GOC strategic education review

Optical Confederation response to the call for evidence

The Optical Confederation represents the 13,000 optometrists, 6,000 dispensing opticians, 7,000 optical businesses and 45,000 ancillary staff in the UK, who provide high quality and accessible eye care services to the whole population. The Confederation is a coalition of the five optical representative bodies: the Association of British Dispensing Opticians (ABDO), the Association of Contact Lens Manufacturers (ACLM), the Association of Optometrists (AOP), the Federation of Manufacturing Opticians (FMO) and the Federation of Opticians (FODO). As a Confederation we work with others to improve eye health for the public good.

The Local Optical Committee Support Unit (LOCSU) provides quality, practical support to Local Optical Committees (LOCs) in England to help them to develop, negotiate and implement local objectives in respect of primary ophthalmic services.

The Optical Confederation's Education Committee comprises members nominated by all OC member organisations, Optometry Wales, Optometry Scotland, Optometry Northern Ireland and observers from the College of Optometrists and indeed the General Optical Council itself. It acts as a forum for discussion on a wide range of education topics within optics for unregistered as well as registered staff. Most of the contents of this paper arise from a workshop meeting of the Committee held on November 22, 2016. This paper has been reviewed by committee members and expanded at senior level by the five Optical Confederation bodies. Whilst it is a synopsis of the day it and carries the general thrust of Optical Confederation thinking, it does not purport fully to represent the views of the constituent members of the OC which will make individual submissions to the Strategic Education Review as necessary.

We hope however that this joint submission will be a powerful contribution to the review from the major stakeholders.

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?

As described in the Foresight Project Report, the expected increase in numbers of older people over the next twenty years will lead to greater eye health and care needs. More patients will have combinations of needs alongside any needs for refractive correction. For example many will be living with one or more long term conditions such as diabetes and/or cognitive difficulties such as dementia. There will be more people registered blind and partially-sighted.

These changes will not only affect hospital eye services, which will need to transform to meet rapidly expanding needs; they will also impact significantly on primary eye care as the range of services expands to meet changing needs and expectations including more patients needing low vision and eye health services. These services will, increasingly, be carried out in patients' own, residential and nursing homes alongside supporting social care services.

As the number of patients with more complex eye conditions such as maculopathy, glaucoma and diabetic eye disease increase, many other patients with less complex conditions, currently seen by ophthalmologists, will need to be diagnosed, treated and supported by other professions in community locations, freeing up ophthalmologists to see more complex conditions.

As patients age and are less able to travel, services traditionally seen as secondary care will need to move closer to patients' homes. There is also likely to be an increase in virtual clinics and an expectation for patients to take on more responsibility for managing their own health care. There is likely to be more self-monitoring by patients, including retinal imaging and OCT, and self- measurement and monitoring of IOPs. A different approach to health and social care is required to deal with the ageing population. There should be a move away from the tradition of advising the patient what to do to, to encouraging self care. Healthcare providers would then provide expert support and advice on interpretation of self monitoring results, and this will require good management and communication skills.

The needs of young people are also likely to increase pressure on services, with an increase in myopia among young people already clear.

All of the above will have implications for the modes and models of training for all eye health professionals with much more hands-on training and learning in the community under supervision. This may in turn lead to the need for a new cadre of optical and ophthalmic educators who work in community practice but also teach, supervise and train there as well as in traditional locations.

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?

It is assumed that significant amounts of care will shift from hospital to community settings as that is the stated policy of all four UK governments and has been the professional direction of travel for some time. The speed and extent of this change will depend on several issues, not least the drive and will of governments and NHS leaders to expand services to meet the eye health needs of the population, and the

opportunities created for professionals and community practices to embrace change whilst maintaining commercial viability. For example, care in Wales is already shifting strongly towards the community. Experience there has shown how care can shift on a widespread scale, supported by a flourishing national university base.

While there is widespread support for an extension of community services, firstly, some ophthalmology departments have embraced change faster than others and second, not all optical practices can immediately embrace it. This is in part driven by local commissioning and the historical cross subsidy of service by product sales. The sight test fee is now worth less in real terms than when the NHS was established in 1948 despite the significant expansion in clinical requirements and a requirement to invest in additional equipment. The current funding system combined with inconsistent commissioning of extended primary eye care services has acted as a barrier to change. A national commissioning system in England combined with an economically robust commercial model for service delivery would be a great enabler.

The optometry degree currently focuses on performing sight tests, case finding, diagnosis, and management of eye disease and disorders. But there is not time within the degree to provide some of the additional skills that may be needed in extended roles. Increased HEFCE funding would facilitate the opportunity to add content to the degree without extending the length of the course.

Providing proof to commissioners that practitioners already possess the skills to deliver enhanced services is an additional barrier. Optometrists and dispensing opticians often need to demonstrate or be accredited in existing core skills in order to participate in services.

Qualifying students in all optical professions are likely to have a more diverse marketplace to enter into, and may require, or wish to obtain, specialist skills such as therapeutics, medical retina or advanced glaucoma, or even physician assistant-type skills on entry to the profession or in the first few years of specialist community practice. In dispensing optics this applies to skills in managing some minor eye conditions, advance paediatric dispensing, and advanced low vision management.

The OC suggests that a further potential barrier to the development of the right skill-sets in each of the optical professions is the fact that they have several regulators. If that situation continues there would be value in the relevant regulators working together to develop a unified approach to accrediting education in skills that are shared by more than one profession.

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?

The Way Forward report by the Royal College of Ophthalmologists acknowledges that different ways of working are required to help meet the increasing demand in ophthalmic services and highlights the development of a multidisciplinary eye healthcare team within the hospital and community as a consistent theme in new care models.

Optometrists and opticians will also provide a far wider range of clinical services in community-based ophthalmic or medical eye centres as autonomous clinicians working independently or within multi-disciplinary teams either directly, virtually or remotely.

Although there will still be a need for highly skilled sight-testing and case finding by optometrists and dispensing and contact lens opticians, the expansion of extended primary eye care services will require optical practice to provide at least the full range of existing skills and often go beyond them into, for example, new therapeutic areas.

The required growth of out of hospital services to meet demand will be dependent on a willingness of optical professionals to up-skill and take on expanded roles, for example, monitoring of moderate risk glaucoma patients beyond the current core competences of optometrists. This will only happen if practices and professionals see sufficient remuneration attached to the new services. Technology developments will mean that refraction could be carried out by more people than currently (both professionals and members of the public). Refraction should remain part of the core contact lens dispensing and undergraduate optometry courses as it remains a core competence and could be added to the core competence of dispensing opticians.

Although not the whole profession, a large proportion (even a majority) will start to take on roles traditionally reserved for medically trained professionals such as GPs and Ophthalmologists. This is already well established in Wales, where much of glaucoma and medical retina care is being moved into primary care. The driver for this is a lack of medically trained professionals to fill posts, a lack of estates space, the cost of both of these, and a push towards care closer to home, which will be increasingly important with an ageing population.

Optometrists are likely to take on many more roles in the future, perhaps even performing minor surgery in clean room environments.

The role of the dispensing optician is also likely to change. It is likely that, as optometrists extend their areas of expertise, they will pass some aspects of their current core role to dispensing opticians.

As practice and education evolve it is also important that dispensing opticians and optometrists retain core skills in dispensing.

There will be a greater need for more pharmaceutical prescribers in community settings, although the volume of patient need means that not all optometrists will need full independent prescribing qualification and status.

Optical practices can and should play a greater role in general health promotion, for example in smoking cessation, healthy living and active ageing partnering, for instance with GP networks and healthy living pharmacies, hearing and dental networks. They can also play an enhanced role in identifying risk, for example of falls in older people, through lighting, contrasts advice and advice on trip hazards or in safe driving.

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?

Education needs to be more clinically and practice-based in order to respond to these changes and needs, but without removing the underpinning theory and ability critically to appraise technology.

Although we recognize that it is difficult to assess for some skills at the age of eighteen, students should as far as possible be selected for their ability to learn, their communication skills and their emotional intelligence as well as pure scientific and academic ability. Work experience/demonstration of interest and commitment and prior and reflective learning should also be factors in selection.

A diversity of courses of differing lengths can produce a broader range of skills, capability and backgrounds into the professions. The provision of a variety of entry points into learning together with clear routes of progression in the career ladder could help achieve this. Modular and other flexible learning models would be valuable, as might the opportunity to train alongside other professionals both within and without the optical sector.

The Optical Confederation would welcome educational approaches that increase the amount of patient contact throughout the course, across the full range of practice. Community, hospital and specialist placements, and placements with GP practices could give the variety needed and help students develop a wider range of professional skills. It would be valuable to emulate courses that have clinical placements throughout, allowing students a wider experience of the work environments available to them. The Optical Confederation would recommend partnerships between educational institutions and training practices (a model from new medical schools).

The Optical Confederation also favours more problem-based learning (PBL), designed to help students emerge with a set of problem solving abilities as well as technical skills. The course should not be seen as "ticking off" a list of technical skills, but as building professional capabilities. Committee members suggested that a modular education system would offer the opportunity for individuals to build towards the kind of professional each wants to be.

This should include the professional understanding that care is more than episodic, that the patient has a history before they enter the practice, will continue to benefit from the eye intervention long after they have left the practice and will also be part of a cohort of the population which the optical practice will service as part of the wider health and social care system.

At the Committee's workshop there was much discussion on the appropriate length of education. For example there was a suggestion of a tiered approach, involving a more flexible pre-registration period to enable some people to qualify for enhanced clinical or specialist enhanced services roles at the same time. Some suggested that to encourage the uptake of specialisms, the courses might need to be extended, might make better use of the current long vacation time for students or might even consider becoming clinical rather scientific degrees if this could be achieved without becoming subject to the current HEFCE-type funding caps.

There was no agreement on the appropriate length of undergraduate education and it was pointed out that an extended duration would have a significant effect on the optical sector, causing a shortage of qualified professionals during the transition period. There is an opportunity, however, in removing the constraints of the present academic year so that the more basic practical experience can be woven into the programme earlier and students prepared for a broadened/varied clinical role within the existing timeframe of study.

On supervision, it was felt that the supervisor role should be formalised, with a framework for supervision skills and knowledge (such as of local protocols and pathways). There also should be mentoring and support for supervisors, perhaps linked to new optical and ophthalmic educator roles as mentioned in response to Question 1.

It was also agreed that pre-registration optometrists would benefit from different supervisors for different specialisms and/or that one supervisor to multiple students could be a formalised future role evolution for highly skilled trainers and supervisors.

Post-qualification education could also be modular and flexible so that practitioners can develop specialties and respond to the way services are commissioned in their areas.

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?

It is recognised that boundaries between professions as currently understood are likely to change and it is likely that the diversity of practice and qualification within the groups will increase. For instance it is likely that optometrists will refract much less frequently – as happened with ophthalmologists in the past.
It is important that these varying levels of practice, qualification and experience are identified and monitored by the GOC to provide assurances for the public, employers and the NHS. These may be more easily understandable and accessible to the public by means of a single competence-based optical register annotated with additional qualifications and specialisms. The GMC is similarly currently consulting on more detail for the medical register to assist public understanding in a similar way.

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?

We are aware that the Optometry Skills Council is making its own separate response to the GOC's call for evidence and we do not propose to go into great detail in this response.

We acknowledge the inevitably subjective nature of visits and assessments but we would suggest that the principles behind accreditation should be:

- Right touch – an administrative burden that is proportionate to the risk
- The need for a balance of skills in the panels of accreditors
- Consistency of application of the standards – so that each insititution is treated equally
- Timely – with limited scope for (mis)interpretation at the different stages of the process

We have also noted that there is a need for cooperation between the regulators who regulate the different professions that contribute to eyecare pathways, again to ensure the greatest possible consistency in education requirements for each of the professions involved.

There is some concern that the competency framework might have encouraged a tick-box mentality among students and therefore discouraged a holistic approach to practice and patients.

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

A number of new qualifications may be required but we do not think that these courses necessarily need to be accredited by the GOC. We do recognise that the GOC might have a role in assuring itself of quality when there is a public safety implication.

There will be several examples as services increasingly move from secondary to primary care. The GOC needs to monitor, pre-empt and enable activity taking place in community practice. There will be many examples over the next twenty years, some of which may not currently be predictable. Next likely areas for consideration might be:

- Minor lid surgery – Chalazion/skin tag removal etc.
- Laser surgery
- Corneal Services – complex contact lenses etc.
- Low vision aid provision, sight loss rehabilitation and CVI registration
- Intravitreal injection

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?

Clinical decision-making and a sense of what it means to have high standards of practice need to have higher prominence. See also our answer to Question 4. This question has also been considered in detail by colleagues from optometry schools, including those on the OC Education Committee, for submission to the GOC. Graduates need to have the ability to adapt to changes in technology.

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?

We also address this in the answer to question 4. There should be a modular approach to learning with more clinical experience built into timetables, and possibly longer terms, with a greater focus on practical experience and clinical decision-making alongside the important theoretical underpinning.

New learning modalities, such as distance learning and methods enabled by new technology should be made available as their validity is proved.

The content and delivery of courses needs to reflect the fact that optical careers may be fluid in future. People who have started in optics as apprentices need to be able to access higher education. Movement through the career ladder should be facilitated by course content and structure.

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

Post-registration training and qualifications are currently harder to access than they should be due to difficulties in finding sufficient supervisors. Greater flexiblity is required, including the use of suitably-qualified optemetrists in place of ophthalmologists to supervise training.

Further changes in training are likely to be influenced by new NICE Clinical Guidelines. NICE is currently working on guidelines for cataract & macular degeneration, as well as reviewing the one on glaucoma.

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?

ABDO will respond in greater depth. The OC endorses ABDO's view that DOs need to join the register equipped with the ability to continue to develop their skills as their careers progress, and with problem-solving skills and the ability to work with the full range of patients, including those who are vulnerable, alongside the full range of technical skills.

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?

ABDO's response states the importance of a greater emphasis on low vision and paediatric clinical experience.

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

Again, ABDO has responded to this question in greater depth. The OC agrees with ABDO's view that there should be a range of specialist qualifications, including 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.

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?

As mentioned above, consideration should be given to students' ability to learn communication skills, their emotional intelligence and reflective learning as well as their academic and scientific ability.

Ethical principles and good habits should continue to be inculcated throughout the undergraduate programme so that these are second nature before students interact with the public and colleagues in real life. Students need to understand why it is important and also the consequences of non-compliance. Assessment should also include students' professionalism in complex situations.

Students will need to understand and demonstrate evidence-based decision-making. Peer review and problem based learning can facilitate building skills in confident clinical decision-making. More patient-centred education can support a less defensive approach to practice.

These skills must be reinforced during pre-registration training as well as the undergraduate syllabus.

It is equally important that registrants stay focused on this area after qualifying. Any changes in expectations need to be compulsory, interactive parts of CET.

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 would simply say that there should be scope to change assessment regimes as new evidence-based methods prove themselves and become available.

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 significant barrier to attaining higher qualifications is the time required to complete the qualification. In some cases, such as IP and the higher glaucoma qualification, this is significantly more onerous than that required by other professions. Another significant barrier to attaining the IP qualification is the lack of available clinical placements. This could be alleviated by allowing those optometrists with appropriate higher qualifications and experience to supervise/mentor rather than the current requirements for ophthalmologists to do so.

Continued legislative protection of the core function of the sight test is essential to draw people to the profession and to protect their wider eye health. Despite the optometry and optical professions diversifying into other more specific avenues of patient care, the sight test remains the key public health measure for

vision correction, early detection of eye disease and prevention of sight loss. Were this to be eroded, the optometry and optical professions would be less attractive to students and the workforce may dwindle, leaving another shortfall in qualified staff for all current and future aspects of optometric and optical care.

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 review should attempt to be as future proof as possible, being open enough to allow for changes and adaption as the profession changes or begins to change. The regulator should lead and facilitate change, not follow or unnecessarily restrict.

The GOC should be aware of how practice is expanding at different rates and in different directions and flexibility to provide for this should be built into the review.

Increasingly professionals will be using their full range of competencies and this needs to be taken into account when things go wrong. Currently errors in judgement are treated harshly. As clinical judgements become more finely nuanced the regulator will need to take this into account in setting standards, in FtP judgements and in penalties.

We wish also to offer some reflections on CET that are relevant to this review.

A current issue identified by the Optical Confederation Education Committee is the inconsistency of examiners and assessors. The application process puts off smaller providers from applying to offer CET and there is inconsistency in what is accepted and what is not.

Many activities that should accrue CET points are not eligible eg – representing the profession, clinical discussions with colleagues, presenting at meetings, and participation in discussions at optical committees or national meetings. There should be a simple way of assigning credit to these activities which are not commercially run or organised but which develop optometrists and opticians professionally and benefit the health service and the public.

Moreover the CET system is overburdensome (despite recent improvements) and heavy-handed and not evidence of professions that have come of age and are comfortable in their own skins. It is now time to drop the term CET which was all the Health Departments would initially part-fund and expand the scope as above and change the name as for the other clinical professions to CPD. We do far more now than simply maintain our base levels of competence and terminology should be brought into line with other professions.