GOC Education Strategic Review

Summary of responses to a call for evidence

Prepared for:

General Optical Council

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Introduction

The General Optical Council (GOC) is the regulator for the optical professions in the UK. Its role is to protect and promote the health and safety of the public. One of the GOC's statutory functions is to accredit and quality assure the education programmes and qualifications that lead to registration with the GOC.

The optical sector is going through a period of significant change as a result of developments in technology and increasing demand for eye care caused by the ageing population. As a result, the roles of optical professionals are likely to change.

With this in mind, the GOC launched an education strategy review with a view to ensuring that the education which optical students receive equips them for the roles of the future.

To commence this review, the GOC published a call for evidence on 15 December, 2016 which asked for feedback on a total of 17 broad ranging questions about the future of eye care delivery and implications of these changes for the education of optical professions.

The full list of questions was as follows:

> *Changes in demand and the impact of changes in eye care delivery:*
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> - *Consultation question 1* – How might the needs of patients requiring eye care change over the next 20 years?
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> - *Consultation question 2* – What changes in how and where eye care is provided will be required over the next 20 years in order to meet patients' needs, and what are the barriers to these changes?
>
> - *Consultation question 3* - How are the roles of optometrists and dispensing opticians likely to change over the next 20 years, and what are the drivers for these changes?
>
> - *Consultation question 4* – How should the education of optometrists and dispensing opticians be structured to enable continuing

professional development throughout their careers, e.g. core training followed by general or specialist practice?

- *Consultation question 5* – What are the implications for the GOC register of likely changes in roles and will the existing distinctions between registrant groups remain appropriate?

GOC's approach to education:

- *Consultation question 6* – What are your views on the GOC's approach to the accreditation and quality assurance of education programmes, including on whether this is an appropriate focus on outcomes and on the use of the competency model to set the standards of education?

- *Consultation question 7* – Should the GOC accredit and quality assure additional or different higher qualifications and if so, on what basis?

Content of education programmes:

- *Consultation question 8* – What are the core skills, knowledge and behaviours which optometrists will need to have on first joining the register in the future?

- *Consultation question 9* – How should the content and delivery of optometry programmes change to ensure that students gain the skills, knowledge and behaviours that they will require for practice and for new roles in the future?

- *Consultation question 10* – How might post-registration training and registrable higher qualifications for optometrists need to change in the future?

- *Consultation question 11* – What are the core skills, knowledge and behaviours which dispensing opticians will need to have on joining the register in the future?

- *Consultation question 12* – How should the content of dispensing programmes change to ensure that students gain the skills, knowledge

and behaviours that they will require for practice and for new roles in the future?

- *Consultation question 13* – How might post-registration training and registrable higher qualifications for dispensing opticians need to change in the future?

Professionalism and consistent standards:

- *Consultation question 14* – How can we ensure students have the professionalism needed to take on new roles, including through the admissions procedures used by education providers, patient experience, supervision and embedding professional standards?

- *Consultation question 15* – How should students be assessed prior to joining the register to ensure that there are consistent and appropriate standards of education, taking into account the different types of education programmes that are emerging?

Barriers to change and other issues to consider:

- *Consultation question 16* – What are the challenges and barriers to improving the system of optical education, including issues that may be outside the remit and control of the GOC, such as legislative change, workforce planning, the funding of education (including higher education, continuing education and training and continuing professional development) and the provision of student placements?

- *Consultation question 17* – Are there any other issues that we should consider in carrying out our review? If so, please set out what they are.

A total of 55 responses to the call for evidence were received between 15 December 2016 and 16 March, 2017. The responses received fell into the following categories: registrants (17), education and training providers (16), professional bodies (9), optical businesses (4), patient groups (3) and other respondents (6). Included in the responses were nine organisations based in the devolved nations. A full list of respondents is provided in the Appendix where consent to be named has been given.

As the questions that were included in the call for evidence were all open-ended, qualitative methods were applied to the analysis. A grounded thematic approach was employed which identified the themes emerging from the verbatim responses and measured their prevalence across all responses.

Independent researcher, Monique Rotik from Collaborate Research, undertook the analysis and has drafted this report which aims to:

- Provide a thematic summary of the main feedback collected against each of the consultation questions.

- Identify variations in responses and exceptional views where these occur.

All feedback has been considered and each category of respondent has been given equal weight. The respondents in most cases have not been named.

The verbatim responses received will also be published on the GOC's website in cases where permission for this has been provided by the individual respondents.

Changes in demand and impact of changes in eye care delivery

Q1   How might the needs of patients requiring eye care change over the next 20 years?

A number referenced the *Foresight Project* report commissioned by the Optical Confederation and the College of Optometrists in their responses to this question and there is broad agreement on what are predicted to be the main developments in patient needs.

The ageing population is expected to lead to a generally increased demand for eye care over a longer period, as well as specifically to:

- Increased demand for treatment of specific conditions associated with ageing (e.g. age-related macular degeneration, glaucoma, cataracts etc.).

- A greater number of patients presenting with complex needs (e.g. multiple pathologies, co-morbidities, dementia, disabilities, frailty and vulnerability).

- More need for care to be provided close to home and in domiciliary settings due to mobility and travel limitations.

Other anticipated developments include:

- A greater prevalence of specific conditions related to lifestyle factors (e.g. myopia in children, vision and eye health issues related to the increased use of display screen equipment, the impact of diabetes and hypertension on eye health).

- Higher patient expectations about the choices available and standards of care they receive, related to having more information and options available to them (e.g. online purchase of optical appliances, use of technology as part of diagnosis/management of conditions).

- More involvement by some patients in monitoring and management of their conditions, aided by technology. However, it is noted that this type of self-management role will not be accessible to all patients.

- Some patient groups additionally expect a rise in both children and adults with learning disabilities seeking eye care (for example, referring to trends in *Improving Health and Lives*, a report by the Learning Disability Observatory).

Q2   What changes in how and where eye care is provided will be required over the next 20 years in order to meet patients' needs and what are the barriers to these changes?

There is consensus on what are predicted to be the developments in eye care provision and also what may be barriers to achieving these changes.

It is generally expected that more optical care will need to be provided in the community, including in domiciliary settings, in response to the changing needs of patients (reported in response to the previous question) as well as to comply with government policy and alleviate pressure on already overstretched hospital eye services (HES). It is noted that this movement is already underway, although it is not consistently developed across the UK. For example, it is reported by some respondents that the provision of optical care in the community is more advanced in Scotland than England.

It is foreseen that the diagnosis and non-surgical treatment of all less complex conditions will be possible in primary settings in the future, as well as rehabilitation and ongoing management of low risk and stable conditions following discharge from HES. Some also anticipate that minor surgical procedures will take place in community settings.

This is predicted to require the further development of enhanced service provision, such as Minor Eye Conditions (MECS), Low Vision services and others, within the community.

It is anticipated that such provision will need to be by multi-disciplinary teams in order to use resources efficiently and enable holistic, joined up care to be provided.

Some patient groups and others specifically raised the theme of what would constitute suitable future care for vulnerable children and adults. One

respondent for example, would like to see a nationwide service for both children and adults with learning disabilities, or at a minimum a consistency in local arrangements so that any person with a learning disability can access good quality and appropriate eye care in their local community, wherever they happen to live.

Other expected developments include:

- A greater emphasis on prevention, including via patient education, as well as support and advice to help patients self-manage their conditions.

- Early intervention e.g. via vision screening programmes for children.

- A greater use of technology in diagnosis, including the automation of refraction, as well as the possibility of more virtual and remotely delivered care. However, it was also pointed out that not all would be able to take advantage of technology, meaning that alternatives need to be available for those who can't.

- A greater division between sales/supply of optical appliances and eye health.

However, a number of potential barriers to realising these changes have also been identified, including:

- Insufficient integration between primary and secondary care provision, especially a lack of connectivity of IT systems preventing electronic communication and referral, as well as unwieldy care pathways. For example, some respondents perceive referrals from optical professions to HES currently needing to be via GPs as unnecessary and perceive that there is a lack of clear clinical governance structures for new models of care. In addition, there have been reports of variable NHS commissioning practices across the UK, with optometrists currently underutilised in some areas.

- Insufficient General Ophthalmic Services (GOS) funding in the NHS and limits of the current dominant business model that subsidises clinical care with the sale of optical appliances. The funding pressure is expected to increase significantly as more time is likely to be required

with patients to deliver more clinical care and enhanced services. There will also be a need for investment in new equipment.

- Insufficient clinical competence, confidence and professional willingness among optical professionals to undertake new roles. This is seen to be linked to the content and structure of existing education and training as well as uncertainty about how the new roles would be remunerated, the nature of career progression and how training and development would be funded and supported. For example, some specific comments have been made by respondents with ophthalmic backgrounds, including that:

  o They perceive that no agreed skill set currently exists whereby an ophthalmologist discharging patients to primary care can be sure that the non-medic primary care clinician has had the relevant training to manage the patient being discharged.

  o They have concerns about risks to patient safety but no time to support non-medical colleagues and develop new working practices.

- Lack of awareness and confidence in the evolving role of optical professions:

  o This is believed to be an issue both for patients and other health professionals.

  o Some respondents have specifically made reference to the current business model leading some in the public to perceive eye care as profit-motivated by the sale of optical devices, and for some professionals to feel competing sales pressures, both of which are at odds with moving optical professionals towards becoming 'GPs of the eyes'.

  o Some also mentioned the need to engender cultural change and build receptiveness among the public specifically to the increased focus on prevention and health-related education.

In addition, it has been noted that a number of measures would need to be in place to ensure patient safety and confidence given these changes:

- Careful monitoring of the training, registration and continuing professional development (CPD) of practitioners to provide 'proof of competence'.

- Robust governance systems and protocols.

- Protection, particularly of children and vulnerable patients, in the provision of optical services. Some respondents suggest that dispensing to both of these groups should be by a qualified registrant.

Q3 How are the roles of optometrists and dispensing opticians likely to change over the next 20 years, and what are the drivers for these changes?

An enhanced clinical role is widely expected for both optometrists and dispensing opticians (DOs):

- For optometrists this is predicted to cover the full gamut of eye health and sight loss prevention including identification of disease, minor eye care services and community follow-up following discharge from secondary care.

- For DOs it is envisaged to mean involvement in the delivery of Low Vision services, referrals and eye-health advice, with a delegated role also in refraction enabled by technology and greater automation. However, an alternative path is also foreseen for DOs that would be to specialise in commercial or management aspects of practice rather than on the clinical side.

There is also generally anticipated to be:

- More involvement of the optical professions in screening, diagnosing and managing systemic as well as ocular conditions.

- More cross working and co-management of patients.

- More working in specialist roles including new specialisms (e.g. in old age and children).

- Greater automation within diagnostics enabling a greater emphasis to be on interpretation rather than on gathering information, and some tasks

(e.g. related to refraction) to be delegated/performed by more people than currently.

- More focus on prevention including through wider health promotion.

It is felt that these changes will mean that professionals will be working to the full extent of their existing training and will require some new or enhanced skills, both in clinical practice and in leadership and management to support patient care. For example, it is expected that:

- Communication will become even more important as clinical role expands and there is increased emphasis on interpretation.

- There will be a greater likelihood of having patients present with wider issues than just relating to optical health, meaning that practitioners will need to have sufficient diagnostic skills and better links with other health care providers.

- Upskilling will be required to enable greater self-sufficiency within specialist areas in order to improve patient pathways (e.g. low vision practitioners able to refract and prescribe to prevent patients being inconvenienced by long wait times and re-referrals).

In addition, the expected increase in patients with disabilities, complex needs and, specifically vulnerable patients, is believed to have some implications for the future role of optical professions:

- It is anticipated that patient safeguarding will become more important. A suggestion has been made to change the restricted categories to include vulnerable adults and patients with high prescriptions.

- There is also believed to be an increasing need for optical professionals to be aware of their obligations to provide reasonable adjustments and accessible information, as well as having a proper understanding of consent and capacity issues.

- It is felt likely that more formalised professional specialisms will be needed in the eye care of people with, for example, learning disabilities or dementia.

The drivers for these changes, as previously mentioned, are perceived to be a combination of:

- The need to alleviate pressure on overburdened HES.

- A response to government policy for more healthcare to be provided in the community.

- Technological advancement and change.

- Evolving patient needs and demand.

It is widely felt to be important that registrants don't lose control of the eye examination (e.g. to non-registrants or patient self-testing) as a consequence of the role changes outlined above, as it is believed to be the eye examination that encourages the public to regularly visit the optician and provides the best opportunity to identify issues. It is worth mentioning that one respondent had specifically mentioned that they do not support the delegation of refraction even to DOs because they believe that to allow professionals who are not competent at performing a full eye examination to refract in isolation leads to a risk that such pathologies will be missed. However, most who made comments about possible increased delegation of refraction to DOs do not appear to share these views.

Q4   How should the education of optometrists and dispensing opticians be structured to enable continuing professional development throughout their careers, e.g. core training followed by general or specialist practice?

This question has been interpreted broadly with responses extending beyond purely structural elements to touch also on the content and delivery of optical programmes.

A particular focus of comment has been on future undergraduate training but views have differed on how to ensure this is fit for purpose:

- Most, though not all, are of the view that compulsory core training within undergraduate degrees needs to be at a higher level than it is currently in order to meet the demands of enhanced services and more medical

and extended role care. In particular, there is a consensus that core training needs to be more clinically and practice based.

- However, a number of respondents were unsure about how to incorporate the additional content required to raise standards without an increase in the length of the undergraduate degree. Some believe that longer courses are needed while others question the desirability or feasibility of moving to longer degrees, for example due to insufficient Higher Education Funding Council for England (HEFCE) funding or because of expected difficulties in attracting students.

- Some also identified a trade-off between focusing just on core content within undergraduate training versus enabling students to commence training in specialist areas. Some are of the view that specialist training should be reserved for graduates, e.g. via higher qualifications or within specialist practice, while others see merit in a 'core plus' approach to undergraduate education.

- In addition, there are differences of opinion as to what content will be required as part of future compulsory core training. While there is consensus that the intention should be for new registrants to be qualified to treat all common eye health conditions, there are differing views on what would achieve this. For example, a number feel that increased focus on therapeutics will be required including enabling some or all graduates to qualify as Independent Prescribers (IPs). However, others believe that IP qualifications should be restricted to registrants who are in practice, as is the case currently (e.g. to ensure sufficient practical experience or to make sure that supply does not exceed demand).

However, there is accord on some aspects of how core training should be delivered:

- Modular and flexible learning models are felt to have value (e.g. 'earn while you learn', blended learning etc.).

- There is believed to be learning to be had from approaches adopted in medicine and dentistry.

- There is interest in enabling some aspects of training to be provided alongside other professionals.

- There is a commonly held view that training should particularly aim to develop skills in problem-ssolving, decision-making and quantifying risk in order to build professional capabilities.

- It is felt that practical experience should be woven into the programme at an early stage so that students are prepared for a broadened and more varied clinical role.

- There is support for core training to be maintained as a two-part process within which there is an undergraduate programme followed by a period of time working under supervision (pre-registration). It is believed that this is the best approach to ensure new registrants are able to practise as primary eye care practitioners and can be a functioning part of standard local eye health schemes anywhere in the UK.

In addition, there is consensus on what are regarded to be desirable principles or outcomes of the approach to education, both for qualification and ongoing professional development, including that it should:

- Be clinically focused and experientially based.

- Reflect the changing scope of practice and represent emerging specialist areas.

- Be accessible, cost effective, nationally recognised and supported by other relevant professional bodies.

- Build strong communication and problem-solving skills.

- Engender an ongoing culture of learning, which in turn was felt to require a transition:

  - From educating individuals to perform specific functions (sight testing, fitting contact lenses and dispensing spectacles) to producing health professionals who can adapt and specialise as they develop in their careers.

- From the current Continuing Education and Training (CET) system to CPD, with a focus on experience and developing skills, not just maintaining entry level skills, as is discussed further in responses to Q10 and Q13).

- Provide a career progression path for optical professionals which is both clear and flexible.

  - For example, it has been suggested that a common education/career path should be developed for the optical professions that enables entry by those whose entry level qualifications were gained in the workplace as well as school leavers.

  - One optical businesses suggested that highly trained non-registrants could be enabled to undertake part-time study in optometry alongside part time work at an optical practice and supervision, as is currently possible for dispensing opticians, without first needing to qualify as a DO.

  - In a similar vein, another respondent mentioned that they perceive a need for nationally recognised qualifications for unregistered support staff who are working in practices and labs:

    - To provide essential background knowledge and help to develop key behaviours, communication skills and the important understanding of the boundaries for their clinical authority; and

    - To enable access to a career path for those who wish to go onto become DOs or optometrists.

Q5   What are the implications for the GOC register of likely changes in roles and will the existing distinctions between registrant groups remain appropriate?

There are mixed views as to whether the GOC should retain the current optometrist/dispensing optician distinction on the register (to reflect differences in training and clinical responsibilities) or dispense with these

(because of an expected blurring of boundaries between the professions moving forward as referred to in response to Q3).

However, there is accord that it will be important that varying levels of practice, qualification and experience are identified by the GOC to provide assurances for the public. This is expected to lead to an increased need to record different competencies or specialisms in the future e.g. via specialist register/s, sub-lists or annotations. It is also believed to be incumbent on the GOC to monitor if those with registrable specialisms are using these regularly in practice, and keeping up-to-date, in order to protect patient safety.

It is seen as important that, when making adjustments to the structure of the register, the GOC takes care not to over-complicate the register so the public can use it as a decision-making tool. In order to be useful to members of the public, as well as others (e.g. to help employers to judge suitability of registrants to perform roles), it has been variously commented that:

- It is imperative that the register is accessible, regularly updated and accurate.

- The GOC should consider incorporating clever search functionality into the register.

- It should be easy for lay people to distinguish between those with relevant professional training and those without (patient groups have reported that this is not straightforward for them to do currently).

- The GOC should explore bringing other health professionals (e.g. orthoptics) under its registration or, as a minimum, have better links to registers of other health professionals involved in the provision of eye care.

There has been a suggestion to drop the student register; a reason for this was not provided and it does not appear to be a commonly held view. On the other hand, it has also been suggested by one respondent that, if optical assistants become more involved in dispensing in the future, this could evolve into being a registrable profession.

The response to this and other related questions also included some comments on the possible implications and trade-offs associated with the further development of specialist roles within optical practice. For example, one respondent expressed a hope that the profession moves as a whole into enhanced roles and does not fragment into disparate skill sets and registrant groups. A related view is that diversifying the profession to stratify specific roles risks there being inadequate provision of sufficiently trained generalists in the delivery of primary care ophthalmology services.

GOC's approach to education

Q6 **What are your views on the GOC's approach to the accreditation and quality assurance of education programmes, including on whether this is an appropriate focus on outcomes and on the use of the competency model to set standards of education?**

Most responses express support, in principle, for the GOC to continue its independent governance of training provision by accrediting and quality assuring education programmes. Some patient groups and others commented that commercial bodies involved in the provision and award of further qualifications should, in particular, be the focus of close GOC governance and potentially restricted in such provision.

There are, however, some exceptions to this view. A couple of education providers have questioned whether the current approach, of focusing what they perceive to be a large proportion of GOC resource on visiting universities who provide degrees in optometry, is the best way to protect the public. They argue that as most of student interaction with patients occurs during the pre-registration placement year, the main GOC focus may be better placed to ensure that supervision and experience are to an appropriate standard.

It is generally felt, even by the majority which is supportive of the GOC's involvement in this area, that the GOC's approach to accreditation and quality assurance of education programmes should be less input-driven and more focused on outcomes, with a particular emphasis on ensuring that patient safety is protected.

Some also feel that where inputs are considered it should be mainly to ensure that:

- Curricula and assessment protocols are in line with modern methods of clinical education.

- There is appropriate leadership and sufficient support in place for both students and teachers.

There is a related and commonly held view that the GOC's approach should not seek to prescribe standardised methods (so institutions have flexibility to select the most appropriate approach for their setting and to innovate) but that it should seek to ensure standards are equivalent across training institutions.

It is also felt to be important that the approach is consistently and proportionately applied (one respondent specifically commented that they do not believe that this has always been the case).

Some suggest that, in designing its future approach to accreditation and quality assurance, the GOC should consider the available evidence base on what makes the most demonstrable difference when training students.

A suggestion has also been made by one respondent that where courses are training students for medical-type roles, the accreditation framework should be developed in co-operation with medical national agencies.

While the principle of a competency framework to set the standards of education is supported, a number have stated that they feel the current model requires review and potential adaptation to be suitable for the future setting of the standards of education. For example, it is a commonly held view that the current competency model encourages a tickbox response to compliance and needs to be adapted to ensure students receive a rounded understanding of how to apply the skills to decision-making.

In addition, some specific comments made on this theme included that:

- The system may need to become more flexible, and more regularly updated, in order to relate to modern practice and be the definitive entry-level to the register and registrant CET.

- New frameworks may need to be developed in areas where there is expected to be an expanded scope of practice.

- The Royal College of Ophthalmologists' Common Clinical Competency Framework for non-medical professionals working in HES could be used to inform the structure of CPD for those wishing to progress into health-focused roles.

There has also been a suggestion made that the GOC may wish to consider an alternative (or additional) approach to accreditation and quality assurance of education programmes involving standardised exams of graduating students, perhaps building on the College's Scheme for Registration (SfR), a theme which has also been covered in responses to Q15.

The General Medical Council (GMC) in its response to this question made no recommendation for the GOC but shared its own experience in this area. The GMC regulates medical schools by setting outcomes that graduates must meet. It also sets standards for all stages of medical education and training.   In addition, the GMC is also now looking at introducing a medical licensing assessment that would create a single, objective demonstration that those applying for registration with a licence to practise medicine in the UK can meet a common threshold for safe practice.

Q7   Should the GOC accredit and quality assure additional or different higher qualifications and, if so, on what basis?

There are mixed views on whether the GOC should accredit and quality assure additional or higher qualifications:

- Some feel that it should and that this will become increasingly important as the optical professions become more involved in clinical care.

    o A specific comment made by one respondent holding this view was that they believe a framework for entry level and advanced standards will be required to ensure higher qualifications are sufficiently advanced.

- Others believe that the GOC should only intervene in this area if the specialist area will appear on the register or if the qualification will lead to a change in scope of practice (due to the risk of variation of quality and to minimise risk to the public).

- And still others are of the view that the GOC's involvement in this area is not required as there are existing methods, both internal and external to

the training institutions, to ensure quality control so the GOC's involvement risks causing duplication and confusion.

If the GOC is to be more involved in this area in the future, it is felt that close collaboration with the sector will be required to determine the best methods.

The College of Optometrists has specifically proposed that it continues its system of accrediting a broad range of service-specific higher qualifications for the optometrist profession and that the GOC accredits it to do so.

A suggestion has also been made that the GOC should first concentrate on reviewing the approach to undergraduate education before it moves onto the area of higher qualifications.

The GMC has shared its approach in this area in its response to this question. The GMC sets standards and approves postgraduate curricula and assessment systems, and has recently revised its standards for approving medical speciality curricula. The GMC has also recently agreed a framework of generic professional capabilities (GPCs) that are broader human skills, such as communication and team working, needed by doctors across all medical specialties to help provide safe and effective patient care. In future all postgraduate curricula will reflect the GPCs.

Content of education programmes

Q8   What are the core skills, knowledge and behaviours which optometrists will need to have on first joining the register in the future?

A number of points made in response to Q4 also apply to this question.

There is broad agreement on the following points with respect to the requirements of graduating optometrists:

- That they have a mix of scientific, technical, clinical and professional skills.

- That they have an understanding of wider patient health needs, experience of multi-disciplinary working and an understanding of the importance of clinical governance.

- That they have the ability to make sound clinical decisions, which is believed to require well developed problem-solving, critical reflection, analytical and evaluative skills, an ability to utilise primary research and other external data (e.g. from automated processes) as an evidence base for practice, and an understanding of legal requirements and managing risks.

- That enhanced skills in some areas (i.e. current specialist skills) will become part of core requirements. There are different views about what the specific new areas should be beyond MECS and low vision (e.g. various suggestions include basic therapeutics and prescribing, improved diagnostics, public health and lifestyle factors, ageing and condition-specific skills, patient management and care pathways etc.) but agreement that the intention should be to enable optometrists to provide basic eye care to all patient groups, including those with disabilities and complex needs.

- That they have a well-developed understanding of what it means to be professional. This is itself defined broadly (see also responses to Q14) and perceived to include:

o   A sense of social responsibility and commitment to patient care.

o   Good communication and interpersonal skills, both to patients of all types/abilities and inter-professionally. This is also perceived to include an understanding of how to deal with complaints and feedback, and their duty of candour.

o   An understanding of basic management (including delegation and supervision), as well as leadership and mentoring skills.

o   An appetite to be lifelong learners and adaptable through their careers. This is also perceived to include the ability to balance independence of practice with knowing how and when to seek advice.

Some specifically referred to the QAA Subject Benchmark Statement for Optometry that they believe encapsulates the core requirements for optometrists when first joining the register.

Only a minority have suggested that there may be a consequential reduction in the need for traditional skills to make way for additional content requirements. In fact, some patient groups stated their concern at the potential for optometrists to spend less time on learning/being involved in refraction, as auto-refraction is less reliable with in adults with certain disabilities.

Some patient groups and others also call for practitioners to have, as a core competency, the ability to triage patients with disabilities/complex needs or vulnerable patients and the knowledge of how to access a referral pathway to an accredited/qualified practitioner with appropriate speed.

In addition, a patient group has suggested that it is important for practitioners to have developed core skills that recognise the need for additional time, and adapting techniques or communication strategy for a person who may be uncomfortable or anxious with the prospect of a sight test or onward treatment.

Q9 How should the content and delivery of optometry programmes change to ensure that students gain the skills, knowledge and behaviours that they will require for practice and for new roles in the future?

A number of the responses made to Q4 also apply to this question.

There is agreement that the objective of optometry programmes should be to ensure that, by graduation, students have gained the requisite skills, knowledge and behaviours required for practice.

Most, though not all, believe this will require changes to the content and delivery of undergraduate programmes. Specific suggestions made on this theme include that there should be:

- Sufficient room within the programme for enhanced service delivery (perhaps through a core programme combined with elective specialisms as well as absorption of some current specialist skills into core training).

- More and earlier exposure to patient episodes requiring practical decision-making (including by increasing clinical placements).

- An increased focus on problem-based learning (PBL). Various respondents also referred to case-based learning, evidence-based practice, outcomes-based learning and experiential situated learning methods etc.

- A culture of lifelong learning instilled in the programme.

In addition, a patient group has called for optional undergraduate courses, or post-registration high qualifications, to be offered specifically in the field of eye care for vulnerable populations.

It is felt by a number that accommodating this additional content will require consideration of lengthening courses or having longer terms.

In addition, the following suggestions regarding the future design and delivery of optometry programmes have been made:

- That optometry training is brought more in line with the approach taken for medicine and dentistry.

- That there should be more opportunities for inter-disciplinary learning, perhaps via parts of the course content provided alongside other eye health professionals.

- That modular and flexible learning models should be considered, including the opportunity for more e-learning, blended learning, part-time and earn-as-you-learn etc.

  o One respondent points out that delivery of education is already seeing such changes, e.g. flipped classrooms, recorded lectures, on-line chat rooms, inter-active discussion boards, blended learning. This respondent believes that students are likely to increasingly demand to study where/when they like so classroom activities will need to become more flexible.

  o Another respondent, however, poses a contrary view about modular learning that new registrants might not recognise that they will need all of their knowledge in daily practice as they can't control what comes into their consulting room.

The point has been made by some education and training providers and others that the GOC's approach to determining the content and delivery of future optometry programmes should not be too prescriptive but:

- Aim to obtain a consensus among the education providers and professional bodies to determine the core skills to be covered in the programmes.

- Thereafter provide the freedom for individual establishments to pursue their chosen specialities and research projects.

There have also been comments made specifically about the content and delivery of training during the pre-registration period including that:

- It should cover all competencies and modes of practice.

- Pre-registration students need to receive sufficient support from supervisors.

- There may be a need also to consider increasing the length of the pre-registration period.

Finally, some points particularly relating to future teaching and supervision have also been made in response to this question:

- Some have suggested that there should be more involvement of optometrists in teaching and that there is a strong case for creating a new accredited cadre of optometrist educators/lecturers who could teach or supervise equally well in practice, clinic or academic settings. There is interest in the GOC further exploring with others in the sector the scope for recognising, registering, supporting and rewarding those who acquire such teaching and supervision skills in addition to their clinical skills.

- The College of Optometrists believes that introducing a specific regulatory requirement would help ensure sufficient availability and quality of supervision. They point out that they have developed a supervisor competency framework and online training that they suggest could be helpful in ensuring a consistency of standards.

Q10 How might post-registration training and registrable higher qualifications for optometrists need to change in the future?

It is believed that the intention of post-registration education and qualifications should be to enable registrants to upkill in response to patient and practice needs and, in so doing, progress their careers.

This is deemed to require the development of appropriate competency frameworks and for there to be clear career paths available so that registrants can put higher qualifications and further training to use.

One respondent suggested that there is an initial need for the GOC and other stakeholders to agree the skills needed to participate in enhanced services. These could then be used by courses as curriculum aims and by the GOC to ensure that each accredited course is being delivered to a uniform standard.

However, it is also felt that areas in which higher qualifications and training are provided will evolve, as new technology and eye care needs develop and that additional specialist areas are likely to be required.

There is a general belief that higher qualifications in future should include a significant element of experiential learning. For example, it has been suggested that higher qualifications should build on general experience and involve a period of supervised or mentored experience and ongoing CPD to both consolidate learning and stay up-to-date. It has also been suggested that there is better integration with HES. Some specific models have been mentioned as having merit in terms of providing experientially based training, e.g.:

- The Scottish 'teach and treat' clinics model; and

- Locally delivered hands-on training offered by Wales Optometry Postgraduate Education Centre (WOPEC).

As mentioned, there is a specific point of debate about whether IP should be included as part of future undergraduate degrees or alternatively restricted to graduates following some time in practice, as is the case currently.

From the demand side, it is regarded as important that registrants see the pursuit of further learning as feasible and desirable. This, in turn, is believed to be affected by the flexibility and affordability of courses, the level of support provided and associated career opportunities. Some specific points have been made with respect to this theme:

- There has been a call to address the current difficulty in finding supervisors. As a way of doing this, it has been suggested to substitute ophthalmologists with suitably qualified optometrists where this is not currently permissible.

- It is also believed to be important for the quality of supervisors to be assured. A suggestion that relates to this point is that specialist training should be completed in order to become a supervisor of trainees, and the type of trainee needs to be relevant to the skills of the supervisor.

- There have been calls for additional funding to be made available to help with the associated time spent studying and time spent out of practice, in order to make the higher qualifications more accessible.

- As previously mentioned, it is felt that additional training in specialist modules that significantly expand the scope of practice should be recognised on the GOC register.

- In addition, it is believed to be important to have a nationally recognised system so that an optometrist who has achieved a higher qualification does not need to be reaccredited to do the same job in the adjacent commissioning area.

The area of continuing professional development has also been covered in some respondents' feedback to this question. CPD is seen to play an important role in consolidating higher learning and ensuring those with higher qualifications remain up-to-date. In addition, it is expected that retraining will be needed to upskill in the newest technologies as they are discovered.

While CET is to be the subject of a separate review, it has been frequently raised in response to this Education Strategic Review. There is a commonly held view that the current CET system is not fit for purpose, as it is perceived to result in a tickbox approach, and maintenance of entry level standards, rather than genuine development. There is wide support for the sector to move towards a CPD model in order to ensure learning becomes more linked with, and relevant to, individual learning needs within the context of the professional's own practice. It is acknowledged that monitoring compliance will be more challenging with CPD but it is believed this can be done by providing evidence of practical experience and keeping up-to-date e.g. by keeping a portfolio.

Q11 What are the core skills, knowledge and behaviours which dispensing opticians will need to have on first joining the register in the future?

It is believed by many that, in future, dispensing opticians should be able to demonstrate the same core skills that they currently have along with additional knowledge/skills in the areas of pathology and management of conditions to support optometrists and patients.

Specifically, it has been suggested that dispensing opticians will need to upskill in order to be:

- Better able to recognise eye conditions as they could have more of a triage role.

- More involved in delivering low vision services, rehabilitation and support to people living with vision impairments.

- Able to undertake basic refraction and eye examinations in the expectation that there will be some degree of delegation of these areas by optometrists to DOs in the future.

- Understand the needs of children, those with low vision, as well as vulnerable patients and those with complex needs, in order to provide the necessary treatment and/or referral.

- Equipped to dispense in the area of highly customisable eyewear, including potentially acquiring skills in Computer Aided Design (CAD).

In addition, it is felt that many of the more general requirements outlined for optometrists also apply to dispensing opticians, for example the demonstration of:

- Sound, evidence-based decision-making, including problem solving and situation management.

- Strong communication and interpersonal skills.

- The ability to work in a multi-disciplinary team.

- A thorough understanding of what it means to be professional.

- An appetite to enquire, acquire new skills and adapt throughout their careers.

Some are also of the view that DOs will require enhanced sales and business management skills as some will be well suited to practice manager and optical business leader roles.

One respondent expects DOs to be future custodians of all technology in practice and therefore that they will additionally need to have a good understanding of current and emerging technologies.

Q12 How should the content and delivery of dispensing programmes change to ensure that students gain the skills, knowledge and behaviours that they will require for practice and for new roles in the future?

A number of the general points made about future optometry programmes are also felt to be relevant to dispensing programmes. In particular, it is perceived that both professions will require a greater emphasis on clinical skills and gaining hands on experience, as well as understanding risk management and enhanced communication skills.

To achieve this, it is expected that dispensing courses will need to cover a number of enhanced service areas in future, such as:

- Basic optometry pathology recognition skills.

- Instrumentation and refraction.

- MECS and Low Vision.

- Specialised dispensing e.g. paediatric as well as to vulnerable patients and those with complex needs.

- Design if dispensing opticians are to be involved in making bespoke frames and lenses through 3D printing technology.

Another suggestion made by several is that the core programme should include commercial management modules (covering HR, governance etc.). In addition, one respondent commented that they believe a more vocational element needs to be included to incorporate fashion, window display, frame purchasing, and general retail knowledge and skills.

It has been suggested that one approach to evolving the content of dispensing programme might be to adopt some of the current Contact Lens Optics (CLO) curriculum.

In terms of the delivery of future dispensing programmes, some feel that the course length may need to be increased.

It has also been suggested that the provision of increased clinical exposure lends itself well to:

- Distance learning (via virtual classrooms, webinars etc.), provided that adequate and appropriate supervision is provided.

- Blended learning programmes that allow students to put into practice skills and knowledge learned immediately and alert them to what they need to provide to their patients.

A specific comment made by one optical business is that they would like it to be made possible for service providers to train and approve DOs in-house.

Q13 How might post-registration training and registrable higher qualifications for dispensing opticians need to change in the future?

Relatively fewer responded to this question.

One specific response from a registrant supported the principle of developing more opportunities for higher qualifications for DOs. This respondent is of the view that many DOs are now studying on a degree route and are capable of progressing to Master & PhD programmes or post qualification diplomas in certain subjects.

It has been suggested that the general direction of higher qualifications for DOs should be to develop skills in order to meet the future demands of the health service and prescribing needs.

More specifically, one respondent expects future higher qualifications for DOs will cover low vision, paediatric dispensing, practical refraction, research skills, diabetic screening, vision screening, MECS, refractive surgery care, dry eye management, supervising trainees, and contact lens qualifications.

Some practical points about the delivery of post-registration training and higher qualifications have also been made:

- It is felt that higher qualifications need to be easily accessible and that a variety of methods should be available by which a practitioner can broaden their skillset post-registration (including part-time and work-based options depending on the qualification).

- It is believed to be important that practitioners keep up-to-date via CET/CPD when applying higher qualifications in their own practice areas and that compulsory peer review/peer discussion should be required for DOs.

- It has also been suggested the career pathway model should enable a DO to move to Orthoptics or Optometry with appropriate higher qualifications and training.

One respondent believes that, beyond the currently registrable CLO qualification, further higher qualifications should not be regulated by the GOC.

The views expressed about the limitations of the CET system for optometrists are also perceived to apply to DOs. In addition, a couple have stated that they would like to see general retail matters business, vocational eyewear and technical products included in CET for DOs.

Professionalism and consistent standards

Q14 How can we ensure students have the professionalism needed to take on new roles, including through the admissions procedures used by education providers, patient experience, supervision and embedding professional standards?

As mentioned previously, demonstrating the requisite professionalism is perceived to require:

- Strong communication skills.

- Emotional intelligence.

- A thorough understanding of professional standards and ethical principles, including the consequences of non-compliance.

- Evidence-based decision making.

- The ability to undertake reflective learning.

- Leadership and management skills.

In order to ensure this, several responses propose a change to the admissions process which would involve taking into consideration (e.g. via interview or an exam similar to the Health Professionals Admissions Test (HPAT)) additional factors beyond academic performance in order to select those with most opportunity to develop these professional qualities. However, some respondents acknowledge that:

- This change would require additional resources to administer.

- Some aspects of professionalism are learnt, so it may not be fair only to select prospective students already possessing these qualities.

- If recruitment is limited to those applicants who already show excellent communication skills at interview (for example), there is risk of a reduction in diversity of students.

A related point is that accrediting prior learning (e.g. as an optical assistant or in another healthcare profession) is expected to play a part in future admissions procedures.

In addition, it is generally perceived that:

- Professional principles should be embedded into the undergraduate curriculum from an early stage, with a patient-centred approach to learning and a focus on developing leadership, management and communication skills as well as other competencies.

- The methods of learning used should support the development of professionalism (e.g. PBL, inter-disciplinary learning, practical experience, decision-making in complex environments, evidence-based decision making, peer review etc.).

- Professional behaviour needs to be role-modelled by teachers and supervisors. This in turn requires there to be sufficient and appropriate training and supervision available for students which has implications for the future availability and training of supervisors as well as for teacher/student ratios and ensuring teachers have sufficient practical experience to fulfil this role.

- There needs to be rigorous grading systems that assess professionalism as well as other scientific, technical and clinical skills.

- Professionalism needs to be reinforced during undergraduate clinical placements, in pre-registration training and throughout registrants' careers, including via CET/CPD.

One education and training provider has mentioned that it believes it to be unfortunate that the GOC standards for students do not currently refer to their professionalism within the educational context. For example, they report that there is no specific requirement to engage meaningfully with the learning environment, and no specific mention of academic malpractice.

It was also suggested that there needed to be adaptations to the current CET system to emphasise and develop professionalism, e.g. by increasing the focus on personal reflection including patient feedback and complaints.

Q15 How should students be assessed prior to joining the register to ensure that there are consistent and appropriate standards of education, taking into account the different types of education programmes that are emerging?

There is broad agreement that, to ensure that sufficiently high and consistent standards are demonstrated by new registrants, a system needs to be retained for the independent assessment of all optometry students at the point of graduation (currently in the UK this is via the College's SfR), along with a period of assessed and supervised practice prior to entering the register.

A similar view on the value of external assessment of graduating students has been expressed with respect to DOs. It has been suggested by one respondent that consistency can only be gained by an external awarding body delivering the same fair and rigorous assessment to all seeking registration.

A number of respondents support the continuation of the College's SfR unchanged for optometry but some feel that the current approach may warrant review. For example, it has been variously suggested that:

- The approach should be evaluated to ensure that it is valid (assessed against a defined role/competency framework), objective (judgements against agreed standards/not subjective) and reliable (not affected by individual assessor or time of assessment).

- Objectivity could be improved by introducing a portfolio of records, increasing assessment of work performance (e.g. by observation), including knowledge and understanding tests, requiring submission of reflective logs and requiring responses to case scenarios.

- It may be more appropriate to tailor the assessment approach to the Core Competency Groups. For example, one respondent felt that communication competency elements were difficult to assess with limited direct observation and patient records.

- There needs to be increased coverage of certain areas (e.g. Low Vision and testing children).

A couple of proposals for an alternative approach to SfR have also been made:

- As mentioned (in Q6), there has been a suggestion that the GOC may wish to consider an alternative (US-style) approach involving standardised exams of graduating students. However, comments suggest that most feel otherwise and believe that a combination of examinations and assessment would be more suitable.

- A suggestion has also been made to base the approach on the current UK medical model which they believe to be well validated.

It is widely perceived that there needs to be a review of the current use of competencies as the basis for pre-registration student assessment and a move to more outcome-based measures:

- With a greater emphasis on demonstrating analytical skills and the ability to synthesise information from various sources to make decisions.

- And evidenced by more than just the number of patient episodes.

In addition, ensuring consistency of pre-registration training has been particularly highlighted as a challenging area given the variety of supervision and practice settings. As a lot of pre-registration training is now in-house there is a risk that the line between business and professional education will become blurred. For example, it has been suggested that the pre-registration system can be used to the advantage of some employers, potentially to the detriment of students if they are seen as a cheap workforce.

Given this, it has been suggested that some process for the independent assessment of standards in this area may also be warranted. Respondents also proposed that the role of supervisor should be further formalised, for example with a framework for supervision skills and knowledge, to ensure the supervisor has the appropriate knowledge required. More systems for mentoring and support of supervisors have also been called for.

Barriers to change and other issues to consider

Q16 **_What are the challenges and barriers to improving the system of optical education, including issues that may be outside the remit and control of the GOC, such as legislative change, workforce planning, the funding of education (including higher education, continuing education and training and continuing professional development) and the provision of student placements?_**

All of the challenges and barriers referred to by the GOC in the question wording have been acknowledged by respondents in their replies. In addition, some referred again to the answers they had given in response to questions about barriers to changing eye care delivery in Q2.

The most commonly mentioned education-specific barriers overall include:

- Insufficient funding for both undergraduate education and further education and training (including insufficient HEFCE funding and DOs not receiving DOCET funding).

- The potential for the time required for students to complete qualifications to increase in future to accommodate new content, which may deter students from choosing to study for optical qualifications.

- A lack of clinical placements to provide the required experiential learning.

- The large number of students completing undergraduate degrees currently, resulting in high student to teacher ratios and potentially impacting on calibre of graduates.

- A possible resistance by some education institutions to consider change.

A number of the barriers are believed to lie outside the control of the GOC and some are perceived to extend beyond the parameters of the system of education.

Q17 Are there any other issues that the GOC should consider in carrying out its review? If so, please set out what they are

Some wider issues beyond education have been raised in response to this question. These mainly relate to different views on how to adapt both business models and regulation to the expected changes in demand and eye care delivery while ensuring patient safety continues to be protected:

- As mentioned in response to Q3, it is widely regarded that the continued legislative protection of the eye examination will be critical for the sector as this is believed to provide the best opportunity to encourage regular patient visits and the opportunity to diagnose conditions.

- In addition, it has been suggested that the categories of patients which come under the regulated dispensing function be expanded (to include vulnerable patients, those with high prescriptions and requiring specialised appliances) in order to ensure their safety.

- On the other hand, one optical business is proposing that businesses be afforded greater flexibility so that suitably trained non-registrants can undertake certain restricted tasks under supervision. This is being proposed to alleviate the expected greater pressure on resources from registrants undertaking enhanced and more clinical roles.

- A suggestion has been made that there should be penalties for employers putting undue pressure particularly on students during the pre-registration period (e.g. re short testing times or conversion pressure), which prevents them from providing the best possible care.

- Another specific point made relating to changing optical roles is that more complex decisions mean there are less likely to be definitive answers, and it is felt that this needs to be taken into account by the GOC where there have been errors of judgement or things have gone wrong.

- It has also been suggested that the GOC's approach to registering overseas practitioners may also need to be reviewed.

The other main theme amongst responses to this question relates to views on how the GOC should go about this Education Strategic Review. For example it has been variously suggested that the approach should:

- Be bold, innovative and embracing of the future.

- Be sufficiently flexible to adapt as the profession changes and to respond to unforeseen challenges and opportunities.

- Be more facilitative than prescriptive.

- Focus on the protection of the public while also supporting the professions to meet emerging challenges and realise their potential.

- Acknowledge and look to address the potential pressures and conflicts of interest associated with registrants being health care providers who are mostly employed by retailers.

Respondents

List of respondents to the Call for Evidence where consent to be named has been provided.