the opportunity to be done on a one to one basis. For single parents or individuals with partners working unsociable hours, this will open up new opportunities for them.*
>
> Contact lens optician

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

4.5.7 ***Figure 10*** shows that almost half of respondents felt that the proposed changes would have a positive impact on other individuals and groups (48%), whereas 24% thought the impact would be negative. One in ten (10%) thought there would be no impact and 17% did not know.

Figure 10 – Do you think any of the proposed changes will impact – positively or negatively – on any other individuals or groups? For example, trainees, patients and the public, current providers of approved qualifications, placement providers, employers and devolved nations?
Base: Overall (29); Individuals (21); Organisations (8)



4.5.8 Respondents were asked to describe what impact and individuals or groups they were thinking of when answering this question, and 11 responses were received. These responses are presented below, split between perceived positive, negative, and mixed impacts.

4.5.9 Positive impacts, which focused on maintaining or reducing the cost of training:

> *Financially, if individuals aren't having to travel as far for block releases or they can be done one-to-one, this brings down the cost to the employer, making it a more attractive option.*
> Contact lens optician

> *There may be additional costs to trainees and employers to meet the new standards but these may be initial costs only in that once new systems/schedules have been put in place then there will only be the running costs, similar to current costs*
> Dispensing optician

4.5.10 Negative impacts, which included the potential lowering of pay for contact lens opticians, and the potential reduction in standards posing a risk to the public.

> *As previously stated the level 6 minimum qualification, i.e. same as DO and lower than optometry may influence employers pay scales.*
> Dispensing optician

> *As previously stated the apparent two tier CLO practitioner may find their compensation affected.*
> Provider of GOC approved qualification(s)

The changes will cause potential harm to the public as there will be CLO's without clinical expertise or experience who are rushed through the exam system in order to satisfy the multiples thirst for sales of profitable soft contact lenses rather than optimal lens choice for the patient themselves.

Contact lens optician

The level of expertise in the diagnosis and management of anterior eye conditions will be reduced if these proposals go ahead unaltered

Optometrist

4.5.11 Mixed impacts:

We believe this has a positive impact on trainees. But as per our comments, potentially somewhat negative impact on providers if not clarified.

Optical defence/representative body

I have a hope that it will improve standards, but standards that are relevant to today's world. If, for instance, an education programme was proving to be the 'best' available then it should encourage alternative providers to improve their offering. Anything that minimises cost is also a positive as the salaries of DO are not a fair reflection of their skillset and the cost of completed a CLO qualification may be prohibitive.

Contact lens optician

5. Registrant focus group feedback

This section of the report details the feedback from the five focus groups held with GOC registrants. During the groups, registrants discussed the seven key proposals of the consultation, followed by the six outcomes from the Outcomes for Approved Qualifications document, which are covered in turn within this chapter.

Key proposals

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

Please note that feedback from the first proposal (Candidates will acquire a qualification approved by the GOC leading to specialist entry to the GOC register as a contact lens optician) has not been included, as participants felt this was clear and self-explanatory, and therefore it was not widely discussed.

5.1 Academic award or regulated qualification

Summary of the proposal

The approved qualification will be either an academic award or a regulated qualification at a minimum of Regulated Qualification Framework (RQF) (or equivalent) level 6.

Agreement that this is an appropriate level of qualification which recognises the knowledge and skill required from contact lens opticians

5.1.1 In general, most participants felt that setting the approved qualification for contact lens opticians at RQF level 6 or equivalent was appropriate, explaining that it was reflective of the level of knowledge required of contact lens opticians and the requirements placed upon them in practice, and therefore should not be set any lower than this. It was suggested by some participants that having this qualification match the dispensing optician qualification also felt appropriate, bringing the two qualifications in line at the same level.

> *I think that's about right. I certainly don't think it should be any lower than that. Because the amount of knowledge involved – there's quite a lot to it. I think even a DO should be a level 6, which is what they've changed it to recently. So yeah, I think that's about right.*
>
> Trainee contact lens optician, England

5.1.2 It was also highlighted that setting this qualification at level 6 was justified, as it increased the level of knowledge and skill of dispensing opticians up to a higher level specifically in the area of contact lenses. Participants explained that the current dispensing optician qualification does not cover contact lenses at this level, and therefore this qualification would bring contact lens opticians up to a level 6 in this specialty.

> *As dispensing opticians, we have a knowledge of contact lenses. But that level of contact lenses for the general dispensing is nowhere near the level 6. The level of dispensing knowledge is level 6, but this then brings your contact lens knowledge up to that level. And I think that would be appropriate.*
>
> Contact lens optician, Scotland

> *Although the DO is still a level 6, the contact lens side of it isn't the equivalent of a level 6. So then by doing the contact lens qualification you're bringing up your contact lens knowledge to a level 6 knowledge.*
>
> Contact lens optician, England

5.1.3 Some participants said that setting the contact lens optician qualification at this level may help to improve the standing and recognition of both contact lens opticians and dispensing opticians, which they felt were under-utilised roles in the optical workforce that are not used to their full potential.

> *I have been concerned about the under-utilisation of DOs and CLOs… DOs and CLOs are very highly qualified, but they don't always get to use their education and that experience. So for me, I wouldn't want it any lower than this.*
>
> Contact lens optician, Scotland

> *The way that multiples sort of deal with DOs and CLOs, it's like we're kind of considered second fiddle and we're not used to our full capability…They could make a lot more use of them and they could have a wider spanning role.*
>
> Dispensing optician, England

The qualification could be set at a higher level, exceeding the dispensing optician qualification, but this may not be practical

5.1.4 Although many participants were in favour of the qualification being set at a high level as an academic qualification, some highlighted that if it was set at RQF level 6, this would match the level of the dispensing optician qualification. They explained that this seemed at odds with the contact lens qualification being an additional qualification for dispensing opticians, as in their opinion the qualification should be at an even higher level to differentiate contact lens opticians from dispensing opticians. It was felt that setting the contact lens optician qualification at an even higher level would recognise the additional knowledge, skill and responsibility of contact lens opticians who have gained the additional qualification.

> *I would say that perhaps it should be at a higher level than the dispensing qualification because the candidates have achieved that and then they're moving on to something specialist.*
>
> Contact lens optician, England

> *The dispensing optician, even without the CLO, is broadly pretty responsible…In the framework of avoiding patients going to A&E, with the NHS so short of money and the elderly population living longer, our roles as DOs are different. We are there to listen and to advise and to signpost and refer. So I would say the qualification should be higher than level 6.*
>
> Contact lens optician, England

5.1.5 It was suggested that increasing the level of this qualification would go further in increasing the recognition and standing of the contact lens optician role, particularly amongst the public and patients. Some participants felt that the levels of responsibility and accountability of contact lens opticians had increased in recent years, becoming more in line with those of an optometrist, and therefore an increased level of qualification would help to recognise this.

I would say that it needs to be higher, in order to let the public know that we are there to provide a certain level of care. We have a duty of care to them, and we're responsible. If you set it too low, then it's almost like anyone can do it. Whereas setting it higher, it does become a bit more specialist.

Contact lens optician, England

To reflect our level of care and responsibility. It may not be on par with an optometrist, who is responsible to diagnose a brain tumour…but actually it's not that far off, because we need to tell the patients what they're at risk from, and be up to date with disease, and look after our elderly patients. And the responsibility is with us, because optometrists do not have the time.

Contact lens optician, England

5.1.6 However, there was discussion amongst participants about what level, above RQF level 6, the contact lens optician qualification could be set at. In response to those who suggested that it should be set at RQF level 7, some participants felt that this would be difficult to achieve in terms of structuring the qualification, gaining relevant experience, and the length of study. It was also felt that increasing the level of qualification could result in it becoming overly academic, which was not necessarily in line with the practical role of contact lens opticians. Therefore, it was felt that increasing the level beyond RQF level 6 may cause issues and deter dispensing opticians from taking the qualification.

I think also one of the other things that we need to look at is that it's not purely an academic qualification, it is a practical qualification as well. And I think the level 7, higher levels, seem to be much more academic.

Contact lens optician, Scotland

From my point of view, if it was at level 7, because the qualification is a relatively short one, it's how many credits at level 7 you'd be able to achieve with it. You wouldn't be able to do a full masters or anything like that. So it might put off people if they had to achieve sort of a full masters level. So I think level 7 is a very fair thing to say, but we probably wouldn't be able to achieve a whole masters just for a very small part of it.

Contact lens optician, England

5.2 Removing the duration and location requirements for clinical experience

Summary of the proposal

There will be no proposed minimum/maximum or recommended time or credit volume for an approved qualification or specified location or duration of clinical experience, other than the requirement that an approved qualification leading to specialist entry to the GOC register as a contact lens optician must integrate approximately 225 hours of learning and experience in practice.

Increased flexibility for trainees and employers

5.2.1 Some participants could see the potential benefits of this proposal, as they felt that the removal of the minimum amount of time specified in clinical experience for the contact lens optician qualification could allow for increased flexibility. They explained that gaining clinical experience as part of the qualification can be difficult, especially when continuing their duties as a dispensing

optician. A number of participants who had qualified as contact lens opticians recalled experiences during their training of being promised time to gain clinical experience, but then being told they were needed to dispense instead. Therefore, it was suggested that, by stating that there is no specified minimum recommended time for clinical experience, this could increase flexibility for trainees, who would no longer have to struggle to achieve a specific number of hours and instead could sit their examinations when they feel ready to do so.

> *When I was qualifying, it was not easy to find a practitioner on the high street who would fulfil their promises…In most practices, they can't afford more than one DO, and every potential CLO is a DO already. So they want their money's worth out of you. I was promised the job, and after a year, I still hadn't done anywhere near even 40 hours of practice in the consulting room.*
>
> Contact lens optician, England

> *I suppose the theory is that if you do 175 quality hours and you are showing the competences and you are capable of doing the exams, does it matter than you've not done 225 hours? I guess that's where the argument is. If you're someone who is excessively competent, can you do that in a lower amount of hours? As long as you can pass the exams, does it matter?*
>
> Contact lens optician, England

> *I think it would appeal more to employers…If they're close to 225 hours and they've got their exams, they're not drastically running around trying to squeeze in another five hours, or postponing it by six months because they haven't managed to do the hours, because of sickness or being pulled off clinics and stuff. So I can see the benefit..*
>
> Contact lens optician, England

5.2.2 However, participants focused more on the benefit of increased flexibility for employers, who it was suggested would be able to gain qualified contact lens opticians in a shorter period of time under these proposals. Some participants highlighted that this would help meet the increasing demands of employers.

> *Clearly employers are keen for their training CLOs to be qualified as soon as they possibly can, and maybe there's that possibility that the student will be pushed ahead…Clearly employers might think, 'Great, I don't have to do 30 days with them, now I can do five days with them and say, 'Go and sit your exams'.' You might have students going ahead and taking exams that have been told they're ready for, but haven't…effectively, 'done their time'.*
>
> Contact lens optician, England

> *Maybe the influence of some businesses towards the GOC – that this is what they need. Pressure from employers that we actually need to get people through quicker. And in this very unusual time that we exist in, where practices are very far booked ahead, where patients are not able to collect lenses because there's no aftercare being done, because places have been shut for COVID and all that kind of thing. So you can see where pressure may come from. But it shouldn't be a drop in standards.*
>
> Contact lens optician, Scotland

Could represent a shift towards true learning rather than box-ticking

5.2.3 A small number of participants highlighted that the proposal to remove minimum and maximum time requirements suggested a move towards focusing on actual learning and ensuring a trainee knows, can show, or can do something, based on the outcomes approach of Miller's Pyramid. They explained that this would represent a positive move away from simply spending a required number of hours in a particular area, which could be viewed as box-ticking rather than true learning, which may result in better qualified contact lens opticians.

> *I would say though that I think it's leaning more on making sure people can do something, because I was reading through the document and it was about the account record called Miller's reference of learning. And I think the point that makes sense to me is, don't make someone do something for a certain amount of hours, make someone do something until they can really do it properly, and really know how to do it. Sometimes when you remove a minimum time from something, someone will actually do it more thoroughly, potentially, because they're having to show to a higher level that they do understand it.*
>
> Dispensing optician, Scotland

> *You're taking the emphasis away from just ticking boxes. Instead of looking at the hours of time spent, we're looking at what they can actually do. So changing the focus maybe.*
>
> Contact lens optician, England

Unease about removing minimum time requirements and ambiguity of the word 'approximately'

5.2.4 In general, most participants expressed concern and unease about the removal of the minimum time requirement for clinical experience during the contact lens optician qualification training. Many participants said that they were particularly uncomfortable about the use of the word 'approximately' to describe the suggested number of hours of clinical experience to be obtained under the proposals, as it was open to a wide range of interpretation and therefore open to abuse.

> *I actually think that you need to have a set figure that they have got to achieve as a minimum. Because if you're just saying 'approximate', are people just going to do the minimum required? I think it has to be set at either 225 or above. Having an 'approximate' doesn't work for me.*
>
> Contact lens optician, England

> *This one does make me slightly nervous. As soon as you start talking about 'approximately' so many hours, where does 'approximately' go? Where do we sort of start, and how much experience are we expecting our people to have? We're suggesting that the qualification must be sort of public-facing, and then at the same time we're saying, '…but we're not going to say how much public-facing time you need'.*
>
> Contact lens optician, England

5.2.5 It was suggested that this approach could lead to some trainees completing a significantly smaller number of hours of clinical experience, and some participants said that the proposal signalled a move towards deregulation, which they felt would lead to falling standards in the profession.

> *I think, inherently, humans try and do the bare minimum, and it just leaves it open. So what would we accept? Is 175 okay? Or 185? Where do you draw the line?*
>
> Contact lens optician, Scotland

I also feel like if they remove that minimum and just put it as an approximate, it's almost like the start of like, a deregulation of sale of contact lenses. It almost feels like it's not that important.

Trainee contact lens optician, England

Risk of not gaining enough clinical experience

5.2.6 The main concern expressed was that the increased flexibility that replacing a minimum time requirement for clinical experience with an approximate number of hours may create could also increase the risk of trainees not gaining sufficient clinical experience to become contact lens opticians who are prepared for practice. Participants explained that this could be caused by trainees themselves, their employers, or a combination of both.

The risk is that they're not going to get the experience required. You've got to see a lot of people over a lot of days to get a broad spectrum of what clinical practice is.

Contact lens optician, England

5.2.7 A number of participants explained that, in order to gain worthwhile clinical experience and have the opportunity to gain useful and meaningful interactions with different patients and conditions, a reasonable amount of time was required, with suggestions of at least a year or more. It was felt that removing the minimum time requirement could lead to trainees rushing through their clinical experience without gaining worthwhile knowledge and skills to equip them as contact lens opticians. Some participants highlighted the benefit of seeing a patient over an extended period of time, which could be unachievable if sufficient time in clinical practice is not available to trainees.

I would say at least a year even if it's just one or two days a week for that year, so that you can build up the experience with different lenses. It's very different fitting a spherical soft lens to a GP toric or a multifocal even, and getting the fit right, working out if there are any issues, how you're going to correct them, what you can do to change things. You can't do that just overnight. It is a learned experience, and that experience is very valuable. So I think at least a year, minimum of one day a week.

Contact lens optician, England

If you can do 225 hours in three or four months, I don't see how you can follow a patient, like a new contact lens patient, for 12 months or more, which is important. It's about following a patient over a period of time and seeing how contact lenses impact on their eye, on their cornea, etc. You won't get that depth of experience. If you can do 225 hours in three months, or whatever was suggested, you can't do a six-month or a 12-month aftercare.

Contact lens optician, England

5.2.8 A number of participants felt that the recommendation of approximately 225 hours was, in reality, fair and not excessive, and that it should be achievable for trainees. Some went further, stating that, rather than being reduced or removed, the minimum amount of clinical experience should be increased to ensure that trainees have sufficient time to gain the required knowledge and skills.

Just for context, I think the 225 hours is based on something like 30 days at 7.5 hours. To me, 30 days is not excessive. That's one day every fortnight, pretty much, so that's not an awful lot over a year.

Contact lens optician, Scotland

225 hours is not nearly enough to give the public and other colleagues the confidence to let them loose on their own. I just don't think that's enough. Not nearly enough.

Contact lens optician, England

5.2.9 Furthermore, some participants expressed the concern that this proposal may result in too few hours being spent in clinical practice at the expense of book-based and academic learning. They felt that the wording of the proposal was open to interpretation and could allow trainees and employers to reach the recommended number of hours via 'learning' rather than 'experience', particularly if clinical experience is difficult to obtain.

They're not listing separately, the hours of learning with the experience, they're lumping it together. So you can pass without any experience. That's how I read it.

Contact lens optician, England

5.3 Providers must involve feedback from stakeholders

Summary of the proposal

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

An expected, reasonable and positive proposal

5.3.1 This proposal was viewed by the majority of participants as an important and expected aspect of the provision of a training course, and therefore was viewed as reasonable. Some participants explained that they expected that a range of stakeholders would be consulted during the design, delivery and assessment of a training course for an approved qualification, and were therefore unsurprised and happy to see this proposal.

Getting feedback can only be positive because it means that you can use that to improve.

Dispensing optician, England

It's pretty good sense to me. I think that covers most people, doesn't it?

Contact lens optician, England

5.3.2 It was felt that there were benefits to including feedback from all listed stakeholders in the process. Some participants said that gaining feedback from the wider team and other healthcare professionals was very important due to increased multi-disciplinary working within practice and across healthcare. Others emphasised the importance of patient input into the process to ensure public understanding.

It's a range of people, so it's not just the person who's doing the qualification, it's their employers, it's their supervisors, it's other members. So if you're training as a CLO, you're getting feedback from optoms that you're working with, and people that you you're using to do delegated tasks and stuff like that. I think if it's someone who, even if they're not directly supervising you, if you're part of their team, and they can see your progression and see how the course is working for you, that can only be a good thing as well. Because it's not about passing an exam or meeting a particular standard, and that's the end of it, it's about integrating into the team and it working for everyone.

Contact lens optician, England

Ensure feedback is fairly weighted from stakeholders and not weighted towards large employers

5.3.3 Some participants highlighted the importance of ensuring feedback from stakeholders is fairly weighted to avoid those with a vested interest having an unfair say in the design, delivery and assessment of the contact lens optician qualification. In particular, concerns were raised about the potential influence that large employers could have, and felt that it would be important that measures were in place to ensure feedback was received in a balanced and fair manner.

> *Will it be equal weight? Or will they weight the approved qualification on what the employers want, or what the patients need, or what? So how even, or how equal, will the qualification design be designed by feedback?...I think it should be weighted equally. I have a fear that it will be weighted towards employers. But I feel that it definitely should have feedback from across the board. But I'd like to see evidence that it was weighted evenly, or at least with, say, patients in more mind rather than employers.*
>
> Contact lens optician, England

> *I think it's important that it has that range of people as well…You don't want it to be made purely by employers who are going to be looking for the cheapest way to push people through a course, or patients who are going to want it the other way, and want an hour to ask all the questions they want. So I think you do need that balance of people with different priorities to be able to kind of level out.*
>
> Dispensing optician, Scotland

Questions as to whether feedback from patients and other healthcare professionals is necessary

5.3.4 A small number of participants questioned the relevance of gaining feedback from all the stakeholders listed in the proposal, suggesting that it was a long list. In particular, it was suggested that feedback from patients in the design, delivery and assessment of the contact lens optician qualification may be irrelevant and unnecessary due to their lack of understanding of contact lens opticians' qualifications. Some participants also questioned the relevance of feedback from other healthcare professionals if their role is unrelated to optometry and contact lenses.

> *Patients aren't necessarily going to know what the criteria are and the competencies that need to be covered. I know they can feel looked after or not feel looked after, but that's kind of their scope…that feels a bit ambiguous.*
>
> Dispensing optician, England

> *Members of the public are not experts. For example, people might think, 'Oh, he's a great optician'…but because he's nice and he asks you about your holidays, that doesn't make him a great optician. But the public might have that perception because the person is communicative, rather than being really expert clinically…Other healthcare professions – yes, if they're ophthalmologists, maybe, but a dentist or a nurse? I think it's the people who are doing the course, the people who are supervising them, and the people who have put the framework in for the education, they should be giving feedback.*
>
> Contact lens optician, Scotland

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

Summary of the proposal

An outcomes-based approach is used to specify knowledge, skills and behaviours using an established competence and assessment hierarchy known as 'Miller's Pyramid of Clinical Competence' (knows; knows how; shows how; and does).

An easy to understand system that will provide consistency and flexibility

5.4.1 Although not all participants were aware of Miller's Pyramid before taking part in the consultation, it was generally viewed as a simple and easy to understand system of assessment, which would benefit both providers and trainees. Participants explained that they liked the different levels of competence, increasing from cognition to behaviour, and felt it would be easy to apply and assess during training. It was also suggested that this system of assessment would help focus trainees more on the application of their learning in a practical setting, and that it would be an improvement on the current system in place, which was viewed as potentially confusing.

> *I've not come across Miller's Pyramid before, but looking into it, I really like it. I think it is that level of understanding. You learn about it academically, you can then apply that knowledge, you can show how it's been used, and then you just do it as a sort of natural thing to do. So I think it does show a good level and depth of understanding. It's not just knowing what that is, but how that then impacts, and then showing that you can do it without thinking about it.*
>
> Contact lens optician, England

> *I thought how nice it was, quite clear. And yes, we all do have to 'know' and 'show' and 'know how'. I would say most opticians would agree that that's a good way. It's just summarising what we have to do anyway.*
>
> Dispensing optician student, England

> *I think it's important, because as the diagram obviously highlights, knowing something isn't the end-all because anyone can learn a fact out of a book, and knowing a fact doesn't mean you understand something. So I think this is just about trying to push people to get that understanding rather than just the knowledge. Because intelligence and ability within a role is not about your ability to recall facts, it's about your ability to put things together and do things based on a deeper understanding.*
>
> Dispensing optician, Scotland

A logical choice as it is already used for the dispensing optician qualification and in the education of other healthcare professions

5.4.2 Registrant feedback in relation to the use of Miller's Pyramid was generally positive amongst most participants. A common response to this proposal was that adopting Miller's Pyramid for specialist qualifications was a logical choice as it had already been adopted for the optometry and dispensing optician qualifications, and would therefore provide consistency and familiarity for those who decide to continue their education and training.

> *The dispensing and optometry qualifications have already adopted this, so it would be extremely strange if contact lens didn't. I'm in favour of it. I think it's a pretty good system.*

It's certainly a step up from what we have at the moment, which is kind of 'ability to' or 'knowledge of'.

Contact lens optician, England

The assessment should focus more on 'shows how' and 'does' as experience is crucial

5.4.3 When discussing the use of Miller's Pyramid, some participants explained that they felt direct experience was the most important aspect of training, particularly for contact lens optician training. Therefore, they suggested that assessment of the contact lens qualification should be more heavily weighted towards the 'shows how' and 'does' measures of the scale, rather than 'knows how' and 'knows'.

I think it needs to be weighed heavily on what the individual can show and demonstrate. You can get far with knowledge, but you can't get as far as with demonstrating what you've learned with that experience.

Contact lens optician, Scotland

The experience is key. If you've got a patient who may be upset or struggling, or you've got to break bad news to the patient, if you've done it several times then you know how to handle it from that point on. Whereas if you've only ever read about it and know what you've got to say, but never actually had to say it…It wouldn't protect the public at all.

Contact lens optician, England

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

Summary of the proposal

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

Some concerns about consistency and varying standards of qualification

5.5.1 A number of participants questioned how consistency would be maintained if the assessment of the contact lens optician qualification was the responsibility of providers. Some thought that, without the level of consistency provided by the current system of assessment, the difficulty of achieving the qualification may vary from provider to provider, creating some areas of the country where it is easier to become qualified than others, or where contact lens opticians are better qualified and more experienced than others. The potential for providers to become more likely to pass their trainees, perhaps unintentionally or to knowingly improve their pass rates, driven by financial gain, was also highlighted by some participants.

There's always that concern of impartiality. You know, if you're doing the training and doing the exams for people, there's that risk of people being put through because they've done the course. Whereas at least with ABDO being a separate examiner, it's very impartial. That would be my only concern, that it's being monitored and checked regularly.

Contact lens optician, England

It's kind of like marking your own homework, isn't it? And some would argue that ABDO would want everyone to pass. I've actually heard the opposite said, that ABDO would want to fail you so that they make more money from resits. So you can't win. That's where the GOC come in, to ensure that they are fair.

Contact lens optician, Scotland

I worry that that all leads to two-tier or three-tier CLO qualifications because you'll have several colleges, several providers, providing different types of courses and qualifications. So Anglia might do one course, ABDO does another, Bradford does yet another…I think you will have varying standards.

Contact lens optician, England

5.5.2 Some participants felt that the potential for varying standards of assessment could result in a multi-tiered system of qualifications across the country, which could result in placing patients at risk if contact lens opticians are not all qualified to the same standard.

I personally don't like that idea at all. The patients, the public, should have a standardised practitioner in front of them.

Contact lens optician, England

I wouldn't like to see the public being put at risk of going into a shop and [being told], 'I've only got a silver standard CLO', but [having] absolutely no idea what that means, because those letters after the name don't mean anything to [them].

Contact lens optician, England

5.5.3 However, it was highlighted by some participants that the current system of assessment is not consistent, and therefore this proposal was justified, assuming the correct levels of regulation are in place. It was also suggested that any issues relating to inconsistency of assessment could be overcome by careful regulation from the GOC to ensure that all providers are working to the same standards, as set out in the new proposed documents.

It's not to say that people who get the qualification in one place are going to be better than somebody else. But I know that the way they're assessed is extremely different. So Anglia Ruskin use a lot of OSCE stations, where they demonstrate one particular competence at the moment, for instance, whereas ABDO exams do sort of much longer sections where a whole aftercare will be done, a whole initial assessment will be done and things. We can argue about what's better, but it's not really about that…Will the GOC be consistent in all the courses that they review?

Contact lens optician, England

The key thing with this one is just making sure that the GOC is ensuring that the standards are sort of a level playing board across the field. To me, it's not an issue in itself that each university will have its own exams, because that's what happens in universities for every other subject. It's just about making sure that there is that consistent standard and that the GOC is in a position to really police that and make sure that no-one is making things a bit easier so that people will go through their course and make the university more money.

Dispensing optician, Scotland

Potential benefits of increased accessibility and improved standards

5.5.4 Despite concerns about consistency, a number of participants thought that the proposal to make providers responsible for the assessment of the contact lens qualification may bring some benefits. It was suggested that allowing providers to assess in their own way could increase accessibility for trainees if different options were available, such as full-time and distance learning, and courses which are assessed with exams or via practical assessment, which may support those with different learning styles.

> *I think it's a good thing. Because, as has been said, the structure of the course is quite different from ABDO to Anglia Ruskin. I've had to do both for my dispensing, and they work in different ways. And I think different people have different learning methods, and it allows a bit more flexibility for the person choosing where they want to learn, rather than having to go to one place because it's the only place in the country that does it. As long as it's regulated in terms of the assessments being on the same level.*
>
> Contact lens optician, Scotland

> *The way they structure the courses will be different. You might have a full-time option, or a distance learning option. And especially now with COVID and things, people are not so willing to travel and go away for a week or two weeks at a time. So perhaps that will open up other methods of learning to people.*
>
> Contact lens optician, England

5.5.5 It was also suggested that trainees may benefit from having their provider carry out their assessment, as everything would happen in the same location, reducing the need to travel, and trainees may feel more comfortable being assessed by their provider who they are already familiar with.

> *I think actually it's better for the person that's providing the qualification and the assessment to be combined…I did my dispensing optician degree with Anglia, which at one point potentially, I was then going to have to do ABDOs exams, which would have meant then travelling to a different part of the country, which isn't a huge deal, but it would have meant a bit further to have to go. And then also, if you're doing the exams under the same people that you've studied with and the same lecturers, I would feel a bit more confident with doing them. Whereas if it's someone completely different, it would really throw me off.*
>
> Trainee contact lens optician, England

5.5.6 Some participants thought that this proposal had the potential to raise standards in contact lens optician qualifications, as it could foster competition between providers.

> *An organisation or institute that delivers a really high degree of support and education will get a reputation for that, and make others raise their game…You could see that the whole standards could be raised by sort of raising the degree of competition.*
>
> Contact lens optician, Scotland

5.6 Providers are responsible for recruiting trainees to course programmes, recognition of prior learning

Summary of the proposal

Providers of approved qualifications will be responsible for recruiting and selecting trainees onto a programme leading to an award of an approved qualification. Recognition of prior learning can be deployed to assist the progression of trainees whose progress to specialist registration has stalled.

Agreement with providers being responsible for recruitment of trainees

5.6.1 Registrant participants were in agreement with the proposal for the providers of approved qualifications being responsible for recruiting and selecting trainees onto a programme leading to an award of an approved qualification. Most explained that this made logical sense, or that they assumed this was already the case.

> *I think the first statement, the providers of the qualifications recruiting and selection trainees onto the programme, I think that's fair. I think I support that. And I think it's the way it's done already.*
>
> Dispensing optician student, England

Recognising prior learning is a positive change which increases flexibility

5.6.2 The proposal to recognise prior learning to assist the progression of trainees whose progress to specialist registration had stalled was generally viewed as a positive change by participants. They thought it would make the process of undertaking the contact lens optician qualification more flexible for those who wish to do it, which would benefit certain groups of people such as those who may take time away from work to have children, to care for someone, or because of illness. It was also suggested that recognising prior learning increased flexibility as not all dispensing opticians would start this training at the same stage in their career, meaning that levels of knowledge and experience will vary, and therefore this should be taken into consideration.

> *I think the recognition of prior learning is a good idea. I read that as someone who may have started the CLO course and dropped out due to ill health, or pregnancy, or family emergency, or something like that, and therefore hasn't been able to finish it. And maybe they've gone out for a year or two years and then come back and said, 'I've got this many credits from a year ago, can that be applied?' And they've said, 'Yes, this is how we can work it in'.*
>
> Contact lens optician, England

> *When we're looking at people whose progress has stalled, that helps out people who have been, either through ill health, or maybe some career break, or pregnancy, whatever it may be…To recognise that not everybody has the luxury of starting a course and finishing it within the recognised time period is really pertinent. When I studied I was living at home and my mother made me dinner every night. I worked in the day and I came home and studied at night. To have done that when I had two young children a few years later would have been well-nigh impossible. People would think, 'Oh, I have too much going on, I'll come back to this'. So some recognition that you've done some of it, rather than having to start maybe at the beginning…Some recognition of your previous efforts is, I think, worthwhile.*
>
> Contact lens optician, Scotland

5.6.3 Recognition of prior learning was also viewed as beneficial for those who may have begun their education in other countries, as this proposal would mean their previous studies and training could be used towards their progression to become a contact lens optician, rather than having to start from the beginning unnecessarily or undertake additional assessments.

> *I think for qualifications from other countries, and maybe things like optometry, certainly we should be recognising if someone's already shown on a different course that they're able to refract or they're able to assess a bit of a contact lens, then we shouldn't necessarily need to assess that same thing again.*
>
> Contact lens optician, England

Some questions raised about how prior learning would be measured

5.6.4 Although attitudes were generally positive towards the recognition of prior learning, some participants raised questions about how this would work in reality. These questions focused on exactly how prior learning would be recognised, as participants wondered at what stage of the training certain levels of knowledge and experience would place an individual, and how their prior knowledge would be measured and verified to ensure a fair approach is taken. Some participants also questioned how far back in time prior learning should be recognised, as it was felt that after a while, it would be safer and fairer to expect a dispensing optician to begin their training again from the start, or to refresh their knowledge in a particular area to ensure it is up to date.

> *Would this need to be on an individual case basis, this recognition? Because you could have people with qualifications that they've taken in other countries, and whether or not they would count as prior learning, what they're done.*
>
> Contact lens optician, England

> *I think that with a few years' break, you certainly need to go over everything you already knew. Because if you don't use it, you lose it, up to a point.*
>
> Contact lens optician, England

> *It's very easy to lose even basic slit lamp skills if you're if you're not doing it on a regular basis. So I think, yes, by all means take into account that previous knowledge, but you've got to bring it up to date before you can accept it. You've got to be able to show that that knowledge is still there and still current.*
>
> Contact lens optician, England

5.7 Outcomes for Approved Qualifications

Within each registrant focus group, participants discussed the six outcomes from the Outcomes for Approved Qualifications document, providing any feedback they had about the wording, the requirements listed within each outcome, the level assigned on Miller's Pyramid, whether they are realistic and achievable, and whether they thought anything was missing. This feedback is summarised below for each outcome.

Outcome 1 – Uphold professional standards

Contact lens opticians establish relationships with others based on professional understanding and respect; acting as part of a multidisciplinary team they ensure that continuity of care across care settings is not compromised.

- *O1.1 Establishes relationships with other professionals based on understanding, trust and respect for each other's roles in relation to contact lens and other care, and works collaboratively to ensure the delivery, transfer and continuity of care is assured and not compromised [Knows how]*
- *O1.2 Undertakes a patient consultation in an appropriate setting, taking account of confidentiality and understands the issues involved in obtaining valid consent and maintaining dignity and respect in accordance with regulatory standards and contractual requirements. [Knows how]*
- *O1.3 Introduces self and role to the patient/carer and confirms patient/carer identity. [Shows how]*

5.7.1 All registrant participants agreed that this outcome and its requirements were realistic and achievable, explaining that these were actions that they were already accustomed to in practice and that these were expected as standard.

> *I think that's realistic and achievable.*
>
> Contact lens optician, England

5.7.2 The only suggestion for changes from some participants was that all the requirements within this outcome should be set at the 'shows how' level to emphasise the importance of upholding professional standards amongst contact lens opticians.

> *All that is bread and butter stuff, it's what you should be doing. But I kind of think it should be elevated to 'shows how' rather than 'knows how'.*
>
> Contact lens optician, England

> *I think that's probably where the 'shows how' comes into it though, that you know, and can show, different levels to different people based on your understanding of that person and your relationship with that person. So I think that's quite a good use of the Miller's principle of 'shows' rather than just 'knows'…So I think that's quite a good use of that pyramid.*
>
> Dispensing optician, Scotland

Outcome 2 – Person centred care

Contact lens opticians must have a patient centred approach, be adaptive and work collaboratively with others in the best interests of the patient. They must understand their role appreciating uncertainty, ambiguity and limits to their knowledge and the process of contact lens fitting as part of a multidisciplinary approach to a patient's ocular health.

- *O2.1 Assesses the communication needs of the patient/carer and adapts consultation appropriately (e.g. for language, age, capacity, physical or sensory impairments). [Knows how]*

- *O2.2 Works with the patient/carer in partnership to make informed choices, aiming for a good outcome for the patient which meets the professional aims of the practitioner. [Knows how]*
- *O2.3 Identifies, recommends and fits contact lenses to achieve vision correction and/or eye health goals, including explaining where patient expectations cannot be met and/or when contact lenses cannot be fitted. [Does]*
- *O2.4 Explains to the patient the potential risks and benefits of contact lens wear and any management options/treatment, including the importance of hygiene regimes, wearing compliance and when to seek further advice. [Does]*
- *O2.5 Encourages patients to take responsibility for their ocular health and to respond to contact lens conditions appropriately. [Shows how]*
- *O2.6 Works within scope of practice and recognises when to refer or seek guidance from another member of the healthcare team or a specialist. [Knows how]*

5.7.3 Again, in response to this outcome participants were in agreement that it was realistic and achievable, as it is consistent with how contact lens opticians and dispensing opticians currently operate.

> *I think it's realistic in terms of it's very much aligned with the strategy for dispensing opticians anyway, in terms of the communication, the building the relationships, working as part of a larger team, having the know-how to approach for additional help, or recognise when there's any warning signs. So I think it's all consistent and realistic with what we do and say now. I can't see anything quickly that comes as a shock.*
>
> Dispensing optician, England

> *I think they all seem to be logical and make sense.*
>
> Contact lens optician, Scotland

5.7.4 A number of participants suggested that, as with outcome 1, most of the requirements of this outcome should be set at the higher level of assessment on Miller's Pyramid of 'shows how', again to emphasise that, as contact lens specialists, they are able to demonstrate their level of knowledge and training. In particular, it was felt that the assessment level of the first requirement (assesses the communication needs of the patient/carer and adapts consultation appropriately) should be increased to 'shows how', as consideration of the diverse range of communication needs of patients was viewed as increasingly important. However, it was acknowledged that assessment at this level may be difficult.

> *I think for me, the one that jumps out is the very first one. I think it's potentially a bit more important than just 'knows how'. I guess as a contact lens optician, generally you are going to be seeing younger patients, but in optics as a whole you see a lot of people with sort of combinations of vision and hearing deficiencies and any kind of impairments, so knowing how to speak to everyone and how to communicate properly with everyone is really very important for a practitioner. So I think maybe that one could be a bit higher.*
>
> Dispensing optician, Scotland

> *From a practical point of view, how would you actually implement that within the course assessment? It's the outcomes, so you wouldn't necessarily, if you were going to do your practical exams, get someone who was deaf or who needed a carer there. So you're not going to be able to necessarily demonstrate to 'show how' level. It's like when you're doing your driving test and they say, 'What would you do if there was ice on the road?' and you explain what you would do. You're demonstrating that you know how, they can't produce ice from nowhere. Maybe that's why it's only a 'knows how' rather than a 'shows how'.*
>
> Contact lens optician, England

Outcome 3 – Ocular examination

Contact lens opticians must conduct a detailed examination of the anterior eye and related structures using appropriate instrumentation and clinical techniques they have learned. They must apply their knowledge to understand the implications of their findings and identify appropriate clinical responses including diagnosis, clinical management, contact lens fitting or referral.

- *O3.1 Demonstrates knowledge of appropriate instrumentation for detailed inspection of the anterior segment of the eye, related ocular adnexa and tear film. This should include methods of illumination, filters and other instrument attributes. [Knows how]*
- *O3.2 Assesses the anterior segment, related ocular adnexa and tear film in a systematic sequence. [Does]*
- *O3.3 Assesses the curvature and regularity of the cornea and any other dimensions required for contact lens fitting. [Does]*
- *O3.4 Evaluates results using evidence-based knowledge to make differential diagnoses and inform an appropriate management plan including referral when appropriate. [Does]*
- *O3.5 Has acquired knowledge of common systemic conditions and their ocular impacts and contact lens implications. [Knows]*
- *O3.6 Recognises the signs and symptoms associated with relevant ocular conditions, (including, but not exclusively, anterior eye disease, dry eye, red eye and foreign body), differentiates normal from abnormal findings, manages the conditions appropriately and refers where necessary. [Shows How]*
- *O3.7 Recognises the signs, symptoms and contact lens implications of non-systemic (ocular) pathological conditions. [Knows]*
- *O3.8 Manages contact lens induced complications for all types of contact lenses. [Shows how]*
- *O3.9 Uses appropriate grading scales, and creates and maintains accurate and contemporaneous records of all patient advice and management decisions in line with relevant legislation. [Does]*

5.7.5 This outcome was also viewed as realistic and practical, and some participants explained that the requirements listed were useful as they clearly set out the process of a practical examination for contact lens optician trainees.

> *It summarises the whole practical exam. When I qualified, things just weren't clear at all. We had to figure things out a lot ourselves. This is really all quite helpful for the person taking on the course really, because it ticks off a lot of stuff and tells them exactly what you've got to do.*
>
> Contact lens optician, England

5.7.6 Some participants suggested that the assessment level for O3.1 should be increased to the 'shows how' or 'does' level as it references the demonstration of knowledge and was seen as critical to the ocular examination process. The same feedback was suggested for O3.5.

> *I would have thought the first one would have been a 'shows how'? Because it's saying about demonstrating knowledge, the 'detailed inspection of the anterior segment of the eye'. So you'd think that that would be a case of showing someone that you know how to do that rather than just knowing how to do it?*
>
> Dispensing optician, England

> *They should be able to use the correct instrumentation.. That's not just a 'knows how', that should be a 'shows how', maybe a 'does'. Certainly when I qualified as a CLO, that was part of my practical examination, that I had to be able to light the segment of the eye properly using instrumentation…You've got to be able to do it, because you need that as part of your*

> *contact lens fitting capability. You can't see problems without the correct instrumentation and correct lighting and everything. So that's got to be a 'does', I think.*
>
> Contact lens optician, England

> *I would say O3.5 has to go up to 'does' from 'knows' because that's what you're presented with in practice most days, somebody that's come in with a damage on the eye, because contact lens fitting is bad, or a patient that comes in with hay fever that's got an issue with their eyelid. You've got to know and you've got to act on it. You've got to know how to and what's legal for you to be able to do. It's got to go up, it's far too low.*
>
> Contact lens optician, England

5.7.7 It was also suggested that the requirements should reference 'accurate' assessment where it is referenced in O3.2 and O3.3.

> *Maybe in that 3.2, they need to put 'accurate assessment' rather than just an 'assessment'.*
>
> Contact lens optician, England

> *Outcome 3.2 – it says, 'Assesses the anterior segment, related ocular adnexa and tear film in a systematic sequence'. It doesn't say anywhere that they've done it accurately. There's nowhere actually that says they can look at an eye, but have they looked at it in any kind of accuracy, in order to be able to note it down.*
>
> Contact lens optician, England

5.7.8 Participants discussed the wording 'all types of contact lenses' referenced in O3.8. Some were surprised that the outcomes would expect contact lens opticians to show how to manage complications for all types of contact lenses, explaining that this was potentially asking too much of contact lens opticians. However, it was suggested that this wording may have been deliberately used to future-proof the Outcomes document as new types of contact lenses are manufactured.

> *I think there are some contact lens complications that some CLOs might not be able to manage. They might need to refer. I might be wrong. Is this giving them a lot more to do?...This feels to me like they're expected to do more than they're expected to on the high street.*
>
> Dispensing optician student, England

> *I think partly it's to try and future-proof it. You see more hybrids and things like that these days, so rather than just saying soft and rigid, because there are some others in there.*
>
> Contact lens optician, England

Outcome 4 – Verification and identification

Contact lens opticians exercise personal responsibility by checking lenses applying the methods and techniques they have learned to verify that they are correct as per contact lens specifications.

- *O4.1 Understands how to assess using the appropriate instruments, the dimensional measurement and other features of contact lenses to identify where possible and enable their replication. [Knows how]*
- *O4.2 Understands how contact lens parameters are measured to International Organisation for Standardisation (ISO) standards of tolerance. [Knows how]*
- *O4.3 Recognises and differentiates between the design features of contact lenses. [Shows how]*

5.7.9 Most participants had no issues with this outcome and felt it was generally acceptable. However, some participants felt that the requirements within this outcome, particularly O4.1 and O4.2,

represented useful background knowledge, but would not necessarily be relevant to contact lens opticians in day-to-day practice. It was suggested that this type of knowledge was quite specialised and would be more relevant for those specialising in contact lens manufacture. Therefore they felt that the 'knows how' level of assessment was about right.

> *They make sense, but they've been of almost zero use to me in the last 20 years, in all honesty. It's all stuff that you can understand, but it's like Pythagoras' theory to me. How often do you actually use this in a day-to-day practice? I suppose the 'knows how' is useful. If you were then going to go on and specialise a bit further it might be more relevant.*
>
> Contact lens optician, England

> *I think those competencies belong to a different qualification. They're on contact lenses, but they're just not relevant to a contact lens optician. I would agree with the last one.*
>
> Contact lens optician, England

5.7.10 A number of participants also suggested that O4.3 was set at too high a level of assessment on Miller's Pyramid, and should be 'knows how' rather than 'shows how', in line with O4.1 and O4.2. These participants discussed that this requirement was likely referring to the use of a radiuscope, something which they explained was rarely seen or used in practice, and that the process of differentiating between the design features of contact lenses is unnecessary in practice.

> *This is on use of radiuscope and things like that. I actually think this needs to stay at 'knows how', because nobody ever uses a radiuscope in practice now. They don't use one in the hospital. Lenses come through as we expect them to be, we've no need to measure them. If they're not fitting correctly, we just order a new one and get it exchanged. I support this just being taken down and out of having to be demonstrated in an exam scenario.*
>
> Contact lens optician, England

Outcome 5 – Contact lens fitting and aftercare

Contact lens opticians take a shared approach to evidence-based decision-making (sometimes in complex and unpredictable contexts) by assessing patients' planned use / clinical needs and recommending an appropriate lens to achieve desired outcomes, managing the fitting and aftercare of patients with contact lenses and adapting the management plan where necessary.

- *O5.1 Takes a comprehensive history eliciting any information relevant to the fitting, aftercare and use of contact lenses. [Does]*
- *O5.2 Interprets and investigates appropriately the presenting symptoms of the patient. [Does]*
- *O5.3 Interprets relevant patient records to ensure knowledge of the patient's ocular and contact lens history and management to date. [Shows how]*
- *O5.4 Interprets relevant patient information (i.e. prescription, history and any relevant information supplied by an optometrist or medical practitioner) and clinical findings to assess the indications and contraindications for contact lens fitting. [Shows how]*
- *O5.5 Discusses contact lens options and makes appropriate recommendations allowing patients to make an informed choice; selects and fits the most appropriate contact lens and parameters for the planned use and clinical needs of the patient. [Does]*
- *O5.6 Assesses the fitting of a contact lens (soft, rigid and new modalities/materials where applicable) using a variety of techniques; adjusts lens parameters where appropriate. [Does]*
- *O5.7 Issues unambiguous and complete contact lens specifications which meet legal requirements. [Shows how]*

- *O5.8 Instructs the patient in contact lens handling (i.e. hygiene, insertion and removal, etc) and how to wear and care for the lenses including appropriate action to take in an emergency. [Shows how]*
- *O5.9 Demonstrates a routine contact lens aftercare consultation in compliance with the requirements of the Opticians' Act. [Does]*
- *O5.10 Investigates, identifies and manages any contact lens adaptation or aftercare issues. [Shows how]*
- *O5.11 Informs patients of the importance of continuing contact lens and general ocular aftercare and provides information on arranging aftercare and relevant emergency procedures. [Shows how]*
- *O5.12 Selects and fits the most appropriate complex/specialist contact lens for the planned use and clinical needs of the patient (e.g. refractive management, therapeutic, prosthetic and cosmetic contact lenses); manages the ongoing contact lens care of own patients. [Shows how]*
- *O5.13 Recognises the signs and symptoms of sight threatening conditions/ocular emergencies requiring immediate treatment and manages them appropriately. [Shows how]*
- *O5.14 Understands and applies relevant local protocols and professional guidance on the urgency of referrals e.g. The College of Optometrists' clinical management guidelines. [Knows how]*

5.7.11 As with the other outcomes, participants said that they generally agreed with this outcome, its requirements, and the level of assessment that had been assigned on Miller's Pyramid.

> *I like that these are all 'shows how' and 'does'. I think that's important, because it actually demonstrates that you're capable of doing what you're supposed to be doing.*
>
> Dispensing optician, England

> *It's important that they're all measured practically rather than just showing an understanding of it. I think the way they've worded it all makes sense to me. If we all operated to that level of standard, then I think it'd be a great thing.*
>
> Contact lens optician, Scotland

5.7.12 The majority of feedback for this outcome was related to O5.12 (selects and fits the most appropriate complex/specialist contact lens for the planned use and clinical needs of the patient; manages the ongoing contact lens care of own patients). A number of participants said they were surprised by the inclusion of 'therapeutic, prosthetic and cosmetic contact lenses' in this requirement, especially set at the level of 'shows how', as they thought the fitting of these lenses could be quite specialist and was something which they would consider referring. It was therefore suggested that reducing the level of assessment to 'knows how' may be more appropriate for most contact lens opticians.

> *The thing I wonder about is the complex/specialist contact lenses, because I don't feel like on my course we went into that enough. So therapeutic prosthetic, I know what I could do, I could refer it on, but I don't personally feel I could fit it myself. So if that's what that competency is they would need to put a bit more guidance into the course itself to be able to fit those. I don't think it covers it enough.*
>
> Contact lens optician, England

> *When it comes to the prosthetic and cosmetic lenses, that's a hospital thing. I would certainly have knowledge of what you would do and where I would refer, but whether or not I would actually show…'Shows how' might be the wrong thing.*
>
> Contact lens optician, Scotland

Outcome 6 – Learning and development

Contact lens opticians must maintain their clinical and contact lens knowledge and skills appropriate to their scope of practice; they must work within their areas of expertise and competence to achieve desired patient outcomes.

- *O6.1 Demonstrates appropriate clinical and diagnostic skills within personal scope of practice. [Does]*
- *O6.2 Understands common ocular conditions, presenting symptoms and urgency e.g. glaucoma, retinal detachment and age-related macular degeneration (AMD). [Knows]*
- *O6.3 Understands the principles and maintains knowledge of evidence relating to myopia management. [Knows how]*
- *O6.4 Demonstrates knowledge of refractive techniques including the principles of binocular vision management. [Shows how]*
- *O6.5 Understands the range of lenses available including soft, rigid and new materials/modalities. [Knows]*
- *O6.6 Understands the clinical application of all contact lens types e.g. optical, therapeutic, protective, diagnostic, prosthetic and cosmetic. [Knows]*
- *O6.7 Understands and safely applies knowledge of the drugs and staining agents used in clinical practice, including any relevant risks and side effects. [Knows how]*
- *O6.8 Understands the various forms of ocular surface diseases (e.g. dry eye) and maintains knowledge of available management options. [Knows how]*
- *O6.9 Implements infection prevention and control in optical practice. [Does]*
- *O6.10 Understands the methods of disinfection of contact lenses / contact lens containers including awareness of the different solutions used in contact lens practice, their constituents, the importance of maintaining sterility and common pathogens. [Knows how]*
- *O6.11 Applies current legislation to contact lens practice and understands the relevant legislation surrounding the use of common ocular drugs. [Shows how]*
- *O6.12 Evaluates advances in contact lens practice, the evidence behind management strategies and any emerging safety concerns. [Knows]*
- *O6.13 Demonstrates a reflective approach to learning and own development of contact lens practice to ensure continued alignment with current best practice. [Shows how]*
- *O6.14 Understands continuing education and professional requirements (e.g. continuing professional development (CPD)) within contact lens practice. [Knows]*

5.7.13 Feedback for this outcome was generally positive, with participants stating that the requirements listed marked a significant improvement from the previous Continuing Education and Training (CET) scheme, which they felt was too much of a 'tick box' exercise and not useful. By contrast, participants felt that this outcome listed relevant learning and development opportunities that would be useful in practice and that would actually assist with their continuing development as contact lens opticians.

> *The old CET was just kind of literally, tick every box. Sometimes it was barely relevant, but it ticked the box. Whereas all of this is something that I would find useful in daily practice.*
>
> Contact lens optician, England

> *I like this better than the CET cycle that we've just finished. Just because sometimes you were literally digging through to kind of tick a box. Whereas all of this, every single thing on here is useful.*
>
> Contact lens optician, England

6. Patient focus group feedback

This section details feedback from patients in the two online focus groups with members of the public who currently used contact lenses at least once a week.

Experiences of contact lens wearing

6.1.1 When asked what made them decide to try contact lenses, participants mostly discussed the practicalities of wearing contact lenses over glasses. Participants felt that wearing contact lenses was more appropriate when taking part in sports, leisure activities and exercise as they were concerned about glasses falling off their face or getting damaged. Another practical reason for wearing contact lenses was due to the recent issue of wearing face masks and PPE during the pandemic which causes glasses to steam up and vision to be obscured.

> *I played sports and they were constantly getting knocked off my face.*
>
> Female, England, 35-54

> *I've probably worn them a little bit more in the last couple of years because of the face masks. If I wear glasses they steam up and I can't see.*
>
> Male, England, 35-54

6.1.2 Another common reason for trying contact lenses was for aesthetic purposes. It was felt that wearing contact lenses gave participants more confidence than wearing glasses, which participants often described as making them feel unattractive, or not like themselves. These participants highlighted that their own negative opinions of wearing glasses and desire to try contact lenses began around adolescence as they became more aware of their self-image.

> *I waited for my 14th birthday because the optician said I couldn't have contact lenses before. They always felt so uncomfortable, and I had those very geeky NHS glasses that were thick at the side. I was an adolescent, I didn't feel attractive.*
>
> Female, England, 35-54

> *I wore glasses from about 13 to 19 or 20, and I just felt like a geeky nerd. I'm really short sighted as well, so they were quite thick glasses. I just wanted to look better, it was just a vanity thing.*
>
> Male, England, 35-54

6.1.3 Although participants were generally happy with their contact lenses, a number of 'teething issues' were reported from when participants first began wearing them. The main issue discussed was getting used to wearing contact lenses, from putting them in to becoming accustomed to the feeling or sensation of them in their eyes. A small number of participants also said they could sometimes feel their contact lenses moving around in their eyes. Other issues included dry and irritated eyes, which was mostly put down to wearing contact lenses for too long, and struggling to find appropriate lenses due to having a 'bad' prescription or complex eye conditions.

> *Because I have allergies…it used to irritate my eyes. They used to be running all the time and sometimes my eyes would get dry. So it was a really difficult process for me to get adjusted to.*
>
> Female, Wales, 18-34

I've got quite a bad prescription…[which] wouldn't allow me to have contacts because I have to have the really thick toric ones. And because of my astigmatism they have to be weighted…So it's only in the last seven or eight years that I've managed to get contact lenses that I can wear for a prolonged amount of time…I had to wait for technology to catch up to allow me to use contact lenses.

Male, England, 18-34

6.1.4 The main benefits of wearing contact lenses suggested by participants linked back to the reasons why they decided to begin wearing them. This includes an improved sense of confidence and self-esteem due to not wearing glasses and the belief that wearing contact lenses is better for playing sports, exercising or taking part in leisure activities. One participant suggested that contact lenses were more cost effective for going on holiday or during the summer, as they explained that it was cheaper to wear non-prescription sunglasses over contact lenses than to buy prescription sunglasses.

I suppose you can save on money…I've got prescription glasses and prescription sunglasses which all add up, but if I wear my contact lenses I can wear non-prescription sunglasses which are a lot cheaper for going on holiday or when it's sunny.

Female, England, 35-54

6.1.5 Participants were asked if they would recommend wearing contact lenses to other people. A few said they would recommend wearing contact lenses as they had improved their vision, whilst it was more widely agreed that they would recommend wearing contact lenses with some caveats which they had learned from experience. These included how to wear contact lenses properly and for an appropriate length of time, investing in better quality contact lenses, looking after eye health and aftercare.

I remember the first time my optician put my lenses in for me. When they came in it felt like magic. I felt like somebody had hit a button on the back of my head, and I could suddenly go, 'Oh man, I can see properly!'…For that, I would recommend it.

Male, England, 35-54

Be more mindful of eye health than you might think to be, if you're going to wear contact lenses.

Female, England, 35-54

I would recommend them, but I've said to my daughter…'If you wear them, don't wear them all day, don't wear them every day. Just wear them for a few hours at a time.' Because excessive use of mine is what dried my eyes out so badly. Wear a bit of both, glasses and contact lenses, and use drops.

Female, England, 18-34

6.1.6 However, not all participants agreed, with a small number who said they would not necessarily recommend contact lenses as they were a short-term solution for issues such as playing sports and did not provide the same quality of vision as wearing glasses.

I find it's just a little less precise, contact lenses. It's a little bit off and it's never quite as good as glasses. I don't know if that's because of the way they're made, but I just always find they're slightly less precise than my glasses. I only really wear them for football.

Male, England, 18-34

I'm varifocal with both lenses and glasses and I just find that the lenses sometimes don't give me the best vision, so glasses are obviously better for me…It depends on what I'm doing though, really.

Female, England, 55+

Experience of visiting an opticians for contact lenses

6.1.7 As seen in previous research, there was a general assumption amongst participants that they would receive a good standard of care when visiting an opticians for their contact lenses as they trusted that optical professionals would have the necessary knowledge and training.

Not only are they looking at your eye and checking your eye health, they are advising you on essentially putting a piece of plastic over your eye…You want to have knowledgeable people telling you what they're going to be doing with your eyes…They told me that contact lenses wouldn't be the best vision until technology caught up, and I took that advice, because I was told by who I believed were fully trained people.

Male, England, 18-34

6.1.8 Some participants felt confident that they would receive a good standard of care when visiting an opticians because they had consistently received good service from a specific chain or branch over a number of years. These participants praised certain elements of previous visits to their chosen opticians, such as thorough examinations, practitioners working hard to find the appropriate contact lenses, and trusting larger brand names.

I'm on the contact lens scheme with Boots so it's a yearly check-up and they're pretty thorough. I feel really confident in their service because I've had a very good and positive experience with them, even when I moved house and went to a different branch.

Female, England, 35-54

I'm with Specsavers on the contact lens scheme and they've been really good for me…I just trust it because it's a well-known brand name as well.

Female, England, 18-34

6.1.9 Opinions and experiences were mixed when discussing the quality of communication when visiting an opticians for contact lenses. For those who were positive about the communication they had received, this was mostly due to the familiarity with their optometrist and subsequent continuity of care, being kept up to date, friendly staff, and being provided with the opportunity to ask questions if necessary.

I've always been to Specsavers, and I'm quite lucky that I do get to see the same one or two people every time…I was seeing my first optician for the first 20 odd years of my life until he retired.

Male, England, 18-34

I had an appointment last week for my contact lenses and it was an hour and a half – they were very thorough, they checked me a few times and I could ask any questions I had.

Male, Scotland, 18-34

6.1.10 Those who felt that communication could have been improved attributed this to not being kept informed, a lack of rapport with or consistency of optical professionals, poor communication between staff, and misunderstanding the patients' needs.

I've generally been satisfied with the services that Boots have provided me but it's just the lack of communication...I feel like they're not the best at communicating with you and keeping you updated as to what's happening. When you go there sometimes they're very silent, and I feel like they don't want to talk to you because they're so busy.

Female, Wales, 18-34

It'd almost be good if when you went to the opticians, you could see the same one each time so they kind of knew you and you didn't have to keep explaining yourself.

Female, England, 18-34

6.1.11 Thinking specifically about the last time they had visited an opticians in relation to their contact lenses, most participants said they had a positive experience which was largely due to the optical professional they had seen, the quality of their eye examination and their perception of good value for money. However, a small number of participants felt their most recent visit could have been improved. For these participants, this was due to long waiting times to book an appointment and struggling to find comfortable and appropriate contact lenses.

I see the same optometrist at my practice all the time because I've got really complex vision…and I trust her implicitly…It's an independent one.

Female, England, 55+

Wanting to get an appointment is difficult as well. There's a huge waiting time…You have to wait a bit longer for a contact lens appointment, I think it's because they don't have many people that do contact lenses where I go.

Female, England, 35-54

I feel like maybe Specsavers' lenses are cheaper…Maybe if I go somewhere else and pay for a more quality lens then I'll find ones that are more comfortable. Because although I still wear them, I do struggle with them. They're not comfy…I just feel like perhaps they haven't got an extensive range there.

Female, England, 18-34

6.1.12 Participants were also asked about the information they received during their contact lens appointment about how to care for them, such as cleaning and storage. Those who could recall receiving this information felt that it was helpful and consistent. However, some could not remember the last time they were provided with information, or believed that information is not needed at every appointment and should only be given when there is a change to the contact lenses or prescription.

They always give advice at the contact lens appointment.

Male, Scotland, 18-34

I had a problem with dry eye when I was working in an office and she gave me good advice about storage, cleaning, bacteria. Really good advice.

Female, England, 55+

I wear dailies so I don't have to follow any particular routine, but if I did swap to ones where I had to use a liquid or lotion, I think they probably would show me what to do.

Female, England, 18-34

Awareness of and attitudes towards contact lens opticians

6.1.13 Participants were asked what they knew about the different roles of those who work within an opticians. A small number of participants were able to name specific roles such as 'optometrist', which they often referred to as an 'optician', and 'dispensing optician'. However, most were unsure as to what each role was responsible for within an optical practice.

> *I do see three different people doing three different roles – one for testing my eyes, one for fitting my glasses and one for doing my contact lenses. But I don't know the difference.*
>
> Female, England, 35-54

> *I know there's an optometrist but I don't know what it is that they do exactly.*
>
> Female, England, 35-54

6.1.14 Participants were read a short description of the roles of 'optometrist' and 'dispensing optician', with further explanation about how dispensing opticians can gain additional specialist qualifications to become a 'contact lens optician'. When asked whether they knew about the different roles, a small number of participants said they had assumed there was a difference but could not describe or explain the difference between the roles and their responsibilities. This assumption was typically borne from experience, where participants explained they usually see different people or visit a different floor of their opticians depending on whether they are attending an appointment for their contact lenses or glasses.

> *I know I go upstairs for contact lenses and it's downstairs for glasses.*
>
> Female, England, 18-34

> *I wasn't aware there was a hierarchy of qualified staff. I thought there would be admin staff and then the people who can do everything with your eyes.*
>
> Male, Scotland, 18-34

6.1.15 Although participants were generally unaware that the role existed, they were able to list a few benefits of the contact lens optician role. One benefit was that patients would have more confidence in contact lens opticians because they would be perceived to be better trained and specialised in contact lenses. Participants also believed that contact lens opticians would provide a holistic approach due to being specialists, which was favourable amongst some participants.

> *I do think there's benefits to patients, because they'll have more knowledge and you'll feel more confidence in the services that they're providing as well…They can give you more of a holistic overall service.*
>
> Female, Wales, 18-34

> *They might be more helpful because they would know how to treat the symptoms and prescribe the right contacts, perhaps.*
>
> Female, England, 18-34

6.1.16 Another benefit to the role of contact lens optician was that it would be more efficient for patients and less confusing if they were able to see one person to advise on both glasses and contact lenses, rather than two separate optical professionals. Relating to patient experience and efficiency, some participants also felt that it would be easier to get an appointment for their contact lenses if more optical professionals were qualified to advise on them.

It can be confusing when you go and see three different people in the opticians and you don't know who's doing what…There's that continuity of care as well when you go and see the same person. It's not confusing, and you feel more secure.

Female, England, 35-54

I was thinking it would be more efficient, just being able to see one person and not having to wait in between one appointment and the next appointment. And sometimes those appointments aren't on the same day. So it would just be much more efficient.

Female, England, 35-54

6.1.17 Most participants said they would be happy to see a contact lens optician. The consensus was that they would assume that a contact lens optician is adequately trained and knowledgeable on contact lenses and eye health to be in that role, with some suggesting that patients may receive better service from someone who is seen to specialise in contact lenses.

As long as someone is qualified to dispense lenses, I'd feel comfortable with them.

Male, England, 18-34

You might feel like you're getting a better service because you're being seen by someone who's a contact lens specialist.

Female, England, 35-54

6.1.18 However, not all participants agreed, as it was felt by some that seeing a contact lens optician rather than an optometrist would depend on the complexity of a patient's eye health and their prescription. These participants considered optometrists to be experts in vision and eye health and explained that some patients would prefer to have an appointment with an optometrist than a contact lens optician if they had more complex eye conditions or prescriptions.

If you've just got straightforward eye problems, you know, short sighted or whatever, and you just need contact lenses, then just go and see that person. With more complex conditions, then I'm happier seeing the optometrist.

Female, England, 55+

Now I've got older and I've got more problems with my eyes, it might be more beneficial to see someone that's a lot more experienced to give me the advice.

Female, England, 35-54

6.1.19 As seen previously in this research and other consultations, participants typically said they would assume that contact lens opticians would be adequately trained with the appropriate checks being carried out when asked if they would trust in the ability of contact lens opticians to treat patients.

I don't think about it. I just assume…I'm blind to authority, pun not intended.

Male, England, 35-54

If somebody holds a job title, you assume that they're qualified and had the relevant training they need to be able to do that. I've not really thought about it or questioned it before.

Female, England, 55+

6.1.20 There was some discussion about the difference between trusting independent opticians compared with multiples. It was generally felt that large brands, such as Specsavers and Boots, could be trusted as it was assumed that there would be rigorous checks on the qualifications of optical

professionals, whereas participants were unsure on how qualifications were checked at independent opticians. Therefore, some participants felt they would be more inclined to carry out their own checks and research should they visit an independent opticians for an appointment for their contact lenses, whilst others assumed there would be a governing body to hold all optical professionals to the same standard.

> *I think it's easier with places like Specsavers, because you assume that they do have that qualification. You assume they are trained…I think if I was at an independent optician, I might be a bit more inclined to kind of look on the wall for their certificate.*
>
> Male, England, 35-54

> *I think if I was going to an independent, one that I didn't recognise the name of somewhere local, I might look into it a bit more. You trust the bigger chains to have done that for you.*
>
> Male, England, 35-54

> *I assume that Specsavers and an independent should have the same type of qualifications and the checks to put that professional out there. For an optometrist you have to go to uni, you have training, and have to pass exams. I assume anybody employing an optical professional will do the necessary checks, regardless of whether they're an independent or a large chain…It's the same with pharmacists and the GPhC as well.*
>
> Female, Wales, 18-34

6.1.21 Participants considered whether they would want to know more about the qualifications of contact lens opticians, such as where and how they were achieved and who approved them, resulting in mixed opinions. Some felt that it would be beneficial for patients to receive more information on this as it could provide more clarity, allowing patients to understand what a contact lens optician is qualified to do. It was also felt that parents would benefit from learning more about a contact lens optician's qualifications to reassure them if their child is attending an appointment with them.

> *I do think it would be beneficial, because…you know there's a contact lens specialist and you can go to that person for your needs regarding contact lenses…It would make things easier for the patients and less confusing, because if you don't know, it can be quite a difficult experience for them...I think it would make the journey simpler for them.*
>
> Female, Wales, 18-34

> *I think if you've got children that you're taking to the opticians, it might be beneficial to have something on the wall that you can see as a parent.*
>
> Female, England, 18-34

6.1.22 However, some participants felt they would not want or need further information about a contact lens optician's qualifications as they would simply assume that they are appropriately qualified, as previously discussed. These participants said they would not want their contact lens appointment to take any longer than necessary, but suggested that the information could be displayed on the wall during the appointment for those who are interested in seeing it

> *I don't want to be sitting there for another 15 minutes while they read off all their qualifications to me at the start of the appointment. If it was a poster on the wall going, 'I'm Dr So-and-so, and this is my job role and I do this…', like they have in some hospitals, then I could read it if I wanted to, or not. I wouldn't want it shoved down my throat when I got in there prior to an appointment to tell me why they're qualified to give me contact lenses.*
>
> Male, England, 18-34

Appendix A – Consultation questionnaire

Education and training requirements for entry to the GOC register as a contact lens optician

Overview

This consultation seeks your views on our proposals to update our requirements for specialist entry to the GOC register as a contact lens optician. These proposals are available to download at the bottom of this page under the 'related' section.

What are we seeking your views on?

- Our proposed **Outcomes for Approved Qualifications for Specialist Entry to the GOC Register as a contact lens optician** ('outcomes for approved qualifications') which describes the expected knowledge, skills and behaviours a dispensing optician must have for the award of an approved qualification for specialist entry to the GOC register as a contact lens optician.
- Our proposed **Standards for Approved Qualifications for Specialist Entry to the GOC Register as a contact lens optician** ('standards for approved qualifications') which describes the expected context for the delivery and assessment of the outcomes leading to an award of an approved qualification for specialist entry to the GOC register as a contact lens optician.
- Our proposed **Quality Assurance and Enhancement Method for Specialist Entry to the GOC Register as a contact lens optician** ('quality assurance and enhancement method') which describe how we will gather evidence to decide in accordance with the Opticians Act 1989 whether a qualification for specialist entry to the GOC register as a contact lens optician meets our outcomes for approved qualifications and standards for approved qualifications.
- Our **outline impact assessment**, which describes our assessment of the impact of our proposals to update our requirements for approved qualifications for specialist entry to the GOC register.

These proposals are available to download at the bottom of this page.

What will our proposals replace?

Together, these documents will replace ‘Visit Handbook Guidelines for the Approval of: A) Training Institutions; and B) Providers for Schemes for Registration for United Kingdom Contact Lens Opticians’ (published November 2007) and the ‘Contact Lens Speciality Core Competencies’ published in 2011 including the list of required core competences, the numerical requirements for trainees’ practical experiences, education policies and guidance contained within the handbooks, and our policies on supervision and recognition of prior learning, which are published separately. You can

read the documents we are proposing to replace, here; **handbook** *<user_uploads/contact_lens_handbook_final_nov_2007_pdf--28--2.pdf>* and **competencies** *<user_uploads/contact_lens_specialty_competencies_2011_pdf--18-.pdf>* .

Why are we consulting?

We would like to hear your views and receive evidence of the impact of our proposals to update our education and training requirements for GOC approved qualifications for specialist entry to the GOC register to ensure that the qualifications we approve in the future are responsive to the changing landscape in the delivery of eye-care services and fit for purpose in each of the UK nations.

Our proposals mitigate the risk that our current requirements (contained within our quality assurance handbooks) become out of date.

The proposed outcomes and standards for approved qualifications and quality assurance and enhancement method together will ensure the qualifications we approve are responsive to the changing needs of patients and service-users and changes in higher education, not least as a result of the COVID-19 emergency, as well as increased expectations of the trainees, commissioners and employers.

What have we consulted on previously?

These proposals are based on our analysis of our responses to our Call for Evidence, Concepts and Principles Consultation 2017-2018, feedback from our 2018-2019 consultation on proposals stemming from the Education Strategic Review (ESR) and associated research, and our public consultation held in July-September 2020 on proposals to update our requirements for GOC approved qualifications leading to registration as an optometrist or a dispensing optician. For more information, please see the GOC's consultation hub. For further information about the ESR, please visit the **ESR policy development and research page** *<https://www.optical.org/en/Education/education-strategic-review-esr/esr-policy-development-and-research.cfm>* **.**

How have we developed our proposals?

Our proposals have been guided by evidence-based policy making and draw upon best practice from other regulators, professional and chartered bodies. You can read our research, background and briefing papers **here** *<https://www.optical.org/en/Education/education-strategic-review-esr/esr-policy-development-and-research.cfm>* **.**

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

We would like to thank everyone who took the time to help us develop our proposals to ensure our proposed outcomes for approved qualifications, standards for approved qualifications and quality assurance and enhancement method protects and benefits the public, safeguards patients, and helps to secure the health of service-users.

You can read the EAGs' terms of reference and membership **here** *<https://www.optical.org/en/Education/education-strategic-review-esr/expert-advisory-groups.cfm>* **.**

What are our key proposals?

Key proposals

a. Candidates will acquire a qualification approved by the GOC leading to specialist entry to the GOC register as a contact lens optician.

b. The approved qualification will be either an academic award or a regulated qualification at a minimum of Regulated Qualification Framework (RQF) (or equivalent) level 6.

c. There will be no proposed minimum/maximum or recommended time or credit volume for an approved qualification or specified location or duration of clinical experience, other than the requirement that an approved qualification leading to specialist entry to the GOC register as a contact lens optician must integrate approximately 225 hours of learning and experience in practice.

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

e. An outcomes-based approach is used to specify knowledge, skills and behaviours using an established competence and assessment hierarchy known as 'Miller's Pyramid of Clinical Competence' (knows; knows how; shows how; and does).

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

g. Providers of approved qualifications will be responsible for recruiting and selecting trainees onto a programme leading to an award of an approved qualification. Recognition of prior learning can be deployed to assist the progression of trainees whose progress to specialist registration has stalled.

What do I need to do?

If you are a member of the public, a patient or service-user, you may only be interested in reading our proposed outcomes for approved qualifications and answering questions 1, 2 and 3 in section 1 (which should take about five minutes to complete in addition to reading the document) along with questions in section 2 (which we are asking everyone to answer) about the impact of our proposals. However, you may well be interested in reading our proposals in full and answering all the questions we've asked in section 1.

If you are a GOC registrant, or an employer of GOC registrants, or you are responding on behalf of a provider of a GOC-approved qualification, a professional membership or third sector body, or another organisation or regulator, you may be interested in reading our proposals in full and answering some or all of the questions in section 1 (which should take about 15-20 minutes to complete in addition to reading the documents.)

Towards the end there are some questions for everyone to answer about the impact of our proposals (section 2, which will take about five minutes to complete).

We recognise our proposals are detailed, with a range of impacts on different stakeholder groups, so if you wish to answer all the questions in both sections of the questionnaire, please do so.

Consultation data will be securely shared with our research partner for this work, Enventure Research, for independent analysis and reporting. We will be receiving data on a regular basis and will adjust our approach to engagement with the sector as guided by Enventure Research.

Privacy statement

The information you provide to us, the GOC (as data controller), will be processed and used in line with our statutory purpose under the Opticians Act as a public task in order to set standards for optical education and training, performance and conduct. For more information regarding how we process your data please see the **full privacy statement** <*https://www.optical.org/en/about_us/data-and-information/privacy-statement.cfm*> on our website.

Right to erasure

Article 17 of the General Data Protection Regulations provides data with the right to erasure; this is known as the right to be forgotten. Right to erasure requests should be sent to the Data Protection Officer (FOI@optical.org) and will be responded to within one calendar month of receipt.

Data controller

We are registered as a data controller with the Information Commissioner's Office, registration number Z5718812. We are committed to maintaining robust information governance policies and processes to ensure compliance with relevant legislation. Any information you supply will be stored and processed

by us or on our behalf, by approved and verified third parties, in accordance with the General Data Protection Regulations and the Data Protection Act 2018.

Introduction

It is helpful for us to know a little bit about you. If you do not wish to provide your name and email address you can leave Q1 and Q2 blank.

1 What is your name?

Name

2 What is your email address?

If you would like to receive further updates about our proposals please provide your email address.

Email

About you

In order to ensure we ask you the right questions, we would like to know a little more about you.

1 Are you responding on behalf of an organisation?

(Required)

Please select only one item

◯ Yes ◯ No

About your organisation

1 On behalf of which organisation are you responding?

Please answer (Required)

2 Which of the following categories best describes your organisation?

(Required)

Please select only one item

- ◯ Provider of GOC approved qualification(s)
- ◯ Optical professional body
- ◯ Optical business registrant
- ◯ Other optical employer
- ◯ Current CET or CPD provider
- ◯ Optical defence/representative body
- ◯ Optical insurer
- ◯ Commissioner of optical care
- ◯ Healthcare regulator
- ◯ Other (please specify)

If you selected 'other', please specify

About you (continued)

1 Knowing who you are helps us to ask you the right questions. Which category best describes you?

(Required)

Please select only one item

- ◯ Member of the public
- ◯ Recent optical patient/service user (or their carer)
- ◯ Dispensing optician
- ◯ Contact lens optician
- ◯ Trainee contact lens optician
- ◯ Optometrist
- ◯ Independent prescribing optometrist
- ◯ Optometry student
- ◯ Dispensing optician student
- ◯ Other (please specify)

If you selected 'other', please specify

Section 1: Consultation questions

1 Have you read the ‘Outcomes for Approved Qualifications for Specialist Entry to the GOC Register as a contact lens optician’ before answering the next two questions?

(Required)

Please select only one item

- ◯ Yes
- ◯ No

2 What impact, if any, will introducing the proposed 'Outcomes for Approved Qualifications for Specialist Entry to the GOC Register as a contact lens optician' have on the expected knowledge, skill and behaviour of future contact lens opticians?

(Required)

Please select only one item

◯ Very positive impact ◯ Positive impact ◯ No impact ◯ Negative impact
◯ Very negative impact ◯ Don't know

3 Is there anything in the criteria in the 'Outcomes for Approved Qualifications for Specialist Entry to the GOC Register as a contact lens optician' that is missing or should be changed?

(Required)

Please select only one item

◯ Yes ◯ No ◯ Don't know

If you ticked 'yes' please provide details.

4 Have you read the 'Standards for Approved Qualifications for Specialist Entry to the GOC Register as a contact lens optician' before answering these questions?

Please select only one item

◯ Yes ◯ No

5 What impact, if any, will introducing the proposed ‘Standards for Approved Qualifications for Specialist Entry to the GOC Register as a contact lens optician’ have on the expected knowledge, skill and behaviour of future contact lens opticians?

Please select only one item

◯ Very positive impact ◯ Positive impact ◯ No impact ◯ Negative impact
◯ Very negative impact ◯ Don't know

6 Is there anything in the ‘Standards for Approved Qualifications for Specialist Entry to the GOC Register as a contact lens optician’ that is missing or should be changed?

Please select only one item

◯ Yes ◯ No ◯ Don't know

If you ticked ‘yes’ please provide details.

7 Have you read the ‘Quality Assurance and Enhancement Method for Specialist Entry to the GOC Register as a contact lens optician' before answering these questions?

Please select only one item

◯ Yes ◯ No

8 Is there anything in the ‘Quality Assurance and Enhancement Method for Specialist Entry to the GOC Register as a contact lens optician' that is missing or should be changed?

Please select only one item

◯ Yes ◯ No ◯ Don't know

If you ticked ‘yes’ please tell us what you think is missing or should be changed.

9 To what extent do you agree with our proposal to replace our handbook for contact lens opticians and related policies with the proposed ‘Outcomes for Approved Qualifications for Specialist Entry to the GOC Register as a contact lens optician,’ ‘Standards for Approved Qualifications for Specialist Entry to the GOC Register as a contact lens optician’ and ‘Quality Assurance and Enhancement Method for Specialist Entry to the GOC Register as a contact lens optician'?

Please select only one item

◯ Strongly agree ◯ Agree ◯ Neither agree nor disagree ◯ Disagree
◯ Strongly disagree ◯ Don't know

Please explain your response

10 Is there anything else you would like to tell us about the education and training of future contact lens opticians?

Please answer

Section 2: Impact of our proposals

We would like to ask everyone the following questions on impact of our proposals.

1 We want to understand whether our proposals may discriminate against or unintentionally disadvantage any individuals or groups sharing any of the protected characteristics in the Equality Act 2010. Do you think our proposals will have a negative impact on certain individuals or groups who share any of the protected characteristics listed below? (Please select all that apply)

(Required)

Please select all that apply

- [ ] Age
- [ ] Disability
- [ ] Gender reassignment
- [ ] Marriage and civil partnership
- [ ] Pregnancy and maternity
- [ ] Race
- [ ] Religion or belief
- [ ] Sex
- [ ] Sexual orientation
- [ ] None of the above
- [ ] Don't know

Please provide details

2 We also want to understand whether our proposals may benefit any individuals or groups sharing any of the protected characteristics in the Equality Act 2010. Do you think our proposals will have a positive impact on any individuals or groups who share any of the protected characteristics listed below? (Please tick all that apply)

(Required)

Please select all that apply

☐ Age ☐ Disability ☐ Gender reassignment ☐ Marriage and civil partnership

☐ Pregnancy and maternity ☐ Race ☐ Religion or belief ☐ Sex

☐ Sexual orientation ☐ None of the above ☐ Don't know

Please provide details

3 Do you think any of the proposed changes will impact – positively or negatively – on any other individuals or groups (for example, trainees, patients and the public, current providers of approved qualifications, placement providers, employers and devolved nations)?

(Required)

Please select only one item

◯ Very positive impact ◯ Positive impact ◯ No impact ◯ Negative impact

◯ Very negative impact ◯ Don’t know

4 Please describe the impact and the individuals or groups concerned. We are particularly keen to understand further any financial or other impacts we haven't considered in our accompanying impact assessment.

Please answer

Further information

1 Can we publish your response?

(Required)

Please select only one item

◯ Yes ◯ Yes, but please keep my name / my organisation's name private ◯ No

Equality, diversity and inclusion

We welcome consultation responses from everyone, regardless of age, disability, gender reassignment, race, religion or belief, ethnicity, sex, sexual orientation, marriage and civil partnership, pregnancy and maternity.

We don't want anybody to miss out or be disadvantaged because of the way we work and we try hard to make sure this doesn't happen. The following questions help us to understand who we are reaching with our surveys, so that we can make sure that everybody has the opportunity to get involved.

You do not have to answer these questions (just click 'Prefer not to say'), but we would be grateful if you did. Your answers to these questions will be treated as confidential and held securely in line with data protection requirements. They will not be considered or published alongside your name or anything else that might identify you.

For more information about how we use information like this across the General Optical Council, please visit the **Equality, Diversity and Inclusion section of our website** *<https://www.optical.org/en/about_us/equality-and-diversity.cfm>* .

If you are responding on behalf of an organisation, please do not respond to these questions.

1 Age

Please select only one item

◯ Under 25 ◯ 25-34 ◯ 35-44 ◯ 45-54 ◯ 55-64 ◯ 65+
◯ Prefer not to say

2 Gender

Please select only one item

◯ Female ◯ Male ◯ Intersex ◯ Non-binary ◯ Prefer not to say

3 Gender identity

Is your gender identity different from the gender you were assigned at birth?

Please select only one item

◯ Yes ◯ No ◯ Prefer not to say

4 Sexual orientation

Please select only one item

◯ Bisexual ◯ Heterosexual/straight ◯ Gay/lesbian ◯ Other ◯ Prefer not to say

5 Marital status

Please select only one item

◯ Civil partnership ◯ Divorced or civil partnership dissolved ◯ Married
◯ Separated ◯ Single ◯ Widowed ◯ Prefer not to say

6 Ethnicity

Please select only one item

◯ White - English/Welsh/Scottish/Northern Irish/British ◯ White - Irish
◯ White - Gypsy or Irish Traveller ◯ Other White background (please specify)
◯ Black or Black British - Caribbean ◯ Black or Black British - African
◯ Other Black background ◯ Asian or Asian British - Indian
◯ Asian or Asian British - Pakistani ◯ Asian or Asian British - Bangladeshi
◯ Asian or Asian British - Chinese ◯ Other Asian background
◯ Mixed - White and Black Caribbean ◯ Mixed - White and Black African
◯ Mixed - White and Asian ◯ Other mixed background ◯ Other - Arab
◯ Other ethnic group ◯ Prefer not to say

7 Religion/belief

Please select only one item

◯ No religion or belief ◯ Buddhist
◯
Christian (including Church of England, Catholic, Protestant and all other Christian denominations)
◯ Hindu ◯ Jewish ◯ Muslim ◯ Sikh ◯ Other (please specify)
◯ Prefer not to say

If you have selected 'other', please specify

8 Disability

The Equality Act 2010 defines disability as a physical or mental impairment which has a substantial long-term effect on a person's ability to carry out normal day to day activities. Do you consider yourself to have a disability?

Please select only one item

◯ Yes ◯ No ◯ Prefer not to say

9 Pregnancy/maternity

Are you pregnant, on maternity leave, or returning from maternity leave?

Please select only one item

◯ Yes ◯ No ◯ Prefer not to say

10 Carer responsibilities

Do you perform the role of a carer?

Please select only one item

◯ Yes ◯ No ◯ Prefer not to say

Appendix B - Detailed free-text consultation responses

Is there anything in the criteria in the 'Outcomes for Approved Qualifications for Specialist Entry to the GOC Register as a Contact Lens Optician' that is missing or should be changed? Please explain

Full response from ABDO

O2.2 'Good outcome' should be amended to 'best outcome'. Although the best outcome may not be achieved it should still be the initial aim.
O2.3 Consider changing the term 'eye health goals' to 'eye health needs'.
O2.5 As healthcare practitioners CLOs will and should engage in patient communication about health issues other than just those related to contact lenses or ocular issues. For example, conversations around diabetes and the needs for regular checks, smoking cessation support, indications of possible high cholesterol levels and getting checked out. Should be expanded to read as:
Encourages patients to take responsibility for their ocular health and to respond to contact lens and other and other health conditions appropriately.
O3.1 This outcome should be expanded to include the word technology, to ensure it is future-proofed for changing methods and approaches to anterior eye examination. The use of diagnostic stains should also be included:
Demonstrate knowledge of appropriate instrumentation and technology for detailed inspection of the anterior segment of the eye, related ocular adnexa and tear film. This should include methods of illumination, filters, other instrument attributes and related use of diagnostic stains.
O3.3 Expand to include regularity also:
Assesses the curvature and regularity of the cornea and any other dimensions required for contact lens fitting.
O5.4 Requires rewording as, although a spectacle prescription may only be provided by the optometrist or medical practitioner, other history and relevant information may be supplied by other healthcare practitioners e.g. pharmacist, dispensing optician, orthoptist. Consider changing to:
Interprets relevant patient information (i.e. spectacle prescription, history and any relevant information supplied by any other health care practitioners) and clinical findings to assess the indications and contraindications for contact lens fitting.
O5.11 This could more clearly reinforce the requirement for the CLO to inform the patient of the need for regular eye examinations with the optometrist. It is also the duty of the CLO to refer the patient to the optometrist when they become aware the patient requires a new eye examination. Consider changing to:
Informs patients of the importance of continuing contact lens aftercare and ongoing routine eye examinations, and provides information on arranging appropriate ocular appointments and relevant emergency procedures.
O6.2 Consider changing to '….and urgency of referral e.g. glaucoma….'

Full response from British Contact Lens Association

O3.4 – Would this mean that students are diagnosing and managing ocular diseases? How is this different from an optometrist? The scope of conditions ought to be defined
O3.6 – How is this different from an optometrist who needs far more practical training and a 4 year degree?
O5.6 – remove *new modalities/materials where applicable' – just keep to soft and rigid? A variety of modalities/materials clearly exist, perhaps there is little need to include this in the wording.
O5.12 – his will be better assessed as knows or knows how (e.g. via a portfolio) rather than *shows how*
O6.2 – These students are GOC registrants and this aspect has already been demonstrated as part of their DO course. This qualification should cover contact lens related competencies, as registrants will continue to maintain their existing knowledge via CPD. Suggest removal of this outcome
O6.3 – Could this be written more widely, i.e. maintains evidence relating to contact lens developments i.e. not just myopia management?
O6.4 – These needs to be framed around contact lenses working from a certified in-date prescription

O6.7 – These students are GOC registrants and this aspect has already been demonstrated as part of their DO course. This qualification should cover contact lens related competencies, as registrants will continue to maintain their existing knowledge via CPD. Suggest removal of this outcome
O6.11 – These students are GOC registrants and this aspect has already been demonstrated as part of their DO course. This qualification should cover contact lens related competencies, as registrants will continue to maintain their existing knowledge via CPD. Suggest removal of this outcome

Is there anything in 'Standards for Approved Qualifications for Specialist Entry to the GOC Register as a Contact Lens Optician' that is missing or should be changed? Please explain

Full response from ABDO

"Below are some suggested changes that will enable the Standards for Approved Qualifications for Specialist Entry to the GOC Register as a contact lens optician' to be aligned to the associated Standards for Approved Qualifications for Dispensing Opticians and Optometrists. These have been highlighted as there is no current understanding of why they are different:

S3.2 Should be amended to say ....'The component parts should be linked into a
cohesive programme of academic study, clinical experience and professional practice (for example, Harden's spiral curriculum9)….'

S3.3 It should be considered that although the current process to become a DO requires the trainee to already be qualified and therefore gained work experience. With the changes proposed by the GOC it may be possible for student to train to be qualified as a DO and a CLO through the same educational programme and virtually at the same time (with exception to entry onto the register). Therefore it should be considered that an amended version of the following from the Standards for Optometrists and DOs is added in here.
'The approved qualification must provide experience of working with patients (such as patients with disabilities, children, their carers, etc); inter-professional learning (IPL); and team work and preparation for entry into the workplace in a variety of settings (real and simulated) such as clinical practice, community, manufacturing, research, domiciliary and hospital settings (for example, Harden's ladder of integration10). This experience must increase in volume and complexity as a student progresses through a programme.

It should be considered to add standard 2.10 from the Standards for Optometrists and DOs:
'Summative assessments directly related to the outcomes demonstrating unsafe practice must result in failure of the assessment.'

It should be considered to extend S3.11 to include the following:
'There must be a range of teaching and learning methods to deliver the outcomes that integrates scientific, professional and clinical theories and practices in a variety of settings and uses a range of procedures, drawing upon the strengths and opportunities of context in which the qualification is offered'

An amended version of Standard S3.13 from the Standards for Approved Qualifications for Dispensing Opticians and Optometrists should be considered adding in, such as:
'The outcomes must be delivered and assessed in an environment that places study in an academic, clinical and professional context which is informed by research and provides opportunities for trainees to develop as learners.'

The following standard from the Standards for Approved Qualifications for Dispensing Opticians and Optometrists should be considered adding in:
'Assessment (if undertaken) of outcomes during learning and experience in practice must be carried out by an appropriately trained and qualified GOC registrant or other statutorily registered healthcare professional who is competent to measure students'
achievement of outcomes at the required level (Miller's Pyramid)'

The following standard (S4.2) from the Standards for Approved Qualifications for Dispensing Opticians and Optometrists should be considered adding in:

'The provider of the approved qualification must be able to accurately describe its corporate form, its governance and lines of accountability in relation to its award of the approved qualification.'

The following standard (S4.4) from the Standards for Approved Qualifications for Dispensing Opticians and Optometrists must be added back in:
'The provider of the approved qualification may be owned by a consortium of organisations or some other combination of separately constituted bodies. Howsoever constituted, the relationship between the constituent organisations and the ownership of the provider responsible for the award of the approved qualification must be clear'

S4.4 Should be amended to include the following (S4.6) from the Standards for Approved Qualifications for Dispensing Opticians and Optometrists:
There must be agreements in place between the different organisations/people (if any) that contribute to the delivery and assessment of the outcomes, including during periods of learning in practice. Agreements must define the role and responsibility of
each organisation/person, be regularly reviewed and supported by management plans, systems and policies that ensure the delivery and assessment of the outcomes meet these standards

S5.2 Should be amended to include the following from the Standards for Approved Qualifications for Dispensing Opticians and Optometrists:
* sufficient staff responsible for the delivery and assessment of the outcomes, including GOC registrants and other suitably qualified healthcare professionals;
* sufficient supervision of trainee learning in practice by GOC registrants who are appropriately trained and supported in their role"

Appendix C - Registrant focus group guide

Please note this discussion guide is intended as a guide to the moderator only. Sections may be subject to change during the course of the focus groups if, for example, certain questions do not elicit useful responses. Times shown are based on 75-minute online focus group

BEFORE GROUP START TIME

- Participants asked to join 5/10 minutes early and wait in waiting room to allow the group to start on time
- All participants asked to review the joining instructions
- All participants will have been asked to take part in the online consultation via Citizen Space and read the three new documents

Introduction (5 mins)

- Moderator introduction
- Background to the research:
    - GOC is currently running a consultation on its proposals to update its requirements for specialist entry to the GOC register as a contact lens optician (CLO).
    - Three new documents (Outcomes, Standards, and Quality Assurance and Enhancement Method for Specialist Entry to the GOC Register) have been drafted and the GOC aim to replace the current 'Visit Handbook Guidelines for the Approval Training Institutions and Providers for Schemes for Registration for United Kingdom Contact Lens Opticians' (published November 2007) and the 'Contact Lens Speciality Core Competencies' (published in 2011)
    - As you may know from recently taking part, the GOC is seeking views via an online consultation survey.
    - In addition, we are delivering a programme of other consultation activities, including more focus groups like this with GOC registrants and groups with patients.

- This group is your opportunity to give direct feedback on how the proposed changes to the education and training requirements for entry onto the register as a contact lens optician will affect you and the profession. We will be covering similar areas to the online consultation you completed, exploring your views and experiences in greater depth.

- Confidentiality:
    - Everything said during this discussion is confidential, so please be as open and honest as possible. There are no right or wrong answers.
    - Enventure Research is an independent research agency, not part of the GOC.
    - We may use quotes from this discussion within the report, but these will remain anonymous and any identifying information will be removed.
    - Market Research Society Code of Conduct and GDPR – ensure confidentiality.
    - All views and opinions of all present, no matter what your role or workplace, are important and valid.

- The group will be recorded – thank you for returning your signed consent forms. The recording will only be used to listen back to and write up notes. It is not passed to anyone else, including the GOC, and will be securely deleted once the consultation is over. ***Moderator to start recording and ask everyone to confirm again that this is OK.***

- Whilst I have a good broad understanding of the optical sector, please treat me as a lay person in terms of any abbreviations, acronyms or clinical terminology.

- The session will last for no more than 75 minutes in total. Do you have any questions before we begin?

Warm up (5 mins)

Can you please briefly introduce yourselves in three sentences?

- First name
- Job role/title and workplace setting
- How long you have been working in the optical profession?

The key proposals (25 mins)

Hopefully you have had a chance to go through the consultation documents. First, we will discuss the key proposals that are being suggested by the GOC. There are 7 in total.

Moderator to go through each proposal in turn, sharing a summary on a slide, and asking the same set of questions for each proposal.

1. Candidates will acquire a qualification approved by the GOC leading to specialist entry to the GOC register as a contact lens optician.

2. The approved qualification will be either an academic award or a regulated qualification at a minimum of Regulated Qualification Framework (RQF) (or equivalent) level 6.

3. There will be no proposed minimum/maximum or recommended time or credit volume for an approved qualification or specified location or duration of clinical experience, other than the requirement that an approved qualification leading to specialist entry to the GOC register as a contact lens optician must integrate approximately 225 hours of learning and experience in practice.

4. 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.

5. An outcomes-based approach is used to specify knowledge, skills and behaviours using an established competence and assessment hierarchy known as ‘Miller’s Pyramid of Clinical Competence’ (knows; knows how; shows how; and does).

6. 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.

7. Providers of approved qualifications will be responsible for recruiting and selecting trainees onto a programme leading to an award of an approved qualification. Recognition of prior learning can be deployed to assist the progression of trainees whose progress to specialist registration has stalled.

Questions for each proposal:

- What do you think to this proposal?
    - Is it a good or bad idea?
    - Do you agree or disagree with the proposal?
    - Why do you say that?
- Overall, what impact, if any, do you think this proposal will have?
    - Are the overall impacts positive or negative?
- What might the impacts be for:
    - Trainees/students?
    - Registrants?

    - Public and patients?
    - Higher education providers?
    - The optical sector as a whole?
- Are there any barriers that the GOC need to consider if implementing these proposals?
- Do these proposals discriminate against or unintentionally disadvantage any individuals or groups?
    - If so, which groups or individuals?
    - What can be done to avoid this discrimination or disadvantage?

The Outcomes (30 mins)

I would now like to spend the rest of the group looking specifically at the Outcomes for Approved Qualifications for Specialist Entry to the GOC Register as a Contact Lens Optician document.

Moderator to go through each of the six outcomes in turn, sharing a slide showing the listed knowledge/behaviours/skills for each, and asking the same set of questions for each outcome.

Questions for each outcome:

- What do you think to this outcome?
- What do you think to the requirements listed within this outcome?
    - Are they appropriate / relevant?
    - Are they set at the correct level on Miller's Pyramid?
    - Are they realistic / achievable?
    - Do they cover everything they should?
    - Can you foresee any problems or barriers?
- What do you think to the wording of the outcome?

- Thinking about the Outcomes document overall:
    - Do you think they cover everything they should?
    - Do you think there is anything missing?
    - What do you think to the level of detail? Too prescriptive / about right / lacking detail?

The overall impact of the proposed changes (10 mins)

- Are there any other potential impacts that the new documents may have that we have not already discussed?

- Taking all the proposed changed into consideration, what impact do you think they will have on:
    - The expected knowledge, skills, and behaviour of future CLOs?
        - Are the impacts positive or negative?
        - Will there be any differences in impact in different devolved nations in the UK?
    - The optical sector?
    - Students/trainees?
    - Patients and the public?

- Is there anything else that the GOC needs to consider when implementing these changes that we have not already discussed?

Summary and close – moderator to:

- *Thank everyone for their time and input*
- *Direct those who have not already done so to complete the consultation online*
- *Ensure everyone has completed the online consent form*
- *Explain how incentives will be administered*
- *Thank & close*

Appendix D – Patient focus group guide

Please note this discussion guide is intended as a guide to the moderator only. Sections may be subject to change during the course of the focus groups if, for example, certain questions do not elicit useful responses. Times shown are based on 60-minute online focus group

BEFORE GROUP START TIME

- Participants asked to join 5/10 minutes early and wait in waiting room to allow the group to start on time
- All participants asked to review the joining instructions

Introduction (5 mins)

- Moderator introduction
- We are currently working with the General Optical Council (GOC), the organisation which regulates the optical professions in the UK, to find out about what is important to people when visiting an opticians, specifically from those who wear contact lenses, or have experience of wearing them in the past

- Confidentiality:
  - Everything said during this discussion is confidential, so please be as open and honest as possible. There are no right or wrong answers.
  - Enventure Research is an independent research agency, not part of the GOC.
  - We may use quotes from this discussion within the report, but these will remain anonymous and any identifying information will be removed.
  - Market Research Society Code of Conduct and GDPR – ensure confidentiality.
- All views and opinions of all present are valid and your contributions will help shape future GOC policy.
- Please listen to other participants' views and try not to speak over each other.
- The group will be recorded – thank you for returning your signed consent forms. The recording will only be used to listen back to and write up notes. It is not passed to anyone else, including the GOC, and will be securely deleted once the research project has finished. ***Moderator to start recording and ask everyone to confirm again that this is OK.***
- The session will last for no more than one hour. Do you have any questions before we begin?

Can you please briefly introduce yourselves in three sentences?

- First name
- Where you live
- How long you have been wearing contact lenses for / how long did you wear contact lenses for?

Experiences of contact lens wearing (10 mins)

- What made you decide to try contact lenses?
  - *Moderator to explore:*
    - *Preference over glasses*
    - *For sports/leisure*
    - *For work*
    - *Confidence/self-esteem/image*
    - *Improved vision to wearing glasses*

- How would you summarise your experience of wearing contact lenses?
  - Have you experienced any problems?
  - What do you think are the main benefits of wearing contact lenses?
  - Would you recommend wearing contact lenses to other people?

Experiences of visiting an optician for contact lenses (15 mins)

- When you visit an opticians, how confident are you that you will receive a high standard of care?
    - Why do you feel confident? / Why don't you feel confident?
    - *Moderator to explore:*
        - *Previous experience*
        - *Opticians is a chain/known brand*
        - *Qualifications*
        - *Awareness of regulation and standards*

- Thinking back to the last time you visited an opticians in relation to your contact lenses, how did you find the experience overall?
    - Were you satisfied or dissatisfied?
- Why were you satisfied? / Why were you dissatisfied?
    - *Moderator to explore:*
        - *Experience overall*
        - *The process of making an appointment*
        - *Waiting times*
        - *The quality of the eye examination*
        - *The optician who saw them*
        - *The costs*
        - *Communication*
        - *Quality of products*
        - *Other reasons*

- Did you feel you were given time in your appointment to be told about how to care for your contact lenses? E.g. how to clean them, how to store them overnight etc.

- How confident were you in the advice you received from the person you dealt with?
    - Why did you feel confident? Why did you not feel confident?

- Do you know which people in an optical practice are qualified to supply and fit contact lenses?

- Can you remember the job title of the person you saw during your contact lens appointment?

Awareness of and attitudes towards Contact Lens Opticians (15 mins)

Moderator to read out:

Optometrists, who you may know as opticians, are trained and qualified to test your sight, prescribe and fit both spectacles and contact lenses, and can also diagnose eye conditions.

Another role you may have come across when visiting an optician is a 'dispensing optician'. Dispensing opticians advise on, fit, and supply the most appropriate spectacles after taking account of each patient's visual, lifestyle and vocational needs.

Dispensing opticians can complete an additional specialist qualification to become what is known as a 'contact lens optician'. Contact lens opticians are qualified to assess whether contact lenses meet the needs of a patient, and if so, they can fit and supply them, and provide the required aftercare.

- Did you already know about the different optical professional roles?
    - How did you find out about them?
- Had you heard of contact lens opticians before today?
    - How were you aware of this role?
- What benefits do you think there are to dispensing opticians gaining additional specialist qualifications to become contact lens opticians?
- Would you feel any more or less comfortable being seen by a qualified contact lens optician rather than an optometrist, or vice versa?
- Would you trust their ability to treat you?
    - Why/why not?

    - What would make you feel more comfortable?
    - Would you want to know more about their qualifications, such as where and how they were achieved and who approved them?

Communication, consent and shared decision making (10 mins)

Now I would like to focus on communication and the way optical staff speak to you.

- When you last visited or saw an optical professional, how would you rate their communication with you?
    - Was there anything that could have been improved?
- How important is good communication between optical professionals and patients?
    - What is it more important than?
        - *Moderator to explore whether it's more important than other factors such as cost, convenience of appointment etc.*
    - What is it less important than?
    - What could be the consequences if there is not good communication between optical professionals and patients?
- Do patients have a responsibility to also communicate well with optical professionals?
    - Why/why not?
    - When do they have a responsibility to communicate well with optical professionals?
    - What could be the consequences if a patient does not communicate well with an optical professional?
- When optical professionals treat patients, they are supposed to ask for their consent before doing so. How important is asking patients for their consent?
    - Is consent something you normally think about when visiting an opticians?
    - When is it appropriate for consent to be asked?
    - How do you think consent should be asked for and recorded?

Now I would like us to think about the way that decisions are made about how to look after patients. Shared decision-making is a process in which optical professionals and patients may work together to select tests, treatments, or support packages for patients, based on clinical evidence and the patient's informed preferences.

- Have you heard the phrase 'shared decision-making' before?
    - If so, where and in what context?
- When you visit an opticians, how important is informed shared-decision making between you and the optical professional?
    - Is it something people think about when visiting an optical professional?
    - Why is it/is it not?
- Can you think of any experiences where you have experienced shared decision making with any healthcare professionals? What did you think about this experience?
- What level of involvement do you/patients in general want in decisions about eye care services?

Summary and close (5 mins)

- Is there anything else that you would like to add that we have not discussed today?
- Based on everything we have discussed today, what do you think are the most important things that we have discussed?

Moderator to:

- ***Thank everyone for their time and input***
- ***Mention that patients and the public are welcome to take part in a consultation survey about the CLO specialism on the GOC website***
- ***Ensure everyone has completed the online consent form***
- ***Explain how incentives will be administered***
- ***Thank & close***

Annex 3

Fraser Consulting

Education strategic review:

Revised requirements for Specialist Entry to the General Optical Council's register as a Contact Lens Optician

Equality, Diversity and Inclusion Impact Assessment

Clare Fraser

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October 2021

Contents

1. Executive Summary

Key Findings

1.1 This assessment finds comprehensive evidence that the General Optical Council has systematically paid due regard to its statutory equality duties in its proposals to update requirements for Specialist Entry to the GOC register as a contact lens optician.

1.2 The shift to an outcomes-based approach, which focuses on the care delivered to different patients in different settings, puts the patient first. This supports the advancement of equality and elimination of discrimination with regards to the wider public health, particularly as there can be disparities in health outcomes.

1.3 The replacement of minimum/maximum time or credit volume with specified hours of learning and experience in practice could reduce the cost of training. This is highly relevant in terms of diversity in the optical profession where there are disproportionately fewer Black, Asian or other Minority Ethnic contact lens opticians.

1.4 Involvement and feedback is centred in the revised requirements. Participation by the people who use and care about optical services should enable an increased understanding of the patient experience and how to respond to diverse needs.

1.5 Good practice in equality, diversity and inclusion has been noted throughout the draft documents, including:

- Working collaboratively in a multi-disciplinary approach should enhance the profession's ability to meet the diverse needs of patients.
- The learning methods and assessment should support the diverse needs of registrants.
- The need to work within own scope of practice and recognise when to refer or seek guidance should mitigate the potential for harm and should inform a better understanding of how to meet the needs of people who share protected characteristics.
- The requirement to collect and use equality data will support measuring progress in the advancement of equality.
- The focus on the importance of aftercare and risk management should support addressing wider health inequalities where behavioural risks to health are more prevalent in some parts of the population than others.
- The systematic approach to ensuring contact lens opticians maintain clinical knowledge and skills and evaluate advances in contact lens practice should support how the profession harnesses rapidly evolving technology for the benefit of the health of the wider public.

1.6 The proposed continuous improvement should enhance how the specialty attracts greater diversity and learns from the experience of underrepresented groups.

2. Introduction

Proposal

2.1 The General Optical Council (GOC) proposes to update requirements that underpin the approval of qualifications for Specialist Entry to the GOC register as a contact lens optician.

A consultation has been launched which seeks views on three proposed documents:

- **Outcomes for Approved Qualifications** for Specialist Entry to the GOC register as a contact lens optician, which describes the expected knowledge, skills and behaviours a dispensing optician must have, for the award of an approved qualification, to gain Specialist Entry to the GOC register as a contact lens optician.
- **Standards for Approved Qualifications** for Specialist Entry to the GOC Register as a contact lens optician which describes the expected context for the delivery and assessment of the outcomes, leading to an award of an approved qualification, for Specialist Entry to the GOC register as a contact lens optician.
- **Quality Assurance and Enhancement Method** for Specialist Entry to the GOC Register as a contact lens optician which describe how the GOC will gather evidence, to decide in accordance with the Opticians Act 1989, whether a qualification for Specialist Entry to the GOC register as a contact lens optician meets the outcomes for approved qualifications and standards for approved qualifications.

Scope of Legal Obligations

2.2 In summary, in the exercise of its public functions the GOC is obliged to pay due regard to Section 149 of the Equality Act 2010 in respect of advancing equality, eliminating discrimination and promoting good relations.

GOC has a specific duty to assess equality with regards to its functions in Wales and Scotland. While there is no specific duty to assess equality impact in England, the process is accepted as best practice.

Northern Ireland is subject to devolved arrangements as per Section 75 of the Northern Ireland Act 1998, whereby public authorities must promote equality of opportunity and publish equality impact assessments.

A more detailed overview of each of the four nations legal obligations to pay due regard to equality considerations is set out in the Appendix.

Purpose

2.3 This Equality, Diversity and Inclusion (EDI) Assessment has been produced to:

- meet the GOC's statutory obligations with reference to the Section 149 of Equality Act 2010 and Section 75 the Northern Ireland Act 1998; and
- develop recommendations to support GOC in continuous improvement in equality, diversity and inclusion

Protected Characteristics

2.4 There are 8 relevant protected characteristics in the Equality Act 2010, namely:

- Age
- Disability
- Gender Reassignment
- Pregnancy and Maternity
- Race
- Religion or Belief
- Sex
- Sexual Orientation

Marriage and Civil Partnership as a protected characteristic applies only to employment and is not a relevant characteristic in terms of S149 of the Equality Act 2010.

The Northern Irish legislation includes additional protected groups, specifically political opinions and persons with dependents.

3. Current Profile of Contact Lens Specialty Registrants

Overview

3.1 Data is provided which compares protected characteristics of Contact Lens Optician (CLO) specialty registrants to all General Optical Council registrants. This analysis explores Sex, Age, Race and Religion of Belief. Analyses of other protected characteristics has not been included given the small proportion of registrants' declarations (for example, less than 1% of Registrants have declared a disability and approximately 3% of registrants state that they are lesbian, gay or bisexual).

Sex

3.2 Table 1 shows there is a lower proportion of female CLO Specialty Registrants than All Registrants.

Table 1: Sex – Contact Lens Specialty Registrants with All Registrants

	CLO Specialty		All Registrants	
Female	715	56.03%	18,384	62.62%
Male	561	43.97%	10.975	37.38%
Total	**1276**	**100.00%**	**29,359**	**100.00%**

Age

3.3 Broadly, CLO Specialty Registrants have an older age profile with 31.97% aged 55-64 compared with 14.37% of All Registrants (excluding students). There is a more even spread of age amongst All Registrants. CLO Specialty Registrants' age profile has a significantly lower distribution between ages 25-34 and 35-44.

Table 2: Age – Contact Lens Specialty Registrants with All Registrants (excluding Students)

	Under 25	25-34	35-44	45-54	55-64	65+	Total
Contact Lens Optician Specialty	1	93	279	353	408	142	**1276**
	0.08%	7.29%	21.87%	27.66%	31.97%	11.13%	**100.00%**
All Registrants (excluding students)	940	6792	6902	4510	3416	1031	**23,591**
	3.65%	29.33%	29.04%	18.97%	14.37%	4.36%	**100%**

Race

3.4 There is less ethnic diversity in the CLO Specialty Registrant group, where the proportion of White Registrants is 22.99 percentage points higher than the proportion of All Registrants.

The ethnic profile of CLO Specialty Registrants broadly aligns with data from the Higher Education Statistics Authority (HESA), where 70% of post graduate students in Academic Year 2019-2020 were from a White background. [1]

Table 3: Race – Contact Lens Specialty Registrants with All Registrants

	White	Black / Black British	Asian / Asian British	Mixed/ Multiple	Other ethnic group	Prefer not to say	Total	
Contact Lens Specialty	72.02%	0.78%	13.32%	0.24%	0.94%	12.70%	**1276**	**100.00%**
All Registrants	49.03%	1.52%	32.74%	0.99%	1.61%	14.10%	29359	100.00%

Religion or Belief

3.5 Table 4 shows a significantly higher proportion of Christian CLO Specialty Registrants and a significantly lower proportion of Muslim Registrants. Religion and Belief is often interrelated with Race, with 99.5% of Muslims in the UK who are BAME[2].

There is no significant difference when comparing the proportion of Hindu, Sikh and Jewish CLO Specialty Registrants compared with all Registrants.

Table 4: Contact Lens Specialty Registrants with All Registrants

	CLO Specialty	All Registrants
Christian (incl. Catholic)	40.58%	27.40%
Muslim	3.60%	17.12%
Hindu	6.96%	9.18%
Sikh	2.58%	4.08%
Jewish	1.64%	0.96%
Buddhist	0.16%	0.45%
Any other religion/faith	0.00%	0.00%
No religion	26.19%	21.81%
Prefer not to say	18.30%	18.99%
Total	**100.00%**	**100.00%**

[1] Figure 5, HE Enrolments by Personal Characteristics, HESA 19/20
[2] Census 2011

Fitness to Practise

3.5 At the last Fitness to Practice (FtP reporting date (31 March 2021), no CLO Specialty Registrants were subject to an FtP investigation. It is noted that the COVID-19 pandemic may have affected the occurrences of CL practice.

Table 5: Race – Fitness to Practice CLO Specialty Registrants and All Registrants

	Registrants subject to an FTP Investigation	% of complaints against total registrant specialism
CLO Specialty Registrants	0	0
All Registrants	59	0.20%

4. Equality Impact Assessment of New Requirements for Contact Lens Opticians

Outline

4.1 This section considers how the GOC has paid due regard to Public Sector Equality Duty (PSED) in the three documents setting out the new requirements, the content of which are individually considered. This stage of the assessment will begin with a focus on key changes to the current process.

Removal of Minimum/Maximum Time or Credit Volume

4.2 The existing CLO Specialty course takes a minimum of one year to complete. The Association of British Dispensing Opticians' (ABDO) College states that most students take an average of 18 months to 2 years depending on clinic time in practice. [3]

In the revised proposals, there will not be a proposed minimum/maximum or recommended time or credit volume for an approved qualification, specified location or duration of clinical experience, other than the requirement that an approved qualification leading to Specialist Entry to the GOC register, as a contact lens optician, must integrate approximately 225 hours of learning and experience in practice.

This could shorten the length of time it takes to gain a Specialist Entry and the reduce the cost to the trainees who are not paid during training days. There is frequently a link between protected characteristics and with socio-economic status. For example, BAME groups are more likely to be in poverty than White groups. This socio-economic link is not limited to race – lone parents (who are predominantly female) and people with a disability also face higher levels of relative poverty.

The data presented at Section 3 showed lower CLO Speciality participation by females and registrants aged 35-44. People in this age group are more likely to have responsibility for childcare. The removal of the minimum/maximum time or credit volume could positively affect and encourage participation by females aged 35-44.

The data presented in Section 3 noted that there was some disparity in the profile of CLO Registrants and All Registrants in relation to Sex, Race and Religion or Belief. The proposal to remove minimum/maximum time or credit volume should positively impact protected groups as it should reduce barriers and increase participation.

Outcomes Based Approach

4.3 The revised Outcomes use 'Miller's Pyramid of Clinical Competence'[4], an outcomes-based approach to specify knowledge, skills and behaviours, using an established competence and assessment hierarchy. Outcome based education can be summed

[3] ABDO Contact Lens Certificate

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

up as results-oriented thinking. It is the opposite of input-based education, where the emphasis is on the educational process. An outcome-based approach focuses on the care delivered to different patients in different settings, and should increase confidence in the quality of professional practice.

The shift to an outcomes-based approach which puts the patient first should support the advancement of equality and elimination of discrimination with regards to the wider public health, particularly where there is disparity in health outcomes which can be experienced by protected groups.

Increased Involvement and Feedback from Stakeholders

4.4 Participation, by the people who use and care about optical services, should enable an increased understanding of the patient experience and how to respond to their diverse needs, including those people who have the poorest health.

The proposal to increase involvement and feedback demonstrates taking steps to meet the needs of protected groups and promoting good relations. This should also improve access to services and reduce differences in health care in different communities.

Outcomes for Approved Qualifications for Specialist Entry to the GOC register as a contact lens optician

Introduction

4.5 The Outcomes describe the expected knowledge, skills and behaviours a dispensing optician must have to be awarded an approved qualification for Specialist Entry to the GOC register as a Contact Lens Optician. The Outcomes are organised into seven categories which are separately explored below. Observations are made on good practice in paying due regard to the PSED.

Clinical Competence

4.6 The use of Miller's Pyramid to demonstrate clinical competence should enhance confidence in the capability of meeting the needs of diverse groups as emphasis at the higher levels of competency is based on observed performance.

Outcome 1: Uphold Professional Standards

4.7 Working collaboratively in a multi-disciplinary approach should enhance the profession's ability to meet the diverse needs of patients. Multi-disciplinary approaches can improve services through robust decision making and can increase the likelihood of early intervention.

The focus on mutual trust, understanding and respect in relationships with other professionals complements an ethical approach and will assist with continuity of care.

The need to undertake consultation in an appropriate setting should complement the advancement of equality and meeting the needs of protected groups, who may have additional needs or preferences in respect of clinical settings.

Assessing the communication needs and adapting consultation appropriately effectively pays due regard to the need to make adjustments for people with a disability. It should also decrease the risk of discrimination against people who do not speak English as a first language.

Outcome 2: Person Centred Care

4.8 A person centred approach advances equality as it increases the likelihood that individual needs will be met. This includes needs based on people's equality characteristics such as disability, culture, language, gender, religion, sexual orientation.

Working in partnership to make informed choices complements the requirement to communicate effectively and to engage diverse patients/carers in health care decisions.

The need to work within own scope of practice and recognise when to refer or seek guidance should mitigate the potential for harm and should inform a better understanding of how to meet the needs of people who share protected characteristics.

Outcome 3: Ocular Examination and 4: Outcome 4: Verification and Identification

4.9 While the relevance of these Outcomes with the PSED is comparatively remote, the focus on quality accompanied by an evidence-based approach should enhance the clinical response.

Outcome 5: Contact Lens Fitting and Aftercare

4.10 Issuing unambiguous contact lens specifications should decrease the risk that contact lenses are used inappositely. The use of the term “unambiguous” should increase the likelihood that all patients will understand, including patients with learning differences or those who speak English as a second language.

The focus on the importance of aftercare and risk management should support addressing wider health inequalities where behavioural risks to health are more prevalent in some parts of the population than others.

Outcome 6: Learning and Development

4.11 The requirement for maintaining clinical and CLO knowledge and skills should enhance the ability to meet the needs of diverse users.

The requirement to evaluate advances in contact lens practice should assist with the advancement of equality and reducing health inequality. For example, contact lenses as drug delivery devices will open up further opportunities for unique uses of contact

lenses, such as monitoring diabetic control. Wide variations in healthcare exist in diabetes, with those living in deprived areas less often achieving glycaemic control targets.

Standards for Approved Qualifications for Specialist Entry to the GOC register as a contact lens optician

4.12 The standards describe the expected context for the new delivery and assessment of the proposed Outcomes leading to an award of an approved qualification for Specialist Entry into the GOC register as a Contact Lens Optician.

Standard 1: Public and Patient Safety

4.13 Adherence to the GOC's Standards of Practice should promote inclusion as the Standards are highly relevant to good practice in equality, diversity and inclusion, which include effective communication, respect and listening to the patient.

The arrangements to mitigate the risk of harm should assist with the duty to pay due regard to the need to eliminate discrimination.

Standard 2: Selection and Admission of Trainees

4.14 This broadly aligns with externally recognised best practice, namely the Supporting Good Practice in Admissions guidance[5] produced by Supporting Professionalism in Admissions and published by UCAS.

From the outset there is a clear focus on fairness and transparency, and the Standard makes it clear that educational providers must comply with relevant equality and diversity legislation.

Selectors should be trained to apply selection criteria fairly, including training in equality, diversity and unconscious bias. This reflects the intention to take steps to eliminate discrimination. Selectors may include a mix of academic/administrative staff, which should complement fair decision making. There is a specific requirement for selectors to be trained in applying selection criteria fairly including training in equality diversity and unconscious bias.

The Standard requires educational providers to provide comprehensive information about the course to applicants, including the entry criteria, description of the selection process and the total cost/fees that will be incurred. Protected groups can experience higher poverty levels, for example lone parents, and to support the promotion of equality it is important to provide plenary information to inform decision making.

[5] Available at https://www.ucas.com/file/233016/download?token=6dAVLopd

Standard 3: Assessment of Outcomes and Curriculum Design

4.15 Curriculum design and delivery must involve and be informed by feedback from a range of stakeholders who must be appropriately trained and supported, including in equality and diversity. This should support the profession in learning more about the needs of patients from protected groups and should assist with the amplification of their voices. It also encourages participation by people from protected groups.

Assessments must be valid, reliable, robust, fair and transparent, and ensure equity of treatment for students. Reasonable adjustments must be made to teaching and assessment for students with specific needs to demonstrate that they meet the Outcomes. This indicates taking steps to meet the needs of people from protected groups where these are different from the needs of other people.

The Standards provide that a range of teaching and learning methods must be used. The use of a range of teaching and learning methods should support engagement of students with diverse needs and preferences.

The selection of outcomes to be taught and assessed must be informed by feedback from a variety of sources, including patients and other healthcare professionals. This should support the amplification of diverse voices in curriculum design.

Equality and diversity data and its analysis must inform curriculum design, delivery and assessment of the approved qualification. This analysis must include student progression by protected characteristic. In addition, the principles of equality, diversity and inclusion must be embedded in curriculum design and assessment and used to enhance students experience of studying on a programme leading to an approved qualification. This focus on data supports the advancement of equality as it should facilitate the development of action to close gaps.

Standard 4: Management, Monitoring and Review of Approved Qualifications

4.16 Evaluation will include feedback from stakeholders and minimum evidence shall include trainees' consultative mechanisms and a range of other input sources, including patients and third sector bodies.

The Standard states that trainees must be able to raise concerns and that these must be recorded and evidenced. This should support the elimination of discrimination as concerns may be related to protected characteristics, and the recording should support the development of actions to address potential unfair treatment.

Standard 5: Leadership, Resources and Capacity

4.17 Educational providers must demonstrate effective induction, peer support and mentoring. This support will be particularly relevant for protected groups. Additionally, trainees must have effective support for health and wellbeing, which

should advance equality and demonstrates taking steps to meet the needs of people who share protected characteristics. This is highly relevant in the current pandemic environment, where there has been a decreased in wellbeing and an increase in reports of mental health issues.

Quality Assurance and Enhancement Method

4.18 This describes how the GOC will gather evidence to decide in accordance with the Opticians Act whether a qualification for Specialist Entry to the GOC register as a Contact Lens Optician meets the Outcomes for Approved Qualifications and Standards for Approved Qualifications.

This approach is underpinned by a greater emphasis in the views of stakeholders, including patients, service users and the public. This greater emphasis should enhance how CLO Specialists meet the needs and experience of diverse groups.

Separate arrangements will be made with ABDO to ensure that the route to Specialist Entry is maintained for trainees who graduate from qualifications approved before 2021.

Migration to the "new" approval includes "teaching out". This longer-term perspective should support students from protected groups who may need to consider personal circumstances in the move to increased work-based learning.

A staged approach to qualification approval is used from the initial proposal to the final decision about whether the qualification is able to meet the outcomes and standards. Each stage includes a requirement for comprehensive evidence about quality, readiness and mitigation of risk. The later stages include patient, service user and public engagement, which should assist with ensuring that qualifications result in practice which understands the needs of protected groups.

In the event that a provider is asked to halt recruitment at the end of Stage 4, the provider must confirm to the GOC how the interests of trainees currently studying will be best served, which could include a transfer or alternative academic award without cost to the student. This provision should mitigate disruption for trainees, particularly for those from protected groups where there can be additional barriers to progression.

The proposed method of assurance and enhancement should assist with continuous improvement in learning from good practice and ensuring that professional knowledge stays up to date.

Evidence includes stakeholder engagement and feedback from patients and carers. It also refers to the requirement to provide evidence about selectors' training in equality, diversity and unconscious bias, which supports the elimination of discrimination.

The systematic approach to collecting and using equality data will enhance the mainstreaming of equality and the development of evidence-based actions to better meet the PSED.

Evidence should be provided to indicate that the staff profile can support the delivery of the Outcomes and the student experience, including staff/student ratios. This should increase confidence in sufficient resources being available to support the needs of protected groups.

5. Continuous Improvement

Area	Action
Attracting diversity	Advise Educational Providers that marketing of courses must be inclusive and consider how to reach underrepresented groups. Learn from the experience of CLO registrants from underrepresented groups about what supports success and what can hinder progress. Explore interventions that address differential attainment, such as how non-supervisory mentors can support progression. Encourage Educational Providers to develop actions to address imbalances following equality data analyses.
Building competency	Promote CPD to enhance how the profession mentors specialty entrants. Commission research regarding differential attainment and disadvantage in specialty optical education.
Monitoring	Consider whether supplemental HESA analyses could enhance monitoring equality impact, such as analyses of indices of multiple deprivation. Measure the impact of diversity and unconscious bias training by asking participants to reflect on how the training has enhanced practice.

Annex: Applicable Legislation

UK Wide: Section 149 of the Equality Act 2010 (the Public Sector Equality Duty)

In the exercise of its functions as a public authority, GOC must have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not

The Act explains that having due regard for advancing equality involves:

- Removing or minimising disadvantages suffered by people due to their protected characteristics.
- Taking steps to meet the needs of people from protected groups where these are different from the needs of other people.
- Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.

The Act states that meeting different needs involves taking steps to take account of disabled people's disabilities. It describes fostering good relations as tackling prejudice and promoting understanding between people from different groups. It states that compliance with the Duty may involve treating some people more favourably than others.

Northern Ireland – Northern Ireland Act 1998

Section 75 of the Northern Ireland Act 1998 refers to devolved arrangements which are similar to the mainland obligations, specifically:
(1)A public authority shall in carrying out its functions relating to Northern Ireland have due regard to the need to promote equality of opportunity—
(a)between persons of different religious belief, political opinion, racial group, age, marital status or sexual orientation;
(b)between men and women generally;
(c)between persons with a disability and persons without;
and
(d)between persons with dependants and persons without.

Specific National Obligation to Publish Equality Impact Assessments.

Public Authorities in Scotland, Wales and Northern Ireland are obliged to publish Equality Impact Assessments. While there is no specific duty in England, the Equality and Human Rights Commission advise on this approach as best practice.

Outline Impact Assessment Screening Tool

Name of policy or process:	**Education Strategic Review (ESR)**
Purpose of policy or process:	To update our requirements for GOC approved qualifications for specialist entry to the GOC register as a contact lens optician
Team/Department:	Education
Date:	February 2021
Screen undertaken by:	Simran Bhogal (Education Manager - Policy, Projects & Research)
Approved by:	Marcus Dye (Interim Director of Regulatory Strategy)
Date approved:	Outline for Council March 2022

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. Section two considers the impacts, costs, benefits and risks of our proposals to update our requirements for GOC approved qualifications leading to specialist entry to the GOC register as a contact lens optician.

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 on whether any of our proposals raise any particular equality and diversity issues. Alongside this consultation we are undertaking an Equality Impact Assessment which will be published in March 2022.

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 and December 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 assessment (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 and bespoke projects 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 the Department of Health and Social Care (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 and make changes where required.

Reputation and media: The proposals to update our requirements for GOC approved qualifications leading to speciality registration for entry to the GOC register as a contact lens optician continues to attract press and stakeholder attention. 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 March 2022, we anticipate completing this element of the ESR workstream within agreed timescales and cost tolerances. This concludes the ESR.

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

Please put commentary below about reasons for Information Governance ratings:

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

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

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

C) Human Rights, Equality and Inclusion	High Risk	Medium Risk	Medium Risk	Low Risk	? or N/A
Main audience/policy user	Public			Registrants, employees, or members	
Participation in a process (right to be treated fairly, right for freedom of expression)	Yes, the policy, process or activity restricts an individual's inclusion, interaction or participation in a process.			No, the policy, process or activity does not restrict an individual's inclusion, interaction or participation in a process.	
The policy, process or activity includes decision-making which gives outcomes for individuals (right to a fair trial, right to be treated fairly)	Yes, the decision is made by one person, who may or may not review all cases	Yes, the decision is made by one person, who reviews all cases	Yes, the decision is made by an panel which is randomly selected; which may or may not review all cases.	Yes, the decision is made by a representative panel (specifically selected). No, no decisions are required.	
	There is limited decision criteria; decisions are made on personal view	There is some set decision criteria; decisions are made on 'case-by-case' consideration.	There is clear decision criteria, but no form to record the decision.	There is clear decision criteria and a form to record the decision.	
	There is no internal review or independent appeal process	There is a way to appeal independently, but there is no internal review process.	There is an internal review process, but there is no way to appeal independently	There is a clear process to appeal or submit a grievance to have the outcome internally reviewed and independently reviewed	
	The decision-makers have not received EDI & unconscious bias training, and there are no plans for this in the next 3 months.	The decision-makers are due to receive EDI & unconscious bias training in the next 3 months, which is booked.	The decision-makers are not involved before receiving EDI & unconscious bias training.	The decision-makers have received EDI & unconscious bias training within the last 12 months, which is recorded.	
Training for all involved	Less than 50% of those involved have received EDI training in the last 12	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; and there is no further training planned			months, which is recorded.	
Alternative forms – electronic / written available?	No alternative formats available – just one option	Yes, primarily internet/computer-based but paper versions can be used		Alternative formats available and users can discuss and complete with the team.	
Venue where activity takes place	Building accessibility not considered	Building accessibility sometimes considered		Building accessibility always considered	
	Non-accessible building;	Partially accessible buildings;	Accessible buildings, although not all sites have been surveyed	All accessible buildings and sites have been surveyed	X
Attendance	Short notice of dates/places to attend	Medium notice (5-14 days)of dates/places to attend		Planned well in advance	
	Change in arrangements is very often	Change in arrangements is quite often		Change in arrangements is rare	
	Only can attend in person	Mostly required to attend in person		Able to attend remotely	
	Unequal attendance / involvement of attendees	Unequal attendance/ involvement of attendees, but this is monitored and managed.		Attendance/involvement is equal, and monitored per attendee.	
	No religious holidays considered; only Christian holidays considered	Main UK religious holidays considered	Main UK religious holidays considered.	Religious holidays considered, and ability to be flexible (on dates, or flexible expectations if no alternative dates).	
Associated costs	Potential expenses are not included in our expenses policy	Certain people, evidencing their need, can claim for potential expenses, case by case decisions		Most users can claim for potential expenses, and this is included in our expenses policy; freepost available.	
Fair for individual's needs	Contact not listed to discuss reasonable adjustments, employees not aware of reasonable adjustment advisors.	Most employees know who to contact with queries about reasonable adjustments		Contact listed for reasonable adjustment discussion	
Consultation and Inclusion	No consultation; consultation with internal employees only	Consultation with employees and members	Consultation with employees, members, and wider groups	Consultation with policy users, employees, members and wider groups.	

Outline Impact Assessment Screening Section Two: ESR Deliverables (for post-registration specialty qualifications)

Step 1: Scoping the IA

Name of the policy/function:	**Education Strategic Review**
Assessor:	Simran Bhogal (ESR Project Manager)
Date IA started:	2016
Date IA completed:	May 2021
Date of next IA review:	May 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 as a contact lens optician.
Approver:	Marcus Dye (Interim Director of Regulatory Strategy)
Date approved:	Feb 2022

Q1. Screening Assessment

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

Q2. About the policy, process or project

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

Aim: To assess the key impacts of our proposals to update our requirements for GOC approved qualifications for specialist entry to the GOC register as a contact lens optician.
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 as a contact lens optician. An Expert Advisory Group (EAG) for Contact Lens Opticians was formed 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, and an updated quality assurance process to be held in common for both Contact Lens Optician and Independent Prescribing approved qualifications. The three proposed documents will replace 'Visit Handbook Guidelines for the approval of 'Training Institutions' and 'Providers for Schemes for Registration for United Kingdom Contact Lens Opticians' (published November 2007), as well as the 'Contact Lens Speciality Core Competencies' published in 2011. This includes the list of required core competences, the numerical requirements for trainees' practical experiences, education policies and guidance contained within the handbooks, and policies on supervision and recognition of prior learning, which are published separately. Together, these documents mitigate the key risk that our current requirements become out of date. They have been drafted to ensure the post-registration qualifications we approve are responsive to a rapidly changing landscape in the commissioning of eye-care services in each of the devolved nations and so that the skills and abilities of our registrants remain up to date.
Who will benefit: Patients and the public; registrants; employers: other healthcare professionals, local/national workforce training/commissioning bodies and the NHS; GOC staff, EVPs and committees: providers of GOC approved and provisionally approved qualifications and their trainees.

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

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

Key proposals
a. Candidates will acquire a qualification approved by the GOC leading to specialist entry to the GOC register as a contact lens optician.

b. The approved qualification will either be an academic award or a regulated qualification at a minimum of Regulated Qualification Framework (RQF) (or equivalent) level 6.
c. There will not be a proposed minimum/maximum or recommended time or credit volume for an approved qualification, specified location or duration of clinical experience, other than the requirement that an approved qualification leading to specialist entry to the GOC register, as a contact lens optician, must integrate approximately 225 hours of learning and experience in practice.
d. The provider of the approved qualification must, in the design, delivery and assessment of an approved qualification, involve and be informed by feedback from a range of stakeholders, including patients, employers, trainees, supervisors, members of the eye-care team and other healthcare professionals.
e. An outcomes-based approach is used to specify knowledge, skills and behaviours, using an established competence and assessment hierarchy known as 'Miller's Pyramid of Clinical Competence' (knows; knows how; shows how; and does).
f. Providers of approved qualifications are responsible for the measurement (assessment) of students' achievement, of the outcomes at the required level, (on Miller's Pyramid) leading to an award of an approved qualification.
g. Providers of approved qualifications will be responsible for recruiting and selecting trainees onto a programme leading to an award of an approved qualification. Recognition of prior learning can be deployed to assist the progression of trainees whose progress to specialist registration has stalled.

Q4. Gathering the evidence

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

Available evidence – used to scope and identify impact
Research and consultation: • Call for evidence (report June 2017) • Research to learn from other professions/overseas (Nov 2017) • System leaders' roundtable (Nov 2017) • Consultation on concepts/principles report (April 2018) • Research with newly qualified/employers (June 2018) • Development of standards/learning outcomes with Committees, Expert Advisory Group other external stakeholder groups (Summer 2018) • Education Provider Forum (October 2018) • Consultation on draft Education Standards and Learning Outcomes (November 2018-Feburary 2019) • Education Visitor Panel and Advisory Panel feedback (Jan-Dec 2020)

- Expert review and input from the Quality Assurance Agency (QAA) (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 (August 2020 – October 2020)
- QAA RQF Levels Research Report (November 2020)
- Expert Advisory Groups developmental activity and feedback (September 2019 – February 2022).
- EAG review of British Contact Lens Association (BCLA) CLEAR - Contact Lens Evidence-based Academic Report
- Informal stakeholder engagement and public consultation (September 2021-January 2022)

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 took place across 15-weeks from 20 September 2021 - 3 January 2022 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 Enventure Research.

Summary of the feedback from consultation:

Consultation responses has been independently analysed by our research partner, Enventure Research, and a consultation report will be prepared by Enventure Research and 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 individual and stakeholder responses to the proposals contained in our consultation have been analysed and will be published on our website following Council's decision in March 2022.

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
- 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 new 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. A Sector Strategic Implementation Steering Group (SSISG) has been established to provide sector leadership and assist at a strategic level to overcome issues and to coordinate action/ workstreams to ensure the most advantageous external

operating environment for providers and potential providers of GOC-approved qualifications, as they work towards implementing the new GOC requirements for approved qualifications in optometry and dispensing optics, this forum will also support our post-registration qualifications. 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 roundtables and consultations 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 as a contact lens optician, 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, as the dispensing optics qualification also supports an outcome-orientated approach ensuring 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 'Visit Handbook Guidelines for the approval of 'Training Institutions' and 'Providers for Schemes for Registration for United Kingdom Contact Lens Opticians' (published November 2007), as well as the 'Contact Lens Speciality Core Competencies' published in 2011 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 Quality Assurance & Enhancement Method (QA&E).

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 to the GOC register as a contact lens optician 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 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;
- 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 healthcare 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 a contact lens optician 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 as a contact lens optician 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

There may be additional costs to trainees:

- For current contact lens trainees whose progression has stalled, and who wish to transfer (potentially with advance standing/RPL) into the new, CLO 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 at the same time, or shortly after gaining an approved qualification in dispensing optics, 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 the GOC register as a contact lens optician 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 level 6 qualification; and
- Providers (awarding organisations) offering an Ofqual-regulated level 6 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

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

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

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 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.

Wider impacts 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 (ABDO) offering a GOC approved 'registrable' post-registration qualifications due to increased market competition, and are continuing dialogue with ABDO;
- 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, inter-professional 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 are 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 qualification 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 contact lens optician at the point of registration better aligns with other healthcare regulatory systems for qualification approval and post-registration specialty annotation.

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

Step 3: Monitoring and review

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

Longitudinal Research

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

Impact Measurement

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

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

CPD impact

InJanuary 2022 we introduced our new requirements for Continuing Professional Development (CPD). 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. The Sector Strategic Implementation Steering Group (SSISG) will continue to provide sector leadership and assist at a strategic level to overcome issues and to coordinate action/ workstreams to ensure the most advantageous external operating environment for providers and potential providers of GOC-approved qualifications, as they work towards implementing the new GOC requirements for approved qualifications in optometry and dispensing optics, this forum will also support our post-registration qualifications. 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 (EQIA) 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 (three months from initial completion).

Date: May 2022 and annually thereafter.

Contact Lens Opticians - Outcomes Delphi Verification Exercise Report (September 2021)		
Outcome prior to Delphi Recommendation	**Delphi Recommendation**	**CLO Expert Advisory Group view (September 2021)**
O1.2 Establishes relationships with other professionals based on understanding, trust and respect for each other's roles in relation to contact lens and other care. [Knows]	EAG consider original wording or to remove	Outcome removed and O1.1 reworded to: "Establishes relationships with other professionals based on understanding, trust and respect for each other's roles in relation to contact lens and other care, and works collaboratively to ensure the delivery, transfer and continuity of care is assured and not compromised." [Knows How]
O1.3 Undertakes the consultation in an appropriate setting, taking account of confidentiality and understanding the issues involved in obtaining valid consent, dignity and respect in line with regulatory standards and contractual requirements. [Knows How]	Change to: "Undertakes a patient consultation in an appropriate setting, taking account of confidentiality and understanding the issues involved in obtaining valid consent, dignity and respect in line with regulatory standards and contractual requirements." [Knows How]	Delphi recommendation accepted with amendments: "Undertakes a patient consultation in an appropriate setting, taking account of confidentiality and understands the issues involved in obtaining valid consent and maintaining, dignity and respect in accordance with regulatory standards and contractual requirements." [Knows How]
O2.2 Identifies, recommends and fits contact lenses to achieve vision correction and/or eye health goals, including explaining where expectations cannot be met and/or when contact lenses cannot be fitted. [Does]	Change to: "Identifies, recommends and fits contact lenses to achieve vision correction and eye health requirements whilst explaining outcomes and managing patient expectation when contact lens usage do not meet patient requirement or cannot be fitted." [DOES]	Delphi recommendation rejected; instead, the word "patient" was added to O2.2: "Identifies, recommends and fits contact lenses to achieve vision correction and/or eye health goals, including explaining where *patient* expectations cannot be met and/or when contact lenses cannot be fitted." [Does]
O3.6 Recognises the signs and symptoms associated with relevant ocular conditions, (including, but not	Change Miller's Pyramid of Clinical Competence level to "Shows How".	Delphi recommendation accepted.

exclusively, anterior eye disease, dry eye, red eye and foreign body), differentiates normal from abnormal findings, manages the conditions appropriately and refers where necessary. [Knows How]		
O3.7 Recognises the signs, symptoms and contact lens implications of non-systemic pathological conditions. [Knows]	Change to: "Recognises the signs, symptoms and contact lens implications of non-systemic (ocular) pathological conditions." [Knows]	Delphi recommendation accepted.
O3.9 Uses appropriate grading scales, and creates and maintains accurate and contemporaneous records of all patient advice and management decisions in line with relevant legislation. [Does]	Change Miller's Pyramid of Clinical Competence level to "Shows How".	Delphi recommendation rejected with Miller's level remaining at "Does".
O4.1 Understands how to assess using the appropriate instruments, the dimensional measurement and other features of contact lenses to identify where possible and enable their replication. [Knows How]	Remove.	Delphi recommendation rejected.
O4.2 Understands how contact lens parameters are measured to International Organisation for Standardisation (ISO) standards of tolerance. [Knows How]	Remove.	Delphi recommendation rejected.
O4.3 Recognises and differentiates between the design features of contact lenses. [Shows How]	Change Miller's Pyramid of Clinical Competence level to "Knows How".	Delphi recommendation rejected with Miller's level remaining at "Shows How".
O6.1 Demonstrates appropriate clinical and diagnostic skills within personal scope of practice. [Does]	Change to: "Demonstrates appropriate clinical and diagnostic skills within personal level of practice knowledge and competence." [Does]	Delphi recommendation rejected.

O6.4 Demonstrates knowledge of refractive techniques including the principles of binocular vision management. [Shows How]	Remove.	Delphi recommendation rejected.
O6.9 Implements infection prevention and control in optical practice. [Shows how]	Change Miller's Pyramid of Clinical Competence level to "Does".	Delphi recommendation accepted.

SPOKE

Sector Partnership for Optical Knowledge and Education

Project 1

Indicative Guidance

SPOKE
Sector Partnership for Optical Knowledge and Education

Contents

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Project 1 - Indicative guidance

Methodology

This guidance was developed with input from a wide range of sector stakeholders, many of whom volunteered significant time and effort at short notice. Five writing groups were formed (22/09/21), working asynchronously as well as meeting on MS Teams, to focus on Outcomes 1 and 2, 3a, 3b, 4 and 5, and 6 and 7 each with a facilitator. Initial drafts were considered at a consolidation meeting (13/10/21), with representatives of each group present, at which point a format and content style was selected, and groups asked to refine their output accordingly. At that point the group determined that whilst an overarching assessment mapping table would be of value, the indicators themselves needed to be focused on final outcomes, such that learning and scaffolding approaches as well as examples of good practice present in early drafts would be held over for future projects. Revised and combined outputs, including overarching assessment materials prepared by the steering group were then considered and developed further at a refinement meeting (02/11/21), again comprised of writing group representatives. The revised compiled documents were shared with the Advisory review group, who were asked to feed back via a JISC online survey (11/11/21). Feedback was reviewed and incorporated at a further finalisation meeting including representatives of GOC (25/11/21), as well as via MS Teams before submission to GOC (30/11/21).

The support and expertise of the writers has been invaluable in completing the project. Accordingly, members of the writing groups are listed at the end of the document.

Purpose

The guidance is intended to support course teams and approval panels by developing and expanding on the meaning of the outcomes as indicators and providing references to resources that address elements in more detail. It deliberately does not address how students may be developed to achieve the outcomes, focusing instead on the terminal level specified. Some suggestions for assessments that may be effective in measuring outcomes are also provided. The intent is to be inclusive of innovative practice and developments in the profession, whilst capturing the key features of registrants in the two professions as described by the outcomes. It should therefore not be viewed or deployed in a way that is constraining or assumes that it is entirely comprehensive. The SPOKE contributors consider it important that it is viewed as a live document, that is updated regularly with good practice examples as they are identified during approval and review processes, and expect that excellent practice will emerge that is not yet captured here.

Structure

In order to provide the opportunity to reflect the distinctive characteristics and nuances of the two professions, two separate indicative guidance tables have been prepared. In addition, an assessment typology and mapping table is provided to assist course teams with developing assessment strategies that are able to cover all outcomes effectively, without undue burden on the learner or delivery team. Relevant background resources, selected by the writing groups, are cited in the table and presented after the assessment tables.

Outcomes for Registration – Dispensing Optician

Outcome 1. Person Centred Care

Patient well-being/care is an optical professional's primary concern and must be at the heart of all decisions made about patient care (Standard 1). Optical professionals must be able to employ an adaptive and personalised approach to patient care, considering the patient's social, clinical, personal, and cultural needs whilst challenging their own conscious and unconscious bias (Standards 4 and 13). Where care requires the involvement of other professionals, they must be able to collaborate effectively (Standards 3, 6, 7, 10, 11 and 14).

Outcome		Level	Indicator	References /resources
O1.1	Actively listens to patients and their carers to ensure patients are involved in and are at the heart of decisions made about patients' care.	**Does**	• Effectively communicates with patients and carers to obtain all relevant history and symptoms using a combination of verbal, non-verbal, and written skills. • Actively seeks confirmation of patient understanding and involves patient in decisions made regarding their own healthcare.	(1) (2) (3)
O1.2	Manages desired health outcomes of patients, taking into consideration any relevant medical, family, and social history of the patient, which may include personal beliefs or cultural factors.	**Does**	• Recognises the importance and significance of family history, signs, and symptoms. • Recognises patients' physical, emotional, intellectual, and cultural background and adapts care and communication appropriately. • Adheres to relevant aspects of the Equalities Act.	
O1.3	Protects patients' rights; respects the choices they make and their right to dignity and privacy	**Does**	• Adheres to the Law as set in the Opticians Act. • Complies with the GOC Standards of Practice 1-19.	
O1.4	Ensures high quality care is delivered and puts into place adaptive measures as needed for different environments (such as domiciliary, prisons and special schools).	**Shows How**	• Adapts own practise to ensure appropriate care of all patients. • Recognises when environmental factors should be adapted to accommodate individual patient needs.	
O1.5	Commits to care that is not compromised because of own personal conscious and unconscious values and beliefs.	**Does**	• Develops an awareness of differing values and belief structures and seeks to care inclusively, with attention to the potential impact of own beliefs on patient care.	
O1.6	Obtains and verifies continuation of valid consent from adults, children, young and vulnerable people, and their carers and records as appropriate.	**Does**	• Adheres to legal requirements when gaining consent. • Applies the various policies that a practice is required to have on display or on file including safeguarding children and adults, chaperone policy, complaints and data management.	
O1.7	Demonstrates effective clinical decision-making, diagnosis, evaluation and makes appropriate and timely referral, where this is needed to meet a patient's needs.	**Does**	• Demonstrates an awareness of referral pathways and can accurately refer when appropriate. • Recognises their scope of practice and the role of referral in effective person-centred care. • Designs and implements an appropriate management plan, in line with individual patients' clinical needs and preferences.	
O1.8	Refers and signposts as necessary to sight loss and other relevant health services.	**Does**	• Advises on accessing and makes appropriate referrals to low-vision services, in line with patients' best interests. • Is able to direct to relevant health and social care services for patients at risk.	

Outcome 2. Communication

Communication is key to effective patient and public interactions (Standard 2). Optical professionals must be able to communicate effectively with patients and other professionals. Optical professionals must be able to adapt their approach and style according to specific individual needs and in a manner that is supportive of achieving desired outcomes (Standards 1, 10 and 13). This includes written and verbal communication, as well as recognising non-verbal cues (Standards 3, 4, 11, 12 and 13).

Outcome		Level	Indicator	References /resources
O2.1	Conducts communications in a sensitive and supportive manner adapting their communication approach and style to meet the needs of patients, carers, health and care colleagues and the public	**Does**	• Demonstrates effective communication using verbal, non-verbal, and written skills. • Seeks and communicates relevant information from and to patients in an effective and appropriate manner. • Ensures the effective implementation of individual management plans, checking patient understanding by actively adapting their communication approach.	
O2.2	Acts upon non-verbal cues from patients or carers that could indicate discomfort, a lack of understanding or an inability to give informed consent.	**Knows How**	• Identifies patients who have poor or non-verbal communication skills or those who are confused, reticent or who might be misled. • Adapts communication to ensure those patients are managed appropriately. • Ensures appropriate consent and assent has been obtained from relevant carers and patients, in instances where the patient has limited ability to engage fully.	
O2.3	Communicates effectively within a multi-disciplinary healthcare team and works collaboratively for the benefit of the patient.	**Does**	• Recognises the diverse contributions of both clinical and non-clinical colleagues including those from other professions, and adapts own communication methods, style and content to ensure the delivery of effective patient care. • Recognises the varying roles of other allied health and medical professionals and their contribution to person centred care.	
O2.4	Critically reflects on how they communicate with a range of people and uses this reflection to improve interactions with others.	**Does**	• Demonstrates how to deal effectively with patient concerns. • Discusses how to deal with a patient who needs information about disease and its ocular impact, its treatment, and the possible ocular side effects of medication. • Recognises and manages patient's expectations and aspirations, and situations where these cannot be met. • Can identify instances of miscommunication and how this could be avoided/identifies areas of improvement in their own interactions.	

Outcome 3. Clinical Care

Optical professionals are professionally accountable and personally responsible for achieving desired patient outcomes according to their individual scope of practice. Working within their limits of competence (Standard 6), and exercising professional judgement, they must engage in evidence-informed clinical decision-making for all patients (Standards 5, 7 and 8).

Outcome		Level	Indicator	References /resources
O3.1	Undertakes safe and appropriate ocular examinations using appropriate techniques and procedures to inform clinical decision-making within individual scope of practice.	**Does**	• Justifies the choice of clinical procedures used on appropriate techniques for clinical investigations. • Has an awareness of own limitations to conduct clinical examinations, and work within limits of competence. • Appraises the risk balance of clinical techniques used to examine patients. • Ensures patient and practitioner safety during all clinical processes and procedures.	(4) (5) (6) (7) (8) (9) (10)
O3.2	Engages with developments in research, including the critical appraisal of relevant and up-to-date evidence to inform clinical decision-making and improve quality of care.	**Does**	• Uses a range of research sources to influence their practice. • Demonstrates information literacy. • Appreciation of the quality of evidence. • Synthesises research evidence to inform clinical management of patients. • Able to effectively communicate pertinent research evidence to peers and patients to justify clinical decisions.	(4) (5) (7) (9) (11)
O3.3	Engages with technological advances in eye health and broader healthcare delivery and the significance of specific developments for enhancing patient outcomes and service delivery.	**Does**	• Uses new technologies in diagnosis, treatment and management of ocular conditions. • Uses appropriate technology in consultation, referral and clinical data exchange. • Keeps abreast of emerging technologies and their potential application in clinical practice.	(12) (13)
O3.4	Analyses visual function from a range of diagnostic sources and uses data to devise a clinical management plan for a patient in areas that include the following: • Dispensing of optical appliances • Low vision/visual impairment • Refractive management • Anterior eye and contact lenses • Ocular and systemic disease • Binocular vision • Paediatrics	**Does**	• Applies normative data in the interpretation of results of visual function tests. • Uses clinical data to formulate a management plan across a range of ocular conditions. • Analyses clinical data in light of presenting signs and symptoms. • Demonstrates effective management across the specified range of patients.	(4) (5) (6) (8)

	• Patients with learning disabilities and complex needs • Occupational optometry			
O3.5 Meets the following clinical practice outcomes for registration as a dispensing optician:				
O3.5a (i)	Acts as a first point of contact for patients for their eye health needs by investigating, diagnosing and managing individuals' functional and developmental visual conditions, including those related to age.	**Does**	• Takes a relevant history from individual patients and any other appropriate person involved in their care (relatives/carers and others). • Interprets the results of history-taking and the examination of the refractive and ocular motor status and ocular health of individual patients to inform clinical decision-making and care management plans. • Records all aspects of the consultation, the findings of all tests and relevant communications with patients, their carers and colleagues, ensuring that records are accurate, legible, dated, signed, concise, contemporaneous and securely stored. • Accepts responsibility and accountability for professional decisions and actions as a first point of contact, including in responding to individual patients' needs, managing risk, and making appropriate referrals.	(14) (15)
O3.5a (ii)	Completes an informed clinical assessment of individual patients' needs and uses this to dispense, fit and advise on the safe and effective use of spectacles, low-vision appliances and ophthalmic appliances.	**Does**	• Interprets and dispenses a prescription using appropriate lenses, frame choice and accurate facial and frame measurements. • Measures and verifies optical appliances in line with relevant standards, guidelines, and evidence. • Prescribes, advises, and dispenses appropriate vocational and special optical appliances in accordance with personal eye protection regulations and relevant standards. • Manages and dispenses appropriate optical appliances, suitably adjusted for paediatric patients and for patients with complex or additional needs, including by adapting the practice environment and practice activity in line with individuals' needs. • Manages cases of non-tolerance. • Identifies and advises patients who could benefit from a low vision assessment. • Assesses patients whose vision is not meeting their needs including full history-taking and evaluation of visual requirements. • Evaluates the clinical findings of low-vision assessments, applying knowledge of low-vision optics to dispense appropriate simple and complex low-vision aids and provide relevant advice. • Advises on accessing low-vision services and makes appropriate referrals. • Manages and assesses vision, refractive error, binocular status, and visual acuity. • Evaluates optical products and advancement in technology of ophthalmic lenses and frame manufacture in order to provide patients with the most appropriate optical appliances.	(4) (16) (17) (18) (19)

			• Analyses a wide range of prescriptions recognising potential problems and appraising suitable lens solutions, modifying a prescription in accordance with legal requirements relative to the visual task analysis for individual patients' requirements. • Appraises and understands facial development with an ability to relate anatomical features and material properties to the dispensing of optical appliances. • Appraises and completes all facial measurements required for bespoke eyewear, including the ability to modify where necessary frames for children and patients with craniofacial abnormalities. • Modifies, repairs, adjusts and accurately fits optical appliances. • Manages and dispenses prescriptions including high and/or complex prescriptions recalling knowledge of optical performance and production of the appliance in order to meet patients' visual and aesthetic needs.	
O3.5a (iii)	Advises on the safe and effective use of contact lenses and removal in an emergency.	**Does**	• Recognises methods of selecting and fitting contact lenses and the importance of aftercare regimes for patients with both soft and rigid contact lenses to maintain ocular health. • Advises and discusses possible contact lens options for the intended use and clinical needs of the patient. • Instructs the patient in the handling of soft and rigid lenses and how to wear and care for them. • Demonstrates the method of removal of a contact lens in an emergency.	
O3.5a (iv)	Accurately identifies patients' conditions and their potential need for medical referral in a timely way, including when urgent or emergency attention is required.	**Does**	• Investigates and interprets the results of history-taking and clinical findings (i.e., a recognition of abnormality and correct interpretation of common investigative tests) to formulate an appropriate management plan, recognising and acting when a referral is appropriate. • Recognises the clinical signs/presentation of common ocular abnormalities and appropriately advises and/or refers patients in line with local or national pathways. • Manages patients presenting with a range of posterior and/or anterior ocular conditions. • Recognises the clinical signs of sight- and life-threatening conditions that require immediate treatment and takes appropriate action. • Appraises the need for and urgency of making a patient referral, using relevant local protocols and national professional guidance, and acts accordingly. • Advises individual patients on the implications and care options arising from the detection of common ocular abnormalities, making referrals when in patients' best interests for their receipt of timely, efficacious care.	(4) (16)
O3.5a (v)	Recognises the use of common ophthalmic drugs, to safely facilitate optometric examination and the diagnosis/treatment of ocular disease.	**Does**	• Adheres to legal requirements for the use and supply of common ophthalmic drugs. • Appraises the appropriate use of common ophthalmic drugs used to aid refraction and treatment of ocular conditions and its compatibility with other treatments the patient is receiving.	(4) (17) (20)

			• Identifies adverse ocular reactions to medication and advises, manages, and refers in line with individual patients' needs. • Recognises the indications and contraindications of commonly used ophthalmic drugs and responds in light of these to uphold patient care and safety.	

Outcome 4. Ethics and Standards

Optical professionals must uphold high professional standards and ethics through honesty, integrity and lifelong development. They are responsible for ensuring the care and safety of patients and the public. Optical professionals must work within their scope of practice and current legislation (Opticians Act 1989 ('the Act'), GOC Standards of Practice for Optometrists and Dispensing Opticians) to ensure their own practice (including supervised and delegated activities) meets all legal and professional requirements and is equitable for all.

Outcome		Level	Indicator	References /resources
O4.1	Upholds the values and demonstrate the behaviours expected of a GOC registrant, as described in the GOC Standards of Practice for Optometrists and Dispensing Opticians.	**Does**	• Applies and embodies the relevant optical standards to their patient interactions, in clinical records, in the practice environment, with colleagues and their personal conduct.	(17) (21)
O4.2	Acts openly and honestly and in accordance with the GOC Duty of Candour guidelines.	**Does**	• Applies candour appropriately, and explains its relevance in creating trust between the public and the optical profession. • Differentiates between being candid and making a protected disclosure ('whistleblowing') to the GOC or other relevant regulatory bodies. • Identifies scenarios in practice where being candid is not beneficial to the patient or the public.	(17) (22)

O4.3	Understands and implements relevant safeguarding procedures, local and national guidance in relation to children, persons with disabilities, and other vulnerable people.	**Shows How**	• Identifies and applies, where necessary, national safeguarding protocols relating to healthcare professionals working in primary or secondary care.
			• Identifies and applies local protocols in place to support healthcare professionals in managing instances of safeguarding issues, such as:
			  ○ Local safeguarding team's role in providing advice, training opportunities, and their contact details to the local healthcare professionals
			  ○ Role of the 'designated' safeguarding doctor or nurse in the local area
			• Explains the common signs of maltreatment, abuse, and neglect of children and vulnerable adults.
			• Recognises their responsibilities in ensuring the non-registered staff in their practice understand their responsibilities in relation to safeguarding.
			• Demonstrates detailed knowledge of internal and external protocols regarding the recording and safe referral of safeguarding issues.
				(23) (24) (25) (26) (27) (28) (29) (30)

			• Demonstrates an understanding of the groups of people that are at a higher risk of experiencing safeguarding issues, including but not limited to: 'Looked after children', elder abuse, domestic abuse, adults with learning disabilities. • Explains the minimum requirements of an effective chaperone policy and its role in safeguarding children and vulnerable adults.	
O4.4	Applies the relevant national law and takes appropriate actions i) to gain consent and ii) if consent cannot be obtained or is withdrawn.	**Does**	• Evaluates the appropriateness of different types of consent to dispensing, delegated functions, triage and release of information. • Applies the principles of consent to practice and dispensing situations and evaluates situations when implied and implicit consent are required, including appropriate recording. • Establishes if a patient has the capacity to consent and if they are unable to consent, who is able to give consent on their behalf. • Recognises that lack of capacity to consent may be temporary or may be withdrawn, describe examples of these situations and the actions that should be taken. • Applies the current legislation on data protection, confidentiality, and consent with respect to sharing information with patient's relatives or carers. • Ability to explain clinical tests and referrals, together with the risk and benefits in a way the patient is able to understand in order to obtain informed consent. • Reflects on different situations from the student's own practice regarding consent.	(31) (32) (33)
O4.5	Recognises and works within the limits of own knowledge and skills. Seeks support and refers to others where appropriate.	**Does**	• Identifies situations where they cannot perform / complete desired technique and demonstrates appropriate action. • Demonstrates appropriate action in situations when unable to interpret results. • Shows evidence of appropriate referral to other professionals in a variety of situations. • Shows evidence of consulting other professionals in making decisions. • Identifies gaps in own knowledge and makes and appropriate management plan to address this.	(16) (15) (17)
O4.6	Understands the professional and legal responsibilities of trainee and student supervision and of being supervised.	**Knows How**	• Understands GOC Standards of Practice relating to supervision. • Understands guidance produced by other professional bodies (e.g. ABDO). • Identifies when direct supervision might be appropriate. • Understands how to ensure the level of supervision is appropriate for the colleague and the task and the level of experience.	(34) (35)
O4.7	Demonstrates the fulfilment of professional and legal responsibilities in supervising unregistered colleagues undertaking delegated activities.	**Does**	• Delegates appropriate activities to unregistered colleagues, applying relevant legislation, standards and guidance. • Monitors knowledge and skills of unregistered colleagues, including adequate training and assessment for regulated activities. • Demonstrates appropriate supervision of unregistered colleagues.	(16) (17) (21) (36) (37)

O4.8	Complies with health and safety legislation.	**Does**	• Applies current health and safety legislation and professional body guidance to their practice environment. • Demonstrates appropriate infection control procedures. • Considers both personal and environmental hygiene when dealing with patients and colleagues.	(38) (39)
O4.9	Complies with equality and human rights legislation, demonstrates inclusion and respects diversity.	**Does**	• Acts in line with equality and human rights legislation in the context of patient care and the workplace. • Demonstrates compassionate and professional behaviour, delivers patient centred care and an inclusive and fair approach towards patients and colleagues. • Recognises the potential impact of their own attitudes, values, beliefs, perceptions and bias (conscious and unconscious) on individuals and groups and identifies personal strategies to mitigate this. • Appreciates the importance of handling sensitive personal information and responding to any information divulged by the patient in a sensitive and unbiased fashion. Maintains confidentiality and respects an individual's dignity. • Gives consideration to any equality, diversity and fairness issues from the outset when assessing a patient, particularly for groups of people who share protected characteristics.	(40) (41) (42)
O4.10	Understands the patient or carer's right to complain without prejudicing the standard of care provided.	**Knows**	• Describes why and how to act in the best interests of patients, without bias, if the patient has made a complaint. • Relates the relevant GOC Standard of Practice (18) the practitioner's duty to: respect the rights of the patient, provide or comply with an employer's complaints process and respond appropriately to complaints. • Explains clearly to a patient how to complain and informs them of the routes available.	(17) (43) (44) (45) (46) (47)
O4.11	Adheres to the ethical principles for prescribing and to legislation relating to medicines management.	**Shows How**	• Applies the regulations regarding the use, storage, and disposal of ophthalmic drugs used in ophthalmic practice. • Respects the limitations in prescribing and treating yourself and others close to you. • Shows how to report incidents of adverse reactions to medical devices or medicines using the appropriate reporting schemes. • Maintains appropriate knowledge regarding the drugs administered in the practice, especially contraindications and side effects, and understands how to access the relevant information relating to the medicines used. • Explains the requirement to register with the MHRA under specific circumstances (e.g. the assembly of spectacles), and identify the products regulated as class 1 medical devices. • Takes appropriate measures when delegating the instillation of ophthalmic drugs.	(48) (49) (50) (51) (52) (53) (54)
O4.12	Complies with legal, professional and ethical requirements for the management of	**Does**	• Keeps clear, accurate, and contemporaneous records, understanding the GOC's and professional bodies' advice and guidance in relation to record keeping.	(55) (56) (57) (58)

	information in all forms including the accuracy and appropriateness of patient records and respecting patient confidentiality.		• Produces records which are accessible, and contain all relevant patient details and history, measurements and details of assessment findings, consent obtained, referrals made, and advice. • Ensures that records contain the name of any staff undertaking delegated tasks/functions. • Demonstrates a systematic understanding of the principles of data protection and freedom of information legislation in relation to the use and disclosure of health data. • Grants, where appropriate, a patient's Right to Access their health data, and demonstrates a detailed knowledge of the Subject Access Request (SAR) protocols relevant to ophthalmic practice.	(59) (60) (61) (62)
O4.13	Manages situations under which patient confidentiality may be breached in order to protect a patient or the public, in line with relevant guidance on disclosing confidential information and/or with the patient's consent.	**Shows How**	• Demonstrates a detailed understanding of the GOCs disclosing confidential information guidance, including when to make disclosures in the public interest and complying with external investigations. • Explains responsibilities to the patient when making a disclosure without their consent. • Gives examples of circumstances where it may be necessary to share information without consent.	(63) (56)
O4.14	Applies eye health policies and guidance and utilises resources efficiently to improve patient outcomes.	**Does**	• Demonstrates a working knowledge of shared care schemes, glaucoma triage, pre and -post-cataract referral schemes and other locally-commissioned Enhanced Optical Services (EOS). • Refers patients appropriately to optometry-led triage services or secondary care where appropriate to improve patient care and outcomes, whilst reducing unnecessary delays. • Navigates service commissioning and care information effectively, in order to establish and refresh knowledge of local health systems when changing location, and over time. • Accesses public health information and campaigns (e.g. smoking cessation) for the benefit of patients. • Takes account of national guidance e.g. NICE, ABDO guidance. • Appropriately distinguishes between patients who require referral to secondary care and those who can be referred to an optometrist.	(9) (64) (65) (66)
O4.15	Maintains professional boundaries with patients and others, taking into consideration the additional needs of vulnerable people and specific requests/requirements.	**Does**	• Recognises the boundaries between patient and clinician, both within and outside the workplace. • Communicates appropriately with and respects the needs of vulnerable people and those with specific requests/requirements. • Demonstrates interpersonal behaviours showing sensitivity to a range of physical, emotional, and protected characteristics in individuals. • Maintains acceptable professional boundaries within the testing room and during an eye examination. • Where appropriate, uses chaperones and adopts professional boundaries with children and vulnerable adults.	(67) (68) (69) (70)

			• Maintains a professional distance between the practitioner and the patient, understanding that using social media can blur personal and professional boundaries	
O4.16	Understands the role of carers and the power of attorney.	**Knows How**	• Recognises the reasons why a patient may not have mental capacity and require a power of attorney. • Knows the different types of power of attorney and when they might be given.	(71) (72)
O4.17	Complies with legislation and rules concerning the sale and supply of optical appliances.	**Does**	• Applies the legislation and professional body guidance surrounding sale and supply of spectacles and of powered and zero powered contact lenses. • Applies the legislation and optical body guidance surrounding sale and supply of low vision aids.	(16) (73) (74) (75)
O4.18	Provides clarity on services available and any associated payments	**Does**	• Makes patients aware of costs of goods and professional services before they commit to payment. • Itemises costs of eye care and ophthalmic devices. • Makes information available to patients in a format they can understand, taking into account any disabilities. • Works within relevant consumer legislation. • Signposts patients to alternative goods or services, should they decline a recommendation. • Differentiates between sight testing as defined in the Opticians' Act and additional optional services. • Provides clarity to patients about NHS funded services available within an area.	(76) (77)

Outcome 5. Risk

Optical professionals have a responsibility to protect and safeguard patients, colleagues and others from harm (Standard 11). Optical professionals must understand and work within the limits of their competence recognising the evolving nature of personal practice (Standard 6). They should be able to identify when people might be at risk and be candid when things have gone wrong to ensure a safe environment for patients and the public (Standards 12, 16 and 19).

Outcome		Level	Indicator	References /resources
O5.1	Recognises when their own performance or the performance of others is putting people at risk and takes prompt and appropriate action.	**Does**	• Recognises conditions that could affect the ability to practise safely, including alcohol dependence, drug abuse, mental health issues and other medical conditions and how these conditions can affect safe practice. • Applies, where appropriate, the principles and procedures of whistleblowing when a colleague may be putting patients at risk, recognising the correct authority to approach. • Undertakes further training, develops existing skills and acquires new competences that will enable safe practice in the future in line with new techniques and technologies. • Identifies and addresses own major learning needs using regular reflection of own practice.	(30) (68) (78)

O5.2	Knows how to manage complaints, incidents or errors in an effective manner.	**Knows How**	• Identifies professional obligations, including duty of candour, when a patient complains. • Recognises what constitutes an incident or error in practice. • Explains the respective roles of the business, the OCCS, the GOC and the NHS as channels for complaints. • Recognises when they would need to report a complaint/ incident to an external body, e.g. ICO, MHRA, NHS. • Gives examples of strategies to manage complaints in practice.	(47) (30) (79) (80) (22) (81)
O5.3	Address any health and safety concerns about the working environment that may put themselves, patients or others at risk.	**Knows How**	• Identifies their role and responsibilities relating to health and safety at work as an employee or employer. • Recognises situations that might constitute a concern over health and safety. • Explains how to escalate health and safety concerns relating to their environment. • Recognises when a protected disclosure (whistleblowing) is appropriate.	(21) (30) (38) (82)
O5.4	Applies due process for raising and escalating concerns, including speaking-up and protected disclosure if all other routes have been pursued and there is reason to believe that patients or the public are at risk.	**Knows How**	• Recognises their professional duty to raise concerns. • Explains the GOC Whistleblowing Policy and how to operate within its principles. • Explains the GOC Fitness to Practice Procedure. • Explains 'protected disclosures' as laid out in the Employment Rights Act. • Recognises the importance of acting with clarity, honesty and objectivity and keeping record of any steps taken when raising concerns or dealing with those made against them. • Recognises circumstances in which practice falls below the level expected by a competent optometrist or dispensing optician and can identify situations where patient safety, dignity, or comfort may be compromised. • Uses their judgement in identifying where premises, equipment, resources, policies or systems may be unfit for purpose. • Recognises that errors and near-misses should be shared openly and be able to learn from their own and others' errors to promote a culture of safety. • Assesses the appropriate promptness by which a concern should be addressed/escalated depending on severity and risk. • Differentiates between the official and non-official channels by which a concern can be raised and identifies the appropriate channel depending on severity and risk. • Identifies where to access independent help, support or advice when raising a concern or dealing with a concern raised against them.	(30) (22) (79) (83)

O5.5	Applies infection prevention control measures commensurate with the risks identified.	**Does**	• Safely applies appropriate measures to minimise risk of infection, applying relevant current guidance. • Identifies risk of person-to-person transmission and transmission via object. • Identifies appropriate measures to minimise risk of infection, including: hand hygiene, surface disinfection, use of PPE, use of disposable items, (e.g. tonometer heads), where possible, decontamination of tonometer heads/diagnostic contact lenses etc., proper treatment of open bottles of contact lens solutions/saline. • Uses appropriate methods to deal with disposal of controlled, clinical and offensive waste, including both non-hazardous and hazardous waste. • Carries out a risk assessment, applying appropriate principles.	(84) (85) (86) (87) (88)
O5.6	Understands the importance of maintaining their own health to remain healthy and professionally effective.	**Knows How**	• Recognises the importance of wellbeing and how to seek help when the need arises, drawing from the relevant professional resources. • Recognises conditions that could affect their own ability to practice safely, including alcohol dependence, drug abuse, mental health issues and other medical conditions. • Recognises signs and symptoms of these conditions and explains how to act and when to inform the GOC.	(4) (16) (17) (89) (90)
O5.7	Able to risk assess i) patient's clinical condition and ii) a situation in clinical practice and make appropriate clinical decisions.	**Does**	• Uses knowledge of the subject and techniques in a routine manner to evaluate and formulate management plans and solutions to problems encountered in practice. • Applies underlying concepts and principles outside the context in which they were first studied. • Applies strategies of clinical decision-making skills within ophthalmic dispensing practice. • Applies the principles of clinical reasoning and evidence-based practice and the steps in problem solving. • Effectively triages patients presenting with ocular conditions.	(91)

Outcome 6. Leadership and Management

Optical professionals must understand the importance of clinical leadership, as determined by their scope of practice, and be able to work within their area of expertise and competence to achieve desired patient outcomes (Standards 1, 6, 11 and 12). Working collaboratively within healthcare teams and with other professionals, optical professionals should promote and engage with clinical governance requirements, service improvements and local and national public health initiatives (Standard 10).

Outcome		Level	Indicator	References /resources
O6.1	Undertakes efficient, safe and effective patient and caseload management.	**Does**	• Recognises when services/teams are under pressure and acts in a responsible and considered way to ensure safe practice. • Recognises stress in self and others.	(92)

			• Demonstrates ability to work with team members to manage the needs of various stakeholders, whilst keeping patient care at the forefront.	
O6.2	Works collaboratively within healthcare teams, exercising skills and behaviours of clinical leadership and effective team-working and management in line with their role and scope of practice.	**Shows How**	• Respects the duties of other members of the practice team and understands how working together provides the best possible care for the patient. • Is familiar with local and national shared care initiatives, as well as the roles that practice employees play in these initiatives. • Interacts with colleagues and patients in a manner which is: compassionate, empathetic, supportive, fair, and respectful. • Acts within the Clinical leadership competency framework.	(78) (93) (94) (95) (96)
O6.3	Engages with clinical governance requirements to safeguard and improve the quality of patient care, including through contributing to service evaluation and development initiatives.	**Knows How**	• Demonstrates a systematic understanding of the legislation for the safeguarding of children and vulnerable adults. • Recognises where an individual may require protection and knows how to take action using appropriate local measures to secure the individual's safety. • Is able to articulate an understanding of the principles of data protection and freedom of information legislation in relation to the use and disclosure of health data. • Demonstrates awareness of appropriate circumstances for disclosure of patient information in protecting the individual and society.	(25) (97) (98)
O6.4	Recognises and manages adverse situations, understanding when to seek support and advice to uphold patients' and others' safety.	**Knows How**	• Demonstrates a systematic understanding of the legislation for the safeguarding of children and vulnerable adults. • Recognises where an individual may require protection and knows how to take action using appropriate local measures to secure the individual's safety. • Demonstrates awareness of appropriate circumstances for disclosure of patient information in protecting the individual and society. • Demonstrates an understanding of whistleblowing policies and procedures.	(99) (100)
O6.5	Takes appropriate action in an emergency, providing care and clinical leadership within personal scope of practice and referring or signposting patients as needed, to ensure their safe and timely care.	**Does**	• Aware of the appropriate referral pathways aligned to scope of practice. • Manages patients with signs and/or symptoms of a health emergency.	(101) (102) (103)
O6.6	Engages with population and public health initiatives and understands how population data should inform practice and service delivery.	**Knows How**	• Has a skill set specific to using data for improvement of health care processes and systems. • Ability to understand and critically appraise epidemiological research particularly with regards to eye health. • Awareness of epidemiology of common eye conditions and systemic conditions, which manifest in the eye. • Awareness of current CCG activity and public heath eye care initiatives within the UK.	(104) (105)

			• Ability to critically reflect on current service delivery models' impact on public health problems, which relate to eye care. • Ability to utilize knowledge above to inform their practice.	

Outcome 7. Lifelong Learning

Continuing professional development and keeping knowledge and skills up to date is the personal responsibility of all optical professionals working within their scope of practice (Standard 5). Their own performance and that of others must be evaluated by an ongoing process of reflection to inform own learning and development needs, meet service delivery requirements and improve the quality of care for patients (Standard 10). Sources of information could include clinical audit, patient feedback and peer review (Standard 6).

Outcome		Level	Indicator	References /resources
O7.1	Evaluates, identifies, and meets own learning and development needs.	**Does**	• Demonstrates understanding of GOC CPD requirements for registrants. • Demonstrates reflective practitioner status	
O7.2	Supports the learning and development of others, including through acting as a role model and mentor.	**Shows How**	• Acts as a role model, educator, supervisor and mentor, seeking to share best practice, knowledge and skills with other members of the team.	(106)
O7.3	Gathers, evaluates and applies effective patient and service delivery feedback to improve their practice.	**Shows How**	• Demonstrates skills of active listening, empathy, and patient centred care. • Ability to take on board patient feedback and act in a professional manner to optimize patient care. • Demonstrates the ability to adopt a growth mind-set in the face of challenges in order to enhance quality of care.	(107)
O7.4	Engages in critical reflection on their own development, with a focus on learning from experience, using data from a range of information sources (such as clinical audits, patient feedback, peer review and significant event analysis) and identifying and addressing their new learning needs to improve the quality and outcomes of patient care.	**Does**	• Demonstrates the ability to critically reflect- learning from previous shortcomings and utilizing best practice literature to inform future practice. • Creates a yearly personal development plan- identifying and incorporating relevant CPD to fill knowledge gaps and build on areas of interest.	(108)

Outcomes for Registration – Optometry

Outcome 1. Person Centred Care

Patient well-being/care is an optical professional's primary concern and must be at the heart of all decisions made about patient care (Standard 1). Optical professionals must be able to employ an adaptive and personalised approach to patient care, considering the patient's social, clinical, personal, and cultural needs whilst challenging their own conscious and unconscious bias (Standards 4 and 13). Where care requires the involvement of other professionals, they must be able to collaborate effectively (Standards 3, 6, 7, 10, 11 and 14).

Outcome		Level	Indicator	References /resources
O1.1	Actively listens to patients and their carers to ensure patients are involved in and are at the heart of decisions made about patients' care.	**Does**	• Effectively communicates with patients and carers to obtain all relevant history and symptoms using a combination of verbal, non-verbal, and written skills. • Actively seeks confirmation of patient understanding and involves patient in decisions made regarding their own healthcare.	(1) (2) (3) (16) (17) (21)
O1.2	Manages desired health outcomes of patients, taking into consideration any relevant medical, family, and social history of the patient, which may include personal beliefs or cultural factors.	**Does**	• Recognises the importance and significance of family history, signs, and symptoms. • Recognises patients' physical, emotional, intellectual, and cultural background and adapts care and communication appropriately. • Adheres to relevant aspects of the Equalities Act.	
O1.3	Protects patients' rights; respects the choices they make and their right to dignity and privacy	**Does**	• Follows relevant frameworks (see references).	
O1.4	Ensures high quality care is delivered and puts into place adaptive measures as needed for different environments (such as domiciliary, prisons and special schools).	**Shows How**	• Adapts own practise to ensure appropriate care of all patients. • Recognises when environmental factors should be adapted to accommodate individual patient needs.	
O1.5	Commits to care that is not compromised because of own personal conscious and unconscious values and beliefs.	**Does**	• Develops an awareness of differing values and belief structures and seeks to care inclusively, with attention to the potential impact of own beliefs on patient care.	
O1.6	Obtains and verifies continuation of valid consent from adults, children, young and vulnerable people, and their carers and records as appropriate.	**Does**	• Adheres to legal requirements when gaining consent. • Applies the various policies that a practice is required to have on display or on file including safeguarding children and adults, chaperone policy, complaints and data management .	
O1.7	Demonstrates effective clinical decision-making, diagnosis, evaluation and makes appropriate and timely referral, where this is needed to meet a patient's needs.	**Does**	• Demonstrates an awareness of referral pathways and can accurately refer when appropriate. • Recognises their scope of practice and the role of referral in effective person-centred care. • Designs and implements an appropriate management plan, in line with individual patients' clinical needs and preferences.	

O1.8	Refers and signposts as necessary to sight loss and other relevant health services.	**Does**	• Advises on accessing and makes appropriate referrals to low-vision services, in line with patients' best interests. • Is able to direct to relevant health and social care services for patients at risk. •	

Outcome 2. Communication

Communication is key to effective patient and public interactions (Standard 2). Optical professionals must be able to communicate effectively with patients and other professionals. Optical professionals must be able to adapt their approach and style according to specific individual needs and in a manner that is supportive of achieving desired outcomes (Standards 1, 10 and 13). This includes written and verbal communication, as well as recognising non-verbal cues (Standards 3, 4, 11, 12 and 13).

Outcome		Level	Indicator	References /resources
O2.1	Conducts communications in a sensitive and supportive manner adapting their communication approach and style to meet the needs of patients, carers, health and care colleagues and the public	**Does**	• Demonstrates effective communication using verbal, non-verbal, and written skills. • Seeks and communicates relevant information from and to patients in an effective and appropriate manner. • Ensures the effective implementation of individual management plans, checking patient understanding by actively adapting their communication approach.	
O2.2	Acts upon non-verbal cues from patients or carers that could indicate discomfort, a lack of understanding or an inability to give informed consent.	**Knows How**	• Identifies patients who have poor or non-verbal communication skills or those who are confused, reticent or who might be misled. • Adapts communication to ensure those patients are managed appropriately. • Ensures appropriate consent and assent has been obtained from relevant carers and patients, in instances where the patient has limited ability to engage fully.	
O2.3	Communicates effectively within a multi-disciplinary healthcare team and works collaboratively for the benefit of the patient.	**Does**	• Recognises the diverse contributions of both clinical and non-clinical colleagues including those from other professions, and adapts own communication methods, style and content to ensure the delivery of effective patient care. • Recognises the varying roles of other allied health and medical professionals and their contribution to person centred care.	
O2.4	Critically reflects on how they communicate with a range of people and uses this reflection to improve interactions with others.	**Does**	• Demonstrates how to deal effectively with patient concerns. • Discusses how to deal with a patient who needs information about disease and its ocular impact, its treatment, and the possible ocular side effects of medication. • Recognises and manages patient's expectations and aspirations, and situations where these cannot be met. • Can identify instances of miscommunication and how this could be avoided/identifies areas of improvement in their own interactions.	

Outcome 3. Clinical Care

Optical professionals are professionally accountable and personally responsible for achieving desired patient outcomes according to their individual scope of practice. Working within their limits of competence (Standard 6), and exercising professional judgement, they must engage in evidence-informed clinical decision-making for all patients (Standards 5, 7 and 8).

Outcome		Level	Indicator	References/ resources
O3.1	Undertakes safe and appropriate ocular examinations using appropriate techniques and procedures to inform clinical decision-making within individual scope of practice.	**Does**	• Justifies the choice of clinical procedures used on appropriate techniques for clinical investigations. • Has an awareness of own limitations to conduct clinical examinations, and work within limits of competence. • Appraises the risk balance of clinical techniques used to examine patients. • Ensures patient and practitioner safety during all clinical processes and procedures.	(6) (7) (8) (9) (10)
O3.2	Engages with developments in research, including the critical appraisal of relevant and up-to-date evidence to inform clinical decision-making and improve quality of care.	**Does**	• Uses a range of research sources to influence their practice. • Demonstrates information literacy. • Appraises the quality of evidence. • Synthesises research evidence to inform clinical management of patients. • Able to effectively communicate pertinent research evidence to peers and patients to justify clinical decisions.	(7) (8) (9) (11) (109)
O3.3	Engages with technological advances in eye health and broader healthcare delivery and the significance of specific developments for enhancing patient outcomes and service delivery.	**Does**	• Uses new technologies in diagnosis, treatment and management of ocular conditions. • Uses appropriate technology in consultation, referral and clinical data exchange. • Keeps abreast of emerging technologies and their potential application in clinical practice.	(12) (13)
O3.4	Analyses visual function from a range of diagnostic sources and uses data to devise a clinical management plan for a patient in areas that include the following: • Dispensing of optical appliances • Low vision/visual impairment • Refractive management • Anterior eye and contact lenses • Ocular and systemic disease • Binocular vision • Paediatrics • Patients with learning disabilities and complex needs	**Does**	• Applies normative data in the interpretation of results of visual function tests. • Uses clinical data to formulate a management plan across a range of ocular conditions. • Analyses clinical data in the light of presenting signs and symptoms. • Demonstrates effective management across the specified range of patients.	(6) (8)

	• Occupational optometry			
O3.5 Meets the following clinical practice outcomes for registration as an optometrist:				
O3.5b (i)	Acts as a first point of contact for patients for their eye health needs by investigating, diagnosing and managing individuals' functional and developmental visual conditions, including those related to age.	**Does**	• Takes a relevant history from individual patients and any other appropriate person involved in their care (relatives/carers and others). • Interprets the results of history-taking and the examination of the refractive and ocular motor status and ocular health of individual patients to inform clinical decision-making and care management plans. • Records all aspects of the consultation, the findings of all tests and relevant communications with patients, their carers and colleagues, ensuring that records are accurate, legible, dated, signed, concise, contemporaneous and securely stored. • Accepts responsibility and accountability for professional decisions and actions as a first point of contact, including in responding to individual patients' needs, managing risk, and making appropriate referrals.	
O3.5b (ii)	Completes an informed clinical assessment of individual patients' needs and uses this to dispense, fit and advise on the safe and effective use of spectacles, contact lenses, low-vision aids and other ophthalmic appliances.	**Does**	• Interprets and dispenses a prescription using appropriate lenses, frame choice and accurate facial and frame measurements. • Measures and verifies optical appliances in line with relevant standards, guidelines and evidence. • Prescribes, advises and dispenses appropriate vocational and special optical appliances, in accordance with personal eye protection regulations and relevant standards. • Manages and dispenses appropriate spectacles for paediatric patients and for patients with complex or additional needs, including by adapting the practice environment and practice activity in line with individuals' needs. • Manages cases of non-tolerance. • Assesses patients whose vision is not meeting their needs, including full history-taking and evaluation of visual requirements. • Identifies and advises patients who could benefit from simple or complex low-vision aids. • Evaluates the clinical findings of low-vision assessments, applying knowledge of low-vision optics to dispense appropriate simple and complex low-vision aids and provide relevant advice. • Advises on accessing and makes appropriate referrals to low-vision services, in line with patients' best interests. • Identifies, recommends and fits soft and rigid contact lenses to support and enhance individual patients' lifestyle and eye health and provides ongoing care. • Instructs and advises patients in soft and rigid lens handling and how to wear and care for lenses.	
O3.5b (iii)	Makes informed decisions on the treatment and management of ocular abnormalities and disease.	**Does**	• Investigates and interprets individual patients' presenting symptoms and risk factors and identifies the clinical signs of potential abnormality and disease. • Selects and deploys appropriate methods of clinical examination.	

			• Analyses the results of an examination to make a differential diagnosis. • Advises individual patients on the implications and care options arising from the detection of common ocular abnormalities and disease, making referrals in line with local or national pathways, when in patients' best interests for their receipt of timely, efficacious care. • Designs and implements an appropriate management plan arising from a clinical examination and differential diagnosis, in line with individual patients' clinical needs and preferences. • Assesses and evaluates signs and symptoms of neurological significance. • Manages patients presenting with a range of posterior and/or anterior ocular conditions. • Detects the ocular manifestations of systemic disease and advises and refers in line with individual patients' needs. • Treats a range of common ocular conditions.	
O3.5b (iv)	Accurately identifies patients' conditions and their potential need for medical referral in a timely way, including when urgent or emergency attention is required.	**Does**	• Interprets the results of history-taking and clinical findings (i.e., a recognition of abnormality and correct interpretation of common investigative tests) to formulate an appropriate management plan, recognising and acting when a referral is appropriate. • Identifies the signs of disease progression or change in individual patients' clinical status and adapts and advises on their management plan in line with this. • Appraises the need for and urgency of making a patient referral, using relevant local protocols and national professional guidance, and acts accordingly. • Recognises the clinical signs of sight- and life-threatening conditions that require immediate treatment and takes appropriate action. • Detects adverse ocular reactions to medication and advises, manages and refers in line with individual patients' needs.	
O3.5b (v)	Uses common ophthalmic drugs safely to facilitate optometric examination and the diagnosis/treatment of ocular disease.	**Does**	• Adheres to legal requirements for the use and supply of common ophthalmic drugs. • Appraises the appropriate use of common ocular drugs to aid refraction and assessment of the fundus. • Obtains individual patients' informed consent to use common ophthalmic drugs to aid investigation, examination, diagnosis and treatment, including by advising on the potential side effects and associated risks of specific drugs. • Administers common ocular drugs appropriately, effectively and judiciously, exercising caution to avoid errors assure patient safety. • Appraises whether to check the depth of the anterior chamber and measure intra-ocular pressures when administering drugs that dilate the pupil. • Recognises the indications and contraindications of commonly used ophthalmic drugs and responds in light of these to uphold patient care and safety.	

Outcome 4. Ethics and Standards

Optical professionals must uphold high professional standards and ethics through honesty, integrity and lifelong development. They are responsible for ensuring the care and safety of patients and the public. Optical professionals must work within their scope of practice and current legislation (Opticians Act 1989 ('the Act'), GOC Standards of Practice for Optometrists and Dispensing Opticians) to ensure their own practice (including supervised and delegated activities) meets all legal and professional requirements and is equitable for all.

Outcome		Level	Indicator	References /resources
O4.1	Upholds the values and demonstrate the behaviours expected of a GOC registrant, as described in the GOC Standards of Practice for Optometrists and Dispensing Opticians.	**Does**	• Applies and embodies the relevant optical standards to their patient interactions, in clinical records, in the practice environment, with colleagues and their personal conduct.	(17) (21)
O4.2	Acts openly and honestly and in accordance with the GOC Duty of Candour guidelines.	**Does**	• Applies candour appropriately, and explains its relevance in creating trust between the public and the optical profession. • Differentiates between being candid and making a protected disclosure ('whistleblowing') to the GOC or other relevant regulatory bodies. • Identifies scenarios in practice where being candid is not beneficial to the patient or the public.	(17) (22) (110) (111)
O4.3	Understands and implements relevant safeguarding procedures, local and national guidance in relation to children, persons with disabilities, and other vulnerable people.	**Shows How**	• Identifies and applies, where necessary, national safeguarding protocols relating to healthcare professionals working in primary or secondary care. • Identifies and applies local protocols in place to support healthcare professionals in managing instances of safeguarding issues, such as: ○ Local safeguarding team's role in providing advice, training opportunities, and their contact details to the local healthcare professionals ○ Role of the 'designated' safeguarding doctor or nurse in the local area. • Explains the common signs of maltreatment, abuse, and neglect of children and vulnerable adults. • Recognises their responsibilities in ensuring the non-registered staff in their practice understand their responsibilities in relation to safeguarding. • Demonstrates detailed knowledge of internal and external protocols regarding the recording and safe referral of safeguarding issues. • Demonstrates an understanding of the groups of people that are at a higher risk of experiencing safeguarding issues, including but not limited to: 'Looked after children', elder abuse, domestic abuse, adults with learning disabilities. • Explains the minimum requirements of an effective chaperone policy and its role in safeguarding children and vulnerable adults.	(23) (24) (26) (27) (28) (29) (30) (54) (112) (113) (114)

O4.4	Applies the relevant national law and takes appropriate actions i) to gain consent and ii) if consent cannot be obtained or is withdrawn.	**Does**	• Evaluates the appropriateness of different types of consent to clinical tests, dispensing, delegated functions, triage and release of information. • Applies the principles of consent to clinical situations and evaluates situations when implied and implicit consent are required, including appropriate recording. • Establishes if a patient has the capacity to consent and if they are unable to consent, who is able to give consent on their behalf. • Recognises that lack of capacity to consent may be temporary or may be withdrawn, describe examples of these situations and the actions that should be taken. • Applies the current legislation on data protection, confidentiality, and consent with respect to sharing information with patient's relatives or carers. • Is able to explain clinical tests and referrals, together with the risk and benefits in a way the patient is able to understand in order to obtain informed consent. • Reflects on different situations from the student's own practice regarding consent.	(31) (32) (91) (115)
O4.5	Recognises and works within the limits of own knowledge and skills. Seeks support and refers to others where appropriate.	**Does**	• Identifies clinical situations where they cannot perform / complete desired technique and demonstrates appropriate action. • Demonstrates appropriate action in situations when unable to interpret results. • Shows evidence of appropriate referral to other professionals in a variety of situations. • Shows evidence of consulting other professionals in making decisions. • Identifies gaps in own knowledge and makes an appropriate management plan to address this.	(16) (21) (116)
O4.6	Understands the professional and legal responsibilities of trainee and student supervision and of being supervised.	**Knows How**	• Understands GOC Standards of Practice relating to supervision. • Understands guidance produced by other professional bodies (e.g. College, AOP). • Identifies when direct supervision might be appropriate. • Understands how to ensure the level of supervision is appropriate for the colleague and the task and the level of experience.	(21) (117)
O4.7	Demonstrates the fulfilment of professional and legal responsibilities in supervising unregistered colleagues undertaking delegated activities.	**Does**	• Delegates appropriate activities to unregistered colleagues, applying relevant legislation, standards and guidance. • Monitors knowledge and skills of unregistered colleagues, including adequate training and assessment for regulated activities. • Demonstrates appropriate supervision of unregistered colleagues.	(16) (21) (37) (117)
O4.8	Complies with health and safety legislation.	**Does**	• Applies current health and safety legislation and professional body guidance to their practice environment. • Demonstrates appropriate infection control procedures. • Considers both personal and environmental hygiene when dealing with patients and colleagues.	(38) (87) (118)

O4.9	Complies with equality and human rights legislation, demonstrates inclusion and respects diversity.	**Does**	• Acts in line with equality and human rights legislation in the context of patient care and the workplace. • Demonstrates compassionate and professional behaviour, delivers patient centred care and an inclusive and fair approach towards patients and colleagues. • Recognises the potential impact of their own attitudes, values, beliefs, perceptions and bias (conscious and unconscious) on individuals and groups and identifies personal strategies to mitigate this. • Appreciates the importance of handling sensitive personal information and responding to any information divulged by the patient in a sensitive and unbiased fashion. Maintains confidentiality and respects an individual's dignity. • Gives consideration to any equality, diversity and fairness issues from the outset when assessing a patient, particularly for groups of people who share protected characteristics.	(40) (41) (119) (120)
O4.10	Understands the patient or carer's right to complain without prejudicing the standard of care provided.	**Knows**	• Describes why and how to act in the best interests of patients, without bias, if the patient has made a complaint. • Relates the relevant GOC Standard of Practice (18) the practitioner's duty to: respect the rights of the patient, provide or comply with an employer's complaints process and respond appropriately to complaints. • Explains clearly to a patient how to complain and informs them of the routes available.	(17) (121)
O4.11	Adheres to the ethical principles for prescribing and to legislation relating to medicines management.	**Shows How**	• Applies the regulations regarding the use, storage, and disposal of ophthalmic drugs used in ophthalmic practice. • Respects the limitations in prescribing and treating yourself and others close to you. • Shows how to report incidents of adverse reactions to medical devices or medicines using the appropriate reporting schemes. • Maintains appropriate knowledge regarding the drugs administered in the practice, especially contraindications and side effects, and understands how to access the relevant information relating to the medicines used. • Explains the requirement to register with the MHRA under specific circumstances, and identify the products regulated as class 1 medical devices. • Takes appropriate measures when delegating the instillation of ophthalmic drugs.	(48) (49) (50) (51) (53) (122) (123) (124) (125)
O4.12	Complies with legal, professional and ethical requirements for the management of information in all forms including the accuracy and appropriateness of patient records and respecting patient confidentiality.	**Does**	• Keeps clear, accurate, and contemporaneous records, understanding the GOC's and professional bodies' advice and guidance in relation to record keeping. • Produces records which are accessible, and contain all relevant patient details and history, measurements and details of assessment findings, consent obtained, referrals made, and advice. • Ensures that records contain the name of any staff undertaking delegated tasks/functions.	(55) (57) (58) (59) (60) (61) (62) (126)

			• Demonstrates a systematic understanding of the principles of data protection and freedom of information legislation in relation to the use and disclosure of health data. • Grants, where appropriate, a patient's Right to Access their health data, and demonstrates a detailed knowledge of the Subject Access Request (SAR) protocols relevant to ophthalmic practice.	
O4.13	Manages situations under which patient confidentiality may be breached in order to protect a patient or the public, in line with relevant guidance on disclosing confidential information and/or with the patient's consent.	**Shows How**	• Demonstrates a detailed understanding of the GOCs disclosing confidential information guidance, including when to make disclosures in the public interest and complying with external investigations. • Explains responsibilities to the patient when making a disclosure without their consent • Gives examples of circumstances where it may be necessary to share information without consent.	(56) (63)
O4.14	Applies eye health policies and guidance and utilises resources efficiently to improve patient outcomes.	**Does**	• Demonstrates a working knowledge of shared care schemes, glaucoma triage, pre and -post-cataract referral schemes and other locally-commissioned Enhanced Optical Services (EOS). • Refers patients appropriately to optometry-led triage services or secondary care to improve patient care and outcomes, whilst reducing unnecessary delays. • Navigates service commissioning and care information effectively, in order to establish and refresh knowledge of local health and other relevant systems when changing location, and over time. • Accesses public health information and campaigns (e.g. smoking cessation) for the benefit of patients. • Takes account of national guidance e.g. NICE, the College of Optometrists Clinical Management Guidance. • Appropriately distinguishes between patients who require referral and those who can be monitored effectively in practice.	(7) (9) (66) (127) (128)
O4.15	Maintains professional boundaries with patients and others, taking into consideration the additional needs of vulnerable people and specific requests/requirements.	**Does**	• Recognises the boundaries between patient and clinician, both within and outside the workplace. • Communicates appropriately with and respects the needs of vulnerable people and those with specific requests/requirements. • Demonstrates interpersonal behaviours showing sensitivity to a range of physical, emotional, and protected characteristics in individuals. • Maintains acceptable professional boundaries within the testing room and during an eye examination. • Where appropriate, uses chaperones and adopts professional boundaries with children and vulnerable adults. • Maintains a professional distance between the practitioner and the patient, understanding that using social media can blur personal and professional boundaries.	(67) (68) (69) (70)

O4.16	Understands the role of carers and the power of attorney.	**Knows How**	• Recognises the reasons why a patient may not have mental capacity and require a power of attorney. • Knows the different types of power of attorney and when they might be given.	(71) (72) (129) (130) (131)
O4.17	Complies with legislation and rules concerning the sale and supply of optical appliances.	**Does**	• Applies the legislation and professional body guidance surrounding sale and supply of spectacles and of powered and zero powered contact lenses. • Applies the legislation and optical body guidance surrounding sale and supply of low vision aids	(16) (73) (74) (75)
O4.18	Provides clarity on services available and any associated payments	**Does**	• Makes patients aware of costs of goods and professional services before they commit to payment. • Itemises costs of eye care and ophthalmic devices. • Makes information available to patients in a format they can understand, taking into account any disabilities. • Works within relevant consumer legislation. • Signposts patients to alternative goods or services, should they decline a recommendation. • Differentiates between sight testing as defined in the Opticians' Act and additional optional services. • Provides clarity to patients about NHS funded services available within an area.	(76) (77) (132) (133)

Outcome 5. Risk

Optical professionals have a responsibility to protect and safeguard patients, colleagues and others from harm (Standard 11). Optical professionals must understand and work within the limits of their competence recognising the evolving nature of personal practice (Standard 6). They should be able to identify when people might be at risk and be candid when things have gone wrong to ensure a safe environment for patients and the public (Standards 12, 16 and 19).

Outcome		Level	Indicator	References /resources
O5.1	Recognises when their own performance or the performance of others is putting people at risk and takes prompt and appropriate action.	**Does**	• Recognises conditions that could affect the ability to practise safely, including alcohol dependence, drug abuse, mental health issues and other medical conditions and how these conditions can affect safe practice. • Applies, where appropriate, the principles and procedures of whistleblowing when a colleague may be putting patients at risk, recognising the correct authority to approach. • Undertakes further training, develops existing skills and acquires new competences that will enable safe practice in the future in line with new techniques and technologies. • Identifies and addresses own major learning needs using regular reflection of own practice.	(16) (17) (70) (134)
O5.2	Knows how to manage complaints, incidents or errors in an effective manner.	**Knows How**	• Identifies professional obligations, including duty of candour, when a patient complains. • Recognises what constitutes an incident or error in practice.	(22) (47) (79) (80) (135) (136)

			• Explains the respective roles of the business, the OCCS, the GOC and the NHS as channels for complaints. • Recognises when they would need to report a complaint/ incident to an external body, e.g. ICO, MHRA, NHS. • Gives examples of strategies to manage complaints in practice.	(44) (45) (46) (137)
O5.3	Address any health and safety concerns about the working environment that may put themselves, patients or others at risk.	**Knows How**	• Identifies their role and responsibilities relating to health and safety at work as an employee or employer. • Recognises situations that might constitute a concern over health and safety. • Explains how to escalate health and safety concerns relating to their environment. • Recognises when a protected disclosure (whistleblowing) is appropriate.	(17) (21) (30) (38) (82)
O5.4	Applies due process for raising and escalating concerns, including speaking-up and protected disclosure if all other routes have been pursued and there is reason to believe that patients or the public are at risk.	**Knows How**	• Recognises their professional duty to raise concerns. • Explains the GOC Whistleblowing Policy and how to operate within its principles. • Explains the GOC Fitness to Practice Procedure. • Explains 'protected disclosures' as laid out in the Employment Rights Act. • Recognises the importance of acting with clarity, honesty and objectivity and keeping record of any steps taken when raising concerns or dealing with those made against them. • Can recognise circumstances in which practice falls below the level expected by a competent optometrist or dispensing optician and can identify situations where patient safety, dignity, or comfort may be compromised. • Can use their judgement in identifying where premises, equipment, resources, policies or systems may be unfit for purpose. • Recognises that errors and near-misses should be shared openly and be able to learn from their own and others' errors to promote a culture of safety. • Can assess the appropriate promptness by which a concern should be addressed/escalated depending on severity and risk. • Differentiates between the official and non-official channels by which a concern can be raised and identifies the appropriate channel depending on severity and risk. • Identifies where to access independent help, support or advice when raising a concern or dealing with a concern raised against them.	(22) (30) (79) (83)
O5.5	Applies infection prevention control measures commensurate with the risks identified.	**Does**	• Safely applies appropriate measures to minimise risk of infection, applying relevant current guidance. • Identifies risk of person-to-person transmission and transmission via object. • Identifies appropriate measures to minimise risk of infection, including: hand hygiene, surface disinfection, use of PPE, use of disposable items, (e.g. tonometer heads), where possible,	(84) (85) (86) (87) (88) (138)

			decontamination of tonometer heads/diagnostic contact lenses etc., proper treatment of open bottles of contact lens solutions/saline. • Uses appropriate methods to deal with disposal of controlled, clinical and offensive waste, including both non-hazardous and hazardous waste. • Carries out a risk assessment, applying appropriate principles.	
O5.6	Understands the importance of maintaining their own health to remain healthy and professionally effective.	**Knows How**	• Recognises the importance of wellbeing and how to seek help when the need arises, drawing from the relevant professional resources. • Recognises conditions that could affect their own ability to practice safely, including alcohol dependence, drug abuse, mental health issues and other medical conditions. Understands how these conditions can affect safe practice. • Ability to recognise signs and symptoms of these conditions, how to act and when to inform the GOC. • Recognises conditions that could affect their own ability to practice optometry safely, including adequate vision and be able to carry out the essential clinical tests required for safe practice.	(17) (16) (134)
O5.7	Able to risk assess i) patient's clinical condition and ii) a situation in clinical practice and make appropriate clinical decisions.	**Does**	• Uses a range of established techniques to initiate and undertake critical analysis of information, and to propose solutions to problems arising from that analysis • Applies knowledge of the subject and techniques in a routine manner to evaluate and formulate management plans and solutions to problems and issues in clinical practice. • Applies underlying concepts and principles outside the context in which they were first studied and applies symptom-appropriate tests. • Understands and applies the principles of clinical reasoning and evidence-based practice and the steps in problem solving.	(7) (91) (139)

Outcome 6. Leadership and Management

Optical professionals must understand the importance of clinical leadership, as determined by their scope of practice, and be able to work within their area of expertise and competence to achieve desired patient outcomes (Standards 1, 6, 11 and 12). Working collaboratively within healthcare teams and with other professionals, optical professionals should promote and engage with clinical governance requirements, service improvements and local and national public health initiatives (Standard 10).

Outcome		Level	Indicator	References /resources
O6.1	Undertakes efficient, safe and effective patient and caseload management.	**Does**	• Conducts responsibilities in a timely manner, prioritising urgent and important tasks to ensure safe practice. • Acts in a responsible and considered way to ensure safe practice when services are under pressure. • Applies best-practice techniques to promote own health and wellbeing in the workplace.	(140) (141) (142) (143)
O6.2	Works collaboratively within healthcare teams, exercising skills and behaviours of clinical leadership and effective team-working and management in line with their role and scope of practice.	**Shows How**	• Critically evaluates appropriate theoretical frameworks of leadership and management. • Demonstrates the application of theoretical perspectives of multi-professional team working to own practice. • Proactively constructs and develops effective relationships, fostering clarity of roles within teams, to encourage productive working and to positively influence practice.	(144) (145)
O6.3	Engages with clinical governance requirements to safeguard and improve the quality of patient care, including through contributing to service evaluation and development initiatives.	**Knows How**	• Demonstrates a systematic understanding of the components of clinical governance. • Recognises the need to adhere to local and national clinical governance guidelines. • Evaluates own practice, and participates in multi-disciplinary service and team evaluation. • Is able to articulate an understanding of the impact of own and team practice on service function, effectiveness, and quality.	(137) (146)
O6.4	Recognises and manages adverse situations, understanding when to seek support and advice to uphold patients' and others' safety.	**Knows How**	• Demonstrates a systematic understanding of the legislation for the safeguarding of children and vulnerable adults. • Recognises where an individual may require protection and knows how to take action using appropriate local measures to secure the individual's safety. • Demonstrates awareness of appropriate circumstances for disclosure of patient information in protecting the individual and society. • Demonstrates an understanding of whistleblowing policies and procedures.	(25) (147) (148) (149)
O6.5	Takes appropriate action in an emergency, providing care and clinical leadership within personal scope of practice and referring or signposting patients as needed, to ensure their safe and timely care.	**Does**	• Manages patients with signs and/or symptoms of a health emergency. • Demonstrate leadership and determination, managing situations that are unfamiliar, complex or unpredictable. • Demonstrates awareness of local health and safety legislation, policies and protocols. • Aware of the limits of own competence and works within them.	(150) (151)

O6.6	Engages with population and public health initiatives and understands how population data should inform practice and service delivery.	**Knows How**	• Demonstrates awareness of current population and public health initiatives. • Demonstrates an understanding of the need to develop practice and service delivery in response to changing population health needs.	(152) (153)

Outcome 7. Lifelong Learning

Continuing professional development and keeping knowledge and skills up to date is the personal responsibility of all optical professionals working within their scope of practice (Standard 5). Their own performance and that of others must be evaluated by an ongoing process of reflection to inform own learning and development needs, meet service delivery requirements and improve the quality of care for patients (Standard 10). Sources of information could include clinical audit, patient feedback and peer review (Standard 6).

Outcome		Level	Indicator	References /resources
O7.1	Evaluates, identifies, and meets own learning and development needs.	**Does**	• Analyses and responds to own learning and development needs. • Prepares and follows a personal development plan, utilising appropriate learning opportunities.	(154) (155) (156)
O7.2	Supports the learning and development of others, including through acting as a role model and mentor.	**Shows How**	• Demonstrates the skills required to contribute to the teaching and training of students and other healthcare colleagues. • Demonstrates awareness of teaching and learning theories and models in healthcare. • Understands future position as supervisor and mentor.	(106) (157) (158)
O7.3	Gathers, evaluates and applies effective patient and service delivery feedback to improve their practice.	**Shows How**	• Demonstrates a systematic understanding of how audit of clinical practice can improve clinical outcomes. • Actively seeks and is open to feedback on own practice by colleagues to promote ongoing development. • Undertakes effective reflection and analysis of feedback. • Proactively formulates and implements strategies to act on feedback and make improvements to practice.	(107) (159) (160) (161)
O7.4	Engages in critical reflection on their own development, with a focus on learning from experience, using data from a range of information sources (such as clinical audits, patient feedback, peer review and significant event analysis) and identifying and addressing their new learning needs to improve the quality and outcomes of patient care.	**Does**	• Assesses own learning needs and engages in self-directed learning to maximise potential and improve outcomes. • Critically reflects on own practice, and participates in multi-disciplinary service and team evaluation formulating and implementing strategies to act on learning and make improvements. • Actively engages in peer review to inform own practice, formulating and implementing strategies to act on learning and make improvements. • Demonstrates how audit can contribute to improvement in the quality and/or efficiency of patient care.	(137) (162)

Assessment

Assessment is used to measure the achievement of learning outcomes and to drive and guide further learning. Assessments will need to be selected with due regard for the outcome to be assessed, the levels (both Miller's Pyramid and relevant Higher Education framework) at which that outcome must be met. Consideration should also be given to ensuring validity, reliability and fairness and accordingly marking rubrics, methods of standard setting (such as Angoff or Ebel), moderation and standardisation must also be considered as well as staff and student workload. A wide variety of resources exist in the literature to support and underpin individual assessment design as well as overall assessment strategies, and these are therefore not addressed here. The following materials are intended to summarise common methods of assessment and map these against possible GOC outcomes they might be deployed upon. The mapping table shows ways in which outcomes might be assessed, but it should be recognised that these are not the only ways to measure each outcome. Equally, outcomes may be assessed by only one method, or subjected to multiple methods, as determined by the provider's overall assessment strategy.

Typology of assessment methods

Written assessment

Research proposal/Audit proposal

Written work to describe a potential project activity, typically referencing current state of the art and relevant literature sources. May include resource considerations as well as Key Performance indicators (KPIs) and outputs.

Dissertation/Project thesis/Meta-analysis/Literature review

An extended piece of writing (typically 5000-15000 words) presenting and evaluating a project or evaluation of the literature or published data. May include introduction, methods, results, data analysis and discussion and take the form of a thesis or research article. Alternative forms may more strongly resemble a literature review. At level 6 this may provide relatively incremental insights into a research question, or summarise current thinking. At level 7/11 this should demonstrate a critical awareness of current knowledge, and the ability to tackle complex issues with some elements of originality.

Workbooks

A proforma template that is completed by the student. May often be used to scaffold or exemplify higher level activities such as reflective writing or practical reports.

Practical report

A structured report of an investigative or practical activity, typically structured in the Introduction, Methods Results And Discussion (IMRAD) format, or a subset of sections from IMRAD focussed on specific skills that were developed during the activity.

Problem solving task

A written response to a specified challenge or problem, that proposes and justifies one or more solutions – demonstrating analytical, evaluation and applications of knowledge. May include research and information management elements as well as written communications skills. Lower-level problem solving tasks frequently including scaffolding questions or templates to guide student approaches to solutions.

Essays

An extended piece of writing (typically 2000-4000 words) addressing a specified question. May often take the form of thesis, antithesis, synthesis.

Case record review/Case report

A commentary summarising and evaluating the overarching learning that can be drawn from the review of multiple patient/case records.

Reflective writing

A focussed piece of writing that considers one or more experiences with a view to evaluating positive and negative features objectively, ideally in the context of current good practice and professional information sources or references. Outputs are intended to provoke improved performance over time and may include action planning and developmental activities.

Journaling/Logbook

An approach that diarises experiences, typically in a tabular or database format, often accompanied by narrative that summarises key features or learning points.

Performance/Practical

Oral / Poster presentation

A live or recorded spoken presentation accompanied by relevant media to convey information on a specified topic, and sometimes for a specified type of audience which may differ from the assessor. Typically requires research activities as well as visual and oral presentation skills. Live formats typically include question and answer elements.

Case discussion (unseen)

Students are asked to discuss the meaning and interpretation of history and diagnostic information from one or more patients, with whom they are not familiar, typically selected from a bank by the assessor. Often used to ensure that students correctly identify and respond appropriately to less common conditions that might otherwise be difficult to simulate or document.

Student selected case discussion

Students are asked to present and discuss one or more cases that they have experienced and documented, that meets specified conditions. Typically used to ensure that appropriate breadth of experience is assessed.

Patient history taking

Students are required to work with real or simulated patients to take and document their history. Commonly part of other “performance” based assessments.

Simulated patient assessments

Students are required to undertake common procedures using peers or actors are subjects. This may include “scripted” elements to mimic real life challenges and conditions.

Direct observation in practice

Students are observed working in a practice setting. Actors may be used instead of patients, to enhance consistency and standardisation. Has the advantage of realism, but can be challenging to standardise effectively.

Time limited assessment

It should be noted that purpose and utility of timed assessments may be varied by time, elements of choice, mechanism (handwritten or computer based), location (remote or in a hall), oversight (invigilated/proctored or unsupervised), unpredictability (unseen, take home, predetermined) and materials permitted to be used (limited or fully open book, limited or unrestricted use of online materials, provided materials, memory only). It is important to select and communicate the conditions under which time assessments will take place.

Multiple Choice Examination Questions (MCQs)

The candidate is required to select the correct answer from amongst a list of distractors. A variety of formats exist (single best answer, extended matching etc) each with their own advantages. It is often considered difficult to write effective and rigorous questions and distractor answers, especially for higher level assessments, and particularly when deployed with open books or without invigilation or proctoring. Effective where strong problem solving or recall skills are required and can be subject to post hoc standard setting processes to remove poor performing questions.

Short answer questions

Often used to test comprehension or decision-making skills, especially when combined with a requirement to justify the answer.

Long answers/essays

Extended writing under exam conditions (typically 500-1000 words). Use depends on the conditions of the examination – and may range from testing memorisation of factual material (unseen, invigilated) to problem solving and evaluation (open book, and "take home").

Scenario-led comprehension/ evaluation questions

The student is presented with a scenario, data, case reports or even a published article. Multimedia formats including videos may also be adopted. One or more questions are used to test any or all of understanding, data analysis, evaluation, problem solving, situational judgment and decision making.

Assessment Methods Mapping

			Written assessment									Performance/Practical						Time limited assessment				
	Outcome	Level	Research proposal/Audit proposal	Dissertation/Project thesis/Meta-analysis/Literature review	Workbooks	Practical report	Problem solving task	Essays	Case record review/Case report	Reflective writing	Journaling/Logbook	Oral/ Poster presentation	Case discussion (unseen)	Student selected case discussion	Patient history taking	Simulated patient assessments	Direct observation in practice	OSCE	MCQs	Short answer questions	Long answers/essays	Scenario-led comprehension/ evaluation questions
O1.1	Actively listens to patients and their carers to ensure patients are involved in and are at the heart of decisions made about patients' care.	**Does**							X	X			X		X	X	X	X				
O1.2	Manages desired health outcomes of patients, taking into consideration any relevant medical, family, and social history of the patient, which may include personal beliefs or cultural factors.	**Does**					X		X	X			X			X	X	X				X
O1.3	Protects patients' rights; respects the choices they make and their right to dignity and privacy	**Does**					X		X	X			X			X	X	X				X
O1.4	Ensures high quality care is delivered and puts into place adaptive measures as needed for different environments (such as domiciliary, prisons and special schools).	**Shows How**					X		X	X			X	X		X						X
O1.5	Commits to care that is not compromised because of own personal conscious and unconscious values and beliefs.	**Does**							X	X		X	X	X		X	X					X
O1.6	Obtains and verifies continuation of valid consent from adults, children, young and vulnerable people, and their carers and records as appropriate.	**Does**							X		X		X	X		X	X					
O1.7	Demonstrates effective clinical decision-making, diagnosis, evaluation and makes appropriate and timely referral, where this is needed to meet a patient's needs.	**Does**					X		X	X			X	X		X	X	X				X
O1.8	Refers and signposts as necessary to sight loss and other relevant health services.	**Does**					X		X	X	X		X	X		X	X	X				X

			Written assessment									Performance/Practical						Time limited assessment				
	Outcome	Level	Research proposal/Audit proposal	Dissertation/Project thesis/Meta-analysis/Literature review	Workbooks	Practical report	Problem solving task	Essays	Case record review/Case report	Reflective writing	Journaling/Logbook	Oral/ Poster presentation	Case discussion (unseen)	Student selected case discussion	Patient history taking	Simulated patient assessments	Direct observation in practice	OSCE	MCQs	Short answer questions	Long answers/essays	Scenario-led comprehension/ evaluation questions
O2.1	Conducts communications in a sensitive and supportive manner adapting their communication approach and style to meet the needs of patients, carers, health and care colleagues and the public	**Does**										X	X	X	X	X	X	X				
O2.2	Acts upon non-verbal cues from patients or carers that could indicate discomfort, a lack of understanding or an inability to give informed consent.	**Knows How**								X	X	X				X	X	X				X
O2.3	Communicates effectively within a multi-disciplinary healthcare team and works collaboratively for the benefit of the patient.	**Does**										X	X	X		X	X					
O2.4	Critically reflects on how they communicate with a range of people and uses this reflection to improve interactions with others.	**Does**						X		X	X	X		X						X	X	X

			Written assessment									Performance/Practical						Time limited assessment				
	Outcome	Level	Research proposal/Audit proposal	Dissertation/Project thesis/Meta-analysis/Literature review	Workbooks	Practical report	Problem solving task	Essays	Case record review/Case report	Reflective writing	Journaling/Logbook	Oral/ Poster presentation	Case discussion (unseen)	Student selected case discussion	Patient history taking	Simulated patient assessments	Direct observation in practice	OSCE	MCQs	Short answer questions	Long answers/essays	Scenario-led comprehension/ evaluation questions
O3.1	Undertakes safe and appropriate ocular examinations using appropriate techniques and procedures to inform clinical decision-making within individual scope of practice.	**Does**														X	X	X				
O3.2	Engages with developments in research, including the critical appraisal of relevant and up-to-date evidence to inform clinical decision-making and improve quality of care.	**Does**	X	X				X	X	X		X								X	X	
O3.3	Engages with technological advances in eye health and broader healthcare delivery and the significance of specific developments for enhancing patient outcomes and service delivery.	**Does**	X	X		X	X	X		X		X	X								X	
O3.4	Analyses visual function from a range of diagnostic sources and uses data to devise a clinical management plan for a patient in areas that include the following: • Dispensing of optical appliances • Low vision/visual impairment • Refractive management • Anterior eye and contact lenses • Ocular and systemic disease • Binocular vision • Paediatrics • Patients with learning disabilities and complex needs • Occupational optometry	**Does**								X	X			X	X	X	X	X					

			Written assessment									Performance/Practical						Time limited assessment				
Outcome		Level	Research proposal/Audit proposal	Dissertation/Project thesis/Meta-analysis/Literature review	Workbooks	Practical report	Problem solving task	Essays	Case record review/Case report	Reflective writing	Journaling/Logbook	Oral/ Poster presentation	Case discussion (unseen)	Student selected case discussion	Patient history taking	Simulated patient assessments	Direct observation in practice	OSCE	MCQs	Short answer questions	Long answers/essays	Scenario-led comprehension/ evaluation questions
O3.5	Meets the following clinical practice outcomes for registration either as a dispensing optician or an optometrist.	**Does**																				
O3.5a (i)	Acts as a first point of contact for patients for their eye health needs by investigating, diagnosing and managing individuals' functional and developmental visual conditions, including those related to age.	**Does**													X	X	X	X				
O3.5a (ii)	Completes an informed clinical assessment of individual patients' needs and uses this to dispense, fit and advise on the safe and effective use of spectacles, low-vision aids and other ophthalmic appliances.	**Does**							X						X	X	X	X				
O3.5a (iii)	Advises on the safe and effective use of contact lenses and removal in an emergency.	**Does**							X							X	X	X				
O3.5a (iv)	Accurately identifies patients' conditions and their potential need for medical referral in a timely way, including when urgent or emergency attention is required.	**Does**							X				X	X	X	X		X				X

			Written assessment									Performance/Practical						Time limited assessment				
Outcome		Level	Research proposal/Audit proposal	Dissertation/Project thesis/Meta-analysis/Literature review	Workbooks	Practical report	Problem solving task	Essays	Case record review/Case report	Reflective writing	Journaling/Logbook	Oral/ Poster presentation	Case discussion (unseen)	Student selected case discussion	Patient history taking	Simulated patient assessments	Direct observation in practice	OSCE	MCQs	Short answer questions	Long answers/essays	Scenario-led comprehension/ evaluation questions
O3.5	Meets the following clinical practice outcomes for registration either as a dispensing optician or an optometrist.	**Does**																				
O3.5b (i)	Acts as a first point of contact for patients for their eye health needs by investigating, diagnosing and managing individuals' functional and developmental visual conditions, including those related to age.	**Does**													X	X	X	X				
O3.5b (ii)	Completes an informed clinical assessment of individual patients' needs and uses this to dispense, fit and advise on the safe and effective use of spectacles, contact lenses, low-vision aids and other ophthalmic appliances.	**Does**							X					X	X	X	X	X				
O3.5b (iii)	Makes informed decisions on the treatment and management of ocular abnormalities and disease.	**Does**					X		X				X	X				X		X		
O3.5b (iv)	Accurately identifies patients' conditions and their potential need for medical referral in a timely way, including when urgent or emergency attention is required.	**Does**							X				X	X	X	X		X				X
O3.5b (v)	Uses common ophthalmic drugs safely to facilitate optometric examination and the diagnosis/treatment of ocular disease.	**Does**				X			X				X	X		X	X		X	X		

			Written assessment									Performance/Practical						Time limited assessment				
	Outcome	Level	Research proposal/Audit proposal	Dissertation/Project thesis/Meta-analysis/Literature review	Workbooks	Practical report	Problem solving task	Essays	Case record review/Case report	Reflective writing	Journaling/Logbook	Oral/ Poster presentation	Case discussion (unseen)	Student selected case discussion	Patient history taking	Simulated patient assessments	Direct observation in practice	OSCE	MCQs	Short answer questions	Long answers/essays	Scenario-led comprehension/ evaluation questions
O4.1	Upholds the values and demonstrate the behaviours expected of a GOC registrant, as described in the GOC Standards of Practice for Optometrists and Dispensing Opticians.	**Does**						X		X	X		X	X		X	X				X	X
O4.2	Acts openly and honestly and in accordance with the GOC Duty of Candour guidelines.	**Does**								X	X		X	X		X	X					X
O4.3	Understands and implements relevant safeguarding procedures, local and national guidance in relation to children, persons with disabilities, and other vulnerable people.	**Shows How**						X		X	X	X					X				X	X
O4.4	Applies the relevant national law and takes appropriate actions i) to gain consent and ii) if consent cannot be obtained or is withdrawn.	**Does**								X	X		X	X	X	X	X					
O4.5	Recognises and works within the limits of own knowledge and skills. Seeks support and refers to others where appropriate.	**Does**								X			X	X		X	X					X
O4.6	Understands the professional and legal responsibilities of trainee and student supervision and of being supervised.	**Knows How**			X					X									X	X		X
O4.7	Demonstrates the fulfilment of professional and legal responsibilities in supervising unregistered colleagues undertaking delegated activities.	**Does**								X				X		X	X		X			X
O4.8	Complies with health and safety legislation.	**Does**				X				X						X	X					
O4.9	Complies with equality and human rights legislation, demonstrates inclusion and respects diversity.	**Does**								X	X			X		X						X
O4.10	Understands the patient or carer's right to complain without prejudicing the standard of care provided.	**Knows**					X			X			X	X					X	X		X

			Written assessment									Performance/Practical						Time limited assessment				
	Outcome	Level	Research proposal/Audit proposal	Dissertation/Project thesis/Meta-analysis/Literature review	Workbooks	Practical report	Problem solving task	Essays	Case record review/Case report	Reflective writing	Journaling/Logbook	Oral/ Poster presentation	Case discussion (unseen)	Student selected case discussion	Patient history taking	Simulated patient assessments	Direct observation in practice	OSCE	MCQs	Short answer questions	Long answers/essays	Scenario-led comprehension/ evaluation questions
O4.11	Adheres to the ethical principles for prescribing and to legislation relating to medicines management.	**Shows How**	X		X	X	X		X	X	X		X	X		X						
O4.12	Complies with legal, professional and ethical requirements for the management of information in all forms including the accuracy and appropriateness of patient records and respecting patient confidentiality.	**Does**							X				X	X	X	X	X					
O4.13	Manages situations under which patient confidentiality may be breached in order to protect a patient or the public, in line with relevant guidance on disclosing confidential information and/or with the patient's consent.	**Shows How**							X				X	X	X	X	X					X
O4.14	Applies eye health policies and guidance and utilises resources efficiently to improve patient outcomes.	**Does**				X	X		X	X			X	X								X
O4.15	Maintains professional boundaries with patients and others, taking into consideration the additional needs of vulnerable people and specific requests/requirements.	**Does**								X			X	X		X	X	X				
O4.16	Understands the role of carers and the power of attorney.	**Knows How**										X	X						X	X		X
O4.17	Complies with legislation and rules concerning the sale and supply of optical appliances.	**Does**			X	X			X				X	X	X	X	X					
O4.18	Provides clarity on services available and any associated payments	**Does**										X				X						X

			Written assessment									Performance/Practical						Time limited assessment				
	Outcome	Level	Research proposal/Audit proposal	Dissertation/Project thesis/Meta-analysis/Literature review	Workbooks	Practical report	Problem solving task	Essays	Case record review/Case report	Reflective writing	Journaling/Logbook	Oral/ Poster presentation	Case discussion (unseen)	Student selected case discussion	Patient history taking	Simulated patient assessments	Direct observation in practice	OSCE	MCQs	Short answer questions	Long answers/essays	Scenario-led comprehension/ evaluation questions
O5.1	Recognises when their own performance or the performance of others is putting people at risk and takes prompt and appropriate action.	**Does**								X			X	X		X						X
O5.2	Knows how to manage complaints, incidents or errors in an effective manner.	**Knows How**			X							X				X			X	X		
O5.3	Address any health and safety concerns about the working environment that may put themselves, patients or others at risk.	**Knows How**			X							X							X	X		X
O5.4	Applies due process for raising and escalating concerns, including speaking-up and protected disclosure if all other routes have been pursued and there is reason to believe that patients or the public are at risk.	**Knows How**			X							X				X						X
O5.5	Applies infection prevention control measures commensurate with the risks identified.	**Does**				X						X				X	X					
O5.6	Understands the importance of maintaining their own health to remain healthy and professionally effective.	**Knows How**					X			X												X
O5.7	Able to risk assess i) patient's clinical condition and ii) a situation in clinical practice and make appropriate clinical decisions.	**Does**					X						X	X		X		X				X

			Written assessment									Performance/Practical						Time limited assessment				
	Outcome	Level	Research proposal/Audit proposal	Dissertation/Project thesis/Meta-analysis/Literature review	Workbooks	Practical report	Problem solving task	Essays	Case record review/Case report	Reflective writing	Journaling/Logbook	Oral/ Poster presentation	Case discussion (unseen)	Student selected case discussion	Patient history taking	Simulated patient assessments	Direct observation in practice	OSCE	MCQs	Short answer questions	Long answers/essays	Scenario-led comprehension/ evaluation questions
O6.1	Undertakes efficient, safe and effective patient and caseload management.	**Does**							X		X						X					
O6.2	Works collaboratively within healthcare teams, exercising skills and behaviours of clinical leadership and effective team-working and management in line with their role and scope of practice.	**Shows How**					X						X	X		X	X					X
O6.3	Engages with clinical governance requirements to safeguard and improve the quality of patient care, including through contributing to service evaluation and development initiatives.	**Knows How**	X		X																	X
O6.4	Recognises and manages adverse situations, understanding when to seek support and advice to uphold patients' and others' safety.	**Knows How**								X						X			X	X		X
O6.5	Takes appropriate action in an emergency, providing care and clinical leadership within personal scope of practice and referring or signposting patients as needed, to ensure their safe and timely care.	**Does**					X						X	X		X		X				X
O6.6	Engages with population and public health initiatives and understands how population data should inform practice and service delivery.	**Knows How**		X	X							X								X	X	

			Written assessment									Performance/Practical						Time limited assessment				
	Outcome	Level	Research proposal/Audit proposal	Dissertation/Project thesis/Meta-analysis/Literature review	Workbooks	Practical report	Problem solving task	Essays	Case record review/Case report	Reflective writing	Journaling/Logbook	Oral/ Poster presentation	Case discussion (unseen)	Student selected case discussion	Patient history taking	Simulated patient assessments	Direct observation in practice	OSCE	MCQs	Short answer questions	Long answers/essays	Scenario-led comprehension/ evaluation questions
O7.1	Evaluates, identifies, and meets own learning and development needs.	**Does**			X					X	X			X								
O7.2	Supports the learning and development of others, including through acting as a role model and mentor.	**Shows How**			X							X				X	X					
O7.3	Gathers, evaluates and applies effective patient and service delivery feedback to improve their practice.	**Shows How**	X	X	X					X		X										
O7.4	Engages in critical reflection on their own development, with a focus on learning from experience, using data from a range of information sources (such as clinical audits, patient feedback, peer review and significant event analysis) and identifying and addressing their new learning needs to improve the quality and outcomes of patient care.	**Does**	X	X	X	X			X	X	X	X		X								

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Amendments to the GOC "Requirements for Approved Qualifications in Optometry or Dispensing Optics" document / clinical practice indicators proposed by SPOKE with further EAG/Stakeholder feedback			
Dispensing optics			
Outcome Criterion and Original provision	Revised recommended provision/action proposed by the Sector Partnership for Optical Knowledge and Education (SPOKE)	EAG advice and further stakeholder feedback	Final indicator to March 2022 Council
3.4 Analyses visual function from a range of diagnostic sources and uses data to devise a clinical management plan for a patient in areas that include the following: • Dispensing of optical appliances • Low vision/visual impairment • Refractive management • Anterior eye and contact lenses • Ocular and systemic disease • Binocular vision • Paediatrics • Patients with learning disabilities and complex needs • Occupational optometry (Does)	Discuss whether Miller's level should be "Knows how" rather than "Does" for Dispensing Opticians.	Discussion took place and it was agreed to keep level at "Does" for Dispensing Opticians.	N/A
03.5a (i) Acts as a first point of contact for patients for their eye health needs by investigating, diagnosing and managing individuals' functional and developmental visual conditions, including those related to age. (Does) *Indicator* Interprets the results of history-taking and the examination of the refractive and ocular motor status of individual patients to inform	Interprets the results of history-taking and the examination of the refractive and ocular motor status and ocular health of individual patients to inform clinical decision-making and care management plans.	Accepted (to add "and ocular health)	Interprets the results of history-taking and the examination of the refractive and ocular motor status and ocular health of individual patients to inform clinical decision-making and care management plans.

clinical decision-making and care management plans.			
03.5a (i) Acts as a first point of contact for patients for their eye health needs by investigating, diagnosing and managing individuals' functional and developmental visual conditions, including those related to age. (Does) *Indicator* Records all aspects of the consultation, the findings of all tests and relevant communications with patients, their carers and colleagues, ensuring that records are accurate, legible, dated, signed, concise, contemporaneous and securely stored.	Query the relevance of this indicator to Outcome 03.5a.	The EAG had already carefully considered the indicator's location in the document and is content with its current position.	Records all aspects of the consultation, the findings of all tests and relevant communications with patients, their carers and colleagues, ensuring that records are accurate, legible, dated, signed, concise, contemporaneous and securely stored.
03.5a (iii) Advises on the safe and effective use of contact lenses and removal in an emergency. (Does) *Indicator* Instructs the patient in the handling of soft/rigid lenses and how to wear and care for them.	Instructs the patient in the handling of soft and rigid lenses and how to wear and care for them.	Accepted (to insert "and" to "soft/rigid")	Instructs the patient in the handling of soft and rigid lenses and how to wear and care for them.
03.5a (iv) Accurately identifies patients' conditions and their potential need for medical referral in a timely way, including when urgent or emergency attention is required. (Does) *Indicator* Recognises the clinical signs/presentation of common ocular abnormalities and appropriately advises and/or refers patients.	Recognises the clinical signs/presentation of common ocular abnormalities and appropriately advises and/or refers patients in line with local or national pathways.	Accepted (to add "in line with local or national pathways.") Further stakeholder feedback: Amend above to "in line with professional guidance and local pathways."	Recognises the clinical signs/presentation of common ocular abnormalities and appropriately advises and/or refers patients in line with professional guidance and local pathways.
03.5a (iv) Accurately identifies patients' conditions and their potential need for medical referral in a timely way, including	Manages patients presenting with a range of posterior and/or	Accepted (to replace "red eye" with "a range of posterior and/or	Manages patients presenting with a range of anterior and/or posterior ocular conditions.

when urgent or emergency attention is required. (Does) *Indicator* Manages patients presenting with red eye.	anterior ocular conditions.	anterior ocular conditions) Further stakeholder feedback: Amend order of above to “a range of anterior and/or posterior ocular conditions.”	

Optometry			
Outcome Criterion and Original provision	Revised recommended provision/action proposed by the Sector Partnership for Optical Knowledge and Education (SPOKE)	EAG advice and further stakeholder feedback	Final indicator
03.5b (i) Acts as a first point of contact for patients for their eye health needs by investigating, diagnosing and managing individuals’ functional and developmental visual conditions, including those related to age. (Does) *Indicator* Interprets the results of history-taking and the examination of the refractive and ocular motor status of individual patients to inform clinical decision-making and care management plans.	Interprets the results of history-taking and the examination of the refractive and ocular motor status and ocular health of individual patients to inform clinical decision-making and care management plans.	Accepted (to add “and ocular health”)	Interprets the results of history-taking and the examination of the refractive and ocular motor status and ocular health of individual patients to inform clinical decision-making and care management plans.
03.5b (i) Acts as a first point of contact for patients for their eye health needs by investigating, diagnosing and managing individuals’ functional and developmental	Query the relevance of this indicator to Outcome 03.5a.	The EAG had already carefully considered the indicator’s location in the document and is	Records all aspects of the consultation, the findings of all tests and relevant communications with patients, their carers and colleagues, ensuring that records are accurate, legible, dated,

visual conditions, including those related to age. (Does) *Indicator* Records all aspects of the consultation, the findings of all tests and relevant communications with patients, their carers and colleagues, ensuring that records are accurate, legible, dated, signed, concise, contemporaneous and securely stored.		content with its current position.	signed, concise, contemporaneous and securely stored.
03.5b (ii) Completes an informed clinical assessment of individual patients' needs and uses this to dispense, fit and advise on the safe and effective use of spectacles, contact lenses, low-vision aids and other ophthalmic appliances. *Indicator* Identifies, recommends and fits contact lenses to support and enhance individual patients' eye health.	Identifies, recommends and fits soft and rigid contact lenses to support and enhance individual patients' lifestyle and eye health and provides ongoing care.	Accepted (to add "soft and rigid", "lifestyle", and "and provides ongoing care") Further stakeholder feedback: Change to "soft or rigid contact lens as appropriate". Add "vision" after "patients".	Identifies, recommends and fits soft or rigid contact lens as appropriate to support and enhance individual patients' vision, lifestyle and eye health and provides ongoing care.
03.5b (ii) Completes an informed clinical assessment of individual patients' needs and uses this to dispense, fit and advise on the safe and effective use of spectacles, contact lenses, low-vision aids and other ophthalmic appliances. *Indicator* Instructs and advises patients in soft/rigid lens handling and how to wear and care for lenses.	Instructs and advises patients in soft and rigid lens handling and how to wear and care for lenses.	Accepted (to insert "and" to "soft/rigid") Further stakeholder feedback: Change to "Instructs and advises patients in handling soft or rigid lens as appropriate, and how to wear and care for their fitted lenses."	Instructs and advises patients in handling soft or rigid lens as appropriate, and how to wear and care for their fitted lenses.
03.5b (iii) Makes informed decisions on the treatment and management of ocular abnormalities and disease. *Indicator*	Advises individual patients on the implications and care options arising from the	Accepted (to add "in line with local or national pathways")	Advises individual patients on the implications and care options arising from the detection of common ocular abnormalities and disease, making

Advises individual patients on the implications and care options arising from the detection of common ocular abnormalities and disease, making referrals when in patients' best interests for their receipt of timely, efficacious care.	detection of common ocular abnormalities and disease, making referrals in line with local or national pathways, when in patients' best interests for their receipt of timely, efficacious care.	Further stakeholder feedback: Amend above to "in line with professional guidance and local pathways" and after "best interests" add "so that they receive"	referrals in line with professional guidance and local pathways, when in patients' best interests so that they receive timely, efficacious care.
03.5b (iii) Makes informed decisions on the treatment and management of ocular abnormalities and disease. *Indicator* Manages patients presenting with red eye.	Manages patients presenting with a range of posterior and/or anterior ocular conditions.	Accepted (to replace "red eye" with "a range of posterior and/or anterior ocular conditions) Further stakeholder feedback: Amend order of above to "a range of anterior and/or posterior ocular conditions."	Manages patients presenting with a range of anterior and/or posterior ocular conditions.
03.5b (iii) Makes informed decisions on the treatment and management of ocular abnormalities and disease. *Indicator* Treats a range of common ocular conditions.	Remove this indicator due to re-wording of a previous indicator.	Accepted	Indicator to be removed
03.5b (v) Uses common ophthalmic drugs safely to facilitate optometric examination and the diagnosis/treatment of ocular disease. *Indicator* Administers common ocular drugs appropriately, effectively and judiciously, exercising caution to avoid errors.	Administers common ocular drugs appropriately, effectively and judiciously, exercising caution to assure patient safety.	Accepted Further stakeholder feedback: Replace "assure" with "ensure".	Administers common ocular drugs appropriately, effectively and judiciously, exercising caution to ensure patient safety.

03.5b (v) Uses common ophthalmic drugs safely to facilitate optometric examination and the diagnosis/treatment of ocular disease. *Indicator* Appraises whether to check the depth of the anterior chamber and measure intra-ocular pressures when administering drugs that dilate the pupil.	Remove this indicator as too specific.	Accepted	Indicator to be removed

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Education and training requirements for entry to the GOC register as a contact lens optician

Feedback from Statutory Committees

Purpose of this annex

The Opticians Act (1989) requires Council to 'consult and seek advice' from Standards and Education Committees. As post registration specialty qualifications do not lead to qualification as an optometrist or a dispensing optician, there is no statutory requirement for Council to seek advice from the statutory committees. However, there is value in the Committees' expert input into the development of the proposals in advance of Council consideration. On 24 February 2022 the Education Committee and Standards Committee met to discuss the proposals and in addition, the Registration Committee and Companies Committee also discussed the proposals (attached at annex one of the Council papers). All except one Committee were quorate (the Standards' Committee currently has no lay members and is therefore inquorate). This report contains the Committees' feedback to inform Council's discussion and decision.

Education Committee: Feedback

- There was broad support for the education and training requirements for entry to the GOC register as a contact lens optician.
- The new requirements are high level and less restrictive for providers giving rise to the question of whether it will be more difficult to measure against the outcomes and quality assurance requirements.
- The new requirements are a step forward to meet the demand and protect the public.
- However, implementation was felt to be a risk. Lack of widespread knowledge on CLO responsibilities and training was a concern. The Committee felt that there ought to be separate monitoring of CLO implementation because of its specialist nature.
- 225 hours is not unreasonable expectation for clinical experience, however, there may be varied interpretation of "approximately". Would it be better to say +/- no more than 5% or some other clarifying statement? It might be necessary, for example, to say that where less than 225 hours is planned for a programme, this would need to be explained and approved beforehand?
- The proposals won't make qualifying as a CLO less attractive, but they have potential to improve the proposition. What might help is where a provider can educate and train CLO qualifications alongside ophthalmic dispensing (parallel qualifications). There was a point raised about a lack of broad experience if the CLO hasn't had time to be an independent practitioner. However, 60% of CLOs are currently over 45. Could the changes mean a younger and more diverse workforce?
- In addition to the Committee's feedback on the CLO education and training requirements, there was support in relation to changes to the indicators contained within the Clinical Practice category of Outcomes for Ophthalmic Dispensing and Optometry with no concerns raised.

Standards Committee: Feedback

The Standards Committee agreed that:

- with respect to the use of the term ‘approximately’ in reference to the number of clinical hours it would be necessary to complete for the qualification, might not be appropriate terminology and could lead to inconsistency of patient experience; Council is asked to consider a minimum number of hours to ensure a consistent base level of patient and clinical experience. As a counter, at the meeting, it was suggested that current wording indicates expectations but allows flexibility of approach to individual students and by individual institutions as long as they demonstrate outcomes are met. .

Registration Committee: Feedback

- The changes are well thought through. As time changes will there be a need for a further review and how do we enable future proofing? Future documentation needs to be designed in a way that is easier to review and update.
- There is an aspiration to qualify people as a dispensing optician and a contact lens optician at the same time. Some universities tried to do this in the past but discontinued.
- The importance of clear communication to stakeholders to ensure they know what this change means and what the benefits are for them was discussed and that all concerns are addressed in a formal response with an acknowledgement that what is currently delivered isn’t necessarily unfit for purpose.
- It was noted that there could be an issue regarding consistency between what is understood (resulting from the changes) and what ends up being delivered. It was asked what can be done to ensure consistency between the two?
- Clarity was requested on the title for those newly qualified under the proposals to avoid confusion within the profession.
- The issue of consistency between CLO education and training for dispensing opticians and optometrists was raised to ensure the GOC’s requirements should be the same for each.

Companies Committee: Feedback

- The Companies Committee were content with the proposals and had nothing further to add to the Advisory Panel discussion.

Public Council

Draft Budget and Business Plan 2022-2023

Meeting: Wednesday 16 March 2022 **Status:** For approval

Lead Responsibility: Leonie Milliner, Chief Executive and Registrar
Paper Author(s): Sarah Martyn, Interim Head of Secretariat
Manori Wickremasinghe, Head of Finance

Purpose

1. To seek Council's approval of the 2022-2023 budget and associated business plan for publication

Recommendations

2. Council is asked to approve:
   - the budget for 12 months to 31 March 2022 (Annex 1); and
   - the 2022-2023 business plan (Annex 2).

Strategic Objective

3. Agreement of the budget and associated business plan is critical for delivery of all strategic objectives.

Background

4. The business plan and budget reflects our plan 'Fit for the Future' strategy for 1 April 2020 to 31 March 2025 and describes what we plan to do in the 2022/23 financial year to achieve our vision of being recognised for delivering world-class regulation and excellent customer service. Within the business plan we outline the key work programmes we aim to deliver in 2022/23 for each strategic objective.

5. The business plan and budget have been developed through the work undertaken since October, taking into account:
   - a review of the progress made in delivery of the current business plan;
   - review of financial performance and quarter three reforecast;
   - planning by managers responsible for delivery; and
   - direction from SMT about priority activities to achieve the strategic objectives.

Analysis

6. SMT has considered this final draft budget and believes it to be aligned with achievement of the GOC's strategic objectives and the 'Fit for the Future' strategic plan; effective delivery of the GOC's regulatory functions and achievable with the resources included in this budget. The draft budget was reviewed in detail by Audit, Risk and Finance Committee on 3 March 2022.

7. We continue our plan for a breakeven position for business-as-usual operations as planned, ensuring long-term financial stability. The surplus before strategic expenditure for the budget is £48k (2021-22 £1.251m). The results after the strategic expenditure, but before the investment gains is a deficit of £1.871m (2021-22 a surplus of £425k). The final result for the budget year is a deficit of £1.624m (2021-22 a surplus of £1.271m.)

8. The budget paper also sets out the proposed investment from our reserves. Whilst our business-as-usual budget achieves a better than breakeven bottom line, there will be a deficit of £1.624m after investment in strategic projects and unrealised investment gains. Of the £1.92m investment into strategic projects, £1.238m has been pre-approved and as mentioned in the page 7 of Annex 1, our 2021/22 surplus of £1.271m will be added to the general reserve to off-set a sizeable amount (around two thirds). This represents an appropriate use of those funds held in our general reserve funds.

Finance

9. There are no additional financial implications of this work

Risks

10. The following risks are associated with finance, as identified in the corporate risk register with additional linked risks around retention/capability and performance against our plans and objectives:
    - The GOC fails to deliver value for money.
    - The GOC is unable to deliver its strategic plans, programme of change, and business as usual either sufficiently quickly or effectively.
    - Financial impact on reserves arising from additional cost of Covid-19 and/or reduced income.
    - Capability and Resilience: Small teams leads to over reliance on particular individuals, causing burnout and errors and/or impacts organisational delivery if absent or on departure.
    - Inability to monitor performance and delivery of strategic objectives: risk that the GOC does not fulfil its public protection role effectively and efficiently, and a related risk to its reputation, if a business plan and budget that sets out objectives for protecting the public, is not supported with sufficient resource to deliver the plan.

11. There is also a risk to the GOC's reputation and ability to deliver the plan if the financial performance is above or below budget. These risks are generally considered to be low and are mitigated by having a quarterly business planning and budgeting review process.

Equality Impacts

12. Work on equality and diversity will be completed and published alongside the summary business plan.

Devolved Nations

13. In creating the business plan consideration has been given to issues affecting the devolved nations. These will be addressed in the course of the GOC's work, particularly through the standards strategic review and the implementation of the stakeholder engagement strategy.

Other Impacts

14. There are no other impacts.

Communications

15. The business plan and budget will be shared with staff following agreement by Council.

16. The agreed business plan will be published externally on the GOC website.

Next Steps

17. A review of progress against the business plan and budget will be undertaken and reported to the Audit, Risk and Finance Committee quarterly. Progress will be tracked against the business plan and variance between predicted and actual activity and spend every quarter. The purpose of this is to:
    - enable managers to track progress against the plan and budget, to identify any required changes to the plan or budget forecast caused by increases or decreases in activity, delays or unplanned events and the impact these changes will have on our ability to deliver the plan and budget;
    - enable SMT to have an overview of progress in order to ensure delivery of the plan and strategic objectives set by Council; and
    - enable Council to have assurance that the plan and budget is being delivered, and are therefore delivering the GOC role in protecting the public and achieving the strategic objectives.

Annexes

Annex 1: Budget for 12 months to 31 March 2023
Annex 2: 2022-2023 business plan

Budget for 12 months to 31 March 2023

General Optical Council
Budget – 2022-23

Contents

General Optical Council
Budget – 2022-23

GOC Summary P&L 2022-23 budget

	Year 1 2021-22 Q3 Forecast £'000	Oct'21 Forecast £'000	Year 2 2022-23 Budget £'000	Variance with Oct'21 £'000
Income	9,979	10,409	9,994	(415)
Expenditure	8,728	9,961	9,946	(15)
Surplus / (Deficit) before reserve expenditure	**1,251**	**448**	**48**	**(400)**
Reserve Expenditure	826	1,127	1,920	(793)
Surplus / (Deficit) after reserve expenditure	425	(679)	(1,871)	(1,191)
Unrealised Investment gains	846	457	247	(210)
Surplus / (Deficit)	**1,271**	**(222)**	**(1,624)**	**(1,401)**

Highlights

The surplus before strategic expenditure for the budget is £48k (2021-22 £1.3m). The results after the strategic expenditure, but before the investment gains is a deficit of £1.9m (2021-22 a surplus of £425k). The final result for the budget year is a deficit of £1.6m (2021-22 a surplus of £1.3m).

General Optical Council
Budget – 2022-23

Table A
Budget 2022-23 analysis according to departments and projects
Income and Expenditure Accounts

	Year 1	Year 2		
	2021-22	2022-23		
	Q3 Forecast	Oct '21 Q2 Forecast	Budget	Variance with Oct '21
	£'000	£'000	£'000	£'000
Income				
Registration	9,719	10,179	9,737	(442)
Dividend Income	240	200	246	46
Bank & Deposit Interest	0	10	1	(9)
Other Income	20	20	10	(10)
Total Income	**9,979**	**10,409**	**9,994**	**(415)**
Expenditure				
CEO's Office				
CEO	259	283	218	65
Governance	609	685	668	17
Total CEO's Office	**868**	**968**	**886**	**82**
Regulatory Strategy				
Director of Regulatory Strategy	190	126	130	(4)
Policy	187	325	275	50
Communications	216	209	292	(83)
Standards	60	96	92	4
Education	460	777	760	17
CPD	349	254	268	(14)
Total Regulatory Strategy	**1,463**	**1,787**	**1,817**	**(30)**
Regulatory Operations				
Director of Regulatory Operation	115	120	125	(5)
Case Progression	1,857	1,927	2,057	(130)
Legal	273	179	203	(24)
Hearings	889	1,172	1,122	50
Total regulatory Operations	**3,133**	**3,398**	**3,507**	**(109)**

General Optical Council
Budget – 2022-23

Table A (Contd.) -Income and Expenditure Accounts (Contd.)

	Year 1	Year 2		
	2021-22	2022-23		
	Q3 Forecast	Oct '21 Q2 Forecast	Budget	Variance with Oct '21
	£'000	£'000	£'000	£'000
Corporate Services				
Director of Corporate Services	123	153	135	18
Facilities	966	1,049	1,063	(14)
Human Resources	466	494	544	(50)
Finance	430	488	502	(14)
Registration	435	558	561	(3)
Total Corporate Services	**2,421**	**2,742**	**2,806**	**(64)**
IT (BAU)	715	931	810	121
Depreciation & Amortisation	**128**	**135**	**120**	**15**
Total Expenditure	**8,728**	**9,961**	**9,946**	**15**
Surplus / (Deficit) before reserve expenditure	**1,251**	**448**	**48**	**(400)**
Reserve Expenditure				
Standards Review and Implementation	0	0	188	(188)
Completion of CPD project	148	14	44	(30)
Education Strategic Review	226	143	201	(58)
IT Strategy Project	287	298	438	(140)
Change	105	519	811	(292)
Strategic Projects	0	0	215	(215)
Complex Legal Cases	54	0	0	0
Project Depreciation & Amortisation	6	154	24	130
Total Project expenditure	**826**	**1,127**	**1,920**	**(792)**
Surplus / (Deficit) after project expenditure	**425**	**(679)**	**(1,871)**	**(1,191)**
Unrealised Investment gains	**846**	457	247	(210)
Surplus / (Deficit)	**1,271**	**(222)**	**(1,624)**	**(1,401)**

General Optical Council
Budget – 2022-23

Table B

Budget - Including Project Expenditure

	2022-23		
	Q2 Forecast	Budget	Variance from Q2 forecast
		£'000	
Income			
Registration	10,179	9,737	(442)
Dividend Income	200	246	46
Bank & Deposit Interest	10	1	(9)
Other Income	20	10	(10)
Total Income	**10,409**	**9,994**	**(415)**
Expenditure			
Staff Salaries Costs	5,375	5,911	(536)
Other Staff Costs	241	473	(232)
Staff Benefits	123	133	(10)
Members Costs	1,275	1,190	85
Case Examiners	122	128	(6)
Professional Fees	607	885	(278)
Finance Costs	75	77	(2)
Case Progression	708	750	(42)
Hearings	198	208	(10)
CPD & Standards	139	113	27
Communication	61	71	(10)
IT Costs	798	782	15
Office Services	977	949	28
Other Costs	101	51	50
Depreciation & Amortisation	289	144	145
Total Expenditure	**11,089**	**11,865**	**(776)**
Surplus / Deficit	**(680)**	**(1,871)**	**(1,191)**
Unrealised Investment gains	457	247	(210)
Surplus / (Deficit)	**(222)**	**(1,624)**	**(1,402)**

General Optical Council
Budget – 2022-23

Reserve expenditure to be approved by the Council
The year-end surplus for the current year is expected to be £1,271k as per the latest forecast (January 2022.) That's a £782k improvement from the previous forecast. £487k of this improvement is due to unrealised gains from higher than expected performance in the investment portfolio. Delays and savings of operations contributed to the increased surplus by £301k. This surplus will be added to the general reserve at the end of the year.

We propose to use this surplus to improve operations in 2022/23 enhancing our services for public benefit in line with our Strategic Plan. This means that the increase in overall reserves levels will be short term, as the 2021-22 surplus funds will be invested into strategic projects. This effectively off-sets a substantial proportion of the 2022-23 deficit after strategic/project expenditure. Several smaller strategic projects aligned with our new Change programme were identified after the latest forecast. We were unable to produce business cases for these smaller strategic projects for approval in the usual manner due to timing between the Q3 forecast (January) and the March Council meeting. As well as these new smaller scale projects, the IT strategic project costs, are pending approval. A significant part (£172k) relates to people costs as we have identified project work, not BAU will be the focus of much of the team. We have incorporated these projects into our proposed 2022/23 budget pending approval and will bring detailed business cases to Council in 2022/23.

TABLE C
Additions to strategic expenditure/reserves, pending approval:

	£'000
NEW Strategic Projects Pending Approval	
EDI/FtP research- new project, not yet scoped	50
Workforce data analysis - new project, not yet scoped	15
Enhanced consultation for legislative change (including business regulation and issues raised from Call for Evidence)	60
People Plan Programme[3]	75
Total **NEW** Strategic Projects for approval	200
Existing projects extended for implementation monitoring[1]	
Standards Review and Implementation	188
Completion of CPD project	44
Total **EXTENDED** projects for implementation monitoring	232
Transferred from BAU to Strategic Expenditure - approved expenditure[2]	-
IT Strategic Project	127
Transfer from BAU to Strategic Expenditure	127
Project expenditure pending approval[4]	-
IT Strategic Project- ongoing cost	482
Transfer from BAU to Strategic Expenditure	482

NEW Strategic Projects Approved	**£'000**
Analysis of Call for Evidence on legislative reform. Council approved in July 2021	15

General Optical Council
Budget – 2022-23

1 Projects are existing and have completed the originally intended stage. The implementation is now categorised as project instead of BAU. Approval pending for CPD project due to classification change from BAU to project.

2 On-going projects. Transferred cost related to project from BAU. 30% of IT staff cost transferred to the project as they will be heavily involved in projects in 2022/23.

3 People Plan Programme is a new project identified as part of GOC Refresh. This will include pay benefit review, culture -values and behaviour and an appraisal function review.

4 IT strategic project spend is pending approval either because the work is yet to be scoped or the proposed spend has been moved from BAU where pre-approval would not have been required. The sum is broken down into £172k apportionment of IT staff from BAU to project work, £75k for a new telephony system (to be scoped), £55k for potential consultancy costs and £136k for IT development work (CRM, MyGOC completion, website and SharePoint enhancements).

Staff Pay Award

A provisional staff pay award of eight percent is included in the budget following discussions with Remuneration Committee and ensuring achieving a balanced budget within the business-as-usual operations.

Business Plan and Budget
April 2022 – March 2023

Introduction

The General Optical Council (GOC) is the UK-wide regulator for optometrists and dispensing opticians, student optometrists and dispensing opticians, and optical businesses. We exist to protect the public by raising standards in the optical professions.

Our regulatory functions are:

- Setting the standards expected of optometrists, dispensing opticians, optical businesses and students
- Maintaining a register of those who are qualified and fit to practise, to train or carry on business as optometrists and dispensing opticians
- Investigating and acting where registrants' fitness to practise, to train or carry on business, is impaired
- Setting the standards for education and approving qualifications leading to registration

Foreword

As we enter the third year of our five-year strategic plan, 'Fit for the Future: 2020-2025' we do so in the knowledge that the ongoing pandemic has had an unprecedented impact upon patients, members of the public and our registrants. We know we will need to continue to be agile and empathetic in our response to emerging regulatory issues as we continue to deliver our operational functions and planned programme of work to fulfil our statutory objectives and in doing so, protect the public.

In this, our 2022-2023 business plan, we set out an ambitious programme of work and investment strategic projects aligned to our five-year strategic plan. We will continue to work with the sector, universities, and education providers as we take forward the implementation of our broadscale changes to the qualifications we approve. In January 2022 we launched our new three-year continuing professional development (CPD) scheme and closed down our old continuing education and training (CET) scheme, so it is right that in this year's business plan we apply effort to support registrants' engagement in our new approach to professional development and arrangements for registrant review and CPD providers' audit.

We finally launched the modern and refreshed GOC website after much delay alongside our new CRM system, making it easier for registrants to engage with our enhanced services. This year we plan to revitalize our approach to communications with an enhanced focus on engagement and co-production, critical to the success of the delivery of our strategic plan, as well as continuing to communicate key information that is clear, relevant, and timely to optical professionals, patients and stakeholders.

We will continue to realise the benefits of our investment in the GOC Refresh and the establishment of our new Change Directorate in the acceleration of our investment in our IT capability, the development of our People Plan and the implementation of our new customer care and engagement strategy, whilst continuing to support our registrants to deliver excellent eye care with our full range of business-as-usual activities.

Our recent success in reducing the fitness to practise (FtP) caseload has been driven by focusing on the right cases and dealing with those cases more appropriately. Over the course of the coming year, we expect that to translate into improved end-to-end timescales enabling us to invest resource in activities that prevent things from going wrong in the first place. Our FtP learning bulletin continues to be welcomed by our registrants.

Foreword

Last year the Covid-19 emergency remained at the forefront of our work and inevitably this resulted in our need to be more agile by accelerating some aspects of our strategy and delaying others. We will use the surplus generated by delays and savings in some of our planned 2021/22 activity to improve operations and invest in strategic projects in 2022/23, enhancing our services for public benefit in line with our strategic plan and our vision of being recognised for delivering world-class regulation and excellent customer service.

Finally, we will continue to put GOC values, our public duty to progress equality, diversity and inclusion as well as our commitment to become an anti-racist organisation at the heart of all we do.

I look forward to working with all our stakeholders to deliver this ambitious programme of work for the year ahead.

Leonie Milliner, Chief Executive and Registrar

Our mission, vision and values

Our mission, vision and values

Our ‘Fit for the Future’ strategy for 1 April 2020 to 31 March 2025 describes what we plan to do over the next five years to achieve our vision of being recognised for delivering world-class regulation and excellent customer service.

Our values

The interests of patients and the general public are at the heart of all we do, and we aspire to the timeless seven (Nolan) public sector principles of public life (selflessness, integrity, objectivity, accountability, openness, honesty and leadership).

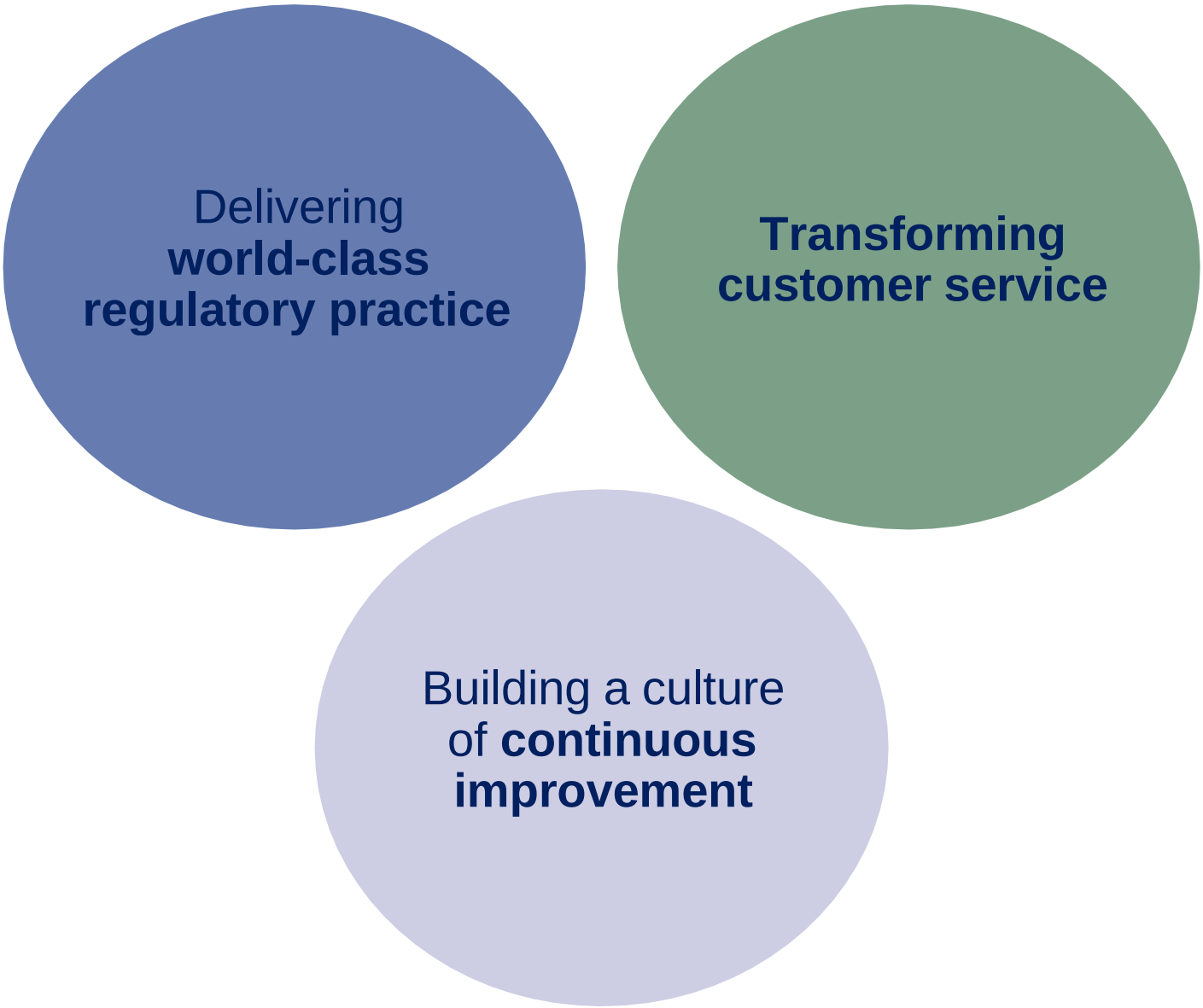
Our values underpin the way we work with each other, and with the public, our registrants and partner organisations:

- We act with **integrity**
- We pursue **excellence**
- We **respect** other people and ideas
- We show **empathy**
- We behave **fairly**
- We are **agile** and responsive to change

Our strategy

Strategic objectives

Our priorities are organised under three overarching strategic objectives:



2022/23 year in view

This business plan sets out our work programmes, milestones and high-level outputs that we plan to deliver alongside our business-as-usual activity in 2022/23 in order to deliver our three strategic objectives. We plan to achieve a break-even position in relation to our business-as-usual, while investing some of our reserves in strategic projects.

Work programmes

Below we outline the key programmes of work and strategic projects that we plan to undertake in 2022/23 and when they will occur. When the timing provides a single date, i.e., December 2023, this describes the date when the activity or project is expected start, or to be completed. When the timing provides a date range, i.e., April 2022 – June 2022 this describes the period in which we expect the activity or project to commence or to be completed. Some work programmes and strategic projects will take longer than a single year to complete, and some projects have already started but have yet to be completed. This is indicated below with a longer date range than the 2022/23 business plan.

Strategic Objective One – Delivering world-class regulatory practice		
Activity	**Start**	**Finish**
Develop business cases for any legislative reform following the GOC call for evidence, including any additional research required or development of policy positions	July 2022	Mar 2023
Develop and consult on new standards of practice, taking account of the outcome of the call for evidence and legislative reform consultations	Oct 2022	Mar 2023
Publish and implement new education and training requirements for GOC post-registration approved specialty qualifications	March 2022 and June 2022	2024/25 and beyond to 2026
Implement new education and training requirements for approved qualifications leading to registration as an optometrist or a dispensing optician	March 2021 (Ongoing)	2024/25 and beyond to 2028
Commission longitudinal research to measure the impact of the new education and training requirements	Jan 2023	March 2023

2022/23 year in view

Strategic Objective One – Delivering world-class regulatory practice		
Activity	**Start**	**Finish**
Commission knowledge hub/ information exchange to support providers and potential providers of post-registration approved qualifications in their design of qualifications to meet our new education requirements	Sept 2022	Dec 2022
Develop and consult on changes to non-UK registration scheme to ensure alignment with new education and training requirements	Sept 2022	March 2023
Implement new CPD scheme, including audit and portfolio review	January 2022 (Ongoing)	Dec 2024
Engage with DHSC's planned programme of regulatory reform	January 2022 (Ongoing)	March 2023
Develop business case for workforce data modelling/data analysis	April 2022	July 2022

2022-2023 year in view

Strategic Objective Two – transforming customer service		
Activity	**Start**	
Develop and implement a customer care and engagement strategy, working with both internal and external stakeholders	May 2022	May 2023
Review the effectiveness of our governance structure	April 2022	July 2022
Development and launch of new MyGOC website for registrants based on Microsoft 365	Jan 21 (Ongoing)	Dec 2022
Publish FtP learning bulletins	April 2022	March 2023
Review communications strategy and launch revised corporate branding	Jul 2022	Dec 2022
Review and implement new illegal practice strategy and protocol	April 2022	Sept 2022
Project to automate registration processes	Jan 21 (Ongoing)	March 2023
Scope, develop and implement replacement of existing phone system	May 2022	Dec 2022

2022-2023 year in view

Strategic Objective Three – building a culture of continuous improvement		
Activity	**Start**	**Finish**
Develop and implement a secure portal to share information with external parties involved in fitness to practise, registration and qualification approval and quality assurance as well as Council and committees	May 2022	January – March 2025
Development of CRM to support regulatory functions	April – June 2022	January – March 2025
Develop and implement a fitness to practise case management system	April 2022	April 2023
Develop a business case to review data collection of different groups of registrants' protected characteristics to better inform regulatory policy and assessment of impact	March 2022	March 2023
Develop and test business case / feasibility study for clinical performance coaching (or similar) for cases that do not meet the regulatory threshold	Sept 2022	March 2023
Develop and implement a three-year management development programme	June 2021 (Ongoing)	January – March 2024
Review of GOC premises and working environment	April – June 2022	January – March 2025
Archive management project to reduce historic paper records	June 2022	March 2023
Develop and implement a People Plan	June 2020 (Ongoing)	January – March 2023
Review, implement and embed a flexible hearings process	March 2022	January – March 2023
Review of internal banking and accounting procedures	June 2021(Ongoing)	January – March 2024
Develop a business case for a new systems solution for human resources and finance	Sept 2022	March 2023

What will success look like?

We will measure our success through the following high-level outcomes:

In aspiring to be world-class we should be rated highly by the Professional Standards Authority. We will aim to meet all their standards but will not let this get in the way of trying new and innovative approaches to regulation.

We should also retain the confidence of the optical professions and we will measure this through an annual registrant survey and regular stakeholder survey, looking, for example, at the extent to which we follow our values including behaving fairly, acting with integrity and pursuing excellence.

Public confidence in the professions we regulate is already strong and we expect this to be maintained if we are to uphold high standards. By protecting the public, we are also protecting the reputation of the optical professions. We have instigated an annual public perceptions survey and will continue this throughout the period of this plan.

We expect customer satisfaction with the GOC to increase if we deliver on our customer care and engagement strategy. We do not have a robust baseline and will prioritise the development of this as part of the development of our customer care and engagement strategy in 2022/23, with an emphasis on patients, the public and registrants.

We will measure success on a business as usual basis quarterly at senior management team land at Council, providing success measure indicators, RAG rated progress reporting and an indication of changes which have occurred from the previous quarter.

Council will receive the following, updated balanced scorecard report quarterly:

Quarterly Performance Dashboard – 2022/23

Better than last quarter	Off track
Roughly same as last quarter	At risk
Worse than last quarter	On track

FINANCE

Budget Operate within budget – Tolerance is ±10%	Q1	Q2	Q3	Q4
Reserves Operate within our reserves policy – Tolerance is ±10%	Q1	Q2	Q3	Q4
Change Deliver agreed planned strategic investment – Tolerance is ±10%	Q1	Q2	Q3	Q4

CUSTOMER

FTP timely updates Customers who receive an update every 12 weeks – Target is ≥90%	Q1	Q2	Q3	Q4
Registration Application forms completed – Target is ≥90%	Q1	Q2	Q3	Q4
Education quality of CPD provision CPD provision meets registrant expectations – Target is ≥90%	Q1	Q2	Q3	Q4

PEOPLE

Investment in People Planned events realised – Target is ≥90%	Q1	Q2	Q3	Q4
Turnover Staff turnover – Target is ≤17% (excluding FTCs ending)	Q1	Q2	Q3	Q4
Vacancy Rate Staff vacancies – Target is ±10% of total headcount (not FTE)	Q1	Q2	Q3	Q4
Engagement Index Staff engagement score – Target is to achieve an upward trend	Q1	Q2	Q3	Q4

PERFORMANCE

FTP Timeliness FtP cases resolved within 78 weeks (rolling medium) – Target is ≥60%	Q1	Q2	Q3	Q4
Education Approved qualifications adapted to meet new education and training requirements – Target is 100% by September 2025 (apart from CoO SfR)	Q1	Q2	Q3	Q4
Registration Quality & Accuracy Overall accuracy – Target is ≥98%	Q1	Q2	Q3	Q4

2022-2023 Budget

	2022-2023 **Budget** £'000
Income	9,994
Expenditure	9,946
Surplus / (Deficit) before reserve expenditure	**48**
Reserve Expenditure	1,920
Surplus / (Deficit) after reserve expenditure	(1,871)
Unrealised Investment gains	247
Surplus / (Deficit)	**(1,624)**

Quarterly Performance Dashboard – Q3 21/22

↑	Better than last quarter
↔	Roughly same as last quarter
↓	Worse than last quarter

Off track	C08(22)
At risk	
On track	

FINANCE

Budget Operate within budget with a positive variance.	↑
Reserves Operate within our reserves policy	↑
Efficiency Programme progress Realise 90% of planned efficiencies	↔

PERFORMANCE

FTP Timeliness 67% of concerns will be resolved within 78 weeks	↔
Education timeliness in assessing conditions 71% conditions reviewed on time	↓
Registration quality & accuracy 98% accuracy overall	↔

PEOPLE

Investment in People Realise 90% of planned events	↔
Sickness Absence 2.6% or less (minus COVID)	↓
Engagement Index Achieve an upward trend in the staff engagement score	↑

CUSTOMER

FTP timely updates 85% of customers receive an update every 12 weeks	↔
Registration 90% of all application forms completed within target	↔
Education quality of CET provision 90% of CET provision meets registrant expectations	↔

* Tier 1 errors are the most serious and are reserved for errors where the applicant should not have been put on to the register

KPI status (current)	Bullet points about the RAG status of the KPI and a comparison from last quarter and what/how/when improvement(s) will take place	Budget implications	Associated risks
FINANCE Reserves Operate within our reserves policy	• General reserve levels increased to £4.5m (target is £3.8m) due to high levels of surplus in Q3 Accounts. Several delayed projects and BAU operations as well as savings contributed to high surpluses during first 3 quarters. Some of the delayed operations will be carried out in Q4. • Reserve levels will be reviewed at Q3 forecast which is being carried out now.	• More funds available to spend.	• Non-compliance with reserves policy
PEOPLE Sickness absence 2.6% or less (minus COVID)	• Sickness rates have begun to increase again with a small number of long term sickness cases appearing. Overall total remains below the benchmark still.	• None	• Ability to cover work with reduced staffing.
PERFORMANCE FTP Timeliness 67% of concerns will be resolved within 78 weeks	• Since 1 April 2021, case examiners and the FtPC have concluded 93 cases (70 substantive CE decisions and 23 substantive FtPC decisions). Of these, 43% have concluded within 78 weeks (no change on Q2). • Comparison with last quarter – Performance is at the same level as last quarter and remains well below target, continuing to reflect the passage of older cases through the system to closure. The rolling closed case median (for both CE and FTPC decisions) is consistent at 98 weeks (against 78-week KPI) • Improvement – In Q1, we implemented a revised structure within case progression to dedicate a senior-level focus on the active progression of a number of remaining complex cases. In Q2 we have added additional case officer resource via secondment of trainee lawyers from our panel law firms, and in Q3 we added a case progression lawyer whose function is to solely to support the case officers with case progression, providing dedicated legal support that has been lacking at investigation stage. In Q4 the Head of Casework Operations transfers to the Change Directorate to launch a new 2022/25 FtP Improvement Plan. • The age of cases at pre-CE stage continues to improve, although the open medians fluctuate as expected. The median age of active investigations (cases not yet at case report stage) at 31 December were 37 weeks from date of complaint and 23 weeks in stage 2; these are higher than is ideal, but the overall age profile of cases at stage 2 is healthier than it was in May 2021 when we had 18 active investigations aged over 100 weeks – this is now reduced to 6 cases. Stage 3 is also improving. Although the in-stage median has crept up to 17 weeks, we moved a total of 14 stage 3 cases on in Q3, resulting in an improved age profile at stage 3, and with the three oldest cases expected to be moved to stage 4 in the next month.	• A small additional spend was required in Q3 on external legal input. • Possible additional spend in late Q4 to cover departure of in-house advocate	• Re-implemented COVID restrictions delaying or adjourning a small number of substantive hearings. • Number of new referrals currently projects at 42% increase on 2020/21, with 68% projected increase in investigations being opened.

General Optical Council

GOC Internal Operational Business Plan 2021- 2022

Quarter 3 Report (1 Oct 2021-31 Dec 2021)

This document provides Council with a top-line status report on internal business as usual and project-related tasks directly linked to the external business plan and aligned to our strategic objectives. Where the status of a task is either at risk or missed, or where the change is negative, a full update will be provided.

Priority
- ● **Critical** — Absolutely must be in place for the GOC's continued existence
- ● **Essential** — Must be in place to support day-to-day operations

Status
- ● **On track**
- ● **At risk**
- ● **Off track**

Change
- 🡅 **Better than last quarter**
- 🡇 **Worse than last quarter**
- → **Roughly same as last quarter**

Department	Timing	Status	Priority
Case Progression	Q3	2x on track ● 1x off track ●	● Critical
Case Progression	Q3	1x at risk ●	● Essential
CET	Q3	3x on track ●	● Critical
CET	Q3	5x on track ●	● Essential
Comms	Q3	3x on track ●	● Critical
Comms	Q3	5x on track ● 1x off track ●	● Essential
Education	Q3	3x on track ●	● Critical
Education	Q3	1x on track ●	● Essential
Facilities	Q3	3x on track ●	● Critical
Facilities	Q3	1x on track ●	● Essential
Finance	Q3	2x on track ●	● Critical
Finance	Q3	9x on track ●	● Essential
Hearings	Q3	N/A	● Critical
Hearings	Q3	3x on track ●	● Essential

Department	Timing	Status	Priority
HR	Q3	N/A	● Critical
HR	Q3	1x on track ● 1x at risk ●	● Essential
IT	Q3	1x on track ● 1x at risk ●	● Critical
IT	Q3	1x on track ● 1x at risk ●	● Essential
Legal	Q3	1x on track ●	● Critical
Legal	Q3	6x on track ●	● Essential
Policy & Standards	Q3	1x on track ●	● Critical
Policy & Standards	Q3	1x on track ● 1x at risk ● 1x off track ●	● Essential
Registration	Q3	4x on track ●	● Critical
Registration	Q3	4x on track ●	● Essential
Secretariat	Q3	6x on track ● 1x off track ●	● Critical
Secretariat	Q3	8x on track ●	● Essential
Standards/Secretariat	Q3	N/A	● Critical
Standards/Secretariat	Q3	N/A	● Essential

Department and Task	Bullet points about the Status & Change grading	How/when task will be brought back on track	Budget implications and associated risks
Case Progression – **PSA task** *FTP timeliness* Q1-Q4 | 🔴 Off track | ➔	• Decision/closure medians continue to be high as older cases progress through the system. However, the open age of the triage caseload – median six weeks – and the stage 2 caseload – median 41 weeks from date of complaint have reduced significantly by end Q3 • This is an indicator of improved future end-to-end performance.	• We estimate that we have lost approximately eight months on our 2019 projections over the last year, which indicates that our objective of achieving a 78-week end-to-end median by the middle of Q3 this year, has slipped to Q1 of the following year and focused work continues to ensure that this is met. • A restructured casework leadership team will provide greater case direction for investigators and help build manager capability. • Increased legal recruitment albeit delayed, should improve the pace of decision-making throughout case progression.	• Far lower than projected disclosures on hearings have increased the age profile at stage 3 which is a critical risk for our end-to-end deliverable. • This will result in delayed costs to our hearing function for 2021/22 (see below) • Due to delays in legal recruitment and an inability to recruit at the level required for our more complex work, more cases will have to be instructed out increasing our legal charges will be in the region of £100,000 for the second half of the year. • The recent advocate recruit has decided not to continue with the GOC and a decision has been taken not to revisit in-house recruitment until the pay issue can be addressed
Case Progression *115 substantive case examiner decisions* Q1-Q4 | 🟡 At risk | ➔	• Number of decisions to be made by case examiners during the year.	• 66 substantive decisions made by CEs for the YTD – 57% against a 75% ambition • There are a number of cases at pre-CE stage (including 18 currently at reps/comments) and notwithstanding the reduced number of concerns being opened, we expect to improve on the percentage over the last quarter	• Limited for year end. • Some recovery during Q4 but will be limited
Comms *Consultation Framework* Q1 | 🔴 Off track | ➔	• Sets out the code of best practice for consulting with our stakeholders	• Delayed due to sickness absences in both Policy & Standards and Comms and then the launch of the new website. • The new framework will be presented to SMT in Q4.	• There is a risk that our consultations will not be developed and published consistently across the organisation and therefore externally. There are no implications on the budget.
HR *Recruitment* Q2-Q3 | 🟡 At risk | ➔	• Despite the challenges of remote recruitment and an increasingly difficult market, recruitment continues successfully in the main. • Some roles have proved challenging, possibly due to salaries not paying market rates but we will shortly be receiving salary benchmark data to check this against. • On the positive side, *Hireful* has proved popular with end users and has enabled a significant increase in the number of roles we can run simultaneously	• Salary benchmarking data received and will be matched and any adjustments agreed in or before the next pay review. • Full review of pay policy scheduled for 2022. • Advertising budget increased significantly for remainder of 21/22 and thereafter.	• The key risk is delays to projects through inability to fill roles
IT (BAU) *Exploring opportunity for collaboration across regulators* Q1-Q4 | 🟡 At risk | ➔	• Discussion with other regulators to explore opportunities.	• This process did not start in Q3 due to work volume but will start in Q4.	• Possible savings through joint procurements although unclear on appetite for such activities. • Minimal risk with documented requirements.
IT (BAU) *IT Policy* Q1 | 🟡 At risk | ➔	• Explains to users their key responsibilities for the proper usage of GOC IT systems including security, care of equipment, use of the internet and email, data storage, and training.	• The revised draft IT Policy is being finalised after business consultation. Feedback has been received on the equalities impact assessment from our EDI partner and will go back to SMT with the revised policy in early Q4 ready for implementation in late Q4 (for policy dissemination) and Q1 2022-2023 (for new accounts/licences).	• Increased costs for setup, training, and licences, although not significant compared to the overall IT budget. • Aim of policy changes and use of GOC licences is to reduce risk through secure data exchange and usage.
Policy & Standards *Carry out background research into Standards of Practice for individual registrants* Q1-Q2 | 🟡 At risk | ➔	• Revision of standards for individual registrants in line with strategic plan in order to ensure continued public protection, taking opportunities to harmonise standards across the different healthcare professions likely to work together as part of multi-disciplinary teams.	• At risk due to long-term staff absences and the need to prioritise the CET project. Tried to partially address through recruitment of administrator but this was not successful. • Initial work begun in Q3 with discussion at Education and Standards Committees. A business case and project plan will be produced to agree the work plan and timescales going forward, taking into account the call for evidence on the Opticians Act (as Standards is one of non-regulatory levers through which we can effect change).	• Budgetary implications: we will make savings of £40k to be transferred to 2021/22. • Delay considered a minimal risk as we are still within the timescales we have committed to in the Strategic Plan and we have now started the work in Nov 2021 with a discussion at Education and Standards Committees.
Policy & Standards *Prepare new draft of Standards of Practice for individual registrants for consultation* Q3-Q4 | 🔴 Off track | ➔	• Revision of standards for individual registrants in line with strategic plan in order to ensure continued public protection, taking opportunities to harmonise standards across the different healthcare professions likely to work together as part of multi-disciplinary teams.	• Due to prioritisation of the CET project and staff sickness, this work has been re-phased into the new business plan for 2022/23 – this will still be in line with objectives in the strategic plan.	• See immediately above.
Secretariat *Conflicts of interest training* Q1-Q4 | 🔴 Off track | ➔	• Policy reviewed and approved by Council in Q2.	• Mandatory training to all members has been delayed and is now planned for Q4 2021/2022 - Q1 2022/2023.	• Budget implication: Consideration being given to external training due to lack of in-house resource

PUBLIC
C10(22)

Council

Financial performance report for the period ending 31 December 2021 and Q3 forecast of 2021/2022

Meeting: 16 March 2022	**Status:** for noting
Lead responsibility: Yeslin Gearty (Director of Corporate Services)	**Paper author:** Manori Wickremasinghe (Head of Finance)

Purpose

1. To provide a summary of the financial reports and the latest forecast for year 2021/2022 presented to ARC.

Recommendations

2. Council is asked to:
   - **note** the financial performance for the nine months ending 31 March 2021 in Annex one
   - **note** the Q2 forecast for the current year 2021-22 in Annex two.

Strategic objective

3. This report is relevant to delivery of all our strategic objectives.

Background

4. The forecast for 2021/22 relates to year 2 of the current strategic plan and is consistent with delivery of the current year's business plan.

Analysis

5. The December 2021 financial performance showed a surplus of £1,313k on business-as-usual activities and £870k before portfolio gains/losses. The report compares these results to the Q2 forecast. The results have improved against both budget and the Q2 forecast. Remote working, embedded efficiencies, savings, and several delayed operations have all contributed to the high surplus levels. Detailed analysis of performance and the risk of achieving Q2 forecast is included in the report (Annex One).

6. The high surplus level of December financial performance impacts the Q3 forecast made in January. The Q3 forecast is a part of a quarterly exercise using both actual performance to December and future predictions for Q4. The Q3 forecast for the current year is included in Annex two.

7. The new forecast, which includes initial cost on GOC refresh, projects a £1.271m surplus (£1.251m in business as usual) at the end of the current year. The forecast makes a part of a larger five-year forecast which enables us to make better decisions regarding new projects, working capital, cashflow, and reserves management.

Finance

8. There are no additional financial implications of this work.

Risks

9. The following risks are associated with finance, as identified in the finance risk register:
   - The GOC fails to deliver value for money
   - The GOC is unable to deliver its strategic plans, programme of change, and business as usual either sufficiently quickly or effectively
   - Financial impact on reserves arising from additional cost of Covid-19 and/or reduced income.
   - Capability and Resilience: Small teams leads to over reliance on particular individuals, causing burnout and errors and/or impacts organisational delivery if absent or on departure.

10. Reporting and monitoring financial performance against budgets and forecasts are a fundamental part of managing and mitigating these risks.

Equality Impacts

11. No equality impact has been undertaken.

Devolved nations

12. There are no implications for the devolved nations.

Communications

External communications

13. None planned.

Internal communications

14. The financial report and the forecast are shared with the Leadership Team and SMT as part of the regular financial reporting process.

Attachments

Annex one: Financial performance report for period ending 31 December 2021.
Annex two: Q3 Forecast for 2021-22.

Financial Performance Report for the Period ending 31 December 2021

General Optical Council
Financial Performance Report for the 09 months ending 31 December 2021

Contents

General Optical Council
Financial Performance Report for the 09 months ending 31 December 2021

G O C :- Summary P & L to 31 Dec 2021

	Actual £000's	Budget £000's	Variance £000's	Q2 Forecast £000's	Variance £000's
Registrant Income	7,395	7,206	189	7,412	(17)
Other Income	213	169	44	218	(5)
Expenses - BAU	(6,295)	(7,326)	1,031	(6,497)	201
Surplus / (Deficit) -BAU	**1,313**	**49**	**1,264**	**1,133**	**179**
Project expenditure	(443)	(561)	118	(500)	57
Surplus / (Deficit) -before portfolio Gains/Losses	870	(512)	1,382	633	236

Highlights

The results before unrealised gains/losses for the period ending 31 December 2021 show a positive variance of £1,382k against the budget and £236k against the Q2 forecast. The results before strategic projects (BAU) show a positive variance of £1,264k against the budget and £179k against the Q2 forecast.

The total registrant income of £7,395k is £189k higher than the budget and £17k less than the forecast. The total expenditure (including projects) of £6,738k is £1,149k favourable to budget and £258k to forecast.

The above budget is the originally approved budget. We have incorporated subsequent approvals made by the Council into the forecast.

Key drivers of the improved performance

Remote working, embedded efficiencies, and several delayed operations continue to make savings. Q1 and Q2 forecasts captured £272k savings (ref. table 3, page 7) made during the first half of the year.

Fresh Covid restrictions made us increase remote working again, resulting in more savings in facilities, hearings, and meeting costs.

Savings included several efficiencies. and delays in staff recruitments E.g., Consultancy work on the CET Evaluation project was brought in-house. Delays in staff recruitments and high levels of vacancies also contributed to the savings (ref table 2-page 6 and table 4- page 7).

Risks of achieving Q2 Forecast

(Please note this part of the report is now obsolete as we have an updated Q3 forecast presented with this report as Annex 2 to C10(22).

Delays and difficulties in recruiting suitable staff may impact workload and delay operations in some areas. Several recruitment campaigns are currently underway. There has been a challenge to recruit staff at the required quality. Increased activities of the economy have also impacted in the recruitment market, making recruiting the right candidates at the bottom of our current salary bands a challenge. This may force us to spend more on recruitment agencies and use temporary staff when facing recruitment delays. We had an 83% headcount compared to forecast numbers at the end of December. (Ref. table 4 – page 7).

There is a slight risk of not capturing some costs when activities have longer than annual repeat cycles. These need to be recorded in the 5-year forecast. All costs in activities changing departments need to be captured carefully.

Several of the delays will affect the 22/23 budget. E.g., A 15-day hearing was postponed to 22/23.

The Case progression forecast depends on assumptions made on legal cases progressing to Case examiner levels during the current year etc. These timings could be changed and under review at each forecast. The planned level of activity is expected to be met by Q4.

The forecast was updated to include several additional items approved by the Council since the original approval was made in February. E.g., additional funding to Case Progression to improve the operations and close more of old cases. Return to Old Bailey project was approved with £365k new budget from reserves. GOC Refresh will add further changes.

The Return to Old Bailey (Office fit-out Project) is a capital project and will not affect the surplus of this year.

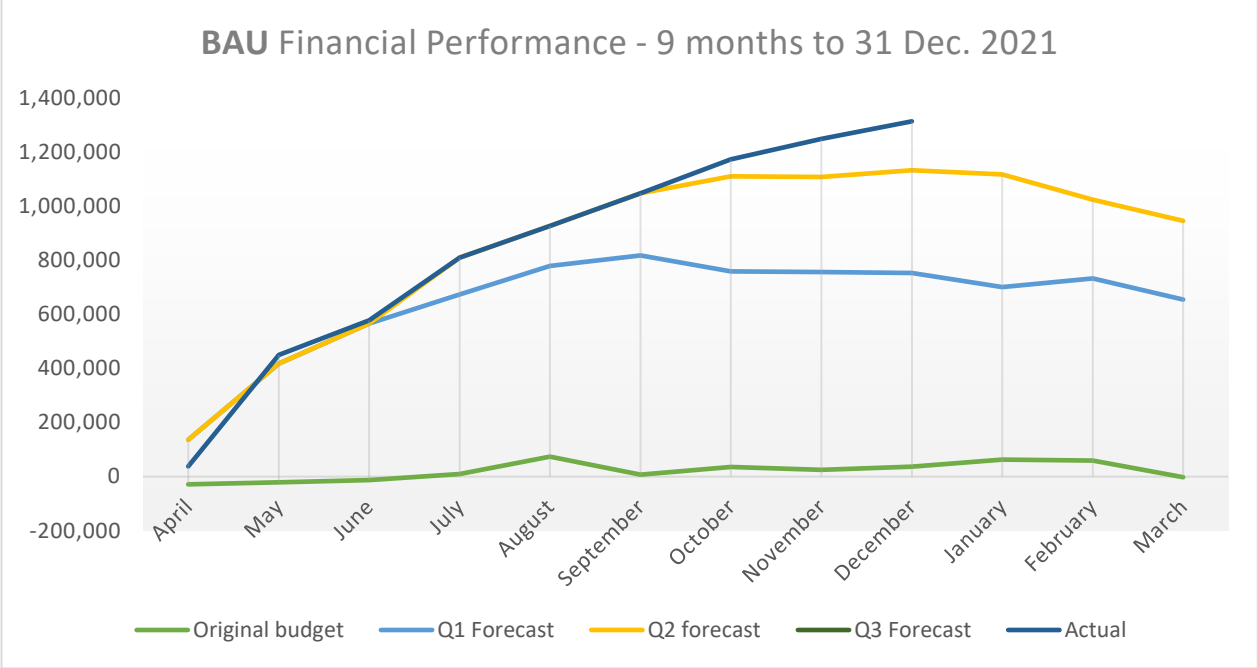
Future Impacts (So what?)

Due to the healthy surplus build-up, departments can now be encouraged to request more resources to meet their business plans. Our coordinated planning ensures we are mindful of effects on future years.

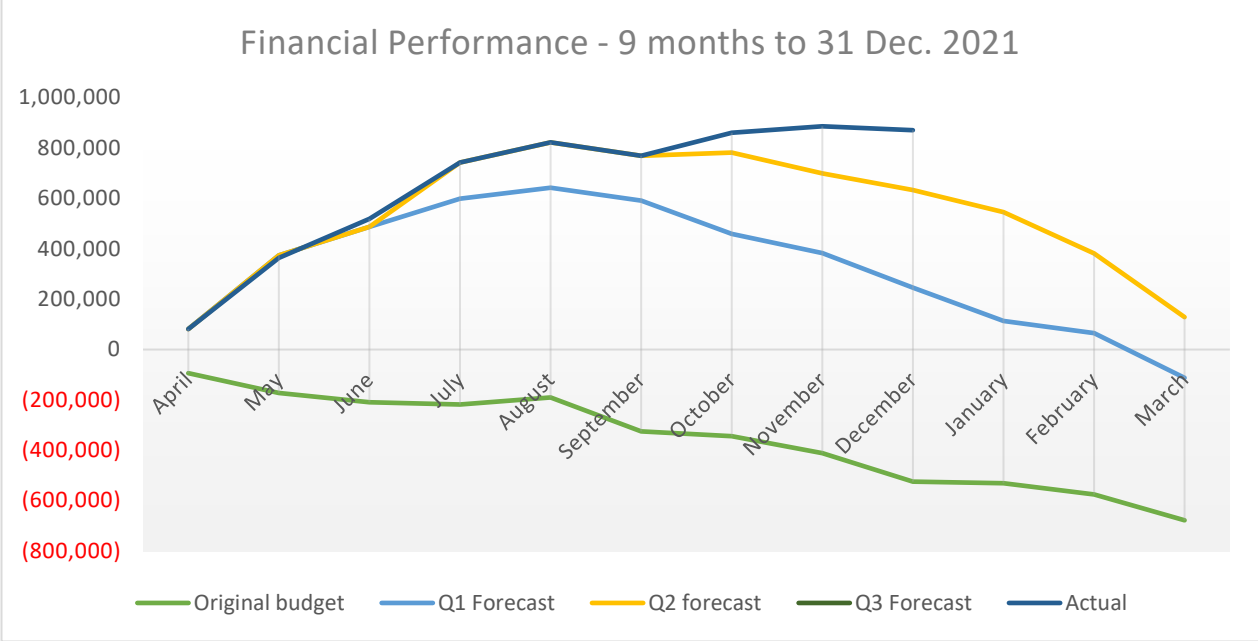
Some delays will impact 22/23, making the planning of BAU break-even point a challenge.

Clearly defined business cases and plans need to be set out accurately, recognising any changes required at each forecast.

Graphical analysis on Financial Performance and Variance

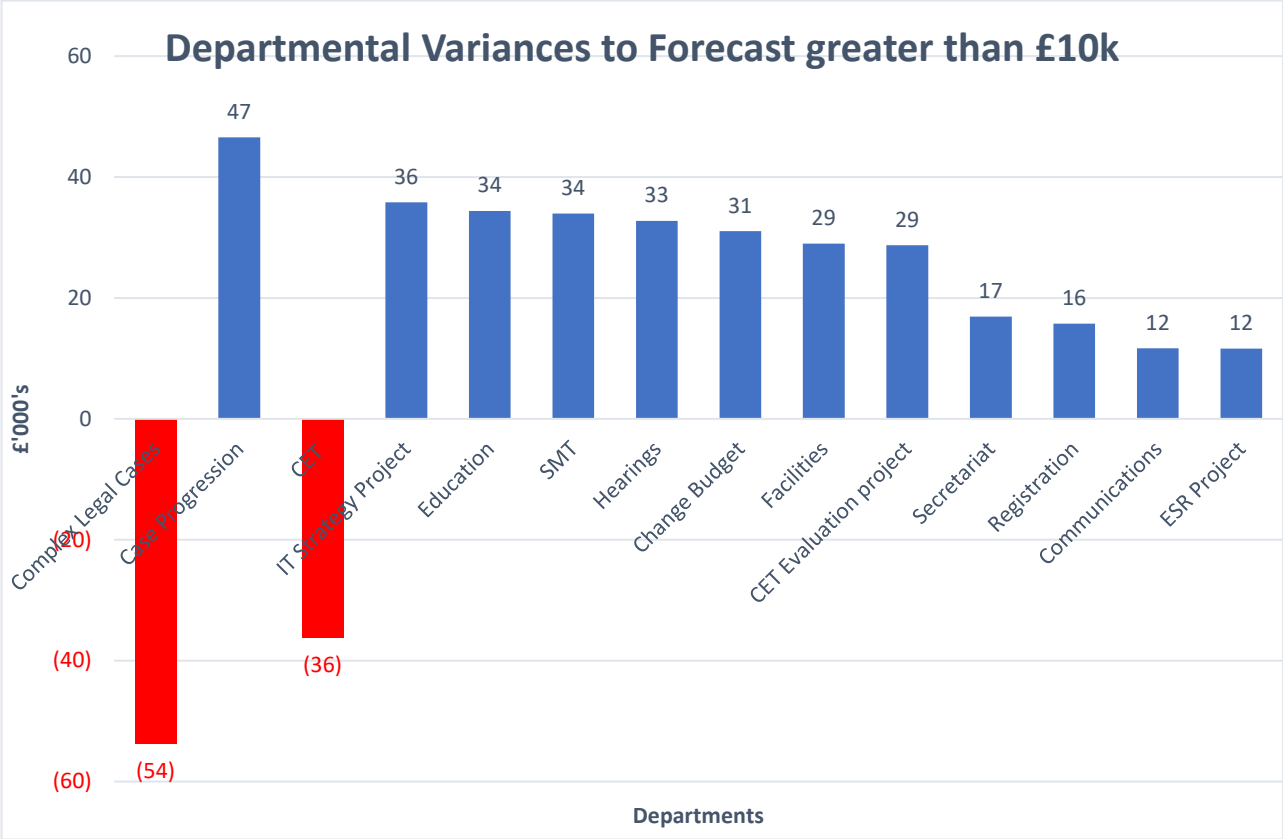


Graph 1



Graph 2

General Optical Council
Financial Performance Report for the 09 months ending 31 December 2021



Graph 3

Cash and Cash Equivalent Summary - 31 December 2021

	Actual £'000	Budget £'000	Variance £'000	Q2Forecast £'000	Variance £'000
Cash at Bank	847	440	407	624	223
Short term Investments	1,850	1,350	500	1,850	0
Working Capital	**2,697**	**1,790**	**907**	**2,474**	**223**
Investments	9,601	9,186	415	9,449	152
Total	**12,298**	**10,976**	**1,322**	**11,923**	**375**

Table 1

Analysis of expense variance -December	
Savings	£'000
Efficiency	1
Covid related savings	14
Covid related delays	0
Other savings	134
Staff vacancy gaps (excluding efficiency measures)	87
Other delays and timing	127
Others	27
Additional expenses	390
Additions	(132)
Others	0
Total Expense Variance	258

Table 2

Analysis of savings over past quarters					
Savings	Q1	Q2	Q3	Q4	Total
	£'000	£'000	£'000	£'000	£'000
Efficiency	29	0	1		30
Covid related savings	37	11	14		62
Other savings	112	83	134		329
Total Savings					421

Table 3

Headcount December 2021 (F T E's)

	Actual FTC Dec-21	Actual Perm. Dec-21	Actual Total Dec-21	Q2 Forecast Dec-21
Chief Executive Office	-	7.0	7.0	9.0
Strategy	2.0	7.3	9.3	9.3
Education	1.5	9.8	11.3	13.0
FTP	4.0	28.0	32.0	39.8
Resources	1.0	24.9	25.9	28.9
Change	1.0	-	1.0	4.0
Total Headcount	**9.5**	**77.0**	**86.5**	**104.0**

Table 4

General Optical Council
Financial Performance Report for the 09 months ending 31 December 2021

Table A
Income and Expenditure Accounts Including Project Expenditure

	April - December			April - December		
	Actual £'000	Budget £'000	Variance £'000	Actual £'000	Forecast £'000	Variance £'000
Income						
Registration	7,395	7,206	189	7,395	7,412	(17)
Dividend Income	195	147	48	195	197	(2)
Bank & Deposit Interest	0	7	(7)	0	0	0
Other Income	18	15	3	18	21	(3)
Total Income	**7,608**	**7,376**	**232**	**7,608**	**7,630**	**(22)**
Expenditure						
Staff Salaries Costs	3,375	3,727	352	3,375	3,482	107
Other Staff Costs	181	153	(29)	181	207	25
Staff Benefits	86	93	7	86	91	5
Members Costs	540	983	443	540	598	58
Case Examiners	40	61	21	40	52	12
Professional Fees	296	393	97	296	332	36
Finance Costs	76	53	(23)	76	75	(0)
Case Progression	627	465	(162)	627	575	(52)
Hearings	120	159	39	120	127	8
CET & Standards	233	256	22	233	234	1
Communication	24	26	2	24	29	5
Registration	6	8	2	6	6	(0)
IT Costs	351	555	204	351	391	39
Office Services	675	754	79	675	668	(7)
Other Costs	12	100	89	12	33	21
Depreciation & Amortisation	98	102	4	98	98	(0)
Total Expenditure	**6,739**	**7,887**	**1,148**	**6,739**	**6,997**	**258**
Surplus / Deficit	**869**	**(511)**	**1,380**	**869**	**633**	**236**
Unrealised Investment gains	786	202	584	786	248	538
Surplus / (Deficit)	**1,656**	**(309)**	**1,965**	**1,656**	**881**	**775**

General Optical Council
Financial Performance Report for the 09 months ending 31 December 2021

Table B
Income and Expenditure Accounts

	April - December			April - December		
	Actual £'000	Budget £'000	Variance £'000	Actual £'000	Forecast £'000	Variance £'000
Income						
Registration	7,395	7,206	189	7,395	7,412	(17)
Dividend Income	195	147	48	195	197	(2)
Bank & Deposit Interest	0	7	(7)	0	0	0
Other Income	18	15	3	18	21	(3)
Total Income	**7,608**	**7,376**	**232**	**7,608**	**7,630**	**(22)**
Expenditure						
Executive Office						
CEO's Office	171	261	90	171	195	24
Secretariat	457	529	72	457	474	17
Total Executive	**628**	**790**	**162**	628	669	41
Strategy						
Director of Strategy	88	106	17	88	88	0
Policy	101	161	60	101	100	(2)
Standards	34	106	72	34	34	0
Communications	153	167	14	153	165	12
Total Strategy	**377**	**540**	**163**	**377**	**387**	**10**
Education						
Director of Education	73	81	8	73	83	10
CET	268	273	5	268	232	(36)
Education	330	484	154	330	364	34
Total Education and Standards	**670**	**838**	**167**	**670**	**679**	**8**
FTP						
Director of FTP	86	83	(3)	86	86	0
Case Progression	1,320	1,156	(164)	1,320	1,367	47
Legal	228	280	52	228	223	(5)
Hearings	628	993	366	628	661	33
Total FTP	**2,262**	**2,512**	**251**	**2,262**	**2,336**	**74**

General Optical Council
Financial Performance Report for the 09 months ending 31 December 2021

Table B (Contd.)

	April - December			April - December		
	Actual £'000	Budget £'000	Variance £'000	Actual £'000	Forecast £'000	Variance £'000
Resources						
Director of Resources	92	102	10	92	92	(0)
Facilities	714	800	86	714	743	29
Human Resources	339	355	16	339	349	9
Finance	285	283	(2)	285	291	7
IT	507	622	115	507	515	9
Registration	323	382	59	323	338	16
Total Resources	**2,260**	**2,544**	**284**	**2,260**	**2,329**	**69**
Depreciation	98	102	4	98	98	(0)
Total Expenditure	**6,295**	**7,326**	**1,031**	**6,295**	**6,497**	**202**
Surplus / (Deficit) before project expenditure	**1,313**	**50**	**1,263**	**1,313**	**1,133**	**180**
Project Expenditure						
CET Evaluation project	138	117	(21)	138	167	29
Education Strategic Review project	137	219	82	137	149	12
IT Strategy Implementation	85	225	140	85	121	36
Change Budget	29	0	(29)	29	63	34
Complex Legal Cases	54	0	(54)	54	0	(54)
CRM Amortisation	0	0	0	0	0	0
Total Project expenditure	**443**	**561**	**118**	**443**	**500**	**56**
Surplus / (Deficit) after project expenditure	**870**	**(511)**	**1,381**	**870**	**633**	**237**
Investment gains	786	202	584	786	248	538
Surplus / Deficit	**1,656**	**(309)**	**1,965**	**1,656**	**881**	**775**

General Optical Council
Financial Performance Report for the 09 months ending 31 December 2021

Balance Sheet as at 31 December 2021

	2021-22 31 December 2021 £'000	2020-21 31 March 2021 £'000	Variance £'000
Fixed Assets			
Refurbishment	609	664	(55)
Furniture & Equipment	124	148	(23)
IT Hardware	26	45	(19)
IT software	0	0	0
IT Software - Working Progress	174	163	11
Refurbishment WIP	10	0	10
Total Tangible Fixed Assets	**943**	**1,019**	**(76)**
Investment	9,611	8,860	751
Total Fixed Assets	**10,554**	**9,879**	**675**
Current Assets			
Debtors, Prepayments & Other Receivable	218	537	(319)
Short term deposits	1,850	7,700	(5,850)
Cash and monies at Bank	847	660	187
Total Current assets	**2,915**	**8,897**	**(5,982)**
Current Liabilities			
Creditors & Accruals	579	676	(97)
Income received in advance	2,370	9,004	(6,634)
Provision for rent	239	469	(230)
Total Current Liabilities	**3,188**	**10,149**	**(6,961)**
Current Assets less Current Liabilities	**(273)**	**(1,252)**	**979**
Total Assets less Current Liabilities	**10,282**	**8,627**	**1,655**
Long Term Liabilities	0	0	0
Total Assets less Total Liabilities	**10,282**	**8,627**	**1,655**
Reserves			
Legal Costs Reserve	700	700	0
Strategic Reserve	2,000	2,000	0
Covid -19 reserve	1,800	900	900
Infrastructure / dilapidations	1,250	500	750
Income & Expenditure	4,531	4,527	4
Total	**10,282**	**8,627**	**1,655**

Q3 Forecast Report for 12 months to 31 March 2022

General Optical Council
Q3 Forecast Report – 2021-22

Contents

General Optical Council

Q3 Forecast Report – 2021-22

GOC Summary P&L Q3 forecast 2021-22

	Budget £'000	Q1 forecast £'000	Q2 forecast £'000	Q3 Forecast £'000	Variance to Budget £'000	Variance to Q2 Forecast £'000
Income	9,750	9,977	10,033	9,979	229	(54)
Expenditure (BAU)	9,750	9,323	9,088	8,728	1,022	360
Surplus / (Deficit) before reserve expenditure	**0**	**654**	**945**	**1,251**	**1,251**	**306**
Reserve (Strategic & legal) Expenditure	676	767	817	826	(150)	(9)
Surplus / (Deficit) after project expenditure	(676)	(113)	128	425	1,101	296
Unrealised Investment gains	269	434	359	846	577	487
Surplus / (Deficit)	**(407)**	**321**	**487**	**1,271**	**1,678**	**783**

Highlights

The new Q3 forecast for 2021/22 was prepared for ARC approval with comparisons against the previous quarterly forecast and budget.

The budget for the current year was approved in February 2021 and at a breakeven level for BAU operations. Since then, the surplus before project expenditure (BAU surplus) has increased at each forecast.

The key drivers of improved performance are:

The actual performance for the first nine months changed from previous forecast due to both savings and delays. The latest projections reduce the expenses for Q4 further from the Q2 forecast. Total savings and efficiencies of £421k made during the nine months are absorbed by forecasts.

Fresh Covid restrictions introduced in Q3 resulted in savings in hearings, meetings, and facilities-related costs. Delays in staff recruitments and high levels of vacancies also contributed to the savings. E.g., head count in December was 87/104. Some efficiencies such as providing in-house expertise instead of external consultancies increased the savings, reducing expenditure forecast.

The investment portfolio performance improved and was well above targets during the last 9 months. The forecast for the last quarter is on par with our risk grade. Our investment managers (Brewin Dolphin) project slower growth in 2022.

General Optical Council
Q3 Forecast Report – 2021-22

Risks to achieving the Q3 Forecast

The highest risk although at a lower likelihood would be loss of unrealised investment gains due to the possibility of market volatility. We hope this risk is minimal with only 2 months to complete 2021/22.

We have minimised the volatility of complex legal cases by identifying them and earmarking them for legal reserve. Cases costing £54k are identified to be funded by the legal reserve.

Currently, there is a large amount of staff recruitment underway. Delays in finding suitable staff in time may, in turn, delay some operations or progress against project plans.

General Optical Council

Q3 Forecast Report – 2021-22

Table A
Income and Expenditure Accounts

	Year 1 2021-22				
	Budget	Q1 Forecast	Q2 Forecast	Q3 Forecast	Variance
	£'000	£'000	£'000	£'000	£'000
Income					
Registration	9,524	9,745	9,765	9,719	(46)
Dividend Income	196	199	242	240	(2)
Bank & Deposit Interest	10	8	0	0	0
Other Income	20	25	26	20	(6)
Total Income	**9,750**	**9,977**	**10,033**	**9,979**	**(54)**
Expenditure					
CEO's Office					
CEO	357	272	271	259	12
Governance	697	616	631	609	22
Total CEO's Office	**1,053**	**888**	**902**	**868**	**34**
Regulatory Strategy					
Director of Regulatory Strategy	251	230	230	190	40
Policy	237	212	213	191	22
Communications	223	207	221	216	5
Standards	128	101	86	60	26
Education	622	569	501	460	41
CET	330	315	315	349	(34)
Total Regulatory Strategy	**1,789**	**1,634**	**1,566**	**1,468**	**98**
Regulatory Operations					
Director of Regulatory Operation	112	114	115	115	0
Case Progression	1,515	1,663	1,901	1,857	44
Legal	374	425	266	273	(6)
Hearings	1,325	1,113	973	889	84
Total regulatory Operations	**3,326**	**3,315**	**3,256**	**3,133**	**123**

General Optical Council
Q3 Forecast Report – 2021-22

Table A (Contd.)
Income and Expenditure Accounts (Contd.)

	2021-22				
	Budget	**Q1 Forecast**	**Q2 Forecast**	**Q3 Forecast**	**Variance**
	£'000	**£'000**	**£'000**	**£'000**	**£'000**
Corporate Services					
Director of Corporate Services	135	116	123	123	(0)
Facilities	1,060	1,009	1,002	966	36
Human Resources	471	483	465	466	(1)
Finance	440	439	429	430	(1)
Registration	501	471	477	435	42
Total Corporate Services	**2,607**	**2,518**	**2,496**	**2,421**	**75**
IT (BAU)	844	834	738	715	23
Depreciation & Amortisation	**131**	**134**	**128**	**128**	**0**
Total Expenditure	**9,750**	**9,323**	**9,086**	**8,728**	**358**
Surplus / (Deficit) before reserve expenditure	**(0)**	**654**	**947**	**1,251**	**304**
Reserve Expenditure					
Completion of CPD project	128	191	184	148	36
Education Strategic Review project	256	225	202	226	(24)
IT Strategy Project	292	181	259	287	(28)
Change	0	171	172	105	67
Strategic Projects	0	0	0	0	0
Upcoming Projects	0	0	0	0	0
Complex Legal Cases	0	0	0	54	(54)
Project Depreciation & Amortisation	0	0	0	6	(6)
Total Project expenditure	**676**	**767**	**817**	**826**	**(9)**
Surplus / (Deficit) after project expenditure	**(676)**	**(113)**	**130**	**425**	**295**
Unrealised Investment gains	269	434	359	**846**	487
Surplus / (Deficit)	**(407)**	**321**	**489**	**1,271**	**782**

General Optical Council

Q3 Forecast Report – 2021-22

Table B
Q3 Forecast - Including Project Expenditure

	2021-22				
	Budget	Q1 Forecast	Q2 Forecast	Q3 Forecast	Variance from Q2 forecast
				£'000	£'000
Income					
Registration	9,524	9,745	9,765	9,719	(46)
Dividend Income	196	199	242	240	(2)
Bank & Deposit Interest	10	8	-	-	0
Other Income	20	25	26	20	(6)
Total Income	**9,750**	**9,977**	**10,033**	**9,979**	**(54)**
Expenditure					
Staff Salaries Costs	5,025	4,880	4,843	4,609	234
Other Staff Costs	410	527	522	308	214
Staff Benefits	116	115	123	117	6
Members Costs	1,256	960	838	823	15
Case Examiners	140	145	141	67	74
Professional Fees	561	600	586	476	110
Finance Costs	131	121	111	68	43
Case Progression	560	626	710	865	(155)
Hearings	179	163	139	169	(30)
CET & Standards	132	175	175	260	(85)
Communication	55	56	51	47	4
IT Costs	668	589	572	656	(84)
Office Services	1,061	997	964	902	62
Other Costs	1	2	0	51	(51)
Depreciation & Amortisation	131	134	128	134	(6)
Total Expenditure	**10,426**	**10,090**	**9,903**	**9,554**	**349**
Surplus / Deficit	**(676)**	**(113)**	**130**	**425**	**295**
Unrealised Investment gains	269	434	359	846	487
Surplus / (Deficit)	**(407)**	**321**	**489**	**1,271**	**782**

General Optical Council
Q3 Forecast Report – 2021-22

Detailed analysis of the Q3 forecast

Revenue

Overall revenue forecast at £9,979k has marginally reduced from the Q2 forecast by £54k. Registration income decreased by £46k from the Q2 forecast, largely due to fewer new registrants than forecasted. The decrease was partly offset by higher-than-expected non-UK registrant applications. We also expect less income through CPD provider registrations since the new scheme does not have a category for paying a higher fee for fast processing.

Unrealised investment gains of £846k include the high level of increase of portfolio valuation during the first nine months of the year and a marginal forecast of increase for the Q4. Brewin Dolphin projects both negatives and positives for 2022, positives outweighing the negatives.

Expenditure

Table A shows the traditional directorate/department-based analysis categorises while table B shows the type of expenditure including strategic expenses.

Efficiencies and savings

£149k of efficiencies and savings made during the last quarter is absorbed into the current forecast.

Delays to Year 2

Several activities were delayed to Year 2 and the cost is included in the 2022-23 budget. E.g., a 15-day hearing.

Staff Salaries

Key highlights from Table B are the high positive variance of staff salary costs (+£234k) and other staff costs (+£214k). Staff salary costs were reduced due to several vacancies during the period. As at 31st December there were 17% vacancies in staff numbers compared to Q2 forecast projections. 20 vacancies are expected to be filled by the year-end, bringing headcount totals to the latest forecast levels.

Headcount Projection (FTE's) - 2021-22

	Budget	Q1 Forecast	Q2 Forecast	Q3 Forecast
	Mar-22	Mar-22	Mar-22	Mar-22
Chief Executive Total	10	9	9	7
Regulatory Strategy	23.3	23.3	23.3	25.3
Regulatory Operations	28	38	39.6	38.8
Corporate Services*	26.9	26.9	28.9	21.9
Change*	0	0	8	14
Total Headcount	88.2	97.2	108.8	107

** IT department changed from corporate services to Change in Q3 forecast*

PUBLIC
C11(22)

COUNCIL

Independent Audit of FtP Decisions 2020-21

Meeting: 16 March 2022 **Status:** for noting

Lead responsibility: Dionne Spence, Director of Regulatory Operations
Paper Author: Dionne Spence, Director of Regulatory Operations
Council Leads: Tim Parkinson and Lisa Gerson

Purpose

1. To provide independent assurance that decisions made within Fitness to Practise (FtP) cases comply with legislation, rules and decision-maker guidance, and that they meet the overarching GOC objective of protecting the public.

Recommendations

2. Council is asked to **note**:
   2.1 the findings of the 2020-21 audit (Annex 1); and
   2.2 the management responses and actions taken in respect of the learning points arising (Annex 2) and consider possible additional measures in response to the recommendations contained in the report.

Strategic objective

3. This work is included in our 2021-2022 business plan and contributes to the achievement of the following strategic objective: delivering world class regulatory practice.

Background

4. The Professional Standards Authority (PSA) carries out an annual performance check on the healthcare regulators to assess their effectiveness in protecting the public and promoting confidence in the profession.

5. Each regulator is asked to provide the PSA with the evidence of how they have met the Standards of Good Regulation for each of the core regulatory functions, which the PSA considers along with other information, before producing the PSA annual performance review report that is published and submitted to Parliament.

6. This annual audit has been conducted to comply with PSA fitness to practise standard 16:

'The regulator ensures that all decisions are made in accordance with its processes, are proportionate, consistent and fair, take account of the statutory objectives, the regulator's standards and the relevant case law and prioritise patient and service user safety.'

Analysis

7. The audit was conducted by RadcliffesLeBrasseur (RLB), solicitors. This was the sixth annual audit conducted by RLB and the second since they successfully re-tendered for the audit contract in early 2020.

Audit Scope and Methodology

8. This audit included decisions made between 1 April 2020 and 31 March 2021. Although all categories of decision are reviewed, the audit focuses primarily on higher-risk decisions, for example:
   - cases closed by case examiners (CEs), by the Investigation Committee (IC) and by the Registrar at triage stage – considered higher risk as they are decisions based on the documents alone and without a public hearing,
   - cases closed by the Fitness to Practise Committees (FtPC), and
   - decisions of the FtPC not to issue an interim order, following an application by the GOC.

9. For this audit we again increased the number of decisions reviewed that were taken by the Registrar at triage stage. This was one of the risk management mechanisms we committed to when we enhanced the Acceptance Criteria in July 2019 and have consistently increased the sample size since.

10. The audit was conducted using the following methodology:

    - whether the relevant FtPC / CEs / Registrar had sufficient information available to make the decision concerned;
    - whether relevant procedural requirements were complied with, including providing the registrant with a suitable opportunity to make representations and the complainant with an opportunity to comment on the registrant's representations;
    - whether the decision accorded with the GOC's published guidance;
    - whether the decision was well reasoned such that a member of the public would be able to read the determination and understand the reasoning; and
    - whether the decision met the requirements of the GOC's equality and diversity policy.

11. The categories and sample sizes for which the audit was conducted are outlined below:

TRIAGE DECISIONS		Total	Sample	%
1	Decisions at triage to open a case	65	5	7.5
2	Decisions at triage not to open a case	272	34	12.5
CASE EXAMINERS' DECISIONS				
3	Decisions of the Case Examiners - take no further action	53	15	28
4	Decisions of the Case Examiners - issue a Registrant with advice	12	4	33
5	Decisions of the Case Examiners - issue a warning	16	10	62
6	Decisions of the Case Examiners - minded to issue a warning	9	8	88
7	Decisions of the Case Examiners - request further information	8	1	12.5
8	Decisions of the Case Examiners - refer for Performance Assessment	0	0	n/a
9	Decisions of the Case Examiners - refer for Health Assessment	0	0	n/a
10	Decisions of the Case Examiners - refer a matter to the FTPC	37	5	13.5
11	Decisions in cases reviewed under Rule 15 of the General Optical Council (Fitness to Practise) Rules 2013	2	2	100
12	Decisions in cases reviewed under Rule 16 of the General Optical Council (Fitness to Practise) Rules 2013	37	8	22
INVESTIGATING COMMITTEE DECISIONS				
13	Decisions on Performance or Health Assessments	0	0	n/a
FtPC DECISIONS				
14	Decisions of the Fitness to Practise Committee - issue an interim order	6	2	33
15	Decisions of the Fitness to Practise Committee - take no further action	10	7	70
16	Decisions of the Fitness to Practise Committee - issue a warning	1	1	100
OTHERS				
17	Appeal Case	0	0	n/a

12. The cases to be audited were selected randomly by RLB ensuring the independence and objectivity of the process.

Audit Findings

13. The auditor's overall finding was:

> *"We confirm that the findings made in this audit demonstrate substantial compliance with the Council's statutory obligations. They also demonstrate compliance with the Council's own procedural requirements and guidance. Whilst we have identified a number of cases where there were errors in decision making most were regarded as not having been material to the outcome. In a small number of cases we identified material errors and we detail those in this report…"*

14. The report contains many positive observations including:

FtP Team

- *In the majority of the cases which we reviewed the decision with respect to referral for consideration of an Interim Order were clear and appropriate.*
- *In the majority of cases the allegations were expressed in a clear and unambiguous manner. We address a small sample of cases where there was scope for improvement.*
- *We saw evidence of European alerts being submitted and appropriate European alert closures also being circulated. We also saw evidence of case workers following up with registrants to obtain their indemnity information and to check whether they intended to file representations. Decision letters relating to warnings contained clear information about the nature and effect of the warning.*

Triage

- *Triage decisions were generally completed promptly following receipt of information.*
- *We reviewed 5 triage decisions to open an investigation. We regarded the decision to open an investigation as appropriate in each case.*
- *We reviewed 34 triage decisions not to open an investigation. These covered a range of themes, including health and conduct, and related to both business registrants and individuals. A small number of cases were a cause for concern.*
- *Whilst the initial decisions of the Case Workers were generally reasonable and clearly explained, we saw evidence of the benefits which senior Case Worker review brings to the Triage process. On occasion this led to a different disposal whilst on other occasions it led to a more sophisticated and appropriately reasoned consideration of the case.*

Case Examiners / Investigation Committee

- *In general, the real prospect test was correctly stated in the Case Examiners' decisions and was correctly applied. In previous audits we have identified examples of determinations where the Case Examiners had misstated the test. We did not encounter any such examples in this year's sample.*
- *Case Examiners' decisions routinely noted the registrant's date of first registration and their fitness to practise history.*
- *Decisions generally emphasised that it was not the Case Examiners' role to determine whether the Registrant's fitness to practise is impaired.*
- *It was common for the Case Examiners to identify potential breaches of the Code or Standards in their decision, identifying the relevant paragraph numbers. This is a practice which we have previously endorsed, as it is important for allegations to be related to the relevant professional standards documents.*
- *As in previous years, our review of determinations demonstrated Case Examiners engaging well with the evidence and setting out their assessment clearly.*

- *We reviewed 19 decisions in these categories (closure with no further action/ advice). Save for specific issues dealt with specifically elsewhere in this report, the decisions were appropriate and were generally well reasoned with appropriate reference being made to relevant standards and guidance.*
- *We reviewed 5 decisions to refer cases to the FTPC. In each case we regarded the decision as appropriate and well-reasoned.*

Fitness to Practise Committee

- *There were a number of areas of good practice we observed, including Committees setting out the background at the outset of the determination, clear summaries of legal advice provided, and clear and careful analysis of the evidence including explanations of why one witnesses evidence was preferred over another's.*

Material Errors

15. The auditor identified two cases where he considered that case examiners had incorrectly or failed to apply relevant case law or guidance in their decision not to refer the matter to an FtPC, and a further error identified in a case where a warning had been issued in respect of a single clinical incident where there was an over-reliance placed on the absence of harm, rather than what the conduct signalled on respect of the potential future risk of harm.

16. We reviewed these findings and considered whether the case should be referred back to CEs under Rule 15 of the Fitness to Practise Rules 2013. We sought legal advice on the issues and concluded that these cases should not be reopened.

17. CEs were provided with a detailed case law update during their annual training date in November 2021 and we undertook a broader review of our decisions to ensure there have been no other cases closed on the sole basis of absence of actual harm.

18. The report has been shared with our new dedicated casework lawyer who will quality assess all CE decisions and we have extended the remit of our determination review group to include any decisions that raise concern. The concerns raised have also been fed back to our case progression teams for wider learning and improvement.

19. A final concern was raised over a Registrar decision to close a student dishonesty case in triage without considering the additional dishonesty demonstrated within the provider's initial investigation. The GOC accepted that more could have been done to follow up with the provider in respect of their findings and action taken and we have written to the provider for further information.

Learning Points

20. The report also contains a number of learning points. Where these relate to decision-making, they were addressed at the FtPC member training in September

2021, and at CE / IC training in November 2021. The lead auditor attended the training events to walk through the learning points with decision-makers. All material issues were dealt with at the training events and have been fed back to individual teams for further discussion and training.

21. The learning points, and actions taken, are set out at Annex Two and it is noted where the actions are complete.

Finance

22. The cost of the audit came within the approved budget.

Risks

23. The audit was presented to the Audit Risk and Finance Committee on 20 January 2022.

24. The main risk of not undertaking this audit, or not following the recommendations as outlined in the audit, is that the GOC may fail to fulfil its overarching objective to protect the public and that confidence in our decision making could be undermined.

Equality Impacts

25. An Equality Impact Assessment has not been completed in respect of this audit.

Devolved Nations

25. There are no issues for the devolved nations identified in this report.

Other Impacts

26. No other impacts have been identified arising from this audit.

Communications

External

27. The overall assurance level arising from the audit has been communicated with the PSA. They have asked to see the report in its entirety which we will share once laid before Council.

Internal

28. The key points from the audit have been communicated with
    - GOC Senior Management Team
    - GOC Audit, Risk and Finance Committee
    - FtP Committee chairs and members
    - Case Examiners and Investigation Committee members
    - GOC FtP staff

Annexes

One: RadcliffesLeBrasseur: Audit of Decisions 2020-21
Two: GOC Management Summary and Responses

RadcliffesLeBrasseur LLP

Audit of decisions of case examiners, investigating committees and fitness to practise committees

(1 April 2020 – 31 March 2021)

Contact: Stewart Duffy | T. 020 7227 7418 | E. stewart.duffy@rlb-law.com

October 2021

INTRODUCTION

The Professional Standards Authority (PSA) has responsibility for overseeing the UK's nine health and care professional regulatory bodies, including the General Optical Council. Each of the nine health and care professional regulatory bodies is legally required by Section 27 of the National Health Service Reform and Health Care Professions Act 2002 to cooperate with the PSA.

The PSA carries out an annual review of each health and care regulatory body's performance, assessed against performance standards. The PSA publishes Standards of Good Regulation and issued new standards which were effective from January 2020. These replaced the 2016 version. One of those fitness to practise performance standards in the 2016 version (Standard 8) requires each regulatory body to put in place a mechanism for reviewing decisions made during the fitness to practise process:

> *"All fitness to practise decisions made at the initial and final stages of the process are well reasoned, consistent, protect the public and maintain confidence in the profession."*

In meeting this standard, each regulator is expected to implement its own mechanism to audit fitness to practise decisions and to ensure there is feedback to its Committees of any learning points arising from the audit.

In the new Standards the equivalent provision is Standard sixteen which states:

> *"The regulator ensures that all decisions are made in accordance with its processes, are proportionate, consistent and fair, take account of the statutory objectives, the regulator's standards and the relevant case law and prioritise patient and service user safety."*

The General Optical Council appointed RadcliffesLeBrasseurLLP to conduct an independent audit of decisions made by the Case Examiners and the Investigation and Fitness to Practise

Committees of the Council in relation to cases concluded in the period 1 April 2020 – 31 March 2021. This report is the product of that audit.

EXECUTIVE SUMMARY

We confirm that the findings made in this audit demonstrate substantial compliance with the Council's statutory obligations. They also demonstrate compliance with the Council's own procedural requirements and guidance. Whilst we have identified a number of cases where there were errors in decision making most were regarded as not having been material to the outcome. In a small number of cases we identified material errors and we detail those in this report (Cases 2021/040, 2020/081, 2020/002 and 2018/486).

We also identified a number of learning points which the Council may wish to consider as part of its ongoing process of quality improvement.

AIMS AND METHODOLOGY

Objective

The objective of this audit was to assess whether the decisions made by the Case Examiners and the Investigation and Fitness to Practise Committees, during the audit period, were in accordance with the Council's role in protecting the public interest. The public interest includes protecting the public, maintaining public confidence and declaring and upholding proper standards of conduct. It is also accepted that there is a public interest in registered practitioners not being harassed by unfounded complaints. In the course of the audit we also make observations on other aspects of the case handling process which may impact on decision-making.

Assessment

In assessing cases, the audit of each case took into account the following issues:

- Compliance with procedural requirements
- Application of relevant guidance
- Clarity of reasoning

Audit Scope and Sampling

Prior to conducting the audit we were provided with the numbers of cases falling within each of these categories and details of the case identifier for each case, together with the date on which the relevant decision was made. Within each category a sample of the cases was reviewed with the exception of the cases in categories 6,11,16 and 18 where 100% of cases were reviewed. In respect of each category of cases, the sample was randomly selected by using a web based random sequence generator. The total number of cases and sample chosen in each category were as follows:

		Total Number	Defined Sample
TRIAGE DECISIONS			
1.	Decisions at triage to open a case	65	5
2.	Decisions at triage not to open a case	272	34
	CASE EXAMINERS' DECISIONS		
3.	Decisions of the Case Examiners to take no further action	53	15
4.	Decisions of the Case Examiners to issue a Registrant with advice	12	4
5.	Decisions of the Case Examiners to issue a warning	16	10
6.	Decisions of the Case Examiners that they are minded to issue a warning	9	2 (8)
7.	Decisions of the Case Examiners to request further information	8	3 (1)
8.	Decisions of the Case Examiners to refer to the Investigating Committee for Performance Assessment	0	0
9.	Decisions of the Case Examiners to refer to the Investigating Committee for Health Assessment	0	0
10.	Decisions of the Case Examiners to refer a matter to the FTPC	37	5
11.	Decisions in cases reviewed under Rule 15 of the General Optical Council (Fitness to Practise) Rules 2013	2	2
12.	Decisions in cases reviewed under Rule 16 of the General Optical Council (Fitness to Practise) Rules 2013	37	8
INVESTIGATING COMMITTEE DECISIONS			
13.	Decisions on Performance or Health Assessments	0	0
FTPC DECISIONS			
14.	Decisions of the Fitness to Practise Committee to issue an interim order following an application by the General Optical Council	6	2

15.	Decisions of the Fitness to Practise Committee to take no further action	10	7
16.	Decisions of the Fitness to Practise Committee to issue a warning	1	1
OTHERS			
17.	Appeal Case	0	0
18.	PSA Letters	3	3

Note: In the course of reviewing decisions in one category the auditor was naturally lead to review decisions in a different category in respect of the same case. Thus the total number of decisions reviewed in each category is higher that that set out above for categories 6,7 and 12.

Conduct of the Audit

The audit was conducted remotely by reviewing the record of the decision together with the electronic case records of all of the selected cases, including relevant correspondence, statements and other documents. Hearing transcripts were not reviewed. In order to assess compliance with relevant requirements we designed an aide memoire for use by the auditors to ensure that relevant factors were considered.

Relevant Law and Guidance

In conducting the audit, we took into account the following material:

- The Opticians Act 1989 ("the Act")
- General Optical Council (Fitness to Practise) Rules 2013 ("the Rules")
- The Sale of Optical Appliances Order of Council 1984
- Code of Conduct
- Standards of Practice for Optometrists and Dispensing Opticians
- Standards of Practice for Optical Students
- Code of Conduct for Business Registrants

- Standards for Optical Businesses
- The GOC's Standards Framework
- GOC Acceptance Criteria
- Guidance for the Investigation Committee/Case Examiners
- Guidance regarding warnings issued by the Investigation Committee
- GOC Guidance for Fitness to Practise Committees
- GOC Guidance for Performance Assessment
- GOC Indicative Sanctions Guidance
- PSA Performance Standards
- Relevant case law relating to Fitness to Practise
- General Optical Council's Equality and Diversity Policy

THE TRIAGE PROCESS

In this section, we summarise findings made in relation to cases falling within the various categories, together with overall conclusions.

Triage Decisions

We reviewed a total of 39 triage decisions. The triage decisions were typically appropriate and sufficiently reasoned. However, there were a few areas which we have selected for thematic comment.

Risk Assessment at Triage

Risk Assessment is an important part of the triage process and we note that the initial risk assessment is reviewed regularly. We identified a few cases where we felt the approach to risk assessment merited comment. We noted a particular theme around assessment of future risk and reliance on the absence of harm in the index complaint.

In previous reports we have considered the role which the occurrence of harm, or its absence, plays in assessing fitness to practise concerns. We noted that the absence of harm may be fortuitous, it may result from the intervention of a third party - for example where a patient who is disatsified with an assessment seeks a second opinion within a short space of time. In assessing future risk the absence of harm in the index case may be a poor indicator. It is crucial that the assessment considers the nature of the alleged act or omission and the potential of such acts or omissions to cause harm.

In Case 2020/106 the risk was assessed as low. In attributing that risk level the decision noted:

> *"[T]here is no element of patient harm here and although she had to ask for copy of prescription; it was given."*

We do not disagree with the risk level, however, the framing suggests that the absence of harm to the complainant determined the assessment of the future risk posed by the registrant if the allegations are true.

There appeared to be a tendency in Triage decisions to equate the absence of harm in the index complaint to an absence of future risk. There also appeared to be a tendency to assess only clinical safety risks. It is important that paragraph 2.9.2 of the Acceptance Criteria is applied with care.

In Case 2020/309 concerns were raised regarding a registrant pactising in breach of Interim Order of Suspension. The complaint suggested that particular patients may have been offered appointments with the registrant but then cancelled those appointments for their own reasons. The Case Officer noted:

> *"- No actual appointment/eye test took place as the patient indicated she was going to cancel the appointment. As such, no harm has been caused."*

There is no express acknowledgment that the mitigation relied on here was fortuitous and could not be relied upon in the assessment of future risk. Later in the decision it was noted:

> *"Working whilst under an interim suspension order is no doubt serious; however, without any evidence that this is in fact happening (and without any way to obtain confirmation), proportionality needs to be exercised. As such, my recommendation would be for this matter to be closed. With the information we have, there is no evidence of 'actual risk or harm'."*

The available evidence suggested that a company owned by the registrant was offering appointments whislt the registrant was suspended. There was no direct evidence that those appointments were with the registrant. We agree that there was no direct evidence of the registrant breaching her suspension and, in that sense, there was no evidence of 'actual risk' to patient safety. However, the decision did not note the reasons for the existing IO suspension which would be relevant both to the assessment of clinical risk, and risk to the public interest if the allegation were through.

Learning Point 1

We repeat the learning point raised in last year's report:

The Case Preparation Team should be reminded of the following points:

1. The absence of harm to the complainant (or patient(s) who is/are the subject of a complaint) may merit limited weight in assessing the future risk posed by the Registrant if the alleged concerns are true. Significant departures from expected standards do not inevitably result in actual harm on every occasion.

Protected Characteristics

We reviewed three cases where the issue of discrimination based on a protected characteristic was a potential feature.

In Case 2020/072 the complaint was summarised as follows:

> *"The complainant's father, Mr X, was advised to book an appointment six weeks after cataract surgery. Three attempts were made to attend…, but the practice cancelled on each occasion. When the complainant asked why they could not see X, the optometrist responded: 'I hope you appreciate that your father is in a wheelchair and wheelchair patients take longer than usual and I have other people to see'."*

We noted that in the risk assessment the concern was framed in this way:

> *"This complaint regards **an inappropriate comment** and **no patient harm** was caused. An attempt was made to rebook the appointment."*

Two aspects of this framing concerned us. Firstly, framing the complaint as being about an "inappropriate comment" mischaracterised the complaint. Secondly, the assessment that no patient harm was caused adopted an unduly narrow, clinical, view of the issue of harm.

Rather than being a complaint about a comment, the complaint was about three cancelled appointments which, based on the practice's alleged explanation, had been cancelled

because the patient was in a wheelchair, and thus their appointment would take longer. If the complaint is accurate, then the practice knew that the patient was in a wheelchair and cancelled their appointment for that reason. That would very likely constitute discriminating in respect of access to care based on a disability - not simply making an inappropriate comment. Whilst no optical harm might have resulted, being discriminated against on the grounds of a disability harms patients' dignity and undermines their right to equality.

We note the following analysis in the triage documentation:

> *"It is not clear that the cancelled appointments were a result of the patient's disability, as the business's response points to a reduced service at the practice, and the referral does not suggest that the patient suffered as a result of not being seen sooner. The practice would not have been obliged to ensure the patient could be seen within a certain timeframe for a routine check-up."*

However, that shares the same two weakness identified above. The question here is not whether there was an obligation to ensure the patient could be seen within a certain timeframe, but rather whether, having given an appointment, there was an obligation not to cancel on the grounds that this patient's assessment would take longer as a consequence of their disability. If appointments were being cancelled, was that being done in an equitable and non-discriminatory manner?

We note that the case was then discussed at a case clinic, and reviewed at a further case clinic following receipt of a practice response which was described as "not particularly substantial". The registrant's input was sought following which the following analysis was set out:

> *"It is my view that regulatory intervention would be disproportionate in this case. There is a history of care being provided by the practice (this registrant) and it is stated on behalf of the registrant that the intention was simply to ensure there was sufficient time to examine the patient. This could amount to indirect discrimination (because it implies that non-disabled patients were prioritised) – that would be a judgement for CEs. [Emphasis added]*

However, there was no stated intent to refuse the patient care and, even though the facts are disputed, the practice has taken steps to improve in respect of patient notes and patient communication, and the registrant has taken personal steps in this regard.

Having worked through the questions at section 6 of the Triage guidance, I am satisfied that the practice has made reasonable attempts to resolve the matter at a local level, that the registrant has (without admitting the facts) taken steps to learn from this incident, and that there do not appear to be any residual ongoing risks to patient safety or to the public interest if an investigation is not opened. Based on the complaint correspondence, I agree that the OCCS may be able to assist in mediating a more acceptable tangible outcome for the complainant. "

We cannot be satisfied from the language of the decision that the true gravamen of the allegation was considered. Whilst it was recognised that the conduct could have involved prioritisation of non-disabled patients which would constitute discrimination, the decision does not expressly consider whether – if established – that would constitute misconduct which might merit a formal response. The decision maker observed there was "no stated intent to refuse the patient care" but does not acknowledge that that is not inconsistent with a finding of discrimination.

This is the sort of scenario where the practice is best placed to demonstrate the absence of discrimination e.g. by demonstrating that multiple appointments were cancelled for numerous people – both disabled and non-disabled. Following the High Court's decision in *Kuzmin v General Medical Council* that is an important factor to consider. If there is prima facie evidence which in the absence of a good explanation would be sufficient for a finding on the balance of probability, then the process facilitates such allegations proceeding. In otherwords, the absence of positive evidence of a discriminatory motive does not mean an allegation will fail.

In Case 2020/77 there was a complaint about a registrant who had rushed appointments in respect of a number of patients. One of the patient's was hard of hearing. There was no suggestion that the registrant had treated that patient differently to the other patient who complained, and who was not hard of hearing. We were reassured to see that the decision did implicitly acknowledge that the failure to accommodate a patient's particular needs could constitute discriminatory behaviour. The decision included reference to the relevant standard "Show respect and fairness to others and do not discriminate (13)".

In Case 2020/021 the complainant indicated that she was unable to submit a written complaint because she had recently had a cataract operation and had no one to assist her. The Council was supportive in facilitating the complainant by discussing the matter by telephone. We noted that when the triage decision was made the team made a number of efforts to call the complainant and explain the outcome to her. Unfortunately non of the calls were answered. Nonetheless, the case is a clear example of the Council making appropriate adjustments to meet a particular complainant's needs.

Referencing the Acceptance Criteria

The GOC introduced Acceptance Criteria in November 2018. We saw a number of cases where these were expressly referred to in the decisions about opening, or not opening, investigations; Cases 2019/280, 2020/021 and 2020/072 are examples.

Considering Applications for Interim Orders at Triage

In the majority of the cases which we reviewed the decision with respect to referral for consideration of an Interim Order were clear and appropriate. We identified one case which merit comment.

In Case 220/281 concerns were raised regarding the clinical management of two patients. In one instance the concern included a potential failure to manage acute vision loss. When the issue of an interim order was considered it was determined that no interim order was

required because there was “no immediate risk”. However, it was not clear how that conclusion was reached in the face of what, in principle, is a generalisable risk from failure to treat a serious condition. As noted elsewhere in the report, it is important that the absence of harm in the index case does not relied upon in assessing future risk.

Delay at Triage

Triage decisions were generally completed promptly following receipt of information. However, we noted a small number of cases where there appeared to have been lengthy triage periods. These included Case 2019/284 which invovled a student who had self-referred on health grounds and where the Triage process took 3.5 months to complete. Even allowing for the fact that a GP report was obtained the time scale involved was long.
In Case 2019/272 there was a 3.5 month delay between receipt and coming to FTP team in a conviction self-declaration case. However, the need to expedite consideration was acknowledged by the Triage team.

Case 2017/305 related to a corporate registrant’s promotional offer of free surgery to students. There was a concern that the surgery being offered would be inappropriate for a significant proportion of students on the basis of their age. There was a long delay between receipt of the concern, in October 2017, and resolution, in April 2020. It is understood that this resulted, in part, from problems identifying an expert to prepare an advice. However, the case was ultimately closed based on publicly available guidance that minimum age for the surgery is 18, and thus most students would be old enough to consider it. We also note that the decision does not evidence there ever being a suggestion that a procedure would have been undertaken without an appropriate clinical assessment in advance, including an assessment for suitability for the procedure based on grounds of age. Whilst acknowledging the benefits of hindsight, there was scope for this matter to be closed more promptly.

Not Formulating Allegations

It was rare in this sample for the Council not formulate allegations against the registrant and to simply send the case, without particulars of allegation, for consideration by the Case Examiners.

In Case 2017/374b the decision noted that the registrant had no adverse fitness to practise history, but had a conviction for fraud. The case being considered involved allegations of inappropriate charging. The Fitness to Practise history was described as follows:

> *"The Registrant has no relevant fitness to practise history with the GOC. However, in November 2002 he was convicted of seven counts of fraud and one count of deception at Leeds Crown Court. This was declared to the GOC in 2005 when the Registrant was a student optometrist."*

The Council withdrew the case by sending it to the Case Examiners with an invitation to close it but without drafting allegations. However, there was ample material to draft allegations and for real prospect test to be applied, even if the outcome was inevitable.

> **Learning Point 1**
>
> As we noted last year, the formulation of allegations can prove a helpful tool in the analysis of evidence and making important aspects of that analysis explicit. That is so even when it appears to the Case Work Team that the allegations seem unlikely to be proved. That is ultimately an assessment for the Case Examiners to make.

Triage Decisions to Open a Case

We reviewed 5 triage decisions to open an investigation. We regarded the decision to open an investigation as apporpriate in each case.

Triage Decisions Not to Open a Case

We reviewed 34 triage decisions not to open an investigation. These covered a range of themes, including health and conduct, and related to both business registrants and individuals. A small number of cases were a cause for concern.

Case 2021/040 invovled a university student who had been investigated by their university in relation to allegations of plagiarism. The plagiarism was admitted and the registrant relied on the recent death of her mother in mitigation. She was permitted to continue her studies with penalties in relation to the work which she had plagiarised. The Council determined to close the matter at triage on the basis that the University's resolution was adequate in all the circumstances.

However, the file contained evidence of further significant developments in the University process. The registrant had admitted that the story of her mother's death was a complete fabrication and, not surprisingly, she was to face a further university disciplinary hearing. Those developments placed the case in a much more serious category. There was no mitigation for the originally dishonest plagiarism and there was further dishonesty of a significant kind within the disciplinary process. The dishonesty was not disputed and, if proved, could result in erasure. In our view this was a case which should have been considered by the Case Examiners and not closed at triage.

We saw evidence of the misapplication of the Acceptance Criteria in Case 2020/263. The complainant employee raised concerns about the propriety of the registrant employer's approach to payments during furlough. It was clear that the complainant had raised the concern with the HMRC also. The triage decision stated:

> *"The matters raised are of a criminal nature and we are not able to investigate criminal matters unless a conviction/caution has been accepted by a registrant. As there has been no proof of fraudulent activity by the optometrist, we should wait for the conclusion of HMRC's investigation and ask [the Complainant] to share with us if an adverse outcome is reached."*

This is followed by reference to the Acceptance Criteria:

> *"Under the AC 2.15 The following will be considered in turn to decide whether a conviction /caution*
>
> *could constitute an allegation that fitness to practise is impaired:*
>
> *2.15.1 Is there a criminal conviction / caution? No*
>
> *2.15.2 Is the conviction/ caution linked to the registrant's professional practice? No conviction to assess*
>
> *2.15.3 Is it in the wider public interest to investigate the conviction / caution? No conviction to investigate*
>
> *As there is no conviction, we do not have the remit to investigate this matter."*

In our view this misapplies the Acceptance Criteria by adopting too narrow a view. The relevant section of the Acceptance Criteria (paragraphs 2.12 – 2.16) is expressly headed "A Conviction or Caution", reflecting the terms of Section 13D of the Opticians Act 1989. Whilst it is clear that an allegation of impairment on the grounds of conviction or caution cannot be made in the absence of either a conviction or caution, it is not the case that conduct which might be criminal in nature only comes within the Council's jurisdiction at the point of conviction/caution.

It is crucial that the assessment extends to consideration of the conduct under the rubric of the misconduct ground of impairment also. A failure to do so would lead to perverse results. For example, a registrant who is charged with sexual assault on a patient during a consultation would escape regulatory action – including interim measures - because they had not yet been convicted.

Whilst it was an error to treat the alleged conduct as falling outside the Council's jurisdiction, we agree that the HMRC/employing organisation would be much better placed to assess and investigate the concerns. The options available to the Council were to open an investigation and liaise directly with the HMRC/employing organisation or to close the case at triage and trust in being informed of an adverse outcome from the HMRC/employing organisation's investigations by the complainant or the HMRC/Employer. However, we note that the evidence here did not go beyond the mere assertions of the complainant who did

not provide further information when requested to do so by the Case Worker. In our view the preferred course would be to rely on direct communication with the investigating authority rather than the complainant. It is possible that that could have been achieved through the tracking route.

Senior Case Worker Input

Whilst the initial decisions of the Case Workers were generally reasonable and clearly explained, we saw evidence of the benefits which senior Case Worker review brings to the Triage process. On occasion this led to a different disposal whilst on other occassions it led to a more sophisticated and appropriately reasonsed consideration of the case.

In Case 2020/222 the original decision was to open a case. The Case Worker took up a suggestion to discuss the case at the Triage Clinic. This led to further information being obtained from the registrant's employer which permitted a decision not to open a case as there was satisfactory evidence of the registrant's prudent management of the adverse health condition and a good support network.

Case 2020/110 also involved a registrant with a health condition which had been self-declared. We had concerns about the Case Officer's analysis which included the following:

> *"The Registrant doesn't pose a risk to the safety of the public or himself, he has shown insight about the symptoms of his condition and how it may affect his fitness to practice. The Registrant is also* ***not looking for work at the moment and therefore his condition cannot affect his fitness to practice as he's not practicing [sic]****." [Emphasis added]*

This discloses an error of reasoning. The Court of Appeal decision in *Clark v General Optical Council* made it clear that a registrant's intention (or commitment) not to practise in the future was not a basis to permit an unfit registrant to remain on the register without restrictions. Here, the Case Officer has placed undue weight on the registrant's intentions while assessing clinical risk and has not considered the risk to the public interest of an unfit

registrant be entitled to practise without restrictions. We were pleased to see that these issues were resolved upon by the Senior Case Worker who arrived at the same outcome for different reasons. Whilst the differnces may appear sublte they are nonetheless important. The Senior Case Worker noted:

> *""LA's recommendation is correct in noting that, under the AC, an investigation is only likely to be opened if a registrant is suffering from a health complaint and it poses a risk to the safety of the public or the registrant themselves. Given his honesty in disclosing this, and the insight he has shown into his condition and the decision to withdraw himself from active practice, this cannot amount to an allegation of impaired FTP and the case is closed.* ***The registrant is managing his health appropriately, and for this reason does not pose a risk to patients****." [Emphasis added]*

Nonetheless, we had some residual concern in this case given the absence of independent evidence of the current degree of impairment. Whilst the registrant clearly had insight, in so far as they acknowledged having a progressive dementia, **"**A letter form the registrant's consultant neurologist did not comment on whether he should be practising." On the available evidence it is possible that the registrant was impaired to a greater extent than they accepted. We believe it would have been reasonable to open an investigation to obtain independent evidence of the degree of impairment. However, the chosen resolution was not unreasonable given the engagement by the registrant. The following actions were taken:

> *"Two [sic] actions to take please:*
>
> *1. Registrant to be asked to provide a supportive letter from his specialist if he intends to start practising again*
>
> *2. Registrant to be asked to keep declaring at annual retention, with an update as to his work status and his condition.*
>
> *3. Pop-up alert to be added to CRM (Registration) page that if any such notification is received, FTP are to be informed (quoting this case ref)"*

Reliance on the fact that a registrant is not currently working as a factor mitigating risk was also seen in Case 2020/260 where the initial risk assessment included:

> *"Although the concerns raised about Registrant are worrying, the risk remains medium as the Registrant is not currently practicing [sic] therefore any risk to the public is eliminated."*

There was no discussion of why the registrant was not working nor any assessment of whether that was capable of changing. In the absence of clear reasons supporting a contrary view the fact that a registrant is not working – as opposed to cannot work - should not be relied upon when assessing the need for public protection.

In Case 2020/239 the Case Officer's decision was not to open a case because of passage of time since the conduct which gave rise to the complaint (4 years). The case involved allegations of serious dishonesty to the value of £32,000. In effect, it was alleged that the registrant was involved in a conspiracy with her partner, which involved her being paid an income in respect of work which she had not undertaken, and the money then being used for the benefit of her partner. There was clear evidence of large, regular payments being received by the registrant which far exceeded any payments properly due to her. The Case Officer appeared to accept the registrant's denials, given in interview, at face value. The Case Officer observed:

> *"In ascertaining whether an investigation should be opened against this registrant, I am unsure, however am leaning more towards recommending this matter be closed. This is because:*
> *Should this matter be referred to investigations and then onto FTPC, it is unlikely they will find current impairment, given that the issues raised happened some 4 years ago."*

In our view, any uncertainty as to whether a case should be opened should be resolved in favour of opening a case. We were pleased to see a decision to open a case by the Senior Case Officer who was rightly more cautious of the Registrant's denials.

"It's worth noting here that while the registrant has claimed ignorance of KR's actions, there is a substantial amount of evidence to the contrary suggesting her central involvement in his actions makes this unlikely. Regardless, not being aware that she is party to fraud would not relieve her of all guilt.

It is not our role to assess evidence in Triage. Rather, we must determine if an allegation of impaired fitness to practise has been raised. Given the information submitted, a full investigation must be opened for the matter to be brought before the case examiners."

Consideration of Council's Powers

The Case Plan in Case 2020/180 describes the complaint as follows:

"We received a new complaint on 3 August stating that the registrant has 'misused his status as a fellow professional to sexually harass and intimidate my young adult daughter online by posting a pornographic photo and film of himself.'

It was noted that the matter was reported to the police who decided to take no action. The Case Plan reflects careful consideration of the evidential challenges and the essential difficulty was noted:

"The complainant's comments amount to hearsay evidence without the daughter's engagement, and there is little scope for obtaining evidence of the posts."

And later it was noted:

"Even if the mother was able to obtain the pictures/screenshots, we cannot allege that these were sent inappropriately because we do not have a statement from the daughter to that effect. One possible defence argument is that it was consensual or that he uploaded pictures not meant for her."

We note that there was no express consideration of the Council's powers to require the disclosure of information, and the possiblity that service providers could have been compelled to disclose relevant communications. Nonetheless, we acknowledge the central difficulty created by the possibility that there had been consent to the transmission of such images. In the absence of co-operation from the daughter such a defence would be uncontroverted.

Considering reasonable inferences

Case 2019/080 invovled concerns that a registrant who was the subject of an interim order of suspension was continuing to practise. Following a review of the evidence the Triage Case Plan notes:

> *"There may be an allegation then that the business made fraudulent claims for patient dispenses, and that unregistered practitioners signed them off. It is not clear from the information here that X breached his suspension order though."*

Reference is made to approaching the practice for records and it is noted that they may not co-operate because they are unregistered. There is no consideration of the Council's powers to require disclosure.

Generally, the decision to close two of the concerns was clear and sensible. The decision to close the third concern – in relation to potentially fraudulent claims - was more problematic. The reason given for closure was that the signature on the potentially fraudulent claim form could not be deciphered and the business is unregistered. However, the question of who would benefit from any fraud is not considered. The business is named after an individual who is a registrant. If the business is operated by a company the beneficial owners will be identifiable on Companies House' website. If it is not a company then a search of the ICO website should identify the data controller, which is a surrogate indicator of ownership. If the business is owned by a registered optician and any fraudulent claim would result in a payment to the business there would be a basis to infer motive. The illegible signature may be a deliberate rouse. That possibility appears not to have been considered.

Nonetheless, the matter was the subject of a counter fraud investigation and the GOC notified the complainant that they would reconsider matters in due course in light of the outcome of that investigation.

Learning Point 2

Decision-makers should be reminded:

(1) That they ought not to rely on the fact that a registrant is not working when considering whether action on the registrant's registration may be required.

(2) It is important to exercise caution in assessing exculpatory evidence on the papers.

(3) the absence of evidence as to motive does not exclude the possibility of an adverse motive being inferred from the surrounding circumstances. In cases where there is a possibility of an innocent motive it may be entirely proper to test that issue by putting the case to the registrant. As noted in *Kuzmin v General Medical Council*, a registrant's failure to provide evidence of the innocent explanation may mean that the inference of an improper motive is more compelling.

CASE EXAMINER DECISIONS

General Observations

The Case Examiners are the principal decision makers at the early stage of the fitness to practise process. They exercise a filtering function, determining whether cases ought to be referred to a hearing before the Fitness to Practise Committee [FTPC]. They also exercise important functions with respect to referral of cases to the Investigating Committee for consideration of Health Assessments or Performance Assessments. The Case Examiners also determine applications under Rule 15, to review cases which have previously been closed without referral to a hearing, and applications under Rule 16, to cancel referrals to the FTPC.

In general, the real prospect test was correctly stated in the Case Examiners' decisions and was correctly applied. In previous audits we have identified examples of determinations where the Case Examiners had mistated the test. We did not encounter any such examples in this year's sample.

Case Examiners' decisions routinely noted the registrant's date of first registration and their fitness to practise history. We note that in Case 2019/61 the decision records that the registrant, a body corporate, had previously been fined in fitness to practise proceedings. However, the nature of the conduct which resulted in the fine is not recorded in the decision and thus it is not clear whether there is a thematic relationship between the historic case and the current concern. (see related comments on Case 2017/374b above).

We noted that decisions described the two-stage real prospect test and emphasised that the Case Examiners were not making factual findings. We also noted that the decisions cited the pertinent provisions of the Code of Conduct or Standards which were engaged. The majority of determinations referred to relevant Guidance, although it remains relatively uncommon for determinations to include specific citations, or to quote specific provisions which were deemed relevant by the Case Examiners. However, we saw numerous examples

of the Case Examiners' Guidance being referred to and quoted in respect of two specific topics, namely:

- conflicts of evidence e.g Cases,
- culpable ommissions Cases;

The vast majority of decisions included a clear description of the material which had been reviewed. However in Case 2019/172 the determination included the following:

"The Case Examiners have considered all of the evidence in this case which includes: "

However, no description of the evidence followed. In Case 2019/189 it was not made clear what evidence was considered.

In Case 2016/309 the Case Examiners stated that they

> *"…have carefully considered the documentary material placed before them. This includes – but is of course not limited to – the material within the two large electronic bundles provided to them* ***("the Bundle")****, the Subsequent Case Examiners' decisions, and the Representations (and the documents provided with the Representations)."*

For a reader with access to the decision alone the reference to "two large bundles" is not particularly informative.

Decisions generally emphasised that it was not the Case Examiners' role to determine whether the Registrant's fitness to practise is impaired.

Learning Point 3

Case Examiners should be reminded of the need to provide a clear indication of what evidence has been considered.

FINDINGS

As the majority of the decisions which we reviewed involved the application of the same decision making framework, we have set out our observations thematically in a manner which broadly reflects the chronology of a case's progression through the fitness to practise process.

Case Preparation

<u>Preparation of Papers for the Case Examiners</u>

We encountered a small number of cases where errors in drafting of allegations were picked up by the Case Examiners and where these could have been spotted before the papers were referred to them.

In Case 2019/324 the Case Examiners identified an error in the numbering of the allegations:

> *"The Case Examiners note that there is an error in that allegation 2 occurs twice in the listed allegations. Below they have renumbered the second allegation to that of allegation 3. They have addressed each part of the allegation in turn below: …"*

In Case 2019/247 the Case Examiners identified an error in the dates referenced in the allegations. They flag the error and make clear the basis on which they are proceeding with their consideration:

> *"As a preliminary point: the Representations state that the dates in allegation 3 are incorrect and should read 21 March 2009 and 17 October 2019. The Case Examiners have reviewed the case documents and agree that the dates of Allegation 3 do indeed appear to be incorrect and that the appropriate dates should be 21 March 2009 and 17 October 2019. It is on that basis that the Case Examiners proceeded."*

Ensuring Allegations Are Clear and Unambiguous

In the majority of cases the allegations were expressed in a clear and unambiguous manner. We address a small sample of cases where there was scope for improvement.

In Case 2019/30 the allegations related to the measurement/recording of IOPs in mutiple patients. The allegations were of misconduct. However, the essence of the problem appeared to be use of an outdated practice in a mistaken belief that it remained acceptable. There appears to have been no consideration of whether this ought to have been alleged as Deficient Professional Performance, as an alternative to misconduct. That might have been more appropriate.

There was no evidence that the registrant's practice reflected a deliberate or cavalier departure from current expectations. However, we noted that the Case Examiners did not expressly analyse what lay at the root of the problem. They may have been assisted in so doing if the drafting had required them to consider both misconduct and deficient professional performance.

In Case 2019/324 the Case Examiners commented on the drafting of allegation 3 in the following terms:

> *"On or around 8 August 2019, you inappropriately carried out examinations with insufficient time.*
>
> *The Case Examiners agree that this allegation is not well framed and somewhat vague. The Case Examiners agree that the term 'insufficient' is difficult to define and that the time taken to perform an examination will vary from practitioner to practitioner. The Case Examiners however have paid particular attention to audits undertaken by the Registrant's employers and agree that important aspects of many of the examinations are unrecorded and that some of the appointment durations are very short, even for an experienced optometrist. The Case Examiners note that when the Registrant was initially challenged with regard to the short testing times he did not attempt to justify their brevity, but rather explained why the brevity had arisen,*

namely a desire to study and difficulty transitioning from a secondary care setting to a primary care setting. Considering the information, the Case Examiners agree that the examination durations are shorter than those which might be reported by a reasonably competent optometrist and for this reason this part of the allegation passes the first stage of the test."

We regard the Case Examiners' assessment as appropriate. The gravamen of the concern is not that the examinations were hurried but rather that they were incomplete or performed to an inadequate standard.

Case 2018/486 involved a serious of allegations that the registrant had "failed to" do various things during a clinical encounter. The allegations then included:

2. *Your conduct at e. (i), and/ or e. (ii), and/or e. (iii) was inappropriate in that it was:*

    a. *Not in accordance with the Sight Testing (Examination and Prescription) (No. 2) Regulations 1989; and/or*

    b. *Contrary to section 26(1) of the Opticians Act 1989;*

This drafting is unecessary. The alleged failure connotes the existence of a duty and it is not necessary to separate alleged the source of the duty. Similar drafting was noted in Case 2019/24.

Case 2018/503 invovled allegations of sexual motivated conduct. There was an allegation that the comments/touching were inappropriate because there was no clinical justification:

"g. Your actions at 1a and/or 1b and/or 1c and/or 1d and/or 1e and/or 1f were inappropriate in that there was no clinical justification for your actions or comments; and/or you continued to make comments even though you were asked to stop by Ms B and Ms A;

h. Your actions at 1a and/or 1b and/or 1c and/or 1e and/or 1f were sexually motivated in that you were in;

i. Pursuit of sexual gratification; and/or

ii. Pursuit of a future sexual relationship"

However, the interactions at issue were between the registrant and a colleague and not in respect of clinical encounter. The Case Examiners commented:

> *"Despite being referred to in the allegation, we do not consider the existence or otherwise of any "clinical justification" to be a relevant factor. The absence of a clinical justification does not mean or otherwise indicate that the relevant acts, if proven, were inappropriate. There is no suggestion or argument by anyone that there was a clinical justification for any of the acts alleged."*

The true gravamen of the allegations was captured in the allegation of sexual motivation and thus the inclusion of this additional allegation did not impair the Case Examiners in their consideration of the case. Nonetheless, the allegation that the conduct was without clinical justification was unnecessary.

Case 2016/309 the allegation was of a failure to conduct an appropriate exam "in that you failed to adequately record their patient notes."

> "*The Council alleges that you, X, a registered Optometrist:*
>
> *2) On or around 28 March 2014, you:*
>
> *b. Failed to conduct an appropriate examination on Patient K's eyes **in that you**:*
>
> i. *Failed to adequately record their patient notes; and/or;*

We regarded this drafting as unhelpful. It is possible that an adequate exam was conducted but not recorded. It was also possible that the exam conducted was inadequate. While the relevant issues are captured by the drafting the recording and conduct of the exam ought to have been kept distinct.

The Use of Alternatives

The allegations in Case 2020/39 included the following:

The Council alleges that in relation to you, Mr X, a registered optometrist:

1. *On or around 5 November 2019, you failed to conduct an adequate sight test on Patient A in that you:*

   a. *Failed to detect signs of a detached retina in Patient A;*

   b. *Did not make an urgent referral for Patient A for further investigation and/or treatment;*

   c. *Did not provide adequate advice to Patient A in relation to the symptoms reported;*

And by virtue of the facts set out above, your fitness to practise is impaired by reason of misconduct.

The obligation to refer arises where the clinician identifies a reason necessitating referral, such as a detached retina. Where the clinician fails to identify a justification for referral the absence of a referral is merely the consequence of that wider failure. Here allegation 1(a) should have been followed by "and/or". If retinal detachment was detected the failure to refer would stand on its own. However, if the detachment was not detected then the absence of an identified cause of the presenting condition may have been sufficient to warrant a referral.

Relying on Outcomes in Drafting Allegations

We noted only a single case where allegations were drafted in a manner that relied on the effect of a registrant's alleged conduct as determinative of whether the conduct was inappropriate. As we observed in each of the last three years' audits, that is an approach which should be avoided. The reliance on the outcome is misplaced. The act or omission is either inappropriate or it is not. The outcome might illustrate why the conduct is considered inappropriate but it does not determine that issue.

We saw the approach in Case 2019/24 where it was alleged that:

> *"Your actions at 1a(i) and/or 1a(ii) and/or 1a(iii) and/or 1a(iv) and/or 1a(v) and/or 1b and/or 1c and/or 1d and/or 2a and/or 2b was* ***inappropriate in that Patient A's***

referral was delayed *by your actions and as a result Patient A did not receive the care required in a timely manner;"*

Allegations which relate to the conduct of others

A small proportion of cases considered by the Council follow on from investigations conducted by third parties. This sometimes leads to inappropriate drafting, where the conduct that is alleged is that of the third party. The following, from Case 2019/136, is an example in a case where the ICO had made findings:

"1. On or around 3 May 2019 the Information Commissioners Office determined:

(a) That you had not complied with your data protection obligations under the Data Protection Act 1998 and General Data Protection Regulation

(b) That you failed to respond to the complainants Subject Access Request of December 2018 within the statutory time frame."

As drafted, the allegation relies on the fact that a finding was made, not that the finding was itself correct. As it happens, the Case Examiners dealt with this case pragmatically and the drafting issues did not stand in the way. A similar issue arose in Case 2019/230 where the allegations were drafted following NHS case review. The reference to the clinical records review in this allegation is both unnecessary and, as drafted, alleges that the culpable conduct post-dated the clinical review:

"Following a clinical records review *by NHS England, for some or all, of the patients listed in Schedule A,* ***you****:*

a. *Failed to adequately measure and record the patient's Intra Ocular Pressures ("IOPs"), despite the patients presenting with risk factors of glaucoma. …"[Emphasis added]*

Whilst these issues were rare they serve as a reminder of the need for caution when allegations arise from investigations or actions taken by third parties.

Alleging Culpable Omissions

In previous audits we had noted some issues with the application of the first stage of the realistic prospect test where allegations were framed as a "failure" to undertake a particular action. This issue appears to have been effectively addressed by Case Examiners. Where allegations are framed in this way Case Examiners are consistently referencing the relevant guidance and considering the existence of a duty.

Ensuring Clarity as to the Grounds on which Impairment is Alleged

The majority of decisions set out clearly the statutory ground(s) of impairment which the Council relied upon and correctly cited the relevant provision of section 13D of the Act. We encountered a single case where there was a lack of clarity in relation to the statutory ground relied upon by the Council.

In Case 2019/61 the alleged conduct was followed by this statement:

> *"And by virtue of the facts set out above, your fitness to carry on business is impaired by reason of:*
>
> *a. misconduct; and/or*
> *b. practices or patterns of behaviour occurring within the business which you knew or ought to reasonably to have known of and which amount to misconduct"*

However, only misconduct is referred to in the introduction and s.13D(3) of the Act was quoted with reference to misconduct only.

Learning Point 4

The Case Preparation Team should be reminded that:

(1) Outcomes should not be relied upon in drating allegations; and
(2) Allegations should relate to the conduct of the registrant and not the findings of a third party.

(3) In preparing cases relevant statutory grounds and the corresponding parts of the Act should be cited.

Reference to Relevant Guidance

We saw regular reference to the Guidance for Case Examiners albeit that the approach to referencing this is quite variable. We saw frequent and specific references to the guidance on conflicts of evidence and culpable omissions.

We noted a small number of cases where reference was made to a publication by the Professional Standards Authority. There were also a small number of cases where reference was made to Guidance published by the College of Optometrists. These included Cases 2019/264, 2019/265 and 2019/301.

Reference to Relevant Standards

The Council's Standards of Practice for Optometrists and Dispensing Opticians and Standards of Practice for Optical Students came into force on 1 April 2016. We note that those standards are relevant to the assessment of registrant's conduct where that conduct occurred after 1 April 2016.

It was common for the Case Examiners to identify potential breaches of the Code or Standards in their decision, identifying the relevant paragraph numbers. This is a practice which we have previously endorsed, as it is important for allegations to be related to the relevant professional standards documents. Case 2017/345a was a notable exception. In Case 2017/195 the Case Examiners referenced the Standards when they ought to have referred to the Code. The error was not material.

There are still occasions where both the Code and the Standards are relevant to the alleged conduct. Case 2019/247, 2018/317 and 2017/386 involved such conduct and both the Code and the Standards were appropriately cited. We were also reassured to see appropriate reliance on the Standards for Optical Students in Case 2019/242 and 2018/443.

As we noted last year (2018/19), as time progresses it will be increasingly unlikley that the Case Examiners will need to have regard to the Code of Conduct. Nonetheless, the examples cited above demonstrate the importance of considering when the underlying conduct occurred and referring to the appropriate set of professional standards.It was premature to attempt any assessment of the impact of the introduction of new Standards for Business Registrants which took place in October 2019.

Assisting the Lay Reader

In previous reports we have commented on the clarity of drafting in relation to clinical matters which would assist the lay reader of a decision. We noted a number of positive examples of this in this year's sample and have chosen to provide a few illustrations of these to acknowledge them. We encourage Case Examiners to have this issue in mind when drafting their determinations.

Cases 2020/39 and 2018/58, which included good explanation around relevant optical issues. The determination in Case 2019/200 specifically considered the complainant when setting out some of the basic principles:

> *"Weighing up this evidence as we are entitled to do, we agree that there is not a realistic prospect of proving this part before the FTPC on the evidence presented. For Ms B's understanding we make clear that this decision simply reflects the fact that it is the GOC that brings this case and carries the burden of proving its case before the FTPC (to the 'civil standard' - Rule 38)."*

Case 2019/264 included a clear description of some of the clinical matters which were relevant to the decision on disposal. It serves as an example of the sort of approach which can be helpful in demystifying matters for the lay reader.

> "13. In reaching a decision the Case Examiners have reminded themselves of the nature and causes of flashes and floaters.
>
> *14. A posterior vitreous detachment (PVD) is the most common cause of flashes*

and floaters in the middle-aged population. Throughout life, the vitreous liquefies and eventually detaches from the retina. A PVD most commonly occurs between the ages of 55 and 65. Approximately 50% of the population experience flashes and floaters. A PVD is a normal ageing process.

15. There are, however, other causes of flashes and floaters; most seriously a retinal tear or detachment. The Case Examiners have, therefore, reminded themselves of the nature and recognised warning signs of retinal detachment. Retinal detachment occurs when the thin lining at the back of the retina begins to pull away from the blood vessels that supply it with oxygen and nutrients. Without prompt treatment, it will lead to blindness in the affected eye."

The determination in Case 2019/137 also included a clear explanation of the impact of changing contact lens manufacturer:

"For the avoidance of doubt, trial (or diagnostic) lenses are provided on a trial basis in order to establish, over a period of time, if the prescription is satisfactory in the 'real world' rather than the examination room. There is no evidence from Patient B that the prescription is incorrect. However, the lenses that are recorded on the record are not those that were supplied to Patient B. Changing lens manufacturer or design can make significant differences to the fitting of the lenses, and, in the Case Examiners' view, the averagely competent optometrist would view the changing of lens types without documentation and appropriate advice as unsafe. There is, therefore, a realistic prospect that the facts of allegation 3b will be proved if the case is referred to the FTPC."

We encourage Case Examiners to have the lay reader in mind when drafting decisions related to clinical concerns.

Additional Observations

We saw evidence of European alerts being submitted and appropriate European alert closures also being circulated. We also saw evidence of case workers following up with registrants to obtain their indemnity information and to check whether they intended to file representations. Decision letters relating to warnings contained clear information about the nature and effect of the warning.

Consideration of the Registrant's Representations

We have noted that Case Examiners have responded to the outcome of previous audits in detailing the material which they have reviewed and in making clear whether representations from the Registrant have been received and considered. This is addressed in differing ways but in all but one case it was clear whether representations had been received and considered. In the first interim decision in Case 2018/317 no reference is made to representations from the registrant. However, that is not a criticism in the context of the decision which was a decision to adjourn for further information. We noted that in Case 2018/186 the Case Examiners specifically commented that no representations were received. In Case 2017/282 we saw evidence of Case Examiners taking particular care to demonstrate that all of the Registrant's representations had been considered.

> *"We have considered the documentary material before us, including all of R's representations (including, for the avoidance of doubt, R's letter dated 20 December 2019)."*

In Case 2019/137 we also saw Case Examiners taking care to reassure registrants that they had not been disadvantaged by errors in the preparation of their submissions. The allegations related to patients A – E. The Case Examiners noted:

> *"On comparing the GOC allegations to those in the representations, the Case Examiners note the following anomalies in the numerical annotation within the representations:*

- *Reference in the representations numbered 4 relate to GOC allegation 3*
- *Reference in the representations numbered 3 relate to GOC allegation 3a and 3b*
- *Reference in the representations numbered 5 relate to GOC allegation 4*
- *Reference in the representations numbered 6 relate to GOC allegation 5*
- *Reference in the representations numbered 7 relate to GOC allegation 6*

Therefore, for the avoidance of doubt and in the interest of fairness, the Case Examiners have considered the representations using the numerical referencing based on the GOC allegations and have carefully considered the responses to these irrespective of the incorrect numerical referencing in the representations."

Caution in considering documentary evidence

We saw evidence that Case Examiners were appropriately cautious about weighing documentary evidence and assertions by registrants. Case 2018/443 is an example, relating to a student registrant, who faced allegations of retrospectively amending clinical records. The Case Examiners noted:

"The Case Examiners have considered carefully the Registrant's painstaking and reflective personal statement. They also note that he made a self-referral; however, it is also noted that this was only after the stage 2 assessor had identified alterations in relation to patients A and B and an investigation into his actions had commenced. The Case Examiners consider that the FTPC should weigh the evidence, including any oral evidence from the Registrant, to determine the degree of insight he has into his actions, and the level of risk to the public and/or to the public interest arising."

Similar caution was evidence in Case 2019/137, which was referred to the FTPC. The Case Examiners commented:

"[The registrant] states that 'Following my receipt of the GOC's concerns, I implemented an immediate audit of my practice to consider ways in which we could immediately address any issues '. The Case Examiners note that the audit was not provided to GOC investigators or as part of the representations. This is, therefore, a bare assertion that is unsupported by any evidence."

These examples demonstrate an appopriate degree of caution in dealing with the unevidenced assertions of registrants.

Early Closure

The 5-year Rule

The relevant guidance to Case Examiner's states:

> *"24. When considering an allegation, the case examiners may unanimously determine to close certain categories of case which, in the public interest, ought not to proceed through the fitness to practise procedure. The categories of case are as follows:*
>
> - *An allegation which arises from events which occurred more than five years before the matter was brought to the attention of the GOC, (except in exceptional circumstances).*
>
> - *An allegation which is made by a complainant who wishes to remain anonymous or has indicated that they do not wish to co-operate further (although case examiners must bear in mind the GOC's own powers of investigation as set out in section 13D); or*
>
> - *Any allegation which the case examiners consider is vexatious in nature."*

This Guidance was engaged by the facts in Case 2019/61 and the Case Examiners appropriately considered the Guidance:

> *"The Case Examiners have considered the details of the case, giving particular attention to the public interest. The Case Examiners are unanimous in determining that, there are no relevant 'exceptional circumstances' to necessitate further consideration of this matter.*
>
> *There is no evidence of any ongoing issues with this Business Registrant. The matter relates to a Dispensing Optician who had been working under a franchise awarded by*

the Business Registrant. The Dispensing Optician reported to the Business Registrant that he had been working outside the scope of his practise by undertaking activities that required registration as a contact lens optician. As a result of this, the Business Registrant conducted an investigation and withdrew the franchise from this practitioner and required the franchisee to self -report to the GOC which he did with immediate effect.

Whilst the Case Examiners have not made a decision on the nature of the relationship between the Registrant and the Dispensing Optician in his position as a franchisee, they are agreed that the matter relates to a single incident that was resolved by the Registrant over five years ago. There is no information to suggest that there are ongoing issues that would necessitate further involvement of the regulator and there are also no additional public interest reasons to necessitate further consideration.

Furthermore, with regard to this allegation, due to the passage of time, it would not be possible for the Business Registrant to give reliable answers to questions about this matter as full documentation relating to this matter are no longer available. Any further enquiries would therefore be unfair. The Case Examiners do not consider there to be any other public interest reasons which constitute 'exceptional circumstances' thereby necessitating further action."

The Case Examiners approach to this matter was generally appropriate. However, we would raise a note of caution about the Case Examiners determining matters at the filtering stage on the question of whether a fair hearing would be possible. Where the passage of time has resulted in the absence of evidence which is probative of the allegations that is a factor which the Case Examiners can weigh in the balance in applying the real prospect test at Stage 1. However, if there is *prima facie* evidence which could prove the allegations then consideration of the difficulties for the registrant in defending themselves should be approached with caution. In most cases those issues will be best dealt with as a preliminary matter before the FTPC with full argument and legal advice.

We note that the guidance on early closure includes reference to anonymous complaints. We noted that there were a number of anonmous complaints which were considered in the triage process and which did not lead to a case being opened. We believe this probably accounts for the absence of examples of Case Examiners closing cases on this basis.

The Application of the Realistic Prospect Test

Limb 1: Facts

As in previous years, our review of determinations demonstrated Case Examiners engaging well with the evidence and setting out their assessment clearly. There were a small number of cases which gave rise to a concern and we consider those in greater detail below.

Case 2019/020 related to a registrant whose former employers had concerns about her health and alcohol use. We were concerned about an inconsistency in the approach to the application of the real prospect test to two inter-related allegations. The Case Examiners determined that there was a real prospect of proving that the registrant had consumed alcohol at work and during working hours. However, they ignored that finding when they concluded that there was "no direct evidence" that the registrant was under the influence of alcohol. The relevant paragraphs are set out below:

> "*b. consumed alcohol on your work premises during work hours;*
>
> *There is no dispute that bottles of alcohol were found in the Registrant's bag. The Case Examiners note from the witness statement of C that she saw the Registrant drink from a wine bottle. The Registrant gives a different account and says that she drank from a bottle of coke.*
>
> *There is a conflict in the evidence, however the dismissal letter of 4 January 2019 states that they could not categorically say that the Registrant, "was under the influence of alcohol on the day in question."*
>
> *The Case Examiners note there is a conflict in the evidence. It appears to be agreed that the Registrant drank from a bottle of some sort but the contents are disputed. This could only be resolved by the FTPC if the case is referred.*

Therefore, the Case Examiners agree that this part of the allegation passes the first stage of the realistic prospect test because in a conflict of evidence they must take the evidence at its highest.

c. *attended to patients, namely 4 patients, whilst under the influence of alcohol and/ or when not fit enough to work;*

The Case Examiners consider that there is no direct evidence that the Registrant was under the influence of alcohol.

As above, the dismissal letter refers to the Registrant stating she was, "exhausted". This indicates that she was not fit to work and she had attended patients.

The Case Examiners therefore agree that this part of the allegation does pass the first stage of the realistic prospect test in relation to being unfit only."

We were also concerned that the approach to the alleged health related impairment in this case was misplaced.

"3. You have a health condition set out in Schedule A;
The Case Examiners have referred letter from GP of the Registrant. This states that at a review on 24 February 2020 the liver function test and gamma GT were normal. She has been abstinent of alcohol since August 2019. It concludes that she is stable and has a good work life balance and in his opinion she is fit to work.

The Case Examiners also note the dismissal letter of 4 January 2019 which states that the Registrant was dismissed because the writer believed that: "there has been a fundamental loss of trust and confidence in [the Registrant's] behaviours, professionalism and ability to fulfil [her] job role as required by X Opticians."

The Case Examiners therefore agree that this part of the allegation does not pass the first stage of the realistic prospect test."

Whilst the recent blood tests may support a contention of current abstinence that does not preclude the registrant from having the alleged condition, albeit in remission. Abstinence may be relevant to an assessment of the risk of relapse but in the absence of specific

evidence on that point the Case Examiners should be very cautious in concluding that the risk has normalised.

Furthermore, the Case Examiners had determined there was a real prospect of proving that the registrant had consumed alcohol at work yet the registrant denied that. That creates a concern in relation to relapse and risk management. In that context the reference to abstinence from alcohol since August 2019 is an implied concession that alcohol consumption was an issue prior to that.

Reliance on the employer's stated reasons for dismissal needs to be approached with care. Such reasons may reflect a strategic approach on the part of the employer to mitigate the risk of a claim from the dismissed employee. In this case it should not have been relied upon as evidence of the absence of a health condition.

It is also important to consider the impact of a determination that the registrant does not suffer from a health condition when considering misconduct and impairment in relation to the consumption of wine at work. Without a health condition as mitigation the consumption of alcohol whilst on duty would pass the second stage of the real prospect test.

However, it is clear that the Case Examiners were prepared to attribute the conduct to some form of ill health, which gave rise to a lack of "self-awareness":

> *"These are two incidents within a space of some three months. The conduct appears to be largely attributed to a period of ill health and what may be considered to be a lack of self-awareness at the material times. There is no evidence of a clinical failing on the part of the Registrant on those days (only a low number of patients were attended) but that does not detract from the fact that patients could have been put at risk of harm. The Registrant was dismissed from X Opticians for the reasons set out paragraph 63. Given the letter from the GP and the testimonials it would appear that the Registrant has undergone some remediation and recognises that she should not attend patients when she is not fit to work.*

The Case Examiners agree that the parts of the allegations which passed Stage one of the realistic prospect test do not pass Stage two of the test. However, the decision is finely balanced because the crux of the matter is recognising the need not to work when not fit to do so and what appears to be an inability on the part of the Registrant to recognise this is potentially of great concern.

The Case Examiners are satisfied that in respect of the present allegations that no public safety matter or wider public interest matter is engaged in the given circumstances because no patient was actually harmed, the clinical records were satisfactory and NHS investigation revealed no failings in her duty to justify a referral to the FTPC."

We note the Case Examiners acknowledgement that the matter was finely balanced, and the reliance on the absence of actual harm in the particular case- rather than the potential for harm. In our view the Case Examiners should have erred on the side of caution and referred the matter. We are fortified in that view in light of the other issues, which we identified above. We comment separately on the warning in this case elsewhere in the report.

Learning Point 5

Echoing Learning Point 6 in last year's report, the Case Examiners should be reminded that in considering the Real Prospect Test with respect to factual allegations they should not rely on the findings made by third parties.

Dealing with Conflicts of Evidence

In Case 2018/58 the Case Examiners' determination turned on the question of the evidence available to support certain allegations. They noted:

"regrettably no direct evidence would be available from Patient A at any potential hearing."

However, the relevant section of the determination provided no explanation as to why that was the case. Only later in the decision was it noted that the patient had been terminally ill

at the time of the relevant appointment. The implication being that the patient was incapacitated or dead. We note that the decision in the joined case states, in terms, that Patient A has since died. The same clear statement should have been included in this determination to avoid any doubt.

Dealing with Conflict of Expert Evidence

In Case 2019/24 the Case Examiners were assisted by the views of two independent experts. One expert was of the view that the registrant's failure to undertake a fundus examination was below but not far below the expected standard. That view is noted by the Case Examiners. The same expert noted:

> "*5.8 The status of Patient A's eyes at the appointment on 30th August 2018 is not known. In my opinion it is likely that some evidence of dome shaped maculopathy was present but that it would have been difficult to detect with currently available optometric tests. Had a dilated fundus examination been conducted using a stereoscopic method i.e. Volk examination on a slit lamp then it is possible that a slightly raised area at the macula may have been visible.*
>
> *5.9 In my opinion, it is impossible to say if a reasonably competent Optometrist would have detected the dome-shaped maculopathy even with a dilated stereoscopic fundus examination due to its subtle nature. If a dilated fundus examination did show domeshaped maculopathy then I would have expected a reasonably competent Optometrist to refer the patient for an urgent ophthalmological opinion."*

That view was endorsed by the second expert and the Case Examiners correctly concluded that there was no realistic prospect of proving a failure to detect a dome shaped maculopathy.

However, in considering whether those allegations, which they determined passed stage 1 of the real prospect test, were capable of establishing misconduct the Case Examiners cited only one of the experts who said:

"Failure to conduct an external and internal eye examination in a patient with reduced visual acuity would fall far below the standard of a reasonable competent optometrist. In my opinion, the indications for conducting ophthalmoscopy far outweigh the reasons for not and in this case may have contributed to delayed referral for a potentially sight threatening condition."

The Case Examiners do not grapple with the tension between that view and the view of the first expert cited earlier, who would not support a finding of misconduct, at least in respect of the absence of fundoscopy. That is potentially significant as the Case Examiners went on to impose a warning. Whilst we are not saying that the Case Examiners came to an unreasonable outcome, such apparent tension between the experts on a central issue ought to have been expressly acknoweldged and squarely addressed.

Learning Point 6

The Case Examiners should be reminded of the crucial need to grapple with conflicts in evidence, or the evidence of experts which would tend to support an outcome different from that which the Case Examiners reach.

In Case 2018/486 the Case Examiners placed reliance on Patient A's recollection in reaching their decision one allegation. However, the way in which the Case Examiners presented matters was ambiguous. The relevant paragraphs were as follows:

"The Case Examiners note that the type of ophthalmoscopy performed is not recorded. The Registrant states that she performed indirect ophthalmoscopy and that this is what she does routinely. In her comments on the representations, ***Patient A states that she has no memory of indirect ophthalmoscopy*** *being performed during the eye examination.*

The Case Examiners agree that this represents a conflict of evidence and that their Guidance directs them in instances like this to accept the evidence of the patient at

its highest. For this reason, the Case Examiners agree that this allegation passes the first stage of the test."

Any assertion by a lay patient that they cannot recall whether "indirect ophthalmoscopy" was performed raises an obvious question – what does the patient understand by the term indirect ophthalmoscopy and is that accurate. Without some indication as to whether the patient properly understands the term the patient's evidence can be accorded little weight. The reader is not able to judge whether the patient understood the issue she was being asked to address.

Limb 2: Impairment

General Observations

In previous audits we noted that there were many cases where the Case Examiners recorded that there was no real prosepct of establishing current impairment without separately addressing whether there was a real prospect of establishing the relevant statutory ground. That was less of an issue in recent years samples.

Separately Considering Misconduct/Conviction and Impairment

In previous reports we have noted the importance of considering the Real Prospect Test with respect to the alleged ground of impairment and the issue of impairment separately. In this year's sample there were some cases where a clear distinction was not maintained.

In Case 2019/265 the Case Examiners made a distinct conclusion on the issue of misconduct at stage 2 but in so doing considered irrelevant matters. We also noted that they did not expressly acknowledge the lack of repetition in last 5 years as a relevant factor to be considered.

The Case Examiners began by addressing relevant principles in relation to misconduct:

> *"The Case Examiners went on to consider the second limb of the realistic prospect test in relation to allegations 1a, 1b(iii), 1b(iv), 1b(v), 2a(ii), 2a(iii), 2a(iv) and 2a(v), namely if the facts were found proved by the FTPC, would they be so significant that there is a realistic prospect of establishing that R's fitness to practise is impaired to a degree that justifies action being taken against her registration.*
>
> *In considering impairment, the Case Examiners have referred to their Guidance and have considered whether there is a realistic prospect of proving the ground of misconduct. In doing so, they have borne in mind the case of Roylance v GMC [2001] 1 AC 311 where it was said that misconduct is a word of general effect involving some act or omission*

which fell short of what would be proper in the circumstances. To amount to misconduct, any failing should be serious, such that it might be considered deplorable by members of the profession. The Case Examiners have reminded themselves that mere negligence does not constitute 'misconduct', and that a single negligent act or omission is less likely to cross the threshold of 'misconduct' than multiple acts or omissions.

The Case Examiners have also considered the authority of Spencer v General Osteopathic Council [2012] EWHC 3147 (Admin) in determining whether there is a realistic prospect that misconduct could be found proved, "a degree of moral blameworthiness on the part of the registrant likely to convey a degree of opprobrium to the ordinary intelligent citizen" was required. Any alleged misconduct does not mean any breach of duty owed by a registrant, but should be a serious breach for which the registrant could be justifiably criticised."

However, they then proceed immediately to considering impairment without applying the cited principles on misconduct to the facts. In doing so the expressly consider the remedial steps which have been taken in order to reach a conclusion that the threshold for misconduct has not been met.

"The Case Examiners have also considered the need to look forward rather than back. They note the CET that R has done and the improved referral pathways that exist since 2015. They also note that she has instructed her colleagues to comply with the regulatory requirement to give patients a written statement of the reason for referral immediately following the sight test.

Having considered all of the evidence in this case, including the remediative measures that have been put into place the Case Examiners agree that this does not meet the threshold for misconduct referred to above. *This case should not be referred to the Fitness to Practise Committee. [Emphasis added]*

In adopting that approach the Case Examiners have fallen into error. However, we think that it is likely that they would have determined that the stage 2 test for impairment was not met if they had approached the matter correctly.

A similar issue is evident in the determination in Case 2019/230 which related to the registrant's approach to assessing intra-ocular pressure in domicilary practice. The Case Examiners noted:

> *"The Case Examiners agree that lack of provision of accurate intra-ocular pressure measurement for the Registrant's domiciliary patients in particular raises a serious concern about their practice."*

However, despite noting the existence of a "serious concern" they do not really grapple with why it was not sufficiently serious to give rise to a real prospect of establishing misconduct.

> *"The Case Examiners agree that other aspects of the Registrant's practice demonstrated care for their patients which to some degree ameliorated the omissions of adequate tonometry and visual fields examination.*
>
> *For these reasons the Case Examiners agree that the parts of the allegation which passed Stage 1 and considered in the round do not pass Stage 2 of the test.*
>
> *The Case Examiners have considered the evidence and agree that there is no realistic prospect of establishing that the Registrant's current fitness to practise is impaired to a degree that justifies action being taken against his registration. The case, therefore, ought not to be considered by the FTPC."*

The problem here is that the Case Examiners did not specifically address misconduct despite having described the relevant legal principles. It is only in the latter part of the decision, considering a warning, that there is more reasoned engagement with the public interest and the seriousness of the conduct. The Case Examiners note:

> *"The Case Examiners have considered public interest and agree that this matter would raise public interest as it relates to treatment beneath that expected of a reasonably competent optometrist being provided to members of the public who are elderly and/or vulnerable."*

They go on to set out an analysis of the underlying conduct. This is the first time in the decision when the analysis moves towards a framework for the assessment of the 'moral' character of the failings:

> *"The actions of the Registrant as represented by the information examined by the Case Examiners suggests that either the Registrant was unaware that palpation has been an outmoded examination technique for many years, from which they would conclude that the Registrant failed to keep their professional knowledge up to date, or that she was aware and made a decision not to provide current measurement techniques to this vulnerable group of patients. She has stated that the patients would be offered IOP and visual field examination within the practice if deemed to be necessary which may be considered to be contrary to the need and or purpose of a domiciliary visit. The Case Examiners agree that any of the explanations raise concerns about the Registrant's practice."*

That analysis comes too late in this determination. It matters a great deal which of the two possible underlying causes applied. The taking of a conscious decision to deny vulnerable patients a relevant form of assessment would be morally blameworthy and would be sufficient to support a finding of misconduct. It was incumbent on the Case Examiners to consider why they were unable to prefer one possible explanation over the other, and not simply to proceed on the basis that "any of the explanations raise concerns about the Registrant's practice." The true explanation matters not only to the assessment of misconduct but also to the evaluation of current impairment.

Learning Point 7

Case Examiners should be reminded of the importance of considering misconduct and impairment separately. Where conduct is identified as being serious or giving rise to a serious concern there must be clear analysis in relation to the risk of repetition.

Considering Misconduct in Caution/Conviction Cases

Case 2020/81 was an interesting case which initially appeared comparatively straightforward. The Registrant had been convicted of an offence overseas and failed to declare to the Council. The allegation was one of impairment by reason of conviction (for possessing controlled drugs for supply) and misconduct for failing to declare the conviction. The conduct underpinning the conviction was not separately alleged as misconduct.

The Case Examiners determined that the allegation in relation to the conviction was the only one which passed the first stage of the real prospect test. Consequently, they deal with impairment only in relation to that allegation.

> *"The Case Examiners have carefully considered whether, if the facts of part one of the allegation, if proved, are so significant as to indicate that his fitness to practise is or maybe impaired. In light of the fact that the criminal proceedings were dropped, and the conviction has effectively been overturned, the Case Examiners agree that there is no realistic prospect of proving that the Registrant's fitness to practise is impaired."*

We were concerned that the absence of an allegation of misconduct relating to the possession of drugs for supply meant that the Case Examiners did not adequately consider that conduct at the impairment stage. The conduct of possession was effectively admitted, albeit that the conviction was disputed, the Registrant's position being that the conviction had been dropped because he had paid a fine instead.

Whilst the Case Examiners' reasoning with respect to the allegation of dishonesty and delayed declaration are entirely reasonable, their consideration of the issue of impairment on the conviction allegation was brief and insufficient:

> *"The Case Examiners have carefully considered whether, if the facts of part one of the allegation, if proved, are so significant as to indicate that his fitness to practise is or maybe impaired. In light of the fact that the criminal proceedings were dropped, and*

the conviction has effectively been overturned, the Case Examiners agree that there is no realistic prospect of proving that the Registrant's fitness to practise is impaired."

The Case Examiners' conclusion that the "criminal proceedings were dropped" does not adequately describe the position. The Registrant admitted to being fined for possession of drugs for supply. He did not suggest that he was not guilty of the underlying conduct. The contentious issue was simply how that had been dealt with by the foreign criminal process. If there had been an allegation of misconduct in relation to the possession of drugs for supply it would have passed the first limb of the real prospect test. We are also satisfied that such an allegation would pass the second limb test for misconduct and, in all probabilty impairment. However, we do not know what evidence might have been presented by the registrant in mitigation.

Harm as a Factor in Risk Assessment

In Case 2019/324 it appeared that the Case Examiners were unduly influenced by the issue of harm in their Stage 2 consideration. The relevant extract is as follows:

"The Case Examiners agree that even taking into account the symptoms reported by Patient A this case does not demonstrate the, 'classic' signs and symptoms of retinal detachment (floaters and flashes, 'shadows' in vision) that might have immediately alerted the 'reasonable competent optometrist' to conduct further examinations and/or refer. The symptoms as reported required some interpretation, notwithstanding the need to perform more examinations than those performed by the Registrant.

The Case Examiners agree that it is not possible to say that there would have been a better outcome for Patient A had the Registrant detected the retinal detachment. As Professor X notes it is not possible to say with certainty at what stage the retinal detachment was on 31 May 2019, but if the drop in vision is taken to imply a visual field defect, then it is likely that vitrectomy would still have been required with the possible sequelae.

The Case Examiners agree that whilst Patient A's experience was unpleasant and resulted in inconvenience and loss, her communication suggests that there has been significant recovery, notwithstanding the requirement for future cataract surgery." *[Emphasis added]*

The text in bold indicates a significant focus on an assessment of whether the registrant's failings caused harm in the index case. This is echoed in the later comments:

"The Case Examiners agree that within the allegations there is one instance that could be considered 'harm'. The Case Examiners agree that this could not be viewed as crossing the relatively high threshold 'particularly grave'."

The language indicates that the Case Examiners are proceeding on the basis that there must have been 'particularly grave' harm in order to establish misconduct. However, the requirement of gravity relates to the degree of departure from the expected standard, or the degree of negligence and not on the harm caused.

The Case Examiners failed to maintain the proper distinction between misconduct and impairment.

"For the reasons above, namely the possible extent of harm, the insight and remorse of the Registrant and the retraining undertaken by the Registrant the Case Examiners agree that the parts of the allegation which passed stage one of the realistic prospect test, taken as a whole, do not pass stage two of the test.

The Case Examiners are satisfied that no public safety matter or wider public interest matter is sufficient in the circumstances to justify referral to the FTPC."

Furthermore, there is a lack of clarity as to the Registrant's stance on the clinical allegations which makes it difficult for the reader to form a view in relation to insight and remorse.

In addition to the cases already referred to above, we identified a number of other occassions where the Case Examiners relied on the absence of harm in the index case. However, we begin with Case 2019/137 which is an example of the Case Examiners correctly acknowelding that the absence of harm is not determinative:

> *"The Case Examiners also consider that there is evidence that, in respect of two patients, details were not recorded on the records of referrals and the referrals were not made in a timely manner.* ***Whilst there is no evidence of subsequent harm to patients from these alleged omissions, the Case Examiners agree that harm might have ensued and that could have put patients at risk.*** *Failure to make appropriate referrals would engage the public interest and would engender harsh criticism. It might be considered to be deplorable to the point of resulting in opprobrium by the general public and colleagues alike." [Emphasis added]*

In Case 2018/402 the registrant submitted that no harm had resulted from his failure of diagnosis. The Case Examiners dealt with that submission as follows:

> *"The Case Examiners note that in his representations R admits that he did not detect signs of a choroidal melanoma or retinal detachment in Patient A's right eye. He points out that the expert report states that the management of Patient A's condition is likely to have been similar had she been referred in April 2017 (some 5 1/2 months before she was examined by R) outcome, but the Case Examiners note that this is* ***not relevant*** *to whether there is a realistic prospect of this allegation being found proved by the FTPC. In considering whether there is a realistic prospect of proving that R's failure to detect the relevant signs at the time of his examination was a culpable failure, the Case Examiners have considered the expert evidence as to whether or not the melanoma and associated retinal detachment are likely to have been present at the time of the examination in question."*

In Case 2018/486 we noted the same concern which we addressed above in relation to Case 2019/324, namely reliance on the evidence of actual harm in assessing whether the conduct was 'particularly grave'. The Case Examiners noted:

"Given that this was a single incident and **it is not possible state that the actions or omissions of the Registrant had led to significant harm the Case Examiners agree that they cannot consider it 'particularly grave'**. For this reason, the Case Examiners agree that the parts of the allegations which passed stage one, taken as a whole, do not pass stage two of the test.

The Case Examiners are satisfied that no public safety matter or wider public interest matter is sufficient in the circumstances to justify a referral to the FTPC."

However, that was not an adequate assessment in the face of an expert view that the conduct was "far below" the expected standard. There was insufficient consideration of the risk or repetition, insight and remediation. The case is discussed further in the section on warnings.

Following the preparation of the draft of this report the High Court handed down judgment in the case of the *Professional Standards Authority v General Optical Council and Rose* [2021] EWHC 2888. At paragraph 91 of that judgment the Court cautioned against an artificial distinction being made between doing harm and exposing a patient to an unwarranted risk of harm.

" In view of some of the submissions made to the FTPC, and at the hearing of this appeal, about the meaning of some of the individual indicators, the following points arise:

…

b. *Doing serious harm to individuals (patients or otherwise) was distinguished by the FTPC from 'exposure to an unwarranted risk of harm'. In part, that was said to be on the basis that the GOC had not pleaded 'doing serious harm'. The proper reasons for that are considered above –* ***misconduct is pleaded on its inherent qualities rather than being made to turn on proof of outcomes. But if and insofar as the ISG is intended to make any distinction of substance between doing harm and exposing a patient to unwarranted risk of harm – a question which itself merits sober and express reflection on the purpose of this guidance and its application to the facts of the case – then a***

tribunal would in my view be unwise to dismiss exposure to unwarranted risk of harm as irrelevant to sanction without at least pausing to consider all the dimensions of that risk and the degree of culpability to be attached to its creation. *This was a case in which all the risks were fully eventuated and the worst imaginable outcome came to pass; the public is entitled to a proper explanation of how that may or may not be reflected in the determination of sanction." [Emphasis added]*

In our view those observations support the points which we have made above and the learning point below.

Learning Point 8

We echo the learning point raised earlier in the report about the risks of over-reliance on the absence of harm in the index case as a marker of future risk.

Stress Testing Decision-Making

On occasions, Case Examiners may be confronted by a case where the assessment is finely balanced. In such cases it can be particularly useful for Case Examiners to "stress test" their reasoning by considering what outcome the would reach if the followed the alternative assessment. Case 2018/503 is an example of this concept in action. The case involved potentially very serious allegations and the Case Examiners approach evidence an appropriate degree of care in the circumstances. In dealing with the crucial allegation:

h. *Your actions at 1a and/or 1b and/or 1c and/or 1e and/or 1f were sexually motivated in that you were in;*

i. *Pursuit of sexual gratification; and/or*

ii. *Pursuit of a future sexual relationship*

The Case Examiners noted:

"In all the circumstances: without crucial evidence from Ms A, we are not satisfied that there is a realistic prospect of the FTPC finding this particular part of the allegation proven. There may well still be a prospect of doing so, even without evidence from Ms A; but, in our view, it is no more than remote. ***Even if we were***

wrong about that, we would have gone on to find *that – without crucial evidence from Ms A to rebut the evidence from R about the relevant context – there was no realistic prospect of establishing that such a hold amounted to both "misconduct" and "impairment" in the context in which it is said to have occurred."* [Emphasis added]

Such an approach is helpful in the event that there are concerns that by a party that the Case Examiners were wrong to conclude that the prospect of proving the allegation was remote. By expressly stating that they would have gone on to conclude that there was no real prospect of establishing impairment resolves any doubt and may avoid an application for review.

Learning Point 9

Case Examiners should be encouraged to "stress test" their decisions particularly in cases where they feel the issues are comparatively finely balanced.

Reliance on Insight/Mitigation

At stage 2 in Case 2018/402 the Case Examiners determined that the real prospect test was not met. The allegations related to a single clinical appointment and relate to a failure of assessment and referral, this included a failure to take appropriate action in response to an identified visual field defect. Having determined that the alleged conduct passed the threshold for misconduct they observed:

"The Case Examiners note R's expression of remorse and reflection on how he managed Patient A. Despite the seriousness of the case, the Case Examiners agree that the evidence of remediation – including R's reflection on the case, his CET, and the supervisor's assessment of many of his records and referrals over a significant period of time – is sufficient to mean that the Case Examiners agree that the allegation does not pass the second limb of the test. In coming to this view, the Case Examiners have kept in mind the likely impact of the evidence of remediation, and what they consider to be the now relatively low risk of repetition, on the FTPC.

The Case Examiners have carefully considered the evidence in this case and agree that there is no realistic prospect of finding that R's fitness to practise is impaired to

a degree that justifies action being taken against his registration. This case should not be referred to the Fitness to Practise Committee."

However, we were concerned that the determination did not afford the reader any insight into the registrant's explanation for his error. In the absence of that information, it is difficult for the reader to form a view on the issue of insight and future risk. Furthermore, whilst noting that the risk of repetition was low, the Case Examiners did not separately consider whether there may be public interest considerations which might support a finding of impairment.

In Case 2016/309 the Case Examiners set out a detailed sequence of factors which were relevant to their conclusion. These included the following:

"Seventh, related to this, there is the evidence of R having had, since the alleged dishonesty, a very substantial ***health*** *condition. The evidence is that R was diagnosed with Grade 3 Triple Negative Breast Cancer in June 2017; that she has undergone extensive treatment and surgery in the meantime; and that she continues to be under ongoing care. Such a factor is a matter to which the FTPC may reflect on in terms of overall risk of repetition and/or the proportionality of proceedings and/or any potential sanction."*

Such reliance on personal mitigation is something which needs to be approached with considerable caution. In this case it was only one of a number of factors and we do not suggest there was a material error in relation to the outcome. We would have been concerned if the Case Examiners' decision turned on this point.

Learning Point 10

The Case Examiners should be reminded that the assessment of insight and remediation requires a view to be reached as to the root cause of the relevant conduct and whether that is acknowledged by the registrant. A registrant who cannot understand why misconduct occurred faces obvious challenges in guarding against repitition.

Public Interest and Impairment

Although the overarching objective and the public interest were frequently referred to in decisions, it was relatively infrequent that there was detailed consideration of the public interest as a discrete issue and extending to each of the elements of the public interest. However, we note that the sample of cases closed by the Case Examiners with no further action included very few in which the Case Examiners had determined that there was a real prospect of establishing misconduct. Thus it was comparatively rare that the assessment of the public interest and impairment arose for consideration.

Case 2019/242 involved a student who had taken a mobile phone into an exam in breach of the University's regulations. There was evidence that students had been warned about the relevant rule at the outset of the exam. There was no evidence that the phone had been improperly used to gain an advantage in the exam. It was alleged that the conduct was dishonest because it was a breach of the regulations.

We were concerned by the Case Examiners approach to this case. In particular, the following passage from their determination indicates that the Case Examiners considered irrelevant matters in determining that the case ought not to be referred. They stated:

> *"The Case Examiners note that the student is no longer continuing his training with the University of X and so the question of his fitness to undertake training does not arise. They therefore consider that there is no public interest in referring this matter to the FTPC as the conduct which led to the allegations is unlikely to be repeated. The Case Examiners have also considered whether the possibility of the student undertaking training by enrolling with another University.* ***However, they agree that the requirement is to consider current fitness so what might happen in future is not relevant."*** *[Emphasis added]*

The assertion that what might happen in the future is "not relevant" is wrong. The possibility that the registrant may seek to continue his studies in the future is highly relevant. As the Court of Appeal made clear in *Clarke v General Optical Council* the fact that a registrant is not practising at present does not make it appropriate for them to remain

registered without restriction if they are unfit. In this case it might have been accepted by the FTPC that the breach of the University regulations was unwitting and not underpinned by any improper motive. However, it was also possible that the FTPC would conclude that it was deliberate and demonstrated a lack of integrity. That would be a significant finding which would be likely to result in a sanction.

When considering a warning the Case Examiners noted:

> *"The Case Examiners agree that a warning is not appropriate in this case for two reasons. Firstly there is dispute relating to the dishonesty elements of this case and as such there is no basis on which the Case Examiners are able to warn. Secondly, even if this was possible, the Registrant is no longer at the university to undertake training for the warning to have context on future conduct."*

Once again, the Case Examiners were mistaken to rely on the fact that the registrant is not currently studying as a basis not to issue a warning.

In Case 2020/002 the registrant had received a caution in relation to a conspiracy to defraud by passing details of eight customers' payment cards to criminal associates. The matter was disposed of with a warning in case of credit card caution. The registrant was a student and the facts were admitted. We note that the Case Examiners did not make reference to *Donkin v Law Society* and the challenges of reviewing a case on the papers alone. The Case Examiners concluded that there was no real prospect of establishing current impairment on public interest grounds.

> *"After consideration however we agree that whilst the Registrant's conduct has plainly fallen below the standard expected, it falls short, just, of the threshold for referral."*

We disagree. The case involved admitted dishonesty which involved an abuse of the registrant's trusted role as a health professional in training. It was planned and repeated.

Whilst the Case Examiners make reference to overriding objective they do not explain why they determined that there was no more than a remote prospect of finding that maintenance of public confidence required a finding of impairment.

"After consideration however we agree that whilst the Registrant's conduct has plainly fallen below the standard expected, it falls short, just, of the threshold for referral."

The Case Examiners place reliance on disposal by way of caution and the associated charging decision which stated that it was "not in the public interest to take before a court with above circumstances." However, different considerations apply to prosecutions in the criminal courts and the jurisdiction exercised by professional regulators. The Case Examiners give credit to the registrant without tempering it for the obvious reason that he was caught "red-handed". They observe:

"crucially in our view, [R] made full and early admissions"

In a similar vein the make the characterise the behaviour as

"an isolated and short period of errant behaviour"

The Case Examiners made specific reference to the offence at issue not being one of the offences listed in the GOC's Protocol on the handling of criminal convictions disclosed by Registrant's. However, the fact that a particular offence does not give rise to a "presumption against registration, restoration and retention" appears to have been treated as creating a presumption in favour of retention. There is no such presumption. Whilst the absence of the offence from the quoted guidance might be seen as an indication that the Council may not automatically seek erasure that is very far from an indication that a finding of impairment would not be appropriate. It does not rule out the imposition of a suspension or erasure. In our view the approach in this case was materially flawed.

In Case 2017/282 an application was made under Rule 16 to cancel the referral. The determination included the following:

"Overall, in light of the evidence before us now (and in particular the evidence regarding insight, remediation and future risk), it is highly unlikely, now, in all the circumstances, that similar relevant issues will be repeated.

In all the circumstances, as indicated above, we are not satisfied that Stage 2 of the Test is satisfied."

That analysis deals only with the risk of repetition and does not expressly consider the public interest. However, these observations were in the context of a decision where it was already acknowledged that the case in respect of misconduct was weak:

> *" We agree with the submission in the Application that, even if R has breached the Code, the Allegation is or may not be sufficiently likely to cross the threshold of misconduct having regard to the necessary element and degree of moral blameworthiness or culpability."*

Consequently, we are satisfied that the failure to expressly consider the wider public interest did not result in an inappropriate outcome.

Learning Point 11

The Case Examiners should be reminded:

(1) That a registrant's commitment not to practise is of no, or limited, relevance in determining the appropriate disposal of misconduct allegations.

(2) The Public Interest involves a number of considerations all of which ought to be expressly addressed in cases where there is a real prospect of establishing misconduct and in cases where consideration is being given to issuing a warning.

Considering the Availability of a Warning

In considering Stage 2 of the real prospect test in Case 2018/503 the Case Examiners made the following observation:

> "Finally, although this is a factor which has not made any material difference to our decision at this stage, we are mindful that there might be an opportunity – e.g. via a formal warning – to put in place alternative and adequate arrangements to protect the wider public interest."

We regard consideration of the possibility of a warning as an appropriate element of Stage 2 of the real prospect test particularly in cases where the risk of repetition is remote and the question of a finding of impairment on public interest grounds alone is central.

Requests for Further Information

Whilst there were only 3 cases in this sample we reviewed one other request for further information which appeared in the decision documents for other case categories. We did not identify any cases where the power was not exercised but should have been. We regarded these decisions as appropriate and sufficiently reasoned.

In Case 2018/317 the Case Examiner correctly identified that conduct which was clearly capable of being dishonest was not alleged as such and the adjourned consideration of the case to permit the Registrar to consider further allegations. We regarded the decision as appropriate.

In Case 2017/386 the Cases Examiners noted a concern about the drafting of the allegations and a typographical error:

> *"The Case Examiners have concerns regarding the Allegation as currently drafted. Specifically, regarding the dates (2010-2015) that these events are alleged to have occurred. Having reviewed the bundle in detail they note that the dishonesty alleged by X Co extends beyond those dates into 2016. This error has been noted in the representations on behalf of the Registrant."*

They appropriately cited paragraph 30 of their Guidance cited and went on to observe:

> *"The Case Examiners are of the view that this is a serious allegation of dishonesty and in fairness to the Registrant and Complainant alike, the Registrar should reconsider the drafting of the allegation. At the same time the typographical error in relation to [Location Z] could be corrected."*

We regarded the Case Examiners' approach as reasonable.

Case 2018/365 involved allegations related to a registrant's role as a supervisor of a colleague in training. The Case Examiners noted the nature of the allegations and went on to express their concern about an ambiguity in what was being alleged:

*"**Allegation***

The Allegation against the Registrant is framed in the following terms:

The Council alleges that you, … a registered optometrist:

1. On or around 26 August 2018 during a contact lens after care appointment you failed to provide Patient A with an adequate standard of care in that you;

a) failed to adequately supervise the pre-registration optometrist who attended to Patient A in that you;

i. Failed to provide Patient A with adequate advice regarding the contact lens after care system;

ii. Failed to discuss other potential options for Patient A for example the benefits of daily disposables;

iii. Failed to assess Patient A's compliance with the after care system and general contact lens related hygiene;

iv. Failed to discuss with Patient A the risks of wearing contact lenses whilst swimming and the consequences of not complying with advice on how to wear contact lenses safely;

b. Failed to maintain adequate patient records for Patient A in that you:

i. Failed to adequately record any advice given to Patient A regarding the contact lens after care system;

And by virtue of the facts set out above, your fitness to practise is impaired by reason of misconduct.

Decision Reasoning

6. The Case Examiners have decided that their consideration of this case should be adjourned. In the Case Examiners' view, the way the Allegation has been drafted

is ambiguous and is capable of more than one interpretation. As currently drafted, one interpretation is that it is being suggested that the Registrant (as supervisor) was under a duty to perform certain functions during the examination of the Patient. The other interpretation is that the Registrant (in her capacity as supervisor) allegedly failed to ensure that certain tests and/or examinations were performed by the pre-registration optometrist being supervised by her.

7. Additionally, the Case Examiners note that the Registrant's representations state that the supervision at the store is structured and that the level of supervision varies over time. The Case Examiners understand that in order to oversee the supervision of pre-registration optometrists the Registrant enters into an agreement with the College of Optometrists who are the examining body for pre-registration optometrist Scheme for Registration. The Case Examiners agree that in order to aid their decision as to whether the actions of the registrant were adequate, under either interpretation, it would be beneficial to have further information relating to:

- *The responsibilities of the supervisor as part of the College of Optometrists Scheme for Registration at the time of the examination; and*
- *How the Registrant satisfied themselves that the pre-registration optometrist was performing at the required level for contact lens appointments.*

8. The Case Examiners have decided that the appropriate course to take would be to adjourn their consideration of this case, and to direct the Registrar to review the framing of the Allegation against the Registrant, and obtain the further information referred to in paragraph 7 above.

9. The Case Examiners remind the Registrar that if, following any review, the Allegation is amended, it must be provided to the Registrant for representations prior to being sent back to the Case Examiners for consideration. It follows, too, that any additional information collated by the GOC in furtherance of the Case Examiners' request for clarification around the supervision arrangement must also be supplied to

the Registrant for any further representations she may wish to make."

We regarded the Case Examiners approach in this matter as reasonable and proportionate.

Case 2019/189 involved a self-declaration in respect of criminal proceedings. The Case Examiners noted an error in the allegation with respect to the specific offence referred to:

> *"The case report provided to the Case Examiners states that the allegation relates to a conviction for drink driving. For the reasons set out below, the Case Examiners are of the view that the allegation has been incorrectly drafted. What should be alleged against the Registrant is that she has received a conviction for being drunk in charge of a motor vehicle, rather than drink driving. They are separate and distinct offences, and are charged differently under the Road Traffic Act 1988."*

Again, we regarded the approach adopted as reasonable and proportionate.

Closure with No Further Action/Advice

We reviewed 19 decisions in these categories. Save for specific issues dealt with specifically elsewhere in this report, the decisions were appropriate and were generally well reasoned with appropriate reference being made to relevant standards and guidance. We have commented on specific examples which departed from those expectations elsewhere in this report.

Observations

In Case 2018/503 the allegations related to the registrant's conduct with a work colleague who did not engage with the Council's investigation. The allegations included an allegation of that the conduct was sexually motivated. The Registrant's position was that he was in a relationship with the colleague at the relevant time. There were significant evidential difficulties because of the colleagues lack of engagement in the process. The Case Examiners determined to close the matter with advice, as follows:

"ADVICE

In addition, we would advise R – and we would do so in strong terms – to:

a. *identify and complete, as soon as reasonably practicable, a course of some kind (from a reputable provider), or some other suitable form of training or personal development, focused on matters relating to equality, diversity and inclusion in general and to harassment in particular;*

b. *make a substantial effort to genuinely and sustainably embed the principles from the same, along with those set out and referred to above in the Standards, within his future practice and wider career;*

c. *reflect more generally and further on the way in which his conduct, whether inside or outside the workplace, may be interpreted by (and impact on) colleagues, patients and others; and*

d. *really learn the lessons arising out of this case and* ***take all reasonable steps*** *to prevent similar situations arising in the future.*

We felt the reference to "equality, diversity and inclusion" was not directly relevant to the issues in the case and advice in relation to attending a professional boundaries course would have been more appropriate. Furthermore, the reference to taking "all reasonable steps" is not appropriate. The alleged conduct would constitute a breach of the Standards, and should not be repeated. It would be preferable if the Case Examiners simply advised him to adhere to the relevant provisions of the Standards.

Learning Point 12

Case Examiners should be reminded that advice issued to registrants during the fitness to practise process should be clearly linked to the applicable standards of professional conduct promulgated by the Council.

Decisions Not to Warn

Case 2019/172 the decision that a warning should not be issued considered the matter too narrowly:

> *"The Case Examiners note that the Registrant has expressed remorse for the issues raised. As a result, they do not consider that any purpose would be served by a warning and have therefore decided not to give one in the circumstances of this case."*

The approach takes no account of the role of warnings in declaring and upholding proper standards of behaviour. (See also 2019/242 elsewhere in this report.)

Learning Point 13

Case Examiners should be reminded to have regard to the range of purposes served by issuing a warning before determining that a warning is not appropriate.

Warnings and Minded to Warn Decisions

We reviewed more than 10 decisions in these categories as the question of whether a warning was appropriate arose in cases which were closed with no further action. We saw good reference to the relevant guidance on warnings. In nearly all cases the relevant guidance was mentioned. However, in a number of decisions the reference to the guidance

was not extended beyond mention of that guidance. It was rare that detailed reference to the relevant paragraphs of the Guidance was included in decisions or that determinations demonstrated that the Guidance was applied in a stepwise fashion.

In Case 2019/020 considered allegations related to the consumption of alcohol at work. We deal with the Case Examiners approach to the allegations in this case elsewhere in the report. The Case Examiners concluded the matter with the following warning:

> *"The Case Examiners are therefore minded to give a warning in the following terms:-*
>
> *"You are warned that you must ensure that going forward you review and ensure you adhere to GOC Standards for optometrists and dispensing opticians 11 and 17 and in particular you* ***must ensure that at all times you are aware when you are not fit to work*** *and take the appropriate action. If you fail to do so, such conduct may result in the allegations against you being referred to the Fitness to Practice Committee to consider action on your registration.""*

The warning needs to be assessed in light of the earlier observations of the Case Examiners:

> *"Notwithstanding the representations and reflective statement,* ***the Case Examiners are not persuaded that the Registrant has developed the self-awareness to recognise and accept when she is actually not fit to practise for any reason or that she would in future, take the appropriate action and put patient safety at the forefront and above her personal needs.*** *Although she may understand the reasons for not attending patients when unfit to work, the crux of this matter is recognising when she herself is not fit to work at the time and taking the appropriate action even when it might have personal repercussions as she has admitted previously."*

The Case Examiners have identified a fundamental problem with insight and concluded that the registrant does not have the insight required to absent herself from work when she is unwell. In that context is no clear how issuing a warning in the terms cited will have any effect on mitigating future risk. We felt that the approach reflected earlier errors in the Case

Examiners evaluation of the matter, including a failure to determine the nature of any underlying health condition and the risk of relapse. We noted that the determination included references to admissions made by the registrant but it was not clear from the determination what those admissions were.

In Case 2018/486 a warning was issued in respect of a registrant whose the Case Examiners felt showed 'no insight' in their failings. The allegations related to a single clinical encounter. The evidence suggested that the registrant had failed to consider a potential diagnosis of retinal detachment in the face of 'red flag' symptoms and findings including a visual field defect in a patient at high risk of detachment. One expert opined that a detachment was evidence on OCT.

This is another case where reliance was placed on the absence of harm in the index incident, rather than what the conduct signalled by way of future risk of harm:

> *"Given that this was a single incident and it is not possible state that the actions or omissions of the Registrant had led to significant harm the Case Examiners agree that they cannot consider it 'particularly grave'. For this reason, the Case Examiners agree that the parts of the allegations which passed stage one, taken as a whole, do not pass stage two of the test."*
>
> *"The Case Examiners are satisfied that no public safety matter or wider public interest matter is sufficient in the circumstances to justify a referral to the FTPC."*

That view does not address the expert opinion that the conduct was far below the expected standard. At this stage, the Case Examiners do not expressly assess the risk of repetition, insight or remediation or attempt to identify the root cause for the registrant's conduct i.e why did this error happen? Without an assessment of those matters we do not believe that the Case Examiners could properly conclude that there was no real prospect of establishing misconduct and/or impairment.

We noted that some of that missing analysis appeared later in the decision when the Case Examiners considered a warning:

"In particular the Case Examiners note the comments of the clinical adviser and the expert who both identified failings in the performance of the Registrant in this case. In particular, Dr X states that the performance is far below the standard expected of a reasonably competent optometrist.

The Case Examiners feel that it is helpful to highlight several comments from Ms Y including

- '*As the registrant has not conducted any of the tests I would expect when suspecting retinal detachment, I think it would be reasonable to assume that this diagnosis was not considered.',*
- *'Although the visual field defect did correspond to the OCT 'at risk' area and therefore reasonable for the registrant to suspect the visual field defect may be glaucomatous, without a corresponding disc change in my opinion the registrant should have considered other diagnoses as well.'*
- *'In addition, the evidence to suggest that Patient A had developed a field defect due to glaucoma was not conclusive and the registrant has failed to consider the more obvious cause of symptoms in this case.*'
- '*Although I accept that this is an isolated case and that there is reason for the registrant to have suspected glaucoma in Patient A in my opinion a high myope, presenting with increased floaters and a field defect would be much more suspicious of retinal detachment and I feel it is far below the standard of a reasonably competent optometrist not to have conducted a dilated examination or referred urgently on these symptoms.' "*

The following was noted with respect to insight and remediation:

"The Case Examiners note with concern that ***the Registrant shows no insight into the failings*** *which potentially led to the incorrect referral of Patient A. Of particular note is the failure to link, even in hindsight, the retina appearance and the visual field defect with anything other than low pressure glaucoma. Further, omissions and errors with respect to record keeping suggest poor performance in relation to history and symptoms which later appeared to affect decision making around the area of diagnosis and referral.*

The Case Examiners also note Ms. Y's statement that 'Remedial action in terms of further learning on retinal detachment and glaucoma would help lower the risk'. The Case Examiners note that this was undertaken in January 2019."

Thus, a registrant who had already undertaken remedial action was still causing the Case Examiners concern about a lack of insight. The experts opinions were that the conduct fell far below the expected standard. It is unclear how the Case Examiners concluded that the real prospect test was not met in relation to Stage 2. We do not agree that the real prospect test was not satisfied in this case and believe the matter ought to have been referred to the FTPC. The analysis of insight came too late in the determination.

Learning Point 14

Case Examiners should be reminded of the importance of providing sufficient reasons for their decisions in relation to not giving warnings. This should include consideration of the public interest elements of the Council's function.

Reference to Guidance on Warnings

Whilst many made appropriate reference to the Guidance on Warnings, there was a minority where that did not happen.

Representations on Minded to Warn decisions

We were reassured to see the Case Examiners consistently commenting on whether representations had been received in response to the Minded to Warn decision.

Warnings where there are factual disputes

Case 2019/301 (see elsewhere also) involved a single patient and allegations relating to a failure to measure or record IOPs. The registrant's representations on the minded to warn decision contended that the Case Examiners were relying on disputed facts. We were reassured to see that the Case Examiners engaged directly with that contention:

"It is submitted on behalf of the Registrant that advice, rather than a formal warning, would be more proportionate in this case. The principal basis for this is whether a tonometry test was in fact performed. It is asserted that Patient A is confused when describing the two tests of tonometry and visual fields, and that a tonometry test was performed. Therefore, it is argued, the Registrant did not depart from the College of Optometrists guidance and a warning is not proportionate.

The Case Examiners acknowledge in their initial decision that there is dispute on whether the tonometry test was performed. In their view the weight of evidence could suggest that it was not.

However, when considering whether to give a warning the Case Examiners have not given any weight to whether the test was performed or not, but have been solely concerned with the undisputed failure of the Registrant to record the results and the consequences that has for the future management of Patient A's optical health.. "

This raises a question about the proportionality of a decision to warn in respect of a single record keeping omission. However, the Case Examiners go on to provide reasons for issuing the warning including express reference to the Guidance:

"As set out in paragraph 33, quoting the Guidance on Warnings, "Warnings are considered appropriate when the matters complained about would not amount to an impairment of fitness to practise ***but if repeated may do so****." (Our emphasis)*

A warning is a non-disclosable decision to employers and any other enquiries and therefore this does not have any detriment to the career of the Registrant and would only be of significance if there was a repeated failure to record this relevant clinical information within the next four years."

Whilst we note the Case Examiners contention that a warning "does not have any detriment to the career of the Registrant" we would note the importance of considering the practical consquences as well as the legal consequences of warnings as part of the assessment of proportionality.

Considering the Impact of Warnings

In each of the last three years we had noted that there was variable practice in relation to recording the nature and effect of warnings in Case Examiners' decisions. Because the effects of warnings are relevant to an assessment of the proportionality of the decision to warn they ought to be considered by the Case Examiners at the minded-to-warn stage. It would be preferable if they were clearly referenced in minded to warn determinations. Cases 2018/402, 2018/503, 2020/002 and 2019/24 were examples of cases where such analysis was missing. This contrasts with Cases 2019/24, 20-19/230 and 2019/301 where the effect of a warning was addressed in the minded to warn decision.

In previous reports we have noted the importance of considering the issue of proportionality when determining whether to give a warning. We have noted that an aspect of this involves consideration of the practical consequences of warnings and noted that those are often described in decisions only after a decision to issue a warning is made, or are set out in correspondence to the Registrant conveying the decision. We note that it remains common for the effects of warnings not to be described in minded to warn decisions (roughly half of the sample reviewed).

Learning Point 15

We repeat the observations which we made in each of the last two years, namely:

1. Case Examiners should be reminded that the nature and effect of warnings needs to be considered when determining whether a warning is proportionate. Those considerations should be addressed at the Minded to Warn stage. This would serve two distinct functions; Firstly, it would ensure that the issue of proportionality is addressed by the Case Examiners. Secondly, it would afford the registrant the opportunity to address those matters in any representations before a final decision is made.

2. Case Examiners should be reminded to make explicit reference to the relevant guidance on warnings. Decisions should ideally provide a clear indication of any aggravating or mitigating factors which have been considered, in accordance with the guidance.

3. The text of warnings should be clearly anchored in the applicable standards.

Decisions to Refer to FTPC

We reviewed 5 decisions to refer cases to the FTPC. In each case we regarded the decision as appropriate and well reasoned.

There was a single case in this category which we felt merited detailed comment. Case 2020/121 involved allegations related to a video which had been posted on social media in the early part of the COVID pandemic. The Case Examiners determined to refer the matter to the FTPC. The matter was later the subject of a Rule 16 application and the referral was maintained. We noted a striking difference in the level of analysis between the two decision.

On reviewing the intial Case Examiners decision we were concerned that the conduct had not been clearly characterised and certainly the reader was provided with very little information about the content of the video. The registrant, who was in a leadership position in one store of a chain, made a video which he knew would be shared with his colleagues in other stores. The video appeared to promote sharp practice which showed a diregard for COVID related safety concerns. The video was shared on social media, beyond the initially intended audience. The Case Examiners focussed on the sharing on social media and did not sufficiently analyse the intended purpose of the video. In fact, the sharing on social media is something of a 'red herring' in this case.

The Case Examiners did not consider the registrant's conduct on the basis of (1) his known expectations – that the video would be shared internally to influence the behaviour of other stores and, separately, (2) the unexpected development – the sharing of the video on social media. Nor do the Case Examiners really distil what the gravamen of the conduct – namely an invitation to colleagues to prioritise commercial interests over public safety; and not merely the crass use of language in the registrant's reference to having "stole" patients from competitors.

The decision does not give a good sense of the overall tone and content of the video. The full video would need to be considered to determine whether the stealing patients quips

were obviously 'tongue in cheek', as suggested by the registrant, or whether the overall tenor of the video involved a disregard for public health risks.

The Case Examiners referred to Standards 4 and 17 but not Standard 11, the requirement to protect and safeguard patients, colleagues and others from harm. In our view Standard 11 was directly relevant. The decision did not properly separate out misconduct and impairment.

We were pleased to note that the Rule 16 decision addressed the concerns which we had in respect of the original decision and provided a much clearer picture of the underlying conduct and why it was a concern.

> *"The facts of the allegation are admitted by the Registrant through his representations made by [solicitors] on his behalf. The representations go on to say that, 'If (sic) is further admitted that the comments which [R] made as summarised above were inappropriate and [R] apologises profusely for this. However, the Case Examiners cannot consider the video in isolation without appreciating the context in which it was made and the intended audience. Indeed, the comments which [R] made were intended to encourage colleagues that they could provide safe eye care to the community during an unprecedented pandemic and that it was possible to earn some revenue which had been lost since lockdown was imposed. [R] referred to competitors as he honestly believed that the video would only be shared amongst colleagues working in the same business. [R] deeply regrets that other optometry businesses and members of the public have viewed the video and can understand how it creates a poor impression when considered in isolation.'*
>
> *Having viewed the video the Case Examiners agree that the admission is consistent with the evidence."*

We were impressed by the clarity of the analysis which followed:

> *"Whilst this is accepted, the Case Examiners note that in the video the Registrant states (at 1:51) as he shows the bookings currently made, 'We've gone online all, with everything.' He then goes on to say (at 2.02), 'It's just open, all, to everything. We're not*

really seeing much in the way of contact lens work coming through as yet. It's mainly sight tests and walk-ins'.

The Registrant is stating that the Practice was open to everything and this does clearly imply that routine eye care appointments were being accepted and booked by him, contravening the industry guidance in place at the time. It is highly unlikely that the Registrant was unaware the routine eyecare should not have been taking place. *Overall, the impression given by the Registrant is that routine eye care was taking place and this is supported by the complaint emails which show multiple people who watched the video understood the practice to be undertaking routine eye care. Taking this in the context of why the video was made and for who the intended audience were, it would seem to encourage other Specsavers practices to be undertaking routine eyecare.*

The Case Examiners agree with [the registrant's solicitors] that the context of the comments stated in the allegation should be considered. This is not just because the Registrant was advocating 'stealing patients' but that he was advocating stealing patients by being open to all and everything (i.e. including routine eye care) whilst their competitors were following guidance and not providing routine appointments. In further context, the Registrant seems to be encouraging twenty other practices and their directors to follow this example. (Whether the Practice was undertaking routine eye care or not is not particularly relevant when considering the Registrant's actions as an individual registrant, as stated in the allegation.) " [Emphasis Added]

And

"Having reviewed the video and the new evidence provided by [the registrant's solicitors] and taken the context of the alleged comments into consideration, ***the Case Examiners consider the evidence available shows that the Registrant advocates (to twenty other Specsavers stores and their directors) the stealing of patients; his exact words were 'just open, all, to everything' and 'steal from our competitors', suggesting the flouting of the guidance in place due to a pandemic. The guidance in place at the time was not for practices to be open to 'all' or 'everything'****. The multiple complaints indicate that the conduct of the Registrant was found to be 'deplorable' by members of his own profession and would be likely to convey a degree of*

opprobrium to the ordinary intelligent citizen. These matters alleged would therefore cross the threshold to misconduct." [Emphasis Added]

Unlike the analysis set out in the first Case Examiners' decision, the Rule 16 determination captures the gravamen of the alleged conduct very clearly – encouraging colleagues to flout public health guidelines to steal business. We regarded the decision to refer in this case as correct.

Rule 15 Decisions

Rule 15 provides for the Case Examiners to review a decision not to refer an allegation to the FTPC. The Rule imposes a five year time limit between the date of the original letter notifying the registrant of the original decision and the date of any review. The Rule affords a discretion for reviews to be undertaken outside of that time limit where the Case Examiners consider the circumstances to be exceptional. Before the review is conducted, both the maker of the allegation and the registrant must be informed of the decision to undertake a review and their representations must be sought. A decision by the Case Examiners to conduct a review must be unanimous. Upon reviewing the decision the Case Examiners can determine that the original decision should stand, or may issue a warning where one was not issued at the time of the original decision, or refer the allegation to a Fitness to Practise Committee. The Case Examiners may also determine that a warning issued at the time of the original decision should not have been given and remove it from the registrant's record. Upon completion of the review, the registrant, the maker of the allegations and any other person whom the Case Examiners consider to have an interest in receiving notification, including the registrant's current employer, must be notified in writing as soon as reasonably practicable. Where the Case Examiners cannot agree on the outcome of the review then the original decision not to refer the allegation shall stand.

We reviewed 2 decisions made by the Case Examiners under Rule 15. We saw evidence that the procedural requirements of Rule 15 were being appropriately followed. In each case a warning had been issued to a registrant in respect of alleged dishonesty which the registrant had denied. In Case 2019/04 the warning was cancelled. In Case 2017/189 the registrant had come off the register by the time of the Stage 2 consideration.

Rule 16 Decisions

Rule 16 provides for the Case Examiners to review a referral of an allegation to the Fitness to Practise Committee. Before the review is undertaken the Registrar must give the maker of the allegation an opportunity to submit their comments. The Rule does not require the registrant to be notified of the review, or to be afforded an opportunity to submit comments. Where the Case Examiners determine that the allegation ought not to be considered by the Fitness to Practise Committee, they must give a direction to that effect to the Registrar. Where such a direction is given the registrant, the maker of the allegations and any other person the Registrar considers has an interest in receiving a notification, including the registrant's current employer, must be notified in writing as soon as reasonably practicable.

We reviewed 8 decisions in this category 6 of which were made by the Council. In some of the cases the referral to the FTPC was maintained. We regard the decisions made as appropriate. The decisions were generally clear and well-reasoned.

In the 2019/20 Audit Report we noted:

> *"Case 2013/056 provided very little of the relevant background information and so the reader was left to guess at the precise nature of the evidential issues which had led to the application. The determination indicated that these were set out in the Council's application but that if of no assistance when only reading the determination. Some description of the issues ought to have been provided."*

Case 2018/186 related to alleged NHS claims' fraud. At the time of first consideration no representations were received and the case was referred to the FTPC. That decision was appropriate. On review under Rule 16 the referral was cancelled. The determination refers to the Council's application and reference to evidential difficulties faced by the Council but affords no details about the nature and extent of those evidential difficulties.

Case 2017/195 involved a registrant who, at the time of the decision, had been registered for 41 years with no adverse fitness to practise history. There were allegations in respect of multiple patients. The Rule 16 application was limited to allegations 9 – 17, all of which were record keeping allegations. An allegation of falsifying records fell outside of the scope of the application. We noted that although the allegations related to 2015 the Case Examiners referred to the Standards not Code but we did not regard that error as material.

The Rule 16 application followed the receipt of new evidence including an expert report and evidence of the registrant's completion of a training plan in light of which the Case Examiners observed:

> *"The Case Examiners have also considered the need to look forward rather than back, and to consider R's current level of impairment. They note the remedial action that R has done, overseen by NHS Education for Scotland, and the redesign of his record cards. In view of this the Case Examiners agree that there is no realistic prospect of proving that R's fitness to practise – in relation to the allegations of his clinical record keeping that are discussed above – is currently impaired, and these allegations do not pass the second limb of the test. The referral to the FTPC in relation to these allegations should therefore be terminated under Rule 16(4) of The Rules."*

The analysis did not address specifically address whether there was a real prospect of establishing misconduct or deficient professional performance. Nor did it expressly consider the public interest. Nonetheless, we do not believe that those errors are material in terms of the outcome.

Case 2019/233 involved allegations related to a single appointment. The Rule 16 review was prompted by new evidence in the form of a new expert report. The Council conceded that there was no real prospect of impairment being established. The referral was terminated. The decision noted:

> *"The Case Examiners note that in this report, Ms X concludes that the actions of the Registrant fell below the standard of a reasonably competent optometrist, not seriously below those standards."*

And later:

"Having had regard to Ms X's opinion, the Registrant's remediation and the relevant caselaw, the Case Examiners agree that the allegation could not amount to serious misconduct and that there is no realistic prospect of the FTPC finding that the Registrant's fitness to practise is currently impaired."

We note that the determination does not, on its face, explain the disparity of views between the new expert and the original clinical advice. The original Case Examiners' decision included:

"In this case if the facts are found proved in relation to the Allegation, the Case Examiners agree that it would be considered to be serious, deplorable and morally blameworthy to the extent that it would be likely to convey a degree of opprobrium to the ordinary intelligent citizen. In coming to this conclusion, the Case Examiners have considered the opinion of Ms Y, who states (with emphasis added by the Case Examiners), *"To miss a case of substantial retinal detachment would fall far below the standard of a reasonably competent optometrist."* The Case Examiners have further considered the seriousness of failing to investigate and appropriately examine to exclude the presence of a retinal detachment and identify and manage a suspected retinal detachment; particularly in the presence of red-flag signs, symptoms and risk factors. They are agreed that the failure to undertake *all* appropriate or indicated clinical investigations is essential to good practice and the provision of safe and effective care. The failure to do so, in this instance, if found proved, would indicate that patient safety was seriously compromised."

In coming to a significantly different view on the Rule 16 review the Case Examiners ought to have provided substantially more detail specifically addressing how the apparent conflict between the experts was resolved.

We noted that the Clinical Adviser had acknowledged that the presentation was atypical and that the registrant spoke with an ophthalmologist the same day. However, she was concerned that no dilated exam was performed despite the history and the findings of a visual field defect. In other words she was concerned that the registrant had not put herself

in a position to make the diagnosis, rather than with the failure to diagnose the condition *per se*.

The Rule 16 decision does not make it clear who commissioned the expert report. However, we noted that it is not referenced in the registrant's submissions for the R16 process. In describing the evidence reviewed at the Rule 16 stage the Case Examiners simply refer to "the Bundle." Evidence elsewhere in the case file demonstrated that the report was commissioned by the Council.

We noted that the focus in the instructions to the expert was very much on whether the retinal detachment was present at the time of the examination and would have been detectable. Less emphasis was placed on the question of whether the registrant properly put herself in a position to make the diagnosis.

The expert observed:

> *"It is my further opinion that a reasonably competent optometrist would nonetheless have dilated Patient A given the presenting symptoms in conjunction with the visual field test results and the reduced visual acuities, unless they were confident they had examined the internal eye thoroughly."*

The expert goes on to characterise the registrant's failure as "a fundamental error in judgment *"with respect to not considering the possibility of a retinal detachment, given Patient A's symptoms in conjunction with the visual field test results and slight reduction in vision."*

However, the registrant recognised the need for urgent referral and the expert concluded that *"the actions of the Registrant in respect of Patient A on 8 June 2019* ***fell below the standard of a reasonably competent optometrist****."* We regard the disposal in this case as reasonable.

Case 2018/500 also involved divergent expert views. The referral was maintained and the Case Examiners dealt well with the issue of the differing expert views:

> *"The Case Examiners note the difference of opinion between Dr X, who opines that even if proved the failures indicate the Registrant would fall below, but not far*

below the standard of a reasonably competent Optometrist and Ms Y. Ms Y considers missing a potential retinal tear/detachment in a symptomatic patient a 'significant failing if you consider the potentially serious outcome' and further, would be a 'failure to demonstrate competence in his ability to manage patients presenting with eye disease including sight threating eye disease' in accordance with 6.1 of the GOC Core competencies.

The experts do not decide whether the Registrant is impaired. Nor do the Case Examiners. That decision is for the FTPC alone, if and only if, the facts of the Allegation are found proved. However, the Case Examiners agree that, if found proved, the FTPC may consider that a failure to properly and fully record, assess, investigate and then refer 'red flag' symptoms of possible retinal detachment does amount to impairment notwithstanding any mitigating factors because of the significant impact on patient safety."

Appropriate Reconsideration by the Prosecution

The cases reviewed demonstrated appropriate reconsideration of the evidential position by the Council prior to the FTPC hearing.

Case Examiner Referral to Investigating Committee

Health Assessments

There were no cases in which the Case Examiners referred cases to the Investigating Committee for consideration of a Performance Assessment under Rule 12(1)(c) of the General Optical Council (Fitness to Practise) Rules 2013.

INVESTIGATING COMMITTEE DECISIONS

No decisions of the Investigating Committee were reviewed in this year's sample.

FITNESS TO PRACTISE COMMITTEE DETERMINATIONS

Fitness to Practise Committee's decisions not to impose an Interim Order

We reviewed no cases where the Fitness to Practise Committee disposed of applications for an interim order without imposing an order. We reviewed two cases where interim orders were imposed.

In Case 2020/004 the Registrant and Council were in agreement that the threshold for imposing an order was met, and that an order for conditions would be appropriate. However, it was clear that the Committee had applied their own minds to the evidence. The investigation arose from a self-referral in relation to a number of missed diagnoses. They expressly considered the risks which might arise from practice in a locum capacity and identified a suitable condition rather than simply addressing matters in broad terms.

> *"The Committee was however concerned that the Registrant had provided no apparent explanation as to how she had missed these conditions relating to three separate patients during four examinations. Further, the Committee noted that the Registrant had undertaken a course on wet AMD a matter of weeks before the failure to diagnose nAMD in Patient 1 at his post-operative appointment.*
>
> *The Committee was further concerned that these alleged failures had occurred at a time when the Registrant was employed full time at a practice and had access to clinical support. The Committee therefore considered that the Registrant would present an increased risk to patients if she were to be employed in a Locum position without consistent supervision and clinical oversight.*
>
> *The Committee was of the view that the that the risk could be managed by Interim Conditions, but it was not satisfied that the Conditions as drafted and agreed would provide the degree of public protection required."*

The reasoning here is clear and cogent. However, it could have been improved by express reference to the principle of proportionality, which was also relevant.

The second case resulted in a suspension which we regarded as an appropriate outcome. The decision was clear and well-reasoned with appropriate citation of the clinical advice report.

Fitness to Practise Committee Fact Finding Hearings

Decisions of the Fitness to Practise Committee to take No Further Action

We reviewed 7 cases where the Fitness to Practise Committee determined to take no further action with respect to a Registrant. In all but one case the defendant was an optometrist. The exception was a highly unusual case relating to a student dispensing optician with a historic conviction. The decisions were generally clear and well-reasoned. The majority involved allegations of misconduct. There were a number of mixed cases involving misconduct and another ground. There were 2 half-time submissions one of which was successful and resulted in the termination of the hearing (Case 2017/406). In two further cases the alleged ground of impairment was not made out. In three of the remaining four cases where the ground of impairment was established and a finding of impairment followed.

Decisions of the Fitness to Practise Committee to impose a Warning

We reviewed 1 case where the Fitness to Practise Committee determined to issue a warning. This is dealt with in detail below.

Table 2. Summary of FTP Substantive Hearings

	2019/145	2018/221	2019/239	2017/350	2017/406	2018/420	2018/449	2019/122
Progressed Beyond Half-time	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes
Any Facts Proved	Yes	Yes	Yes	Yes	N/A	Yes	Yes	Yes
Ground Established	Yes	Yes	Yes	None	N/A	Yes	No	Yes
Impairment Established	Yes	Yes	Yes	N/A	N/A	No	N/A	No
Warning	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes

Generic Issues Arising in FTPC Determinations

There were a number of areas of good practice we observed, including Committees setting out the background at the outset of the determination, clear summaries of legal advice provided, and clear and careful analysis of the evidence including explanations of why one witnesses evidence was preferred over another's.

Setting the Scene – The Registrant

Two year's ago we noted that it is an almost ubiquitous feature of Case Examiner decisions that they begin by noting the registrant's date of first registration but that this did not happen in FTPC determinations. We noticed a difference in last year's sample where many of the decisions began with a short summary, which included details of the Registrant's registration and experience. We noted that:

> "this reflected a positive response to a learning point in last year's audit where we had noted:
>
> > *"When drafting the background section of the determination the Committee should consider including some brief details of the registrant's professional background including the period for which they have been registered."*

In this year's sample we noted that such a short introduction was provided in less than half of the cases.

The following example is from Case 2017/406:

> *"The Registrant has been registered with the General Optical Council ("the Council") since XXX 1985. He has remained registered at all material times subsequently."*

It is immediately obvious that the registrant is a very experienced pracitioner. In Case 2018/420 the introduction made it apparent that the case related to a practitioner in the early part of their career:

> *"Case 449 The Registrant is a registered student Optometrist, who first registered with the GOC on XX 2017.In autumn XXXX, she began and continues to be a student on an undergraduate BSc (Hons)Optometry degree course at the University XXX."*

In contrast, Case 2017/350 relate to an Optometrist who had been registered since 1966 but this information was not provided at the outset but which was a relevant piece of context.

Capturing Legal Advice

In previous audits, we have commented upon the relatively brief treatment which the Legal Adviser's advice receives in many FTPC determinations. Last year we noted that the issue was considerably less evident. However, there continue to be occasions where the legal advice is reflected in determinations in the following terms:

> *"The Committee has heard and accepted the advice of the Legal Adviser regarding the decision it had to make as more fully set out in the sanctions guidance."* (Case 2019/145)

The problem may be that, on occasion, the essence of the legal advice is set out without being expressly attributed to the legal adviser. In the following example, from Case 2019/239, a phrase - almost identical to that cited above - is followed immediately by a statement of the relevant law. However, it is not clear that whether that is the law as advised by the legal adviser or as determined by the panel. The implication is that they are one and the same.

> *"The Committee has accepted the advice of the Legal Adviser. To qualify as misconduct for the purposes of the Opticians Act 1989, it had to consider whether its findings on the facts demonstrated serious professional misconduct on the part of the Registrant. The question of whether the facts constitute misconduct is for the judgment of the Committee and there is no burden or standard of proof. There is no statutory definition of misconduct, but the Committee had regard to the guidance of Lord Clyde in Roylance v GMC (No 2) 1 AC 311: "Misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a practitioner in the particular circumstances…". Not every finding of fact or departure from the standards would necessarily be serious professional misconduct. The conduct must be serious in that it falls well below the required standards."*

This can be contrast with the following example, from later in the same determination, where the attribution is expressly made:

*"The Committee accepted the advice of the Legal Adviser. **She advised that** whether the Registrant's fitness to practise was impaired was a matter for the judgment of the Committee, not involving a burden of proof, and that the Committee should consider the question of impairment at today's date. She reminded the Committee of the principles set out in the cases of CHRE v Grant and NMC [2011] EWHC 927 (Admin) and GMC v Cohen [2008] EWHC 581."* [Emphasis added]

A similar example is set out below from Case 2017/350 in respect of the legal advice on half-time submissions where the Committee expressly acknowledge that they are paraphrasing the legal advice. In Case 2017/406 the Committee preface their summary of the legal principles with the following:

*"The Committee accepted the advice of the Legal Adviser **whose advice included the following:**"[Emphasis added]*

As we noted in each of the last two years, the audience for FTPC determinations is mixed. While cases will undoubtedly be read by individuals who are very familiar with the process, and relevant case law, the Committee must bear in mind that some readers may only read a single FTPC determination in their lifetime. Consequently, there is value in setting out matters which may seem obvious to those who are regularly involved in those proceedings.

The following example, from Case 2019/122, is a demonstration of familiar core principles being succinctly presented for the benefit of the reader:

"The Committee was aware that the burden of proof rests on the General Optical Council (GOC), and that the standard of proof is the civil standard, namely the balance of probabilities. This means that the facts will be proved if the Committee was satisfied that it was more likely than not that the incidents occurred as alleged."

Learning Point 16

Echoing observations which we have made previously, including 2019/20, we note:

> The FTPC should take care to provide some indication of the nature of the submissions made by the parties and the content of the legal advice received. In the absence of such information it is difficult for the determination to

serve as a standalone document. The absence of such information also makes it difficult for the parties to ascertain whether the submissions and advice have been correctly understood.

Sufficiency of Reasoning

Case 2019/122 resulted in a warning being issued to a Registrant where misconduct had been established but current impairment had not. The allegations related to multiple appointments with the same patient who attended her appointments accompanied by Mr B. Mr B's evidence was central. Many of the allegations were admitted. One, which was not admitted, alleged that the Registrant had "dismissed Mr B's suggestion that Patient A's cataracts could be treated at an hospital;". The allegation was repeated in respect of three appointments and, in each instance was paired with an allegation that the Registrant had failed to refer the patient for assessment of her cataracts. The failure to refer was admitted.

The gravamen of the allegation of dismissing Mr B's suggestion must have been something other than that referral was mandated – that issue was separately alleged. In our view, judged in that context, the allegation connoted an attitudinal failure on the part of the Registrant, an unprofessional discounting of Mr B's concerns.

The Committee accepted the essence of Mr B's evidence but found the allegations not proved, on the basis that Mr B has not specifically suggested that Patient A's cataracts could be treated at the hospital but had simply asked if such treatment was a possibility.

The following extracts from the determination are sufficient to illustrate the Committee's approach:

"2) On or around 10 May 2016 you conducted a sight test on Patient A and you:

c) Dismissed Mr B's suggestion that Patient A's cataracts could be treated at an hospital;

The Committee noted that this particular narrated that 'Dismissed Mr B's suggestion that Patient A's cataracts could be treated at an hospital'. The Committee therefore

determined that the Council required to prove, on the balance of probabilities, that Mr B had suggested to the Registrant that Patient A's cataracts could be treated at a hospital.

The Committee considered the terms of Mr B's witness statement and his oral evidence. The Committee noted that in paragraph 11 of his witness statement, in relation to the sight test of 20 May 2016, Mr B stated that 'I again asked [the Registrant] if the cataracts could be removed, but he again dismissed me, saying the hospital would not do it.' Mr B's witness statement was adopted as his primary evidence in chief and he did not vary or change his position on this matter in supplementary examination in chief, cross examination or questions from the Committee. No evidence was led on behalf of the Council that, in May 2016, Mr B had positively suggested that Patient A's cataracts could be treated at hospital.
The Committee therefore determined that the evidence before it showed that Mr B had asked the Registrant if Patient A's cataracts could be removed, but that Mr B had not suggested that Patient A's cataracts could be treated at hospital.

As the Council required to prove that Mr B had made such a suggestion for the Registrant to then dismiss it, the Committee therefore found particular 2 (c) not proved."

And again for allegation 3(c):

"The Committee again considered the terms of Mr B's witness statement and his oral evidence. The Committee noted that in paragraph 12 of his witness statement, in relation to the sight tests subsequent to 20 May 2016, Mr B stated that 'This happened at every appointment; I believe I saw him about five times in total…..Each visit I would ask him if something could be done about her cataracts and each time he said no. I distinctly remember that during one of the visits he told me that the only circumstances under which something could be done about her cataracts was if (they) got so thick they began to cause pain and/or irritation.' Mr B's witness statement was adopted as his primary evidence in chief and he did not vary or

change his position on this matter in supplementary examination in chief, cross examination or questions from the Committee. No evidence was led on behalf of the Council that, at any sight test subsequent to May 2016, Mr B had positively suggested that Patient A's cataracts could be treated at hospital."

In adopting that approach the Committee had acknowledged the Council's submissions on the point:

"[Counsel for the GOC] further submitted that, essentially, the issue to be decided in relation to particulars 2(c), 3(c) and 4(c) were almost identical. He submitted that as a matter of 'common sense' it is the 'specialist who gives advice and, in this context,' this was the Registrant. He further submitted that Mr B honestly accepted that he could not precisely be sure exactly what happened on which visit, but that did not undermine his evidence. [Counsel for the GOC] explained that there was a degree of support for Mr B's oral evidence from the documentation in the Council's bundle. He referred the Committee to paragraphs 12 and 13 of his Skeleton Argument, Mr B's evidence that in May 2016, May 2017 and April 2018 Mr B asked if Patient A's cataracts could be removed and that the Registrant had said the hospital would not do this. [Counsel for the GOC] submitted that this was the only way the evidence makes sense."

In their review of the case the PSA made the following observation:

"We had concerns about the three charges which were found not proved because it appeared these did not accurately reflect the evidence available (i.e. Mr B's witness statement) about what the registrant and Mr B had said regarding cataract removal. We were also concerned by the panel's approach to these charges which did not appear to contemplate any amendment when the mischief these charges sought to capture was clear on the available evidence. Ultimately we did not consider that these charges, if properly drafted or amended and found proved, would have made a material difference to the outcome of the case. However, overall, we found it difficult

to understand the seriousness of the registrant's clinical failings or the reasons for them due to a lack of detail provided in the decision."

We agree that if findings had been made which reflected Mr B's evidence on the point it would not have made a material difference to the outcome. However, we also agree with the PSA's observation that there was a lack of clarity about the Committee's assessment of the underlying cause of the Registrant's failings; Did he have an honest but mistaken belief that surgical treatment was simply not an option for this patient? Would that reflect a significant deficiency in knowledge? If so, how were the Committee satisfied that had been remedied? How did the Registrant come to change his position and refer the patient later in the chronology? Those are not questions which the determination clearly addresses.

However, the Committee were not blind to the issue. In assessing the Registrant's evidence they noted:

> *"The Committee considered that the Registrant had attempted to assist it, but had* ***consistently failed to provide any reasonable explanation of his approach to some of the concerns identified in the particulars of the allegation****. It did not consider that the Registrant had been evasive, but, due to the lack of any explanation on his part, where there was a conflict of evidence between Mr B and the Registrant, preferred the evidence of Mr B."* [Emphasis added]

Furthermore, in dealing with the specific issue the Committee note the following at Stage 1:

> *"The Committee further noted that during cross examination the Registrant stated that in June 2015 Mr B had told him that Patient A had been told by the hospital that she had cataracts but 'they' [the hospital] could do no more. The Committee further noted that the Registrant stated that he had believed what he had been told, in cross examination that he confirmed that there were cataracts but didn't discuss the option for cataract surgery and that during questions from the Committee on this issue the Registrant accepted that he should have referred Patient A for a second opinion."*

In dealing with the issue of impairment the Committee said this:

"The Committee heard further evidence from the Registrant. He read his reflective statement to the Committee. [Counsel for the Registrant] took the Registrant to copies of various patient records lodged on behalf of the Registrant. The Registrant explained how his practice had changed and developed since the Council intimated that they were investigating a complaint against him in May 2019. The Registrant took the Committee through his Personal Development Plan and Continuing Education and Training record and explained courses that he had undertaken. He re-assured the Committee that he would not act in a manner set out in the particulars of the allegation again. The Registrant explained that if he was faced with a similar situation he would now consider a range of alternative methods of obtaining further information. This would include asking if a patient wished to be given an appointment at another hospital; write to the patient's GP; write to any prior Optometrist to see if a patient's clinical records were available to view and ask more questions of the patient. The Registrant said he would continuously ask himself 'what more could he do'"

Taking the determination as a whole, it appears that the Registrant's explanation for his failure to discuss cataract surgery, or refer for an opinion, was premised on a historic conversation with the patient in which the Registrant was told that surgery was not an option. The Registrant appears to have accepted that he placed too much weight on that information and should have revisited the issue afresh. Thus, his commitments at Stage 2 do relate to the basis which he provided for his error.

In Case 2017/406 concerns about adequacy of reasoning arise in relation to the paired issues of misconduct and impairment. The matter was addressed at half-time in response to submissions from the Registrant. The allegation was as follows:

"On or about 8 April 2016, you failed to conduct an appropriate examination of Patient A's eyes in that you:

(d) Did not fully assess Patient A's fundus;"

This is how the Committee dealt with their review of the evidence and the issue of impairment:

52. The Committee considered that the combination of "red eye" and raised IOP should have been an area of concern and ***a reasonably competent optometrist would have recognised that given these circumstances, it was particularly important to examine Patient A's fundus.*** *Even accepting that Patient A did not consent to a full eye-examination, there were photographs of Patient A's fundus available to the Registrant. While some photographs were clearer than others, there were some that should have raised concern. The Committee did consider that notwithstanding Patient A's ability and willingness to co-operate given that her eyes were sore/weeping/crusted/and her ptosis, that the photographs could have been subjected to further scrutiny. The failure to undertake such scrutiny, or if completed, to record the same, because it is not evidenced, is a serious matter.* ***However, the Committee was of the view that given the circumstances in which Patient A presented, and the difficulties in assessing her, meant that this alleged failure almost four years ago, would not provide a realistic prospect of impairment being found."*** *[Emphasis added]*

On one view the circumstances only served to heighten the need for scrutiny of the information which was available, namely the photographs. The reasoning on impairment does not adequately explain how the Committee arrived at their conclusion, having determined that a failure to scrutinise or record the assessment of the photographs would be "a serious matter." Part of the difficulty here is that the Committee do not separately assess whether the failure would constitute misconduct. The registrant's failure may simply reflect a lack of flexibility in the face of an unusual clinical challenge thus lacking the degree of culpability required to establish misconduct. Alternatively, the Committee may have been satisfied that the risk of repetition was low and that the circumstances would not require a finding of impairment on public interest grounds alone. The problem is that the reader is simply left to speculate.

Issues Specific to Fact Finding Hearings

Dealing with Half-Time Submissions

We reviewed 2 cases (Case 2017/406 and 2017/350) where half-time submissions had been made under Rule 46(8) (b) of the Fitness to Practice Rules, which states as follows:

> *"46(8) Before opening the registrant's case, the registrant may make submissions as to—*
>
> > *(a) whether sufficient evidence has been adduced upon which the disputed facts could be found proved;*
> >
> > *(b) whether the facts, whether they are disputed or proved, could support a finding of impairment."*

We felt the Committees provided appropriate and clear explanations of these in their determinations.

One case in which a half-time submission was unsuccessful was Case 2017/350. The Committee summed up the relevant principle in dealing with such submissions as follows:

> *"The Committee accepted the advice of the Legal Adviser, who confirmed that the case of R v Galbraith [1981] 73 Cr. App. R. 124, set out the test (paraphrased for regulatory proceedings as follows)*
>
> *1. If there is no evidence that the conduct alleged has been committed by the Registrant there is no difficulty. The Committee should stop the case.*
>
> *2. The difficulty arises where there is some evidence, but it is of a tenuous character, for example because of inherent weakness or vagueness or because it is inconsistent with other evidence.*
>
> > *(a) Where the Committee comes to the conclusion that the Council's evidence, taken at its highest, is such that the Committee were properly* directed could

not properly find that the conduct occurred the Committee should find there is no case to answer.

(b) Where however the Council's evidence is such that its strength or weakness depends on the view to be taken of a witness's reliability or other matters which are generally speaking within the province of the Committee and where on one possible view of the facts there is evidence upon which the Committee could properly come to the conclusion that the Registrants conduct (if proved) were sexual, then there is a case to answer and the case should proceed"

In that case the half time submissions were rejected by the Committee. Their reasons for doing so were clearly set out, albeit that they went on to determine that misconduct had not been established. In the other case, where the half-time submissions were successful, we were satisfied that the Committee had provided an adequately reasoned decision.

Assessing Credibility

We note that in Case 2018/449 the Committee begin their consideration of the evidence in this way:

"The Committee first considered the overall credibility and reliability of the witnesses it heard from."

This raised a concern as it appeared to echo what the High Court had considered to be a flawed approach in the case of *Khan v General Medical Council* [2021] EWHC 374 Knowles J Para 107

"In relation to Miss C, the Tribunal's approach was first to consider her credibility generally (at [124]-[136]) and, having done that, and found her to be 'genuine, sincere' and 'credible' ([135]), to consider the individual allegations against Mr Khan at [137]-[173]. But by then its conclusions were foregone because of what it had already decided in the first section that she was 'genuine'. When its reasons for concluding that Miss C was 'credible' are examined, it is clear that the Tribunal fell into the precise trap which Dutta, supra, warned against."

However, from further review of the determination we were satisfied that the Committee had not fallen into the same error as the MPT in Khan. They had not determined the assessment based on witness demeanour. They note:

> ***"Mr G**- He is employed as Registrations Operations Manager for the GOC. He confirmed the contents of both his witness statement and his supplementary statement and adopted them as his evidence in chief. There was no material challenge to the reliability of his evidence and he made appropriate concessions when matters were put to him in cross-examination. For example, when asked to explain whether the Registrant's initial application form being submitted twice was due to a technical error, he said he did not have the personal knowledge to answer that question. The Committee considered his evidence to be clear and reliable. He provided credible evidence about the procedure and process the Registrant, as a student, would have been required to follow when she submitted, online, her initial registration form (twice) and subsequently, her student retention application."*

Not Making Experts Available to the Committee

In Case 2018/221 the Committee was required to deal with an allegation of adverse health. The health condition at issue was one which is known to involve remissions and relapses. Two expert reports had been prepared. However, there was long gap between expert assessment and the hearing (circa 1 year). Apparently reflecting the position at the time of the assessments, the alleged health condition was specified as:

> *"Drug dependency – opioid dependency (F11.2) and crack cocaine dependency (F14.2)"*

We note that by the time of the hearing alternative formulations of that diagnosis may have more appropriate e.g. F14.21 Cocaine dependence, in remission. Given the way the allegation was framed, the health allegation was found not proved as it was taken to require active, current dependency. Although the expert reports had dealt with the issue of relapse risk, there was a lack of clarity in respect of that issue. The experts were not tendered to give evidence because, as the Committee noted -

> *"there was no dispute between the parties regarding the expert evidence."*

We were concerned about this approach. At the time, the Committee did not know what the clinical adviser would say. Considerable time had passed since the assessments. The conditions at issue were acknowledged to be capable of relapsing, and the reports recognised such a risk. Indeed, one of the experts had recommended a further period of random testing and the other expert had identified the "core issue" as "whether the Registrant is able to continue his abstinence from drugs, and if so, there is no risk to patients." In our view, it was far from ideal that the experts were not made available to the Committee. We would have expected the Committee to probe the expert's views - in light of the evidence covering the period since their assessments - so as to form a view on the current risk with the assistance of expert evidence. However, the concerns are mitigated by the nature of the objective evidence of abstinence presented to the Committee and the access which the Committee had to a Clinical Adviser.

Whilst in this case, the Committee did consider the risk of relapse, the framing of the allegation – which may well have been appropriate at the time of the expert reports – created a risk that the Committee would find the allegation not proved based on current abstinence alone and without proper assessment of the risk of relapse. That danger could have been overcome by formulating the allegation differently. This case highlights the inherent challenges in bringing health allegations before the Committee so long after the assessments on which the allegations are based and when those conditions are, by their nature, dynamic and evolving.

Failure to Consider the Public Interest

In Case 2018/420 the Registrant admitted slashing a number of tyres on a colleagues car. The degree of credit which such admissions merited needed to be considered in the context of his knowledge that CCTV evidence was available. The Committee found misconduct but not impairment. They considered a warning, referring to relevant Guidance, but determined not to impose one observing:

"The Committee agreed with the submission that the Registrant's case met all of the examples of relevant mitigating factors set out in the Guidance. It considered what purpose would be served by a warning, given its finding that the misconduct was unlikely to be repeated. ***There was nothing which the Committee considered required a warning to the Registrant which would add to what he had learned from his experiences resulting from his misconduct****." [Emphasis added]*

The Committee's approach was unduly narrow. They do not expressly consider whether the inherent seriousness of the admitted conduct warranted a formal response from the Regulator in order to satisfy the over-arching objective. Reliance on the low risk of repetition is misplaced. That is a factor which is relevant to a determination on impairment and, when present, it places the case in the category where a warning needs to be considered. In short, it will be a feature of almost any case where a warning is issued. Thus, to rely on it as a reason <u>not</u> to impose a warning raises concerns. The outcome is undoubtedly a lenient one but one which, in our view, falls just within the range of reasonable responses.

This issue also arose in Case 2019/145 which also raised concern about the Committee's approach to the *Grant* test. We deal with this case below. Generally, Committee's reasoning around the public interest could be more robust and could go further in considering all elements of the over-arching objective.

Case 2018/449 involved a student optometrist. So far as the Committee's consideration of impairment was concerned the relevant finding was a conviction for permitting her friend to driver her car when she did not have insurance covering those circumstances.

"53) The Committee also took into account Ms Ling`s submission that any Registrant who has a conviction for a driving offence of a similar nature would be unlikely to be referred by the Investigations Committee to a Fitness to Practise Committee for that conviction alone.

54) The Committee determined that this hearing will have been a salutary experience for the Registrant.

55) The Committee concluded that the Registrant's conduct is remediable, has been remedied and is highly unlikely to be repeated.

56) The Committee further concluded that the Registrant has not acted and is not liable in the future to act so as to put a patient or patients at unwarranted risk of harm and neither has she breached any of the fundamental tenents of the profession.

57) The Committee considered the wider public interest. It considered whether or not a finding of impairment was required as a result of the collective need to maintain confidence in the profession, as well as declaring and upholding standards in the profession. The Committee determined that the Registrant's conviction for a motoring offence in 2011 does not necessitate a finding of current impairment on the grounds of public interest."

Whilst we do not suggest that the Committee's conclusion with respect to the public interest was wrong, they have not set out any reasons. They have simply stated that they have considered the matter and they tell us the conclusion they have reached. The decision ought to have set out the characteristics of the offence which the Committee had taken into account in reaching their decision, for example that it did not involve violence, harm to others or an abuse of trust and there was no evidence of *mens rea* or premeditation.

A Truly Exceptional Case

On any view Case 2019/145 was a very unusual case. A student dispensing optician had served a significant prison sentence following a conviction for fraud involving an abuse of trust in her role within a charity. The conviction pre-dated her admission to the register. Although the conviction was declared by her at the time of her application for registration it was 'overlooked' by the Registrar and her application was granted. When this error was realised the issue was pursued as a fitness to practise allegation. By the time of the hearing the registrant had progressed well in her training with positive testimonials. Significantly, her application for registration was prompted by work which she had undertaken in prison as part of her rehabilitation under the auspices of a charity which teaches optical skills. We note that the Committee was not invited to consider any jurisdictional questions.

In our assessment the Committee fell into error in applying the *Grant* criteria. The Committee said this:

> *"In making its determination the panel did have regard to the test referred to in the case of Grant. That test, modified for this case was as follows:*
>
> *'Do our findings of fact in respect of the Registrant's Conviction show that her fitness to practise is impaired in the sense that she:*
>
> > *(a) has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
> >
> > *(b) has in the past brought and/or is liable in the future to bring the profession into disrepute; and/or*
> >
> > *(c)) has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/o*
> >
> > *(d) has in the past acted dishonestly and/or is liable to act dishonestly in the future.'*
>
> *For the avoidance of doubt the Committee considered that only limb (d) of the test was engaged with regard to the past. Although the Council have submitted that limbs b and c were engaged the Committee was not satisfied that they could be.* ***At the time she committed her offence she was not a registrant. Accordingly, she could not have brought the profession into disrepute.*** *The sentencing remarks made it clear that the Charity suffered reputational damage****. She was not in breach of any fundamental tenets of a profession that she had not considered joining at that point." [Emphasis added]***

The approach to limb (b) of the test was too narrow. The Committee did not address the second element – "*or is liable in the future to bring the profession into disrepute".* The fact that her offending predated her registration does not mean that her status as a registrant who had a conviction for a serious fraud offence could not bring the profession into disrepute. Put another way, the admission to the profession of a person who has been

convicted of such a fraud could – without more - sufficient to bring the profession into disrepute. The approach to limb (c) was also unduly narrow. The Committee was wrong to proceed on the basis that someone can only breach a fundamental tenet of the profession whilst they are a member of the profession. If, following registration, a registrant were found guilty of sexually predatory behaviour which occurred before registration, this Committee's approach would mean that that behaviour would not meet the *Grant* test because it does not involve dishonesty. However, we do not regard the errors in this case as material because the Committee correctly addressed limb (d) in respect of dishonesty.

> *"The Committee considered that her past act of dishonesty was sufficiently serious to render her fitness to undertake training to be impaired by virtue of her conviction."*

In going on to deal with the Registrant's evidence of remediation the Committee noted:

> *"The evidence led by the Registrant was not subject to challenge on the basis of credibility and reliability. The Committee considered the Registrant to be a credible and reliable witness. They were satisfied with her reassurance that the conduct would not be repeated. In her live evidence she became a detached observer of her former self when asked about her offending behaviour. She accepted that what she did was wrong. The Committee accepted that she has turned herself around. However it remained troubled that her coping mechanism displayed a lack of full insight and responsibility for her actions and recognition of the impact on others.*
>
> *Her rehabilitation has been confirmed by the live witnesses and the written documentation produced in support of her defence to these regulatory proceedings. The Documentary evidence included a report from a Consultant Psychiatrist who confirmed that it was unlikely that the Registrant would return to harmful drinking. The Committee recognised that the Registrant had achieved considerable success in her optical studies to date.*
>
> *Whilst the Committee considered that there remained a marginal risk of repetition it did not consider this to be sufficiently serious to find that it could make a finding of impairment on public protection grounds"*

The Committee made a finding of impairment on public interest grounds. When dealing with sanction the Committee observed:

> *"Although the Committee had previously determined that the Registrant had limited insight into the impact of her offending on others, she had demonstrated significant insight into her behaviour. She has satisfied the Committee that this behaviour is unlikely to be repeated. The documentation supplied on behalf of the Registrant demonstrates significant remediation.*
>
> *The Committee considered that despite there being a finding of impairment taking no action was, exceptionally, the appropriate course. The Registrant and any future employer will be well aware that her conviction, together with a finding of impairment, are matters that will be taken into account were she to encounter future difficulties with her regulator."*

In the particular circumstances of this case some analogy can be drawn with applications for restoration following erasure. In *Chandra v General Medical Council* [2018] EWCA Civ 1898 the General Medical Council challenged the decision of the Medical Practitioners Tribunal to restore Dr Chandra to the register approximately a decade after his erasure for sexual misconduct. The Court of Appeal remitted the matter back to the Tribunal on the basis that the Tribunal had failed to consider the impact of restoration on all elements of the over-arching objective.

At paragraphs 76 – 79 the Court of Appeal noted:

> *"Ms O'Rourke does not accept that Yeong presents her with any difficulties as it is a case which relates to sanctions. She submits that in a forward looking fitness to practise approach, the effluxion of time serves to change the emphasis from the seriousness of the misconduct to the extent of remediation and therefore a conclusion the applicant is no longer unfit to practise.*
>
> *I do not agree. Whilst I accept that the passage of time is a matter of considerable importance and must properly be weighed in the balance by the MPT on an application to restore, I remain of the view that there is a striking difference between*

cases involving clinical errors or incompetence and matters of dishonesty and sexual misconduct which applies equally at both the sanctions and restoration stage and, accordingly, the observations of Sales J in Yeong are of equal application to a restoration case as a sanctions case.

I accept the submission of Ms Grey that the 5 year minimum period before an application for restoration can be made, is not a 'tariff' after which only issues of public protection (ie remediation) are relevant; all three aspects of the over-arching objective must come into play. In my judgment remediation is essential but not, when coupled with the passage of time, the complete answer to the question the MPT has to ask itself which is: is the applicant now fit to practise having regard to the over-arching objective?

Referring back to Bolton, the Master of the Rolls underlined the critical importance of honesty in a solicitor by reference to the significance to a member of the public of the sale of his or her house, often his or her largest asset (518H). In doing so the Master of the Rolls was alluding to the fact that the honest handling of an individual's money goes to the very heart of the responsibility of a solicitor to that person in particular, and the public in general. Turning to the position of a doctor; I find it hard to imagine any feature in relation to any doctor, let alone a psychiatrist, which goes so entirely to the essence, or heart, of his role as medical practitioner as the entitlement of each and every patient, (whether vulnerable or not) to be entirely confident in the sexual probity of their physician. ***To adopt and adapt the words of the Master of the Rolls taken from 519 A (and quoted at para [52] above): "If a member of the public submits him or herself to a physical or mental examination or consultation by a doctor, he or she is ordinarily entitled to expect that that doctor is a person whose trustworthiness and sexual integrity is not and never has been, seriously in question".****[Emphasis added]*

Later, at paragraphs 90 – 92, the judgment continued:

"In my judgment the MPT made an error of principle. The question is not whether the over-arching objective is 'compromised'. ***The Tribunal is required, by statute, to have***

regard to the over-arching objective which includes the pursuit, i.e. the active pursuit, of the objectives specified in s1(1B) MA 1983, and in my judgment it failed properly to do so. Read overall, the focus of the Tribunal was limited to issues of the applicant's acceptance of his wrongdoing, his insight, the risk of repetition and his competence. The MPT did not address, or address adequately, the issue of whether public confidence and professional standards would be damaged by restoring the applicant to the register, an applicant who had fundamentally fallen short of the necessary standards of probity and good conduct, by his sexual misconduct and dishonesty, albeit many years ago. *[Emphasis Added]*

Ms O'Rourke took the court, paragraph by paragraph, through the reasons and findings of the MPT, seeking to persuade the court that a consideration of the over-arching objective was built in to those findings and, in particular, within their finding that Dr Chandra had 'sufficiently remediated the conduct which led to his erasure and his subsequent sustained dishonesty including before the FTPP".

In my judgment, the Tribunal applied the wrong test. Had they been aware of and considered Bolton, they would have approached the matter as advanced by Ms Grey; they would first have considered with care all the evidence of remediation against the backdrop of the matters which had led to erasure and made findings in that respect. Having made positive findings in this respect, they would then have metaphorically stepped back and balanced those findings against each of the three limbs of the over-arching objective. Only by doing so could they satisfy themselves that, when considering the case overall, including the length of time which has now elapsed, the restoration of the applicant would promote and maintain public confidence and proper professional standards so that, notwithstanding the serious nature of the original misconduct, the over-arching objective would be achieved."

In our view the point which emerges from this assessment is the need for the Committee to pro-actively consider all elements of the overarching objective and the duty to actively pursue those objectives. Whilst many determinations make express reference to the constituent elements of the overarching objective they do not go on to specifically grapple with the impact of their decision on the component elements.

Learning Point 17

Committees should have regard to the obligation to actively pursue the components of the overarching objective and their determinations should demonstrate how that has been reflected in their consideration of the particular case. This should go beyond simply stating what those components are and a general observation that the Committee has considered them.

The Grant Paradox

In this sample we reviewed three cases in which a finding of impairment was made without the imposition of a sanction. One involved a registrant who admitted slashing the tyres of a colleague's car, another involved a registrant who admitted stealing a number of items on a single day whilst in a state of emotional turmoil and the third, and most unusual, involved a registrant who had – prior to her registration – served a prison sentence for fraud.

Whilst the High Court has endorsed the acceptability of such outcomes in a number of contested cases, the making of a free-standing finding of impairment undermines the logical coherence of the fitness to practice regime. It results in registrant's who are deemed currently unfit to practise being on the register without restrictions. It affords no mechanism to demonstrate, or record, when that impairment ceases. The High Court has held that a Registrant who is the subject of a finding of current impairment bears the burden of demonstrating that they are no longer impaired at a review hearing – where such a hearing is directed. Furthermore, the Council's own Guidance for Case Examiners envisages that referral to a Committee hearing should only be made where there is a real prospect of establishing current impairment "to a degree that justifies action being taken against [the Registrant's] registration." In the cases at issue here no such action was taken.

These problems are not of the Council's, or the Committee's, making but have evolved in the post *Grant* era. It is important to remember that the Grant case arose in the context of the NMC regime where Committees do not have a power to warn, and the only avenue to a formal response is through the gateway of a finding of impairment. That is not the position at for the Committee at the GOC.

When considering whether a finding of impairment is required on public interest grounds only, the FTPC does not – in our experience – consider whether a warning would be an appropriate outcome. They only ever consider a warning after a finding of no impairment has been made. In our view had the possibility of a warning being an adequate outcome been considered as part of the process of testing whether the threshold of impairment was met, some or all of these cases would have been concluded with a warning. As the examples below illustrate the rationale for making a finding of impairment was typically to mark the departure from standards in order to maintain public confidence and uphold proper standards. The following is taken from the Committee's decision in Case 2018/221 which is discussed more fully above:

> *"Despite the insight and remediation shown, the Committee was of the view that the matters found proved fly in the face of the fundamental tenets of the profession. Members of the public would be shocked that a member of the profession, who had a long history of drug misuse, had demonstrated such a serious disregard for his professional responsibilities by taking illegal drugs in the work place. After careful consideration,* ***the Committee was of the view that, due to the nature of the matters found proved, the need to maintain public confidence in the profession and to uphold proper standards would be undermined if a finding of impairment were not made in the particular circumstances of this case****."[Emphasis added]*

In Case 2019/239 the Registrant admitted to thefts to the value of approximately £170 on a single day whilst – on her account – she was in a state of emotional turmoil. She had self-declared to the Council and it was accepted the conduct was out of character and was unlikely to be repeated. Whilst misconduct was established, the Committee did not impose a sanction following their finding of current impairment. The following sets out the Committee's reasoning:

> *"The Committee was satisfied that the risk of repetition of dishonest conduct is very low. The Committee agreed with [Counsel for the Registrant]'s submission that the effect of these proceedings on the Registrant has been profound. The Registrant's reassurance to the Committee that there will be no reoccurrence was sincere and*

underlying it were the Registrant's genuine feelings of repugnance and shame in relation to her dishonest conduct. The Committee was persuaded that the shoplifting incident was an aberration and that the Registrant is otherwise of good character.

The Committee therefore concluded that there is no ongoing risk to the public.

The Committee next considered the need to uphold professional standards and to maintain public confidence in the profession. The Committee recognised that the test for fitness to practise endorsed in the case of CHRE v Grant and NMC was engaged. The Registrant's actions on 14 August 2019 brought the profession into disrepute, were a breach of a fundamental tenet of the profession, and the Registrant had acted dishonestly.

The Committee broadly accepted [Counsel for the Registrant]'s submissions that there were a range of mitigating factors in this case which indicated that the Registrant's culpability was at the low end of the scale of seriousness of dishonesty. This was an isolated episode, outside of work, when the Registrant was suffering anxiety and emotional distress. There was no premeditation. The Registrant has provided evidence of positive steps and work undertaken to demonstrate her fitness to practise and good character.

Nevertheless, the Committee recognised that professionalism requires honesty and that the profession depends on the relationship of trust with the public. Dishonesty is considered to lie at the high end of the spectrum of gravity of misconduct. Any dishonest conduct is a serious breach of professional standards and a breach of a fundamental tenet of the profession. A finding of current impairment is therefore required ***to mark the Registrant's departure from the professional standards."*** *[Emphasis Added]*

And later:

"In this case the Committee was concerned only with imposing the sanction that is sufficient to uphold professional standards and maintain public confidence in the profession. It has found no risk to the public. In that regard, the perception of

informed members of the public would be an important indicator of the appropriate sanction. The Committee's view was that members of the public would recognise that these regulatory proceedings have deeply affected the Registrant. The Registrant has had to contemplate and plan for the real possibility that her name might be removed from the register. The finding of misconduct and the finding of impairment were significant findings, which recognised the seriousness of dishonesty."

The reasoning here discloses a risk that the Committee fell into the same error as the MPT in the case of *General Medical Council v Patel* [2018] EWHC 171. In that case the doctor had admitted dishonesty and the MPT concluded the matter with a finding of current impairment and no sanction. The GMC appealed successfully. The Court emphasised that personal mitigation was relevant to the issue of current impairment rather sanction

"… the question of the impact of suspension on the doctor is, for the reasons given by the appellant in reliance on the case of Bolton, of limited relevance, in my judgment. The over-arching purpose of the imposition of a sanction is not punitive, but for the protection of the public, and the effect of the suspension on the doctor has to be looked at in that context. While the MPT referred to the Bolton decision in its determination on the question of sanction, it seems to me they failed to follow the guidance which the Court of Appeal gave in that case, and that was, in my view, a wrong judgment call.

Secondly, I also accept that the MPT placed too much weight on remediation at the sanction stage. The sanctions guidance says that remediation will be taken into account on the question of impairment but the MPT, wrongly, in my view, relied on it very considerably at the later stage in deciding what sanction to apply, and in reaching a conclusion that this was an exceptional case. The correct approach is, in my judgment, with the greatest respect, that identified by Sales J, as he then was, in the Yeong case which I have already referred to, the reasoning of which applies equally to allegations of the misconduct of dishonesty as it does to inappropriate sexual contact between doctor and patient.

He sets out plainly the balance to be struck between the public interest and remediation. One doubts the impact of remediation in non-clinical cases, particularly

where there is an allegation of dishonesty. I can see perfectly well why remediation may be of crucial importance in cases of clinical decisions, but that is not this case. One has to take into account that the misconduct here was for financial gain. It was premeditated, and it put patients at risk. That should, in my judgment, for the reasons given by Mitting J in the Nicholas-Pillai case, lead to a serious sanction. In my judgment, the panel in this case struck the wrong balance."

Nonetheless, we note that in this case there was no premeditation and patients were not put at risk. It is also not clear that the theft was motivated by a desire for financial gain, the circumstances being somewhat unusual. All of those factors are relevant to culpability. Consequently, we accept that the outcome was just within the range of reasonable outcomes but should have been more clearly reasoned.

Learning Point 18

The Council should consider whether the Committee would be assisted by adopting specific guidance on how the possibility of a warning being a sufficient outcome should be considered in the course of determining the question of current impairment, particularly where the Committee is contemplating a finding of impairment on public interest grounds alone.

APPEAL CASE

There were no appeal within the relevant period.

PSA LETTERS

The Council received 3 learning points letters in the relevant period which we were asked to review. We have dealt with the most significant of those above (see Case 2019/122). The PSA's concerns in respect of the other two cases related to the length of time which it took the cases to progress from complaint to conclusion. In one instance it had taken seven years (Case 2014/154) in respect of relatively straightforward allegations of theft which were admitted. In the other case the PSA noted "We were concerned that this relatively simple and agreed matter took about 2 years to reach case examiners and a further year to reach hearing." That case was eventually disposed of under the Agreed Panel Disposal mechanism.

IMPLEMENTATION OF PREVIOUS AUDITS

We note that a number of the learning points raised in this audit echo points made in previous reports. Given the volume of decisions reviewed this is not particularly surprising. As in last year's audit, we note that these issues are less prominent than they have been in previous audits. Nonetheless, there is scope for reinforcing the learning which has emerged from this audit.

EQUALITY AND DIVERSITY

In the report we have dealt with a small number of cases where the factual matrix brought consideration of equality into play. We did not identify any evidence of a differentiation in treatment between registrant's on the basis of protected characteristics. However, in making that observation we acknowledge that we have not undertaken a detailed statistical analysis and we did not have access to the the full range of information about the characteristics of each registrant.

Audit of FtP Decision - learning points and management responses

#	Learning Point	Target	Response	Action	Due by	completed
1	The absence of harm to the complainant (or patient(s) who is/are the subject of a complaint) may merit limited weight in assessing the future risk posed by the Registrant if the alleged concerns are true. Significant departures from expected standards do not inevitably result in actual harm on every occasion.	triage and casework teams	accepted	While the teams have been trained to recognise this point there is a need to reiterate this at more frequent intervals. Managers have been asked to ensure risk is raised at all case meeting and to discuss more broadly during team meetings. Additional head of dip checks will take place to ensure full compliance	Q4 21-22	**complete**
2	Decision-makers should be reminded: a. *That they ought not to rely on the fact that a registrant is not working when considering whether action on the registrant's registration may be required.* b. *It is important to exercise caution in assessing exculpatory evidence on the papers.* c. *The absence of evidence as to motive does not exclude the possibility of an adverse motive being inferred from the surrounding circumstances. In cases where there is a possibility of an innocent motive it may be entirely proper to test that issue by putting the case to the registrant. As noted in Kuzmin v General Medical Council, a registrant's failure to provide evidence of the innocent explanation may mean that the inference of an improper motive is more compelling.* d. *As we noted last year, the formulation of allegations can prove a helpful tool in the*	triage	accepted	We accept the learning point as it relates to specific decisions made. a. The team have been reminded of the case of *GOC v Clarke* to underpin this. Re points b and c - any decision where the decision maker could ' sit on the fence' with a decision should fall in favour of opening a case and this is accepted. The team are aware of their role and should not be giving more weight to certain evidence. In this case, the Senior Officer made the correct conclusions and the wider team has been updated on this. Further training on the GMC case to be provided In relation to point d. we have now secured an additional resource who	Q4 21-22	**in progress**

Audit of FtP Decision - learning points and management responses

	analysis of evidence and making important aspects of that analysis explicit. That is so even when it appears to the Case Work Team that the allegations seem unlikely to be proved. That is ultimately an assessment for the Case Examiners to make.			will provide enhanced legal input into allegation drafting		
3	Case Examiners should be reminded of the need to provide a clear indication of what evidence has been considered.	case examiners	accepted	Included in the CE training day There is a dedicated lawyer Quality Assessing all CE decisions and reports back any concerns with decision making	25.11.22	**complete**
4	The Case Preparation Team should be reminded that: *a. Outcomes should not be relied upon in drafting allegations; and* *b. Allegations should relate to the conduct of the registrant and not the findings of a third party.* c. *In preparing cases relevant statutory grounds and the corresponding parts of the Act should be cited.*	Casework and management	accepted	To be fed back to the casework team and lawyers for enhanced quality control	Q3 21-22	**complete**
Case examiner – general						
5	In considering the Real Prospect Test with respect to factual allegations they should not rely on the findings made by third parties.	CE / IC / review team	accepted	Include in the CE training day. Implement process to review CE decision making through the determination review group structure	25.11.21 Q4 21-22	**complete** **complete**

Audit of FtP Decision - learning points and management responses

6	The Case Examiners should be reminded of the crucial need to grapple with conflicts in evidence, or the evidence of experts which would tend to support an outcome different from that which the Case Examiners reach.	CE / IC / review team	accepted	Include in the CE/IC training day	25.11.21	**complete**
7	Case Examiners should be reminded of the importance of considering misconduct and impairment separately. Where conduct is identified as being serious or giving rise to a serious concern there must be clear analysis in relation to the risk of repetition.	CE / IC / review team	accepted	Include in the CE/IC training day	25.11.21	**complete**
8	We echo the learning point raised earlier in the report about the risks of over-reliance on the absence of harm in the index case as a marker of future risk.	CE / IC / review team	accepted	Include in the CE/IC training day (duplicates LP 1)	25.11.21	**complete**
9	Case Examiners should be encouraged to "stress test" their decisions particularly in cases where they feel the issues are comparatively finely balanced.	CE / IC / review team	accepted	Include in the CE/IC training day and dip sample at the bi-monthly DRG	25.11.21	**complete**
10	The Case Examiners should be reminded that the assessment of insight and remediation requires a view to be reached as to the root cause of the relevant conduct and whether that is acknowledged by the registrant. A registrant who cannot understand why misconduct occurred faces obvious challenges in guarding against repetition.	CE / IC / review team	accepted	Include in the CE/IC training day and consider inclusion in future FtP FOCUS	25.11.21	**complete**
11	a. A registrant's commitment not to practise is of no, or limited, relevance in determining the appropriate disposal of misconduct allegations. b. The Public Interest involves a number of considerations all of which ought to be	CE / IC / review team	accepted	Include in the CE/IC training day	25.11.21	**complete**

Audit of FtP Decision - learning points and management responses

	expressly addressed in cases where there is a real prospect of establishing misconduct and in cases where consideration is being given to issuing a warning.					
12	Case Examiners should be reminded that advice issued to registrants during the fitness to practise process should be clearly linked to the applicable standards of professional conduct promulgated by the Council.	CE / IC / review team	accepted	Include in the CE/IC training day	25.11.21	**complete**
			Warnings			
13	Case Examiners should be reminded to have regard to the range of purposes served by issuing a warning before determining that a warning is not appropriate.	CE / IC / review team	accepted	Include in the CE/IC training day Legal to draft supporting guidance note on warnings to CE's on the point	25.11.21 Q4 21-22	**complete**
14	Case Examiners should be reminded of the importance of providing sufficient reasons for their decisions in relation to not giving warnings. This should include consideration of the public interest elements of the Council's function.	CE / IC / review team	accepted	Include in the CE/IC training day Legal to draft supporting guidance note on warnings to CE's on the point	25.11.21 Q4 21-22	**complete**
15	We repeat the observations which we made in each of the last two years, namely: a. Case Examiners should be reminded that the nature and effect of warnings needs to be considered when determining whether a warning is proportionate. Those considerations should be addressed at the Minded to Warn stage. This would serve two distinct functions; Firstly, it would ensure that the issue of proportionality is addressed by the Case Examiners. Secondly, it would	CE / IC / review team	accepted	Include in the CE/IC training day Legal to draft supporting guidance note on warnings to CE's on the point	25.11.21 Q4 21-22	**complete**

Audit of FtP Decision - learning points and management responses

	afford the registrant the opportunity to address those matters in any representations before a final decision is made. b. Case Examiners should be reminded to make explicit reference to the relevant guidance on warnings. Decisions should ideally provide a clear indication of any aggravating or mitigating factors which have been considered, in accordance with the guidance. c. The text of warnings should be clearly anchored in the applicable standards.					
Fitness to Practise Committee						
16	The FTPC should take care to provide some indication of the nature of the submissions made by the parties and the content of the legal advice received. In the absence of such information it is difficult for the determination to serve as a standalone document. The absence of such information also makes it difficult for the parties to ascertain whether the submissions and advice have been correctly understood.	DtPC	accepted	Include in the FtPC training day and remain under review through DRG	17.09.21	**complete**
17	Committee's should have regard to the obligation to actively pursue the components of the overarching objective and their determinations should demonstrate who that has been reflected in their consideration of the particular case. This should go beyond simply	FtPC and Head of Hearings	accepted	Include in the FtPC training day and remain under review through DRG	17.09.21	**complete**

Audit of FtP Decision - learning points and management responses

	stating what those components are and a general observation that the Committee has considered them.					
18	The Council should consider whether the Committee would be assisted by adopting specific guidance on how the possibility of a warning being a sufficient outcome should be considered in the course of determining the question of current impairment, particularly where the Committee is contemplating a finding of impairment on public interest grounds alone.	FtPC and Head of Hearings	accepted	Include in the FtPC training day and remain under review through DRG	17.09.21	**complete**

Public Council

Members Fees Policy and Review for 2022/23

Meeting: Wednesday 16 March 2022 **Status:** For approval

Lead Responsibility: Sarah Martyn, Interim Head of Secretariat
Paper Author(s): Sarah Martyn, Interim Head of Secretariat

Purpose

1. This paper presents information to support recommendation from the Remuneration Committee to enable Council to set members fees with effect from 1 April 2022.

Recommendations

2. Council is asked to approve:
   - agree the member fees for 2022/2023.
   - approve the member fees policy for publication.
   - approve the recommendation that the fees are reviewed every five years.

Strategic Objective

3. The work to review member fees forms part of the governance work programme in the 2021/2022 business plan.

4. The terms of reference require the Remuneration Committee to provide advice to Council on the payment of fees to members. Council retains responsibility for setting fees paid to members.

Background

5. It is necessary to keep fees paid to members under review to ensure that the GOC remains able to recruit the appropriate calibre of members. In November 2014, Council agreed to move to a three-year process for setting fees, the last review had taken place in 2016. The Hearing Panel member fees were subsequently reviewed with regard to cancellation fees in February 2020.

6. Honoraria for the Chair of Council was reviewed in early 2020 for the recruitment of the new chair.

7. Honoraria for The Senior Council Member was reduced in July 2021 to £2,500 per annum which was in line with the benchmark figure gained from the General Pharmaceutical. The honorarium was benchmarked across the health professional regulatory sector.

8. As a registered charity and the GOC is expected to ensure that the monies of the charity are used to further its aims, and in keeping with other public bodies expected to demonstrate best value for money in all that it does. In order to be transparent, fees and expenses paid to Council members are published disclosed in the GOC's annual report.

Analysis

Chair of Council annual allowances across the regulatory sector

9. As part of the Chair recruitment campaign in 2020 a benchmarking exercise was carried out from which the decision was taken that the Chair's annual allowance would be reduced to £50,000 for 2.5 days per week.

10. The analysis of the Chair benchmarking information shows that the GOC remains broadly comparable with the median rate of other healthcare regulators and closest comparators.

11. The benchmarking is as follows:

Healthcare Regulatory	Annual Allowance paid as at December 2021		Annual Allowance paid as at 2020
General Optical Council	£50,000	@ 130 days p/a	£58,806
General Chiropractic Council	£23,000	@ 78 days p/a	£23,000
General Dental Council	£55,000	@ 156 days p/a	£55,000
General Medical Council	£110,000	@ 156 days p/a	£110,000
General Pharmaceutical Council	£60,000	@ 156 days p/a	£56,000
General Osteopathic Council	£27,000	@ 78 days p/a	£27,000
Health and Care Professional Council	£65,000	@ 156 days p/a	£65,000
Nursing and Midwifery Council	£78,000	@ 156 days p/a	£78,000
Average (just healthcare)	**£58,500**		**137**
Median (just healthcare)	**£57,500**		**156**

Council member annual allowances across the regulatory sector

12. The analysis of the Council member annual allowances benchmarking information shows that allowances have remained static. The GOC allowances are slightly lower than the median rate of other healthcare regulators, but higher than in the wider regulatory field.

13. The benchmarking data is as follows:

Healthcare Regulatory	Annual Allowance paid as at December 2021		Annual Allowance paid as at 2020
General Optical Council	£13,962	@ 36 days p/a	£13,962
General Chiropractic Council	£6,650	@ 15 days p/a	£6,650
General Dental Council	£15,000	@ 35 days p/a	£15,000
General Medical Council	£18,000	@ 48 days p/a	£18,000

General Pharmaceutical Council	£12,500	@ 40 days p/a	£12,500
General Osteopathic Council	£7,500	@ 18 days p/a	£7,500
Health Care Professional Council	£12,000	@ 30 days p/a	£12,000
Nursing and Midwifery Council	£14,724	@ 36 days p/a	£14,724
Average (just healthcare)	**£12,542**		**£12,542**
Median (just healthcare)	**£13,231**		**£13,231**

Committee Chairs annual allowances across the Health Care regulation sector

14. The analysis of Committee Chairs annual allowances benchmarking information has proved hard to source as there are different types of allowances for different committees. The information contained are based on available allowances for Fitness to Practice members shows that the GOC allowances are higher than the median rate of other healthcare regulators and approximately one third higher than closest comparators.

15. The benchmarking data is as follows:

Healthcare Regulatory	Daily Allowance paid as at December 2021	Annual Allowance paid as at 2020
General Optical Council	£372	£3,723
General Chiropractic Council	£350	£1,050
General Dental Council	£353	£3,000
General Medical Council		£2,325
General Pharmaceutical Council		£2,500
General Osteopathic Council		£3,350
Health Care Professional Council	£348	£2,728
Nursing and Midwifery Council	£340	0
Average (just healthcare)	£353	£2,107
Median (just healthcare)	£350	

Committee Members daily allowances across the Health Care regulation sector

16. Data across the Healthcare Regulators for daily allowances has proved hard to source as there are different types of allowances for different committees. The information contained are based on available allowances for Fitness to Practice members.

17. The analysis of Committee Members daily allowances benchmarking information shows that the GOC allowances are in line with the median rate.

18. The benchmarking data is as follows:

Healthcare Regulatory	Daily Allowance paid as at December 2021	Daily Allowance paid as at 2020
General Optical Council	£319	£319
General Chiropractic Council	£300	
General Dental Council	£353	

General Medical Council	£310	£310
General Pharmaceutical Council		
General Osteopathic Council	£306	£306
Health Care Professional Council	£206	
Nursing and Midwifery Council	£310	£310
Average (just healthcare)	£301	£156
Median (just healthcare)	£310	£310

Member Fees 2022/23

19. The members fees have not been increased, but the associated wording has been updated to reflect activity undertaken outside committee meetings.

Member Fees Policy

20. The members fees policy has been reviewed and updated:

- removing paragraph 1.4 about increasing member fees each year
- updating the GOC values in paragraph 1.5;
- recognising that the GOC has staff, employees and workers.
- updating the fee for the Senior Council member;
- updating of senior staff names;
- updating of benchmarking figures.

Finance

21. There are no additional calls on resources.

Risks

22. Failing to have a clear member fees policy will have a detrimental effect on the management of our member services.

Equality Impacts

23. There are no impacts.

Devolved Nations

24. There are no impacts.

Other Impacts

25. There are no other impacts.

Communications

26. The decision will be shared with members and the updated policy will be published on the website.

Next Steps

27. If approved, the revised fees and policy will be implemented with immediate effect.

Annexes

Annex 1: Member Fees 2022/2023

Annex 2: Member Fees Policy

Member fees 2022/23 (effective from 1 April 2022)

Role		Fee (£)
COUNCIL		
Council Chair	annual, paid monthly	50,000
Senior Council Member	annual, paid monthly	16,462
Other Council members	annual, paid monthly	13,962
COMMITTEE CHAIRS		
Chairs of the Hearings Panel and Investigation Committee	daily fee	372
COMMITTEE MEMBERS		
Members, including independent members, (other than Council members who receive an annual fee) Investigation; Education; Standards; Registration; Companies; Audit, Risk and Finance; Nominations; and Remuneration Committees and Hearings Panel members* This allowance is also paid to chairs and independent members, who are not paid an annual fee, who undertake member reviews. *FtPC hearings held via video-link or telephone are not classed as teleconference/ videoconference meetings	daily fee	319
	daily fee* (teleconference/ videoconference)	212
	per meeting of over two and under four hours (teleconference /videoconference)	106
	per meeting of two hours or under (teleconference /videoconference)	54
OTHER		
Members of the Investigation Committee (when acting as a Case Examiner)	per registrant decision fee	159.81
Investigation committee	per case fee	103
READING FEES		
Hearing Panel and Investigation Committee members only. (Paid on an ad hoc basis and authorised by Director of Regulatory Operations or Head of Casework Operations.)	500 - 1499 pages 1500 - 2499 pages 2500+ pages	£50 £75 £100
Investigation committee members when acting as a Case Examiner only. (Authorised by the Head of Casework Operations.)	300 – 499 pages 500 – 999 pages 1000+ pages	55.48 110.97 166. 45
CANCELLATION FEES		
Chairs of the Investigation Committee (if cancelled at five days' notice or less)	half of the daily fee	186

Hearing Panel members will be paid half a day fee for each hearing day cancelled within five calendar days of the scheduled hearing commencement date [capped at seven calendar days]. Hearing Panel members will be paid a full fee for events that conclude earlier than anticipated [capped at full fee for day 1-2; half a fee for days 3-5; no fee thereafter] Pay half a day fee for split event days that are within 28 calendar days of an early finish. [no fee thereafter]. Split events are defined as events scheduled over non-consecutive days.	half of the daily fee daily fee	159.50 319
All other members who are not paid an annual fee (if cancelled at five days' notice or less)	half of the daily fee	159
DEVELOPMENT AND INDUCTION		
For members who are not paid an annual fee (in person)	daily fee	223
For members who are not paid an annual fee (video conference or teleconference)	daily fee	150

MEMBER FEES OLICY

Status of document:	Approved
Version:	V03
Date first approved:	2016
Date reapproved and updates:	**March 2021** To make the policy consistent with the fees and removal of some sections.
Owner:	Head of Governance
Author:	Head of Governance
Relevant legislation:	
Next review date:	March 2025
Linked policies:	Gifts and Hospitality policy Travel and Expenses policy
Equality Impact Assessment:	
	Next EIA review date: June 2022

Contents

1 Policy Statement

1.1. The Council is committed to ensuring that members are paid appropriate fees for the work they undertake for the GOC. This policy outlines how members' fees are set, how fees and expenses are paid, and how and when fees are reviewed. It also provides guidance on who is entitled to additional fees beyond the fees paid for attending meetings.

1.2. As a registered charity there is a need to ensure that the monies of the charity are only used to further the GOC charitable objects and, in keeping with other public bodies, we are expected to demonstrate best value for money in all that we do.

1.3. In addition, fees paid to Council members (trustees) are subject to review by the Charities Commission.

1.4. This approach is consistent with our values – acting with integrity, pursuing excellence, respecting other people and ideas, showing empathy, behaving fairly and being agile and responsive to change.

2 Purpose

2.1. This policy is to ensure that member fees are fair and remain current.

2.2. This policy also provides information on how fees are reviewed every five years against benchmark data and how fees for all members are set at a day rate in line with the median benchmarked fee level.

3 Scope

3.1. This policy applies to all our members. This includes members who hold more than one appointment with the GOC (such as being a member of more than one committee). This policy does not apply to GOC employees (such as case examiners) or workers (such as education visitors).

3.2. The payment of additional remuneration for development, induction activity and undertaking performance assessment of members only applies to members who are not paid an annual fee. This means that Council members are not paid for any additional activity, such as induction or performance assessment, because they are paid an annual fee.

4 How member fees are set and reviewed

4.1. Member fees will be reviewed at least every five years and recommendations prepared for consideration by Remuneration Committee for approval by Council, alongside the budget setting process.

4.2. The review will include consideration of the mean average time commitment of all members over a five-year timeframe. Where the time commitment for the role may have changed, the views of members will be gathered in order to inform the analysis of the data collection.

4.3. For roles remunerated by an annual fee the mean average time commitment will be calculated to include chairing duties, preparation for and attendance at meetings, induction, development and performance appraisal activities as well as membership on Council committees, working groups and/or selection panels.

4.4. If there is a reason to change the time commitment of members outside of the review period, for example, because of a change in responsibilities, the Remuneration Committee and Council will take this into account in reviewing whether to change the fee payable.

4.5. Member fees and day rates will be benchmarked against comparable data, which will include data from other healthcare regulators and at least eight non-healthcare public sector bodies, for which comparable fee data is available, as agreed by the Remuneration Committee (See Annex A).

4.6. A median day rate for Council Chair and members is multiplied by the mean average annual time commitment to identify an annual fee (and paid on a monthly basis).

4.7. An allowance for the Senior Council member is identified by adding a supplement of £2,500 to the annual fee agreed for Council members (and paid on a monthly basis). The supplement includes payment for undertaking a range of activities as detailed in the role description, including undertaking the performance appraisal of the Chair and chairing committee meetings.

4.8. The Chair of the Investigation Committee will be paid for each day they work, this includes when they undertake the performance appraisal of Investigation Committee members. Hearing Panel members acting as a Chair of a Fitness to Practice Panel or Registration Appeals Committee will be paid the chair day rate for each day they work, this includes when undertaking the performance appraisal of Hearing Panel members.

4.9. A median day rate for all other members is paid for each day they work, with the exception of their own performance appraisal, which is unpaid.

5 Fees for development and induction activity

5.1. For members who are not paid an annual fee, additional fees will be paid for:

5.1.1. attendance at induction sessions lasting longer than three hours which have been arranged by the GOC;

5.1.2. attendance as an observer at GOC meetings/hearings as part of a planned induction; and

5.1.3. attendance for development which is directly related to the role and arranged by the GOC.

5.2. The median day rate for development and induction activity is identified from a benchmark data set (Annex A) which includes other healthcare regulators for which comparable fee data is available.

5.3. We will not pay additional development or induction fees for the following:

5.3.1. attendance at a public Council meeting or a committee meeting at which you are not an appointed member (unless it is part of a planned induction – see point 5.1.2 above);

5.3.2. any development which is not directly related to the role and not arranged by the GOC;

5.3.3. attendance at optical conferences or trade exhibitions, consultation events or stakeholder meetings;

5.3.4. development or induction which is delivered in an on-demand or online short course format for less than three hours;

5.3.5. where the member is already being paid for attendance at a meeting on the same day the development or induction was delivered; and

5.3.6. attendance to speak at a GOC meeting, conference or event for the purposes of development or induction, on behalf of the GOC – the payment of speaking fees are dealt with separately in the GOC Gifts and Hospitality policy[2].

6 Teleconference/ videoconference Fees

6.1 Meetings held via teleconference/videoconference (such as MS Teams) do not require members to travel to attend in person. A fee equivalent to two thirds of the daily rate for attendance will be paid to members who are not paid an annual fee for attending a teleconference/videoconference meeting. (Note: a remote FtPC hearing conducted by videolink or telephone is not classed as a teleconference/ videoconference meeting, for which a full fee will be paid.)

6.2 The reduced fee takes into account that the same amount of time will be required to

prepare and attend the meeting as would be the case when attending in person.

7 Reading Fees

7.1. Hearing Panel and Investigation Committee members required to read papers in excess of 500 pages may be paid an additional reading fee. Payment of additional reading fees will require authorisation by the Director of Regulatory Operations or the Head of Casework Operations and only applies to Hearing Panel or Investigation Committee members.

8 Cancellation Fees

8.1. Hearing Panel members may have a hearing cancelled at short notice. As Hearing Panel members are required to commit to attendance at a hearing which can be a number of days or weeks long, if a hearing is cancelled the following terms will apply:

8.1.1. Pay half a day fee for each hearing day cancelled within five calendar days of the scheduled hearing commencement date [capped at seven calendar days];

8.1.2. Pay a full fee for events that conclude earlier than anticipated [capped at full fee for day 1-2; half a fee for days 3-5; no fee thereafter];

8.1.3. Pay half a day fee for split event days that are within 28 calendar days of an early finish. [no fee thereafter]. Split events are defined as events scheduled over non-consecutive days.

9 Fees for other activities

9.1. Members may be asked to undertake other activities for the GOC outside of the responsibilities of the role they have been appointed to. For example, members may be asked to act as selection panel members for the appointment of other members, fill another member role on a temporary basis or participate in a Council workshop or working group.

9.2. For members who are not paid an annual fee, fees for such activity will be paid in accordance with the agreed and published daily fee.

10 Payment of fees

10.1. For the majority of member attendance and/or activity, fees will be automatically authorised and paid to members via payroll within six weeks of attendance at a meeting or completion of an activity. Payments are normally made on the last working day of the month. For meetings held after the 20th day of the month payment will be made the following month.

10.2. For member attendance and/or activity which does not relate to a meeting, workshop or hearing (for example, fees paid for sifting and shortlisting of applications) the Executive will ask the member to confirm the hours worked prior to authorising payment. Once authorised fees will be paid to members via payroll on the next available occasion, normally within six weeks.

10.3. If members wish to be paid via invoice rather than through payroll, they must apply for authorisation from the Director of Corporate Services and provide evidence of self-employment and responsibility for the payment of national insurance contributions to be set up on our payment system. Payment of fees and expenses via invoice will only be paid once an invoice has been received. Once authorised, fees will be paid to members via invoice within six weeks.

11 Payment of expenses

11.1. Members are encouraged to use the GOC reception travel and accommodation booking service wherever possible, so that payment for travel and accommodation can be made directly to the provider and benefits of centralised bookings can be realised. Information on how to use this service will be provided on appointment.

11.2. Whilst attendance at such events as listed in 5.3 will not be additionally remunerated, the GOC will pay any additional expenses incurred which relate to attendance as a member, such as travel or subsistence, in accordance with the GOC expenses policy.

11.3. Expenses booked and paid for by members directly, such as travel, accommodation or subsistence, will be separately reimbursed in accordance with the GOC expenses policy[3], within six weeks of receipt of a valid claim. Claims are normally paid monthly on the last working day of the month. Claims submitted after the 20th day of the month will be reimbursed the following month.

11.4. All expense claims should be submitted using the GOC expenses claim form (available from the GOC Finance Team) and submitted to the GOC Finance Team within two calendar months of attendance or completion of the work, and at the year-

end (31 March) no later than 15 April. In order for a claim to be valid it must be made in accordance with the expenses policy and accompanied by receipts. Any claims made not in accordance with the expenses policy will require approval by the Director of Corporate Services. Claims received more than two months after the event will not be paid.

12. Transparency

12.1 The member fees will be circulated to members and published on the GOC website.

12.2 In accordance with our information disclosure policy, the fees and expenses paid to Council members are published on our website on a quarterly basis and disclosed in our annual report.

13. Questions regarding this policy

13.1. Any questions regarding this policy and its application should be directed to the Head of Governance in the first instance.

Annex A: Benchmarking data sets

Council Chair/Board chair

Healthcare Regulatory	Chair	Annual time commitment	Equivalent day rate
General Optical Council	£50,000	130	£423
General Chiropractic Council	£23,000	78	£301
General Dental Council	£55,000	156	£352
General Medical Council	£110,000	156	£705
General Pharmaceutical Council	£60,000	156	£384
General Osteopathic Council	£27,000	78	£346
Health and Care Professional Council	£65,000	156	£416
Nursing & Midwifery Council	£78,000	156	£500
Average (just healthcare)	**£58,500**	**137**	**£435**
Median (just healthcare)	**£57,500**	**156**	**£420**
Wider Regulatory bodies	**Chair**	**Annual time commitment**	**Equivalent day rate**
Care Quality Commission	£63,000	156	£496
Profession Standards Authority	£34,530	104	£332
Northern Ireland Social Care Council	£17,403	104	£167
Social Care Wales	£32,352	96	£337
Scottish Social Services Council	£26,208	104	£252
Care Inspectorate (Scotland)	£41,808	156	£268
Regulation and Quality Improvement Authority (Northern Ireland)	£19,387	156	£149
Average (including healthcare regulators)	**£62,082**	**34**	**£470**
Median (including healthcare regulators)	**£60,000**	**104**	**£425**

Council/Board member

Healthcare Regulatory	Council Member	Annual time commitment	Equivalent day rate
General Optical Council	£13,962	36	£387
General Chiropractic Council	£6,650	15	£443
General Dental Council	£15,000	35	£428
General Medical Council	£18,000	48	£375
General Pharmaceutical Council	£12,500	40	£347
General Osteopathic Council	£7,500	18	£417
Health Care Professional Council	£12,000	30	£400
Nursing & Midwifery Council	£14,724	36	£409
Average (just healthcare)	**£12,5428**	**35**	**£310**
Median (just healthcare)	**£13,096**	**36**	**£413**
Wider Regulatory bodies	**Council Member**	**Annual time commitment**	**Equivalent day rate**
Care Quality Commission	£7,883	36	£350
Professional Standards Authority	£8,078	6	£240
Social Work England	£5,250	15	£450
Northern Ireland Social Care Council	6,367	24	£265
Social Care Wales	£6,768	24	£282
Scottish Social Services Council	£9,247.08	60	£154.13
Care Inspectorate (Scotland)	£4,2000	24	£175
Regulation and Quality Improvement Authority (Northern Ireland)	£6,202	36	£206
Average (including healthcare regulators)	**£11,973**	**34**	**£344**
Median (including healthcare regulators)	**£8,417**	**30**	**£289**

Committee Chair daily fees Healthcare Regulatory	HP Chair	IC Chair	Visitor panel Chair	Advisory Committee chair
General Optical Council	£372	£372*	£330	NA
General Chiropractic Council	£350	£500	£500	NA
General Dental Council	£353	£353		£353
General Medical Council	£360	£360	£360	£360 - £12,000*
General Pharmaceutical Council			£360	
General Osteopathic Council+	£306	£306		
Health Care Professional Council	£348		£320	
Nursing & Midwifery Council $	£340	£340	NB NMC outsource	
Average	**£293**	**£429**	**£374**	**£353**
Median	**£330**	**£353**	**£360**	**£353**

* IC Chair is paid a meeting fee of £372 per day, plus reading fees.

Visitor Panel Chair is paid £330 per visit plus an annual fee of £6,000, which is an average day fee of £490 based on current average time commitment.

~ Chairs who are legally qualified

+ GOsC pay a half day rate of £153 for a day commitment of less than 3.5 hours; and a £75 reading fee

$ NMC offer discretionary £100 reading fee to HP/IC Chairs /members (on a case by case basis)

Committee member daily fees Healthcare Regulatory	HP member	IC member	Visitor panel member	Advisory Committee member	Independent Committee member	Total
General Optical Council	£319	*£319*	£300	£319	£319	
General Chiropractic Council	£300	£300	£300	£300	£300	
General Dental Council	£353	£353		£353		
General Medical Council	£310	£310	£310	£310		
General Pharmaceutical Council			£300			
General Osteopathic Council+	£306	£306				
Health Care Professional Council	£190		£190	£320		
Nursing & Midwifery Council $	£310	£340	NMC outsource			
Average	**£296**	**£322**	**£280**	**£313**	**£290**	**£301**
Median	**£306**	**£310**	**£300**	**£310**	**£290**	**£303**

+ GOsC pay a half day rate of £153 for a day commitment of less than 3.5 hours; and a £75 reading fee

$ NMC offer discretionary £100 reading fee to HP/IC Chairs /members (on a case by case basis)

GOC IC member rate not included in the average or median calculations

Other Allowances

Healthcare Regulatory	Teleconference	Development and Induction fee	Independent Assessor
General Optical Council	£54 (per meeting of two hours or under) £106 (of over two and under four hours)	£223	£400
General Chiropractic	£150	£300$	£300
General Dental Council		£353$	£500
General Medical Council		£310^	£465^
General Pharmaceutical		£225	
Health Care Professional		£320$	
Nursing & Midwifery		£310$	£260
Average	**£150**	**£288**	**£385**
Median	**£150**	**£310**	**£400**

$ pay the same as they do for attendance at hearings and meetings
^ not available to Chairs.

Public Council

Data Protection and Freedom of Information Policies

Meeting: Wednesday 16 March 2022 **Status:** For approval

Lead Responsibility: Sarah Martyn, Interim Head of Secretariat

Paper Author(s): Sarah Martyn, Interim Head of Secretariat

Purpose

1. To enable Council to review and approve the updated Data Protection and Freedom of Information Policies

Recommendations

2. Council is asked to approve:
   - the Data Protection Policy; and
   - the Freedom of Information Policy.

Strategic Objective

3. This work contributes towards the achievement of the following strategic objective: Building a culture of continuous improvement. This work is included in the 2021/22 Business Plan.

Background

4. These policies were last reviewed by Council as part of the Information Governance (IG) Framework in July 2016. At the time, the Audit, Risk and Finance Committee had delegated authority to review the adequacy of, and changes to these two policies. This approval is in fact retained by Council as it takes responsibility for complying with UK GDPR at the highest level of the organisation. In September 2021, the Audit, Finance and Risk Committee terms of reference were updated to reflect this.

Analysis

5. These two policies have been updated:
   - in line with legislation changes as of May 2020;
   - to reflect improvements following the internal audit; and
   - to reflect post-GDPR implementation and Data Protection Act 2018.

Finance

6. There are no additional financial implications of this work

Risks

7. Not to have appropriate policies in place could cause the GOC to be non-compliant with the Data Protection Act 2018 and the Freedom of Information Act 2000.

Equality Impacts

8. There are no impacts on equality, diversity of inclusion identified.

Devolved Nations

9. Both the Data Protection Act 1998 and the Freedom of Information Act 2000 apply across the UK and there are no implications for any jurisdiction from these policies.

Other Impacts

10. There are no other impacts.

Communications

11. Both the Data Protection Policy and Freedom of Information Policy will be published on IRIS and the GOC website.

Next Steps

12. Following approval:
    - The policies will be published on IRIS and the GOC website.
    - Training for employees, workers, members and contractors working for the GOC who deal with data.

Annexes

Annex 1: Data Protection Policy
Annex 2: Freedom of Information Policy

Data Protection Policy

Data Protection Policy - outlines our approach to complying with the UK GDPR and DPA 2018 and other data regulations, including our roles and responsibilities, our compliance with the seven Data Protection principles, and handling requests for personal data (SARs)

Contents

1. Roles and responsibilities

1.1. The General Optical Council is the Data Controller (ICO registration - Z5718812) and are responsible for determining the purpose of data that is collected and how it is processed.

1.2. As part of our commitment to ensuring that due attention is paid to your responsibilities, we have a number of Information Governance (IG) roles to help us ensure compliance with the legislation. They are:

Senior Information Risk Owner (SIRO) - Director of Corporate Services
• **accountable to the Council for appropriate and effective information risk management** • responsible for and takes ownership of our IG policies and acts as an advocate for IG risks • ensures that an effective information assurance governance structure is in place, including information asset ownership, reporting, defined roles, and responsibilities • ensures that there is a systematic and planned approach to the management and quality assurance of our records.
Data Protection Officer (DPO) - Head of Governance
• **has operational responsibility for data protection within the GOC** • informs and advises the organisation and its employees about their obligations to comply with data legislation • providers technical advice and guidance on matters relating to IG • monitors compliance with data protection laws, including managing internal data protection activities, advising on data protection impact assessments (Impact Assessment Screening Tool), training employees, members, workers, and contractors and conducting internal audits • liaises with the Information Commissioner's office (ICO) when required, and with other regulatory bodies on data protection policy development • supported by the Information Governance Officer who deputises in their absence.
Information Asset Owners - Heads of and those who directly report to Directors
• **accountable to the SIRO for assuring the security and use of their information assets** • identifies, understands, and addresses risk to the information assets that they "own" • responsible for managing the information that is produced, received, owned, and managed by their business area and ensures that this is in line with our policies • continuously reviews and manages their risks • reports any concerns to the SIRO bi-annually, or more frequently, if required • ensures all employees within their department complete mandatory data protection e-learning and that they are aware of their responsibilities concerning personal data • conducts or initiates privacy impact assessments (Impact Assessment Screening Tool), in line with the policy • ensures all processes and contractors are documented, especially those in which high-risk data is processed.

Data Processors - all GOC employees, members, workers, contractors and those who process data on our behalf
• **are personally responsible** for handling information in line with the data legislation and our operational policies and procedures.

2. Data Protection Act 2018 and UK GDPR summary

2.1. Data Protection Act has two main aims:

2.1.1 to protect individuals' fundamental rights and freedoms, notably privacy rights, in respect of personal data processing; and

2.1.2 to enable organisations to process personal information in the course of legitimate business.

2.2. Data protection legislation stipulates how we collect and lawfully process personal data, which is fair to the individuals the information is about (the data subjects) and meets their reasonable expectations. Processing includes virtually anything that can be done to information, including acquisition, storage, and destruction.

2.3. As a data controller, The General Optical Council are responsible for and must be able to demonstrate, compliance with the following seven UK GDPR and Data Protection principles when processing personal data. These principles (which are set out in Schedule 1 of the Act) require that personal information is handled as follows:

Principle 1 – It shall be processed lawfully, fairly, and in a transparent manner about individuals.

Principle 2 – It shall be collected for specified, explicit, and legitimate purposes and not further processed in a manner that is incompatible with those purposes; further processing for archiving purposes in the public interest, scientific or historical research purposes or statistical purposes shall not be considered to be incompatible with the initial purposes.

Principle 3 – It shall be adequate, relevant, and limited to what is necessary for relation to the purposes for which they are processed.

Principle 4 – It shall be accurate and, where necessary, kept up to date; every reasonable step must be taken to ensure that inaccurate personal data, having regard to the purposes for which they are processed, are erased, or rectified without delay.

Principle 5 – It shall be kept in a form which permits identification of data subjects for no longer than is necessary for the purposes for which the personal data are processed; personal data may be stored for longer periods insofar as the personal data will be processed solely for archiving purposes in the public interest, scientific or historical research purposes or statistical purposes

subject to the implementation of the appropriate technical and organisational measures required by the Data Protection Act to safeguard the rights and freedoms of individuals.

Principle 6 – It shall be processed in a manner that ensures appropriate security of the personal data, including protection against unauthorised or unlawful processing and accidental loss, destruction, or damage, using appropriate technical or organisational measures.

2.4. There is an additional principle, known as the 'accountability principle', which requires public bodies to take responsibility for what they do with personal data and how they comply with the other principles.

As such we are required to have appropriate measures and records in place to be able to demonstrate our compliance.

3. Information management

3.1. We will ensure that privacy impact assessments (Impact Assessment Screening Tool) are completed as part of our procurement, policy review, and project management processes.

3.2. We will manage an Information Asset Register to ensure that information and privacy risks are appropriately managed.

3.3. We will ensure that our employees, members, workers and contractors and other people who work for us are trained in data protection and information requests and that their knowledge is refreshed annually. We will also provide supplementary training and guidance to remind our employees and members of our operational expectations.

3.4. We will ensure that there are confidentiality provisions in the contracts of GOC employees, members and workers, including temporary employees or contractors, and similar instructions for those working on our behalf including solicitors, expert witnesses, and third-party suppliers.

3.5. Where no contracts are in place, we will ensure that Data Sharing Agreements are established with any third parties.

4. Lawful basis for processing and privacy notices

4.1. We are clear that different types of data we process are done so under a different lawful basis. This includes processing by:

4.1.1. **Contract** – this applies to the employee, member, worker, contractor and third-party processor data.

4.1.2. **Legal obligation** – for all data subjects when we are required to process their personal data to conduct a legal obligation, such as financial checks or complying with a court order.

4.1.3. **Public task** – for activity related to our four statutory functions, like education and registration of Optometrists, Dispensing Opticians and Optical Businesses, and fitness to practise investigations.

4.1.4. **Legitimate interests** – for activity related to our general working, such as handling queries not related to our functions, corporate complaints, or conducting wider research.

4.1.5. **Consent** – for our marketing and promotional activities, even when in the public interest (but not when the information relates to our public task). The GOC keeps an active register within our CRM system which informs us if individuals have given consent. Individuals will always have the right to withdraw their consent at any time by emailing ig@optical.org.

4.2. We are committed to being open and honest with individuals about how we intend to use their personal data. We ensure that data subjects are given a privacy notice at the time of collection. We make every attempt to ensure that our privacy notices are uncomplicated, in plain English, and in a reasonably prominent position on any hardcopy form or electronic screen. All new privacy notices must be approved by the Data Protection Officer. We also use our privacy statement – published on our website – to go into further detail regarding our use of personal data.

4.3. If we make any changes to our privacy notices or statements, we will update data subjects using the most appropriate method.

5. Individual rights

5.1. Every data subject has rights to how their information is handled. These are the rights:

5.1.1. **to be informed** - the right to be informed about the collection and use of their personal data.

5.1.2. **of access** - the right to access their data and supplementary information. the right of access allows individuals to be aware of and verify the lawfulness of the processing.

5.1.3. **to rectification** – the right to have inaccurate personal data rectified or completed if it is incomplete.

5.1.4. **to erasure** - the right to have personal data erased. The right is not absolute and only applies in certain circumstances.

5.1.5. **to restrict processing** - the right to request the restriction or suppression of their data. The right is not absolute and only applies in certain circumstances.

5.1.6. **to data portability** - the right to data portability allows individuals to obtain and reuse their data for their purposes across different services.

5.1.7. **to object** - the right to object to processing based on legitimate interests or the performance of a task in the public interest/exercise of official authority (including profiling); direct marketing (including profiling); and processing for purposes of scientific/historical research and statistics.

5.1.8. **about automated decision-making and profiling** - the right to be provided with information about the automated individual decision-making, including profiling.

5.2. The lawful basis of processing determines which individual rights can be invoked or requested. More information can be found on www.ico.org.uk.

5.3. All requests to invoke the above rights must be sent immediately to foi@optical.org so that the request can be processed, and further guidance may be offered to data subjects.

6. Subject Access Requests (SAR)

6.1. We will process subject access requests (SAR) in line with the Data Protection Act.

6.2. Data subjects have the right, upon written request, to be informed

- whether or not information about them is being processed by us,
- to be given a description of the information,
- the purpose of our processing and to whom it may be disclosed, and
- to be provided with the information we hold in an intelligible form.

6.3. Employees, members, contractors and those working on our behalf must be trained to recognise requests for information as the request will not necessarily be labelled under the correct legislation and does not require to be specifically phrased as a SAR.
The Information Governance Officer manages SAR requests received, and all requests must be sent immediately to foi@optical.org as we must respond to all requests within one calendar month (30 days) of receipt.

7. Information accuracy

7.1. When collecting personal information, we will endeavour to ensure it is accurately recorded, especially when provided verbally. We will periodically request that data subjects review the data we hold about them to ensure it remains accurate.

7.2. We will help data subjects to update and correct their data (rectification), but we may require evidence or verification to make some changes for data protection purposes.

7.3. We will make every attempt to hold one single version of the information to avoid duplication and minimise the risk of data being inaccurate across versions.

7.4. If we receive information from a third party, we will endeavour to find out how accurate the information is, if there is any doubt of its accuracy, and when it was last verified.

8. Non-UK information

8.1. We will always seek written consent from the data subject before sending any personal information outside of the UK. Individuals will always have the right to withdraw their consent at any time in writing to the GOC.

8.2. We consider Data Protection legislation and regulations during procurement and our decision-making.

9. Volume of personal data

9.1. We are committed to collecting and using only the minimum amount of personal data required for the purpose(s) specified.

9.2. Where de-personalised or anonymous information would suit our purposes, we will always aim to anonymise the information, to reduce the amount of personal data that we hold.

9.3. Each employee, member, worker, contractor or person working on our behalf is responsible for managing their outlook mailbox and their personal space on the IT systems and is expected to regularly review and delete unnecessary emails or documents containing personal information. This includes the sent items, deleted items, and recycle bin.

9.4. The same principle must be applied for shared mailboxes, for which the owner will be identified in the Information Asset Register.

10. Information archiving, retention, and disposal

10.1. We will adhere to our Retention Schedule to ensure that we are not holding personal information for longer than necessary.

10.2. When archiving information, Information Asset Owners are responsible for ensuring that they have an accurate record of the information that has been archived, and ensure any boxes of archived material are labelled appropriately, including:

10.2.1. Information Asset Owners name and department;
10.2.2. type of information;
10.2.3. box number; and
10.2.4. date for destruction.

10.3. When archiving, it is important to group documents by type and retention length, ensuring that one box only contains information of the same type and retention length. Failure to do so will have implications for adherence to our Retention Schedule. Failure to implement may result in disciplinary proceedings.

10.4. When deleting main copies of data, as per the timelines set out in the Retention Schedule, a destruction log must be maintained by the Information Asset Owner. This should contain a list of the information destroyed, the date, and the method of destruction.

10.5. For paper documents containing personal information, these must be securely destroyed in the confidential shredding bins.

11. Information security

11.1. We are committed to protecting all personal information, including in collection, storage and transfer.

11.2. Access to personal information will be restricted to those who need to access it and have the right to access it.

11.3. Personal information must not be disclosed either orally or in writing, whether accidentally or not, to any unauthorised third party without the data subject's consent and without prior authorisation from the Data Protection Officer or delegated manager (such as Head of Case Progression or the Information Governance Officer). Data subjects will always have the right to withdraw their consent at any time in writing to the GOC.

11.4. For further information about standards of conduct expected from all employees, members, and third-party contractors working on our behalf, please refer to our Information Security Policy and our IT Policy (Information Technology Policy.docx (sharepoint.com)) .

Freedom of Information (FOI) Policy

Freedom of Information (FOI) Policy – outlines our approach to managing our Freedom of Information (FOI) duties, including our publications scheme and response to FOI requests.

1. Freedom of Information Act (FOIA) summary

1.1 The FOIA gives people the right to request information from public authorities. It is intended to promote a culture of transparency and accountability amongst public sector bodies and increase public understanding of how public authorities carry out their duties, why they make the decisions they do and how they spend public money.

1.2 All FOIA requests are considered alongside the following legislation:

1.2.1. UK GDPR and Data Protection Act 2018– which provides individuals with a right to access information about themselves; and
1.2.2. Environmental Information Regulations 2004 – which provides individuals with a right to access environmental information. They apply to information held by or on behalf of public bodies carrying out a public function.

1.3 All information we create, or store is subject to the requirements of the FOIA provided that:

1.3.1. we retain possession of the information; or
1.3.2. we have provided the information to another public body; or
1.3.3 the information is held by a third party on our behalf.

Publication Scheme

1.4 Under the FOIA, we are required to proactively publish information and it is a statutory duty to develop and maintain a publication scheme that has been approved by the Information Commissioners Office (ICO).

1.5 Our publication scheme demonstrates our commitment to make certain information publicly available and explains how information can be obtained. The scheme also details if charges are applicable. Our publication scheme is published on our website and is reviewed periodically. Publication scheme | GeneralOpticalCouncil

2. Right of access

2.1 The FOIA gives individuals and organisations the legal right to:

2.1.1. ask if a public authority is holding information; and if so
2.1.2. obtain access to the information held, within 20 working days from the day after receipt of the valid written request.

3. Valid Requests

3.1 Requests for information must be made in writing (paper or electronic) and must state the name and address (postal or email address) of the requester and state the information that they are requesting.

3.2 FOI requests must not be accepted verbally, although where a requester is unable to write their request, we will try to assist them.

3.3 There is no requirement for the requester to explain the reason for their request or to specify that it is a request being made under the FOIA.

4. Exemptions

4.1 Whilst we always look to respond to requests fully, requesters are not always entitled to be given all the information they request.

4.2 Information released under the FOIA must be considered as being released into the public domain.

4.3 There are currently 23 exemptions from the right of access to information, which are set out in Part 2 of the FOIA.

4.4 In broad terms there are two types of exemptions:

4.4.1 Absolute exemptions – where the right to information will not be disclosed under any circumstances.

4.4.2 Qualified exemptions – where we identify a possible exemption, but must weigh up competing interests to decide whether it serves the interest of the public better to withhold or disclose the information. This is known as the public interest test.

4.5 Examples of absolute exemptions are:

4.5.1 Section 21 – Information reasonably accessible by other means

4.5.2 Section 40 – Personal information

4.5.3 Section 41 – Information provided in confidence

4.5.4 Section 44 – Information whose disclosure is prohibited by law

4.6 Examples of qualified exemptions (where the public interest test applies) are:

4.6.1 Section 22 – Information intended for future publication

4.6.2 Section 30 – Investigations and proceedings conducted by public authorities

4.6.3 Section 36 – Prejudice to effective conduct of public affairs

4.6.4 Section 43 – Commercial interests

4.6.5 Section 42 – Legal professional privilege

4.7 When deciding whether to apply a qualified exemption (and withhold information) valid consideration must be given to decide if releasing the information would serve the public interest and whether it would outweigh the reasons behind exemption.

4.8 It is not enough that there is merely a public interest attached to the information being requested. The person making the request has an interest in the information, but this does not constitute "public interest".

4.9 If the requestor has had GOC access restrictions applied under our Acceptable Behaviour Policy, we will consider each request on its merits but may alter the way we correspond regarding the request(s), in line with the restrictions.

5. Handling FOI requests

5.1 This section outlines our legal responsibilities when processing a request.

5.2 FOI requests are co-ordinated by the Information Governance Officer, who will record all FOI/SAR requests and relevant correspondence in line with our Retention Schedule.

5.3 All employees, members, and workers, contractors and those working on our behalf are responsible for ensuring FOI requests are promptly forwarded to the FOI inbox (foi@optical.org) and to respond to requests from the Information Governance Officer promptly.

5.4 We will acknowledge all written FOI requests within 5 working days of the request being received.

5.5 The 20-working day timeline starts from the working day after receipt of the request and continues during working days including if the office is closed to the public.

5.6 Each request will be considered individually on its own merits.

5.7 Our duty is to confirm or deny whether the requested information is held and, if we hold the information, provide it in the requested format. If the requested information is not held, it would normally be reasonable to inform the requester. However, there may be exceptional cases where it would not be reasonable to confirm nor deny if the requested information is held.

5.8 In most circumstances, within 20 working days after the date of receipt, we will tell the requester whether the information is held and if the information is not

considered exempt, we will provide it in the format required as soon as reasonably practical.

5.9 If an exemption is being considered, and we require additional time to complete a public interest test, we will promptly notify the requester of the exemptions that we are considering and provide a new deadline for response. We will not exceed a further 20 working days in order to consider the exemption.

5.10 In some cases, a request may be refused. If so, a refusal notice will be issued setting out the decision, the exemption relied on and the reasons why.

5.11 Responses will always have contact details of the person who has handled the request, except in exceptional circumstances where SMT has agreed through the Acceptable Behaviour Policy that this is not to be completed.

5.12 We will always respond to Freedom of Information request, if the individual is not satisfied with our response we will include in the final response information on their right to contact the ICO and ask them to decide whether the individual's request has been properly dealt with.

Fees

5.13 The FOIA provides for public authorities to either charge for or decline requests for information that would cost more than £450 to respond to. This is referred to as the 'appropriate limit'.

5.14 We are required to estimate whether a request is likely to breach the appropriate limit and, where appropriate, may charge a fee for complying with a request for information.

5.15 Any fee will be calculated in accordance with the FOIA regulations, and the requester will be notified within 20 working days of the request being received. We are not required to comply with the request until the fee has been received in full.

5.16 We will respond to straightforward requests for information free of charge and will only charge when the costs breach the appropriate limit of £450.

6. FOI request appeals and complaints

Stage one: Internal review

6.1 If the requester is not happy with our response they can ask us, in writing and within 40 calendar days of the response, to complete an internal review. Their request should be addressed to the Information Governance Officer.

6.2 An employee with no prior involvement, usually of a higher grade, will reconsider their request and respond within the timescale.

6.3 Internal review requests will be acknowledged within five working days of receipt and a response provided no later than 20 working days after receipt.

Stage two: Complaints to ICO

6.4 Requesters that remain dissatisfied may complain to the ICO on any of the following grounds, failure to:

6.4.1 provide the information requested.
6.4.2 respond to the request within 20 working days.
6.4.3 explain why more than 20 working days were needed.
6.4.4 provide advice and assistance.
6.4.5 provide information in the requested format.
6.4.6 clearly explain any reason for refusing a request; or
6.4.7 correctly applies for an exemption under the FOIA.

6.5 The ICO will decide whether the request has been handled appropriately in accordance with FOIA and will provide a decision notice, to both the requester and the GOC.

6.6 The ICO will not consider a complaint:
6.6.1 when the applicant has not exhausted our internal complaints procedure.
6.6.2 where there has been undue delay in making an application to the ICO.
6.6.3 where the application is frivolous or vexatious.
6.6.4 where the application has been withdrawn or abandoned.

6.7 If the decision goes against us, the ICO will set out the actions that we are expected to take to correct the issues and by when.

Stage three: Information Tribunal

6.8 Either the applicant or the GOC can appeal against the ICO's decision notice to the independent Information Tribunal. Information regarding the right of appeal will be included in the ICO's decision notice.

7. Re-use of Public Sector Information regulations 2015 (RPSI)

7.1 Within the FOIA, the Re-use of Public Sector Information Regulations 2015, allow for 're-use' of some public sector information for a purpose other than

the initial public task it was produced for. This would mean that an organisation can reuse information that has already been published.

7.2 Should you wish to re-use any of our public information in this manner, please email the Information Governance Officer at FOI@optical.org, who will send you a form to complete, sign and return.

Public Council Work Plan			
Q1	**Q2**	**Q3**	**Q4**
28 June 2022	**20 September 2022**	**06 December 2022**	**13 March 2023**
· CEO Report · Chair Report	· CEO Report · Chair Report	· CEO Report · Chair Report	· CEO Report · Chair Report
Assurance	**Assurance**	**Assurance**	**Assurance**
· Q4 financial performance reports · Balanced Scorecard · Business Plan Assurance Report Q1 · Advisory Panel minutes · Corporate Policies · Health and Safety Annual Report · Education Assurance and Quality Assurance Annual Monitoring and Reporting Sector Report 2020/2021 · Optical Consumer Complaints Service (OCCS) Annual Report 2021/2022 · Stakeholder Survey · Registrant Survey · Public Perceptions Survey · PSA performance review 2020/2021	· Q1 financial performance reports · Balanced Scorecard · Business Plan Assurance Report Q2 · Advisory Panel minutes · Corporate Policies · Annual report and financial statements for year ended 31 March 2021 · Equality, Diversity and Inclusion: Annual Monitoring Report	· Q2 financial performance reports · Balanced Scorecard · Business Plan Assurance Report Q3 · Advisory Panel minutes · Corporate Policies	· Q3 financial performance reports · Balanced Scorecard · Business Plan Assurance Report Q4 · Advisory Panel minutes · Corporate Policies · External Audit of Fitness to Practice Decision Making 2021/2022

Strategy	**Strategy**	**Strategy**	**Strategy**
· FTP Performance Review / Update and/or rules changes · Legislative change update	· Legislative change update	· First Draft External Business Plan · Legislative change update	· Budget and Business Plan for 2022/23 · Legislative change update · Standards of Practice for individual registrants for consultation
Operational	**Operational**	**Operational**	**Operational**
· Council Workplan	· Council Workplan	· Council Workplan · Registrant Fees Rules and Future Fee Strategy 2023/2024 · Council member appointments	· Council Workplan · Member Fees Review 2023/2024 · FtP Improvement Programme Update – continuous improvement