Statement on the outcome of the Call for Evidence

Protecting and promoting the public’s health and safety in a changing healthcare environment

November 2014
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Introduction

About us
1. The General Optical Council (GOC) is one of 12 organisations in the UK known as health and social care regulators. These organisations oversee the health and social care professions by regulating individual professionals.

2. We are the regulator for the optical professions in the UK. We currently register around 26,000 optometrists, dispensing opticians, student opticians and optical businesses. Our primary legislation is the Opticians Act 1989 (as amended) (‘the Act’), and we also have a series of related rules that describe how we carry out our statutory functions. Our legislation can be found on our website at www.optical.org/en/about_us/legislation/index.cfm.

3. The GOC has four primary functions:
   • setting standards for optical education and training, performance and conduct;
   • approving qualifications leading to registration;
   • maintaining a register of those who are qualified and fit to practise, train or carry on business as optometrists and dispensing opticians; and
   • investigating and acting where registrants’ fitness to practise, train or carry on business is impaired.

Review of standards
4. We are currently meeting the twenty-four standards of good regulation set by the Professional Standards Authority (PSA). These standards relate to all our functions, including our role in promoting high professional standards. However, we must ensure that these standards keep pace with changes in optical practice and in public expectations. This means reviewing our standards regularly and learning from good practice. We last revised our Code of Conduct for individual registrants and Code of Conduct for business registrants in 2010 and we reviewed our standards of competence in 2011. It is timely, therefore, for us to undertake a further review.

5. The General Optical Council (GOC) has begun a strategic review of the standards which it produces, including:
   • ethical and performance standards for optometrists, dispensing opticians and optical students;
   • standards for business registrants; and
   • standards of competence for education and training – the core knowledge and skills required to be registered with the GOC.

6. The three objectives of the standards strategic review are to:
clarify, and ensure that we fulfil, our statutory role in promoting high standards, including our role in providing guidance;
produce standards of ethics and performance that focus on outcomes, meet the public’s expectations, are clear to registrants and reflect good practice, including the recommendations of recent inquiries, notably the Francis Inquiry; and
ensure that our standards of competence, and system of regulation more generally, enable developments in optical practice that would benefit patients and the public.

7. The third of these objectives reflects the GOC’s firm intention to ensure that our approach to regulation takes into account how the scopes of practice of optometrists and dispensing opticians are likely to change over the next five to ten years and enables developments that would be in the interests of patients and the wider public.

8. We prepared a ‘call for evidence’ request in advance of commencing the review in order to obtain feedback from key stakeholders which could help shape the way we undertake the project and to ensure that the outcomes are fit for purpose. The call for evidence document contained a description of what was proposed by the standards review, gave a brief background and context to the review asked for feedback on certain key areas through a questionnaire. The document can be found on the GOC website: www.optical.org/en/Standards/index.cfm.

9. We prepared the call for evidence with reference to the principles of good regulation\(^1\): proportionate, targeted, consistent, transparent, accountable and agile. We interpret these as follows:

- **Proportionate** – we will identify and target the issues of greatest risk to public safety. We will remove unnecessary bureaucracy.
- **Targeted** – we will ensure that our activity is focused on the areas of greatest risk, or where there is most benefit to public safety.
- **Consistent** – we will work in collaboration with UK health regulatory bodies and other stakeholders to develop consistent policies and procedures.
- **Transparent** – we will explain and publicise our decisions, and make public information about activities and proceedings where possible. We will make roles and responsibilities clear.
- **Accountable** – we will seek, and respond to, the views of our stakeholders. We will consider and review the consequences of our actions through evaluation.

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\(^1\) Better Regulation Executive (2000), *Five principles of good regulation*. 
• **Agile** – we will anticipate change and take timely action. We will ensure that we can respond to changes in the optical sector, including changes in technology.

10. The consultation was open for ten weeks from 31 July 2014 to 10 October 2014 and applied to the whole of the UK.

11. The call for evidence received feedback through written responses and verbal feedback from both an external Standards Consultation event and consultation with the GOC committees.

**Themes from the findings**

12. The key themes from the responses to the call for evidence were as follows:

- There is general support for the objectives of the standards strategic review, including our objective of clarifying the role of the General Optical Council in relation to the production of standards and how these relate to materials produced by others.
- The scopes of practice of registrants are likely to change in future due to changes in technology, an ageing population and increased pressure on NHS.
- The rate of change of scopes of practice will differ in each of the devolved nations and the GOC will need to be mindful of this when setting UK-wide standards.
- The current models for funding and commissioning eye care are related to registrants’ ability to meet our standards.
- There can be tension between commercial pressures on registrants and their ability to deliver high quality care as health care professionals.
- Stakeholders welcome clear communication of the project’s objectives and our plans for widespread consultation, but are keen to ensure that the timescales for consultation are realistic.
- The standards review will impact on delivery of education, production of competence standards and quality assurance of education.
- Our CET scheme will need to evolve with the development of new standards.
- The GOC needs to address gaps in its current regulatory jurisdiction, including regulation of businesses, and should consider the application of standards to all involved in optical care including unregistered practitioners such as optical assistants;
- There is conflicting feedback on whether there should be further recognition of enhanced practice or post graduate qualifications in the future.

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2 Added by the PSA (formerly CHRE) (2010), *Right-touch regulation*. 
- The GOC needs to seek legislative reform to allow the development of the professions and innovation in optical practice.

### Response profile

13. In total we received 24 responses to the call for evidence consultation and will publish all non-confidential responses. Responses were received from the following categories of respondents:

4. Optical training providers - Bradford College; City University London; University of Ulster; Optometry Schools Council (representing 11 universities offering optometry training);

4. Other Health and regulatory bodies – Health and Social Care Board Northern Ireland; Medicines and Healthcare Regulatory Agency (MHRA);

4. Professional associations – College of Optometrists; joint response from the five members of the Optical Confederation and Local Optical Committee Support Unit (LOCSU); The Association of Sport and School Vision Practitioners; Optometry Scotland; Optometry Wales;

2. Patients and or members of the public

2. Patient/Public associations

7. General Optical Council registrants

1. Optical business

14. In addition we collected feedback from 41 participants who attended a Standards stakeholder consultation event on 26 September 2014. Representatives at the meeting where drawn from the optical professions, professional associations, patient representative groups and optical training providers. Feedback from this event is incorporated into this analysis.

15. The call for evidence supporting information and consultation questions used in the call for evidence can be found on the GOC website: [www.optical.org/en/Standards](http://www.optical.org/en/Standards)

16. Feedback was both quantitative and qualitative in nature, although majority was qualitative.

17. Some respondents responded to all of the questions. Others selected certain questions to respond to and some provided responses which did not specifically respond to the questions. As such, the number of responses for each question may vary from the total number of responses received.

18. At the stakeholder consultation event, we asked specific questions on how scopes of practice would change, including the threats and opportunities, similar

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3 The call for evidence and responses can be found on our website: [www.optical.org/en/Standards](http://www.optical.org/en/Standards)
to questions 4a and 4b of the call for evidence. Feedback was collected from workshop groups and then summarised and recorded in a plenary session at the end. Some feedback related to other questions within the call for evidence. It has been included in this analysis as appropriate.

19. Due to the number and length of responses the summary below brings out the themes and does not include direct quotes from the responses unless otherwise stated. However we will publish all non-confidential responses in full on our website.

20. Responses from both the call for evidence and the stakeholder consultation event are included under the question headings.

Findings

21. The responses to the call for evidence are presented in relation to the questions that we asked in the document. Each question is considered in turn with an indication of the response rate, the themes and what feedback respondents gave. We have added comments of our own where necessary to, for example, correct a misunderstanding. Our comments are shown in italics.

1. What are your views on the objectives of the standards strategic review, namely to:

a) clarify, and ensure that we are fulfilling, our statutory role in promoting high standards, including our role in providing guidance;

22. 11 out of 24 respondents answered this question in the call for evidence.

23. Ten responses from a range of different stakeholders supported the objectives with most also commenting that it is important to clarify the role of the GOC in setting professional standards and how they relate to other organisations such as the professional associations. These responses included the College of Optometrists, the Optometry Schools Council, Bradford College, the Health and Social Care Board Northern Ireland, Optometry Scotland, Optometry Wales, a joint response from the Optical Confederation and the Local Optical Committee Support Unit and responses from individual registrants.

24. A response from the University of Ulster questioned the need for GOC to be developing separate standards when these were already produced by the College of Optometrists.

25. GOC comment: we made clear in the call for evidence that it is the GOC’s role as the statutory regulator to set standards for the optical professions. This duty should not be delegated to another organisation as the GOC is the organisation
responsible for legally enforcing standards for all its registrants. The College, along with other bodies, plays an important role in providing guidance for registrants to enable them to use their professional judgement in meeting the standards.

26. Bradford College felt that there was a lack of clarity over the role of GOC and other associations in the production of guidance based on information from the GOC website.

27. GOC comment: we acknowledged in the call for evidence the need for us to clarify our role in setting standards and producing guidance, and to clarify how our standards relate to the guidance produced by others. This is one of the project’s objectives and we intend to develop and consult on the criteria that we will apply in considering whether there is a need for us to produce guidance. We have recently updated our website to provide improved access to the standards.

28. Optometry Scotland, Optometry Wales and the Health and Social Care Board Northern Ireland all cautioned on the need to reflect what is happening locally in terms of standards, particularly within the devolved nations where both standards and scope of practice may vary.

29. A further comment from Bradford College questioned the consistent application of standards and felt that the GOC did not fulfil its remit of applying standards to all optical professionals, i.e. optical assistants.

30. GOC comment: we do not have a legal power to extend regulation to other individuals involved in the delivery of optical care. Introducing statutory regulation for other optical professionals, such as optical assistants, would be a matter for government and would require legislative change. In the meantime, it would be possible for optical assistants to seek the creation of a voluntary register, which involves making an application to the Professional Standards Authority. In the course of the standards strategic review, we will be developing new standards for businesses, including the standards relating to the supervision of optical assistants. More broadly, we are seeking the legislative change required to improve our system of business regulation so that all businesses carrying out restricted functions would need to register with us and meet our business standards.

31. Bradford College supported the idea that the Continuing Education and Training (CET) system promotes high standards.

32. GOC comment: the responses to this question show that there is overall support for the objective of clarifying our role in relation to standards. This view
was also supported by attendees at our public consultation event and by the GOC registration, education, standards and companies committees.

33. There is a need, however, to communicate clearly to stakeholders the need for all healthcare regulators, including the GOC, to set standards and produce guidance in order to meet their statutory functions. Clarifying when it will be appropriate for us to produce guidance and defining how our standards and guidance relates to guidance produced by other organisations will also be important.

b) produce standards of ethics and performance that focus on outcomes, meet public expectations, are clear to registrants and reflect good practice, including the recommendations of recent inquiries, notably the Francis Inquiry; and

34. Ten out of 24 respondents answered this question in the call for evidence.

35. Seven respondents actively supported the objective that the standards should be outcome focussed, meet public expectations, clear to registrants and reflect good practice. These included the College of Optometrists, the Health and Social Care Board Northern Ireland and two individual registrants.

36. The Health and Social Care Board Northern Ireland felt that the current codes of conduct lacked sufficient detail to allow adequate consideration of fitness to practice and assessment without reference to material produced by third parties.

37. Bradford College stressed the absence of standards for optical assistants and de-regulated dispensers. It suggested the need to have a minimum qualification in place for those not working towards an optical qualification.

38. Six respondents referenced the objective of incorporating within the standards the outcomes of healthcare inquiries, particularly the Francis Report on the Mid-Staffordshire NHS Foundation trust. This included the College of Optometrists, Health and Social Care Board Northern Ireland, Optometry Wales, the University of Ulster and the joint response of the Optical Confederation and Local Optical Committee Support Unit.

39. All responses were supportive of need to take the Francis Report into consideration, although most identified potential difficulties in taking the recommendations forward, particularly in relation to improving candour and compassion.
40. The Optical Confederation and the Local Optical Committee Support Unit partially supported the inclusion of some outcomes of the Francis Report, such as duty of candour, but questioned the prominence we had given to areas which they perceived as less relevant, such as compassion. The College of Optometrists and the University of Ulster stressed the need for the implementation of any recommendations to be proportionate, given the context in which optical care is provided and the risks involved.

41. Optometry Wales questioned how the recommendations of the Francis Report could be applied in Wales without further communication from the Welsh Government.

42. The College of Optometrists suggested that the GOC should reference the College of Optometrists guidance when producing its own guidance in order to make it clear to registrants whose guidance should be followed.

43. GOC comment: guidance produced by the College of Optometrists and other organisations plays an important role in helping registrants use their professional judgement to decide how to meet our standards. However, it would not be appropriate for us to say that guidance produced by the College or other bodies should be followed by registrants. This would not be consistent with its status as guidance. It is also worth noting that our current code of conduct only requires registrants to “be familiar with the relevant guidance and advice issued by other organisations and, in particular, that of the professional and representative bodies”.

44. The University of Ulster suggested that there needs to be clear distinction between performance and ethical standards as ethics cannot be measured in same way as performance. It also suggested a clear role for the GOC to regulate and produce guidance on the environment in which care is delivered, particularly to balance the pressures between commercial and professional considerations.

45. GOC comment: overall there was support for this objective from respondents. It was also supported by attendees at the public consultation event and the GOC registration, education, standards and companies committees.

c) ensure that our standards of competence, and system of regulation more generally, enable developments in optical practice that would benefit patients and the public.

46. Ten out of 24 respondents answered this question.
47. Six responses were supportive of this objective and came from the British Standards Institute, the College of Optometrists, the Health and Social Care Board Northern Ireland, an individual registrant and the joint response of the Optical Confederation and Local Optical Committee Support unit. Five respondents were non-committal on the objective, but offered advice and comment. These include Bradford College, an individual registrant, Optometry Wales and the University of Ulster.

48. The joint response of the Optical Confederation and the Local Optical Committee Support Unit highlighted the GOC’s leadership role in redefining legislation to meet the future needs of profession as a key objective. The same organisation was concerned about the prospect of introducing another set of standards that might cause confusion.

49. GOC comment: our objective is to provide a clearer regulatory framework, with greater clarity about our role in setting standards and providing guidance, and about the role of other organisations, including the professional bodies.

50. The Health and Social Care Board Northern Ireland felt that the GOC needs to adapt to ever changing demographics, commissioning models and models of service deliver in order to make these standards forward-facing and appropriate for modern healthcare.

51. GOC comment: overall there was support for this objective from respondents. This view was also supported by attendees at the public consultation event and the GOC registration, education, standards and companies committees.

2. What specific issues do you think we should take into account in developing our standards of ethics and performance?

52. 16 out of 24 respondents answered this question.

53. All responses offered specific topics for consideration in the content of the standards. Those attracting multiple responses were as follows.

54. Five respondents stated that in developing the UK-wide standards we must take account of differences within the devolved nations. These included Optometry Scotland, Optometry Wales, College of Optometrists, Health and Social Care Board Northern Ireland. The GOC Registration Committee supported this and the GOC Companies Committee supported the need for standards which were applicable to all registrants no matter what the setting. In response to question 7, the Optical Confederation and the Local Optical Committee Support unit, also highlighted the need for the GOC to take into account the changes in the devolved nations.
55. Five respondents emphasised the need to produce guidance on how to deal with increasing commercial pressures that might compromise patient care and professionalism. These included the Optometry Schools Council, the University of Ulster, the joint response of the Optical Confederation and Local Optical Committee Support Unit and a registrant. The GOC companies and standards committees identified the need for standards to be consistent for business registrants and individuals to ensure that each support each other in delivering high levels of patient care. These views were also mirrored by a large number of attendees at the public consultation event.

56. Optometry Wales, the Optical Confederation and Local Optical Committee Support Unit thought that standards needed to be clear and easy to use, and use consistent terminology. The GOC standards and companies committees also supported this view. Optometry Wales suggested looking at existing models such as the Pharmacists Ethics Framework. This was also mentioned in the joint response of the Optical Confederation and Local Optical Committee Support Unit. The GOC Standards Committee also suggested drawing on best practice from other professions in the development of standards of ethics and performance and specifically the standards developed by the Care Quality Commission.

57. Five respondents stated that standards should be flexible and not restrict development and innovation in practice. This included the Optical Confederation and Local Optical Support Committee, British Standards Institute, the University of Ulster and Optometry Wales. The GOC Companies Committee particularly emphasised the need for standards to take account of the significant changes in technology that are likely to happen over the next 10 years, with registrants needing to acquire new skills and develop closer working relationships with ophthalmologists to cope with technological change.

58. An individual registrant and the Health and Social Care Board Northern Ireland thought that the promotion of public health should be a core standard. In the response to question seven, the Optical Confederation and the Local Optical Committee Support Unit also identified the increasing role that optical professionals will play in public health provision.

59. The University of Ulster felt that GOC should work with College of Optometrists to develop guidance on candour. The Health and Social Care Board Northern Ireland and College of Optometrists went further to suggest that GOC should signpost to the new College of Optometrists guidance in a collaborative approach to avoid duplication and confusion. The College of Optometrists referenced the current use of some of its own guidance in GOC Fitness to Practice hearings.
60. Further topics included:

- Standards should be developed with an acknowledgement that optical services in the community are low-risk – Optical Confederation and Local Optical Committee Support Unit;
- Standards should be transferable across all healthcare professions – Bradford College;
- There is a need to take into account the increase in community and domiciliary optical care – Optometry Wales, Optical Confederation and Local Optical Committee Support Unit, supported by a majority of attendees at the Standards stakeholder consultation event;
- We should seek to facilitate the reporting of concerns and whistleblowing – Health and Social Care Board Northern Ireland;
- There is a need for guidance on delegation and supervision – Health and Social Care Board Northern Ireland and supported by the GOC Standards Committee;
- There would be value in the provision of information to patients on the risk of eye infections – Medicines and Healthcare Regulatory Agency (MHRA);
- We should ensure that our standards reflect the needs of vulnerable patients – SeeAbility and an individual patient advocate;
- We should take into account the interests of patients with disabilities and special needs – British Standards Institute;
- We should examine registrants’ responsibilities to provide emergency care – anonymous patient;
- We should design standards that enable practice evaluation and audit – Health and Social Care Board Northern Ireland and GOC Standards Committee;
- Evidence-based practice should be considered a future competency – City University;
- We should consider the impact of social media on professionalism – Health and Social Care Board Northern Ireland and the GOC Registration Committee;
- We should ensure standards are realistic and achievable by consulting optometrists in the community – individual registrant;
- Work on professionalism may benefit from dialogue with other healthcare professionals – University of Ulster;
- We should take into account the differences in the structure, and role, of ‘standards’ produced by the College of Optometrists – individual registrant;
- We should recognise the importance of being able to transfer patient records within the healthcare system and between individual practitioners – individual optical business; and
- There should be standardised patient records – individual optical business.
61. In addition to the call for evidence, the GOC standards and registration committees stressed the need for an extensive implementation plan to make stakeholders aware of the new standards and how they should seek to apply them in practice.

62. The GOC standards committee thought that it should be made clear to students how standards also apply to them. They also suggested consideration of standards and/or guidance for locum practitioners.

63. The GOC registration committee identified the need for specific guidance on the use of social media. It also stressed the need to research and evaluate patient expectations in developing the standards.

3. What are your views on how we intend to phase the project work streams?

64. Ten out of 24 respondents answered this question.

65. Six were supportive of phasing including Bradford College, the Health and Social Care Board Northern Ireland, Optometry Wales, Optometry Schools Council, the Optical Confederation and the Local Optical Committee Support Unit.

66. Three respondents suggested that the timescales were ambitious including Bradford College, College of Optometrists and the Health and Social Care Board Northern Ireland.

67. Bradford College commented on fact that we had consulted on the call for evidence for less than the recommended 12 weeks as a result of the schedule of Council meetings. The Optical Confederation and Local Optical Committee Support Unit went further to state that the timescales for future consultation should prioritise input of stakeholders affected by change rather than operational convenience to the GOC.

68. Five respondents requested that if changes to the standards of competence were made, then sufficient time must be given to those affected to be able to implement the changes. This view was supported by the University of Ulster, Optometry Scotland, Optometry Schools Council, Optical Confederation and Local Optical Support Unit. The GOC Education Committee also identified the need for a transitional period to be introduced to take account of qualifications recognised before and after new standards of competence are introduced.

4. Looking to the future:
a) To what extent are there opportunities for the scopes of practice of optometrists and dispensing opticians to evolve in a way that would benefit patients and the public?

69. 15 out of 24 respondents answered this question as part of the call for evidence.

70. All respondents agreed that the scope of practice for optometrists and dispensing opticians would change in the future with a greater role in primary care provision. Some of these changes would present opportunities. This view was shared by the GOC standards, education, companies and registration committees. In addition the majority of attendees at the public consultation event agreed with this view.

71. Six respondents identified that the ageing population and increased pressure on the NHS will create opportunities for all optical professionals to expand their scopes of practice in the future. These included the University of Ulster, Bradford College, British Standards Institute, College of Optometrists, Optometry Schools Council and Optometry Wales. This was a view shared by attendees at the public consultation event. These views were shared by the GOC standards, education, companies and registration committees.

72. Ten respondents felt that optometrists could increase their scope of practice to focus more on eye health and shared care pathways with other healthcare professionals. These included Optometry Wales, College of Optometrists, Optometry Schools Council, Optical Confederation and Local Optical Committee Support Unit, Health and Social Care Board Northern Ireland, Bradford College, University of Ulster, British Standards Institute and an individual registrant. A number of attendees at the public consultation event agreed with this view of increased interaction with other professionals and went on to identify the need for the standards of other healthcare professions to be consistent with those of the GOC to allow for referral and shared care between practitioners.

73. Respondents identified the following specific areas identified where optometrists could play a greater role: diabetic care, glaucoma, cataract diagnosis and treatment, age-related macular degeneration, paediatric optometry and prescribing for acute eye conditions.

74. Optometry Wales identified future technology such as therapeutic contact lenses and use of eye drops to replace injectables as further opportunities for optometrists.
75. Support for expansion of scope in these areas for optometrists was raised at the GOC education, registration and companies committees.

76. There was one dissenting voice from the Association of School and Sportsvision Practitioners, who felt that optometrists should focus on learning the skills to be able to refer care appropriately to other healthcare professionals and not take on the role of ophthalmologists. There was also debate at the GOC Standards Committee over the scope for both optometrists and dispensing opticians to expand in all areas of the care pathway to address increasing demand for services and availability of community care.

77. The Health and Social Care Board Northern Ireland identified that these extensions of scope were already happening in some of the devolved nations and that standard setting needed to take account of this. This point was also raised by the GOC Companies and Registration committees.

78. Seven respondents said that dispensing opticians could expand their scope of practice in areas such as sight testing, refraction, dispensing for low vision patients, rechecking prescriptions, behavioural vision therapy and colourimetry. Respondents included Bradford College, Optical Confederation and Local Optical Committee Support Unit, Health and Social Care Board Northern Ireland, Optometry Wales, an individual registrant, University of Ulster and British Standards Institute.

79. The Association of School and Sportsvision practitioners was that delegation of all or part of sight test to dispensing opticians would create confusion over responsibility for patient care and make it more difficult for patients to complain.

80. Support for expansion of scope in these areas for dispensing opticians was also discussed at the GOC education, registration and companies committees.

81. Members of the GOC Companies Committee suggested that for both optometrists and dispensing opticians working in smaller practices, there will be a need to offer increased customer care and potential focus on areas such as contact lens dispensing in order to compete with larger optical chains.

82. Five respondents predicted an increase in domiciliary and community care in future. These included Bradford College, the joint response of the Optical Confederation and Local Optical Committee Support Unit, an individual registrant and Optometry Wales.

83. Four respondents said that there would be an increase in the amount of vulnerable and disabled patients seen by optical professionals in the future.
These included Bradford College, an individual patient advocate, SeeAbility and British Standards Institute.

84. The University of Ulster, Optometry Wales and Health and Social Care Board Northern Ireland felt that evolving technology and advances in diagnostic equipment offered opportunities to extend scopes of practice. Again this view was shared by the GOC standards, companies, education and registration committees.

b) To what extent are there threats to the current scopes of practice and what might be the impact on patients and the public?

85. Eleven out of 24 respondents answered this question as part of the call for evidence.

86. Three respondents, including the Optometry Schools Council, said that the extension of scopes of practice is being limited by a lack of recognition of optical professionals by the public, other healthcare professionals and the NHS.

87. The University of Ulster and the Optometry Schools Council said that the restrictions of the current sight test legislation were constricting developments in practice.

88. There was concern from an individual registrant and the Optometry Schools Council that inconsistent commissioning and referral models were stifling the ability of registrants to extend their scope of practice. Feedback from a number of attendees at the public consultation event agreed with this view especially given the different NHS commissioning systems operating in the devolved nations.

89. Two individual registrants said that the current funding model for NHS referrals prohibited the extension of scope of practice due to lack of funding. An individual registrant felt that ‘ophthalmic care’ and the sight test should be separated to ensure that both are provided to a high quality, as currently the sight test is used to provide ophthalmic care at reduced cost. This was raised by a number of attendees at the public consultation event. The Registration Committee discussed how the funding model can affect the application of standards in practice. The GOC companies committee also underlined the fact that supermarket chains and online suppliers offering discounted spectacles and contact lenses might drive further changes in the practice model. It also suggested that while the number of independent companies had fallen in the last few years due to reduced finances, there was an opportunity for these businesses to develop specialist service models offering something different to larger chains.
90. Bradford College thought that lack of training, registration and regulation of optical assistants was constraining the expansion of the scopes of practice for optometrists and dispensing opticians.

91. Both the College of Optometrists and Health and Social Care Board Northern Ireland identified developing technology as a threat as well as an opportunity, with the latter citing unregulated use as potentially causing patient anxiety and risk. An individual registrant also highlighted the potential gap in the development of new technologies and those qualified and competent to use them. The GOC companies and standards committees also identified technology as a potential threat to the current practice of optical professionals, with the Companies Committee suggesting that technological changes in the next 10 years would see significant changes in the practice of a large majority of registrants, potentially forcing some to cease practice.

92. The GOC Registration Committee identified the fact that changes in technology and practice that see an increase in self-diagnosis or separation of the sight-test will be embraced by patients as they are quicker and more convenient, irrespective of whether this would be detrimental to eye health. This might require the GOC and other organisations to highlight the adverse effects for the patient. The Committee also said that there was no specific career ladder for optometry which would help to identify specific scopes of practice.

5. In order to facilitate changes in the scopes of practice of optometrists and dispensing opticians that would benefit patients and the public:

a) How should our standards of competence evolve?

93. 13 out of 24 respondents answered this question in the call for evidence.

94. 11 respondents thought that changes would be necessary in the future due to changing scopes of practice. This included the Optometry Schools Council, the Optical Confederation, the Local Optical Committee Support Unit, Optometry Scotland, Optometry Wales, Bradford College, the University of Ulster, the Health and Social Care Board Northern Ireland, SeeAbility, an individual patient advocate and a registrant. Changes related to the need to add to the standards of competence as practise developed and new types of patients became more of a focus. The GOC Companies Committee highlighted the technological developments that would change scopes of practice and create a need to expand core competencies. An individual registrant thought that changes would not be effective until the funding structure changed to make it a more viable business.
95. Five respondents stated that it was important that any changes to standards should not inadvertently restrict practice. These respondents included the University of Ulster, Health and Social Care Board Northern Ireland, Optometry Wales and the joint response from the Optical Confederation and Local Optical Committee Support Unit.

96. The University of Ulster, Optometry Schools Council and Optometry Scotland thought it important to be able to define competence and what it means at different points during the student journey, particularly between undergraduate level and pre-registration year. Optometry Scotland also felt that students should have more patient exposure if they were to work in Scotland, particularly in relation to eye disease and chronic conditions.

97. Two patient representatives, SeeAbility and an individual patient advocate felt the standards of competence should include the requirement to learn about patients with mental and physical difficulties and how to focus consultation to deal with the specific needs of these patients. Feedback from the public consultation event also emphasised the importance of learning communication skills for all patients.

98. Three respondents, Optometry Wales, the Optical Confederation and the Local Optical Committee Support Unit advised against aspirational standards of competence which would create two tier professions. At the public consultation event there was some support for the introduction of aspirational standards of ethics and performance, but the majority view was against setting more than one set of expectations of registrants. However, this view changed to support for aspirational standards when considering Continuing education and training (CET).

99. The GOC registration committee also advised against the introduction of aspirational standards on the basis it may cause confusion as to the standard required for registration and fitness to practise considerations.

100. The GOC education committee considered whether the competency framework could be developed to include competency standards beyond entry level. It was considered that these competencies could inform higher qualifications relating to areas of enhanced practice such as low vision and glaucoma as well as for CET.

101. The College of Optometrists suggested that standards should remain generic to apply to all professions, as being specific would mean less flexibility.

102. An individual registrant suggested further horizon scanning particularly in countries outside of the UK.
103. The University of Ulster questioned whether the current education model of separate undergraduate degree and pre-registration training was the best to deliver and assure standards. It suggested that adequate resourcing for education and ensuring support for students could both be issues. It also highlighted the need to support universities and training providers in the delivery of standards in education.

104. At the public consultation event feedback included the need to make university curricula more consistent and to increase focus on communication skills with the education and training requirements.

b) How should our system of continuing education and training evolve?

105. Ten out of 24 respondents answered this question as part of the call for evidence.

106. Nine of the respondents felt that changes were needed to the CET system. The University of Ulster felt that a review of CET was needed to provide data in order to answer this question.

107. Six of the nine respondents who thought the CET should change felt that it needed to reflect an ethos of continuing professional development rather than simple maintenance of competence. These included the College of Optometrists, Bradford College, Health and Social Care Board Northern Ireland, an individual registrant, Optometry Scotland, Optometry Wales. This was a view shared by a majority of attendees at the public consultation event who felt that standards should be set at a higher level to inspire registrants to learn and develop. However, three respondents – the Optical Confederation and Local Optical Committee Support unit, and the Optometry Schools Council – felt that we should retain the existing system of maintaining competence whilst encouraging those who want to develop further. All who felt CET should change felt that CET competences should continue to be reviewed and updated as scopes of practice change.

108. Optometry Scotland also commented that the system of approval of CET is ‘arduous’ and another registrant and an individual registrant thought that the requirement to gain advance approval for attending a non-UK CET activity was unnecessary and limited registrants’ opportunities to advance their practice.

109. A view from the public consultation event was that informal multi-disciplinary learning should be allowed under the scheme. There was a further suggestion that the peer review element of CET should be increased as this had been a successful element which promoted greater learning and development.
c) How should our system of registration evolve?

110. 12 out of 24 respondents answered this question as part of the call for evidence.

111. Three respondents – the Optometry Schools Council, the Health and Social Care Board Northern Ireland and the University of Ulster – felt that the GOC should consider introducing specialist registers to recognise specialist practice, extended scopes of practice or particular qualifications. The view was supported by the GOC Standards Committee and some delegates at the public consultation event, where it was suggested that clearly distinct areas of practice could attract specialist registration status in the future. Discussion of this area at the GOC Registration Committee concluded that there needed to be a balance between recognising actual extensions of scope and specialist practice as opposed to registering a wide range of different practice methodologies and this view was shared by some participants at the public consultation event. An individual registrant felt that specialist registers should not be developed at present without a discussion on threshold levels for entry.

112. A lay member of the GOC Registration Committee identified that patients already struggle to understand the difference between optometrists and dispensing opticians, let alone a range of other specialist practitioners – clear information on who you will see at a consultation and how they are qualified for specialist practice would be required to make this clear to the patient.

113. GOC comment: there were a number of differing opinions on whether to recognise specialist practice and qualifications through additional registers and further research and analysis will be required in this area.

114. Three respondents identified a gap in the regulation of businesses as the system of regulation does not apply to all businesses. Respondents included Bradford College, the Optometry Schools Council and Optometry Scotland. This was a view also supported by the GOC Companies Committee which believed that standards should apply equally to businesses.

115. Three respondents felt that there was a gap in the registration and regulation of optical support staff and non-registered dispensers which needed to be addressed. This included Bradford College and Optometry Scotland. Delegates at the public consultation event also identified a gap in registration and regulation of locums.
116. The College of Optometrists identified the need to consult those offering post registration qualifications if any changes were made to introduce specialist registers.

117. An individual registrant and Optometry Scotland felt that the GOC should do more to actively regulate the online sale and supply of contact lenses and spectacles. Optometry Scotland went further to say that education of the public was needed in relation to the risks of buying online.

118. Bradford College also felt that student registration should continue in order to ‘impress the code of conduct on them at all times of patient care.’

119. The GOC Registration Committee identified the need to address how online sales of contact lenses and use of new technologies should be regulated in the future.

6. Can you provide examples of where the existing legal framework creates barriers to changes in the scopes of practice of optometrists and dispensing opticians that would benefit patients and the public?

120. Ten respondents out of 24 answered this question as part of the call for evidence.

121. Three respondents identified that the current legislation is too prescriptive in terms of functions, particularly the definition of what is in a sight test and who can undertake this. This restricts scope of practice and the delivery of modern healthcare practices. Respondents included Bradford College, College of Optometrists, Health and Social Care Board Northern Ireland and the University of Ulster.

122. The College of Optometrists also identified that the rules governing the sale and supply of optical appliances were difficult to interpret and could be simplified.

123. The Optometry Schools Council and the University of Ulster thought that the legislation needed to be reviewed further to ensure that it was clear on what functions of eye healthcare and vision services should be restricted to those with a specific qualification.

124. The Optical Confederation and Local Optical Committee Support Unit felt that the most significant barriers to change were not created by the legislation (the barriers they identified are set out under question 4b).

125. An individual registrant identified that legislation governing independent prescribing had been subverted through production of guidance by other
organisations and requested that GOC take back responsibility for setting standards for independent prescribers.

126. **GOC comment:** The competency standards for independent prescribing optometrists are based on the national prescribing standards established by the Department of Health and that apply to all non-prescribing professions. The College of Optometrists publish Clinical Management Guidelines which provide supplementary material to assist registrants in applying their professional judgement.

127. An individual registrant highlighted the need to introduce better legislation to govern online sales and maintain standards.

128. **GOC comment:** We have developed a new strategy for dealing with illegal practice, including the supply of contact lenses online. Any legislative change would take time and would only be applicable to companies operating within the UK so it is necessary, therefore, to adopt a proactive and multi-pronged approach, including continuing to deal with complaints in line with our prosecution protocol, improved information for consumers about how to purchase and wear contact lenses safely and a code of practice for online suppliers of contact lenses to enable consumers to identify suppliers who follow good practice.

7. Do you think there are any other issues that are relevant to our standards strategic review?

129. Eleven of the 24 respondents answered this question as part of the call for evidence with a range of suggestions. Issues were also raised at the public consultation event and by the GOC standards, education, companies and registration committees. The additional issues were as follows:

- Bradford College highlighted the need for all optical staff to attain minimum qualifications.
- The College of Optometrists and the joint response of the Optical Confederation and the Local Optical Committee Support Unit suggested the need for the GOC to work closely with professional associations and others involved in the delivery of its regulatory functions.
- The Optometry Schools Council and the University of Ulster suggested that the GOC needed to develop policy on workforce planning and student entry numbers. Both organisations also suggested that the GOC consider the development of student entry criteria.
- An individual registrant highlighted inadequacies in the training of students in certain areas of practice, including dealing with patients with special needs and tinted lenses and filters.
• An individual registrant highlighted difficulties with standards and accreditation of prior learning experience on some postgraduate courses.
• An individual registrant suggested the need to involve ordinary optometrists in the development of standards and not just academic optometrists.

130. GOC comment: we will consider these additional issues and take them into account in the subsequent phases of the standards review in so far as they are relevant.

What we will do next

131. All of the feedback from this call for evidence will be very useful in informing our standards strategic review, including our work to develop new standards of practice and to review our standards of competence. It has provided useful insight into how the optical professions are likely to change in the future in terms of scopes of practice and healthcare delivery. It has also given us some helpful suggestions in relation to specific content which might be included within the standards and how we could develop our dialogue with other organisations to ensure our standards are fit for purpose.

Project objectives

132. We are pleased that there was broad support for the objectives, phasing and timescales of the project to proceed as planned. The GOC has however noted, however, the need to give further that some consideration as should be made to how best to involve stakeholders, when this should happen and ensuring that sufficient time is put aside for consultation and implementation of any changes.

133. The GOC also welcomes stakeholders’ enthusiasm and will to participate in this work, particularly those bodies who may already be involved in producing guidance for the optical professions. We will seek to engage and work collaboratively with all stakeholders to ensure we produce the best outcomes for patients and the wider public and reduce the potential for confusion among registrants.

Standards of practice

134. The feedback on content, structure and format of the standards of ethics and performance (standards of practice) will be considered in the current workstream in order to develop a set of standards for consultation in May 2015.

135. The GOC has noted the concern in some areas over the need to implement in a proportionate way the findings from recent healthcare inquiries particularly the Francis report. The GOC is keen to learn from the mistakes which have
occurred in other healthcare settings, but will ensure that our standards will take into account the context within which most of our registrants work.

Scopes of practice
136. We will give further consideration to the feedback on likely changes to scopes of practice, including in the devolved nations. Further work will take place as we consider revisions to our standards of competence for training and education. Also, further research and consultation on the value of further recognising areas of enhanced practice and post-graduate qualifications will be needed.

137. Proposals for legislative change will be considered as part of the consideration of scopes of practice workstream. Changes to legislation are likely to be dependent on whether progress is made with the Law Commission review of healthcare legislation that is currently with the Department of Health for consideration.

Business standards
138. Finally, we will review our business standards in the last phase of the project and take account particularly of the feedback on applying regulation consistently to optical businesses.

139. Also as part of the scopes of practice workstream we will consider the need to change our current system of Continuing Education and Training, our system of registration and the system of regulation more generally. We will need to carefully scope out the further work needed to consider, and implement, changes in these areas.

140. Information on the project and the outcomes of public Council meetings will be published on the Standards page of our website. This can be accessed through the following link: www.optical.org/en/Standards/index.cfm.

141. The diagram below was first included in the call for evidence and shows how we intend to phase the project workstreams and the planned timescales for future consultations.
Annex: Responses to the Call for Evidence

Response from Bradford College:

What are your views on the objectives of the standards strategic review, namely to:

A. Clarify and ensure that we are fulfilling our statutory role in promoting high standards, including our role in providing guidance:

The General Optical Council (GOC) promotes high standards for Optometrists and Dispensing Opticians through the regulation of education and training for all registrants both in their initial qualification and continuing development. The GOC's purpose is to protect the public by promoting high standards of education, performance, and conduct amongst opticians (GOC 2014). The promotion of high standards does not extend to the entire industry, namely to unqualified individuals. Since deregulation in 1985 there has been a large change in the frontline workforce within the optical industry. There are many optical dispensers and assistants working within optics (a healthcare environment) who have no minimum level of knowledge or competence. Other regulators under the Professional Standards Agency (PSA) have already taken steps to introduce mandatory qualifications - for example Dental Nurses, Pharmacy/dispensing Assistants and Pharmacy Technicians - which has improved public safety in those sectors.

The GOC website is an easy to use platform enabling access to the expected standards of conduct and competence for the professional members of the optical industry. The GOC website has some links to professional lead bodies (PLB) where guidance can be found. The area where links are found could be clearer, detailing each professional lead body and their duties and a brief description of the guidance they provide. This would make it easier for all registrants and members of the public to find and access guidance with ease. The system of guidance being provided by the PLB rather than the regulator under the PSA was introduced following the 2000 inquiry into Shipman, to ensure that different bodies are responsible for different areas and not all looking at the same points.

The changes to CET requirements have promoted high standards in competence by creating more variation in professional development. The new system ensures that areas of competency are covered. Tracking the competencies and policing the compliance in CET ensures that practitioners are not bypassing particular areas of development. There has also been a marked change in the types of CET available and their content. The new content requires thought and reflection, whereas many previous CET articles were merely a comprehensive reading exercise. The new CET content has been successful in connecting with registrants needs for development by encouraging, reviewing and updating their knowledge. The change in CET has meant more practitioners are looking at areas not previously covered and they are affirming their knowledge in that area. Peer review is one of the new CET formats of delivery. This is invaluable to the industry which can actively share diagnosis and treatment ideas as well as experiences. Although this is not compulsory for Dispensing Opticians, it is still a very important tool for this category of registrants to utilise others' experiences on techniques, procedures, prescription analysis and problem solving.

B. Produce standards of ethics and performance that focus on outcomes, meet public expectations, are clear to registrants and reflect good practice, including the recommendations of recent inquiries, notably the Francis Inquiry:

The GOC provide easily accessible codes of conduct and competency for professional registrants, the first of which: Make the care of the patient your first and continuing concern. Many of the other requirements within the code are also patient centred to ensure that they are treated with dignity, care, politeness, consideration, and are provided with understandable information.

Other specifications within the code relate to performance such as: keep professional skills up to date, maintain adequate records, act quickly to protect patients from risk etc. The code of conduct is for individual registrants and there is also a business registrant code of conduct which includes a requirement for the business to make all registrants comply with the individual code of conduct as a requirement for employment.

Currently there is a gap in the industry where the code of conduct is not enforced. This gap is a major part of the optical workforce, namely the optical assistants and dispensers, all of whom are involved with patient care. The public expect to be in the presence of correctly trained staff when they enter a healthcare environment; and optics should be no exception. To be able to meet customer and public expectations the GOC should consider it's role in the regulation, review or monitoring of optical assistants and unqualified dispensers, and the support of a minimum mandatory qualification for those not working towards an optical qualification. Many tasks are delegated to these 'frontline' staff members that have no minimum level of optical knowledge or competency.

The Francis report recommendations are:

Foster a common culture to put patients first

To foster a common culture, all members of the optical industry should have the same understanding of the standards expected. These standards of ethics, performance and competency should be available and accessible from the GOC. This would help create transparency of expectations for both public and practitioner together with unqualified members of staff. Putting patients first also means educating patients about what we are trying to achieve. Some practices are heavily focussed on spectacle sales and dispensing values, which can deter patients and leave them feeling their needs are not catered for. Optics needs to develop around a healthcare setting - which is difficult when spectacles sales subsidise the true cost of eye examinations. Educating the public about sight loss conditions and particularly preventable conditions would help to encourage the view of optical practice as healthcare settings rather than retail. Putting patients first should be a priority for all in the industry, and educating non GOC registered workers to a nationally recognised level of qualification would help to educate the workforce in not only the optical elements, but the aspects of dealing with patients in a healthcare setting. By providing a mandatory minimum level of knowledge and competency, the optical /
dispensing assistants would provide better patient care from the start of the journey, as these are often the first and last person seen during the visit, particularly in larger stores.

Develop a set of fundamental standards, easily understood and accepted by patients, the public and healthcare staff, the breach of which should not be tolerated.

The fundamental standards that the GOC are preparing for should ensure that they cover all levels of staff in optics and healthcare. These standards should ideally be "standard" across the healthcare industry. A parliamentary publication on the fundamental standards of healthcare (http://www.publications.parliament.uk/pa/cm201314/cmselect/cmhealth/657/65707.htm - point 106 - ) shows some of the suggestions made for the fundamental standards of care. Some of these examples from the Care Quality Commission CQC are as follows;

"I will be cared for in a clean environment."
"I will be protected from abuse and discrimination."
"I will be protected from harm during my care and treatment."
"If I complain about my care, I will be listened to and not victimised as a result."
"I will not be held against my will, coerced or denied care and treatment without my consent or the proper legal authority."

These standards can be applied at all stages of healthcare treatment regardless of the location or grade of staff, whether as a hospital in-patient or being measured for a new medical device (like spectacles) in the community.

A Care Certificate is currently being trialled which has been developed by Skills for Health, Skills for Care and Health Education England, in line with Care Quality Commission (CQC) standards. This is to become a mandatory minimum qualification for all new employees into the healthcare sector.

The (Care Certificate) framework (Health Education England 2014) details the standards expected, helping to raise the knowledge and competency of staff working in healthcare.

Provide professionally endorsed and evidence based means of compliance with these fundamental standards which can be understood and adopted by the staff who have to provide the service.

Compliance with these fundamental standards could be evidenced through a new competency requirement in CET for professionally registered staff. This could also be evidenced by incorporating it into the NHS audit of General Ophthalmic Services (GOS) contracts. Inspections are carried out to ensure NHS funds are being claimed appropriately and they currently focus on policies, procedures and general paperwork. Whilst it is important to check the policies and procedures in place, more focus could be given to patient care. Incorporating some form of observed performance of a patient journey would independently evidence the compliance with fundamental standards and span the staff grades. This form of independent inspection would give an unbiased and transparent assessment.

The Department of Health corporate report 2013-14 (https://www.gov.uk/government/publications/department-of-health-corporate-plan-2013-14/department-of-health-2013-14-corporate-plan) shows one of the Secretary of State responsibilities to be; improving the standard of care throughout the system so that quality of care is considered as important as quality of treatment, through greater accountability, better training, tougher inspections and more attention paid to what patients say. The issue of providing the best care to the public is going to grow, with this being a highlighted area from the Francis recommendations. This is going to mean increased focus on all healthcare industries to ensure the provision of care as well as treatment, providing a better educated workforce that can be evidenced through nationally recognised qualifications.

Ensure openness, transparency and candour throughout the system about matters of concern

Clear guidance on reporting concerns could be given. This guidance should be easily understood and accessible from the GOC. As a healthcare provider we should ensure all staff at all levels are aware that they should report or take action where there is a concern. The GOC publish lists of Fitness to Practice (FTP) hearings on the website often naming the registrant in question. If a sanction is made against the individual it is also published on the GOC register. I do not fully understand the procedure for interim periods: the current illegal practice policy states an investigation would take place; it is unclear whether the registrant would be able to continue practicing whilst the investigation was being conducted.

The clearest way to improve whistleblowing would be to educate unregistered staff regarding the regulations and fundamental standards in place. This would enable them to identify any breach. Optical assistants could be assuming the practitioner knows best and assume they are acting accordingly when in fact a breach could have occurred.

Many optical assistants are unaware of the standards (code of conduct) that the GOC expect all registrants to abide by. Many are also unaware that guidance for individuals is also provided by the many professional bodies. Access to the expectations should be easily understood and made accessible to all. Unless awareness of these expectations is raised to unregistered staff and the public, how can whistleblowing improve? It is clear that we need to ensure that all participants in patient care need some regulation and accountability and this has been a recurring theme through many public enquiries.

Optical assistants should have a minimum mandatory qualification to facilitate accountability of every person involved in each stage of patient care. This would also raise their awareness of the different roles and responsibilities within the optical industry and the importance of each delegated task. Optical assistants - although under 'general supervision' - are unaware of the implications of their actions on patient care. The general public should have access to easily understandable information about the care they can expect from practitioners and staff in the optical industry. The general public should be able to trust the optical industry as a healthcare provider, and not merely as a retail opportunity.
Ensure that the relentless focus of the healthcare regulator is on policing compliance with these standards.

Introducing evidence based compliance to these standards (through an inspection or alternative method) would highlight deficiencies and allow effective policing.

There have been many calls for departments to work better together and where inspections take place to focus on care, not just paperwork. The NHS already have inspections to practices with GOS contracts. These visits could incorporate an inspection of the fundamental standards instead of just checking the papers involved.

Make all those who provide care for patients - individuals and organisations - properly accountable for what they do and ensure that the public is protected from those not fit to provide such a service.

Some effort towards this has been made with the business register. This has brought more accountability to the organisations and a code of conduct to follow. Professionally registered individuals do have accountability for their actions, but not all individuals working in the optical healthcare sector are registered.

A report for the GOC - Risks in the Optical Profession 04/03/2014 - states in the executive summary that 'there is anecdotal evidence of problems arising when dispensing to children is undertaken by unqualified or unregistered practitioners'. It then goes on to say 'this is outside our scope of research'. Further in the report this issue is highlighted again in point 5.45 'it has been raised by some in the optical community that a significant amount of dispensing is undertaken by unqualified people'.

This shows that the issue of unqualified dispensing is something that should be addressed to reduce problems and complaints in the optical industry, in order to gain better public trust. The report also suggests 'this may be an area for future research to establish the actual scale of the problem and associated risks'.

These individuals who are responsible for patient care should have accountability, following a sustainable and accredited training programme such as the Optical Retail Skills Diploma (offered as level2 or level3 qualifications by Pearson Edexcel or WCSM). I have chosen this particular qualification set as they are available as part of an apprenticeship framework. The apprenticeship framework combines nationally accredited courses in optical as well as English and Maths qualifications. The apprenticeship framework also includes training in employment responsibilities and rights, and personal learning and thinking skills which are very desirable skills for a lifelong career. Apprenticeships are being driven by the government and, as such, funding for these courses is available - making them more accessible to employers. The Optical qualification has choices of units (depending on the job role of the learner) allowing them to focus on the aspects that they require (Pre-Screening, Frame, Facial and Spectacle Lens Measurements, Contact Lens Care).

By introducing a mandatory minimum level of qualification, as other healthcare regulators have, and providing fundamental standards or codes of conduct to be followed would make each individual properly accountable for their actions. At the moment, where no formal accredited training has been given, it would be unfair to place proper accountability on the unregistered person. An untrained person is unlikely to make correct and informed decisions at all times, due to a lack of knowledge and/or competency.

Provide for a proper degree of accountability for senior managers and leaders to place all with responsibility for protecting the interests of patients on a level playing field.

Senior managers and leaders need to take a pro-active stance on protecting patients' interests. Some progress has been made to provide a more robust system by introducing the business register. The business registrant code of conduct ensures each person who undertakes activities regulated by the Opticians Act 1989 does so in accordance with the Act'.

This should also mean ensuring unregistered people understand which activities are covered by this Act. Introducing a mandatory minimum qualification would ensure each individual would understand the limits of their authority and therefore the accountability of their actions.

Enhance the recruitment, education, training and support of all key contributors to the provision of healthcare, but in particular those in nursing and leadership positions, to integrate the essential shared values of the common culture in everything they do.

The main point to raise in relation to this recommendation is: 'all key contributors'. Optical assistants have become a very large percentage of our workforce since de-regulation in 1985. Optical assistants can vary dramatically in knowledge and experience, some move up the career ladder into management positions giving them influence over others in the practice. Optical assistants form a very important part of our workforce to whom many tasks are delegated. Tasks such as screening (e.g. fields, auto-tonometry etc.) are an essential part of the eye examination process. Dispensing medical devices including taking measurements and choosing suitable products, conducting contact lens teaches and providing information on caring for contact lenses are all important tasks we are entrusting without sound evidence they are competent or knowledgeable in that area.

The General Pharmaceutical Council GPhC has already introduced minimum mandatory qualifications for all staff working in a pharmaceutical environment and a similar approach could be adopted. The GPhC require all staff working in a pharmacy to gain a minimum of a level 2 NVQ in pharmacy service skills, to include units relating to the job roles they undertake. This is to be started within 3 months of employment. There is also a minimum set of qualifications for registration as a Pharmacy Technician. This registration started as a voluntary register and progressed to a compulsory register on 01/06/2011.

For an Optical mandatory minimum qualification there are already qualifications available at level 2 and level 3 in Optical Retail Skills, which are also available as apprenticeship frameworks (Intermediate or Advanced Apprenticeship in Health). These are currently offered by 2 awarding bodies, Pearson Edexcel and Worshipful Company of Spectacle Makers WCSM otherwise known as SMC. I have chosen this set of qualifications as they are nationally accredited programmes that are adaptable to fit the role of every person working in an optical environment. Unit options cover areas such as Pre-Screening, Frame, Facial and Spectacle Lens Measurements, Contact lens care (including insertion and removal of lenses). The apprenticeship framework also comes with some government funding, making it easier to access the course. This funding is provided because the
framework in place also improves English and Maths skills as well as employment skills and personal learning and thinking skills. These are all skills for life and help to provide a more highly qualified work force.

Develop and share ever improving means of measuring and understanding the performance of individual professionals, terms, units and provider organisations for the patients, the public, and all other stakeholders in the system.

The use of peer review at CET allows different experiences to be shared and adopted by other professionals. The peer review has helped to integrate practitioners from a wider field and therefore share ideas and experiences further. Peer review is also used by Dispensing Opticians, although it is not compulsory and could be utilised further. More accessibility is needed through virtual meeting rooms or webinars to help practitioners attend from more remote areas.

Section 1.120 of the Francis report states:
By bringing all this (report recommendations) together, all who work to provide patient care from porters and cleaners to the Secretary of State will be working in partnership in a common and positive culture.

This highlights the importance of including ALL involved in patient care. Their views should be taken in to consideration when planning fundamental standards, including the views of optical assistants.

C Ensure that our standards of competence, and system of regulation more generally, enable developments in optical practice that would benefit patients and the public.

The standards of competence have greatly improved for professionally registered persons under the new CET scheme. The standards, however, could be improved more in the general industry.

As our aging population grows there will be more demand on eye health services, and to be able to meet the demands we must be prepared from the bottom up. A workforce of qualified optical assistants may be able to take on more responsibility in their role - this would then allow more responsibilities to be taken on by a Dispensing Optician or Contact Lens Optician - allowing the Optometrist or Independent prescriber to take on further duties. Developing the Optical practice, therefore, requires beginning with a robust, trusted workforce to sustain any additional activities.

This method has proven successful within the pharmaceutical industry, who has already introduced minimum mandatory qualifications. Pharmacists have been able to take on additional responsibilities (for example - Medicine Use Reviews (MURs) for GP practices; prescribing duties in hospitals and in minor injury clinics (Scotland); ward rounds with Doctors; providing care home services etc.). This has been achieved by them being able to delegate some of their more routine tasks to registered Pharmacy Technicians, who in turn delegate some of their tasks to trained (to the minimum mandatory requirement) pharmacy assistants.

This is ultimately the goal within optics. There will be more demand on healthcare services due to the aging population and many eye health issues that go alongside old age: re-distributing workload and taking on additional functions would make the detection and management of eye health more accessible. By re-distributing workload within optics the hospital pressures could be reduced and the service would be easier to access in local communities.

2 What specific issues do you think we should take into account in developing our standards of ethics and performance

The main issue is the use of unqualified staff in a healthcare environment. Any standards on ethics and performance should extend to incorporate this category of staff as they make up a large percentage of our workforce.

The NHS are also developing fundamental standards, and all healthcare regulators under the Professional Standards Agency (PSA) should also adopt these where possible. Standards of ethics should be transferable across all healthcare providers, which may necessitate some amending or omitting of certain performance standards.

3 What are your views on how we intend to phase the project work streams

The projected work streams are fairly short although it seems achievable within the timeframe. The consultation period is again shorter than your recommended consultation period of 12 weeks. Whilst I appreciate that this is to consider the responses at the next council meeting; this is not the first time the consultation period has been shortened.
4  Looking to the future

A  To what extent are there opportunities for the scopes of practice of Optometrists and Dispensing Opticians to evolve in a way that would benefit patients and the public

The aging population will lead to a growing number of people with sight problems. This is likely to lead to increased demand for Optical and Ophthalmological care, with more services being provided in community and domiciliary settings and a higher proportion of more vulnerable patients, including people with learning difficulties or dementia. There is also the risk of an increase in avoidable sight loss if eye conditions go untreated or vision goes uncorrected.

The increased demand on the optical sector posed by an aging population has huge potential for our staff development; however none of this can be achieved easily due to already tight time pressures on Ophthalmologists and Optometrists. To be able to expand our scope we must first train and educate our optical assistants to become more valuable assets. The “risks in the optical profession” report, commissioned by the GOC, highlights the issues with dispensing caused by unqualified and unregistered staff and notes that they are real issues which waste a lot of time in practice - often having to be rectified by a Dispensing Optician.

To resolve the issue the Dispensing Optician then spends more time correcting the error and reassuring the patient than the time it initially took to sell. Training Optical Assistants and making them more accountable for their actions would help to free up time for the Dispensing Optician. This time gained can be used to ensure that patients who have more specialist or complex prescriptions can see a Dispensing Optician more quickly, and additional functions could also be taken on.

Low vision - an aging population will also create a larger demand for low vision services. This could become more commonplace in high street practices as the demand increases. Low vision aids can revolutionise a patient’s life and this should not be underestimated. Low vision aids can help patients to maintain their independence for longer, which leads to reduced costs in other healthcare sectors. New low vision products are constantly being produced and are very inventive everyday items such as the liquid level indicator which allows the user to fill their cup of tea to the right level, and talking cookware e.g. thermometers and scales.

Refracting - Dispensing Opticians may be able to take on refracting patients routinely and problem solve refractive errors. Refracting for Dispensing Opticians, including those who have passed a delegated functions courses, have been a matter for debate recently. The GOC have previously stressed that no part of the sight test can be delegated to a Dispensing Optician (D.O) or Contact Lens Optician (C.L.O) even under supervision. Peter Black responded ‘If it is not possible to delegate any part of a sight test then surely any clinically necessary pre-screening for fields, pressures, objective refraction, topography or wave-front aberrometry is also not possible? Yet it occurs daily in almost every practice in the land and is carried out in the main by personnel far less qualified than registered dispensing opticians’ (http://www.opticianonline.net/abdos-peter-black-on-the-right-to-refract/).

This is a very valid argument and it is important to utilise staff in the industry to re-distribute workload and move the industry forward. Allowing D.Os and C.L.Os to gain this delegated function would allow prescription re-checks to be carried out more flexibly. By allowing D.Os to carry out re-checks and refractions Optometrists could focus more on eye disease detection and management. Allowing D.Os to re-check a prescription would not disrupt normal clinics. D.Os are well versed in the issues caused by spectacle intolerance and prescription errors and are probably the most appropriate person as they will be focussing on the best refractive management for the patient as well as providing the best spectacle lens options. Approximately 20% (using registration figures from the strategic themes paper pages 22 and 23) of all registered D.Os have the C.L.O speciality and already over refract contact lenses on a daily basis.

Behavioural Vision Therapy - This may become more popular as more children are diagnosed with attention disorders and learning difficulties. There are studies both to support and not support the benefits of this type of treatment such as: Jennings 2000; Behavioural optometry-a critical review.

St Louis American Optometric Association 1994 (Amblyopia) 1995 (Esotropia and Exotropia) 1998 (accommodation and divergence dysfunction) Colourimetry - This may also become more popular as more children are diagnosed with dyslexia Contact Lens Opticians may also take on additional functions with managing contact lens problems. Although many patients may need to be seen by a medical practitioner, follow ups could take place in community practice.

Orthoptics may also move into general practice for more routine checks and treatment plans.

Diabetic Screening - Could be taken on to reduce pressures on hospital clinics. The Francis report has called for all healthcare providers to work together and share relevant information to authorised healthcare personnel. Routine Diabetic Screening in the community would utilise the flexibility and choice of location as well as an increase in providers. The GOS workforce statistics for England and Wales 31/12/2013 shows over 97% of practitioners are Optometrists compared to Ophthalmic Medical Practitioners so changing the provision into community care would increase the availability of screening appointments.

Optical assistants could undertake accredited units in the use of screening and diagnostic equipment so they understand the implications of the results and understand how to use equipment safely and hygienically. The Optical Retail Skills Diploma (offered by WSCM and Edexcel) have a dedicated pre-screening unit. This particular unit has 4 main learning outcomes each containing specific learning criteria:

- Understand policies and procedures - policies and procedures relating to pre-screening, the importance of following them and what could happen if they were not followed.
- Determine the procedures to be carried out - Convey information to customers, gain consent, record details, describe the range of tests and how they are carried out and responding to requests for information.
- Carry out optical screening procedures - Check patients details, explain the tests and general principles, check equipment is fit for use, refer to relevant person where anomalies occur, describe general principles of diabetes, glaucoma and cataracts and the effect on the eye.
pressures on community practice. The Health and Social Care Information Centre (HSCIC) General Ophthalmic Services Workforce Statistics (Dec 2013) shows that there has been a steady increase in the number of optometrists most likely due to the increase on eye care demands from our aging population. This has also highlighted a decrease in Ophthalmic Medical Practitioners (OMPs) of 50.9% in the last ten years. This change in workforce will also mean further pressures on community practice.

The three major causes of preventable sight loss are:
- Glaucoma
- Diabetic Retinopathy
- Wet Age-Related Macular Degeneration wAMD

According to the UK Vision strategy (www.vision2020UK.org.uk) 2 million diabetic screenings are carried out a year. Routine Screenings in practice would reduce pressures on the hospitals and address workload imbalances between the percentage of Optometrists to Ophthalmic Medical Practitioners. Treatment and management of Glaucoma in community practices would help to educate the general public and give them a greater awareness of the 'silent' threat. More efficient Glaucoma testing in practices has been happening more recently with enhanced services and this could continue to improve and also take on routine management under Independent Prescribers. Making better use out of the resources available in community would make managing Glaucoma easier and more affordable therefore helping to reduce avoidable sight loss. This would also free up time and space in hospitals for procedures that require a clinical hospital environment.

We expect that developments in commissioning and in treatment methods will mean the optics professions can play a bigger role in preventing avoidable sight loss. Registrants will have greater opportunities to provide enhanced services in the community, but will need to keep up to changes in technologies and treatments. Better patient outcomes will also require a more integrated system of care with strong links between optical practices and other parts of the health and care system, including effective collaboration with ophthalmologists and general practitioners.

The report on the economic impact of free examinations in Scotland 2012 (www.aop.org.uk) states that 613,000 additional people had a sight test between 2006-2007, when the free sight test was introduced. This compares to a rise of only 20,000 additional people having an eye test between 2001-2006. This report has reported that this implemented scheme will save around £440 million per annum.

England has come way behind Scotland in campaigning for action on eye health. The enhanced GOS in Scotland has increased the responsibilities of the Optometrist but attracted more patients to have an eye examination, who otherwise would not. Wales have introduced initiative one of the most successful being PEARS Primary Eye care Acute Referral Service. This service is a triage for eye conditions and allows ease and convenience of access as patients can self-refer or be referred by their GP. This is particularly important where GPs do not have the equipment to examine eyes in the same way as an optical practice.

Domiciliary care is likely to see an increased demand as population ages and mobility becomes an issue. Some larger domiciliary companies have Optometrists who are also responsible for dispensing spectacles at the same visit as the test to reduce staffing costs. In some of these larger companies follow up visits for fitting etc. would be carried out by an optical assistant. This is a cause for concern where there is no minimum qualification in place or accountability. People working in this setting are likely to come into contact with more vulnerable persons including those with dementia. The Francis report has called for all persons to be accountable and in the situation of optical assistants entering patients’ homes for spectacle repairs of adjustments this is not the case. Although this activity is not regulated under the Opticians Act is it nevertheless patient care and the GOC should be proactive to ensure the protection and safety of patients in all aspects of eye health care by introducing minimum mandatory qualification for all staff members working in optics.

The optical sector has seen many technological advances in recent years, with changes in the equipment available in practices enhancing what Optometrists can do for patients and enabling them to better track changes in eye health over time. There have also been significant developments in contact lenses and intraocular lens technology. Technological advances are likely to continue, with scope for the development of more remote diagnosis and treatment, and greater automation of eye examinations.
The Francis enquiry will have a lasting impact, leading to all health regulators facing increased public expectations. We need to respond in a proportionate way, speeding up complaints handling and ensuring that our standards reflect the importance of compassion, candour and open communication. The lessons of Francis and other inquiries are relevant across the UK, which will be emphasised by the finding of further inquiries, such as the Levin inquiry in Scotland.

Speeding up complaints handling within optics and meeting customer expectations is no longer just about complaints made only to the GOC. Many complaints go through Optical Consumer Complaints Service (OCCS). The annual report 11-12 for OCCS shows that many of the complaints made against the optical practice are not referred as FTP cases (Annual report 2011-2012 OCCS (http://annualreport11-12.optical.org/the-optical-consumer-complaints-service/). The report also shows that poor service and dispensing, including multifocal and frame selection, equate to 47% of all the complaints made that year. These are all tasks frequently delegated to optical assistants who have no formal requirement for minimum mandatory training or any accountability for their actions.

More detailed information should be made available to the public about complaints made in general not just complaints resulting in a FTP case. Looking at the report commissioned by the GOC (March 2010) Risks in the Optical Profession, many issues are caused by unqualified and unregistered staff - as public awareness increases and expectation grows, they will expect to be treated by persons who are qualified in that area. Currently there is no requirement for optical assistants to have any formal qualification. This leads to many dispensing errors that could have been prevented; every one of which is damaging to the reputation of the industry. To be able to move forward, take on more responsibility, and tackle public eye health we must start from the bottom up and gain the trust and respect from the general public by supplying them with a more knowledgeable and qualified workforce.

Cases where FTP is in question do need to happen more quickly to help protect the general public - this could be through more FTP case examiners/panels across the country to deal with complaints quickly and efficiently and where necessary refer further up the chain.

We expect the UK Law Commission’s review of health care regulation to have a significant impact on our work. Although the timetable for legislative change is uncertain we hope that we will be able to streamline our procedures and governance arrangements, as well as make changes to the way that we regulate businesses and staff.

Information relating to legislative change should be cascaded to all registrants and provide information on the changes made. Where appropriate, registrants should have the opportunity to comment and give feedback.

The inclusion of an eye health indicator in the public health outcomes framework for England is a major development. This could lead to a higher profile for optical services and greater scrutiny of whether the public is receiving a high standard of optical care. Gathering data to measure progress will be a challenge for the professions with a need for a more uniform approach to record-keeping. Linked to this, it may be appropriate for us to increase our focus on promoting eye health where there would be a clear public benefit.

Gathering data to measure progress can always be challenging where this has not been properly collated in the past. Surely in a patient care orientated industry we should pro-actively seek feedback and suggestions for improvement from our patients? By accepting feedback directly from those using our services we can monitor patient satisfaction. The fundamental standards should be written clearly so that all can understand them and generic questions relating to these standards should be generated to use as feedback forms or surveys. There could also be a facility to provide patient feedback on the GOC website, or another suitable site, where patients can go to voice their opinions at any time. Free survey sites are available to use and they can collate this information automatically, therefore reducing expenditure. Surveys could also be posed through the YouGov site. This is an already established survey site where many people fill in surveys for the government for points or prize draw entries. Surveys are posed from all aspects of everyday life from consumer products to politics and include visits to hospitals or GP practices, it would not be out of place to include visits to an opticians.

B To what extent are there threats to the current scope of practice and what might be the impact on patients and the public?

The biggest threat to current practice is the lack of mandatory minimum requirements for optical assistants. Introducing this requirement would improve the knowledge and competency of the workforce but also educate them in the standards expected from other registered staff members. This would improve accountability and whistle blowing as there would be a better understanding of the implications of individual actions on patient care. Many tasks are delegated to optical assistants and this is a trend that is likely to continue due to our aging population and the need to move certain treatments away from hospitals and into community.

5 In order to facilitate changes in the scope of practice of Optometrists and Dispensing Opticians that would benefit patients and the public.

to further their practice. This may be particularly true of new/young 'tech savvy' Optometrists where this may feel like a natural step given the amount of advancing technology appearing in our day to day lives.

Many of the technologies Samantha mentioned seem quite far-fetched for everyday practice but back in the 40s so did the World Wide Web!
A  How should our standards of competence evolve?

The standards of competence should continually be reviewed. This would mean regularly reviewing and updating CET requirements in each category where developments have been made. There may be the need to introduce new units of competency as different scope of practice become part of everyday practice. There may also be a need to create sub topics so that each main theme within a competency is covered over a period of time.

There should also be some sort of standard of competence for optical assistants or dispensers. This should be in the form of a mandatory qualification and Continuing Professional Development (CPD) logs.

B  How should our system of continuing education and training evolve?

The standards of competence should continually be reviewed. This would mean regularly reviewing and updating CET requirements in each category where developments have been made. There may be the need to introduce new units of competency as different scope of practice become part of everyday practice. There may also be a need to create sub topics so that each main theme within a competency is covered over a period of time.

There should also be some sort of standard of competence for optical assistants or dispensers. This should be in the form of a mandatory qualification and Continuing Professional Development (CPD) logs.

Continuing education is an important part of ensuring a safe healthy environment for patients and this should not be neglected for optical assistants. Optical assistants do make up a large number of our workforce and should have a minimum mandatory qualification to ensure that patient care is always at the forefront of the optical industry.

C  How should our system of registration evolve?

Registration is an important part of public trust. Registration of all practitioners should continue as well as business registration. Students who are regularly in contact with patients should also be registered thus impressing the code of conduct onto them during all times of patient care. This is particularly important for pre-registration Optometrists but also consider student Dispensing Opticians who potentially take on more duties as a result of starting the course with relatively little training. This can be the case for those who take the course as day release or distance learning rather than a full time route.

The registration of students is also a deterrent against adverse behaviour as the code of conduct is impressed on them from the start of their professional career. A separate, perhaps voluntary, register of optical assistants who have gained a minimum qualification such as the level 2 or level 3 Diploma in Optical Retail Skills would help the transparency in training of our workforce. This would also help to gain public trust and respect as they can see and check which practices are pro-active in providing fully trained staff.

6  Can you provide examples of where the existing legal framework creates barriers to changes in the scopes of practice of optometrists and Dispensing Opticians that would benefit patients and the public.

Opticians Act 1989 Part IV 24 Testing of sight

I think that the entire profession is aware that a sight test or eye examination is more than merely the testing of sight. The Act details the duties to be performed on sight testing and the title of this section should be changed to 24 Eye Examination. This would highlight the importance of detection and management of eye disease.

The testing of sight should be a separate section and allow for delegated function of refraction to D.Os and C.L.Os.

This change would benefit the public by changing the focus of the eye examination away from just 'testing of sight' and to detecting and management of eye disease. This would help to create a better public image as a healthcare provider and not just retail.

There would also be a massive public benefit in services offered as workload could be re-distributed to remove pressures from other areas of the optical industry. The HSCIC GOS workforce statistics (Dec 2013) show that there has been a 50.9% reduction in OMPs which will have an impact on the services that can be provided in a hospital environment. Optometrists roles will need to evolve to this change in workforce and take on more duties. For this to be successful, delegated functions should be introduced to allow D.Os to take on additional duties. In turn D.O's can support optical assistants (with a minimum mandatory qualification) to take on more responsibilities.

7  Do you think there are any other issues that are relevant to our standards strategic review?

The standards strategic review should seriously consider the implementation of a minimum mandatory qualification for optical assistants. The Risks in the Optical Profession Report (March 2010) highlights that an investigation into the risks and implications of unqualified staff would be something for the GOC to consider. Detailed information about the optical qualifications available can be found on the ofqual register of regulated qualifications (register.ofqual.gov.uk). This details the criteria covered in each unit of each qualification. Further information about the apprenticeship frameworks can be found at apprenticeship frameworks online (afo.sscalliance.org).
General Optical Council

- Code of Conduct for business registrants
- Code of Conduct (for individual registrants)
- About the GOC - online content www.optical.org accessed 01/09/2014
- Risks in the Optical Profession - Final Report - By Europe Economics 04 March 2010
- Standards strategic review July 2014
- Strategic plan 2014/15-16/17 November 2013

Optical Confederation Optics at a Glance 2012 - Sources:

1. Health Survey for England 2001
3. NHS National Services Scotland 2007
7. IOS Scotland Report, General Ophthalmic Services, NHS Scotland, 31 July 2012
8. (HSC) Business Services Organisation, Northern Ireland
12. The College of Optometrists
13. Annual Report 2011-12 General Optical council

The Mid Staffordshire NHS Foundation Trust Public Inquiry - Chaired by Robert Francis QC

Report of the mid Staffordshire NHS Foundation trust Public Inquiry Executive summary 2013

Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report - professor Bruce Keogh KBE 16 July 2013

Care Certificate Framework (technical) April 2014

Standards for the Dental team www.gdc-uk.org 30 September 2013

NHS Careers - Healthcare assistant - training and development

HSCIC GOS Workforce statistics Dec 2013

General Pharmaceutical Council

- Internal Caseworker Guidance - Pharmacy Technician - January 2008
- Policy on minimum training requirements for dispensing pharmacy assistants and medicines counter assistants September 2011
- GPhC minimum training requirements
Dear Ms Bunby,

**General Optical Council Standards Strategic Review: Call for Evidence**

BSI (British Standards Institution) has read with interest the call for evidence for the Strategic Standards Review. We are interested in discussing with the General Optical Council the possible role for British or international standards in facilitating performance improvement across the optical professions. These standards are documents for voluntary use that are developed by all interested parties on the basis of consensus through a trusted, third-party process managed by BSI. More details about BSI and its standards development process are contained in the background on BSI, below.

BSI would like to offer a response to questions 1, 2 and 4 of the call for evidence.

1. **What are your views on the objectives of the standards strategic review, namely to:**
   a) clarify, and ensure that we are fulfilling, our statutory role in promoting high standards, including our role in providing guidance;
   b) produce standards of ethics and performance that focus on outcomes, meet public expectations, are clear to registrants and reflect good practice, including the recommendations of recent inquiries, notably the Francis Inquiry; and
   c) ensure that our standards of competence, and system of regulation more generally, enable developments in optical practice that would benefit patients and the public.

BSI supports the objectives of the GOC standards strategic review. We believe that it ensures GOC is fulfilling its statutory role, whilst responding to recent recommendations, and looking to the future in order to allow optical practices to develop in a way that will be beneficial for patients and the public. The review also provides an opportunity to set explicit performance standards; BSI would be interested in discussing this aspect in more detail with GOC.

2. **What specific issues do you think we should take into account in developing our standards of ethics and performance?**

Section 2 of the call for evidence recognizes the need for standards to be forward-looking, and to take into account where the environment is changing. One of the biggest challenges will be the increase in our ageing population, but also the desire for people to enjoy a high quality of life whilst continuing to live independently from institutionalized care. With an anticipated increase in the levels of care that are provided in the community or in domiciliary settings, optical and ophthalmic practitioners will need to
have an increasing awareness of the effects that physical impairments, dementia and multi-morbidities can have on the demands for their services.

Developing standards should allow practices to demonstrate that they are well-led, and have the changing needs of the public in mind. They should allow practices to demonstrate innovative ways of showing that they are providing an excellent service to the user.

4. Looking to the future:

a) To what extent are there opportunities for the scopes of practice of optometrists and dispensing opticians to evolve in a way that would benefit patients and the public?

b) To what extent are there threats to the current scopes of practice and what might be the impact on patients and the public?

BSI believes that there is an opportunity to evolve the practices of optometrists and dispensing opticians in a way that demonstrates that their businesses are well-led and innovative, and focus on continuous improvement of the services that they offer to patients and the public. This could include ensuring that their services are designed to be accessible to those with physical and mental impairments and a range of long term conditions. It could include awareness of multi-morbidities and the routes towards signposting get support for other conditions. It could also include best practice on information sharing, governance, customer service and complaints handling.

BSI has a background in facilitating the development of standards for service providers, both in the healthcare sector and beyond. BSI is currently working with other healthcare professional and statutory bodies to consider opportunities for where our service standards could align with professional conduct standards. Some examples of our healthcare work include:

- Early discussions with the General Dental Council to develop a service standard for primary care dental practices, to demonstrate best practice, particularly in relation to the ageing population needs;
- A partnership with the Clinical Services Accreditation Alliance (CSAA), which is a cross-Royal College initiative to develop a service based accreditation methodology that serves a variety of stakeholders and is patient focussed. BSI’s role will be to develop an overarching, generic standard that contains the common principles that these services should follow;
- A related discussion with the Care Quality Commission for a standard to underpin accreditation / assessment schemes (particularly for private dentistry practices), in order to provide information and evidence for their regulatory judgements;
- Development of a British Standard with the Academy for Healthcare Sciences, to measure the quality and competence of medical physics services (an expansion of an existing ISO standard covering medical laboratories);
- Development of a code of practice to support the recognition process for dementia-friendly communities (with the Department of Health and Alzheimer’s Society);
- Consideration being given to the development of further sector-specific standards relating to ‘dementia-friendliness’ at a later date.

When considering these opportunities, it is essential that standards development managed by BSI does not duplicate or conflict with the standards of other professional and statutory bodies. We always ensure that there is alignment with standards and codes published by other bodies and that any BSI standard will add value to the organizations that apply them. Therefore we would welcome a discussion with GOC about the possible role for BSI to manage the development of a service standard for optometrists and opticians that could benefit the professionals and the public.
Background on BSI

BSI is the UK’s National Standards Body, incorporated by Royal Charter and responsible independently for preparing British Standards and related publications and for coordinating the input of UK experts to European and international standards committees. BSI has 113 years of experience in serving the interest of a wide range of stakeholders including government, business and society.

BSI also presents the UK view on standards in Europe (via the European Standards Organizations CEN and CENELEC) and internationally (via ISO and IEC). BSI has a globally recognized reputation for independence, integrity and innovation ensuring standards are useful, relevant and authoritative.

BSI, as the UK’s NSB, is responsible for maintaining the integrity of the national standards-making system not only for the benefit of UK industry and society but also to ensure that standards developed by UK experts meet international expectations of open consultation, stakeholder involvement and market relevance.

A BSI (as well as CEN/CENELEC, ISO/IEC) standard is a document defining best practice, established by consensus. Each standard is kept current through a process of maintenance and review whereby it is updated, revised or withdrawn as necessary.

Standards are designed to set out clear and unambiguous provisions and objectives. Although standards are voluntary and separate from legal and regulatory systems, they can be used to support or complement legislation.

Standards are developed when there is a defined market need through consultation with stakeholders and a rigorous development process. National committee members represent their communities in order to develop standards and related documents. They include representatives from a range of bodies, including government, business, consumers, academic institutions, social interests, regulators and trade unions.

We would be pleased to discuss the views expressed in this letter should you so wish.

Yours sincerely,

Richard Collin
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External Policy
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Optometry Wales is the professional umbrella organisation for all community optometrists, dispensing opticians and optometric practices across Wales. Optometry Wales is responding to this consultation by the General Optical Council (GOC) on behalf of all community optometrists, dispensing opticians and optometric practices across Wales.

1. What are your views on the objectives of the standards strategic review, namely to:
   a) clarify, and ensure that we are fulfilling, our statutory role in promoting high standards, including our role in providing guidance;
   b) produce standards of ethics and performance that focus on outcomes, meet public expectations, are clear to registrants and reflect good practice, including the recommendations of recent inquiries, notably the Francis Inquiry; and
   c) ensure that our standards of competence, and system of regulation more generally, enable developments in optical practice that would benefit patients and the public.

Optometry Wales welcomes the GOC’s Standards Strategic Review. We fully agree that the GOC’s role in promoting higher professional standards across the optical professions is of fundamental importance; we also agree that in carrying out its role the GOC should from time to time review what it is doing in this respect to ensure that it reflects the changing needs of the population and the professions, and changes in the environment in which we all operate. This will include both setting standards and providing clear and relevant guidance. We are aware of the responsibility that the GOC has to explore the implications of the Francis Inquiry recommendations for the optical sector, and where appropriate to revise standards, codes of ethics or guidance in order to implement those recommendations.

In Wales, whilst Welsh Government have issued a response to the Francis Inquiry we are not aware of any further formal communications from Welsh Government to the optical sector in Wales as to how these will be implemented. One of the workstreams for Optometry Wales in 2014 is to ensure that within our own remit we provide support to our members as to raising awareness of the recommendations and the implications in practical terms for practices.

One of the biggest challenges we foresee is how best to implement the Duty of Candour; how to ensure excellent communications between those working in the optical professions and optical practices, and their patients; and how to demonstrate compassion. Without further communication from the Welsh Government to practices we would question how this can be achieved in Wales.

We note that the consultation references a variety of other factors – along with the recommendations of the Francis Inquiry – that are affecting our operating environment, such as the ageing population, developments in treatment, new approaches to commissioning and changing expectations of eye care. We would draw the GOCs attention to the different dynamics within devolved government’s such as Wales where all of the above are happening at a rapidly developing pace. In this sense we welcome the GOC’s commitment to keep the legal framework of optical practice under review. In the longer term, we need to prepare for legislative change, following on from the Law Commission review and this consultation provides an important opportunity to review standards until that time. It also provides us with an important opportunity to review what we want to achieve for the benefit of patients and the population so that we can make best use of that opportunity for legislative change when it arises. The GOC should take account of the different modes of practice that have developed in the 4 nations. Regulation should be flexible enough to recognise local protocols so that practitioners are judged according to local variances that may, for example, actively encourage patients to be monitored in the community rather than be referred to secondary care.

2. What specific issues do you think we should take into account in developing our standards of ethics and performance?

Optometry Wales would suggest that one of the strengths of the existing codes of conduct is that they are easy to understand for both public and practitioners. It would be good if the GOC kept simplicity and clarity of expression as a key aim throughout this review. In doing so much recent collaborative work with organisations in Wales such as Community Pharmacy Wales we would suggest that the GOC may wish to look at other models such as the
Pharmacists Ethics Framework, which is simple and easy to understand, and would urge the GOC to consider to what extent it, or something similar, could be carried across for community optical practice.

3. What are your views on how we intend to phase the project work streams?

Optometry Wales are content with the phased approach. It will hopefully enable all concerned to give full consideration to the issues. Attempting to do all stages simultaneously would have implications for the GOC in terms of both time and resource and would make it very difficult for all stakeholders to contribute fully to the process.

4. Looking to the future:
   a) To what extent are there opportunities for the scopes of practice of optometrists and dispensing opticians to evolve in a way that would benefit patients and the public?
   b) To what extent are there threats to the current scopes of practice and what might be the impact on patients and the public?

Technology is advancing all the time but this should not be seen as a threat, rather as an opportunity to develop optometrists’ and dispensing opticians’ scope of practice further in the public interest. In Wales, with the Wales Eye Care Service (WECS) optometrists’ core competencies are currently significantly used in NHS with plans from Government to use these competencies even more as the Welsh Government’s Agenda for Health and its flagship Eye Care Plan is delivered. In Wales WECS accredited optometrists play a significant role in shared care with hospitals, eg reviewing patients with dry AMD, managing patients with glaucoma, and carrying out pre and post-operative work for cataract patients. WECS accredited optometrists also play a role in stable glaucoma monitoring in the community. Looking further ahead, therapeutic contact lenses are included in the Eye Care Plan for Wales. When these therapies become available, registered contact lens opticians should fit and monitor these lenses under a shared care arrangement with ophthalmologists or optometrists. In community dispensing opticians and contact lens opticians, we have a strong body of professionals who are highly skilled in assessing, fitting and supporting patients in the wearing of contact lenses. We should be making better use of these skills; it would help to manage pressures on the hospital sector, which would be in the interests of patients and the NHS.

Looking even further, some of these therapeutic contact lenses and some of the currently injectable therapies will become ministerable by drops. At that stage both optometrists and dispensing opticians could have a far greater role in providing these therapies to patients in the community either independently (for an agreed range of conditions) or under shared care/group management protocols with Ophthalmology Departments.

5. In order to facilitate changes in the scopes of practice of optometrists and dispensing opticians that would benefit patients and the public:
   a) How should our standards of competence evolve?
   b) How should our system of continuing education and training evolve?
   c) How should our system of registration evolve?

Optometry Wales would urge the GOC to stay away from the adoption of an approach to standards, or issues guidance that inadvertently (or intentionally) prohibits or restricts the ability of registered optometrists or dispensing opticians to broaden their scope of practice. This will be against the current rhetoric and ethos of the way in which healthcare is delivered in Wales. As the Eye Care Plan for Wales allows there should be flexibility to allow for developments in the skills and roles of practitioners.

Optometry Wales welcomes the approach to "encouraging professional development" in the standards of competence but we have serious concerns at the proposal for the GOC to introduce core standards and aspirational standards. We are strongly of the view that the regulator taking this approach can only lead to confusion – about what is acceptable, and about which standard is being applied at any particular time. We believe that the aim of the GOC should be to ensure that all clinicians meet the core competencies, and then once they have to them to continue to develop professionally throughout their professional career and in line with (in the case of Wales) the devolved government rhetoric. CET should evolve to allow and positively encourage, wider learning beyond the core competencies. Limiting mandatory CET to core competencies may stagnate learning resulting in loss of skills in areas that were traditionally robust, for example binocular vision and dispensing to children, and potentially restriction of learning to mirror the absolute minimum scope and level of competency required to maintain the profession.

7. Do you think there are any other issues that are relevant to our standards strategic review?

Optometry Wales is grateful for the opportunity to respond to the consultation and for the way in which staff at the GOC have striven to ensure that a fair and democratic canvassing of views from stakeholders has been undertaken.
Response from City University:

Summary statement: Evidence-based practice should be explicitly written into the GOC competency standards to ensure that optometry graduates have the skills and knowledge needed to provide the best possible patient care.

This response relates to point 4 of the call for evidence:
Looking to the future:
a) To what extent are there opportunities for the scopes of practice of optometrists and dispensing opticians to evolve in a way that would benefit patients and the public?
b) To what extent are there threats to the current scopes of practice and what might be the impact on patients and the public?

Over the past two decades, evidence-based practice has been embraced by a wide range of healthcare professions including medicine, nursing, dentistry, speech pathology and physiotherapy.¹ Although the concept was initially introduced as evidence-based medicine, an approach to clinical decision-making based on the best (most reliable) available evidence², it was subsequently broadened to ‘evidence-based practice’ (EBP) to reflect the fact that all health professions (not only medicine) recognised its significance in terms of the quality and safety of health care.³

In view of the fact that graduates within the healthcare professions are expected to be evidence-based practitioners, competency standards now widely include statements on evidence-based practice skills and knowledge. For example, the Speech Pathology Australia competency-based standards include a clear definition of EBP and refer to the need for graduates to demonstrate an evidence-based approach to all aspects of practice.⁴ Recently, Optometry Australia published revised entry-level competency standards which define EBP and specify it as a core element of optometric practice.⁵

These moves reflect the fact that EBP is known to enhance the quality of health care.⁶ In view of this we urge the General Optical Council to include in the Standards a definition of evidence-based practice and clear indications of the skills, knowledge and attitudes to be demonstrated by entry-level optometrists in the United Kingdom. Consistent with the objective of this strategic review, this would ensure the promotion of high standards, reflect best practice, and will benefit patients and the public by ensuring that, from entry level, optometrists in the UK make use of the best available evidence to provide the best possible eye care and advice.

Dr Catherine Suttle
Senior Lecturer in Optometry & Visual Science

Professor John Lawrenson
Professor of Clinical Visual Science

Professor Chris Hull
Professor of Optics of Vision, Divisional Lead for Optometry & Visual Science
References:


Response from Health & Social Care Board (HSCB), Northern Ireland. Health and Social Care Board is established:

- To arrange or ‘commission’ a comprehensive range of modern and effective health and social services for the 1.8 million people who live in Northern Ireland;
- To work with the health and social care trusts that directly provide services to people to ensure that these meet their needs;
- To deploy and manage its annual funding from the Northern Ireland Executive – currently £4 billion – to ensure that all services are safe and sustainable.

1. What are your views on the objectives of the standards strategic review, namely to:
   a. Clarify, and ensure that we are fulfilling, our statutory role in promoting high standards, including our role in providing guidance
   b. Produce standards of ethics and performance that focus on outcomes, meet public expectations, are clear to registrants, and reflect good practice, including the recommendations of recent enquiries, notably the Francis Inquiry, and;
   c. Ensure that our standards of competence and system of regulation more generally, enable developments in optical practice that would benefit patients and the public.

a. HSCB would welcome clarification on Council’s role in promoting high standards and on the provision of guidance. HSCB considers it important that both the professions and the public understand the role of the GOC in terms of promoting high standards and providing appropriate guidance. Council is aware of the synergies and dynamics which exist between it and the College of Optometrists and the representative bodies. Council will appreciate that these bodies also seek to promote high standards of professional conduct and competence. Whilst not mutually exclusive, this has the potential to create confusion among registrants on respective roles and responsibilities. HSCB consider it vital that registrants understand the difference between GOC standards which must be complied with and which would be tested, and
guidance from other sources. Council may consider taking the lead in this area.

b. HSCB would welcome clear standards on ethics and performance that are both outcome based and, in the case of performance, measurable. The current Codes of Conduct lack detail and assessments of fitness to practice aligned to the current Codes can render the need to consider other sources of guidance when considering fitness to practice.

In addition to standards, the review references guidance and acknowledges that these may be used to illustrate how registrants might comply with those standards. Whilst this might be desirable, HSCB would welcome clarity on how such guidance would align with guidance from other organisations, including NICE, MHRA, College of Optometrists and indeed HSCB. Council will appreciate that registrants are expected to comply with local and national standards on clinical governance. In Northern Ireland, with reference to the report on the Francis Inquiry, this will include compliance with adverse incident reporting and learning among other areas.

c. HSCB acknowledges that the challenge for standards on competence should encourage, not impede, professional development which will benefit the public and minimise risk. By adapting to changes in demographics, developments in commissioning, and different models of service delivery, Council can make these standards forward-facing and fit for the modern healthcare environment.

• *What specific issues do you think we should take into account in developing our standards of ethics and performance?*

HSCB recognises the challenge the Council, together with other Regulators, faces in ensuring that registrants are aware that their core values conduct also defines their professional ethics and performance. Whilst the Code of Conduct goes some way in outlining this, HSCB would welcome, but seek clarity on, the anticipated measurable outcomes from promoting professionalism in education and training. In addition Council may consider: the prolific use of social media and how this may impact on the development of ethical standards, Duty of Candour and the raising of concern and delegation. Council may wish to give thought to the development of mechanisms or tools for reflection of performance. Council will be aware of the extensively-reviewed College of Optometrists’ professional guidance, due for publication in October 2014. As this has been produced following wide stakeholder consultation, Council may take the view that this evidence and consensus base could be usefully referenced and signposted in an effort to avoid duplication.
• **What are your views on how we intend to phase the project workstreams?**

Appropriate, if ambitious.

• **Looking to the future:**
  a. *To what extent are there opportunities for the scopes of practice for optometrists and dispensing opticians to evolve in a way that would benefit patients and the public?*
  b. *To what extent are there threats to the current scopes of practice and what might be the impact on patients and the public?*

a. Opportunities to extend scopes of practice are already in place regionally and nationally. Northern Ireland Optometrists are currently engaged in extended roles in both primary and secondary care, and are taking leadership and co-managed roles in cataract, glaucoma, low vision, medical retina and acute red eye. In secondary care, clinical governance arrangements are robust and clearly defined. In primary care enhanced services contractual arrangements rely on similar monitoring and audit. Standards and guidance must reflect these changes. The standards should reflect not only the ethical and performance pillars to underpin these extended roles, but the competencies at undergraduate, post-graduate and career level should also be robust and fit for purpose. Ophthalmic Public Health is an emerging discipline which currently enjoys little exposure at undergraduate or post-graduate level. If society is to convincingly change how we deal with avoidable blindness, competencies should reflect a more structured approach to prevention and health promotion. Council may also wish to examine and critique how other non-university based training programmes in the field of eyecare; for example vision therapy/ school vision assessments challenge or, support a registrant’s scope of practice.

In time, Council may wish to examine the feasibility of registerable degrees, with clinical placements throughout undergraduate training; in the short term, consideration might be given to a Deanery system of training and clinical placement. The Northern Ireland models of Medical and Dental Training Agency, and NI Centre for Pharmacy Learning and Development refers. Such models might allow for structural vocational training, for direct patient benefit. Partners such as the College of Optometrists could continue to play a role in this strategic training programme, ensuring that today’s students are fully equipped to play an integral part in healthcare delivery.

b. Evolving and revolutionary diagnostic equipment has the potential to impact positively direct patient care. For example, Optical Coherence Tomography (OCT) offers enormous potential for disease detection and monitoring. In properly governed clinical situations patient benefit and safety are equally
managed. In the absence of competency-based assessment, unregulated use has the potential for patient anxiety, inconvenience or risk.

5. **In order to facilitate changes in the scopes of practice of optometrists and dispensing opticians that would benefit patients and public:**

   a. **How should our standards of competence evolve?**

   b. **How should our system of continuing education and training evolve?**

   c. **How should our system of registration evolve?**

a. Standards of competence should encourage, not impede, professional development; however, the core undergraduate and scheme for registration competencies should be fit for purpose, and proactively revised, to reflect the current and emerging healthcare environment. It should be one of continuous professional development (CPD), with all that that entails, but build on the successful current CET cycle which refreshes all current competencies. Council should give thought to future revalidation.

c. Council should give thought to future registerable degrees with clinical placements and vocational training. Council should consider specialist registers for those with higher qualifications and demonstrable skills in e.g. glaucoma and medical retina.

6. **Can you provide examples of where the existing legal framework creates barriers to changes in the scopes of practice of optometrists and dispensing opticians that would benefit patients and the public?**

   The current legal sets out **what** should be involved in carrying out a sight test. This is at odds with the regulation of other healthcare professions, and may be considered anachronistic. As the GOC strategic objective is to promote higher professional standards, within the changing environment of healthcare provision, whilst maintaining patient benefit and safety, less detailed requirements specified in legislation would make the regulator more responsive.

7. **Do you think there are any other issues that are relevant to our standards review?**

   No.
Raymond Curran

Head of Optometry, Health & Social Care Board, Northern Ireland.
GOC Standards Strategic Review: Call for Evidence
Protecting and promoting the public’s health in a changing healthcare environment

Response from Optometry, School of Biomedical Sciences,
University of Ulster

Prof Roger S. Anderson FCOptom, FHEA
Dr Raymond Beirne MCOptom, FHEA
Dr Karen Breslin MCOptom, FHEA
Mr Arnold Cochrane MOptom (Course Director, Optometry), FHEA
Dr Julie-Anne Little MCOptom, FHEA
Dr Julie McClelland MCOptom, FHEA, DipTp(IP)
Ms Moyra McClure MCOptom, FHEA
Dr Lisa O’Donoghue MCOptom, FHEA
Mr Patrick Richardson MCOptom, AFHEA
Prof Kathryn J. Saunders FCOptom, FHEA (Head of Subject, Optometry)

1 View on the objectives of the standards strategic review,

a) clarify, and ensure that we are fulfilling, our statutory role in promoting high standards, including our role in providing guidance

Whilst we appreciate the GOC’s interest in providing guidance for professionals, we have the following comments;
What evidence do the GOC have for the current guidance offered by the College of Optometrists not being fit for purpose?
Any new guidance drawn up by the GOC should be written by the profession, for the profession. The College of Optometrists as the professional body should lead this process.
If the GOC establishes guidance for professionals, how will the GOC manage any discrepancies with other guidance offered by other interested parties? Will the addition of another set of guidance further ‘muddy the water’?

b) produce standards of ethics and performance that focus on outcomes, meet public expectations, are clear to registrants and reflect good practice, including the recommendations of recent inquiries, notably the Francis Inquiry.

It is not clear how standards of ethics will be readily measured in terms of outcomes so a distinction would need to be made between standards of ethics and standards of performance. Ethical guidance is already provided by the College of Optometrists and as professionals it is intrinsic in the nature of professionals that we hold ourselves to a higher account. However, we are generally supportive of helping practitioners in reaching high
ethical and performance standards.

There is increasing conflict between commercial and professional considerations in the optical profession and this is an area into which we would welcome the GOC’s input. Optical practices provide clinical services, but are also commercial enterprises. Pressures may be applied to clinicians which threaten to compromise their professional standards e.g. pressure to decrease time given to eye examinations, pressure to ‘convert’ eye examinations to spectacle dispenses etc. The GOC are keen to encourage professionalism; in order to improve standards and protect the public, perhaps they have a role to play in regulating the environment in order to facilitate and support professionalism and best practice? The balance between commercial and professional pressures could be tipped in the patient’s favour through GOC intervention.

c) ensure that our standards of competence, and system of regulation more generally, enable developments in optical practice that would benefit patients and the public.

Standards of competence and systems of regulation should be flexible enough to allow optical practice to grow. The challenge when adding more regulation or more specific standards is to ensure that such changes do not impede development of services that would benefit the public and allow the profession to respond to changing demographics and changing eye health needs. Any changes to standards of competence and system of regulation should be approached in conjunction with full consultation with practitioners, training institutions and professional bodies.

2. What specific issues do you think we should take into account in developing our standards of ethics and performance?

The GOC should consult specifically with the College of Optometrists who have a wealth of expertise in developing standards for the profession using stakeholder engagement and expert review. They should also consult with the training institutions on how such topics are addressed formally and informally in training schemes/programmes.

Consideration should be made of the conflict/balance between professionalism and commercial pressures in modern optical practices. Can professionalism flourish when commercial pressures take precedence? How can these two aspects of optical practice, which have to co-exist because of the funding model used in General Ophthalmic Services, be balanced? Does the GOC have a role in protecting the professional aspect and supporting practitioners who are under pressure from commercial forces to compromise professional, ethical practice?

The Francis report raised the issue of Duty of Candour in professional life. This area of professionalism may require some focus and the GOC and College of Optometrists may wish to collaborate on developing materials to signpost and support professionals in fulfilling their duties in this regard. However, it should be recognized that the Francis report related to hospital-based care and that the practice of optometry is relatively low risk in terms of adverse outcomes for patients and the public. Work on professionalism may also benefit from
inter-disciplinary dialogue with other eye health professionals to explore issues around how all eye care professionals interact with each other and with shared patients.

3. What are your views on how we intend to phase the project work streams?

If changes are made to education and training requirements, providers will need to be given sufficient time to incorporate and quality assure any modifications to their programmes. Most university providers undergo quinquennial review of programmes and changes to programme delivery outside this timeframe are problematic.

4. Looking to the future:
   a) To what extent are there opportunities for the scopes of practice of optometrists and dispensing opticians to evolve in a way that would benefit patients and the public?
   b) To what extent are there threats to the current scopes of practice and what might be the impact on patients and the public?

Modern optometric training and the equipment available in many primary care settings equips optometrists to provide services well beyond a standard sight test. With an ageing population and increasing pressures on time and space in tertiary and secondary care settings optometrists are well placed to provide an increasing range of services for patient and public benefit. However, developments in primary care optical practice are constricted by the legislation surrounding what constitutes a sight test under General Ophthalmic Services. This makes development of specialist services in primary care or in partnership with secondary care more challenging.

The role of optometrists is also limited by the lack of recognition by the public and other professions of the skills and expertise of optometrists. Optometrists in primary care should be the ‘first port of call’ for eye care concerns. The success in terms of patient accessibility, outcomes and costs of models such as the Acute Eye Services scheme in Grampian demonstrate great potential for the UK as a whole. However, trust between eye health providers needs to be built in order for wider progress to be made.

Threats to the current scope of practice, as well as to the potential for increasing its scope, also include the failure to decouple fees for professional services from commercial sales of appliances and a lack of a robust position on regulated practices in relation to eye health care. With regard to the latter, this is pertinent to the sale of appliances and provision of services e.g. refractive correction/prescribing is regulated but various forms of ‘vision therapy’, including treatment of oculomotor disorders, are not regulated and services offering these interventions may be provided by other professions or, indeed, by practitioners with no professional qualification.

5. In order to facilitate changes in the scopes of practice of optometrists and dispensing opticians that would benefit patients and the public:
   a) How should our standards of competence evolve?

Standards of competence should encourage, not impede, professional development. They should reflect the stage of training or career position of the practitioner. There is a need for
a more precise understanding of what is meant by ‘competence’ and whether it is in fact feasible and appropriate to assume that ‘competence’ can be demonstrated by students at stages prior to registration. Standards of competence should distinguish between the types of competence that must be the essential defining criteria for obtaining and maintaining registration as opposed to skills and abilities that trainees must develop and demonstrate prior to registration, which render them fit for training but necessarily not yet competent for practice.

b) How should our system of continuing education and training evolve?

The GOC have developed the scheme for continuing education and training in recent years. How is the effectiveness or otherwise of such a scheme audited and evaluated apart from the GOC knowing who has gained the required number of points? What feedback do the GOC have from registrants? Do most registrants complete the (non-compulsory) reflective aspect of CET point application?

Development and updating of CET provision going forward should ensure that all competencies required to be completed by specialist registrants have an adequate coverage within the GOC’s CET directory.

c) How should our system of registration evolve?

Registration should evolve to meet the needs of the profession and benefit the public. This may require the development of specialist registers beyond those for Independent Prescribing. This could be done in collaboration with the university training institutions and the College of Optometrists who already collaborate in providing higher qualifications that have become accepted by the NHS as a way of recognizing specialist experience and expertise (evidenced by the desirable criteria in NHS hospital optometry job specifications of e.g. Professional Certificate in Glaucoma).

6. Can you provide examples of where the existing legal framework creates barriers to changes in the scopes of practice of optometrists and dispensing opticians that would benefit patients and the public?

Current legislation is prescriptive about what a sight test entails and what tests should be performed, rather than responding to the needs of individual patients. This is at odds with the regulation of other healthcare professions and acts as a barrier to the development of modern services which meet patient’s needs in an efficient and effective manner. A less prescriptive approach to the function of the sight test would make a more responsive environment in which to provide modern services.

There is also a need for a review of the legal framework concerning which aspects of appliance provision and of eye and vision-related service provision should be restricted to professionals holding specific qualifications. This would help to clarify: a) areas in which optometrists and dispensing opticians are legally authorized to develop their practice, b) aspects of provision that should perhaps be restricted to optometrists and/or dispensing opticians (and other professionals) for patient and public benefit.
7. Do you think there are any other issues that are relevant to our standards?

As its role is to protect the public, the GOC should have a view on workforce planning, student numbers and entry standards to optometry training. It is not clear that standards of professionalism and competence in optometry can be adequately maintained in an environment of unrestricted expansion of student numbers driven by the recruitment needs of universities and corporate employers. The number of students applying for entry to optometry has been decreasing over a number of years and is perhaps now stable, but shows no signs of increasing. Against this backdrop, some universities have increased their intake while others have opened new optometry programmes. These additional places can only be filled by relaxing the academic entry criteria. In the interests of assuring standards of professionalism and competence at the point of registration, the GOC should strongly consider the need to regulate admission standards and student numbers as is currently the case for other professional programmes such as pharmacy, dentistry and medicine.
GOC Standards Strategic Review: Call for Evidence

Submission by Dr James Gilchrist on behalf of Optometry Schools Council

Name: Dr James Gilchrist

Address: School of Optometry & Vision Science, University of Bradford, Richmond Road, Bradford, BD7 1DP, UK.

Telephone number: 01274 234630

Email: j.m.gilchrist@bradford.ac.uk

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:

To represent the collective views and interests of the University Schools of Optometry.

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

- Anglia Ruskin University: Dr John Siderov
- Aston University: Dr Frank Eperjesi
- University of Bradford: Professor Edward Mallen
- Cardiff University: Professor Marcela Votruba
- City University: Professor Christopher Hull
- Glasgow Caledonian University: Professor Anita Simmers
- Dublin Institute of Technology: Ms Eva Doyle
- Manchester University: Mr William Holmes
- Plymouth University: Dr Luisa Simo
- University of Ulster: Professor Kathryn Saunders
- Hogeschool Utrecht: Ms Annemarie Brouwer
QUESTIONS

1. What are your views on the objectives of the standards strategic review, namely to:
   a) clarify, and ensure that we are fulfilling, our statutory role in promoting high standards, including our role in providing guidance;
   b) produce standards of ethics and performance that focus on outcomes, meet public expectations, are clear to registrants and reflect good practice, including the recommendations of recent inquiries, notably the Francis Inquiry; and
   c) ensure that our standards of competence, and system of regulation more generally, enable developments in optical practice that would benefit patients and the public.

The objectives of the standards strategic review are clear and the statutory role of the GOC in promoting high standards, including providing guidance, is central to this. We would welcome the introduction of transparent, easy to understand guidance written by optometrists for optometrists, in close collaboration with the College of Optometrists as well as other relevant professional bodies and organisations.

2. What specific issues do you think we should take into account in developing our standards of ethics and performance?

   • Clarification of the meaning and principles of professionalism and its development in the educational/training and practice environments.
   • Standards of ethics and performance focused on patient care.
   • Consideration of the balance/conflict between professionalism and commercial pressures in optical practices.
   • The relationship between optometrists in clinical practice and lobby groups such as manufacturers of commercial products.
   • The need to support practitioners who come under pressure from commercial forces to compromise their professional, ethical practice.

3. What are your views on how we intend to phase the project work streams?

   • In general, the proposed phasing of the project work streams seems very reasonable.
   • If the outcome of the project should require significant changes to education and training, then providers will need to be given sufficient time to incorporate and quality assure any modifications to their programmes. Most university providers have quinquennial review of programmes and major changes to programme structure and delivery outside this timeframe are likely to be problematic.
4. Looking to the future:
   a) To what extent are there opportunities for the scopes of practice of optometrists and dispensing opticians to evolve in a way that would benefit patients and the public?
   b) To what extent are there threats to the current scopes of practice and what might be the impact on patients and the public?

a) There are many areas in which optometrists could offer enhanced services for the benefit of patients and public. These include, for example:
   • Ocular health, notably in the form of closer alliance with ophthalmologists & GPs through shared-care pathways on conditions such as cataract and glaucoma,
   • Specialist health-related eye & vision investigation including ocular imaging and electro-diagnosis,
   • Paediatric optometry from infancy through the school years,
   • Binocular vision & orthoptics services in a primary-care setting,
   • ‘Behavioural’ optometry, in the sense of integration of optometry & occupational therapy for patients with particular needs,
   • Specialist support for occupations and activities (e.g. vision in sport),
   • Ageing, visual impairment & rehabilitation.

The optometry profession, through the combination of its expertise and accessibility, is ideally placed to bring a wider range of clinical services into a primary-care setting and to play a much greater role in helping to integrate eye & vision care with other services such as education and social care. With an ageing population, and increasing pressures on time and space in secondary and tertiary care settings, optometrists are well-positioned to provide an increasing range of services for patient and public benefit. Such developments have training implications including, for example, approaches to risk and to safety, but the university optometry schools are already well-placed to provide this at undergraduate and/or postgraduate level as appropriate, if properly resourced to do so.

b) Threats to the current scope of practice, as well as to the potential for increasing its scope, include:
   • Lack of recognition by both the public and other professionals of the role of optometrists and the distinction between optometrists and (dispensing) opticians. Optometrists in primary care could/should be the ‘first port of call’ for eye & vision concerns.
   • Failure to decouple fees for professional services from commercial sales of appliances,
   • Severe limitation imposed by the current concept of ‘sight test’ under General Ophthalmic Services and the associated low level of sight-test fee. This makes development of specialist services in primary care or in partnership with secondary care very difficult and exacerbates the problem highlighted in the previous point in that sight-test fees must be supplemented by sales,
   • Lack of recognition and incorporation of optometry within the NHS – optometry generally does not feature in discussions on the expanding role of Allied Health Professionals in NHS service development and integration,
   • Lack of a robust position on regulated practices in relation to eye & vision care, whether this is to do with sale of appliances or the provision of services; e.g. refractive correction/prescribing is regulated but various forms of ‘vision therapy’,
including treatment of oculomotor disorders, are not regulated and services offering these may be provided by other professions or, indeed, by practitioners with no professional qualification.

5. **In order to facilitate changes in the scopes of practice of optometrists and dispensing opticians that would benefit patients and the public:**
   a) **How should our standards of competence evolve?**
   b) **How should our system of continuing education and training evolve?**
   c) **How should our system of registration evolve?**

   a) There is a need for a more precise understanding of what we mean by ‘competence’ and whether it is in fact feasible and appropriate to assume that competence can be demonstrated by students at stages prior to registration. In other words, to distinguish between the types of competence that must be the essential defining criteria for obtaining and maintaining registration as opposed to skills and abilities that trainees must develop and demonstrate prior to registration, which render them fit to continue in training but necessarily not yet competent to enter practice.

   b) Continuing education and training should seek to ensure that registrants engage with maintenance of essential competence, and awareness of significant ethical and professional issues. Ideally this should also promote and support changes in the nature and scope of practice where there is evidence that this will benefit patients and public.

   c) In order to facilitate changes in scopes of practice and at the same time benefit and protect patients and public, it seems that the system of registration would need to evolve in close concert not only with evolution of standards of ethics, performance and competence but also with evolution of a revised legal framework to define the legitimate scope of practice of optometry and dispensing optics; see 4b above and 6 below.

   Evolution of registration to meet the needs of the profession and benefit the public may also require the development of specialist registers beyond those for Independent Prescribing. This could be done in collaboration with the university optometry schools and the College of Optometrists who already collaborate in providing higher qualifications that have become accepted by the NHS as a way of recognizing specialist experience and expertise (evidenced already by the desirable criteria in NHS hospital optometry job specifications).

6. **Can you provide examples of where the existing legal framework creates barriers to changes in the scopes of practice of optometrists and dispensing opticians that would benefit patients and the public?**

   In general, as mentioned previously (Q4b), there appears to be need for a review of the legal framework concerning which aspects of appliance provision and of eye and vision-related service provision should be restricted to professionals holding specific qualifications. This would help to clarify: i) areas in which optometrists & dispensing opticians are legally authorized to develop their practice, ii) aspects of provision that should perhaps be restricted to optometrists and/or dispensing opticians (and other professionals) for patient and public benefit.
7. *Do you think there are any other issues that are relevant to our standards strategic review?*

As the standards strategic review concerns the scope of practice in addition to protection of the public, an important question for education and training is how to develop students into registered practitioners who can demonstrate and maintain high standards along with a willingness and ability to expand their professional role. This question has implications for a variety of issues that go hand-in-hand with standards and which should be taken into account in the review, notably:

- **Optometry workforce:** numbers of registrants, numbers of those seeking entry to the profession (students), demographic characteristics and meeting the need for service provision both now and in a future involving greater scope of practice.

- **Optometry education:** is the current framework of university degree + separate pre-registration period in employment the best model for coherent development of standards of ethics, performance and competence; how to ensure adequate resourcing of education and training, with effective support for development of students/trainees at every stage, whether in university or employment.

Given that the objectives of the GOC review are concerned with regulation to improve standards, we would welcome a system of regulation that would emphasise the importance of ‘education for standards’ at pre-registration and post-registration stages, and would support education providers in meeting the needs of the changing profession.

**Closing date for responses is **Friday, 10 October 2014**.**

Send to:
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GOC: Standards Strategic Review: Call for Evidence

Q.1. What are your views on the objectives of the standards strategic review, namely to:

a) clarify, and ensure that we are fulfilling, our statutory role in promoting high standards, including our role in providing guidance;

b) produce standards of ethics and performance that focus on outcomes, meet public expectations, are clear to registrants and reflect good practice, including the recommendations of recent inquiries, notably the Francis Inquiry; and

c) ensure that our standards of competence, and system of regulation more generally, enable developments in optical practice that would benefit patients and the public.

A.1 The role of the GOC is not just to regulate the sector and take fitness to practise cases; the GOC also has an important role to play in promoting the professionalism of the sector, in helping to make it fit for the future, and in promoting the trust and confidence of patients.

The Optical Confederation and the Local Optical Committee Support Unit (LOCSU) therefore welcome the GOC’s Standards Strategic Review. We agree that the GOC has a role in promoting higher professional standards across the optical professions; we also agree that in carrying out its role the GOC should from time to time review what it is doing in this respect to ensure that it reflects the changing needs of the population and the professions, and changes in the environment in which we all operate. This should include both setting standards and providing clear and relevant guidance when necessary.

We appreciate the responsibility that the GOC has to explore the implications of the Francis Inquiry recommendations for the optical sector and, where appropriate, to revise standards, codes of ethics or guidance in order to reflect those recommendations. We note that the GOC has highlighted in its consultation the duty of candour, the need for excellent communications and the need to demonstrate compassion. We agree that excellent communications between those working in the optical professions and their patients is critical, and that this in turn will ensure the sector meets the duty of candour. While we recognise the importance of
demonstrating compassion when needed, given the nature of our professions this
does not seem to us to be one of the most relevant recommendations of the Francis
Inquiry for our sector. We are surprised therefore at the apparent emphasis on it in
the consultation paper.

The consultation paper references a variety of other factors – along with the
recommendations of the Francis Inquiry – that are affecting our operating
environment, such as the ageing population, developments in treatment, new
approaches to commissioning across the four UK countries and changing
expectations of eye care. If the health sector as whole is effectively to meet these
challenges we will all need to develop new approaches to care and treatment. We
therefore welcome the GOC’s commitment to keep the legal framework of optical
practice under review.

In the longer term, the whole sector needs to prepare for legislative change,
following on from the Law Commission review. It is here that the GOC can take a
legitimate leadership role across the sector to help reach agreement about what
needs changing, so that we can make best use of that opportunity for legislative
change when it arises. This consultation provides us with an important opportunity to
review what we as a sector want to achieve for the benefit of patients and the
population in the longer term, along with the scope to review and revise standards
until that time.

We do, however, have some concerns about the suggestion of the introduction of
another set of standards to which practitioners will have to adhere; there are now
growing expectations on practitioners from the GOC, from Area Teams and Local
Health Boards, and from the College of Optometrists. We welcome the GOC’s verbal
assurance during meetings with the members of the Optical Confederation that this
review will not introduce further obligations but will concentrate on clarifying existing
ones.

**Q.2. What specific issues do you think we should take into account in
developing our standards of ethics and performance?**

A.2 It is worth saying at this early stage of the Standards Strategic Review that
community eye health services remain low risk; they are carried out in safe premises
with equipment, record-keeping and staff inspected by and approved by NHS
England. Our members operate in a genuinely open market where money (both
NHS and private) follows the patient. Patient choice drives the sector.

Given the low risk associated with community eye health services, and that the
Government is committed to reducing the regulatory burden on businesses, we
would be very concerned if the GOC envisaged a significant increase in the burden
of regulation as a result of this review, or if this were to be the outcome. It will be important for the GOC to keep the following two principles in mind at every stage:

- regulation, standards and guidance should be proportionate to the low risk and service range of community optical practice.
- regulation and standards must be developed and implemented in ways that allow and indeed support developments in optical practice that will benefit patients and the wider public.

The standards also need to be user-friendly. There can be a tendency for regulators to over-complicate issues; in most cases there is greater merit in simplicity. One of the strengths of the existing Codes of Conduct is that, on the whole, they are easy to understand for both public and practitioners. It would be good if the GOC kept simplicity and clarity of expression as a key aim throughout this review. This review also provides an important opportunity to identify those issues where there may be some ambiguity and which would benefit from greater clarity. The Optical Confederation will be keen to work with the GOC on the development of the standards to help identify and address such issues.

Standards should be consistent in their use of terminology and the obligations put on both individuals and bodies corporate. Current Codes of Conduct for bodies corporate and for individual registrants impose different obligations. A business registrant is required to “take reasonable and proportionate steps” to adhere to the Code of Conduct, whereas an individual registrant “must”. This should be reviewed.

We were reassured from conversations with the GOC that the intention is not to create more obligations for registrants but to provide clarity about the existing obligations, explicitly drawing a distinction between

- what “must” be done, and
- giving guidance about what “should normally” be done (where professional judgement should be applied).

Such guidance will help inform a registrant’s professional judgement as to what course of action to follow. We applaud this intention.

When reviewing its own standards the GOC may wish to look at other models such as the Pharmacists’ Ethics Framework, which is simple and easy to understand, and consider to what extent it, or something similar, could be carried across for community optical practice.
**Q.3. What are your views on how we intend to phase the project work streams?**

A.3 We support the phased approach. It will enable all concerned to give full consideration to the issues. Attempting to carry out all stages simultaneously would impose high costs on the GOC (and therefore on registrants) and would make it very difficult for all stakeholders to contribute fully to the process.

However, it will be important to ensure that proper consultations are carried out at each stage of the process. This means full 12 week (minimum) consultation periods. The timetable for consultations should give precedence to enabling proper input from those who will be affected by them, not the operational convenience of the GOC.

**Q.4. Looking to the future:**

1. *To what extent are there opportunities for the scopes of practice of optometrists and dispensing opticians to evolve in a way that would benefit patients and the public?*
2. *To what extent are there threats to the current scopes of practice and what might be the impact on patients and the public?*

A.4 At present optometrists’ and dispensing opticians’ core competencies are significantly under-utilised in both the NHS and the private sector. As a first step we need to ensure that best use is made of current skills and competences in services such as repeat readings, minor eye conditions, pre and post cataract and low vision etc. The extent to which greater use can be made of core competencies is primarily a matter for NHS commissioners and authorities rather than the GOC. However the GOC has an enabler role (e.g. through the scope of CET – please see our response to Q.5 below).

We want to see the scope of practice of optometrists and dispensing opticians across the UK evolve so that they may play a far greater role in relieving the burden on secondary care, e.g. optometrists managing patients with glaucoma or wet AMD in the community, dispensing opticians and optometrists taking on the role of Eye Clinic Liaison Officers providing emotional support for people with sight loss.

Technology is advancing all the time and new treatments are becoming available. Therapeutic contact lenses are on the horizon. Ideally, when these therapies become available, registered contact lens opticians and optometrists should fit and monitor these lenses.

Looking even further ahead, some of these therapeutic contact lenses and some of the currently injectable therapies will become administerable by drops. At that stage both optometrists and dispensing opticians could have a far greater role in delivering these therapies to patients in the community.
New developments will enable changes in terms of where eye care is provided, how it is provided, and who provides it. It will be important that the GOC develops its standards in such a way that they have sufficient flexibility to accommodate future developments that are in the public interest.

Q.5. In order to facilitate changes in the scopes of practice of optometrists and dispensing opticians that would benefit patients and the public:

a) How should our standards of competence evolve?
b) How should our system of continuing education and training evolve?
c) How should our system of registration evolve?

A.5 It will be important that as part of this review the GOC does not adopt an approach to standards nor issue guidance that inadvertently (or intentionally) prohibits or restricts the ability of registered optometrists or dispensing opticians to broaden their scope of practice. This will be particularly true for the competences. These will need to be sufficiently flexible to allow for developments in the skills and roles of practitioners. For example, some would argue that IP qualified optometrists are already over-regulated. Professionalism, professional leadership and safety are about risk assessment, management and minimisation, not risk aversion. Standards should reflect this.

We welcome the approach to “encouraging professional development” in the standards of competence but we have serious concerns about the proposal for the GOC to introduce core standards and aspirational standards. We are strongly of the view that the regulator taking this approach can only lead to confusion – about what is acceptable, and about which standard is being applied at any particular time. Aspirational standards imply that all registrants should aspire to that level, whereas in fact these are additional standards or competences for those who want to extend their skills and their areas of practice. It would not be appropriate to suggest that those who choose to provide the core service alone are in some way of poorer standard. The GOC’s role is to ensure a basic and safe level of practice. We are not in favour of moves which could result in the introduction of a two-tier profession.

To that end, we would prefer to retain the current system whereby core competences are the standard that all optometrists and dispensing opticians have to reach and maintain in order to practise and to which they are held accountable in terms of the care they provide. The aim of the GOC should therefore be to ensure that all clinicians meet the core competences and demonstrate that they continue to meet those competences. The GOC should then support those who wish to develop and widen their professional skills.

The objective should be to ensure high quality core skills, and to support and encourage those that want to develop additional skills. A more flexible approach to the CET system, which is currently rigidly aligned to core competencies, would help achieve this. And, as part of this approach, it may be appropriate during the
subsequent consultations to review exactly what should constitute the core competences.

Q.6. Can you provide examples of where the existing legal framework creates barriers to changes in the scopes of practice of optometrists and dispensing opticians that would benefit patients and the public?

A.6 The most significant barriers are not created by the legal framework but arise from the commissioning process and the traditional isolationist and silo-working of different disciplines of professional. It would be good if the professionalism standards which all the health regulators are developing

- covered effective hand-over of patient care within and between clinical teams and disciplines, and
- dove-tailed to ensure the effective and safe transfer of patient care to meet the needs of patients and the demands of integrated services between community and hospitals.

In the case of eye care, it is particularly important that the standards of the GOC, GMC (ophthalmologists and GPs) and HCPC (orthoptists) are joined-up and common in this regard.

Q.7. Do you think there are any other issues that are relevant to our standards strategic review?

A.7 Optometrists and dispensing opticians will increasingly play a role in the delivery of both primary and secondary care in the community; it is also likely that they will take on a greater role in supporting and implementing the public health agenda, undertaking screening and working with other health providers to promote healthier lifestyles.

It will be essential – and in the public interest - that these new roles are enabled and not impeded by regulation. They will need to be developed in ways that work in the best interests of patients, ensuring effectively integrated care and consistent regulations and standards regardless of where a treatment is delivered and who it is delivered by. To that end the GOC will need to work closely with the regulators of other health care providers, including those for other eye health professionals, to ensure consistent standards and approaches to regulation, including specifying competences and how fitness to practise cases will be managed.

The way the primary eye care is delivered is diverging in the devolved nations. The GOC will need to have a strategic view about how it will accommodate these divergences as they evolve and about the implications for standards for practitioners in the different nations. As a matter of principle we would not favour a multi-tier profession and, for patient safety, core competences and indeed development options should be identical across the UK.
About Us:

The Optical Confederation represents the 12,000 optometrists, the 6,000 dispensing opticians, and 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 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.

LOCSU provides quality, practical support to Local and Regional Optical Committees (LOCs/ROCs) in England and Wales to help them to develop, negotiate and implement local objectives in respect of primary ophthalmic services. It is a key interface between the optical, representative bodies and the LOCs/ROCs, facilitating robust lines of communication between the national organisations and the grassroots of the professions.

October 2014
Optometry Scotland Comments to GOC Standards Review

October 2014

Three main points commented on and discussed in our conference call today are:

The GOC’s role and standard setting
OS feels that the main role of the GOC is to protect the public as well as provide support to Optometrists in working to standards set nationally and locally. The GOC needs to recognise the requirements locally and consider these in any cases that may arise re fitness to practice and with that said a professional advisor from the same area should be consulted with when looking at evidence for individual cases. Core competencies need to be broadened to cover what standards are set nationally. In Scotland Optometrists are the GP for eyes and the first port of call for any eye problems.

OS would also support revising registration of DOs in full consultation with ABDO.

OS also feels that the GOC could do more to regulate internet sales for contact lenses and spectacles. More could be done here re educating the public of the risks involved.

OS supports regulation of service providers who may apply pressure to Optometrists working for them to achieve targets.

Optometry Students and Pre Reg Year
OS feels that more consideration needs to be given regarding the expectations on students going in to the pre reg year, then when they fully qualify, to what will be expected of them when working in practice. OS feels that more exposure to patients with eye disease and chronic conditions is required when working in Scotland. NES have discussed supporting the pre reg year with OS. Ideas that have been talked about are students spending time in rural practices, hospital setting, teach and treat clinics. NES are looking in to the options available for them to fund pre reg placements in Scotland. OS would encourage the GOC to discuss this further with NES and OS. OS feels that NES could also support GCU in providing a variety of different patient for students to have a better handle on clinical decision making by the time they move on to pre reg year.

CET
OS feels that it can be an arduous job to be a CET provider especially if it not a process that is undertaken on a regular basis.
OS are thankful to have NES as our main interactive CET provider. Colleagues in general practice, dentistry and pharmacy have different protocols for CPD perhaps these should be mirrored in Optometry.

To end OS would request that there is an acceptable period given when the new standards have been set to allow a seamless transition nationally.

Conference Call with GOC Fri 10\textsuperscript{th} Oct 2014

OS representatives:

David Bonellie, Sam Watson, Nicola McElvanney, Gill Syme and Debbie McGill
Response from the Medicines and Healthcare Products Regulatory Agency (MHRA):

‘The MHRA has been contacted by members of the public who have suffered serious eye infections associated with contact lens wear e.g. acanthamoeba keratitis, fusarium keratitis which in some cases has resulted in the removal of the eye. Concerns were raised about the lack of information provided of the risk of these infections prior to choosing to wear contact lenses.

As part of the standards review the GOC may wish to consider providing guidance to optometrists and dispensing opticians on the importance of providing safety information to patients during the initial contact lens consultation about the risks of these infections and contact lens wear.’
9 October 2014

Marie Bunby
General Optical Council
41 Harley Street
London
W1G 8DJ

Dear Marie

Standards Strategic Review: Call for Evidence

The College is the professional, scientific and examining body for optometry working for the public benefit in the UK. We welcome the opportunity to respond to your call for evidence on the standards strategic review.

Responses to questions

1. What are your views on the objectives of the standards strategic review, namely to:

a) clarify, and ensure that we are fulfilling, our statutory role in promoting high standards, including our role in providing guidance;

b) produce standards of ethics and performance that focus on outcomes, meet public expectations, are clear to registrants and reflect good practice, including the recommendations of recent inquiries, notably the Francis Inquiry; and

c) ensure that our standards of competence, and system of regulation more generally, enable developments in optical practice that would benefit patients and the public.

Response

1(a) We believe it is important that both the professions and the public understand the role of the GOC in terms of promoting high standards and providing appropriate guidance.

1(b) The role of the GOC includes producing guidance on professional conduct so that practitioners understand that their private life impacts on their professional life. However, the College’s revised guidance on professional conduct provides
the detail for the GOC’s guidance approach, as the peer view. We believe that it will avoid confusion if the College’s guidance is referenced in the GOC’s guidance so that it is absolutely clear whose guidance should be followed.

We suggest that, while the recommendations of the Francis report must be taken into account, this must be proportionate. The recommendations are the result of bad practices in a hospital Trust and are, therefore, directed at hospital boards, managers, doctors, nurses and commissioners. This does not mean that there are no lessons to be learnt for optometry but a much lower level of risk must be taken into account.

1(c) We agree that the regulator should enable developments in optical practice that would benefit patients and the public. However, it is important that the GOC seeks the views of registrants, the public and professional bodies when it begins such developments.

2. What specific issues do you think we should take into account in developing our standards of ethics and performance?

The College has undergone an extensive review and updating of its professional guidance. This will be issued in October 2014. It has been produced in wide consultation with the profession, patient groups and optical stakeholders, including the GOC, and has been based on the latest evidence and consensus across the health professions. The College has provided detailed guidance for the profession since 1933, when its predecessor body, the British Optical Association, produced its first Code of Ethics. By 1945 the BOA was considering something more than a Code of Ethics and began to develop guidance on professional conduct, which was published in 1946. Since then it has been the College (including its predecessor bodies) which have ensured that the guidance is the peer view and what the profession understands. It is, therefore, crucial that both the profession and the public understand how the two sets of guidance will relate to each other when they are both published and we have stated above that there is a need for the College guidance to be referenced in the GOC’s guidance. It is important that the two organisations work together to signpost each other’s guidance and give common messages, so there is no confusion. Currently the consultation implies that we produce guidance for our members only, but this is not the case. The College’s guidance is taken into account by the GOC for all fitness to practise cases and we believe the profession is currently very clear that it must comply with College guidance.
3. What are your views on how we intend to phase the project work streams
The timescales are quite ambitious from our experience.

4. Looking to the future:
   a) To what extent are there opportunities for the scopes of practice of optometrists and dispensing opticians to evolve in a way that would benefit patients and the public?

   b) To what extent are there threats to the current scopes of practice and what might be the impact on patients and the public?

4(a) The professions already work differently in the different countries due to their separate contractual arrangements. Changes in the demographic of the population and of the profession, changes in technology and in the NHS in England and the devolved administrations mean there are opportunities for both professions to change the way they work and how all eye care health professionals work together. It is not possible to know exactly what this will look like but it is essential that both professions have the skills and resources they need to undertake new roles and these roles must be beneficial for patients’ eye health, as well developing the scope of practice of the professionals.

4(b) There are also threats in that change is inevitable and this will mean that the professions may not be able to continue in their current form. The changes in technology mentioned above are likely to remove the need for optometrists to undertake certain tasks and the ageing population means there will be an increased incidence of eye disease. These will have an impact over the next few years.

5. In order to facilitate changes in the scopes of practice of optometrists and dispensing opticians that would benefit patients and the public:

   a) How should our standards of competence evolve?

   b) How should our system of continuing education and training evolve?

   c) How should our system of registration evolve?
5(a) The standards of competence should remain generic so that they can apply across a range of different roles. Trying to be specific, for example for community schemes and public health work, may result in a degree of inflexibility. The College has published learning outcomes for various clinical higher level qualifications which relate to different roles and, for glaucoma, these have been picked up in the Royal College of Ophthalmologists commissioning guidance in glaucoma and the two Colleges’ joint commissioning guidance for other areas. This might be an area better left to the two Colleges, as they would be able to respond more quickly to changes. For example, this works for the GMC, which provides outcome statements that work for all doctors, and these are supplemented by the Royal Medical Colleges for each specialty.

5(b) We would like to see the CET system evolve to encourage optometrists to take responsibility for professional development in relation to their own roles and undertake continuing professional development that means that they provide good care in their individual practice. We recognise that this is a less prescriptive approach in terms of points and therefore more difficult to police, but thought needs to be given to how this could be achieved.

5(c) If the GOC wishes, in future, to develop its system of registration to reflect enhanced roles for optometrists, the College would wish to be involved at an early stage particularly in any discussions about the status of its Higher Qualifications.

6. Can you provide examples of where the existing legal framework creates barriers to changes in the scopes of practice of optometrists and dispensing opticians that would benefit patients and the public?

Yes – there are a number of places where the legal framework is too specific largely because it was written in a different era. It needs to be future proofed so that patients and the public are protected from bad practice and risky processes, and the professions can modernise themselves to offer the best care to patients. Some of it is difficult to interpret, for example sale and supply, and it would be helpful if this were simplified.
7. Do you think there are any other issues that are relevant to our standards strategic review?

We think it is important that, although the GOC is the regulator, regulation is not just the purview of the regulator and working with its professional bodies with a public interest will strengthen regulation. For example, the GMC works closely in a number of different ways with the Academy of Medical Royal Colleges, recognising the role of the Colleges and taking advantage of the expertise that the Colleges can provide.

Yours sincerely

Bryony Pawinska
Chief Executive
GOC’s Standards Strategic Review: Call for Evidence – SeeAbility Response

Thank you for this opportunity to respond to the GOC’s Standards Strategic Review: Call for Evidence.

People with learning disabilities are 10 times more likely to have serious sight problems than other people but less likely to receive the support they need to access these services.

As a result of our contact with people with learning disabilities and their carers and supporters, SeeAbility is aware of some of the difficulties experienced by people with learning disabilities in accessing sight tests. This includes –

- Uncertainties among carers that the sight test will be accessible and also regarding which optometric service would be best suited.
- Difficulties in providing a sight test where the needs to the patient with learning disabilities were not identified before the appointment
- Communication difficulties
- Inappropriate testing methods
- Inadequate feedback of sight test results
- Difficulties in prescribing suitable spectacles

We are aware of some very good practice and some less so.

We are involved with a number of eye care pathways for people with learning disabilities around the country, including the LOCSU Pathway.

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

In the light of the comments above, SeeAbility would support the introduction of aspirational standards to promote quality eye care for
people with learning disabilities. We feel that this would be useful for optometrists and dispensing opticians in standard eye care settings as well as those involved in a Learning Disability Pathway.

SeeAbility would also support moves to ensure that optometry students have it in their curriculum as to the best way of carrying out an eye exam on a patient with LD/dementia/communication problems.

This could be extended so that it becomes mandatory for trainee optoms to have carried out an eye exam on a patient with intellectual impairment as one of their competency.

Thank you again and we look forward to following the outcomes of the consultation.

Stephen Kill
Eye Care and Vision Manager South of England
SeeAbility
October 2014