

## How to respond

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The simplest way to provide a response is through our online consultation response form, which can be accessed here: <https://www.optical.org/en/get-involved/consultations/index.cfm>

If you are unable to submit your feedback online, then please use the form below to submit your written feedback. If you are unable to provide your response in writing or you require the consultation form in a different format, please contact us on +44 (0)207 580 3898 to discuss reasonable adjustments that would help you to respond.

This form should be emailed or posted to:

Simon Grier  
General Optical Council  
10 Old Bailey  
London, EC4M 7NG

Email: [sgrier@optical.org](mailto:sgrier@optical.org)

The data presented in our analysis will be summarised and supported by direct quotes from some of the responses received. These quotes will either be attributed to a named respondent or anonymised, depending on your preference as indicated in the consultation response form.

Alongside the analysis, we intend to publish the individual responses that we have received, unless you have indicated that your response is to remain private.

All data submitted will be stored securely and in accordance with data protection principles.

## Publication of consultation responses

Unless you state otherwise we will assume you are happy for us to publish your response, including your name, and to share it with other appropriate bodies and stakeholders. We would however encourage named responses where possible and particularly from representative organisations so that we can reflect that the response is on behalf of members / stakeholders rather than an individual response.

Please tick here if you are only happy for us to share your responses anonymously:

Your name or the name of your organisation:

**Dr James Gilchrist, on behalf of Optometry Schools Council**

Your email address:

**j.m.gilchrist@bradford.ac.uk**

Which category of respondent best describes you?

- Member of the public
- Optical patient
- Optometrist
- Dispensing optician
- Student – optometry
- Student – dispensing
- Optical business
- Education or training provider
- Optical professional body
- Other optical employer
- Healthcare regulator
- Other (please specify below)

## GOC Education Strategic Review - Call for Evidence

### Submission by James Gilchrist on behalf of Optometry Schools Council

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**Are you replying on behalf of an organisation?** Yes

**Name of the organisation:** Optometry Schools Council (OSC)

**Your position:** Chair

**Nature of the organisation's work:**

Representing the University Schools of Optometry.

OSC Members (Universities & Optometry School Heads and/or Representatives):

Anglia Ruskin University	Professor John Siderov
Aston University	Dr Leon Davies
University of Bradford	Professor Edward Mallen
Cardiff University	Professor David Whitaker
City University	Dr Ahalya Subramanian
Glasgow Caledonian University	Professor Anita Simmers
Dublin Institute of Technology	Ms Eva Doyle
University of Hertfordshire	Dr Joy Myint
Manchester University	Mr William Holmes
Plymouth University	Professor Paul Artes
University of Ulster	Professor Kathryn Saunders
Hogeschool Utrecht	Ms Annemarie Brouwer

## **Changes in demand and the impact of changes in eye care delivery**

### **Consultation question 1 – How might the needs of patients requiring eye care change over the next 20 years?**

The proportion of older people in the population is expected to increase significantly with corresponding increase in the prevalence of eye disease, in particular cataract, glaucoma and age-related macular degeneration (AMD). In addition increases in prevalence of diabetes and hypertension are anticipated.

In the younger population, the increasing prevalence of myopia is well-documented, and the use of display screen equipment with intensive near-work demand is likely to result in increased prevalence of dry-eye conditions and asthenopia.

Older patients will need eye care that is accessible and wide-ranging. There is likely to be a greater need for ongoing monitoring of chronic conditions such as glaucoma and AMD, whether at home or in hospital/community clinics, and a greater demand for domiciliary and low-vision services.

Children at increased risk of myopia development, and with high near-work demand through educational and social use of display screens, should have ongoing eye and vision care, in particular through early and school years. To meet this need there should ideally be more comprehensive care, with optometry in a position to provide every service from refraction and dispensing, through assessment and management of sensory and oculomotor (binocular) vision anomalies, to ocular health assessment.

While recognising the likelihood of more use of familiar (e.g. phone or tablet-based) technology across all activities from refraction to ocular health assessment there will be patient groups, notably the very young and old and those with disabilities, for whom a technology-centred approach to assessment may not be feasible. To meet the needs of these patients it is essential that optometrists remain able to undertake assessment and management using traditional methods.

In the interests of patients of all ages, eye and vision care should be better integrated across relevant services. Also, vulnerable patients in particular should be protected from the risk of neglecting their health needs due to the fear of high cost and sales pressure; there will be an increasing need to separate health-related aspects of eye-care from the provision of appliances, and to regulate accordingly.

### **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 patient's needs, and what are the barriers to these changes?**

Capacity in hospital ophthalmology is currently failing to meet demand [Foot B. & MacEwan C. Surveillance of sight loss due to delay in ophthalmic treatment or review: frequency, cause and outcome. *Eye* 2017; 1-5, doi:10.1038/eye.2017.1]. More eye health care needs to be provided outside the hospital setting and by optometrists.

To meet eye-health demand, there will need to be a shift of the load from secondary to primary care. Some activities now carried out by ophthalmologists could be carried out

by optometrists taking on a greater role in the assessment, diagnosis and treatment of ocular health conditions. This will require better integration of systems to enable joined-up management of patients' care across health (ophthalmologists, optometrists, GPs & others) and social care services.

To meet the needs of children, in whom the prevalence of eye disease is relatively low, there must be emphasis not only on eye health but also on visual development, and on ensuring clarity and comfort of vision at school. To achieve this, optometry will need to be in a position to provide comprehensive eye and vision care at all ages from infancy, and parents and teachers will need more awareness of children's vision and the importance of better integration of health and educational services.

Barriers to these changes include:

1. Inadequate Funding – primary eye and vision (optometry) services are not funded adequately at present; all provision is currently subsidised by sale of appliances, as the sight-test fee barely covers the cost of refraction let alone the provision of additional services related to eye health and visual function. This is unsustainable and there will be no prospect of any effective progress towards meeting the future needs of patients unless an acceptable service-based funding model can be realised. [Shickle D, Davey CJ, Slade S. Why is the General Ophthalmic Services (GOS) Contract that underpins primary eye care in the UK contrary to the public health interest? *Br J Ophthalmol* 2015; 99: 888-892. doi:10.1136/bjophthalmol-2014-305345]
2. Professional Insecurity – there is resistance in every profession towards relaxing control of its own domain, which manifests as lack of trust between professionals and unwillingness to embrace a shared approach. Such attitudes are a barrier to achieving the changes in scope of practice needed for optometrists to undertake activities currently associated with ophthalmologists and orthoptists, and for opticians to undertake activities currently associated with optometrists. It will be necessary to identify what the new landscapes of professional responsibility will look like and how they can integrate to ensure that each profession is properly recognised, respected and remunerated.
3. Inadequate communication between professionals – this is currently a problem with eye health services, both within primary care (GPs and optometrists) and between secondary and primary care (ophthalmologists and optometrists). Optometry practices are not fully regarded as part of the health service; they do not have a presence on the health service network and so cannot communicate electronically with other service providers. In addition, there often seems to be lack of regard for the role of the optometrist, in that feedback on referrals may be sent from ophthalmologist to GP but not to the referring optometrist.
4. Unwieldy care pathways – multi-professional working requires more streamlined methods of communication and also more agile and efficient pathways for patient management. It is no longer sensible for most referrals from optometry to ophthalmology to be routed via the GP, an outdated practice that generally adds little but cost and delay. To meet future, and indeed present, needs it should be possible for any professional within an effective integrated care structure to refer directly to any other.

5. Legal implications of reliance on technology and patient self-diagnosis – issues around how to regulate these, what information should be obtained by the professional in addition to that provided by the patient, and who is responsible for what?
6. Support for professional development – expansion of professional roles requires additional education and training. There will be a need to ensure that optometrists are given time for this and that the cost is covered. Currently there is variation across the country, and across employers, in terms of financial support and encouragement for optometrists to undertake additional training, including postgraduate qualifications. Closely allied to this is the fact that roles involving greater levels of responsibility require professionals to maintain and improve their knowledge and skills more assiduously than they may have done in other roles. This requires a culture of continuing education that is centred on CPD rather than CET.
7. Patient Trust – as noted above, optometry continually suffers from lack of funding for clinical services to such an extent that this provision must be subsidised by sales of appliances (spectacles and contact lenses). Although such provision is an essential and inseparable element of eye & vision care for the majority of patients, an effect of this business model is that optometrists may come under pressure from employers to maximise ‘conversion’ from sight-test to dispensing (that is, always to issue a prescription so that sale of an appliance becomes possible or likely). In turn, a consequence is that this practice may damage patient trust in optometrists. For older adults, for example, Shickle & Griffin (2014) conclude that “Not-for-profit services co-located with other public services are needed to address concerns about cost of spectacles, lack of trust in optometrists, and poor access to eye examinations in local settings.” [Shickle D, Griffin M. Why don’t older adults in England go to have their eyes examined? *Ophthalmic Physiol Opt* 2014; 34: 38–45. doi: 10.1111/opo.12100]. Similarly, for younger patients, Shickle et al. (2014) conclude “... young adults need to be made more aware of eye health issues, so that optometrists are seen as more than somewhere that sells spectacles” [Shickle D, Griffin M, Evans R, Brown B, Haseeb A, Knight S & Dorrington E. Why don’t younger adults in England go to have their eyes examined? *Ophthalmic Physiol Opt* 2014; 34: 30–37. doi: 10.1111/opo.12099].
8. Awareness of Optometry – the issue of patient trust described in the previous point often goes hand in hand with lack of awareness of optometry and the role of optometrists in health care. To a large extent, optometry is rendered invisible to the public by two aspects of its position. One is that, although optometrists are employed by the NHS and work in hospital practice, optometry itself is not identified as a profession within the NHS [e.g. <https://www.healthcareers.nhs.uk/>]. On the other hand, the vast majority of optometrists who work in community practice are presented by their employers, and identified by the public, as ‘opticians’, with no recognition of the fact that the expertise, permitted activities and roles of optometrists and (dispensing) opticians are distinctly different.

**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?**

We expect that optometrists will be more involved in the assessment and (co-) management of ocular health conditions and provision of a wider range of services, such as domiciliary care & visual rehabilitation, for the elderly. We also see a need for optometrists to be able to provide all eye and vision care services for children, including cycloplegic refraction, orthoptic and binocular vision management and spectacle dispensing as appropriate. Significantly this will include children with special needs and disabilities for whom the proper management of refraction, dispensing and oculomotor issues, in addition to ocular health monitoring, is especially important.

The essential aspect of the optometrist's role change is from 'refractionist' to 'eye & vision health practitioner'. The optometrist should be recognised, by the public and by other professions, as the 'GP for eyes and vision' – the optometrist should be the natural first port of call for advice on all aspects of eyes and vision. We note that the emphasis here must be on eyes AND vision, not on eye health alone. While it is clearly important and pressing for optometry to expand its role in eye health, it is equally important that members of the public should be able to consult a registered professional who can advise with authority on all sorts of issues involving vision. Optometrists are currently the only eye-care professionals whose undergraduate education involves detailed study of normal and abnormal visual perception, in addition to refraction and ocular health. Optometrists should also have the knowledge and expertise to evaluate published evidence relating to eyes and vision, to undertake assessments and treatments in accordance with available evidence, and to advise patients accordingly.

The drivers for these changes, some noted previously, include: 1) changes in population demographics leading to increased need/demand for services, 2) lack of capacity for ophthalmology-related services in secondary care, 3) the growth of provision, in response to demand, for vision 'therapies' to help children with progress in school, along with 4) the natural motivation of professions to 'upskill' and increase their scope of practice.

**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?**

Undergraduate education of optometrists should provide the strongest possible foundation for continuing professional development. To support this, there must be emphasis on:

1. Professionalism – not only to engender appropriate attitudes and behaviour towards others, but also to foster a mature approach to academic study, scope of knowledge and practice, use of evidence, etc., and the need to place this in a broad, long-term context that goes beyond the immediate priority of achieving success on the degree programme.

2. Perspective – the ability to integrate knowledge, skills and professional behaviour with awareness of the broader context of the optometrist's role and the needs of the patient. This takes time to develop and requires repeated reinforcement, especially for students who are relatively immature or inexperienced on admission to university.
3. Scientific Literacy & Evidence-based Practice – students must not only develop skills in routine aspects of clinical assessments, they also must understand underlying scientific principles of all their skills and have knowledge of where these principles come from and the essential literature associated with them. Through this approach, students gain a solid understanding of how and why their methods work, as well as of their boundaries and limitations. Also important in this context is the need for students to know how to read and interpret published literature, appraise new methods and undertake collection and analysis of data. Such skills are transferable to other disciplines as well as from earlier to later stages of a practitioner's career.
4. Clinical Skills – as is the case at present, optometry programmes must introduce students to clinical skills at the earliest possible stage, and allow enough time for these to be developed and consolidated until they can practise on patients. When students have developed their basic skills to a safe standard then they may be permitted to graduate from university and proceed to consolidate these skills in real practice settings. Thus, we establish a structure and principle that ongoing professional development of clinical skills will take place in the setting that gives the student/practitioner best access to patients, with supervision and mentoring by other practitioners with skills appropriate to that stage of development. The undergraduate programmes produce graduates who are safe to enter pre-registration training, but do not / cannot produce fully developed entry-level clinicians, especially if these should be expected to have higher-level (more specialised) knowledge and skills to meet future needs.
5. Communication – students and practitioners must be able to communicate their understanding of their discipline to patients, to other lay people (e.g. parents or carers) as well as to other professionals inside and outside of eye and vision care. For many students the ability to describe and explain things, and in doing so to evaluate and reflect upon their own understanding, has not been developed at school, and does not come naturally. The structure of optometry education must be such that development of the students' ability to communicate descriptions, explanations, results of assessments and advice based on these results, should run parallel to development of clinical skills.
6. CPD and Postgraduate Qualifications – optometry education providers should be able to support continuing professional development through provision of higher-level programmes and qualifications, to complement development of practitioners' practice-based skills. Thus, staff in optometry education must themselves have higher-level qualifications and expertise, whether this is in clinical skills, non-clinical teaching and/or in research and scholarship related to the needs of optometry.
7. Recognition of Postgraduate Qualifications – these need to be fit for purpose within any UK geographic setting to avoid the need to 'retrain' when an optometrist relocates. Commissioners and service developers and providers should recognise



the content of current university programmes and avoid re-training unnecessarily beyond up-dating practitioners' knowledge, equipment and skills and/or ensuring consistent approaches to agreed protocols. Curricula on accredited courses are published and learning outcomes transparent, and duplication of training should be avoided.

We note that undergraduate programmes in optometry already include, and place a good deal of emphasis on, the priorities discussed above. Undergraduate education based on this core foundation, followed by postgraduate study aligned to experience in both general and specialist practice, will provide a structure to support continuing professional development. Mandatory post-registration activity should also prioritise CPD rather than CET.

**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?**

Scope of practice and roles of the GOC-registered professions will change, but a distinction between optometrists and (dispensing) opticians should remain to reflect differences in education, training and the activities that the two professions are permitted to undertake. As noted previously, the public needs a clearer understanding of the different professions and their roles. The GOC has a responsibility to help this by maintaining separate registers when professions are substantively different, and also to indicate on each register when individual optometrists and opticians hold specialist qualifications.

**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?**

The issue of accreditation and quality assurance of education programmes is fundamental to any review of the GOC's role in optometry education. Some would question whether the GOC should accredit undergraduate optometry programmes at all. It might be argued that focus on accreditation and periodic re-accreditation of undergraduate programmes, in which students necessarily gain a very limited amount of real-patient/practice experience, uses a great deal of GOC resource and diverts attention away from standards in the pre-registration period. This is where students get most of their real-patient experience prior to registration, and therefore where there is potentially a greater risk to patient safety unless the trainee is closely supervised.

Any such an argument against GOC accreditation of undergraduate optometry programmes would be set in the context of the following observations: 1) all degree programmes must be validated and periodically re-validated by their own host universities, and this process involves external experts, who are typically experienced senior academics from other universities, 2) all UK university optometry schools work to a benchmark for optometry programmes set by the Quality Assurance Agency for Higher

Education (QAA) [<http://www.qaa.ac.uk/en/Publications/Documents/Subject-benchmark-statement-Optometry.pdf>], 3) all optometry schools recognise and conform to the standard required for students to enter the College of Optometrists' Scheme for Registration, which oversees the pre-registration period, 4) all university optometry schools are members of the Optometry Schools Council, which enables sharing of information on good practice, methods of assessment, etc., across all the schools.

Having said that, and given the assumption that the GOC will continue to accredit optometry programmes, the following points represent our broad consensus view of some important issues that we feel should inform the GOC approach:

1. Patient Safety – the natural rationale for involvement of the GOC in accreditation and quality assurance of undergraduate programmes is to protect the public. In this context the crucial issue is adequate supervision of students by registered optometrists. This is perhaps an example of where the GOC, and other bodies within the profession, may have a better understanding of acceptable standards than the higher education institutions (HEIs) themselves. Thus, the ability of the GOC to set accreditation conditions related to resourcing of programmes is important, and makes it clear to institutions that adequate staff-student supervision ratios are a *sine qua non* for provision of degree programmes in optometry.
2. Educational Standard – the QAA Optometry Benchmark Statement sets out a framework for optometry education that recognises the standard of university degrees in science-based subjects. It is important that the GOC should endorse this approach, and require that programmes maintain the standing they have achieved over the period of some 50 years since optometry in the UK became a graduate profession. The minimum standard of entry to the optometry profession must continue to be at BSc Hons level and it is essential that programmes are regarded primarily as degrees in scientific knowledge and understanding, and not as qualifications based principally on demonstration of clinical/technical skills. The recently published Foresight Report (<http://www.opticalconfederation.org.uk/activities/foresight>) details the probable significant changes in practice that will occur due to developments in technology. Therefore, now more than ever, we regard it as essential that undergraduates continue to be taught basic scientific principles which underlie such technology so that they can make reasoned decisions based on its output. Once again there is a role here for the GOC to ensure that programme providers provide adequate resources to achieve and maintain this standard of education; in particular this requires a sufficient number of highly-qualified academic staff having, between them, a wide range of expertise to provide serious in-depth teaching of basic principles in optometry and vision science.
3. Programme Length – to continue to assure the standards asserted in the previous point, and also to accommodate the expectation that the scope of optometry practice will widen to encompass higher levels of health-related knowledge and skills, our view is that there must be no pressure to shorten optometry degree programmes; for example by omitting basic educational content or by attempting to 'fast-track' 3-year programmes into 2 years by removing students' long summer vacation periods. Students need consolidation time for development of clinical skills and degree-level understanding of taught material, as well as for extra-curricular activities that are an essential part of normal student life at university. In addition, members of academic staff need time to design course activities, prepare teaching materials, conduct assessments and undertake other activities including research and scholarship.

(Note: one exception to this principle, already successfully in operation, is the BSc Career Progression programme at University of Bradford, which students normally complete from start to finish in under two years. However, the students admitted to this programme are already registered dispensing opticians with at least two years of post-qualification experience in practice, so they start with a good deal of relevant prior knowledge and core skills. We do not consider that this approach would be feasible with inexperienced and less mature 'school leaver' students).

4. Consistency – it is important that GOC accreditation and quality assurance standards and procedures are applied consistently to all education providers. In terms of standards, this applies for example when universities require optometry programmes to adhere to internal regulations that may be markedly different to those in other institutions. Thus, a student in one institution may be permitted to progress between stages (years) of the programme with some marks below 40%, or without having achieved pass marks in all modules, while another institution might demand a higher standard of achievement. If the GOC supports or requires a particular standard for accreditation of one programme, this should be applied consistently across all accredited programmes. Here we note that, in general, OSC supports the principle that, within its accreditation and quality assurance role, the GOC should be able to require institutions to set standards in optometry that may be higher than those permitted in other programmes. A second element involving the need for consistency is in the application of the standards set out in the GOC Handbook for Accreditation. We appreciate that strenuous efforts have been made by the GOC in recent years to update the optometry handbook in an effort to improve consistency, and that this has been undertaken in cooperation with OSC. However we note that, in spite of this, standards recently applied in the (provisional) accreditation of new programmes seem inconsistent with those that have been applied to established programmes over the same period.
5. Outcomes-based approach – in general we welcome an approach to optometry accreditation based on identifying desired outcomes. This is consistent with the approach in clinical education across a range of disciplines. It is helpful for programme providers and prospective students to have a clear view of exactly where a programme is going and what its end results should be. However, we have two caveats. The first is a concern that focus only on outcomes without regard for the need to assure certain inputs runs the risk that providers may fail to recognise and provide the minimum level of resource needed to achieve the desired outcomes (points 1 and 2 above) – thus it is our view that the GOC should not necessarily define precisely the educational route that should be taken by a provider and its students to achieve the desired outcomes, but should define the minimum that a provider must do to comply with conditions necessary to enable outcomes to be achieved with the numbers of students enrolled. In effect the GOC, in discussion with OSC, the College of Optometrists and other relevant stakeholders, would introduce a resource model into the accreditation handbook, to guide the development and administration of optometry programmes. Our second caveat on an outcomes-based approach is that literal implementation of the principle, in the form of a specification list of required outcomes, quickly has the effect of diverting students from any broadly-based view of education towards a tick-box or checklist approach. This is a drawback of the competency model (see next point).

6. Competency Model – there are a number of undesirable features of the current two-stage competency model in optometry education. Briefly, these are:
  - a. As noted in the previous point, specification of a list of competencies that students must achieve has the effect that all but the strongest students soon adopt a tick-box approach, sometimes to the extent that they become focused only on what they need to do to have a particular competency ‘signed-off’ that they lose all sight of its wider context.
  - b. The concept of competence at undergraduate level is problematic – if a student is deemed ‘competent’ in a particular clinical skill then there is some degree of implication that they should be fit to apply that skill in practice, perhaps without supervision. Indeed, we are aware that this approach may be taken by some pre-registration supervisors, assuming that a graduate who has achieved all Stage 1 competencies needs no further supervision in respect of these. This does not seem to be in the public interest. We tend to the view that optometrists should only be deemed competent at the point of registration, when they are considered to be fit to practise unsupervised, and that this idea of competency is necessarily overarching and not piecemeal, in the sense that the optometrist is considered to be competent to practise, not competent in some basic skills and incompetent in others. At undergraduate and pre-registration level, therefore, we would favour an approach in which education providers focus on identifying students’ levels of clinical skill, and their ability to evaluate and interpret information and carry out various activities appropriately according to the clinical context, rather than ticking-off isolated competencies.
  - c. The existing competency model presents various anomalies – it involves some competencies that are small and precise but others that are broad and less precisely specified, and it also includes some competencies that appear to be essentially the same at both Stages 1 and 2.
7. Patient Episodes – the current handbook for optometry accreditation includes a requirement for students to see minimum numbers of ‘real’ patients in a variety of categories: primary care, contact lens, binocular vision, etc. To provide even this modest number of patient episodes for every student on a typical UK optometry programme is extremely resource-intensive in terms of staff and clinic facilities, and logistically complex for clinic timetabling. Programme providers nevertheless achieve these difficult requirements, even though: a) there appears to be no evidence to support the idea that a student needs to have seen a particular number of patients in order to be fit to enter pre-registration practice, and b) the amount of patient experience gained under these requirements is less than a pre-registration trainee would be expected to gain during the first few weeks in practice. Our broad consensus view is that, while students at university must be given opportunities to examine real patients, it is difficult to justify stipulating any specific number of patients to ensure that a graduate is fit/safe to enter pre-registration training.

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

We are in favour of the GOC accrediting higher qualifications, such as independent prescribing, which enable optometrists to expand their scope of practice into specific areas that require additional specialist qualifications. However, we do not see the need for further regulation of higher qualifications such as many of those offered by the College of Optometrists in conjunction with the universities. These qualifications do not

change the right to practise in specific areas, but are an aspect of continuing professional development, and it is appropriate that the GOC should continue to accredit the College of Optometrists and/or universities to oversee these.

## **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?**

The core skills, knowledge and behaviours expected of students undertaking undergraduate optometry programmes (who are currently GOC registrants) are outlined in the current QAA Benchmark Statement for Optometry.

For optometrists joining the register as fully-qualified practitioners we propose the following requirements as priorities, which are mindful of possible developments in the role of optometry in the future as have been discussed previously:

- Patient Safety – there must be confidence that the registrant has the core skills and knowledge to ensure that patients are managed safely.
- Professionalism – there must be no evidence, through the period of study/training prior to registration, to support any concerns about the attitudes and behaviour of the registrant towards patients, colleagues and others, or about the honesty and integrity of the registrant.
- Knowledge – scientific foundations of the discipline, to support the application of core skills and clinical decision making; public health issues and the role of optometry; health care ethics; evidence that underpins clinical practice.
- Core Skills – all skills as now, none of which should be lost in the foreseeable future, including the ability to carry out subjective refraction and retinoscopy; ability to communicate verbally and in writing; ability to obtain and use primary research as an evidence base for clinical practice; ability to interpret evidence on the evaluation of methods of assessment and treatment.

### **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?**

It is our view that the content and delivery of existing optometry programmes already ensures that students gain the skills, knowledge and behaviours required to enter pre-registration practice. We are not aware of any evidence to support a view that radical change in optometry programme content and delivery is necessary.

Naturally, of course, programme content and delivery develops progressively to anticipate and take account of changes in optometry practice and the profession. This has always been the case. In relation to technology, for example, universities have generally led these changes rather than following them – many generations of students have been introduced to new technologies and methods of assessment at university, long before these are commonly found in practice. The universities have always been proactive in terms of undertaking and promoting research that has the potential to change the future of optometry in practice. This forward-looking approach has also been supported over many years by the College of Optometrists, which publishes journals and funds research scholarships for optometrists. It would not be unreasonable to claim that

the current standing of optometry as a health-care profession, which provides the basis for the now anticipated changes in scope of optometry practice, has been achieved largely as a result of academic and clinical leadership in education by the universities and the College of Optometrists.

Provision of optometry education is demanding – programmes are resource-intensive and expensive to deliver, but do not attract clinical levels of funding as is the case for programmes in medicine and dentistry. Optometry programmes are led and delivered by academic staff (principally optometrists) who have higher degrees and other higher qualifications, and who bring advanced levels of clinical expertise and specialist knowledge in both clinical and non-clinical areas. Most academic staff in optometry schools are involved in research and scholarship, and optometry teaching is informed by evidence from research.

Given this context, our views on the priorities for optometry programmes may be summarised as follows:

1. Sustainability – recent growth in the number of optometry schools and, therefore, in the total number of optometry students seems unsustainable. It is already the case that both established and new schools find it difficult to recruit staff with suitable academic qualifications and experience. It is also the case that the total number of applicants to optometry programmes in the UK now barely exceeds the number of places available – taking account of this alongside the facts that graduate salaries are falling and a very large majority of optometry students come from an ethnic minority sector of the population (i.e. there appears to be very little awareness of/interest in optometry in the majority of the population), it is difficult to see how optometry can continue to attract a sufficient number of applicants with the academic ability and qualities to succeed on the degree programme and gain professional registration.
2. Programme content and length – we commented on programme length in response to Question 6 above. Here we wish to reiterate that view and also to point out that we feel it is neither desirable nor feasible to remove significant amounts of content from current optometry programmes in order to make way for other higher-level material. The notable example here is refraction. In our view it is absolutely essential that optometrists should retain all of their present skills, including the ability to undertake both subjective and objective (retinoscopy) refraction. There are recent reports, for example, of how retinoscopy has been abandoned or discouraged in practice, due to the availability of auto-refractor technology, resulting in patients with certain conditions not being effectively assessed. Even if, in time, the majority of optometrists should cease to work as refractionists in favour of roles in ocular and visual health, refraction is so fundamental to the understanding of eye health and visual function that it must remain at the core of the optometrist's knowledge and skills. In overview, therefore, our broad consensus tends to the view that optometry degree programmes will need to be longer (minimum 4 years) if they are to do justice to inclusion of higher-level material on ocular health assessment in addition to existing content. We understand that some within the optical professions are under the misapprehension that current optometry programmes include material that is irrelevant to optometry practice or involves only reiteration of basic A-level material. This is not the case. It is the case that existing optometry programmes do already include essential material on professionalism, communication, scientific literacy and evidence-based practice.

3. Delivery – there have been changes in optometry programme structures and modes of delivery. These include the introduction of integrated degrees, in which students undertake practice-based pre-registration training within the degree programme. This, in turn, encourages if not necessitates delivery of some course content electronically in a ‘distance learning’ format. A significant advantage of the integrated programme structure is that it recognises the benefits for students of gaining real practice experience as early as possible, and enables the teaching of basic scientific knowledge to be connected explicitly to clinical practice. Thus, it is a model that naturally supports the principles of outcomes-based learning in which curriculum content closely reflects the needs of the developing optometrists in practice, and experiential learning in which there is the opportunity for students to gain experience of a wide range of different patient types and conditions as they present in practice. The involvement of students in real practice at different stages of the programme also helps students to develop their understanding of professionalism and requires them to adopt appropriate attitudes and behaviours. There is some consensus in OSC that we would welcome and support a general move to a minimum 4-year integrated programme as the ‘standard’ model for optometry education in the UK. However, such a change would need a good deal of discussion and cooperation across the sector. Integrated programmes require that a sufficient number of practices are willing and able to take students for periods of practice-based experience, and those students cannot be treated as employees as they are under the traditional pre-registration system. It is not yet clear whether a sufficient number of optometry practice owners will have the level of commitment needed for integrated programmes to be a sustainable model for optometry education. Our view in OSC is that most of the clinical experience required prior to full registration should be obtained in real practice settings. Universities do not have the resources to provide all this experience ‘in-house’, nor would it be in the students’ interest to do so. Whether students gain their practice experience through continuation of the established arrangement of a pre-registration period following graduation, or through the development of more integrated programmes, the onus is surely on the employers to increase their commitment to optometry education in order to ensure that students are fully supported to the point of registration.

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

Post-registration training leading to higher qualifications is currently provided by the College of Optometrists and by the universities. Employers and other organisations also provide training for a variety of general and specific needs. It is difficult to specify any particular way that this needs to change. As with undergraduate education, post-registration training and qualifications will naturally adapt to needs and demands over time. In general, however, such training will need to support optometrists’ varied and changing aspirations, and be of use in any UK setting. Perhaps the most important issue for post-registration training is the need for it to be set in the context of CPD rather than CET, in order to focus it around specific needs of individual practitioners and their patients.

**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?

No response.

**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?

No response.

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

No response.

### **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?

We would like to pose the question - what does the GOC and/or the profession consider is lacking in terms of the professionalism of current registrants? More information on how professionalism appears to be deficient would be valuable in determining how this issue should be addressed through education.

We might consider that procedures could be introduced to assess professional attitudes at the university admissions stage, which would improve student selection. However, a significant practical problem with this is that optometry nationally is now recruiting rather than selecting, as the total number of applicants does not greatly exceed the number of places available. Any method of selection may result in some schools being unable to fill programme places. A second difficulty is the following: while there are some students who exhibit appropriate professional attitudes and behaviours instinctively when they enter university, many do not because they are inexperienced and relatively immature. However, almost all students in the latter category develop their professionalism during their time as students, and practise it instinctively when they enter the pre-registration period.

The university optometry schools currently embed professionalism at all levels of their programmes. Some also have specific modules or curriculum streams focused predominantly on professionalism and ethics. What constitutes professionalism should be apparent and learnt through interaction with supervisors and lecturers at university and in pre-registration and post-registration practice. Institutions, including the College of Optometrists through the Scheme for Registration, should be confident that supervisors and lecturers/demonstrators exhibit professional behaviour in their student interactions.



**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?**

We commented on the issue of consistency in our response to Question 6 above. The QAA benchmarking for Optometry should aid in the application of a consistent approach to optometric education across institutions. Academic institutions have both internal and external quality assurance. External quality assurance through QAA and External Examiner reports should be monitored by the GOC. In particular, the GOC should examine and follow-up on External Examiner reports in order to facilitate their process of accreditation and review. Where GOC review/accreditation visits make recommendations and/or requirements the standards applied to all institutions should be clear and consistent. If there is consistency in the educational approach, content and assessment procedures, this should allow a more consistent entry standard to the pre-registration period.

Notwithstanding differences in types of undergraduate programmes, and in the internal organisation of these programmes, the quality assurance arrangements described in the previous paragraph help to ensure consistent standards for entry to the pre-registration period. However, the question relates to assessment of students prior to joining the register, and the Scheme for Registration managed by the College of Optometrists is a valuable arrangement for 'ironing out' variations in an effort to assure parity of standards at the point of registration. It seems essential that this arrangement should be retained, to provide a comprehensive, independent and consistent assessment before registration.

We note that the emphasis in this question is not only on assessment but also on 'consistent and appropriate standards of education'. It is important to observe that a large proportion of students' education prior to registration is in pre-registration practice, usually after graduation from university. A significant challenge is to ensure consistent and appropriate standards in this setting. It is widely reported, for example, that pre-registration trainees in some practices do not get the support they need, and some are expected to meet targets as employees rather than being fully supported as students.

**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?**

A number of issues and concerns relevant to this question have been addressed previously, but the following points summarise our views of principal challenges and barriers:

1. University funding – this is currently not sufficient to support any increase in curriculum content or in the volume of 'in house' clinical experience in undergraduate programmes. To expand the curriculum in order to produce optometry graduates equipped to undertake more health-related work in the future, schools will need to increase programme length to obtain more study time and the income to support it.

We must emphasise once again that university optometry programmes consistently, and over a period of many years, achieve high standards of academic education and clinical training for a standard tuition fee, with no additional DoH support such as is enjoyed by programmes in medicine and dentistry. In spite of this lack of recognition of any case/need for clinical funding of optometry education, the university schools have led the development of optometry as a health-care discipline and responded to changes affecting the profession in practice. Clinical practice in optometry has evolved far beyond the standard that was expected 30 or more years ago, but with no commensurate increase in funding for undergraduate education. It is unrealistic to expect significantly more of the universities now on existing funding. If there is a recognised need for more advanced clinical training at undergraduate level then additional funding must be forthcoming. Here the GOC and other significant stakeholders may have an important role to play in supporting an effort to secure clinical-level funding for university optometry programmes.

Even with such an increase, however, it must be expected that students will still need to gain most of their experience externally in practices or hospitals, which will have to bear much of the cost of providing this unless higher, clinical levels of funding for optometry education can be obtained. This, in turn, will bring further challenges in that there may be a shortage of good-quality pre-registration positions or (in the context of integrated programmes) practice placements. These problems are significantly exacerbated by the following issue ...

2. Over-supply of graduates – with an ageing population and the increased need for basic and enhanced (primary) eye care services, there is potential for the role of optometrists to increase and become even more valuable than it currently is. Optometry should be a profession that attracts bright and motivated students. However, this will only happen if it is seen as a profession and career worth training for at least four years to enter. This will not be the case if the number of optometry programmes continues to increase and the number of students on each of those programmes also escalates. This does not promote quality amongst applicants; it is already apparent that the increasing intake has driven down entry standards (see UNISTATS/KIS published data) and this will consequently be reflected in the calibre of those entering the profession. If the GOC and profession are truly seeking individuals who are receptive to and able to adapt to change as technology, patient demographics and treatments change, then it is in the patient and public interest that this issue is addressed. It is the ‘elephant in the room’; HEIs are putting pressure on courses to take more students with no increase in the resources required to provide high quality training, and optical companies looking for willing (cheap?) workers are encouraging institutions to develop new courses. These larger or new courses will need to lower entrance standards to fill places, because the pool of applicants is now too small to be sustainable but, once enrolled, no university will want to fail its students. This may not lead to unemployed optometrists, but it is likely to lead to lower standards in the profession as salaries decrease and quality also drops. This is not in the public interest.
3. Pre-registration Period – the variation in standards of pre-registration training is a significant challenge. Currently, for example, there is no standard for the time allowed for a trainee to examine a patient, and standards of supervision are variable in spite of the best efforts of the College of Optometrists to assure quality of supervision through the Scheme for Registration. A significant advantage of integrated degree programmes in this respect is that the university is responsible for the quality of its

students' education, whether this is within the university or in practice, so practice owners and supervisors must work in partnership with the university (and the College of Optometrists) and comply with the university's required standards. Although this is desirable in terms of quality, it poses a challenge in that: a) some practice owners may be discouraged from entering such an arrangement unless they can see direct benefit to their practice, thus putting further pressure on availability of placements, and b) the universities themselves will need the resources to undertake the intensive quality assurance required to be confident that every student on placement is being educated to the appropriate standard. Therefore, whatever model is adopted for practice-based experience, there are significant challenges to assuring consistency and quality in the practice setting.

**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.**

The GOC needs to apply standards consistently across all educational institutions and settings, including pre-registration practice. Where possible, these standards should be evidence-based.