Sector Partnership for Optical
Knowledge and Education

SPOKE (specialist qualifications)

Project 3

Enhancing the scope of practice in optical professionals

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Project 3 – Enhancing the scope of practice in optical professionals

Executive Summary

There is a great deal of enthusiasm for, and value placed upon, qualifications to enhance the scope of practice of optical registrants.

Contact Lens Optician qualifications are very longstanding, and delivery mechanisms are well developed. The transition to the Education and Training Requirements (ETR) required minimal modifications to the curriculum and remaining delivery challenges are largely restricted to case mix and follow up appointments.

Therapeutic prescribing qualification providers and trainees, in contrast, whilst attracting hundreds of applicants across the UK each year, are reporting significant challenges in placement delivery. These include overall capacity, equality of access to setting and supervision, geographical availability and consistency of placement experience. Commissioning of services for qualification holders also suffers from geographical variability. ETR provides the opportunity to address some of the issues (e.g. through increased flexibility of supervision requirements) but UK-wide funding and support systems will be required to address the ongoing issues and capitalise on the benefits of ETR.

It is also clear that significant confusion remains in the sector about the changes invoked by, and the timings of, the transition to ETR, and that further multi-audience (applicants, placement providers, ophthalmologists, HES etc.) communications from the GOC would be beneficial.

Potential solutions for action are proposed throughout the document and summarised in Annex A.

Methodology

Project Three - '*Enhancing the scope of practice in optical professionals'*, was launched at the SPOKE networking and collaborative writing event on 23rd January 2024. In small round-table discussion groups, representatives from across the sector (including employers, qualification providers and sector bodies) considered the challenges and opportunities arising from revising the curricula. Key themes emerging from these discussions are presented below alongside recommendations for action from the participants. The report, themes, and proposed actions were reviewed and discussed further by participants in two further online refinement workshops on 10th and 14th June 2024.

Background

Specialist qualifications enable registrants to offer enhanced services and increased scope of practice. The ETR allow for more flexibility in implementation of these qualifications. This project explores ways in which providers can ensure that the new qualifications:

- meet the needs and emerging needs of patients
- are understood and have recognised value in healthcare service provision
- support learners in accessing and benefitting from the right experiences

in the light of the changes introduced by ETR, and the context of developments in optical practice and services.

The project is focused on the registerable specialist qualifications, although there was naturally some mention of other post registration qualifications such as the College's higher qualifications during the sector discussions.

Changes introduced by ETR

In addition to a shift from describing the qualifications in terms of competencies to an outcomes-based approach (specified with reference to Miller's pyramid) the new education and training requirements for both specialist types of qualification have introduced the following notable changes.

For GOC-approved qualifications in Additional Supply (AS), Supplementary Prescribing (SP) and/or Independent Prescribing (IP) categories:

- A single provider must be responsible for the whole qualification which will be at RQF level 7/11
- There is no longer a requirement for supervisors to have two years' experience
- It is no longer necessary for Ophthalmologists to supervise therapeutic prescribing trainees
- Trainees will no longer be required to have been practising for two years before undertaking an AS, SP or IP qualification
- Clinical experience for independent prescribing will increase to 90 hours.

For Contact Lens qualifications:

- A single provider must be responsible for the whole qualification which will be at RQF level 6/10
- Trainees will no longer be required to have been practising for two years before undertaking the qualification
- Clinical experience for contact lens qualifications requires a minimum of 225 hours.

Project outputs

The sector discussion groups felt that the changes to prescribing qualifications would have greater impact on course delivery than those for contact lens specialisms. This may be because qualified supervisors, appropriate experience for learners and career enhancement opportunities for contact lens qualification holders are much more accessible, due to the widespread commercial provision of contact lens services throughout primary care. In contrast, therapeutic prescribing services vary geographically, are not yet universal in primary settings, are dependent on tightly controlled commissioning, have much lower numbers of potential supervisor practitioners and may require experience in multiple settings to establish sufficiently varied case mix. As a consequence, the group concluded that maintaining sustainability of prescribing qualifications must be addressed. All specialist qualifications will require changes to the methods of academic assessment and quality assurance to accommodate an outcomes-based focus. However, therapeutic prescribing has logistical challenges and workforce drivers including service commissioning. The outputs of SPOKE specialist projects one and two (indicative guidance) already address many of the academic methodological considerations – project three complements this by delineating and making recommendations to address the infrastructural concerns of sector stakeholders.

Emerging Themes

The stakeholder concerns can be divided into three main categories, discussed in more detail below.

Sector awareness and navigation of change

There is still considerable confusion across the sector regarding the timing and impact of transition to ETR for specialist qualifications. Whilst the qualifications for initial registration have been implemented for first enrolment over a restricted timescale, the timing for implementation of ETR and length of the transition period for specialist qualifications is less clear to registrants, funders and placement providers.

As an example, increased flexibility of supervisory requirements for clinical experience in prescribing is widely welcomed, but there is ongoing uncertainty about which provider's qualifications the ETR now applies to, and why "handbook" qualifications still require an Ophthalmologist mentor rather than an IP Optometrist DPP, and furthermore what the rationale for the difference is. This is exacerbated in multiprofessional settings when there is comparison with other non-medical prescribing professions, all of whom are operating on ETR-like regulations.

The qualifications for initial registration have benefited from extensive provider communications in addition to those produced by GOC, but therapeutic prescribing has fewer providers, all of whom deliver courses across the UK in mostly remote format, and most of whom have not yet finalised their ETR plans. This lack of clarity, coupled with the scale of change for prescribing, is significantly increasing the risk of disengagement or poor compliance with expectations amongst potential placement setting providers.

Since prescribing trainees could take four years or more to complete their qualification after the last delivery of the "handbook" qualification academic modules, the transition is likely to be protracted. To avoid additional

bottlenecks in qualification completions (see also placement accessibility below) it would be helpful to explore ways further align the old and new routes to qualification and develop communications to explain necessary differences in qualifications that are likely to be delivered in parallel over many years.

Recommended actions:

- GOC consider what elements of handbook and ETR qualification expectations could be further aligned
- Communications are developed to ensure the timelines for, and expectations during the transition period, and the ongoing validity of the different routes, are better understood by all stakeholders.

Accessibility of clinical experience

Placement delivery

Concerns were raised around access to clinical placements, given that demand already exceeds supply in settings that offer services suitable for exposing the learner to a wide enough range of conditions to underpin the desired scope of practice, and trainees often need to request extensions to the two years post academic course completion in order to arrange a suitable placement. This is compounded by restrictive practices relating to high fees and the developing problem of commercialisation of hospital placements, following post-pandemic shortages in training capacity. Access to placements can be particularly difficult in rural and coastal areas, where it could be argued there is greatest need for enhanced services. There is clearly sufficient demand in the form of applications for IP qualifications, and increased scope of practice availability would improve services in the community, but only if people can gain the right experience.

Whist the increased flexibility in supervisory requirements should enable more diverse settings to offer placements, very few outside of the Hospital Eye Service can offer the full range of experience needed. This means that that providers and learners will likely need to find ways to manage, document and quality assure multi-setting experiences, against a backdrop of very limited funding availability.

It was suggested that the ability to secure a placement has already become a matter of “who you know” or where you work in the industry. These issues have resulted in long waiting times for placements and a ‘bottleneck’ of trainees waiting to complete this section of their training.

ETR compliant qualifications require placements and supervision to be in place at, or soon after, the start of the course, but the infrastructure to facilitate and quality approve arrangements is not in place, and individual providers are reliant on UK-wide recruitment and remote delivery to recruit sufficient numbers to maintain courses’ financial viability.

Questions were raised about how the increased cost of oversight of placement learning (potentially at great distance and across multiple settings) for ETR might be funded. This is further exacerbated by the inequitable impact of market-driven placement provider charges for access to experiential learning, which conflicts with qualification provider requirements for transparency about course costs. There were also concerns that the balance of responsibility between the student and the qualification provider for sourcing placements was unclear. This lack of clarity over who is responsible for organising and overseeing the content of placements may result in students continuing to have to source their own placements, which in turn brings into question whether the increased levels of qualification provider oversight intended by ETR will be delivered.

The outcomes state that experience must be ‘patient-facing’ but, whilst the handbook route allows for up to 55% of time to be simulated, no equivalent percentage is stipulated in the ETR. Hospital clinics can be very specific and fast-moving and often do not allow time for explanations of treatments and medical programmes, whereas simulated environments can provide a more effective learning experience. It was suggested that allowing a set percentage of simulated learning could improve placement capacity without undermining quality of experiential learning. Suggestions included: virtual clinic settings where students can interact with patients, without having to be present in a hospital and teaching aids that combine clinical teaching videos with discussions on the outcomes of making wrong and right decisions.

The changes for contact lens opticians are less significant and more easily managed. Whilst it can often be difficult to ensure students can see all types of contact lens patients required, this is something that is accommodated more readily by collaboration with neighbouring practices. The increased flexibility of supervision under ETR may potentially make this situation slightly easier.

CLOs do not have the same issue with organising placements because the qualification tends to be employer driven, and experience takes place in the employment setting. Prior to starting the course, the employer has to guarantee a certain, minimum amount of time to undertake contact lens work and signs an undertaking to confirm this commitment. There is, however, a need to protect the time for CLO learning and supervision and ensure that trainees and supervisors do not get pulled into other tasks covering for staff absences or shortages. Whilst protected time has been established, in reality there is a real need to 'defend' this and allow the student to gain sufficient experience to become fully qualified.

Recommended actions:

- Modelling of the level of demand for placements for both handbook and ETR prescribing qualifications, including the size of the backlog of trainees already seeking placements having completed the academic learning on the handbook qualification route should be undertaken. This will determine the size of shortfall and underpin planning to ensure there is capacity to meet trainee and workforce needs.
- Mechanisms to increase availability and accessibility of IP placements across the UK should be identified, with a focus on
    - increasing numbers of placement settings that participate
    - increasing visibility of available places to all who are seeking them
    - increasing consistency of fees levied by settings
    - developing mechanisms to support multi-setting placement experience
    - accessing healthcare education funding
    - developing UK-wide shared services to give economy of scale (for placement facilitation, approval and delivery)
- Develop a UK-wide business case for "teach and treat" enhanced practice /services community clinics, building on learning from devolved nations
- Make access to placements fairer and more efficient by introducing a single application system
- Consider what quantities and types of simulated learning might be used to complement (or substitute for) patient-facing experience.

Supervision

There are concerns that registrants may not be willing to take on the commitment and additional responsibility of becoming supervisors, possibly due to inertia in the profession and a lack of financial reward. Equally, employers must be prepared to allocate time and facilities for the supervisor to support learning – without any external funding compensation or retention of the learner within that workplace.

With the removal of the requirement for supervisors to have 2 years of experience before supervising trainees, there is a new need to ensure that supervisors are sufficiently clinically experienced and educationally capable to ensure a positive learning experience as well as assure patient safety. Qualification providers will need to ensure that supervisors, distributed across the UK and multiple settings per learner, are trained and supported to manage the wide variety of developmental and experiential stages of learners undertaking qualifications.

Fear of being subject to GOC proceedings for errors made by learners is a key barrier to becoming a supervisor. Registrants know that they can use their clinical CPD activities as evidence of their efforts to maintain competence, should they experience a GOC fitness-to-practice in relation to their own practice. However, in the absence of a CPD domain specifically for Education, registrants feel unable to take the same steps to derisk the act of supervision. They are thus concerned that they could not produce good evidence that they have taken specific steps to ensure they are undertaking the role safely and effectively.

The provision of a wider range of education-specific learning and tools to support supervisors, and recognition through structured qualifications and ongoing CPD would increase confidence in, and engagement with, supervision.

Recommended actions:

- Consistent methods to communicate the "stage" learners are at, and experiences they have already undertaken, should be developed
- The concepts of Practice Educator and Task Supervisor developed in SPOKE project 4 should be extended to specialist qualifications to reflect their roles, and enable diverse and multi-setting experiences
- A nationwide scheme for supervisor training be developed to ensure that
    - supervisors do not need to meet differing requirements for multiple qualification providers
    - learners develop an appropriate scope of practice with consistent support across settings
    - supervisors are equipped to determine the limits of their scope of practice in which their clinical experience is sufficient for supervision and learner development activities
    - there is consistency of supervision across all specialisms (including IP and CLO)
- Mechanisms should be established to ensure adequate numbers of supervisors are available to deliver specialist workforce development, including
    - Increasing the recognition and status of supervision across the sector
    - including education and mentoring of others as a core expectation of all registrants
    - requiring education specific CPD to be provided and undertaken
    - setting expectations to employers around
        - remuneration and incentives for supervision
        - time and facilities allocated for supervisory duties and training
        - tools and support to enhance supervisor confidence and capability

Case mix

To qualify as a specialist registrant, practitioners need to learn to manage a suitably diverse range of cases effectively. Case mix describes the variety of patient types and conditions that specialist registrants encounter, and the placement case mix underpins the scope of practice of a newly qualified prescriber or specialist practitioner. The choice of setting strongly influences case mix and as observed above, many settings can only offer some of the required elements of experience. Stakeholders observed that there are significant difficulties in specifying consistently what an appropriate case mix might be, and there is limited steer on this in the ETR Outcomes. Equally, it was asked whether perhaps a specialist registrant with a more limited case mix could qualify, but that more limited scope of practice should then be indicated by an annotation to the qualification? Such an approach could then allow later development and extension with additional annotations post registration.

It is likely that a portfolio approach to assembling evidence for meeting outcomes will be required – which in turn requires a consistent approach from learners and setting supervisors alike to determining what activities might result in "sign off". It is likely that DPPs may also vary in approach and rigour in determining whether outcomes are met, on the basis of evidence presented by learners.

Gaining sufficient breadth of case mix is also a concern for CLOs, however as the qualification has been established for more than 30 years there are not the same concerns as in IP. It was felt that the majority of patients needed for case record requirements do come up in everyday practice however, there are issues with gaining experience for 'a clinical issue that requires management' and 'lens refitting'.

Recommended actions:

- Guidance should be developed to indicate what constitutes an appropriate diversity of case mix to underpin consistent (universal) specialist registration, and whether learners with a more limited case mix could still qualify, but with a limited scope of practice
- Consideration should be given to means of enabling appropriate case mixes to be achieved, especially across multiple settings, perhaps including development of an inventory of practices' typical case mix for qualification providers
- Methods for assuring consistency of approach across multiple (remote) settings should be developed and shared across the sector.

Workforce utilisation

Career pathways

The need for clearly specified pathways for care and a consistent, multiprofessional shared understanding about where and how optometry contributes, and what, if any, additional qualifications might be required, was highlighted by sector representatives at the SPOKE event. It is particularly important to establish and communicate this to optical and other professionals to enable informed choices for both individual careers and healthcare service development.

The core skills and scope of practice of optometrists dispensing opticians and contact lens opticians are frequently underestimated by other health professions, as are the post-registration optometric qualifications, including MECS and prescribing. There is a lack of consistency amongst commissioning bodies about the level and types of qualifications required to undertake activities autonomously, and even under delegation. Whilst some frameworks, such as those developed by NECRT, have been well received, their implementation is dependent on individual hospital leaders. Optometrists in some locations are reporting being instructed that they need additional qualifications to undertake services requiring core skills, and incorrectly, that they require prescribing qualifications (rather than specialist pathological experience or qualifications) to contribute to specialist services.

There is also the concern that many newly qualified prescribing optometrists, and those considering training, find themselves unable to utilise the qualification in their location, because local commissioning frameworks only allow relevant services to be offered in a secondary setting.

There is learning to be gained from devolved nations developments in this area, as well as private practices who have successfully developed business models enabling commercially viable services, where patients can access management and treatment that is currently normally only available in the Hospital Eye Service.

Recommended actions:

- ETR should be used to re-characterise core skills for optometrists and contact lens opticians covering specialist qualifications, and ensure that the capabilities of these optical professionals at all levels are communicated strongly and consistently to healthcare stakeholders (including registrants from optical and other professions, commissioners and patients)
- Titles such as 'medical optometrist' (for specialist qualification holders in primary settings) which will have resonance with patients and other healthcare professionals, should be developed to ensure the scope of practice of specialist optical professionals is properly recognised.
- Clear and consistent messaging around the role and career structure for optical professionals should be used to attract and retain high calibre students
- Comms/campaigns should be developed to influence patient and medical professionals' perceptions to gain sector-wide support for optometrists USP as "GPs for eyes"

Commissioning and funding

It was strongly felt by the group that the GOC has a responsibility to ensure that standards of care are maintained, and the public is protected from avoidable sight loss through poor quality or inaccessible services. This role is particularly important when considering the impact of increasing registrant scope of practice through specialist qualifications.

There is a need to reduce ophthalmology waiting times and avoidable sight loss by increasing access and availability of enhanced optometry services. The lack of national NHS education funding for optical professions coupled with localised management of commissioning has led to regional inequalities in career pathways and commissioning.

Consistent funding mechanisms, coupled with the measures described above to capitalise on the potential for ETR to increase placement capacity and accessibility, would allow staff to be upskilled faster across all regions, and would remove the reliance on individuals and large multiples paying for specialist training. This could readily deliver a community-based workforce to intervene in the management of conditions that are currently having to be referred on to secondary care. In addition to providing better continuity of care, this would allow more patients to be treated, more quickly, nearer to home.

As mentioned above, there are many regions where the FP10 is not available, preventing prescribing services, and these same inconsistencies are widespread across the commissioning of other enhanced ophthalmic services.

Recommended actions:

- National funding is sought for optometrists to take on additional responsibilities, perhaps following the tiered approach for the involvement of community pharmacy in emergency care and enhanced services
- Lobbying of Government and Ministers to recognise the necessity and value of the optical professions, in enabling an active and employed ageing population, and prioritise them for funding
- Increased public awareness of optometrists' and dispensing opticians' capabilities would also increase the visibility, perceived value, and likelihood of utilisation for healthcare purposes, of the profession

Maintaining competency post-qualification.

Continuing professional development (CPD) and reflective practice are crucial for maintaining competency post-qualification, especially in areas of developing practice. However, CPD and acquiring knowledge may not be sufficient to maintain competency, particularly in the absence of an active and regular role in delivering specialist clinics. It is important to consider how practitioners with specialist qualifications are enabled to ensure they remain current and confident in the patient-facing elements of their specialist practice.

Participants queried whether there is a need for clinical revalidation that goes beyond domain-specific CPD.

Recommended actions:

- GOC consider whether some activity in addition to or integrated into CPD requirements might be used to assure continued competence in specialist registration e.g.
    - patient-facing (or simulated) specialist clinical practice activities
    - Communication mechanisms for registrants to share cases, and expertise and raise awareness
    - Multiprofessional case record discussions – to draw attention to complex cases that might not otherwise be seen in routine practice

Annex A – Summary of proposed actions

Table to indicate ongoing and new activities to address actions

Recommendation	Suggested Action	Timeframe
Actions to support stakeholders during transition – awareness		
• Communications are developed to ensure the timelines for, and expectations during the transition period, and the ongoing validity of the different routes, are better understood by all stakeholders.	• SSISG to inform on needs. • GOC comms team to action.	Urgent – asap during 2025
Further regulatory development		
• GOC consider what elements of handbook and ETR qualification expectations could be further aligned • The concepts of Practice Educator and Task Supervisor developed in SPOKE project 4 should be extended to specialist qualifications to reflect their roles and enable diverse and multi-setting experiences.	• GOC action. Should be addressed by revisions to QA approach (enabling alignment of handbook qualifications with ETR via notation).	Requires GOC Council approval in Dec 2024
• Consider what quantities and types of simulated learning might be used to complement (or substitute for) patient-facing experience. • Guidance should be developed to indicate what constitutes an appropriate diversity of case mix to underpin consistent (universal) specialist registration, and whether learners with a more limited case mix could still qualify, but with a limited scope of practice	• Could be handled by SPOKE continuation project or equivalent. Would require GOC Council approval of funding, or alternative mechanism for delivery.	2025 – So would need to be early in contract.

• GOC consider whether some activity in addition to or integrated into CPD requirements might be used to assure continued competence in specialist registration e.g.
  ○ patient-facing (or simulated) specialist clinical practice activities
  ○ Communication mechanisms for registrants to share cases, and expertise and raise awareness
	• Should be incorporated into GOC CPD review.	Next review opportunity.

○ Multiprofessional case record discussions – to draw attention to complex cases that might not otherwise be seen in routine practice		
Actions to understand and address shortages in placement capacity, and to assure quality		
• Modelling of the level of demand for placements for both handbook and ETR prescribing qualifications, including the size of the backlog of trainees already seeking placements having completed the academic learning on the handbook qualification route should be undertaken. This will determine the size of shortfall and underpin planning to ensure there is capacity to meet trainee and workforce needs.	• Could be handled by SPOKE continuation project, or equivalent.	Suitable for a 2026/7 project, if funded.
• Mechanisms should be established to ensure adequate numbers of supervisors are available to deliver specialist workforce development, including ○ Increasing the recognition and status of supervision across the sector ○ including education and mentoring of others as a core expectation of all registrants ○ requiring education specific CPD to be provided and undertaken ○ setting expectations to employers around ▪ remuneration and incentives for supervision ▪ time and facilities allocated for supervisory duties and training ▪ tools and support to enhance supervisor confidence and capability	• Incorporate into GOC CPD review. • Strengthen through next registrant standards review. • Consider during Review of standards for Businesses	Next review opportunity. Longer term – next review opportunity. Current
Increasing placement capacity by enabling multi-setting experiences		
• Consideration should be given to means of enabling appropriate case mixes to be achieved, especially across multiple settings, perhaps including development of an inventory of practices' typical case mix for qualification providers • Methods for assuring consistency of approach across multiple (remote) settings should be developed and shared across the sector.	• GOC to support (or influence clinical education funders to support) a central system for facilitating recording and managing experiential learning. (see also below)	As soon as possible to maximise impact post transition

• Consistent methods to communicate the “stage” learners are at, and experiences they have already undertaken, should be developed		

Collaborative actions to ensure UK-wide consistency		
• Make access to placements fairer and more efficient by introducing a single application system • Mechanisms to increase availability and accessibility of IP placements across the UK should be identified, with a focus on ○ increasing numbers of placement settings that participate ○ increasing visibility of available of places to all who are seeking them ○ increasing consistency of fees levied by settings ○ developing mechanisms to support multi-setting placement experience ○ accessing healthcare education funding ○ developing UK-wide shared services to give economy of scale (for placement facilitation, approval and delivery) • A nationwide scheme for supervisor training be developed to ensure that ○ supervisors do not need to meet differing requirements for multiple qualification providers ○ learners develop an appropriate scope of practice with consistent support across settings ○ supervisors are equipped to determine the limits of their scope of practice in which their clinical experience is sufficient for supervision and learner development activities ○ there is consistency of supervision across all specialisms (including IP and CLO)	• GOC to support (or influence funders to provide) a central system for facilitating recording and managing experiential learning. (see also above)	As soon as possible to maximise impact post transition

Influencing actions to ensure contribution of professions is properly recognised and supported		
• Comms/campaigns should be developed to influence patient and medical professionals' perceptions to gain sector-wide support for optometrists USP as "GPs for eyes" • Lobbying of Government and Ministers to recognise the necessity and value of the optical professions, in enabling an active and employed ageing population, and prioritise them for funding • ETR should be used to re-characterise core skills for optometrists and contact lens opticians covering specialist qualifications, and ensure that the capabilities of these optical professionals at all levels are communicated strongly and consistently to healthcare stakeholders (including registrants from optical and other professions, commissioners and patients) • Titles such as 'medical optometrist' (for specialist qualification holders in primary settings) which will have resonance with patients and other healthcare professionals, should be developed to ensure the scope of practice of specialist optical professionals is properly recognised • Develop a UK-wide business case for "teach and treat" enhanced practice /services community clinics, building on learning from devolved nations • Increased public awareness of optometrists' and dispensing opticians' capabilities would also increase the visibility, perceived value, and likelihood of utilisation for healthcare purposes, of the profession • National funding is sought for optometrists to take on additional responsibilities, perhaps following the tiered approach for the involvement of community pharmacy in emergency care and enhanced services	• GOC comms where possible to promote optical professions successes. • GOC to continue influencing OfS, DHSC, NHSE and equivalent bodies in the devolved nations to promote the importance for UK eye health and the contributions of the optical professions to it.	Current and ongoing.
• Clear and consistent messaging around the role and career structure for optical professionals should be used to attract and retain high calibre students	• SPOKE continuation Project, or equivalent, could produce resources for outreach purposes.	Early action will maximise impact