General Optical Council

GOC response to consultation on revised Standards of Practice for Optometrists and Dispensing Opticians, Standards for Optical Students and Standards for Optical Businesses

December 2024

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Executive summary

1. In February 2024 we launched a consultation on changes to the standards that we set for the students and fully qualified individuals and optical businesses we regulate. These are the Standards of Practice for Optometrists and Dispensing Opticians, Standards for Optical Students and Standards for Optical Businesses.

2. The consultation ran from 14 February 2024 to 8 May. We received 39 written consultation responses and held eight stakeholder events to give stakeholders the opportunity to discuss the changes.

3. Stakeholders generally supported the proposed revisions to the standards and agreed that we have addressed some important topics as part of this Standards Review. Where we received feedback, which was beyond the scope of this review, it will be revisited as part of the forthcoming review of the Standards for Optical Businesses or fed into our other workstreams where appropriate.

4. We mostly received feedback around the drafting of the proposed introductory statements and the proposed revisions to the standards rather than the substantive underlying policy position and have considered all comments carefully. We have made some changes to improve clarity, brevity, legal alignment and/or to set clear expectations.

5. We recognise that stakeholders would value additional guidance to support implementation of the standards, particularly where we have set new expectations. We have committed to developing guidance on the care of patients in vulnerable circumstances and maintaining appropriate sexual boundaries once the standards are published.

Introduction

6. The General Optical Council (GOC) is the regulator for the optical professions in the UK. We currently register around 33,000 optometrists, dispensing opticians, student optometrists and dispensing opticians and optical businesses.

7. As part of our statutory duty to set standards for the performance and conduct of our registrants, we have three sets of standards:

   - Standards of Practice for Optometrists and Dispensing Opticians
   - Standards for Optical Students
   - Standards for Optical Businesses

8. Our standards are applicable to all dispensing opticians and optometrists, whether students or fully qualified, and those optical businesses we regulate, across all practice settings. They are an overarching set of standards setting minimum expectations, to which registrants must apply their professional judgement.

9. We launched the Standards Review project in April 2023. The purpose of the review was to:

   - make any necessary updates to the current standards that reflect changes to practice or changing patient expectations;
   - ensure that the current standards are fit for purpose; and
   - ensure that the standards reflect the current context within which registrants practise, students are trained, and businesses operate.

Consultation process

10. We undertook a full public consultation on our proposed changes to the standards, which was open for 12 weeks from 14 February 2024 to 8 May 2024, in accordance with our consultation policy.

11. We hosted the online consultation on the GOC's Consultation Hub, and offered respondents the option of submitting e-mail responses to our mailbox consultations@optical.org. We made the consultation available in English and Welsh. We also welcomed full or partial responses.

12. During the consultation phase we facilitated eight stakeholder events, to give stakeholders the opportunity to discuss the changes with us and ask questions. We held four open events for registrants, one of which was aimed specifically at student registrants. We held individual events for Fitness to

Practise members, business registrants, and others. We also published a consultation webinar for stakeholders who were unable to attend a stakeholder conversation.

13. We promoted the consultation and associated stakeholder events in several ways, including through our website (press release and blog), registrant newsletters and our social media channels.

14. We received 39 written consultation responses from a range of stakeholders including optometrists, dispensing opticians, students and representative bodies, as well as a business registrant, patient organisation, education provider, mediation service and a regulatory body.

15. The organisations who were willing to be named were:

- Optical Suppliers Association
- Optometry Wales
- College of Optometrists
- Association of Optometrists (AOP)
- Association of British Dispensing Opticians (ABDO)
- FODO – the Association for Eye Care Providers
- Bexley Bromley and Greenwich LOC
- Professional Standards Authority (PSA)

16. We are grateful for the all the feedback we received and have taken this into account when drafting the final sets of standards.

Approach to producing this response

17. The consultation asked respondents to indicate the extent of their agreement or disagreement with the proposed changes to the standards using a Likert scale[1]. When reporting the results, we have grouped ‘strongly agree’ and ‘somewhat agree’ responses as ‘agree’, and ‘strongly disagree’ and ‘somewhat disagree’ responses as ‘disagree’, for clarity. In annex 1 we have included graphs which show the Likert scale responses for each question.

18. Generally, we asked respondents whether the proposed introductory statement or standard was a) clear and b) sets appropriate minimum expectations of registrants. In relation to new standards, we asked whether the proposed new standard a) specifically addressed the issue under consideration and b) was clear.

[1] Likert Scale | SpringerLink

19. As some of the proposed changes were interrelated, comments about one change were frequently repeated in response to other. We recognise that there is also overlap between some of the questions we asked in the consultation and in the responses we received. To avoid duplication in this report we have, where appropriate, noted that the feedback received was similar to an earlier question and highlighted any additional points.

20. Respondents were encouraged to provide comments whether they agreed or disagreed with our proposed changes. We reviewed every comment received. We are unable to include individual responses to all comments within this report. Any comments that have been included are produced verbatim.

21. Throughout this report we will refer to specific standards that have been revised using the standard number, for example, standard 6.1. We recognise that the numbering in the Standards of Practice for Optometrists and Dispensing Opticians differs from the numbering within the Standards for Optical Students.

22. To address this, we refer to the number within the Standards of Practice for Optometrists and Dispensing Opticians first, and then the number within the Standards for Optical Students in brackets afterwards. For example, we have proposed a revision to standard 6.1 (5.1).

23. When referring to the Standards for Optical Businesses we will simply refer to the relevant standard, for example, standard 1.1.4.

Findings

Section 1: General feedback

24. Throughout our engagement activities and the public consultation, we have identified recurring themes within the feedback, which we have set out below. Where possible, we have not repeated these themes in the subsequent sections, to ensure the document remains focussed.

25. Stakeholders suggested that we review the following to ensure that all registrants could understand and apply the standards in their practice:

    a) The use of terms ‘must’ and ‘should’ to ensure we set standards which are appropriate and proportionate
    b) The brevity and succinctness of the proposed revisions to improve clarity and only make changes where absolutely necessary
    c) Whether we should define terms such as ‘professional judgement’ to aid interpretation
    d) Alignment of language to relevant legislation to ensure our expectations are consistent with the law
    e) The appropriateness of aligning language with that used by other regulators to set consistent standards of behaviour across the health professions
    f) The level of detail provided and whether it is sufficient to enable registrants to apply the standards in practice
    g) The need for additional guidance and/or training to accompany the revised standards

Our response

26. These standards are applicable to all optometrists and dispensing opticians, whether students or fully qualified, and wherever they practise. As a result, the standards must remain overarching and are not intended to be prescriptive about how registrants should meet the standards. Registrants need to use their professional judgement to decide how they will meet the standards. Many of the terms within the standards need to be interpreted within the context in which they are used. As such, we do not propose to add definitions to the standards but will develop guidance in a limited number of areas.

27. We have reviewed the use of ‘must’ and ‘should’ and redrafted the standards to remove these phrases where possible, in line with the current standards. Where we have used ‘must’ this relates to a legal obligation. We have used ‘should’ where there is an ethical or regulatory duty, or where the standard relates to circumstances which might not apply to all registrants.

28. We have considered the comments about the brevity, succinctness and levels of detail in our standards, as part of our process of reviewing all the feedback we received during the consultation. Where appropriate, we have made changes to the standards to improve their clarity. These changes are set out in the relevant sections below.

29. We note the comments we received on the extent to which our standards should align with other regulators' standards, or with relevant legislation. We recognise that some of our registrants may work in multi-disciplinary teams alongside other healthcare professionals, (regulated by different regulators) and unregulated staff. As part of our process of reviewing the standards prior to consultation, we looked at the standards set by other regulators, to ensure that there was broad consistency in the principles we set, whilst recognising the differences in the work environment and practice of our registrants. Where possible, we have aligned our standards with legislation, noting that there are some differences in legislation across the four nations.

Section 2: Leadership and professionalism

2.1 Summary of consultation events

30. Some stakeholders welcomed the proposed new statement, noting that leadership is important and that addressing it via the introductory text was appropriate and proportionate. Other stakeholders questioned the purpose of the proposed statement, felt that the statement was open to interpretation, or that the statement could be missed in the preamble.

31. Feedback at the events particularly focused on the extent to which demonstrating leadership included contributing to the education and training of others. Some stakeholders argued that there should be a separate standard on this point, or that it should be included in the proposed leadership statement, whilst others suggested using the term ‘supporting’ rather than ‘contributing’.

32. Conversely, one stakeholder suggested, “*To expect a minimum standard that someone would be responsible to contribute to the educational training of others seems to me not to be a minimum. That's kind of an above and beyond when you're taking responsibility for others*.”

33. Other issues raised included whether the use of examples in the proposed leadership statement were helpful or confusing, and whether examples of contributing to education and training could be woven throughout the standards.

2.2 Summary of consultation responses

<u>Clarity of the introductory statement</u>

34. Figure 9 shows that most respondents (25 or 64%) agreed that the introductory statement is clear. Just nine respondents (or 23%) disagreed. Of the remaining five respondents, four (or 10.5%) did not answer this question and one (or 2.5%) neither agreed nor disagreed.

35. Respondents expressed a range of views on the proposed statement, with a particular focus on the concept of leadership. Some feel that the reference to leadership is too narrow, does not encompass wider skills and is not reflected within the standards themselves. There is also a concern that the term ‘leadership’ is open to interpretation, may not be appropriate in all practice environments, and could be misinterpreted by commercial entities, potentially leading to inappropriate pressure on staff. One respondent highlighted a lack

of distinction between clinical and commercial leadership, which they felt could lead to confusion among practice teams.

36. Respondents do support the inclusion of leadership in the standards but seek more practical examples, particularly for students. The examples provided in the statement are considered too vague by some, whereas others feel that the current wording is beneficial.

Appropriateness of the proposed statement

37. When asked whether the proposed statement sets appropriate minimum expectations of registrants, Figure 9 shows that half of respondents (19 or 49%) agreed, and eleven respondents (or 28%) disagreed. Of the remaining respondents, three (or 7.5%) did not answer the question, and six (or 15.5%) neither agreed nor disagreed.

38. While some respondents see the focus on leadership and professionalism as essential and aligning with public expectations, others are concerned that not all registrants will assume leadership positions, though they believe leadership should still be taught. Some respondents requested clarity on how registrants will be measured against these principles, as they are unclear how complaints against a registrant would be handled by Fitness to Practise.

39. Several respondents have expressed concerns about the practical implications of the proposed statement, and the expectations of leadership, especially for students or newly qualified registrants who may lack experience or training in this area. One respondent suggested that students should focus on their core skills rather than leadership at the early stages of their education, whereas another respondent suggested the standards for optical students should be amended, to set realistic expectations for the development of leadership skills during their education.

40. Respondents also recommend that the standards should emphasise the support of the next generation of registrants, suggesting specific amendments to encourage supervision and mentorship. There is also a suggestion to include collaboration with allied professions in the standards.

41. Lastly, one respondent believes that the standards should include guidance on demonstrating leadership in eye care and sight loss support, as well as addressing health inequalities and ensuring equal access to healthcare services.

42. A sample of the comments we received in response to these questions are shown in the box on the following page.

"*Critical that registrants see themselves as leaders*" (Optometrist)

"*I think that either the 'examples' sentence needs to be expanded or discarded. I would prefer an expansion to clarify expectations. Although in the existing standards, the word 'contributing' would benefit by being updated to 'supporting'*." (Contact Lens Optician)

"*We feel the reference to leadership throughout the standards it too narrow and does not reflect wider skills. In the proposed change to the role as a professional there is reference to examples of demonstrating leadership which includes role modelling professional behaviours and contributing to the education and training of others. However, we feel this is not reflected in the standards themselves with enough focus or importance*." (Education provider)

"*As a principle, there is no quibble with embedding the concept of leadership into everyday practice, but there is potential for ambiguity without clear elaboration on the traits and attributes of leadership....*" (AOP)

"*...The Standards for Optical Students should set a realistic expectation for students and give trainees the scope to learn, develop and practice these skills throughout their student experience. As it currently stands, this statement implies that students would need to develop these leadership skills prior to the start of their study which sets an unrealistic expectation and does not ensure trainees will be able to develop and hone these skills throughout their student experience*." (College of Optometrists)

2.3 GOC response

43. Having reviewed the feedback and compared our interpretation of leadership with that of other regulators, we are assured that we have adopted an appropriate and proportionate position and have included similar skills and attributes, which we believe are important for safe and effective practise. However, we have made some small revisions to the introductory statement, to ensure that it is as clear as possible.

44. We note the variation in responses on whether leadership should be included in the Standards for Optical Students and have considered all the issues raised. As outlined in the consultation document, our view remains that all registrants, including students, should demonstrate leadership skills. We recognise that students will develop their leadership skills as they progress through their training, just as they develop their other professional skills and knowledge and consider that this point is adequately addressed by inclusion of the phrase "relevant to their scope of practice". Further, the existing Standards for Optical Students already address this by stating: "We have therefore

produced these specific standards for optical students which can be applied in the context of your study, taking account of the fact that you will develop your knowledge, skills and judgement over the period of your training."

45. When we consulted on the proposed statement, we did not include supporting the education and training of others within the examples of leadership that students could demonstrate. However, we note stakeholder feedback that students should demonstrate those skills and have amended the statement in response to include "supporting the education and training of others".

46. In July 2024, we published the findings of a survey of optical businesses we register. The survey highlighted that business registrants felt that newly qualified optometrists and dispensing opticians required further development of their leadership and management skills. We believe this provides further evidence of the need to set clear expectations in relation to leadership. [2]

47. We acknowledge that some respondents consider there should be a separate standard for the education and training of students and non-registrants. We do not consider this would be appropriate, as not all registrants will have the opportunity or resources to support the education and training of others. Whereas the specific standards set out behaviours which are essential to protect the public, the opening statement can be used to support the development of professional norms and in this case signals the importance we place on registrants helping to train future generations.

48. To improve the proposed statement, we have amended it to:

- Remove the word 'contributing' and replace with the word 'supporting'
- Include another example of leadership, "suggesting innovative solutions to problems"
- Remove the phrase "…and should be applied to all aspects of your work" and replace it with "…relate to all aspects of your work"

[2] goc-business-registrant-survey-report-final.pdf (optical.org)

Section 3: Care of patients in vulnerable circumstances

3.1 Summary of consultation events

49. Some stakeholders welcomed the proposed introductory statement. One said it is a '"*broader definition of what vulnerable means and I think it's a much more modern way you've phrased it and more relevant"*. Another stakeholder suggested that "*from a hearings point of view, this does cover all of the kind of common themes we would tend to see in [a] hearing*".

50. Stakeholders raised some specific concerns about the application of the revised standards in practice. Some questioned whether patients would disclose details of circumstances which made them vulnerable, whilst others focussed on the difficulties registrants might face in identifying signs of vulnerability or on how registrants could explore a patient's circumstances without being overly intrusive or making assumptions.

3.2 Summary of consultation responses

3.2.1 Responses regarding the introductory statement

Clarity of the introductory statement

51. Figure 10 shows that the majority of respondents (24 or 61.5%) agreed that the proposed introductory statement is clear. Only six respondents (or 15.5%) disagreed. Of the remaining respondents, seven (or 18%) did not answer the question, and two (or 5%) neither agreed nor disagreed.

52. Respondents raised concern about the definition of 'vulnerability' being too ambiguous and expressed the need for clarity between what is a legal obligation, for example under the Equalities Act, and what is a regulatory obligation in line with the revised standards. Some respondents support the additional wording, suggesting that it is an improvement which can be used as a prompt for education and training in this area.

Appropriateness of the proposed statement

53. In relation to whether the proposed introductory statement sets appropriate minimum expectations of registrants, Figure 10 shows that around half of respondents (20 or 51%) agreed. A fifth of respondents (8 or 20.5%) disagreed, and a further fifth (8 or 20.5%) did not answer the question. Three respondents (or 8%) neither agreed nor disagreed.

54. Respondents generally support the emphasis on caring for vulnerable patients in the revised standards. They acknowledge the importance of considering a patient's vulnerabilities during consultations and making reasonable

adjustments based on individual needs. Some respondents highlighted specific areas such as paediatrics, domiciliary care, and safeguarding, where registrants were particularly likely to meet people in vulnerable circumstances and therefore the proposed revisions should improve patient care. The importance of considering patients' vulnerabilities in the context of optical businesses is also mentioned, with a recommendation for businesses to support registrants in accommodating patients' needs. There is criticism directed at optical businesses, particularly chain stores, for not providing sufficient time or appropriate environments for optometrists to conduct safe tests on vulnerable patients. Respondents feel that without addressing these fundamental issues, new standards may be ineffective.

55. There is concern about the ability of registrants to identify and accommodate vulnerabilities, given that not all vulnerabilities are visible or acknowledged by patients. Some respondents' express concerns about the potential for assumptions related to vulnerability leading to inadvertent offence or legal issues. One respondent expressed concern that failing to identify a vulnerability could lead to fitness to practise action. There is also a sentiment that the responsibility placed on registrants is too great given the limited time they have with patients.

56. Several responses indicate that if a registrant does not already recognise the importance of considering a patient's vulnerabilities, merely adding it to the standards will not change their behaviour. Moreover, some respondents are unsure about what the minimum expectations are regarding the standards.

57. Finally, it is suggested that the standard of care should be consistent for all patients, with some respondents objecting to the emphasis on taking special care with vulnerable individuals.

3.2.2 Responses regarding the proposed revisions to standards

Clarity of the proposed revisions

58. With reference to Figure 11, two thirds of respondents (26 or 66.5%) agreed that the proposed revisions were clear. Just five respondents (or 13%) disagreed. Of the remaining respondents, a fifth (8 or 20.5%) did not answer the question.

59. Similarly to the responses for questions above, respondents have expressed concerns about the clarity and interpretation of the revised standards. The term "vulnerable circumstances" is deemed unclear, with suggestions to rephrase it to focus on the person being vulnerable rather than the circumstances themselves. There are also recommendations to clarify what constitutes vulnerability by adding explanatory footnotes.

60. One respondent requested elaboration on what constitutes an "adequate assessment" and another suggested that the standards should explicitly reference protection against all types of harm, not just abuse.

Appropriateness of the proposed revisions

61. In terms of whether respondents felt that the proposed revisions to the standards set appropriate minimum expectations, Figure 11 shows that most respondents (23 or 59%) agreed. Six respondents (or 15.5%) disagreed and a fifth of respondents (8 or 20.5%) did not answer this question. Two respondents (or 5%) neither agreed nor disagreed.

62. Most respondents directed us to their previous responses for this question. Just one additional point was raised, which related to the difficulty in setting a minimum standard without accompanying guidance.

63. A sample of the comments we received in response to these questions are in the box below.

> *"Paediatrics and domiciliary are the two areas of most concern* to [organisation]. *The proposal will be hugely helpful in the resolution of concerns we deal with"* (Mediation service)
>
> *"We believe that the amendments to the relevant standards are appropriate. As per our response to Q11 we believe that the standard 15.1 and 15.2 should be the same for all patients."* (Optometry Wales)
>
> *"We do not feel the introductory wording delivers an "interpretation of 'vulnerability'" as advised in the consultation document albeit we welcome and agree that it is right to flag that vulnerable patients may require extra care in practice. However, identifying vulnerable patients, understanding their perception of their vulnerability and taking this into account, raises a degree of challenge. Registrants do not necessarily receive adequate training in this area and therefore if we are suggesting this new introduction, opportunities for training need to be provided."* (ABDO)
>
> *"Vulnerability is variable and patient specific, this is articulated clearly. Additional guidance, with examples, may be useful."* (Optical professional/representative body)
>
> *"The revised wording proposal seems an appropriate improvement for care of individuals, and one that can be used as a prompt for education and training in this area."* (Education Provider)

3.3 GOC response

64. We are pleased to note general support for the inclusion of a statement on patients in vulnerable circumstances and associated revisions to standards.

65. As outlined in our consultation, we believe that this is an important area to address as registrants are likely to interact with patients in vulnerable circumstances regularly as part of their practice. We believe vulnerable circumstances can include a multitude of situations, which go beyond ill health or disability for example. It is our view that while it will not be possible for registrants to identify when a patient might be vulnerable in all situations, they need to be alert and take proactive steps to recognise when a patient might be in a vulnerable circumstance, even where a patient has not explicitly communicated this, so they can adapt their practice accordingly.

66. We agree with the feedback that the revised standards can be used as a prompt for education and training. The GOC's Education and Training Requirements (ETR) have strengthened provision in this area. Further, since the GOC's CPD requirements are mapped to the standards of practice, we would expect this to be reflected in future provision of CPD events. Sector bodies also have a role to support their members in this regard. Given the consultation feedback and since we are introducing enhanced expectations, we will produce guidance for registrants to support the relevant standards. We will produce this guidance after the standards are finalised, and this guidance will be subject to public consultation.

67. Our 2024 Public Perceptions Research 2024 found that the most vulnerable patients experience significantly worse outcomes. Only 63% of patients with four or more 'markers of vulnerability' had their sight tested in the last two years compared to 82% with none. Similarly, 77% of patients with four or more markers of vulnerability were satisfied with their overall visit compared to 94% with none. It is clear that more needs to be done to address the needs of patients in vulnerable circumstances. [3]

68. We note stakeholder feedback in relation to businesses, and whether they should share responsibility for the care of patients in vulnerable circumstances. We will examine this when we begin our review of the Standards for Optical Businesses in 2025.

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[3] Public perceptions research 2024 | GeneralOpticalCouncil

69. We acknowledge the feedback about the clarity, specificity, and interpretation of the proposed revisions, and have reviewed the language and terminology used. Finally, we have reflected on feedback that the standards should be applied equally to all patients and public, and concerns about the wording 'special care' for patients in vulnerable circumstances. However, in making drafting changes, the underlying rationale remains that to achieve equity, registrants may need to adapt their practice to ensure that all patients, regardless of their needs and circumstances, receive safe and effective care.

70. We have made the following changes to the introductory statement on vulnerability:

- Improve clarity around expectations of registrants, by stating, "Consider and respond to the needs of patients who…" rather than "You must exercise particular care when providing services to patients who…". This revision aligns our expectations with the existing standard 13.8 (12.6).
- Remove the word 'special' and replace with 'particular'
- Redraft the phrase "…so a patient's vulnerabilities should be considered as part of each consultation" to "…so consider a patient's vulnerabilities as part of each consultation."

71. We have made the following changes to the standards:

- Removed the phrase "and take special care when dealing with people in vulnerable circumstances" from standard 15.1 (14.1). It is our view that the phrase "Maintain appropriate boundaries…" would already require registrants to adapt their approach in response to patients in vulnerable circumstances.
- Removed the phrase "Take particular care when dealing with people in vulnerable circumstances" from standard 15.2 (14.2). It is our view that "Never abuse your professional position…" makes clear that registrants should not abuse their position regardless of whether the patient is in vulnerable circumstances or not.

72. In addition to the revisions set out above, we have also made clear the legal obligations of registrants by including reference to 'equalities legislation' in the 'compliance with legislation' statement in the introduction to the standards recognising that the law is different in different parts of the UK.

Section 4: Effective communication

4.1 Summary of consultation events

73. Stakeholders raised several questions in relation to proposed revisions to standard 2.2 which would require a registrant to identify themselves, their role and advise patients who will provide their care:

    a) How would the proposed revision work in practice, where patients may see an optical assistant first, and there is no requirement for optical assistants to state their name and role?
    b) Should the standards be made clearer, by requiring registrants to state their 'clinical' role?
    c) How would the proposed revision be addressed by student optometrists, for example, would they be expected to state the name of their supervisor?
    d) What are the expectations around a registrant identifying themselves 'in advance' of a consultation?

74. Some stakeholders suggested that the proposed revision could lead to patients refusing to see more junior staff or students, or that it might leave staff open to abuse from patients. One respondent agreed that sharing their name was appropriate, but not their role, and another respondent suggested that other regulators do not require registrants to share their name and role.

75. On the student issue, one respondent suggested, "...*it's normal practice for you to state in a patient interaction that you're a student optometrist.*" When asked if they currently state the name of their supervisor, the same respondent confirmed, "...*that's not something we have* [done]... *most times the supervisor makes initial contact*." Another stakeholder highlighted that practice differs between undergraduate placements where the fact an individual is a student is often obvious, and a pre-registration placement where it may be less obvious.

76. Stakeholders were generally supportive of the proposed revision to standard 7.6 (6.6), which would require registrants to give patients information about all the available options, including declining treatment, in a way they understand. One concern was raised about use of the phrase, 'all available options'. Stakeholders felt that this detracted from a registrant's ability to apply their professional judgement and give patients information about the 'relevant' or 'appropriate' options available to them. In addition, some stakeholders felt that standard 7.6 (6.6) should include reference to referrals.

4.2 Summary of consultation responses

Clarity of the proposed revisions

77. Figure 12 shows that the majority of respondents (28 or 72%) agreed that the standards are clear. A further fifth of respondents (8 or 20.5%) did not answer the question, and three respondents (7.5%) disagreed.

78. Respondents generally support the proposed revisions to the standards, however, there are recommendations for more precise wording, to better guide registrants, especially when dealing with complex patient needs.

79. A recurring theme is the need to review Standard 7.6 (6.6), where there is concern about the burden of informing patients about "all options available". Respondents suggest rephrasing to "relevant options available" or "appropriate options" and including referrals in the list of recommendations. The importance of including the option of "no treatment or intervention" as part of the consent process is also emphasised, with suggestions to reword standard 7.6 (6.6) to reflect this.

Appropriateness of the proposed revisions

80. When asked whether the proposed revisions set appropriate expectations, Figure 12 shows that two thirds of respondents (25 or 64%) agreed, and five respondents (or 13%) disagreed. Just under a fifth of respondents (7 or 18%) did not answer the question, and a further two respondents (or 5%) neither agreed nor disagreed.

81. Respondents generally support the proposed changes to the standards, valuing good communication and the clarification of roles, especially for registrants who are in training. The changes were described as "pragmatic developments". One response highlighted the importance of information and explanation throughout the consultation process, particularly for patients with learning disabilities and their carers. Additionally, there is support for the 'Hello, my name is' campaign and its focus on compassionate care. However, some respondents suggest that the standards may be overwhelming for registrants due to the level of responsibility required.

82. One respondent highlighted the importance of registrants stating their role, by suggesting, "*some of my clients are under the impression that they are speaking to a surgeon when it is an optometrist because they describe themselves as a "clinician"*". Though, another respondent raised concern about potential negative and unintended consequences for trainees and non-registrants, if patients decline to be seen by them, and/or the revised standards result in a further increase of verbal abuse.

83. A sample of the comments we received in response to these questions are in the box below.

"As an education and training provider that understands the value of good communication, we welcome the changes to the standards and believe they are clear". (Education provider)

"…we are concerned that the obligation to "Give patients information about all the options available to them..." may place an unreasonable burden on registrants…We are also concerned that there is a suggestion (Point 48) that these options include communication around "clinical outcomes" for "non-eye related diseases". It may be that we are introducing a key principle which embraces factors that fall outside many registrants' scopes of practice". (ABDO)

"…Service users may decline to be seen by a student or a non-registrant, making delegating some tasks more difficult and possibly creating tensions between service users and support staff. Staff on the front line are increasingly subject to verbal abuse from service users and this proposed revision may contribute to a further increase in verbal abuse for trainees and non-registrants…" (College of Optometrists)

"…Supporting people to consider the "option of no treatment or intervention" implies maintaining an ongoing professional relationship between the service user and clinician working in partnership to deliver evidence-based patient centred care. Using the wording "declining" may imply a termination of this professional relationship". (College of Optometrists)

4.3 GOC response

84. We are pleased to note general support for the proposed revisions on effective communication.

85. We consider it is essential for patients to know who is providing their care, including whether they are a student or fully qualified registrant. This is an important element of providing consent and making informed choices. Therefore, we have decided to retain this proposal in the final standards.

86. We take concern about abusive behaviour by patients seriously and we will continue to work with stakeholders to address this. The findings of the Registrant Survey 2024 continue to highlight bullying, harassment and abuse experienced by our registrants. Last year, we worked with stakeholder organisations to produce a joint statement setting out a zero-tolerance

approach to abuse in the workplace.[4] The statement recognises that tackling these issues requires the sector to work together to promote and embed a positive working environment based on respect, civility, compassion and inclusion.

87. We recognise that the way in which care is being delivered means that a patient's first point of contact with a practice may not be with a registered health professional. We note that the phrase 'in advance' was being interpreted differently by individuals and had the potential to lead to confusion. We have made small changes to the standard in 2.2 to ensure that registrants are clear on their own responsibilities in this area, but we are not prescriptive about how this outcome may be achieved.

88. We have reflected on whether referrals should be included in standard 7.6 and on balance decided that referrals are sufficiently addressed by standards 6.2 and 10.2.

89. We note stakeholder concern regarding the drafting of standard 7.6 (6.6) and reference to 'all available options'. We want to ensure that registrants can use their professional judgement to identify the relevant options available to patients. However, some options available to a patient may not be relevant or suitable in the circumstances. We have therefore made a revision as set out below.

90. We have made the following changes to the standards:

- Revised standard 2.2 to a) remove words 'in advance' and b) remove reference to 'should'
- Revised standard 7.6 (6.6) to change 'all options' to 'all the relevant options'

[4] Regulator and sector organisations move to tackle significant levels of bullying, harassment and discrimination in optical professions, Regulator & sector bodies to tackle bullying, harassment & discrimination in optical professions

Section 5: Use of digital technologies including artificial intelligence (AI)

5.1 Summary of consultation events

91. We received relatively little feedback on the proposed revisions for digital technologies. One stakeholder suggested, "*I like standard 7 and like that it's been applied to the students as well*". Other stakeholders suggested drafting revisions to reduce ambiguity, e.g. using 'evidence based', 'professional practice' or 'developments in evidence-based practice'. One stakeholder asked whether this standard was necessary, because they already applied their professional judgement to all their practice.

5.2 Summary of consultation responses

<u>Clarity of the proposed revisions</u>

92. Figure 13 shows that three fifths of respondents (23 or 59%) agreed that the proposed revisions are clear, and four respondents (or 10.5%) disagreed. Just over one fifth of respondents (9 or 23%) did not answer the question and three respondents (or 7.5%) neither agreed nor disagreed.

93. Respondents generally agree with the updates to the standards but have expressed some concerns and made some suggestions for improving clarity and specificity of the wording, particularly regarding the use of new technologies like OCT and AI. A recurring theme is the importance of understanding digital technologies and retaining accountability when using digital technologies. Some respondents feel that the standards may be too vague, while others believe there is too much information.

<u>Appropriateness of the proposed revisions</u>

94. Figure 13 shows that of the 39 respondents, 22 (or 56.5%) agreed that the revisions set appropriate minimum expectations, and six respondents (or 15.5%) disagreed. Seven respondents (or 18%) did not answer the question and four respondents (or 10%) neither agreed nor disagreed.

95. Respondents expressed a range of views on the revised standards, with some welcoming the changes and others suggesting they are a pragmatic response to a key area of practice. One respondent questioned the need to tell registrants to use their professional judgement, whereas other responses highlighted the importance of professional judgment when utilising data from digital technologies and raised concern about accountability not being diluted by technology. Some respondents point out that the impact of the standards will depend on how businesses interpret and implement them.

96. There is a concern that the duty to discuss and explain the implications of digital technologies with patients may not be realistic due to their complexity and rapid evolution.

97. Lastly, it is noted that it is crucial for professionals to maintain competencies in traditional 'analogue' eye care and ensure that all patients can access eye care, even if digital technology is not suitable for them. Overall, respondents note the need to ensure that professional standards are maintained without stifling innovation.

98. A sample of the comments we received in response to these questions are in the box below.

"Too vague and concerning that it suggests must use OCT etc to inform if available and could be penalised if hadn't done it and was available" (Optometrist)

"Really important that registrants understand their accountability is not diminished by reliance on emerging technology" (Mediation service)

"The use and implementation of digital technologies will in many instances be taken at a head office level and will therefore be outside of the control of individual registrants. However, where new technology is implemented, we think it is reasonable to expect registrants to maintain their competence by undertaking targeted training when it is appropriate to do so" (AOP)

"Further work would be required on the understanding and capacity by which this should be rolled out. Expecting professionals to be able to make a sound judgement would greatly depend on their individual understandings of data an AI" (Optical consultant)

"*… Additionally, the duty to discuss and explain the implications of digital technologies may not be realistic as their fast pace of progress can be difficult to keep track of. To illustrate, in the GOC engagement sessions we spoke of the challenge of the black box, where technology and algorithms that underpin it may be beyond challenge for normal clinicians…*" (AOP)

"It is important that everyone should still be able to access eye care if digital technology is not suitable for their needs. This is particularly the case when delivering eye care in 'non-clinical' settings such as people's own homes, day centres, and special schools. It is vital professionals are competent and maintain their competencies to deliver 'analogue' eye care and that the increasing use of automated testing does not lead to de-skilling" (SeeAbility)

5.2 GOC response

99. We are pleased that respondents generally welcome the inclusion of a new standard, and the revision of standard 5.3 in the Standards of Practice for Optometrists and Dispensing Opticians, to address the issue of digital technologies. It is our view that this is an emerging area of practice which is likely to benefit patients and the public, however, it is important to recognise that there are risks and limitations which need to be managed effectively.

100. To be clear on our expectations, we are not suggesting that registrants must use digital technologies to inform the care they provide, but that where digital technologies are used, they should be used appropriately, and professional judgement should be applied.

101. We note the feedback around the role that businesses play in the interpretation and implementation of these standards. We are committed to revisiting the use of digital technologies when we review the business standards, to ensure there is alignment between the standards and that expectations of employers are appropriate and made clear.

102. We have not made any further revisions to these standards post-consultation.

Section 6: Equality, diversity, and inclusion

6.1 Summary of consultation events

103. We had a broad discussion on equality, diversity and inclusion at the events. The feedback is best illustrated with reference to the three proposed revisions.

104. Regarding the proposed revision to standard 13.2 (12.2), stakeholders questioned whether the GOC could clarify that professional behaviour includes not tolerating harassment and discrimination in the workplace, and asked whether the standards could go beyond 'protected characteristics', to cover other reasons why an individual may be subject to bullying, harassment or discrimination.

105. With regard to standard 13.4 (12.4), stakeholders commented on the drafting, such as whether the phrase 'online' was specific enough to cover social media, and whether the standard should reference whistleblowing procedures and/or organisational policies. Stakeholders also queried whether the standard should be broadened to a) prevent registrants making disparaging comments about competitors, and b) clarify that making disparaging comments about a colleague, not only makes patients doubt their competence, but also risks undermining the confidence of other colleagues.

106. Some stakeholders welcomed the proposed new business standard requiring employers to provide support for staff who have experienced discrimination, bullying or harassment. However, some practical concerns were raised including whether smaller organisations would have policies in this area, at what point employer support should begin, what adequate support looks like, and whether the term 'staff' includes locums.

107. In terms of the proposed revision to the title of standard 3.3 in the Standards for Optical Businesses, one stakeholder suggested that 'supervised' and 'supported' should be kept separate as supervision is a large area to cover, whilst another stakeholder suggested that the word 'mentored' should be added.

6.2 Summary of consultation responses

6.2.1 Responses regarding the proposed revisions to the Standards of Practice for Optometrists and Dispensing Opticians and Standards for Optical Students

Clarity of the proposed revisions

108. With reference to Figure 14, over two thirds of respondents (25 or 64%) agreed that the standards were clear. Four respondents (or 10%) disagreed,

and eight respondents (or 20.5%) did not answer the question. Two respondents (or 5%) neither agreed nor disagreed.

109. Across the consultation responses for this question, a recurring theme is the language used, particularly concerning the term 'protected characteristics'. Some respondents have provided detailed feedback on specific standards, for example, there is a suggestion to add 'and social media' to Standard 13.4 for clarity on online communications.

<u>Appropriateness of the proposed revisions</u>

110. When asked whether the proposed revisions set appropriate minimum standards for registrants, Figure 14 shows that just under two thirds of respondents (24 or 61.5%) agreed. Only four respondents (or 10.5%) disagreed. Nearly a quarter of respondents (9 or 23%) did not answer this question and two respondents (or 5%) neither agreed not disagreed.

111. There is support for the revisions, in particular adding explicit references to being inclusive and non-discriminatory, however, there is also a call for stronger emphasis on a) providing appropriate care to diverse patient groups, b) tackling health inequalities and c) delivering equality to the communities served.

112. The importance of refraining from disparaging comments and ensuring patients do not doubt staff skills is noted, while another response emphasises the need to protect truthful and necessary disclosures under the Duty of Candour.

113. A sample of the comments we received in response to these questions are in the box on the following page.

“Strongly agree on refraining from comments made in front of patients and making the patient doubt the staffs skills.” (Student dispensing optician)

“The amendments to the relevant standards appear to be appropriate, with the following suggested amendments: Standards 13.2: the language of ‘protected characteristics’ might have a different definition or no definition in Northern Ireland which does not have the Equality Act 2010. This will also need to be considered for the consequential change proposed for 2.2.5 of the Standards for Optical Businesses…” (FODO)

“…We thought the standards could be stronger on emphasising the need to provide appropriate care to diverse groups of patients. Although there is a specific reference to providing reasonable adjustments for disabled patients at 13.8 there appears to be limited reference to the need to be equipped to provide suitable care to other groups, including culturally competent care…” (PSA)

“Needs to have more focus on expectations for delivering equality to the communities they serve. At the moment the focus appears to be mostly on interactions between colleagues” (Ophthalmologist)

6.2.2 Response regarding the proposed revisions to the Standards for Optical Businesses

Clarity of the proposed revision

114. Figure 15 shows that half of the 39 respondents (20 or 51.5%) agreed that the standard was clear, and six respondents (or 15.5%) disagreed. A quarter of respondents (10 or 25.5%) did not answer the question, and three respondents (or 7.5%) neither agreed nor disagreed.

115. Respondents generally support the initiative to address discrimination, bullying, and harassment in the workplace, however, there is a consensus that the standards proposed are too vague or high level and require more specificity to be effectively implemented. Several respondents propose rephrasing the standard to a) emphasise the availability of support rather than mandating the provision of it, b) allow for more flexibility and support to be provided both internally and externally, and c) acknowledge the complexities of HR processes. One response calls for a reference to the Equality Act 2010 to ensure compliance with existing legislation.

Appropriateness of the proposed revision

116. Figure 15 shows that just under half of all respondents (19 or 49%) agreed that the revision sets appropriate minimum expectations, and six respondents (or 15.5%) disagreed. A quarter of respondents (10 or 25.5%) did not answer the question, and four respondents (or 10%) neither agreed nor disagreed.

117. The addition of clear expectations for inclusivity and support for staff facing workplace issues is welcomed by some respondents, especially in light of findings from GOC's registrant survey[5] highlighting the prevalence of such issues. However, the need for clarity on what support is available and how it can be accessed is emphasised, with a preference for including external support options. The importance of businesses having clear policies in place, giving staff information on raising concerns or complaints, and having guidance on behaviour was also highlighted.

118. Some respondents raised concern about the practical application of these standards on the ground, and some worry about creating a system that allows registrants to blame employers for issues, without proper basis.

119. A sample of the comments we received in response to these questions are in the box on the following page.

[5] Registrant Workforce and Perceptions Survey 2023, goc-registrant-workforce-and-perceptions-survey-2023-research-report.pdf (optical.org)

We completely support the principle of support being provided to staff who have experienced discrimination, bullying or harassment. Depending on individual circumstances, the employee might not seek/want this support from their employer. We would suggest that the standard is amended so that the employee is aware of all support available (which may be external if preferred by the employee).” (Optometry Wales)

“We welcome the additions to the business standards to make clear expectations in relation to inclusivity and supporting staff who have faced discrimination, bullying or harassment. We note that the GOC Registrant Workforce and Perceptions Survey 2023[1] found that registrants faced a high level of harassment, bullying and abuse in the workplace. In light of this, making clear that optical businesses have a responsibility to support staff in these circumstances is particularly welcome.” (PSA)

“Whilst welcoming the GOC's recognition of the findings from the 2023 registrant survey, we are concerned that the standard is too “high level” to have a meaningful impact for registrants. We suggest the standard is amended to specifically include “internal and/or external support for staff who have experienced bullying etc..” to address the fact that the issue may well be within the optical business itself and staff have a right to seek external support and guidance…” (ABDO)

6.3 GOC response

120. We are pleased that our proposed revisions around EDI are welcomed by many. The 2024 Public Perception Survey shows that patients from an ethnic minority background and those with a disability, continue to be less satisfied with the care/service provided when compared with white patients and those without a disability. As the regulator we are committed to taking action to reduce inequality and discrimination, by setting explicit expectations of registrants in relation to EDI.

121. We note the request to widen the scope of standard 13.2 (12.2) to include other characteristics which could lead to bullying, harassment, abuse or discrimination and have considered this with reference to the Registrant Survey 2024. The survey findings show broadly similar rates of bullying, harassment, abuse and discrimination as the 2023 survey, which indicates that this remains a “live” issue. The data also shows that discrimination experienced by registrants tends to relate to race, sex, age and religion, all of which are covered by existing equalities legislation. Currently there is insufficient data to suggest a need to widen the scope of the standard.

122. On the issue of whether the term ‘staff’ includes locums, we would interpret this to be the case. We note that there is no legal definition of ‘staff’, and we can therefore reasonably interpret this to include self-employed locums or contractors, as well as employees and workers.

123. In response to concerns about the lack of emphasis on caring for diverse patients, we have strengthened other sections of our standards to address the importance of safe and effective care for patients in vulnerable circumstances. Addressing inequalities is at the centre of our draft corporate strategy 2025-30, although we acknowledge there is more we can do to improve experience of eye care than access to eye care.

124. We have considered all the comments on the proposed new standard under 3.3 of the Standards for Optical Businesses. Our view is that the existing wording would allow for support to be provided by an external provider where appropriate. We are concerned that redrafting the standard to require employers to provide “access to support”, could in effect enable employers to simply signpost staff to external providers, without taking any responsibility for the support provided. Therefore, we have decided not to make changes.

125. Finally, we acknowledge the comment highlighting that the Equality Act 2010 does not apply in Northern Ireland and so the term ‘protected characteristics’ is not applicable across all four nations. We also acknowledge that Scotland and Wales have enacted the ‘socio-economic duty’ set out in the Equality Act meaning there are variations in relation to what constitutes a ‘protected characteristic’ across Great Britain.

126. We have made the following changes to the standards:

- Revised standard 13.2 (12.2) to remove the phrase ‘protected characteristics’ and replace it with ‘characteristics set out in relevant equalities legislation’
- Revised business standard 2.2.5 to remove the phrase ‘protected characteristics’ and replace it with ‘characteristics set out in relevant equalities legislation’

Section 7: Social media, online conduct, and consent

7.1 Summary of consultation events

127. A number of stakeholders made comments about the drafting of the standards on social media, online conduct and consent, such as using ‘personal data’ instead of ‘patient data’ and ‘permission’ rather than ‘consent’. They also queried whether standard 3.3 captured all the ways in which images might be shared, e.g. for research and education.

128. One stakeholder highlighted the benefits and risks associated with sharing images, drawing a distinction between an image shared for the purpose of getting advice on treatment options and sharing an information just for interest. “*So if you had … a WhatsApp group with a local consultants or local NHS Trust then actually you may say I've got this person here, they've got emergency eye condition and share the image….do you think any treatment today or not? I think that’s direct patient care in the patient interest, and I think that’s absolutely proper”* and later, “*But if you've got a WhatsApp group of let's say 500 people…and that image could potentially be downloaded onto each of those 500 people's devices…not to ask consent for that…it just doesn’t feel right…”.*

129. Other stakeholders raised similar concerns about not preventing registrants from obtaining a second opinion, whilst some stakeholders raised concern about images being shared without consent and then monetised for development of AI databases.

130. A number of stakeholders queried whether retinal images without names are in fact identifiable now, or in the future, as every retinal image is unique. One suggestion was to reference ICO guidance on special category data, whilst other stakeholders felt that the issue went beyond what was legally acceptable or not and was an issue of patient and public trust in the profession.

131. One final point raised by stakeholders was the apparent disconnect between standard 3.3 and 14.3 (13.2) and concern that a registrant could share an anonymised image in accordance with 14.3 (13.2), without realising that they need consent as set out in standard 3.3. Some stakeholders also felt that the revision to standard 14.3 (13.2) might encourage registrants to share information on social media.

7.2 Summary of consultation responses

<u>Clarity of the proposed revisions</u>

132. Figure 16 shows that just over half of respondents (21 or 54%) agreed that the proposed revisions were clear, and nine respondents (or 23%) disagreed. Nearly a quarter of respondents (9 or 23%) did not answer the question.

133. Respondents have expressed concerns about the clarity of the proposed revisions to the standards, particularly regarding consent and sharing of patient data. There is a consensus that the term "consent" is being conflated with different meanings, which could lead to confusion. Many agree that sharing patient data should comply with existing data protection laws and organisational policies.

134. One respondent feels that the standards are clear and supportive of minimum behaviour for professionals and students when sharing images, while others believe that the standards still lack specificity.

<u>Appropriateness of the proposed revisions</u>

135. Figure 16 also shows that just over half of respondents (22 or 56.5%) agreed that the proposed revisions set appropriate minimum expectations. Eight respondents (or 20.5%) disagreed and nearly a quarter of respondents (9 or 23%) did not answer the question.

136. The use of social media and other communication platforms like WhatsApp for professional purposes is a contentious issue, with some respondents suggesting that it should be discouraged or clarified, or that the changes do not go far enough. One respondent raised concern about how past social media posts, made before joining the register, might be treated. Conversely, others view the revisions to the standards as positive and an excellent evolution. An education provider finds the standards clear and supportive in setting out the minimum behaviour expected from professionals and students sharing images.

137. A detailed response suggests that explicit patient consent should be obtained before sharing anonymised images online, even for educational reflective practice purposes, and recommends amending the standard to reflect this. It also emphasises the potential future risks of reidentification from anonymised images due to advancements in technology.

138. Advertising and marketing standards have been highlighted as areas needing clearer guidelines to prevent misleading claims and ensure patient understanding.

139. The complexity of the area and the need for further consideration and consultation are mentioned, especially regarding legal aspects such as whether explicit consent is required for transferring patient information as part of a referral or when sharing images. Respondents are seeking additional clarification on what constitutes legal requirements versus minimum expectations within the standards.

140. A sample of the comments we received in response to these questions are in the box on the following page.

“We support the changes made to the standards to strengthen expectation around social media use. Given that social media use has been a particularly high-profile issue within healthcare regulation and a focus for other regulators; in our view the content on the standards on this issue is quite minimal, in particular in relation to the balance between expressing personal views and maintaining appropriate professional standards…” (PSA)

“…Social media, in my view, is not an acceptable forum to share patient information. Expansion on how patient consent would be documented and kept up to date” (Ophthalmologist)

“I'd like to see use of social media actively discouraged. I don't think we should be using WhatsApp for professional use… and the use of secure systems - e.g. NHSmail – encouraged…” (Optometrist)

“Standard 14.3 (13.2) The proposed change to this standard may result in registrants believing it is acceptable to share medical information online and on social media without the patient’s explicit consent, even if the identifiable information has apparently been removed. This includes special category data, which is unique and could be processed to become biometric in future, such as retinal and iris images…” (College of Optometrists)

We strongly disagree with the proposed amendments to 3.3 because it confuses two different definitions of consent. The existing standard 3.3 specifically relates to patients’ consent to care, and it is correct. The proposed revised wording inserts a clause with respect to sharing patient data. The Data Protection Act 2018 and GDPR requires healthcare providers to specify an appropriate lawful basis for processing data. In data protection legislation the term ‘consent’ is one lawful basis, but not an appropriate lawful basis for processing patient data. As a result, inserting the wording “when sharing patient data with others” into 3.3 is problematic but also unnecessary” (FODO)

“The standard as drafted could lead to confusion, as it appears to conflate the consent process and the data sharing process. Generally, within healthcare, processing of patient data will be conducted under the remit of “legitimate interest” or as special category data with regard to health and social care or public health. It is our view that if this standard is to include data-sharing then it should make it clear that consent only applies when you wish to share the data for reasons other than in relation to the patient’s care…” (AOP)

7.3 GOC response

141. We note that there are mixed views about the use of social media and online conduct, and particular concern about the issue of consent in relation to

sharing retinal images. We recognise the need to strike a balance between addressing any public protection concerns about the use of social media or online activity more generally, without unfairly limiting our registrants' freedom of expression or ability to practise their professions.

142. It was suggested that addition of the phrase "when sharing data with others" to standard 3.3 is problematic, as it conflates two different types of consent. On reflection we agree this is the case. Having considered the issue further, we have concluded that it would be disproportionate to require registrants to seek patient consent to share anonymised images, when this is not required by law. We are not seeking to stifle professional discourse or prevent registrants from seeking clinical and professional support, where appropriate. Our existing Standard 14.6 (13.5), which requires registrants to, "Only use the patient information you collect for the purposes it was given, or where you are required to share it by law, or in the public interest" already reflects this position. However, we recognise that technology is developing rapidly, and data protection laws may change during the lifetime of our standards. The Information Commissioner's Office has a body of developing guidance and practice on sharing of patient data, which we will use to assist us in applying legal requirements to optical practice.

143. In summary, the consultation process has been a useful opportunity to discuss these issues, which are complex. On balance, we consider that the existing standards already cover this issue appropriately and have decided not to make any changes to standard 3.3.

144. We have not made any further revisions to standard 14.3 (13.2) post-consultation.

Section 8: Maintaining appropriate professional boundaries, including prevention of sexual harassment

8.1 Summary of consultation events

145. Stakeholders were generally positive about these issues being addressed within the standards, suggesting that it was a difficult topic which had been dealt with well and that the GOC are right to clarify behaviours, actions and communications. However, concerns were raised around whether the proposed revisions to the standards could prevent consensual relationships between registrants.

146. Stakeholders commented on the drafting of the revisions, suggesting a review of specific phrases such as ‘take particular care…’ and ‘with the effect or purpose of causing offence, embarrassment, humiliation, or distress’, and querying whether other phrases such as ‘sexual’ or ‘sexual behaviour’ would be universally understood.

147. Further feedback was received on the scope of the proposed revisions, with some stakeholders suggesting that the standards should also cover favouritism and nepotism, that standard 15.1 (14.1) could be broadened out to include family members of patients for example, and that students could be considered vulnerable, and this may need to be reflected in the standards. One final point made in a couple of events, was that removing the word ‘sexual’ from the proposed new standard, would mean that registrants could not act in a manner which caused offence, embarrassment, humiliation or distress, whether that was sexually motivated or not.

8.2 Summary of consultation responses

8.2.1 Responses regarding the proposed revisions

<u>Clarity of the proposed revisions</u>

148. Figure 17 shows that of the 39 respondents, just over half (21 or 54%) agreed that the revisions to the standards were clear. Five respondents (or 13%) disagreed and nearly a quarter of respondents (9 or 23%) did not answer the question. Four respondents (or 10%) neither agreed nor disagreed.

149. Some respondents found the proposed additions to be sensible and welcome, while others consider them too vague or not going far enough. One response suggests adding the word "all" to encompass all behaviours, actions, and communications.

150. The importance of explicit definitions for terms such as “appropriate” were highlighted, to prevent challenges to the standards. Several responses suggest that the wording around acting in a "sexual way" is vague or odd and could benefit from further clarification.

<u>Appropriateness of proposed revisions</u>

151. When asked whether the proposed revisions set appropriate minimum expectations, Figure 17 shows half of respondents (20 or 51%) agreed. Six respondents (or 15.5%) disagreed and a fifth of respondents (or 20.5%) did not answer the question. Five respondents (or 13%) neither agreed not disagreed.

152. The feedback indicates a general consensus on the importance of clear, explicit standards that differentiate between types of professional relationships. There is also recognition of the need to take boundary violations seriously, as highlighted by media reports and registrant experiences. However, concerns were raised about whether the standards would allow for personal relationships between colleagues or family members working together, and respondents acknowledged that existing relationships between registrants may complicate the application of these revised standards.

153. There is a call for a clear distinction between relationships with patients and those with colleagues, similar to the General Medical Council (GMC) standards, with some suggesting splitting the standard into two separate ones.

154. Concerns about commercial pressures affecting professional judgement were raised, with one respondent noting the conflict between clinical responsibilities and retail demands like 'chair time' and 'conversion rates'. They emphasise the importance of ensuring that commercial interests do not compromise patient safety. The impact of these pressures on patient care, especially in the context of domiciliary care, is highlighted as an area needing further discussion and action.

155. A sample of the comments we received in response to these questions are shown in the box on the following page.

“All of these boundaries should be inherently understood by the basic practice of being a “professional”, but the more explicit additions to the standards remove any scope for grey areas and are welcomed” (AOP)

“We welcome the additions made to the standards in relation to professional boundaries. We have previously highlighted concerns about regulators not always taking boundary violations between colleagues seriously enough and the changes should help to address this issue. This issue has also been prominent in the media and external environment with some registrants reporting poor behaviours in the workplace.” (PSA)

“Concerned that this is not specific enough - does this mean that staff members can never have a consensual relationship? How would this affect families working together?” (Bexley Bromley and Greenwich LOC)

“…We support this revised standard and recommend that the GOC develops further guidance on maintaining appropriate boundaries. As acknowledged by the GOC in paragraph 109 of the consultation document, some registrants are already in relationships with their colleagues or others with whom they have a professional relationship, which may make this standard more challenging to implement and scrutinise in some instances” (College of Optometrists)

8.2.2 Responses regarding the proposed new standard on sexual harassment

<u>Specificity of proposed new standard</u>

156. Figure 18 shows that two thirds of respondents (26 or 67%) agreed that the proposed standard addresses the issue of sexual harassment sufficiently. Just two respondents (or 5%) disagreed, and a quarter of respondents (10 or 25.5%) did not answer the question. One respondent (or 2.5%) neither agreed nor disagreed.

157. Respondents generally support the inclusion of a new standard to address sexual harassment and there is a consensus that all forms of sexual harassment are unacceptable and should be swiftly investigated and acted upon. That said, respondents also raised two key considerations, a) protection for registrants against vexatious complaints b) a need to make clear that existing relationships should have defined boundaries within the workplace.

158. The need for optical businesses to have clear policies on sexual harassment is highlighted, along with the importance of a workplace culture that promotes dignity and respect.

Clarity of the proposed new standard

159. When asked whether the new standard was clear, Figure 18 shows that over half of respondents (22 or 56.5%) agreed, and six respondents (or 15.5%) disagreed. A quarter of respondents (10 or 25.5%) did not answer the question, and one respondent (or 2.5%) neither agreed nor disagreed.

160. Specific concerns were raised about the phrase "you must not act in a sexual way" as it was deemed confusing. One respondent recommends adding a statement to the introductory text setting out the GOC's interpretation of "acting in a sexual way", whilst another respondent recommends, we mirror UK legal definitions of sexual harassment.

161. Another respondent recommends removing sections that discuss the "intended effect" of behaviour, arguing that certain behaviours are not appropriate regardless of intention. Some respondents suggest looking to other professional bodies, such as the GMC for guidance on how to frame the standards and providing examples of unacceptable sexual behaviours, similar to those listed in the GMC guidance.

162. A sample of the comments we received in response to these questions are in the box on the following page.

“The inclusion of such a standard could offer a better mechanism of protection for victims of sexual harassment or abuse, no matter what form it presents itself.” (AOP)

“*In relation to the proposed new standard regarding the requirement not to act in a sexual way, whilst we agree with the sentiment and support the addition, we suggest that further consideration should be given to the wording. Whilst we recognise that the wording: ‘with the effect or purpose of causing offence, embarrassment, humiliation, or distress’ may be intended to avoid outlawing consensual relationships between colleagues, we believe it could be strengthened to make clear that 1) there should be no acceptance of sexual behaviours with patients given the power imbalance, and 2) sexualised language or behaviour is not appropriate in the workplace, irrespective of its purpose or effect…*”(PSA)

“The wording in this new standard could be clearer. The phrase “you must not act in a sexual way” is confusing and ill defined. We suggest that “act in a sexualised manner towards patients” is simpler to understand…” (ABDO)

“Standard 15 new proposed standard: this refers to acting in a ‘sexual way towards patients, students, colleagues, or others with whom you have a professional relationship, with the effect or purpose of causing offence, embarrassment, humiliation, or distress’. This is based on the GMC standards which uses similar wording (GMC Standards, Maintaining personal and professional boundaries 342). However, this particular GMC standard refers only to colleagues, and not to patients. The GMC also has an additional and stronger standard (243) which relates to sexual behaviour toward patients, which does not refer to effect or purpose and is therefore clearer about the prohibition. The GOC standard should therefore, like the GMC, make clear that sexual behaviour toward a patient is not appropriate in any circumstances…” (FODO)

8.3 GOC response

163. We are pleased to note that there is considerable support for implementing a new standard which addresses sexual harassment including between colleagues and revising the existing standards 15.1 (14.1) to clarify that maintaining boundaries applies to behaviours, actions and communications.

164. We note stakeholder feedback suggesting that the new standard on sexual harassment should be split into two standards, with one addressing patients and the other addressing colleagues and others. Having considered this further, we agree that having separate standards would allow us to differentiate our expectations and make clear that consensual relationships

with colleagues may be acceptable, so long as appropriate professional boundaries are maintained at work and the relationship does not result in an inappropriate work environment.

165. A drafting change was suggested to underline that registrants must not create an intimidating, degrading, humiliating or offensive environment for colleagues, students or others with whom they have a professional relationship, regardless of intent. Having reflected on this we agree and have revised the standard accordingly.

166. We have reviewed use of the phrase 'You must not act in a sexual way…' and identified alternative wording, 'You must not engage in unwanted conduct of a sexual nature…' This wording is consistent with the Worker Protection (Amendment of the Equality Act 2010) Act 2023.

167. It has been suggested that employers should have clear policies on sexual harassment and foster a workplace culture that promotes dignity and respect. We will revisit this issue as part of the forthcoming review of business standards. In the interim we note that the Worker Protection (Amendment of the Equality Act 2010) Act will take effect in England, Scotland and Wales in October 2024 and will place a duty on employers to take 'reasonable steps' to prevent sexual harassment. This could include implementing policies and procedures and setting clear expectations around appropriate values and behaviours in the workplace.

168. We acknowledge stakeholder concerns around the potential for vexatious complaints and note that such complaints would not meet our fitness to practise acceptance criteria and would not therefore be investigated.

169. We recognise that the patient experience is not just dependent on the individual providing the care but also the clinical environment in which care is delivered, and commercial considerations can affect the quality of care. We note stakeholder concerns in relation to commercial pressures and will revisit this issue as part of our forthcoming review of the business standards.

170. To improve the proposed statement on sexual harassment, we have:

- Redrafted it as two separate standards.

"You must not engage in unwanted conduct of a sexual nature with students, colleagues or others with whom you have a professional relationship. You must not create an intimidating, degrading, humiliating or offensive environment, whether intended or not. Maintaining sexual boundaries applies to your behaviours, actions and communications"

"You must not engage in conduct of a sexual nature with patients or violate their dignity. Maintaining sexual boundaries applies to your behaviours, actions and communications"

171. We recognise that the new standard has placed additional expectations on registrants. Therefore, after the revised standards are published, we will develop guidance on maintaining appropriate sexual boundaries, and this will be subject to public consultation.

Section 9: Registrant health

9.1 Summary of consultation responses

Clarity of the proposed revisions

172. Figure 19 shows that of the 39 respondents, two thirds (26 or 67%) agreed that the revisions are clear, and three respondents (or 7.5%) disagreed. Just under a quarter of respondents (9 or 23%) did not answer the question and one respondent (or 2.5%) neither agreed nor disagreed.

173. Respondents generally support the revisions to the standards but have requested further clarity. One respondent suggests that the wording should be more specific to practitioner health, like the GMC's revised Good Medical Practice standard. Other respondents emphasised the need for clarity regarding self-awareness of the risks posed by one's health and the importance of seeking professional advice. There is support for the additional wording under standard 11.4 (10.3) and a suggestion to include "employer/training provider" in student standard 10.3 for broader applicability.

Appropriateness of the proposed revisions

174. When asked whether the revisions set appropriate minimum expectations, Figure 19 shows that two thirds of respondents (25 or 64%) agreed, and two respondents (or 5%) disagreed. Just under a quarter of respondents (9 or 23%) did not answer the question, and three respondents (or 8%) neither agreed nor disagreed.

175. One respondent welcomed the additional patient focus in the revised standards, whilst another respondent suggested that the standards should also address situations where colleagues express concerns about a professional's fitness to practise, as self-insight may not always be present.

176. Two specific concerns relating to students were raised, a) the need for clearer guidance regarding medical fitness to train, especially concerning mental health crises and the need for adjustments in study for students, and b) whether the standards should specify the prohibition of training during a period when a student registrant's fitness to practise is in question.

177. A sample of the comments we received in response to this question are in the box below.

> *"This seems a sensible addition to the standards…"* (ABDO)
>
> *"Perhaps should also include, if another colleague has expressed concerns about your fitness to practice you should seek advice. At the moment the onus is on the professional having insight which is not always the case."* (Ophthalmologist)
>
> *"The standards need to be clearer. In some cases, people may not be aware that they pose a risk and should heed the advice of a suitably qualified professional."* (Optical professional/representative body)

9.1.2 Responses regarding the proposed new standard on registrant health

<u>Specificity of proposed new standard</u>

178. Figure 20 shows that almost two thirds of respondents (23 or 59%) agreed that the new standard addresses the issue sufficiently, and five respondents (or 13%) disagreed. Almost a quarter of respondents (9 or 23%) did not answer the question, and two respondents (or 5%) neither agreed nor disagreed.

179. There is support for the introduction of the new standard, with numerous respondents agreeing that staff should not work when they could spread diseases to vulnerable patients. Some respondents believe that the responsibility for enforcing health measures should fall on optical businesses rather than individual registrants, and that GOC should provide clear communications when a serious communicable disease becomes a threat. Additionally, there is a suggestion that the Standards for Optical Businesses need to reflect these considerations.

180. One respondent feels that a scenario where an individual may unknowingly be a carrier of a communicable disease is not adequately addressed. Another respondent advises that in cases of doubt, practitioners should immediately stop practicing and seek medical advice.

<u>Clarity of the proposed new standard</u>

181. Figure 20 shows that half of respondents (20 or 51.5%) agreed that the standard is clear, and just under a quarter of respondents (9 or 23%) disagreed. A quarter of respondents (10 or 25.5%) did not answer the question.

182. Respondents have expressed concerns about the ambiguity of the term "serious communicable disease", both in terms of defining it and the potential for differing interpretations. Several respondents have recommended that the new standard should signpost registrants to their nation's public health advice, with one respondent acknowledging that this may differ between the four nations. Alternatively, there is a suggestion to use the term 'high consequence infectious diseases' to reduce confusion.

183. One respondent raised a specific concern around use of the term 'serious communicable disease', highlighting that the GMC uses the term in a different policy context, which may be confusing for registrants.

184. A sample of the comments we received in response to this question are in the box below.

> *"We support the additional standard on communicable diseases."* (PSA)
>
> "*It would seem a sensible inclusion to suggest that registrants follow their nation's public health advise rather than introduce another additional standard*" (ABDO)
>
> "*…The suggestion from the consultation document is for registrants to follow public health guidance available at the time, however this is not reflected in the new standard…"* (FODO)
>
> "*While the necessity for more plainly stated measures in a post-COVID world is understandable, the inclusion of this standard feels arguably superfluous for individual registrants. These measures should be basic common sense, be a part of wider public health measures, or the responsibility for optical businesses to enforce. The forthcoming substantial review of GOC Business Standards would be the more sensible place to fully address this*." (AOP)

9.2 GOC response

185. We are pleased to note that there is support for the introduction of a new standard, addressing serious communicable diseases.

186. It was suggested that our use of the phrase 'serious communicable disease' differs in context from the GMC's use of the phrase, and this could cause confusion. We acknowledge that there are differences in the policy intention, not least because the GMC standards require vaccination against serious communicable diseases, whereas our standards do not and so our standards

need to have a slightly different focus. We disagree that this will cause confusion for registrants, as we have made our interpretation clear through the standard and clarified it as part of this report.

187. We note that our existing standards require registrants to raise a concern if they feel that a colleague could present a risk to patient safety, as outlined in standard 11.3 (10.2) which states, “Promptly raise concerns about your patients, colleagues, employer or other organisation if patient or public safety might be at risk and encourage others to do the same. Concerns should be raised with your employing, contracting, professional or regulatory organisation as appropriate. This is sometimes referred to as ‘whistleblowing’ and certain aspects of this are protected by law.”

188. We acknowledge the feedback in relation to employers’ responsibilities around registrant health and will revisit this issue as part of the forthcoming review of the Standards for Optical Businesses.

189. We have made the following changes to the standards:

- Standard 10.3 in the Standards for Optical Students has been revised to include reference to ‘employer’
- The new standard on serious communicable disease has been updated to include the following, “For guidance on serious communicable diseases, refer to current public health guidance.”

Section 10: Other changes and areas for consideration

10.1 Compliance with legislation

10.1.1 Summary of consultation responses

Clarity of the introductory statement

190. Figure 21 shows that out of 39 respondents, three quarters (29 or 74.5%) agreed that the introductory statement is clear and two (or 5%) disagreed. Eight respondents (or 20.5%) did not answer the question.

191. There are varying views as to whether the proposed statement should include specific examples of legislation. One respondent called for a more generic and high-level overview of legal and contractual requirements, rather than inclusion of a small number of examples, whilst other respondents suggest the examples are removed and that adherence to legal requirements should be obvious and not need explicit mention. Conversely, some respondents feel the range of example legislation should be expanded to include areas impacting clinical care, such as disability laws, laws around adults with incapacity, the Human Medicines Regulations 2012, the Equality Act 2010 and Advertising Standards Authority codes of practice.

192. One respondent highlighted the need for inclusive language that considers regional terminology, such as "Health Service" instead of "NHS".

Appropriateness of the introductory statement

193. When asked whether the proposed introductory set appropriate minimum expectations, Figure 21 shows that just under three quarters of respondents (28 or 72%) agreed and three respondents (or 7.5%) disagreed. Eight respondents (or 20.5%) did not answer the question.

194. Respondents expressed concerns about the accountability and scope of legal responsibilities for practitioners. There is a recognition that while registrants should comply with legal requirements, the ultimate responsibility often lies with the contractor, and registrants should not be held accountable for service aspects beyond their control. One respondent feels the statement does not go far enough and suggests that breaches should be explicitly regarded as substandard conduct.

195. A sample of the comments we received in response to these questions are in the box below.

> **“***Considering the added focus of EDI matters on this review of the standards, we feel that specific mention of the legal requirements from the Equality Act (protected characteristics) would help to protect registrants further.”* (AOP)
>
> *“We did not feel the range of example legislation was sufficiently directed at areas impacting clinical care – we felt a benefit in including the areas of say disability law, or law around adults with incapacity.”* (Education provider)

10.1.2 GOC response

196. We are pleased to note strong support for the inclusion of a new statement on compliance with legislation, whilst recognising the feedback in relation to the drafting.

197. We have considered whether to include the Advertising Standard Authority’s Code of Conduct. We note that the code is not legislative and that the issue of advertising is sufficiently addressed by standard 16.6 (15.6) which states, “Do not make misleading, confusing, or unlawful statements within your communications or advertising.”

198. We note stakeholder feedback on the scope of legislation referenced in the statement and have broadened it, as set out below.

199. We have made the following changes to the introductory statement.

- Added reference to ‘legislation relating to equalities’
- Added reference to ‘medicines’ legislation, and
- Removed the sentence ‘You may also have other requirements to adhere to if you provide NHS services. If this is the case, you should ensure that they are met’ and replaced it with, ‘If you provide national health services, you should adhere to any additional requirements.”

10.2 Minor amendments and other issues for consideration

200. We asked respondents whether they had any other comments about the proposed revisions or additions to the standards and whether there was anything else we should consider as part of the proposed changed.

Comments on the proposed revisions or additions

10.2.1 Summary of consultation responses

201. A small number of additional points were raised in this section and have been summarised below. Some responses to this question have been addressed under section 12:

    a) Questions were raised about how the revised standards will align with new education requirements and whether they will be adaptable enough to accommodate the CLiP scheme and variations in student training.
    b) The decision to replace 'medical devices' and/or ‘optical appliances’ with 'appliances' in the standards was criticised for potentially creating confusion, as 'medical device' has a clear legal definition.

10.2.2 GOC response

202. We acknowledge the stakeholder comments above and have set out our response to each point below.

203. The College of Optometrists has oversight of the CLiP scheme and GOC approved qualification providers are responsible for managing the associated placements. The College of Optometrists and qualification providers are responsible for ensuring that the scheme meets our education and training requirements, and our standards of practice.

204. We have used the word ‘appliances’ to ensure alignment with The Sale of Optical Appliances Order of Council 1984 and to recognise that ‘appliances’ could include zero powered lenses. We note that ‘appliance’ is not defined within the regulation and consider it would not be appropriate to seek to define it for the purpose of the standards.

205. As part of this review, we have also considered whether it is appropriate for our Standards for Optical Businesses to continue to state, “These standards apply to all optical businesses who are registered with the GOC. However, for the benefit of patients and the public, we would expect all optical businesses to meet them, regardless of whether or not they are currently required to register with the GOC.” At present we do not regulate all optical businesses and have no means of enforcing the standards against non-registrants, so we do not consider this statement remains appropriate and have removed it from the introduction.

206. We have made the following amendment:

- Removed the following statement, “However, for the benefit of patients and the public, we would expect all optical businesses to meet them, regardless of whether or not they are currently required to register with the GOC.”

Comments on other areas to be considered

10.2.3 Summary of consultation responses

207. We asked stakeholders if there was anything else we should consider as part of the proposed changes. Figure 7 shows that just under half of respondents (17 or 43.5%) said no, just over a quarter of respondents (11 or 28%) said yes, and four respondents (or 10.5%) were not sure. Seven respondents (or 18%) did not answer the question.

208. The need for clearer guidance on the responsibilities of supervisors is highlighted, especially in relation to decisions about students’ social media use and competency checks. Some responses suggest that the standards should include more on leadership, mentorship, and the contribution to education and training within the profession.

209. There are calls for increased regulation and training for optometrists dealing with vulnerable groups, such as those with disabilities, to ensure equal access to care.

210. A sample of the comments we received in response to this question are in the box on the following page.

“Our general opinion is that most of the proposed revisions to the existing standards are uncontentious. They mainly serve as a welcome culturally sensitive update to both patient needs, and to wider principles of Equality, Diversity and Inclusion (EDI)” (AOP)

“…SeeAbility would like to see increasing numbers of people having sight tests and for optometrists and dispensing opticians to have a clear understanding of the competencies expected of them in providing this service. We also believe that eye care services for people with learning disabilities need to be more effectively publicised to promote an improved uptake” (SeeAbility)

“…Whilst we welcome the mention of education as an example of leadership in the introduction, we feel that as regulated healthcare professionals, optometrists and dispensing opticians should be under a specific obligation to contribute to sharing good practice through education. We think it should be a standard, and accordingly be associated with specific obligations or a domain in CPD” (College of Optometrists)

“We see this revision of standards as an opportunity to align with other healthcare professions in relation to the culture of leadership and management in relation to supervision and/or mentorship of colleagues. This does not need to be a formalised relationship, but the opportunity to contribute to the education, training and development of the wider team or others. We feel this focus is missing from the revised standards” (Education Provider)

10.2.4 GOC response

211. We acknowledge the stakeholder feedback about guidance for supervisors. As explained in the consultation, we are not proposing to make any changes to the standard on supervision at this time. We have recently commissioned research to develop a risk-based framework on the testing of sight as part of a review of the 2013 statement on the testing of sight. This research may well have implications for our standards relating to supervision so we will review standard 9 once our review of the 2013 statement has completed.

212. We note the comments regarding leadership, mentorship, and contributing to education and training and consider these issues have been sufficiently addressed under section 1 of this report.

213. The Call for Evidence on legislative reform did not provide sufficient evidence of patient harm to justify changing the list of restricted functions. However, we have made changes to the standards to support the care of patients in vulnerable circumstances and have committed to publishing guidance to

contextualise our expectations. We will consider the feedback as part of development of any future guidance.

Section 11: General questions

214. This section summarises the feedback we received in response to consultation questions related to all of our standards, rather than feedback on the changes we proposed.

11.1 Expectations of students and fully qualified registrants

11.1.1 Summary of consultation events

215. At the consultation events, stakeholders expressed diverse views on whether we should have the same expectations of students, as we do for fully qualified registrants. A student stakeholder suggested that expectations should be similar, but not identical, noting that the end goal is to become a fully qualified registrant. Another stakeholder suggested, "…*there is a difference in terms of remit from a student at university compared to when they are a pre-registered on the scheme for registration…"."*

11.1.2 Summary of consultation responses

216. We asked stakeholders whether there should be any difference in our expectations of students and fully qualified registrants.

217. Figure 1 shows that one third of respondents (16 or 41%) answered yes, and one third of respondents (16 or 41%) answered no. The remaining respondents were not sure (4 or 10.5%) or did not answer the question (3 or 7.5%).

218. Respondents generally agree that students should adhere to professional standards similar to those of qualified practitioners, emphasising the importance of professional judgment, patient safety, and the public trust. They recognise that students will have more patient interaction, especially under the ETR, and hence should be held to a common set of standards for the benefit of patients.

219. However, there is also a consensus that allowances should be made for the varying levels of experience and maturity among students. Respondents suggest that while students should maintain high standards of behaviour and professionalism, they should be given more leeway due to their developing judgement and lack of experience. The idea of a developmental approach to applying standards is mentioned, with the expectation that organisations provide appropriate support to students as they progress. Others argue that

from day one, students should be aware of professional behaviours and that this early adoption will benefit their long-term practice.

220. It is acknowledged that students are often supervised and that the responsibility for their actions may lie with their qualified supervisors. Some responses highlight the need for clearer guidance and mentorship for students, suggesting that standards for qualified registrants should explicitly address the role of supervision and mentorship.

221. A sample of the comments we received in response to this question are shown in the box on the following page.

"…As long as there is a requirement for students to be GOC registered, we would argue that it is right that student standards should mirror as closely as possible the standards for optometrists and dispensing opticians on the grounds that:

- *students will be seeing patients during their undergraduate training; patients who altruistically allow their time and healthcare to be used for this public benefit deserve to know that any clinician or student involved in their care is bound by a common set of published professional standards*
- *students will have more and earlier exposure to patients under the ETR*
- *a common set of standards arguably provides greater protection and reassurance for patients than differing university standards…"* (FODO)

"…Ultimately students will always have another fully qualified registrant who is accountable for their actions" (Mediation service)

"…If student registration is to remain, they should be treated the same. The caveat here is that the GOC considers the differing scope of practice…" (Optical professional/representative body)

"I wouldn't expect a student to show the same leadership skills as a qualified practitioner" (Contact lens optician)

"…*Grasping the concept of being a professional is often only afforded following a level of lived experience in working for an organisation or in operating a direct business. As such, we are concerned that the student registrants may be set up to fail around the "Your Role as a Professional" section. We suggest that a softening of the language be used in the students' standards to better reflect the role of supervisors in terms of their essential mentorship in the initial stages of training*…" (AOP)

"…*For students or those early in their careers, it's vital to recognise that they won't have the same depth of experience or "professional judgement" as someone involved in the profession for decades…Therefore, it is important to make allowances for registrants at different stages of their professional development and our expectations of how students, new graduates and established registrants meet, adhere to, and interpret the standards, should reflect this*" (ABDO)

11.1.3 GOC response

222. We note stakeholder views on this issue are broadly split and have fully considered the arguments on both sides. It is our view that the expectations of student registrants should be kept in line with our expectations of fully qualified registrants. However, we would like to draw stakeholders' attention to three statements in the introductory text in the Standards for Optical Students, which

recognise that students are developing their knowledge, skills and behaviours throughout their training period.

“In the early stages of your training you will receive a greater level of support from your tutors and supervisors to assist your decision making. As you become more competent and experienced you will be required to take on increased responsibility for your decisions and professional judgements”

“We will apply these standards in the context of the stage of training you have reached, taking into account the level of support and guidance you have received from those supervising your training”

“We have therefore produced these specific standards for optical students which can be applied in the context of your study, taking account of the fact that you will develop your knowledge, skills and judgement over the period of your training.”

11.2 Impact of the proposed changes on individuals or groups with one or more protected characteristic

11.2.1 Summary of consultation responses

223. We asked stakeholders if they thought that any of the proposed changes could affect any individuals of groups with one or more of the protected characteristics defined in the Equality Act 2010. Figure 2 shows that just under half of respondents (18 or 46%) answered no, and a quarter of respondents (10 or 25.5%) answered yes. The remaining respondents were not sure (6 or 15.5%) or did not answer the question (5 or 13%).

224. Respondents generally support the revised standards, recognising the importance of compliance with equalities legislation and the focus on EDI. Several respondents believe the standards will have a positive impact by raising awareness and potentially offering better protection for individuals with disabilities or vulnerabilities.

225. There is also an acknowledgment of the positive steps taken by the GOC in aligning the standards to better serve patients with protected characteristics, though some suggest further enhancements. The impact assessment accompanying the consultation document is well-received, with an expectation that the new standards will benefit certain groups, particularly women in relation to the standard on sexual boundaries.

226. A sample of the comments we received in response to this question are in the box below.

> *"Although we recognise the moves by the regulator around the importance of EDI, there seems to be a lack of terms such as inequality and inclusion…"* (Education Provider)
>
> *"…we welcome the move by the GOC in more overtly harnessing the standards to help arm the profession in recognising and treating patients with protected characteristics. However, we have noted a few suggested enhancements/tweaks."* (AOP)
>
> *"Positive impact by raising awareness"* (Optometrist)
>
> *"Possibly better protection for those with a disability/vulnerability"* (Optometrist)
>
> *"We are pleased that the GOC has published an Impact Assessment alongside the consultation document and are satisfied that due consideration has been given to the effects of the changes on groups with protected characteristics. As identified in the accompanying Impact Assessment, the new standards are expected to have a differential impact on some groups. Most notably, the new standard relating to sexual boundaries is likely to have a particularly positive impact on women"* (PSA)

11.3. Impact of the proposed changes on any other individuals or groups

11.3.1 Summary of consultation responses

227. We asked stakeholders whether they felt that any of the proposed changes could affect any other individuals or groups, either positively or negatively. Figure 3 shows that sixteen respondents (or 41%) answered no, and a quarter of respondents (10 or 25.5%) answered yes. The remaining respondents answered not sure (8 or 20.5%) or did not answer the question (5 or 13%).

228. Respondents generally view the proposed changes as positive, with several indicating that they will benefit patients, the public, and eye care teams. There is a specific mention of the opportunities for Welsh-speaking members and patients being welcomed.

229. There is a suggestion that registrants should try to be aware of vulnerabilities that are not immediately visible and make reasonable adjustments, with a concern that missing something that could lead to a complaint.

230. A sample of the comments we received in response to this question are in the box below.

> *"General strong statement about respecting boundaries and not harassing colleagues should help"* (Optometrist)
>
> *"We have not identified any additional impacts to those listed in the Impact Assessment"* (PSA)
>
> *"The opportunities for our Welsh-speaking members and their patients will be welcomed"* (ABDO)

11.4 Impact of the proposed changes on the treatment of the Welsh language, and opportunities to use the Welsh language

11.4.1 Summary of consultation responses

11.4.1.1 Responses to question 4

231. We asked stakeholders if the proposed changes would have effects, whether positive or negative, on a) opportunities for persons to use the Welsh language and b) treating the Welsh language no less favourably than the English language.

232. Figure 4 shows that in relation to a), a fifth of respondents (12 or 20.5%) answered no, a fifth of respondents (12 or 20.5%) answered not sure and five respondents (or 8.5%) answered yes.

233. In relation to b), nine respondents (or 15.5%) answered no, nine respondents (or 15.5%) answered not sure, and three respondents (or 5%) answered yes.

234. Respondents generally view the publication of standards in the Welsh language positively, recognising it as a beneficial step for Welsh-speaking practitioners and patients. They believe that having standards available in Welsh will promote equality between Welsh and English speakers and allow for better application and reflection of the standards in one's preferred language. There is reference to the fact that the number of Welsh-speaking optometrists is small, relative to the population, and a lack of Welsh-speaking academics in the field.

11.4.1.2 *Responses to question 5*

235. We asked stakeholders if the proposed changes could be revised to have positive effects or increased positive effects on a) opportunities for persons to

use the Welsh language or b) treating the Welsh language no less favourably than the English language.

236. Figure 5 shows that in relation to a), just under a third of respondents (18 or 30%) were not sure, ten respondents (or 16.5%) answered no, and one respondent (or 1.5%) answered yes.

237. In relation to b), just under a quarter of respondents (or 23.5%) were not sure and seven respondents (or 11.5%) answered no. Ten respondents (or 16.5%) did not answer the question.

238. There were no substantive comments in relation to this question.

11.4.1.3 Responses to question 6

239. We also asked stakeholders if the proposed changes could be revised so that they would not have negative effects, or so that they would have decreased negative effects on a) opportunities for persons to use the Welsh language or b) treating the Welsh language no less favourably than the English language.

240. Figure 6 show that in relation to a), just over a quarter of respondents (17 or 28.5%) were not sure and eleven respondents (18.5%) answered no.

241. In relation to b), just over a fifth of respondents (13 or 21.5%) were not sure and eight respondents (or 13.5%) answered no. Eleven respondents (or 18.5%) did not answer the question.

242. There were no substantive comments in relation to this question.

11.5 GOC response to sections 11.2, 11.3 and 11.4

243. We have not identified any additional impacts as a result of the consultation and have not made any substantial changes to the Equality Impact Assessment.

11.6 The need for an implementation period

11.6.1 Summary of consultation events

244. Most stakeholders agreed that a short implementation period would be reasonable, to give individuals and businesses time to familiarise themselves with the revised standards and implement them. A range of timeframes were suggested, ranging from one month to 12 months, with the majority favouring a three-month period. Stakeholders also highlighted the opportunity to align

implementation of the standards with the new CPD cycle, starting January 2025.

11.6.2 Summary of consultation responses

245. We asked stakeholders if they thought there should be a short implementation period after the new standards are published and before they come into effect.

246. Figure 8 shows that 17 respondents (or 43.5%) answered yes, nine respondents (or 23%) answered no, and three respondents (or 8%) were not sure. A quarter of respondents (10 or 25.5%) did not answer the question.

247. Respondents generally agree that an implementation period is necessary, with suggestions ranging from one month to twelve months. A common timeframe mentioned is three months, which several respondents feel is adequate for registrants to familiarise themselves with the updates and integrate them into practice. However, some argue for a longer period, such as six months or even twelve months, to allow for adequate preparation, training, and adjustment to the changes, whilst others do not consider an implementation period is necessary.

248. A few respondents believe that the changes reflect good practice already in place and do not foresee a need for a significant transition period. Others emphasise the importance of providing sufficient time for all stakeholders, including those who may not have immediate access to support and resources, to adapt to the new standards.

249. The need for clear communication and education about the changes is highlighted, with suggestions for mandatory CPD or other educational activities to support the transition. Some respondents also suggest aligning the implementation dates for all sets of standards to avoid confusion and ensure consistency across the profession.

250. A sample of the comments we received in response to this question are in the box on the following page.

"It seems to be standard practice across the regulators we oversee to allow an implementation period to provide registrants with time to digest the content of the new standards make any necessary changes to their practice. We do not have a view on how long this should be and suggest GOC look at how long other bodies usually allow" (PSA)

"No less than a month and no more than three months. Changes in the Standards will need to be implemented into company policy which takes time, however for the benefit of registrants and the public, the time needs to be kept to a minimum" (Contact lens optician)

"The changes broadly reflect what is already good practice, so we do not believe a long implementation period is necessary. Nevertheless, registrants will need time to familiarise themselves with the updates and optical businesses similarly. Given there has been wide consultation, we believe that three months following finalisation should be sufficient for this. Consideration should be given to how these changes are communicated to individual registrants, especially those who practise outside employment training structures, so that they are fully aware of the changes and their implications" (FODO)

"We agree that there should be a short implementation period before the new standards come into effect and recommend it to be of a minimum of 8 months, as it was when the GOC last consulted on these standards in 2015; they came into effect 8 months (1 April 2016) after publication on 28 July 2015.This would give enough time for registrants, practice owners and businesses to adapt and adjust to the new standards, and to the optical sector bodies, including The College of Optometrists, to review their resources and make the necessary amendments to practice, policy, guidance, and training materials. We also recommend that the GOC delivers appropriate education and promotional activity to help registrants become familiar with the new standards before they come into effect." (College of Optometrists)

"To enable scoping, resource attainment, followed by planning, design and delivery of support and education, we would propose a minimum twelve-month implementation period for HEIs, industry and other stakeholders" (Education Provider)

"As most revisions are light touch enough that they do not require any substantial systemic adjustments, we are not certain that an implementation period is necessary…" (AOP)

11.6.3 GOC response

251. We acknowledge that stakeholders have different views on the need for an implementation period and how long this should be.

252. We c that a short implementation period of approximately three months is sufficient to enable stakeholders to prepare for the new standards, given that the scope/extent of the revisions are limited, and we have already consulted with stakeholders extensively. We consider this strikes the right balance between allowing stakeholders to prepare and quickly implementing revisions which will improve patient and public protection.

253. Therefore, the revised standards will come into effect on 1 January 2025.

Section 12: Other comments received

254. We received numerous comments from stakeholders which were outside the scope of this consultation and related to issues such as basic connectivity issues within the sector, supervision, tele-optometry, student registration, and concerns around the governance of refractive surgery. We have reviewed all comments and will feed them into other workstreams where relevant.

Section 13: Next steps

255. We recognise the importance of effective communications to make registrants aware of the new standards and help them to implement them in their practice. We will work with stakeholders to communicate the changes to the standards, ready for the date on which they come into effect. We will produce targeted material for different audiences, such as education providers, CPD providers and individual registrants.

256. We will update our existing guidance and position statements to reflect the changes to the standards. Where we make substantial changes to those documents, we will hold a public consultation on those changes.

257. We will also begin work to develop new guidance on the care of patients in vulnerable circumstances and maintaining appropriate sexual boundaries. Those pieces of guidance will also be subject to public consultation.

Annex 1: Quantitative data from consultation responses

Annex 1 contains the quantitative data from the consultation questions, presented as bar graphs. Where we have asked more than one question on a particular issue, for example, do you agree the proposed revisions are a) clear and b) set appropriate minimum expectations, we have combined the data in a single graph.

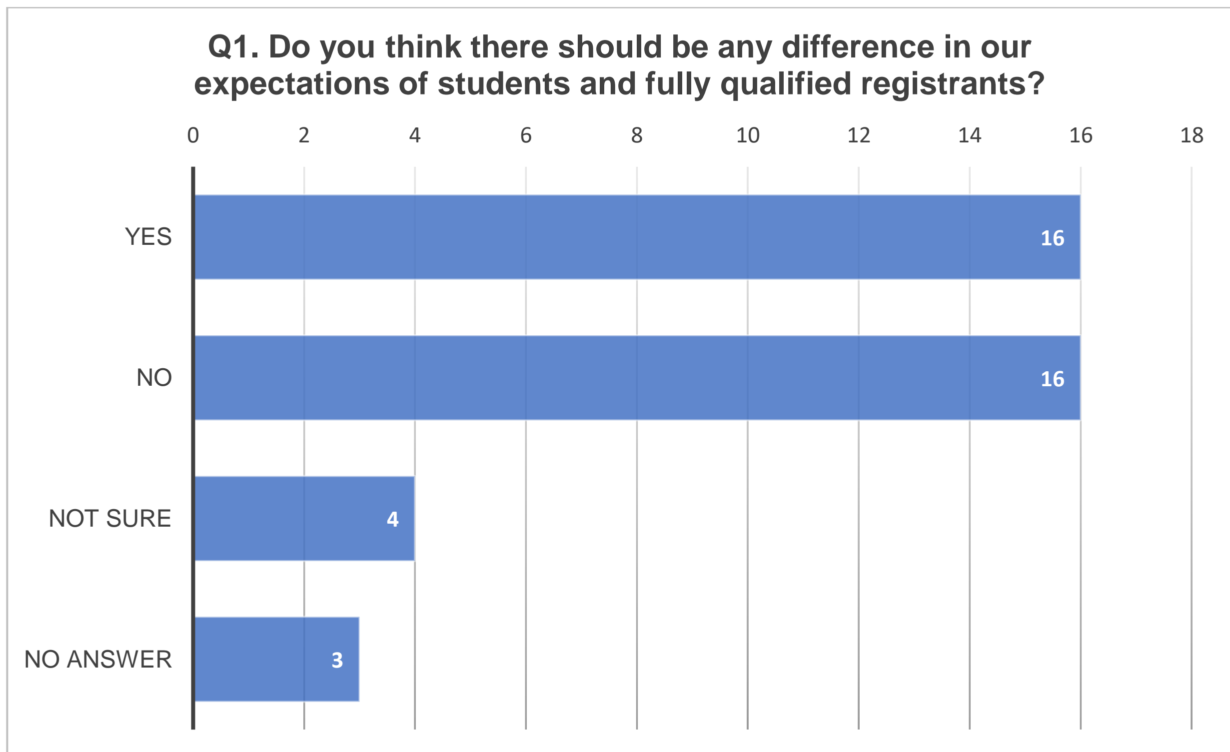

Figure 1: Responses to question 1

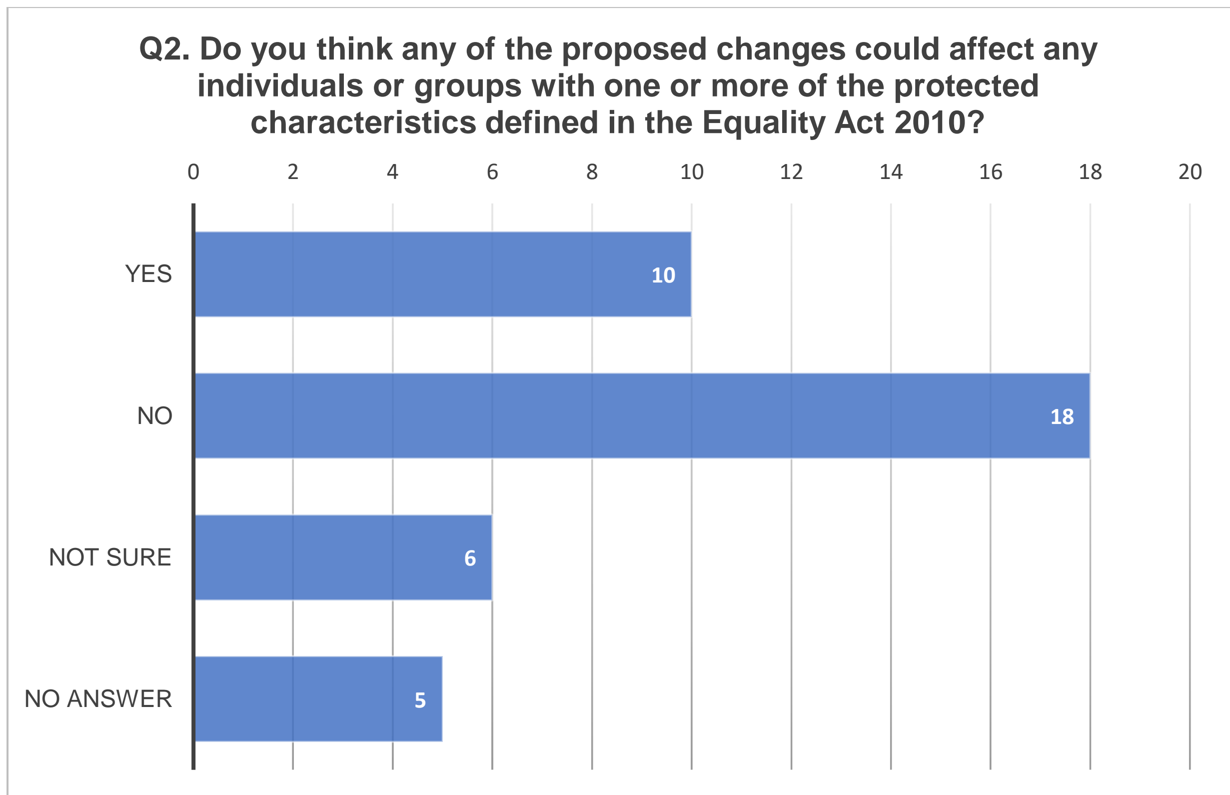

Figure 2: Responses to question 2

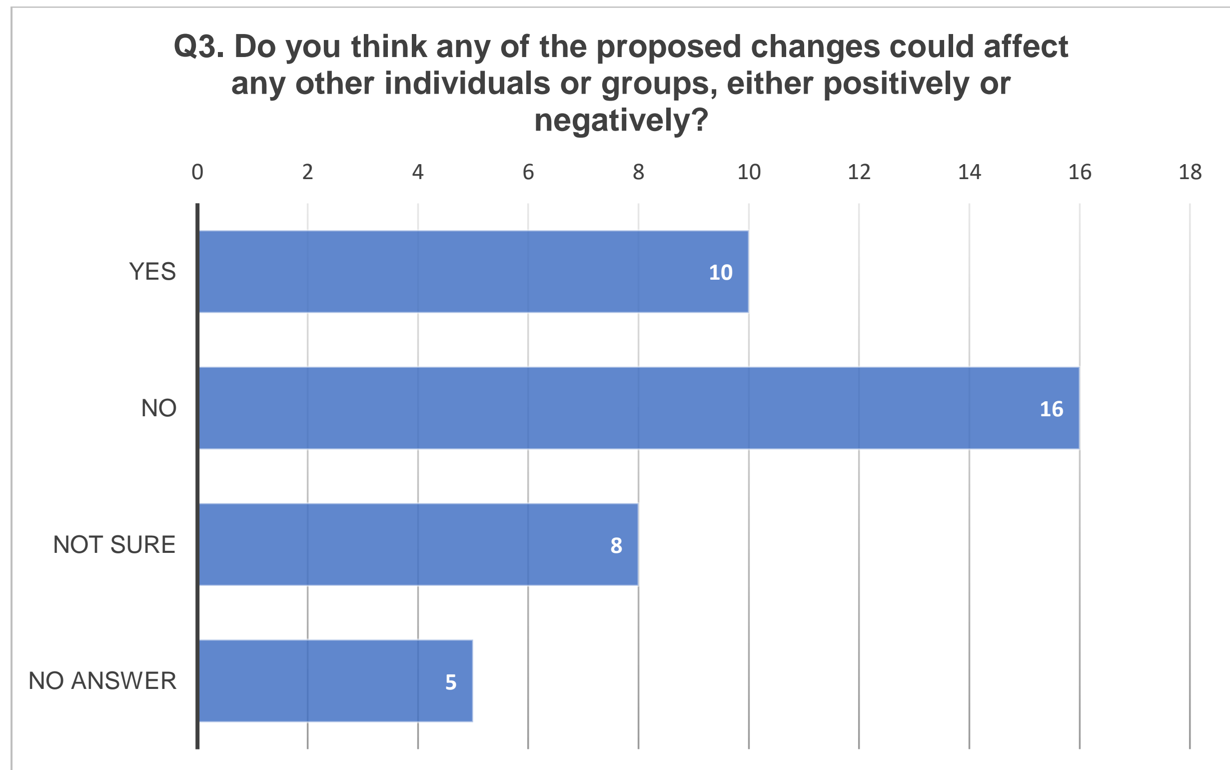

Figure 3: Responses to question 3.

In figures 4, 5 and 6 below, (a) and (b) refer to:

(a) **opportunities** for persons to use the Welsh language, and
(b) **treating** the Welsh language **no less favourably** than the English language?

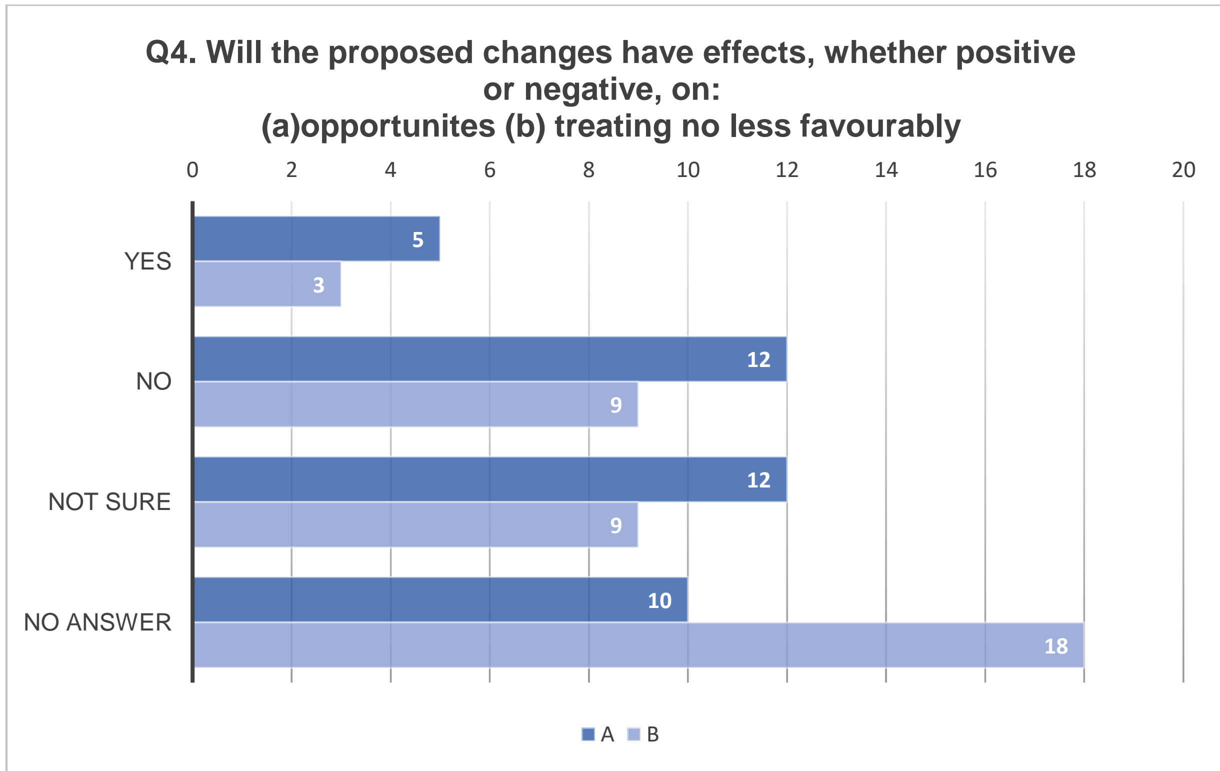

Figure 4: Responses to question 4

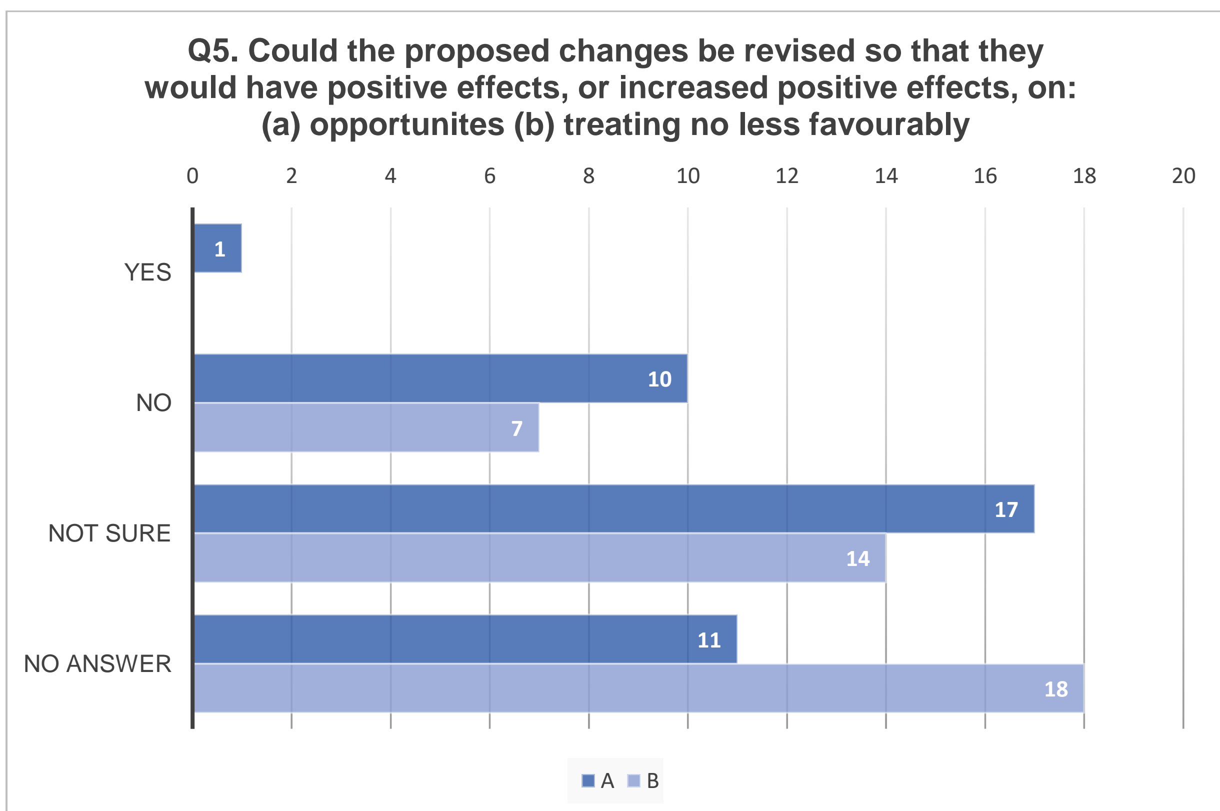

Figure 5: Responses to question 5

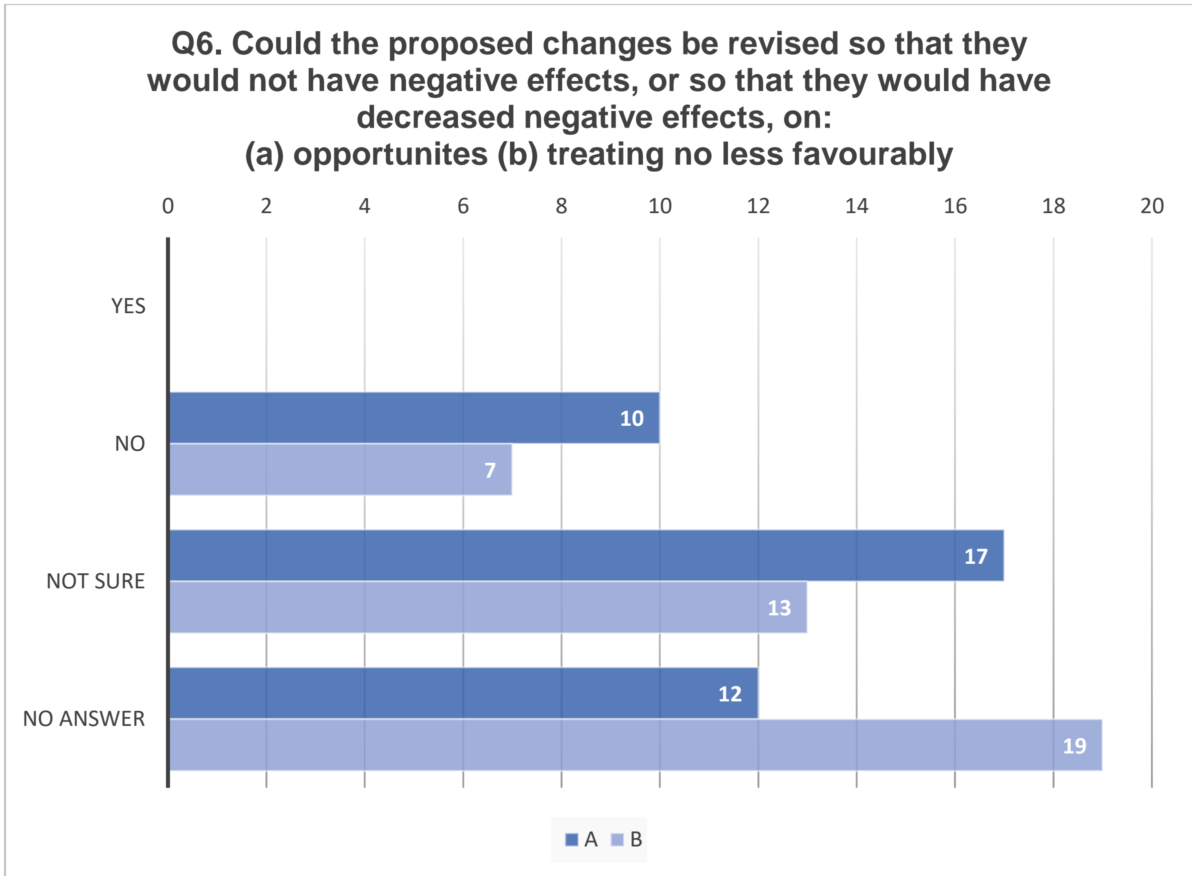

Figure 6: Responses to question 6

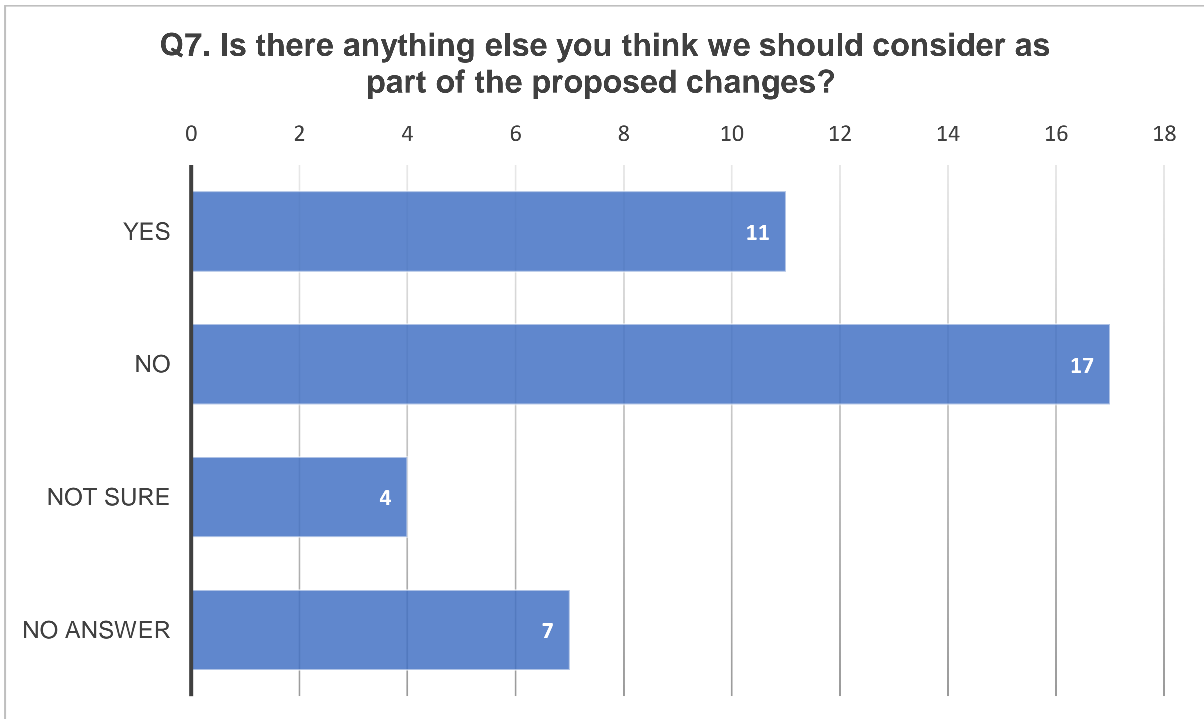

Figure 7: Responses to question 7

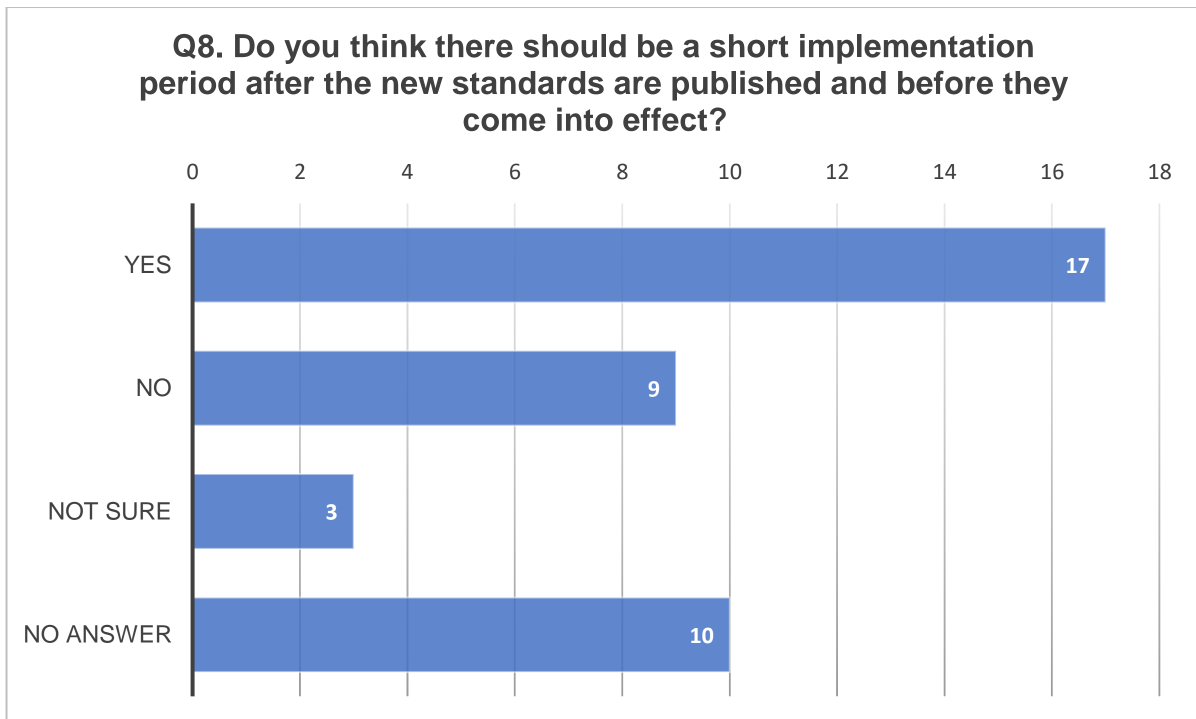

Figure 8: Responses to question 8

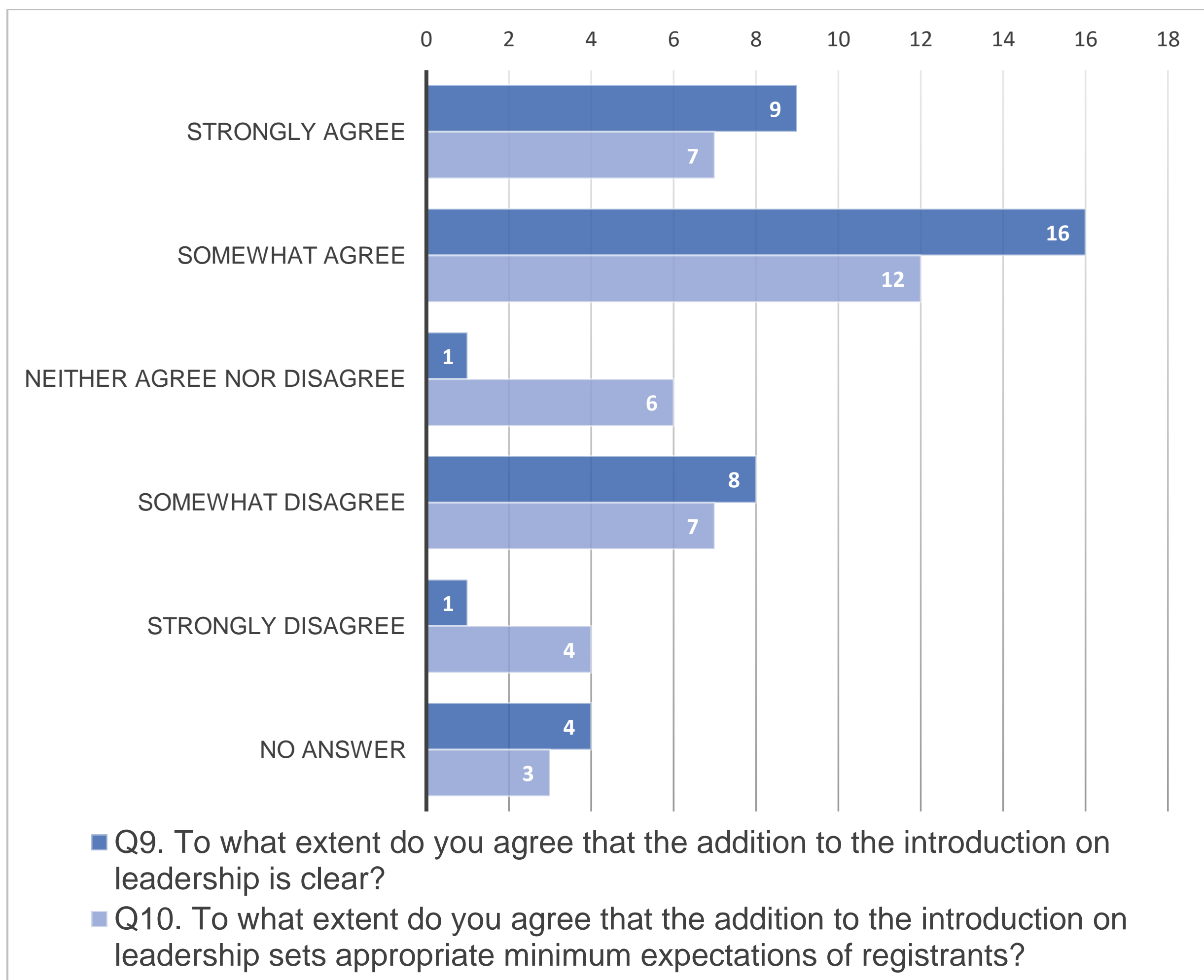

Figure 9: Responses to questions 9 and 10

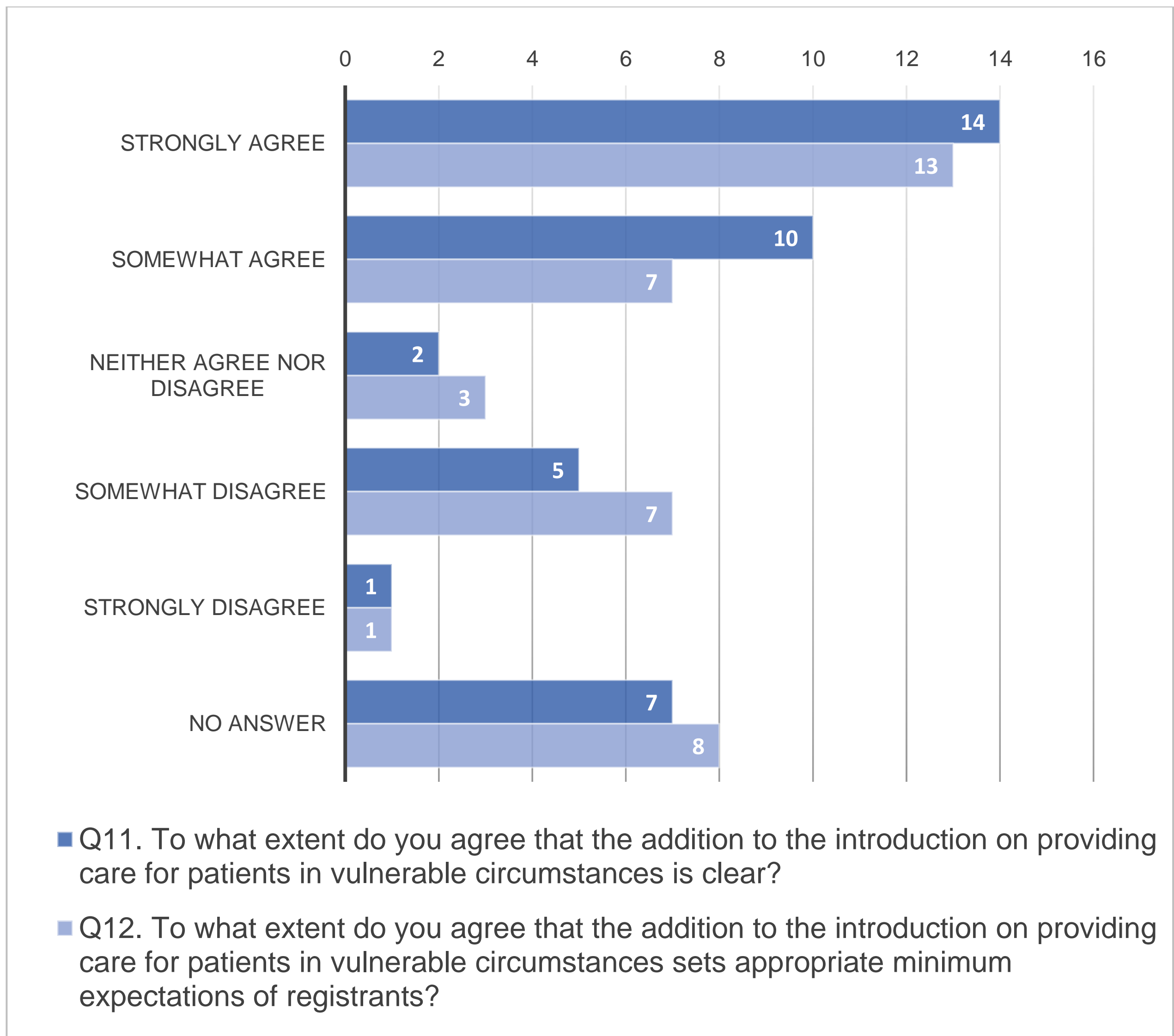

Figure 10: Responses to questions 11 and 12

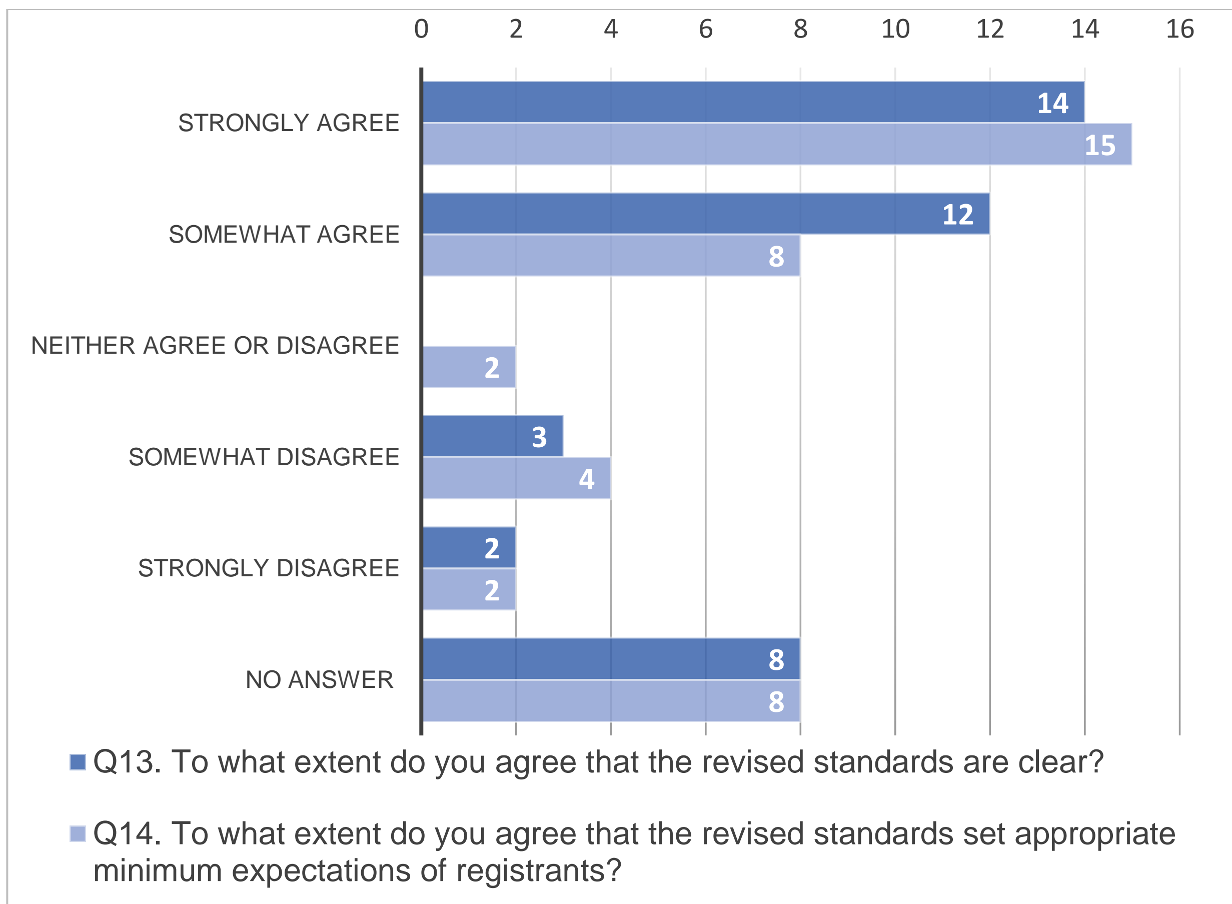

Figure 11: Responses to questions 13 and 14 on care of patients in vulnerable circumstances

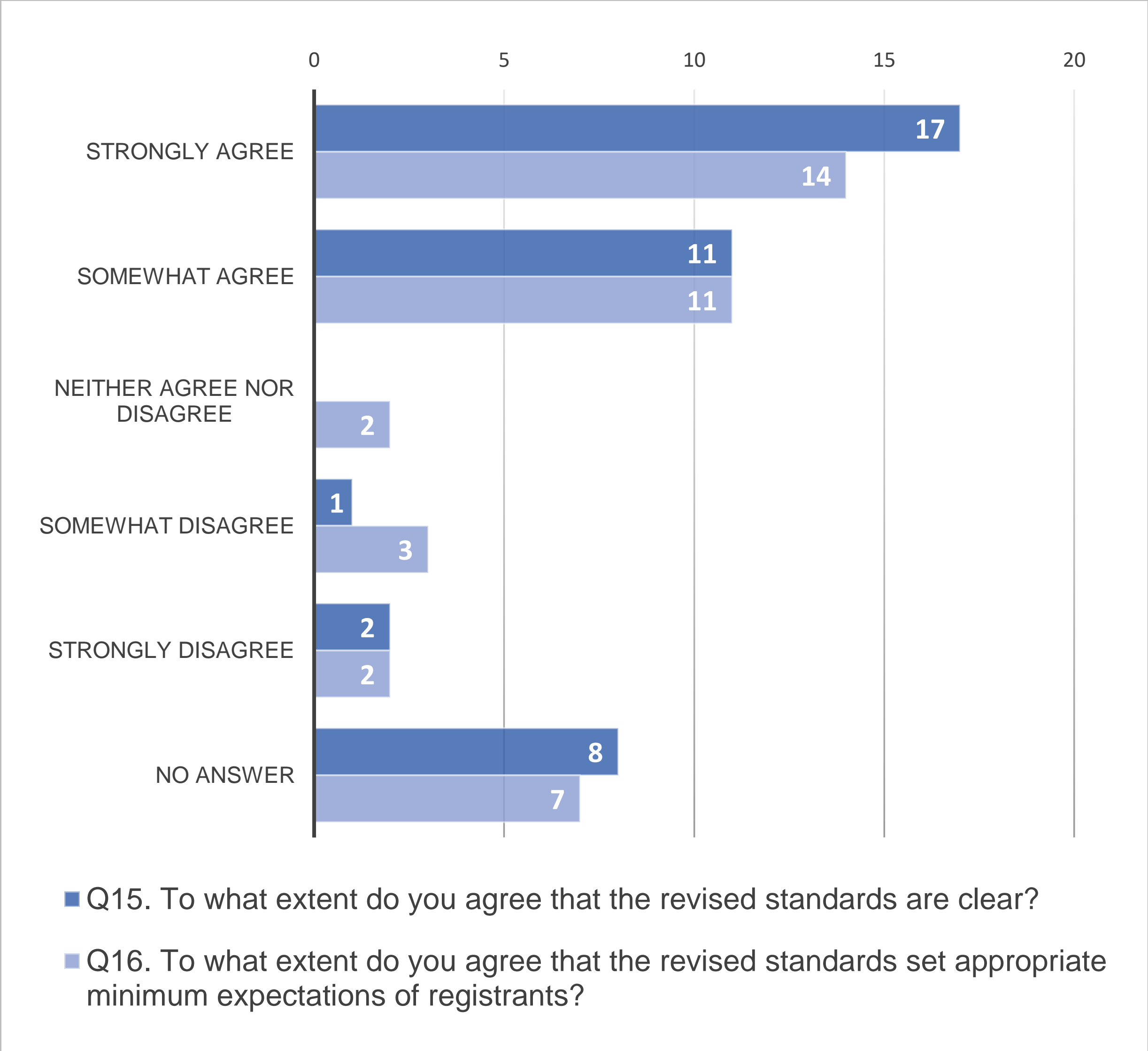

Figure 12: Responses to questions 15 and 16 on effective communication

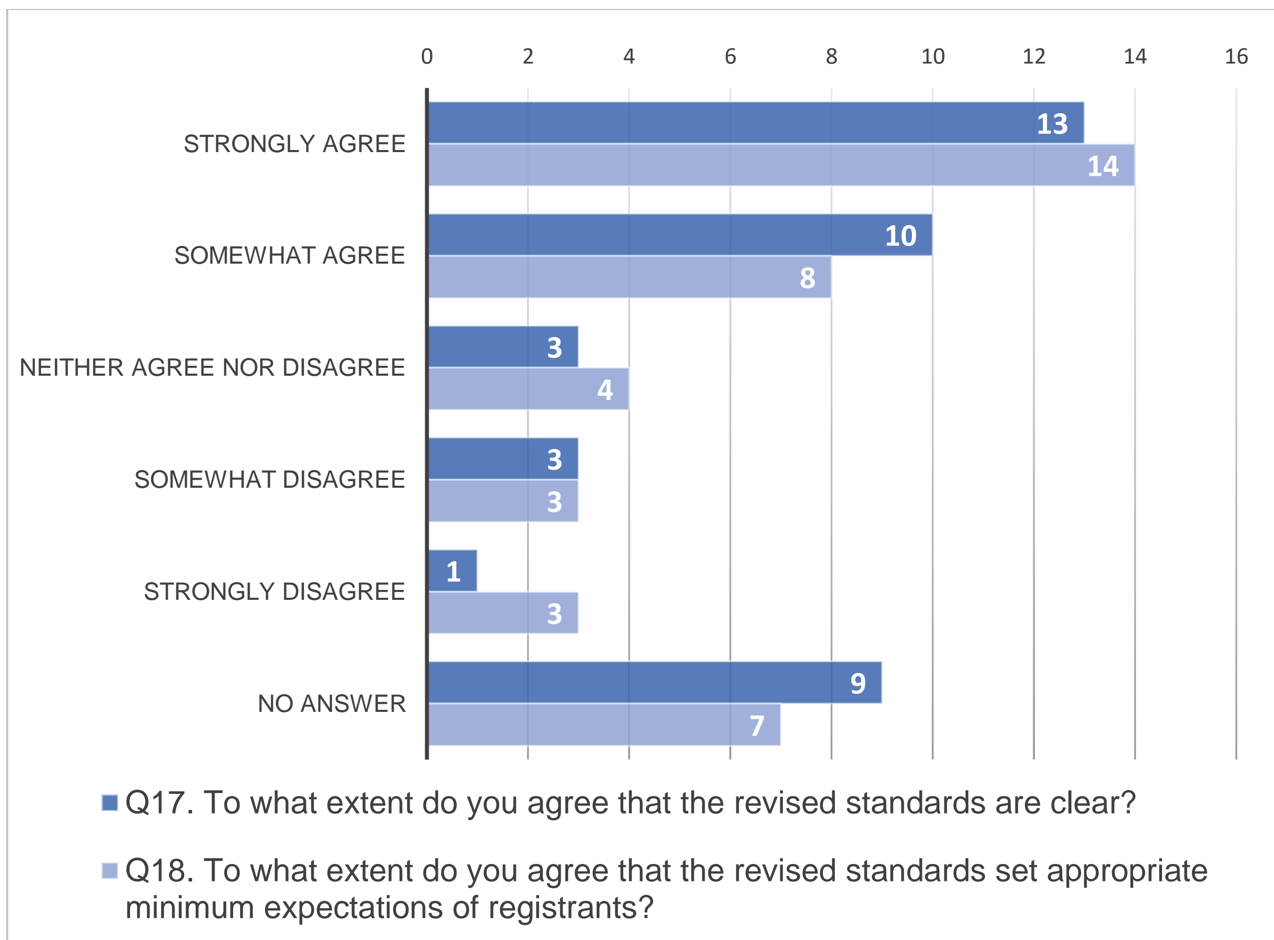

Figure 13: Responses to questions 17 and 18 on digital technologies including AI

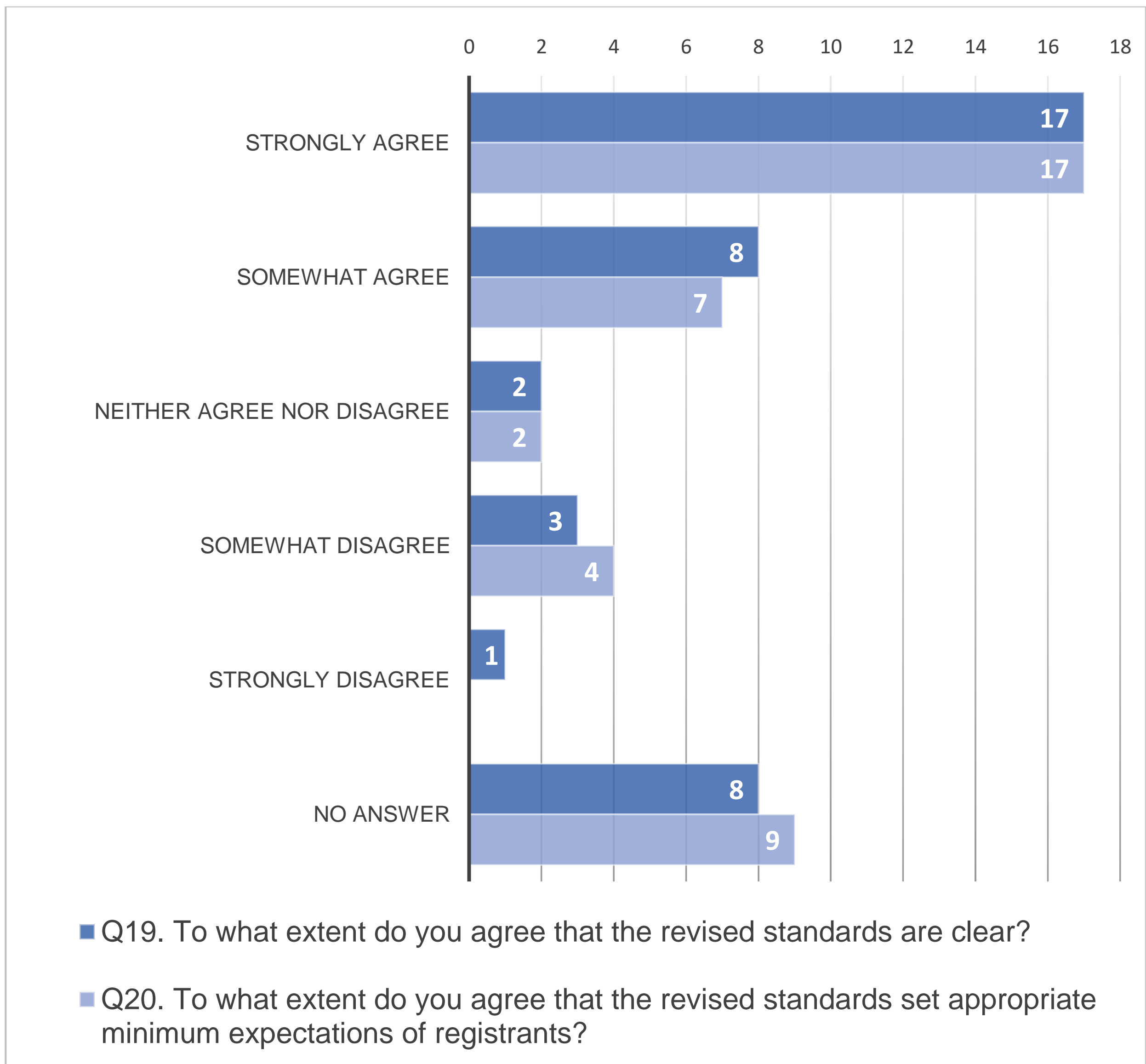

Figure 14: Responses to questions 19 and 20 on equality, diversity and inclusion. (Standards of Practice for Optometrists and Dispensing Opticians and Standards for Optical Students)

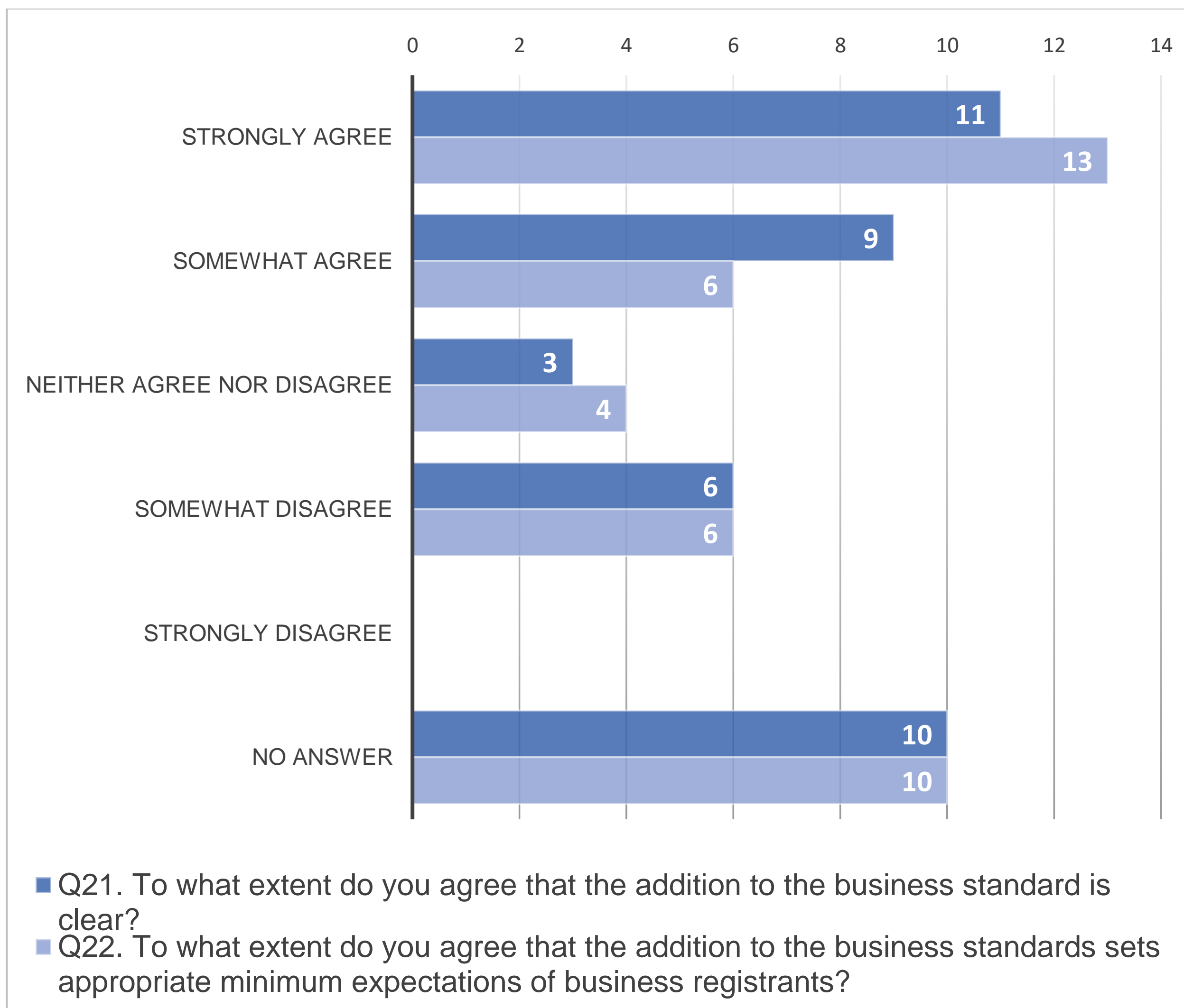

Figure 15: Responses to questions 21 and 22 on equality, diversity and inclusion. (Standards for Optical Businesses)

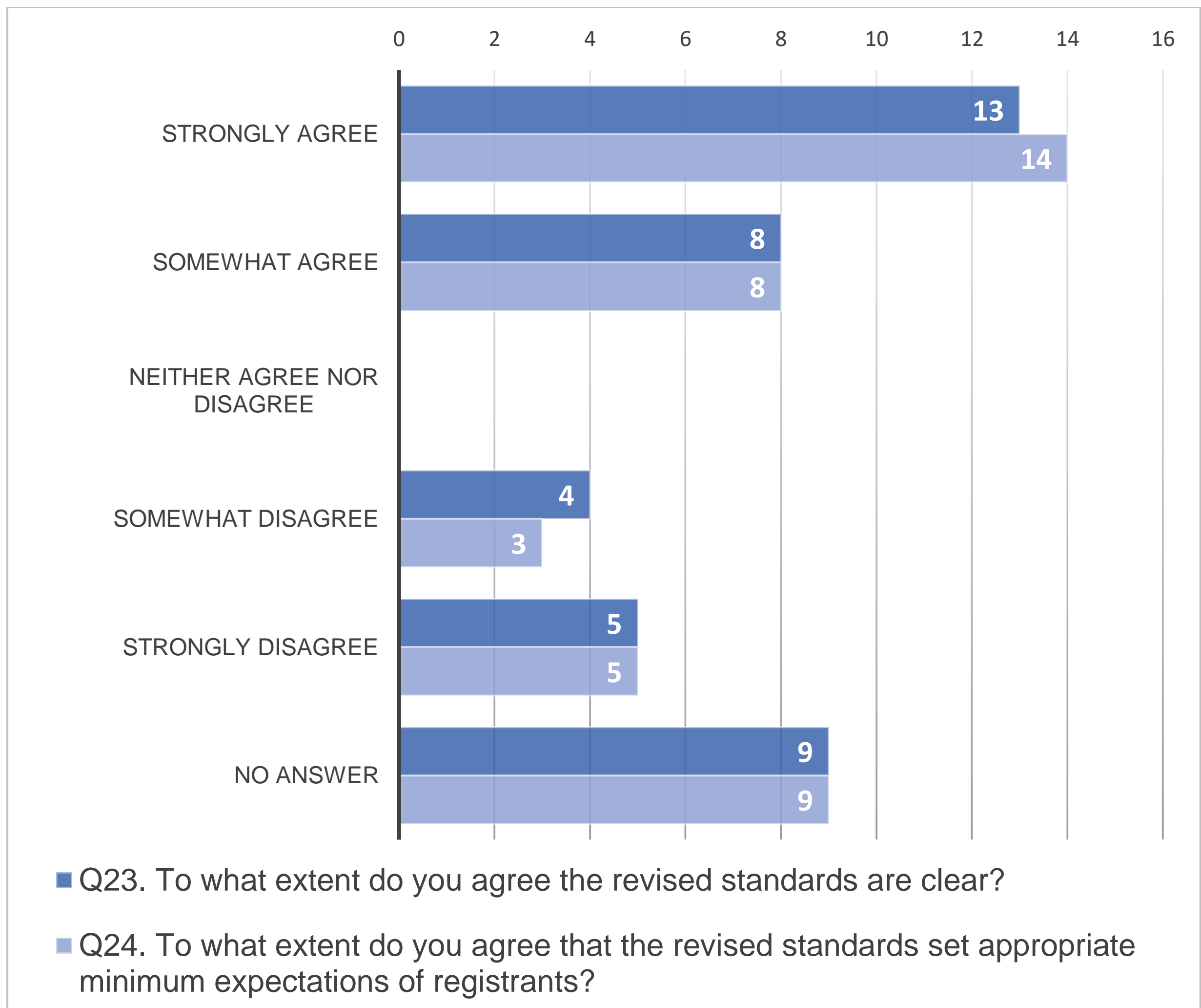

Figure 16: Responses to questions 23 and 24 on social media, online conduct and consent

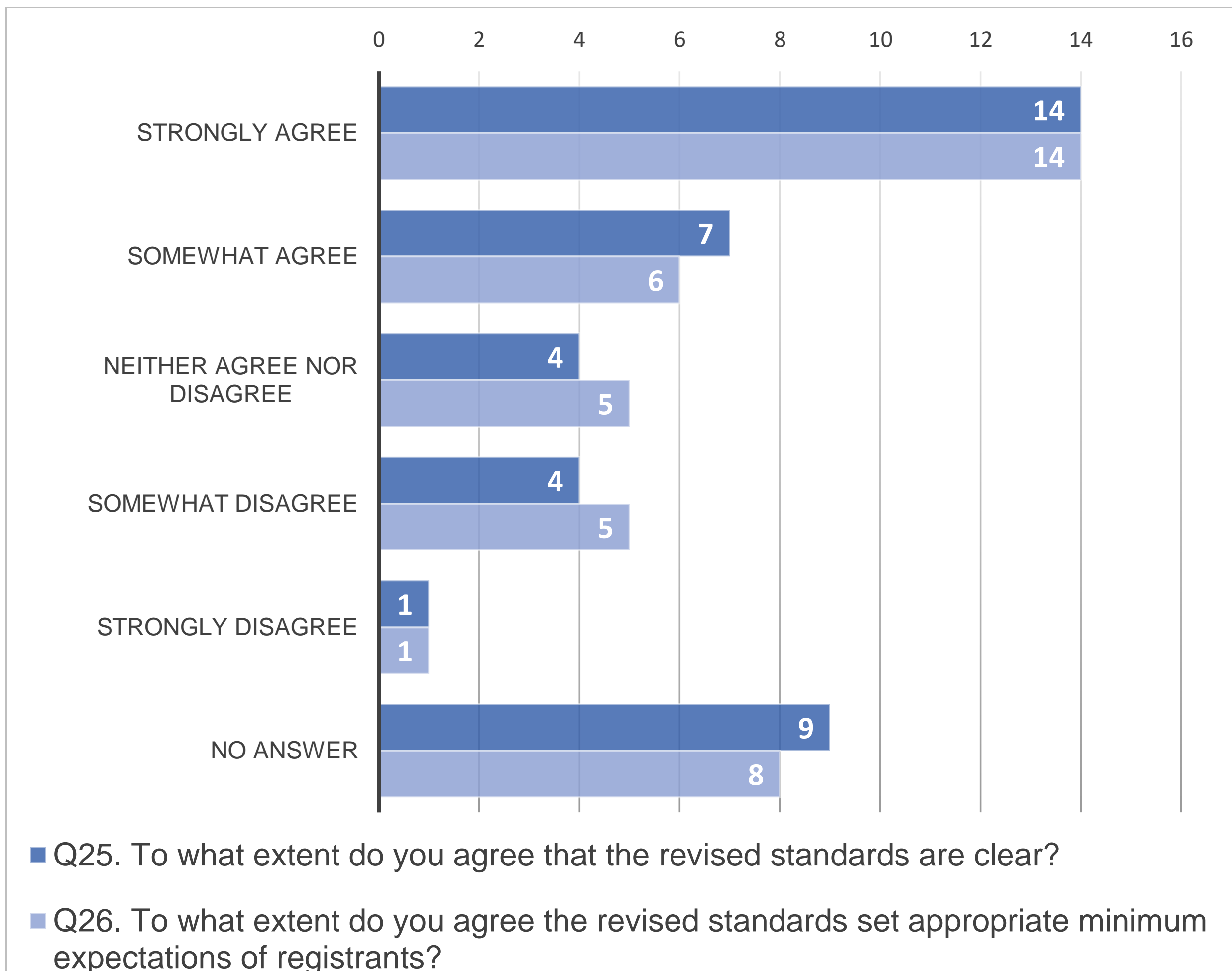

Figure 17: Responses to questions 25 and 26 on maintaining appropriate professional boundaries

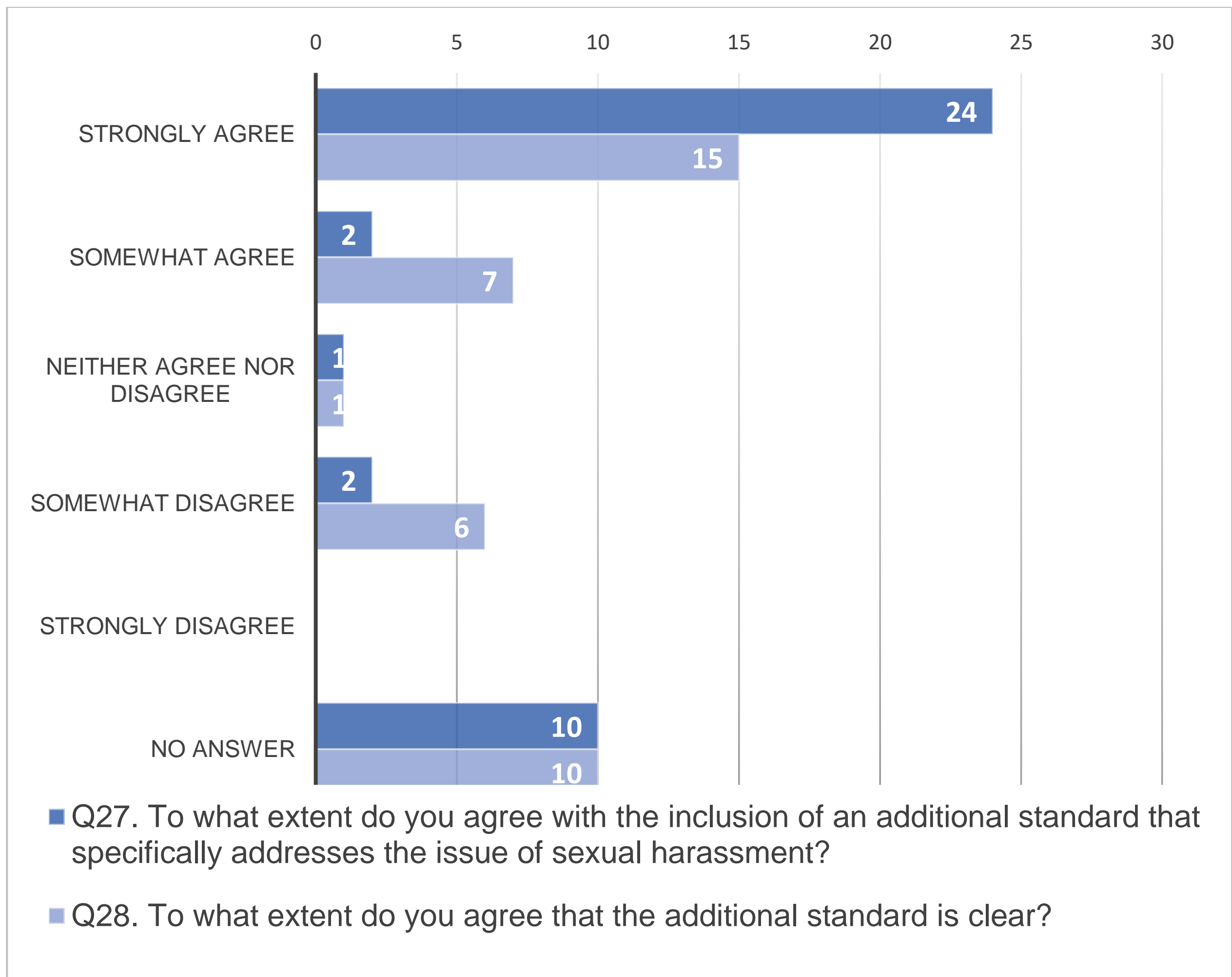

Figure 18: Responses to questions 27 and 28 on preventing sexual harassment

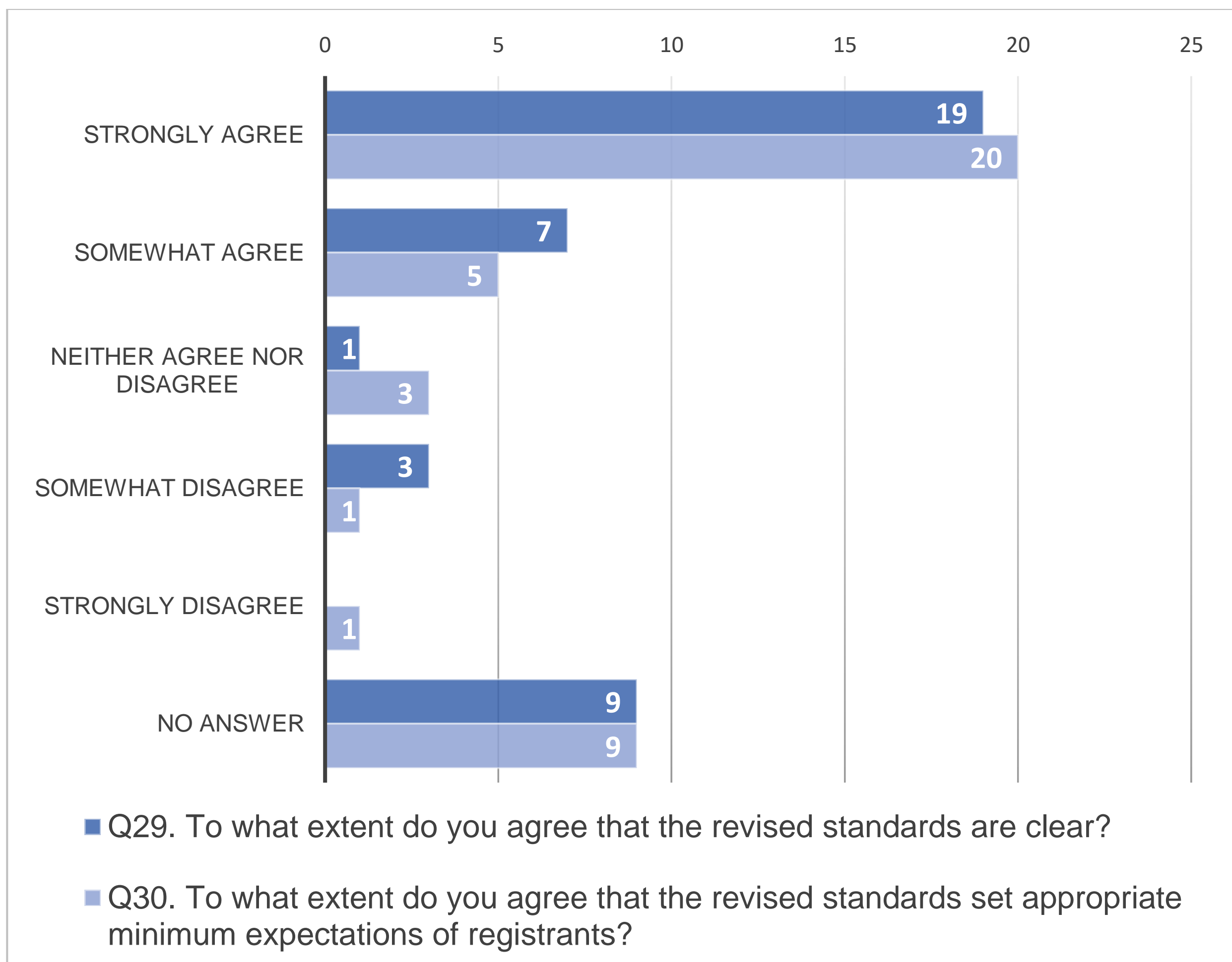

Figure 19: Responses to questions 29 and 30 on registrant health

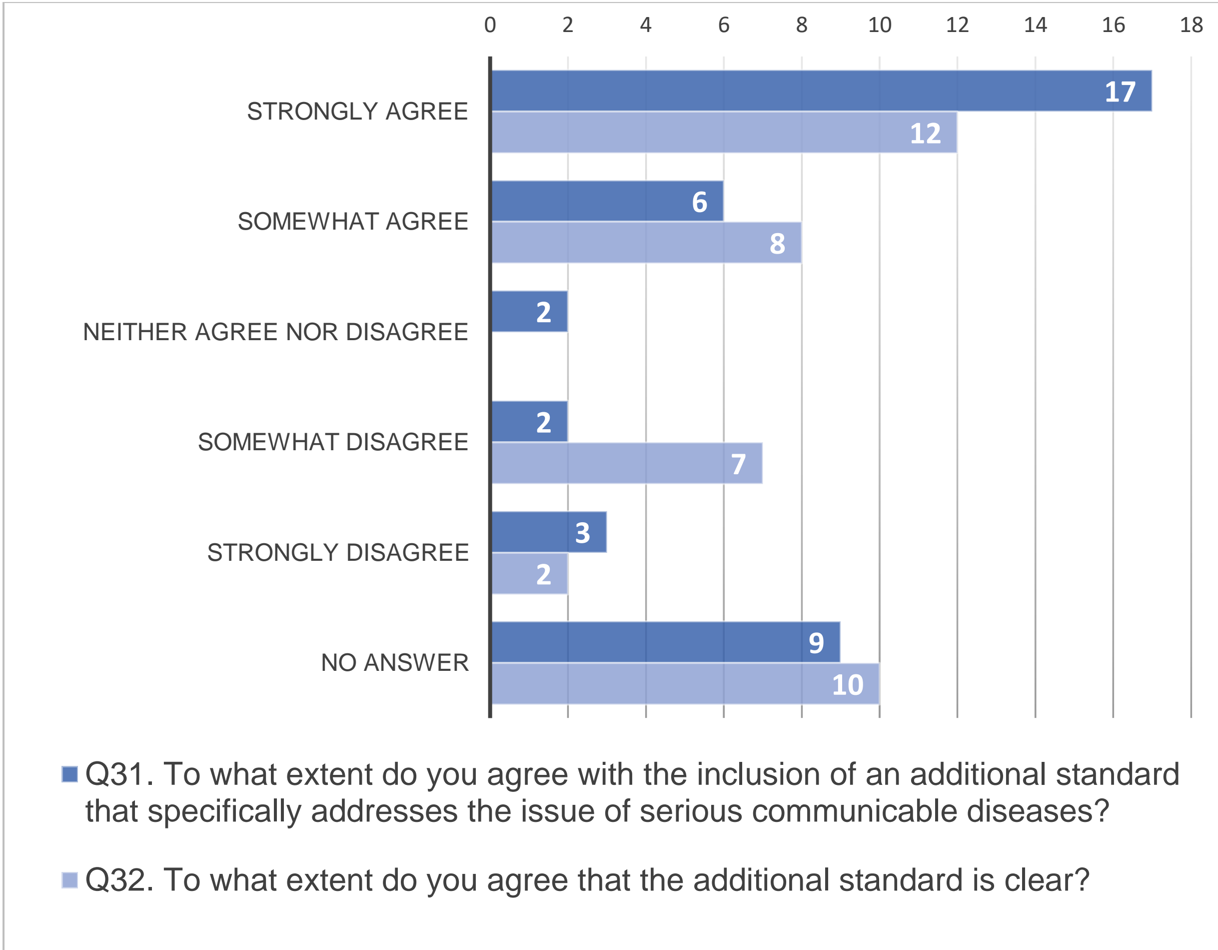

Figure 20: Responses to questions 31 and 32 on new standard for serious communicable disease

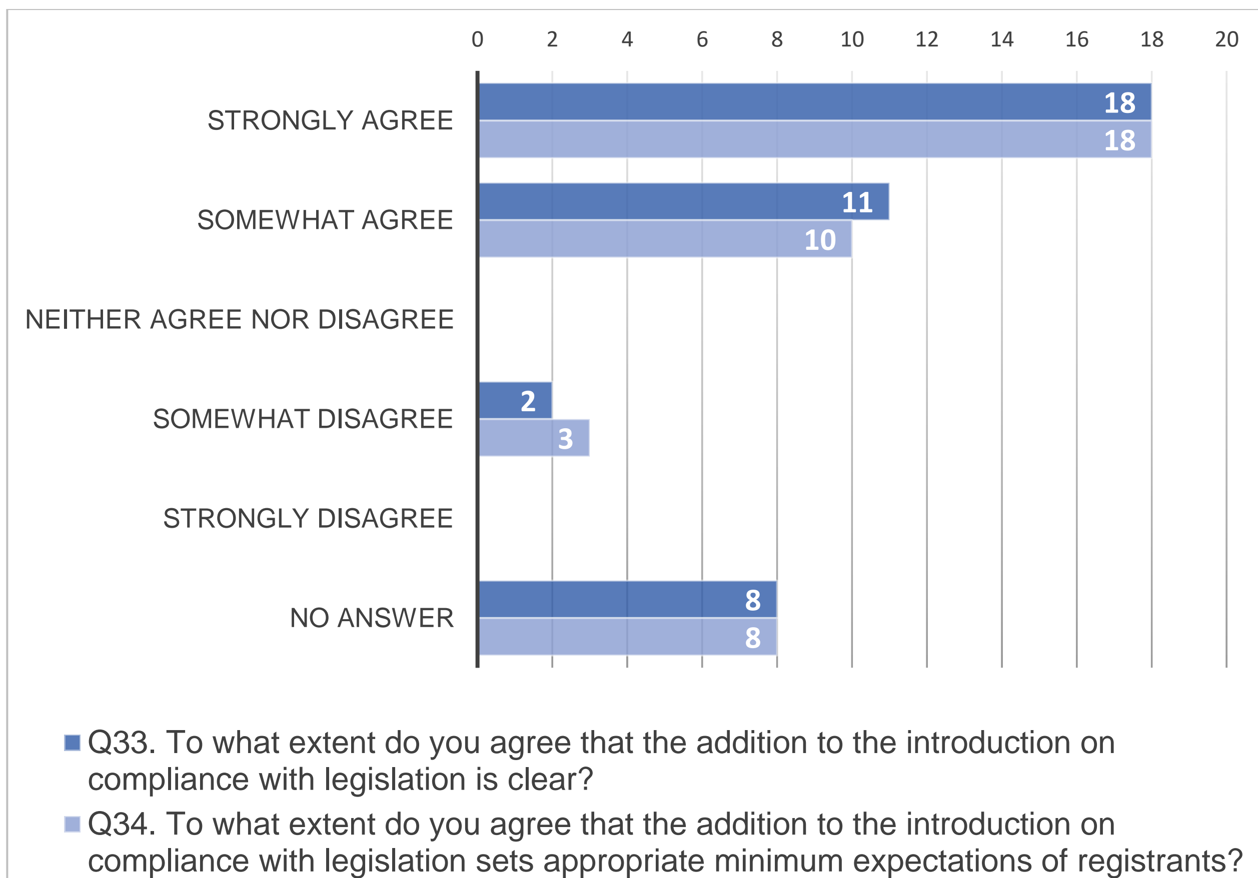

Figure 21: Responses to questions 33 and 34 on compliance with legislation