The Royal College of Ophthalmologists' (RCOphth) response to the General Optical Council's Education Strategic Review Call for Evidence

March 2017

1. Introduction

1.1 The Royal College of Ophthalmologists welcomes the opportunity to respond to this consultation.

1.2 The Royal College of Ophthalmologists is the professional body for ophthalmologists and we champion excellence in the practice of ophthalmology on behalf of our members to optimise care for patients. We set the curriculum and examinations for trainee ophthalmologists, provide training in eye surgery, maintain standards in the practice of ophthalmology, and promote research and advance science in the specialty.

1.3 We work with leaders across the eye health sector to help shape eye services for the benefit of patients.

2. General comments

2.1 Overall we strongly support the GOC in carrying out a review of its education strategy in light of the changing nature of eye care delivery, to ensure that registrants can safely and effectively carry out the extended roles that many have already taken on.

2.2 We welcome that the GOC is gathering evidence on what an updated and current education strategy should look like. We also wish to stress that the complexity and scale of the challenges faced by the eye health sector mean that significant change is likely to continue long after this review. Therefore, we urge you to keep education under review, so that as a clearer picture of the eye care system of the future emerges, the GOC is ready to respond appropriately.

3. Changes in demand and the impact of changes in eye care delivery

Q 1. How might the needs of patients requiring eye care change over the next 20 years?

3.1 As identified in the consultation paper, the population is ageing and demand for eye care is increasing. Not only is the volume of patients increasing, but also the complexity of their needs. New treatments have led to an increase in stable disease which requires long term management. Older patients often

have multiple conditions and social care needs, requiring a range of interventions by different services and professions. There is also set to be an increasing number of children and adults with learning disabilities, who are more likely to have serious sight problems than others.

3.2 Patient expectations are rising too, as other industries become increasingly customer focussed, offering greater convenience to consumers.

3.3 While we acknowledge the potential benefits of automating and enabling patients to play a greater role in their own eye care, we stress the need to view eye examinations as health checks, which require a level of professional oversight. We would therefore emphasise that automation and self-testing should not be seen as an alternative to eye examinations, but more complementary.

3.4 These factors create significant challenges for the consistent delivery of joined up, patient-centred care to necessary standards. One of our greatest concerns is ensuring that patient safety remains paramount as the sector adapts to these changes.

Q 2. What changes in how and where eye care is provided will be required over the next 20 years to meet patients' needs, and what are the barriers to these changes?

3.5 We agree that, where feasible and safe, eye care should be provided closer to home and in ways that are more convenient to patients. By moving more care into the community, this can alleviate dangerous levels of pressure on hospital services and ensure patients are seen within clinically safe timeframes.

3.6 Patients who need complex or specialised care, or with co-morbidities, are likely to still receive their care from hospital services. However, patients with minor eye conditions, stable disease and post-operative cases are the best candidates for receiving their care in the community.

3.7 With more optometrists and dispensing opticians taking on extended roles, and an overstretched healthcare system that could benefit from their greater involvement, we support the direction of change, but there are several barriers to overcome.

3.8 A key barrier is lack of adequate IT systems that allow efficient and safe transfer of data between community and hospital settings.

3.9 Secondly, there must be better collaboration between hospital and community settings in order to decentralise services in a safe and joined up way. Otherwise patients may be 'lost' or transferred prematurely, which could result in inadequate eye care and ultimately sight loss.

3.10 Thirdly, ophthalmologists and community staff must have good working relationships and assurance that the latter have the necessary skills and experience to safely take on clinical work in a sustainable way.

Q 3. How are the roles of optometrists and dispensing opticians likely to change over the next 20 years, and what are the drivers for these changes?

3.11 While there are many examples of excellent practice where optometrists and dispensing opticians are carrying out extended roles, it remains to be established what the best overall methods of including them in assessment, treatment and monitoring pathways are. As new models develop, it is important that their education continues to take account of these changes.

3.12 The RCOphth, along with other professional bodies, including the College of Optometrists, Association of British Dispensing Opticians and Local Optical Committee Support Unit, are exploring this, and we would welcome opportunities to work closely with the GOC on clarifying what good new models of eye care look like, and the necessary workforce needed to deliver them.

3.13 In February 2017, we published the findings from over 200 interviews with ophthalmic clinical leads across the UK about new and developing models of care, within the reports of a study we commissioned called The Way Forward[1]. A significant proportion of the reports' content relates to the use of non-medical eye care professionals in extended roles. We strongly advise drawing on the insights from the research and contacting us to discuss any aspect of it.

3.14 As the consultation paper identifies, funding of extended roles is a significant factor in determining how your registrants may work in the future. Commissioners may need to fund more, and/or commercial eye care outlets take on additional clinical work, however it is unclear how financial sustainability will be achieved by the latter.

3.15 The extent of appetite for taking on additional work by optometrists and dispensing opticians is clearly important and remains to be established.

3.16 We would welcome further discussion around your suggestion that registrants may play a greater role in promoting healthy living and providing advice. While we view eye testing as a part of the eye health system, we would urge caution around how optometrists and dispensing opticians are presented to patients, so that they understand the extent of healthcare and advice that can be provided by non-medically qualified professionals. This is especially important given the variation in focus on retail or healthcare between different practices.

3.17 The patient must remain at the centre of care provision and understand the roles and scopes of practice of those caring for them. Optometrists and dispensing opticians must be clear about their role and responsibilities within the wider eyecare team.

[1] https://www.rcophth.ac.uk/standards-publications-research/the-way-forward/

Q 4. How should the education of optometrists and dispensing opticians be structured to enable continuing professional development throughout their careers, e.g. core training followed by general or specialist practice?

3.18 We agree that education needs to reflect changing scopes of practice, with a potentially much greater emphasis on clinical specialism. The structure should provide enough flexibility so that registrants can choose what focus their scope of practice has, whether more refractive or specific eye conditions.

3.19 In November 2016, we published a series of Common Clinical Competency Frameworks for non-medical ophthalmic healthcare professionals working in hospital eye services, including optometrists[2]. These are a set of clinical competencies agreed by the relevant professional bodies for AHPs in extended roles within Acute and Emergency Eye Care, Cataract, Glaucoma and Medical Retina services.

3.20 The frameworks are structured around three levels of competence, relating to the previous skills and experience of allied eye care professionals taking on extended roles. They should be used to inform the structure of continuing professional development for optometrists and dispensing opticians who wish to progress into health focussed roles.

Q 5. What are the implications for the GOC register of likely changes in roles and will the existing distinctions between registrant groups remain appropriate?

3.21 The way that registrant groups are distinguished must remain clear to patients so that they know what to expect from their practitioner. This may mean a new designation for registrants with enhanced healthcare-oriented roles, and those with a more traditional refractive focus. Appraisal and revalidation similar to the GMC system may be required to ensure confidence in, and recognition of the new role.

4. GOC's approach to education

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

4.1 We would strongly welcome greater quality assurance of additional higher qualifications that support its registrants to take on extended roles. For example, the additional training on glaucoma and medical retina offered by several higher education institutions.

4.2 The most appropriate organisation to provide this quality assurance will largely depend on who is ultimately responsible for the care delivered. If

[2] https://www.rcophth.ac.uk/professional-resources/new-common-clinical-competency-framework-to-standardise-competences-for-ophthalmic-non-medical-healthcare-professionals/

optometrists are to bear clinical responsibility for patients, we would expect the GOC to assure the training that enables them to do so.

5. Content of education programmes

5.1 We have provided comments below on optometrists and dispensing opticians together.

Core skills, knowledge and behaviours which optometrists on joining the register in the future

5.2 Educational content will depend on the intended scope of practice; refraction or health, and any specialisations within health. Key areas include:

- Condition-specific skills and knowledge needed to accurately interpret eye exam results. False positives and unnecessary referrals must be minimised as this wastes resources and reduces the ability of hospital services to see patients with eye disease within clinically safe times.

- Education on diabetes, dementia and lifestyle factors should become part of core education for any registrants involved in clinical care.

- Education should also include awareness of NHS England's Accessible Information Standard, as well as on issues relating to children and adults with disabilities, and legal requirements to provide reasonable adjustments.

Content and delivery of programmes to ensure students gain the skills, knowledge and behaviours that they will require for practice and for new roles in the future

5.3 This depends on additional clinical responsibilities where taken on, however we consider the following essential elements.

- Continuous assessment of learning outcomes and reflection on practice.

- Adequate clinical experience, perhaps similar to that of the pre-registration Foundation 1 and 2 years that medics complete.

- Arrangements for consultant ophthalmologists and other highly experienced ophthalmic hospital staff to impart the necessary competencies, at the right level, to optometrists and dispensing opticians.

Post-registration training and registrable higher qualifications for the future

5.4 They will need to be enhanced to reflect additional clinical responsibilities where these are taken on. We advise that the Common Clinical Competency Frameworks are taken into consideration. As above, working closely with hospital eye services will be important.

6. Professionalism and consistent standards

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

6.1 A key issue is how to manage potential conflicts of interest between the delivery of eye care and sale of glasses or contact lenses.

6.2 Patient and carer involvement and feedback is an important part of developing professionalism for trainee doctors, so we would encourage greater emphasis on this for all healthcare professionals.

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

6.3 We agree that this is an important consideration to ensure that there is an appropriate level of standardisation. Where there is an increase in clinical roles, we would welcome opportunities for focussed discussion with ourselves and relevant education providers.

7. Barriers to change and other issues to consider

7.1 It is essential that patients' needs are the first consideration through these changes. Where there are commercial interests in the delivery of eye health services, we have concerns that these may be allowed to negatively impact on the care that patients receive, unless necessary safeguards are in place.

7.2 Appropriate education and training for staff is a fundamental part of this, as are standards that reflect patient needs and expectations.

7.3 Directing more healthcare to optometrists and opticians also means sharing more responsibility for patient safety. Delineating where responsibility lies will be an important task as these changes progress, and we hope to work closely with the GOC and organisations across the sector to establish this to ensure the best system for patients.

7.4 If responsibility is to be shared then we would expect optometrists and dispensing opticians to be held to standards comparable to those ophthalmologists must adhere to. Ensuring consistent standards across the eye care sector is essential for patient safety and confidence, as well as effective joined up working.

7.5 One important element may be the continuing education requirements. The GMC sets out a more prescriptive system of CPD and revalidation which seeks to provide more assurance that its registrants are safe to provide clinical care. With a shift towards healthcare provision, optometrists and dispensing opticians may also need to demonstrate proven practical competence.