THE COLLEGE OF OPTOMETRISTS

Clinical Learning in Practice (CLiP)
Assessment handbook

January 2026

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CLiP assessment overview

Clinical Learning in Practice (CLiP) assessment is divided into two parts, CLiP 1 and CLiP 2. Each part has one remote and once face-to-face assessment visit. Each assessment visit is divided into tasks (and sometimes sub-tasks), each of which are associated with one or more GOC learning outcomes at a specified level. The complexity of task increases over the duration of CLiP, such that, by the time the student completes CLiP 2 face-to-face visit, they should be fully developed in their practice, and ready to become a full registrant with the GOC.

In addition, CLiP 1 has a written piece of work, the Service Evaluation Project, which is grounded in the student's own practice.

The assessment strategy for CLiP is one of verification and observation. Accordingly, it relies on the use of logged experiences, signed off by approved Supervisors and, where required, backed up by in-practice patient records. Assessors will examine the evidence available for each task and outcome, described in detail in the following pages.

This will be supplemented with an enquiry approach to determining the student's understanding of, and reflections on, their experiences. Assessors will ask follow-up questions when they review logbook entries and pose alternative scenarios to check whether the student can apply what they've learnt to other situations. Assessors will also test the students' ability to make, and rationalise, appropriate clinical decisions on the basis of objective data, in line with GOC standards and other relevant clinical frameworks.

The introductory section of this Handbook provides more detail on the GOC outcomes on which the degree and CLiP programme are based, the logbook in which students will record their experiences and the way the student's risk profile will be used to determine their needs and progress.

The main body of the document provides all the detail for each assessment visit, including what the student needs to have logged in advance of the visit and the marking criteria for assessment.

CLiP patient consultations

Expectations

Students in a CLiP role will work 28 – 31 hours per week, of which around 20 hours should be spent in the consulting room with patients. To be clear, students should not be working on patient consultations for significantly more or less than 20 hours per week. If they worked less, they would not accrue enough logged experience to pass CLiP assessments. If they worked more, the burden of logging entries could become too onerous. Also, students would miss out on important professional experience of other areas of the business.

The recommended number of patients a student should see each day is:

Timeframe	Number
Up to CLiP Part 1 Remote visit (around 9 weeks in)	No more than 4-5 patients per day
Up to CLiP Part 1 Face-to-face visit (around 18 weeks in)	No more than 6-8 patients per day
Up to CLiP Part 2 Remote visit (around 5 weeks into Part 2)	No more than 8-10 patients per day
Up to CLiP Part 2 Face-to-face visit and beyond (around 13 weeks into Part 2)	No more than 12 patients per day

Procedure

Students need to establish procedure for consultation with every patient, so that the patient understands that their record may be used for assessment purposes and the logbook entry is valid for that purpose.

As such, students must:

- Inform the patient that they are a ‘pre-registration optometrist’.
- Explain that the notes they make during and after the consultation may be used by others involved in their assessment.
- Record ‘Verbal consent given for assessment’ (or ‘VCG’) on the in-practice patient record; ‘VCG’ is not required on the CLiP Portal logbook entry.

Records

The student will create the in-practice patient record for the consultation and have this signed off by their supervisor, in line with procedures at the practice. They will also need to create a CLiP Portal logbook entry for each patient they see (details in next section).

Students are expected to create these logbook entries on a regular basis and may need access to patient records to complete this work. Supervisors may need to assist in arrangements for students to complete logbook entries in practice, so they have the necessary access to patient records.

Using the logbook

Creating logbook entries

The logbook is available to all students on CLiP placements as an area of their CLiP Portal account. This allows them to create logbook entries and store and search entries they've already made. Supervisors, assessors and others who are assigned to the student are able to view and search their logbook entries. Supervisors have some editing rights, including the functionality to sign off or 'confirm' entries.

Students are expected to create CLiP Portal logbook entries for every patient they see while working on the CLiP placement and consider how these could be used later as assessment evidence.

Types of logbook entry

Three different entry types can be included in a logbook entry: an 'interaction', a 'reflection' or a 'note'.

- Interaction – this has set fields which allow students to log clinical interactions they have carried out. Most data entered in an interaction is selected from drop-down options.
- Reflection – this has fields which allow students to reflect on a specific interaction and note, for example, what they learnt from it or whether anything could be done differently. The reflection entry also has an open field which allows the student to log stand-alone reflections. Reflection fields are all free-text.
- Note – this is an open text box which can be used to log anything, with no specific fields required. For example, a student may want to use it like a professional diary or journal.

A logbook entry can include all three types or any combination. We expect students to create interactions to record patient consultations and these will be the main types of entry used in assessment.

It is good practice for students to create a reflection at least once a week, recording progress on CLiP and key learning points. This can be used in check-in sessions with supervisors and as a reference to prepare for assessment visits.

Expected features of logbook entries

Students will create a CLiP Portal logbook entry, in addition to the corresponding in-practice patient record, for every student they see while working as a student optometrist on CLiP.

Logbook entries recording patient consultations should all have:

- The same anonymous Patient ID which is used in the in-practice patient record in the 'Reference' field.
- A completed interaction.

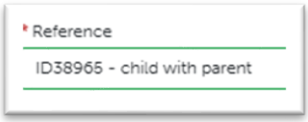
- ‘Student role’ field in the interaction set to ‘Consulting’.
- ‘Patient role’ field in the interaction set to ‘Patient’.
- Items selected in the interaction fields which directly relate to the patient. For example, if ‘Toric’ lens is selected in ‘Tasks undertaken, the student should have fitted a toric lens or seen a patient with a toric lens. Recording that a patient might be suitable for a toric lens in future would not meet the criteria.

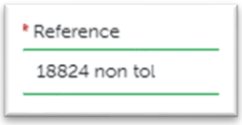
And, throughout Part 1 of CLiP:

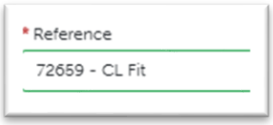
- A learning outcome assigned in ‘Clinical core learning outcomes’ field of the entry; and
- A short written explanation of why the interaction demonstrates achievement of the learning outcome, in the ‘Consultation notes’ field of the interaction.

The student does not need to include detailed information about each patient in the CLiP Portal logbook entry, provided the patient record contains this. However, if they think that the entry is going to be used in assessment, we do advise that they include enough brief information in the ‘Reference’ and ‘Consultation notes’ fields to aid memory.

Adding a brief note about the main feature of the entry in ‘Reference’ will help the student, supervisors and assessor determine which entries to select, for example:







How entries are used

As interaction fields are populated by the student choosing items from drop-down options, the system is able to count and process this content to help everyone involved to monitor the student’s progress. It is worth noting that students are able to log interactions they have observed, but the system will only count for progression purposes if the student consulted with a patient (as opposed to observing a consultation or consulting with a colleague) and the supervisor confirms the entry.

One way in which interactions will be used is to help form the student’s rating in their risk profile. For example, one of the fields a student will need to complete when logging an interaction is the patient’s age profile. These are logged in age ranges e.g. ‘Child 5-6’, ‘Youth 12-16’, ‘Adult 17-45’ and so on. The system will count the number of each type logged and this will contribute to the risk profile the student has at each stage of the placement, visible in a dashboard on the Portal (see ‘Student risk profile’ section).

Certain types of interaction are required as prerequisites for the assessment visits. As the student links interactions to certain GOC outcomes, and the Supervisor confirms them, the system will count these interactions as prerequisites for the visit and this will register on the assessment dashboard for the next visit.

Prior to the assessment visit, the student and Supervisor will be able to review the dashboard and select entries which are suitable for the Assessor to review and discuss at the assessment visit.

Interaction fields

The main categories the student completes when they log an interaction are:

- Patient age group
- Vulnerable?
- Accompanied by
- Other characteristics
- Conditions
- Visual needs
- Tasks undertaken

Most of these areas have sub-categories and a number of items students can select to complete the information. The full list of interaction categories and the items the student can select from are set out in the ‘Student risk profile and dashboard’ section below.

Reviewing logbook entries

The Supervisor's role

The Practice Lead, and Task Supervisors, will be able to sign off (or 'confirm') interactions in the student's logbook and will be responsible for confirming the interactions they supervised. Students will not be able to amend the details of the interaction after it has been signed off.

The Practice Lead should undertake regular review of each student's logbook and confirm the accuracy and authenticity of the logged experience. The Practice Lead should also meet regularly with the student to discuss their progress. It is good practice for the student to document supervisory discussions in their logbook as an agreed record of the meeting.

Supervisors will also need to work with students to help them select the learning outcomes which an interaction or reflection can be linked to and to identify learning outcomes which the student still needs to meet. The dashboards on the CLiP Portal will help Supervisors to identify areas where the student needs to gain more experience.

Checklist for logbook entries

In the early stages of CLiP, and at regular periods throughout, supervisors should check that students are doing the following in their logbook entries:

- Creating a new logbook entry for every patient seen.
- Logging only genuine patients and not, say, consultations carried out with colleagues.
- Only entering details in the interaction which relate directly to the patient. For example, 'Conditions – Glaucoma' would need to be either a patient with glaucoma or the student has carried out additional investigations due to suspected glaucoma.
- Recording Patient ID and brief notes about the entry in the 'Reference' field so this is visible in the logbook grid.
- Using the same anonymous Patient ID as used in your in-practice patient records, for ease of reference.
- Obtaining verbal consent from each patient for their records to be used in assessment (recorded on the in-practice patient record, not logbook).

And, throughout CLiP Part 1:

- Selecting one, and no more than two, learning outcomes in the 'Clinical core outcomes' field of the entry (no more than two per entry).
- Writing a brief explanation in the 'Consultation notes' field of the interaction to explain why they consider this consultation demonstrates that they have achieved the learning outcome(s).

Confirming logbook entries

Supervisors will need to confirm each entry in the CLiP Portal for the system to count toward dashboards, and for the entry to be valid for Assessors to review. Assessors can ask to review logbook records which the student has not presented for assessment, so it is important that all entries are confirmed.

Within the CLiP Portal, supervisors are able to view student logbook entries and can confirm and approve them. While all entries need to be confirmed, entries only need to be approved if they have been selected for review at an assessment visit.

Entries can be confirmed by opening the entry and using a button within that page, or can be bulk-confirmed by selecting entries on a logbook grid view.

We suggest that supervisors:

- Review and confirm entries on a regular basis, at least weekly.
- Agree procedure for who confirms entries, if there is more than one supervisor.
- Establish an agreed system to review and spot-check entries if they are being bulk-confirmed.

Supervisors will need to apply an effective review system if they are confirming logbook entries in bulk, with appropriate checks in place to be sure that the student's entries are authentic, if all entries are not being checked.

This could include:

- Overall review of number and type of unconfirmed entries – does the number of entries match the number of patients the student has seen since entries were last confirmed?
- Overall review of 'Reference' fields in logbook grid: does information about the entries included in the Reference field reflect the patients the student has seen since the last check?
- Spot-check of Patient IDs – do all entries checked have corresponding in-practice patient records?
- Spot-check of Interactions: does the patient information, conditions and tasks undertaken which the student has recorded reflect what you have arranged or discussed with the student since the last check?

Approving logbook entries

When a supervisor approves an entry, it will appear on the student's Assessment Summary Dashboard for the Assessor to consider at the next assessment visit. Although all entries should be confirmed, supervisors only need to approve entries which have been selected for review at an assessment visit.

Students and supervisors should arrange to meet well in advance of assessment visits to review logbook entries, discuss readiness for assessment and identify any areas the student needs to work on. For example, the assessment visit requirements

include types of patient, condition and task and if the student is missing any required experience, the supervisor should work on trying to fill these gaps.

When the student and supervisor agree that entries will be included for the Assessor to review at the visit, the student can use the ‘Include in assessment’ button on the entry, and the Assessor can approve it. The supervisor, as part of the approval process, needs to check that:

- The entries the student has selected fulfil all the requirements set out in the assessment criteria (see Student guidance for the assessment visit and/or CLiP Assessment Handbook).
- The entries, when viewed in the logbook grid, have patient IDs and brief information about the entry in the ‘Reference’ column.
- The student has anonymised the corresponding in-practice patient records correctly.

Student risk profile and dashboard

Reasons for the risk profile

The Supervisor role involves assuring patient safety, overseeing learning, and mentoring and coaching the student on their placement journey. To help Supervisors monitor all these elements, the CLiP Portal has a ‘Risk dashboard’ which provides a snapshot of the student’s experience and risk profile based on what they have logged.

The Risk dashboard shows their progress through a Red-Amber-Green staging process based on counting numbers of experiences they have undertaken. Some advantages of this overview include:

- The Practice Lead and other Supervisors can make judgements about the student’s progress and the level of independence they can be given in practice.
- Supervisors who are less familiar with, or new to, the student will be able to gain an immediate overview of the student’s progress.
- The colour coding against logbook items such as patient type and tasks undertaken highlights where the student still needs to gain more experience in specific areas.

The risk framework

- When students log interactions, they select from drop-down menus to identify features such as the characteristics of the patient, their visual needs, any conditions the student saw and any tasks they undertook.
- Each item which can be selected when logging a patient interaction has a risk rating (see the full table below).
- The higher the risk, the more times a task must be logged (and signed off as safely completed by the Supervisor) before the rating changes from red to amber or from amber to green.
- Expectations are also set for how many of each item the student is expected to have logged and had signed off before each assessment visit.
- Supervisors will be able to use the Risk dashboard to assess how far in line with these expectations the student is.
- This analysis can help determine the general progress of the student as a clinician and how much independence they can be given. For example, whether they are able to see certain types of patient without direct observation.

This table summarises how many logged and signed off interactions are needed for items to show as red, amber or green on the risk dashboard:

	Number of interactions signed off		
Risk Level	**Red**	**Amber**	**Green**
Low	0-1	2-4	5+
Medium	0-4	5-9	10+
High	0-9	10-29	30+
High low volume [HLV]	0-2	3-5	6+

As an example of how this can be used, by the time of the first CLiP assessment (CLiP 1R) all low and medium risk categories should be showing on the dashboard as amber.

- For any 'Low' risk items, that means a student is expected to have 2 or more entries at this stage in their placement.
- For any 'Medium' risk items, a student is expected to have 5 or more entries at this stage.
- 'Accompanied by…' is an example of a medium risk category.
- As such, by the time of the first CLiP assessment (CLiP 1R), at around 12 weeks in, the student is expected to have seen 5 or more patients who have been 'Accompanied by' a parent, carer or other role.

Progression monitoring

Although not a strict requirement, we have set indicative progression markers for how the student's risk dashboard should look as they reach each assessment visit. This ensures that students are getting the right quantity and breadth of experience overall, and can be supported in areas where progress is falling behind. Where a risk status is set as 'must' this is because it's a prerequisite, required evidence for the visit.

CLiP 1R: We expect all low and medium interaction items (except visual needs) should be amber by the time of this assessment visit. High risk items and the medium risk 'Visual needs' items can be red. If there are some red items at the time of the visit, this should be included in the 'Quality assurance of setting and supervision' discussion with the Assessor.

CLiP 1F: All low and medium interaction items (except visual needs) need to be green by the time of this assessment visit. All other interaction items are expected to be amber or green. If any High risk or visual needs items are red, this does not prevent the visit from going ahead, but the student and Assessor should discuss any red items as part of the 'Quality assurance of setting and supervision' discussion.

CLiP 2R: All interaction items should be green, possibly with some amber in high-risk categories. Students **must** be green on low vision, paediatric, vulnerable, non-tolerance and use of drugs.

CLiP 2F: All items are expected to be green before the assessment visit takes place. This will ensure that the student has enough evidence for the Assessor to use in task 3. There is risk that task 3 cannot be completed if the logbook entries are not all green. In this scenario, the Assessor and student will need to discuss, as part of the visit, how they are going to complete the logbook expectations by the end of CLiP.

Understanding the risk dashboard

The table below shows all the items a student is able to log, the risk rating applied to them and the number of interactions the student is expected to have in the logbook at the time of the assessment visit.

The **Field** column represents most of the different fields students need to complete in a logbook interaction.

Category and **Sub-category** are mainly the items students can select in the drop-down options to complete the interaction.

An **asterisk** after a sub-category item (e.g. Cataract*) suggests that the student should add consultation notes (a free text field in the interaction) to provide more detail.

LV after a sub-category item means 'low volume', items a student may see quite rarely.

The main **Risk** categories are: L = Low, M = Medium and H = High.

The category **HLV** is 'High risk - low volume', indicating items, including drugs and emergency referral, for which students are unlikely to reach the normal high risk targets. Expected numbers are set lower for these items, but Supervisors should note that they are still high risk. As such, '[HLV]' is used after the sub-category as a reminder. In line with other high risk activity, the student is considered to need more practice and should aim to exceed the minimum requirement if possible.

Where **cells are merged**, so that there are two or more 'Sub-category' items in the same cell with the same risk rating, this means that any combination of items in that cell will be counted. For example:

- The items in the 'Accompanied by' sub-category (Parent, Friend etc) are in a merged cell with a Medium risk rating.

Parent Carer Family member Friend Interpreter	M	A: 5 - 9

- By the time of the first CLiP assessment (CLiP 1R) the student is expected to have seen 5 or more patients who have been 'Accompanied by' a parent, carer or other role.

- A student could meet the expectation for CLiP 1R if they logged one each of Parent, Carer, Family member, Friend and Interpreter (five entries total).
- As these items are merged, they could also meet this requirement if they logged five ‘Accompanied by: Parent’ entries and did not have any of the other examples.
- However, in Patient age group, ‘Youth 12-16’ is a sub-category in a cell on its own and is also Medium, so the student would need to have five entries for ‘Youth 12-16’ to reach amber.

Youth 12-16	M	A: 5 - 9

Field	Category	Sub-category	Risk	Expected number of logbook entries			
				CLiP 1R	CLiP 1F	CLiP 2R	CLiP 2F
Patient age group		Infant 0-2 (LV) Pre-school child 3-4 Child 5-6 Child 7-11	H	-	A: 10 – 29 or G: 30+	**Must** be G: 30+	G: 30+
		Youth 12-16	M	A: 5 - 9	**Must** be G: 10+	G: 10+	G: 10+
		Young adult 17-45	L	A: 2 - 4	**Must** be G: 5+	G: 5+	G: 5+
		Middle-aged 46-60	M	A: 5 - 9	**Must** be G: 10+	G: 10+	G: 10+
		Older Adult 61-74 Senior 75+	H	-	A: 10 – 29 or G: 30+	Should be G: 30+	G: 30+
Vulnerable?		[Tick-box]	M	A: 5 - 9	**Must** be G: 10+	**Must** be G: 10+	G: 10+
Accompanied by		Parent Carer Family member Friend Interpreter	M	A: 5 - 9	**Must** be G: 10+	G: 10+	G: 10+
Other characteristics	Significant family history		M	A: 5 - 9	**Must** be G: 10+	G: 10+	G: 10+
	Communications challenges	Cultural barriers Language barriers Needs help to communicate Hard of hearing	H	-	A: 10 – 29 or G: 30+	Should be G: 30+	G: 30+
	Comprehension challenges	Neurodiversity (LV) Dementia Learning difficulties	H	-	A: 10 – 29 or G: 30+	Should be G: 30+	G: 30+
	Visual challenges	Visually impaired	M	A: 5 - 9	**Must** be G: 10+	G: 10+	G: 10+

Field	Category	Sub-category	Risk	Expected number of logbook entries			
				CLiP 1R	CLiP 1F	CLiP 2R	CLiP 2F
	Physical Challenges	Physical disabilities	M	A: 5 - 9	**Must** be G: 10+	G: 10+	G: 10+
Conditions	Anterior Segment	Red Eye	M	A: 5 - 9	**Must** be G: 10+	G: 10+	G: 10+
		Cataract*	M	A: 5 - 9	**Must** be G: 10+	G: 10+	G: 10+
		Other*	M	A: 5 - 9	**Must** be G: 10+	G: 10+	G: 10+
	Posterior Segment	Glaucoma	H	-	A: 10 – 29 or G: 30+	Should be G: 30+	G: 30+
		Retinal detachment risk Other retinal disorders*	H	-	A: 10 – 29 or G: 30+	Should be G: 30+	G: 30+
		Dry AMD Wet AMD Other macular disorders*	H	-	A: 10 – 29 or G: 30+	Should be G: 30+	G: 30+
	Refractive errors	Myopia Hyperopia Astigmatism Presbyopia Anisometropia	L	A: 2 - 4	**Must** be G: 5+	G: 5+	G: 5+
	Binocular vision anomalies	Heterophoria Heterotropia Incomitance Amblyopia Other*	M	A: 5 - 9	**Must** be G: 10+	G: 10+	G: 10+
	Systemic disorders affecting the eye	Diabetes Hypertension Other*	H	-	A: 10 – 29 or G: 30+	Should be G: 30+	G: 30+
	Neurological	Specify in notes	H	-	A: 10 – 29 or G: 30+	Should be G: 30+	G: 30+
	Ocular adverse reactions	Specify in notes	H	-	A: 10 – 29 or G: 30+	Should be G: 30+	G: 30+

Field	Category	Sub-category	Risk	Expected number of logbook entries			
				CLiP 1R	CLiP 1F	CLiP 2R	CLiP 2F
	Non-tolerance	Specify in notes	M	A: 5 - 9	**Must** be G: 10+	**Must** be G: 10+	G: 10+
	No conditions found		L	A: 2 - 4	**Must** be G: 5+	G: 5+	G: 5+
Visual Needs	Low Vision	Simple aids Complex aids (LV)	M	-	A: 5 – 9 or G: 10+	**Must** be G: 10+	G: 10+
	Occupational	Vocational Sport Protective	M	-	A: 5 – 9 or G: 10+	Should be G: 10+	G: 10+
		High refractive correction	M	-	A: 5 – 9 or G: 10+	Should be G: 10+	G: 10+
		Single vision	L	A: 2 - 4	**Must** be G: 5+	G: 5+	G: 5+
		Progressive	M	-	A: 5 – 9 or G: 10+	Should be G: 10+	G: 10+
	Contact Lens	Rigid Toric Multifocal Myopia management Bandage Cosmetic Scleral orthoK Other soft lenses	H	-	A: 10 – 29 or G: 30+	Should be G: 30+	G: 30+
Tasks undertaken	History and symptoms		L	A: 2 - 4	**Must** be G: 5+	G: 5+	G: 5+
	Pupils		L	A: 2 - 4	**Must** be G: 5+	G: 5+	G: 5+
	Anterior Segment		L	A: 2 - 4	**Must** be G: 5+	G: 5+	G: 5+
	Posterior Segment		L	A: 2 - 4	**Must** be G: 5+	G: 5+	G: 5+

Field	Category	Sub-category	Risk	Expected number of logbook entries			
				CLiP 1R	CLiP 1F	CLiP 2R	CLiP 2F
	Refraction	Objective	H	-	A: 10 – 29 or G: 30+	Should be G: 30+	G: 30+
		Subjective	L	A: 2 - 4	**Must** be G: 5+	G: 5+	G: 5+
		High refractive	M	A: 5 - 9	**Must** be G: 10+	G: 10+	G: 10+
	Ocular Motor Balance*	Asymptomatic	M	A: 5 - 9	**Must** be G: 10+	G: 10+	G: 10+
		Symptomatic [HLV]	HLV	-	A: 10 – 29 or G: 30+	Should be G: 30+	G: 30+
	Intraocular pressures	Contact tonometry [HLV]	HLV	-	A: 3 - 5 or G: 6+	**Must** be G: 6+	G: 6+
		Non-contact tonometry	L	A: 2 - 4	**Must** be G: 5+	G: 5+	G: 5+
	Visual fields*		M	A: 5 - 9	**Must** be G: 10+	G: 10+	G: 10+
	Additional tests	Keratometry	L	A: 2 - 4	**Must** be G: 5+	G: 5+	G: 5+
		Colour vision Contrast sensitivity	L	A: 2 - 4	**Must** be G: 5+	G: 5+	G: 5+
		Other supplementary tests, e.g. Amsler, OCT *	L	A: 2 - 4	**Must** be G: 5+	G: 5+	G: 5+
	Drugs	Stain	L	A: 2 - 4	**Must** be G: 5+	G: 5+	G: 5+
		Mydriatics [HLV]	HLV	-	A: 3 – 5 or G: 6+	**Must** be G: 6+	G: 6+
		Cycloplegia [HLV]	HLV	-	A: 3 – 5 or G: 6+	**Must** be G: 6+	G: 6+
		Anaesthetic [HLV]	HLV	-	A: 3 – 5 or G: 6+	**Must** be G: 6+	G: 6+
	Management and advice		M	A: 5 - 9	**Must** be G: 10+	G: 10+	G: 10+
	Verification		L	A: 2 - 4	**Must** be G: 5+	G: 5+	G: 5+

Field	Category	Sub-category	Risk	Expected number of logbook entries			
				CLiP 1R	CLiP 1F	CLiP 2R	CLiP 2F
	Dispense		M	A: 5 - 9	**Must** be G: 10+	G: 10+	G: 10+
	Contact Lens	Fit	M	A: 5 - 9	**Must** be G: 10+	G: 10+	G: 10+
		Aftercare	L	A: 2 - 4	**Must** be G: 5+	G: 5+	G: 5+
		Teach	L	A: 2 - 4	**Must** be G: 5+	G: 5+	G: 5+
	Referral	Non-emergency [HLV] Emergency [HLV]	HLV	-	A: 3 – 5 or G: 6+	Should be G: 6+	G: 6+
		Consult with colleague Consult with supervisor Recall	H	-	A: 10 – 29 or G: 30+	Should be G: 30+	G: 30+
	Teamwork	Handover*	L	A: 2 - 4	**Must** be G: 5+	G: 5+	G: 5+
		Delegation*	M	A: 5 - 9	**Must** be G: 10+	G: 10+	G: 10+

Definitions of items in the risk framework and logbook

1. Note on Other characteristics – Visual challenges - Visually impaired

   Definition of **Visually impaired** is that the patient's eyesight requires visual correction. It can be applied to any patient for whom a prescription would be appropriate and where this has been determined during the student's consultation.

2. Note on Conditions – Neurological

   Neurological conditions relate to the brain, spinal cord and nerves. Logbook entries can record conditions where a neurological problem affects a patient's vision.

3. Note on Conditions – Ocular adverse reactions

   This will usually mean that the patient has had an adverse reaction to a drug or other mode of treatment.

4. Note on Visual needs – Low vision – Simple/Complex aids

   Definition of **Low vision** – A person with low vision is one who has an impairment of visual function for whom full remediation is not possible by conventional spectacles, contact lenses or medical intervention and which causes restriction in that person's everyday life. *Low Vision Services Consensus Group. A framework for low vision services in the United Kingdom*. London: Royal National Institute for the Blind, 1999. Both eyes 6/12 or worse (binocular) and/or N6 (with +4 dioptre reading addition) or severely restricted fields (that are consequence of clinical condition). WGOS

5. Note on Tasks undertaken – Intraocular pressures – Contact tonometry

   Contact tonometry is defined here as applanation by using either Perkins, Goldmann or equivalent.

6. Note on Tasks undertaken - Verification

   Verification is the measurement of any type of spectacle lens.

7. Note on Tasks undertaken – Dispense

   A **Dispense** is always face-to-face, and is:

   - dispensing single or multiple low vision aids to one patient,

     OR

   - dispensing a single pair or multiple pairs of single vision or multifocal spectacles to one patient.

   Re-glazing a patient's frame can only be counted as a dispense if measurements are required, the prescription has changed and a dispensing discussion has taken place

8. Note on Tasks undertaken – Contact lens – Fit

   To log a **Contact lens fit**, you need to demonstrate that you have:

   - taken all relevant preliminary measurements
   - decided on an appropriate lens specification
   - ordered or selected the fitting lenses
   - checked the ordered/ selected lenses on the eye
   - instructed the patient to wear the lenses

9. Note on Tasks undertaken – Contact lens – Aftercare

   Contact lens aftercare refers to consultation and advice with a patient sometime after the initial fit, usually where a patient is following up with an issue they have had after wearing lenses for some time.

10. Note on Tasks undertaken – Referral – Consult with colleague / supervisor

    Referral – Non-emergency would be a referral you make in writing to another healthcare professional outside of your practice, such as a written letter of referral to a hospital. It could also mean that you have used one of your practice routes for referring specific conditions or patient types, such as using a button, form or electronic system your practice has set up.

    Referral – Emergency would be a situation in which you send a patient to A&E or to an acute referral ophthalmic area for urgent treatment on the same day.

    Referral – Consult with colleague may be a less formal interaction than you would usually consider a ‘referral’. This can be about any matter regarding a patient which you need to pass to a colleague other than your supervisor e.g. delegation to OA or dispensing optician.

    Referral – Consult with supervisor should be a matter regarding a patient for which you needed to ask the supervisor’s advice, ask the supervisor to sit in on the consultation or you asked the supervisor to take over from you.

GOC learning outcomes

What are learning outcomes?

Learning outcomes are statements of what a learner will know or be able to do by the end of a learning experience. In the summative assessments which take place during the programme of study, those assessing the student should be able to use the learning outcomes as a measure of whether the student has attained the required standard.

The GOC has set learning outcomes for qualification providers to measure what students need to know and be able to do in order to register as an optometrist. These are available in the GOC document ‘Requirements for Approved Qualifications in Optometry or Dispensing Optics’ and are also referenced throughout this document.

The University delivering the degree is responsible for ensuring that any student awarded the degree has met all of the GOC outcomes.

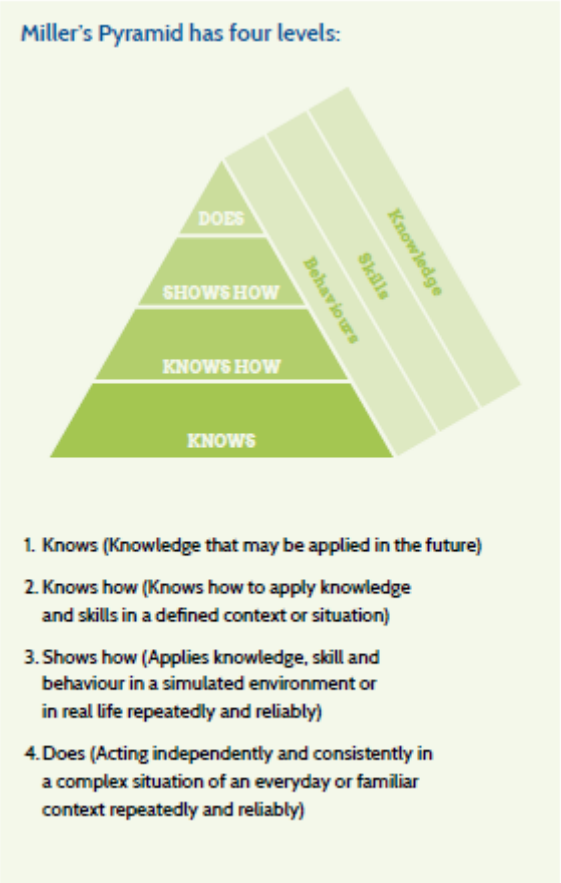
What do the GOC learning outcomes cover?

There are seven sections for learning outcomes in the GOC Requirements:

1. Person centred care
2. Communication
3. Clinical practice
4. Ethics and standards
5. Risk
6. Leadership and management
7. Lifelong learning

Miller’s pyramid levels

As well as setting the learning outcomes, the GOC ascribed levels, using Miller’s pyramid, to each outcome to show the level that the student must attain. There are four levels, ‘Know’, ‘Knows how’, ‘Shows how’ and ‘Does’. More information on Miller’s pyramid can be found in the GOC or SPOKE documents (and see below) but most CLiP outcomes are at the level ‘Does’, meaning that the student is meeting the learning outcome independently and consistently on a regular basis in their daily practice.



Source: GOC Requirements for Approved Qualifications in Optometry or Dispensing Optics (2022)

GOC outcomes covered in CLiP

When the new Optometry Master's degrees were developed, the Universities worked with the College to map the learning outcomes to determine what would be covered by the University and what would be covered in CLiP. To ensure that all students are ready for CLiP, it was also agreed what outcomes will have been met, and at what level, prior to starting placement. For this reason, students cannot start CLiP placements with any outstanding failures on the earlier parts of their course.

The mapping of the learning outcomes includes the level at which each outcome will be assessed. Most of the learning outcomes are assessed at 'Does' level during the CLiP placement. The full mapping can be seen in Appendix I.

Bullet point indicators and SPOKE indicative guidance

The GOC learning outcomes in Section 3 'Clinical practice' mostly have bullet point 'indicators' to show the areas of knowledge and skill which should be encompassed within that learning outcome. For example, learning outcome 3.5a (iii) is:

> 'Advises on the safe and effective use of contact lenses and removal in an emergency.'

This is followed by a number of bullet points detailing what should be incorporated into what the student 'advises', for example:

- Instructs the patient in the handling of soft and rigid lenses and how to wear and care for them.

For the other six sections of learning outcomes, there are no bullet point indicators. However, The GOC commissioned the Sector Partnership for Optical Knowledge and Education (SPOKE) to facilitate knowledge-sharing and support with the new qualification developments. The first SPOKE project was 'Indicative guidance' for the new qualifications, giving more detail of what you might look for when assessing each of the learning outcomes.

This project produced indicative guidance for each learning outcome in Sections 1, 2, part of 3, and 4 – 7. The tables which will be used to detail the assessment framework and tasks in this document refer to the learning outcomes, the bullet point indicators and the SPOKE indicative guidance.

Clinical and Learning-related Core Outcomes

The Clinical core outcomes listed below are considered so crucial to clinical practice that, although they may not explicitly be assessed in every task, if a student failed to perform in one of these areas at any point, it could lead to failure of the task being assessed*. As such, Assessors will be attentive to these outcomes during all four assessment visits, but they are explicitly testing them in CLiP 1F.

Students are advised to pick at least one core outcome to assign to each of the entries they log and use the free text areas in the logbook to describe how they met the outcome.

Learning-related core outcomes (7.1 and 7.4) are integrated into every assessment visit, as part of tasks set for support purposes with no explicit assessment. These tasks are to monitor and establish a developmental trajectory over time that provides evidence for having achieved these two outcomes.

The clinical and learning-related core outcomes are all assessed at 'Does' level.

*In the event of a student failing a task the Assessor would not usually inform the student at the time. However, if a patient is visibly uncomfortable or the student's actions are deemed dangerous, the Assessor will intervene on the grounds of patient safety.

Clinical core outcomes

Outcome / Level	Example failing performance
1.1 Actively listens to patients and their carers to ensure patients are involved in and are at the heart of decisions made about patient's care.	Demonstrates a rude, poor or patronising questioning technique Fails to note critical information provided by patient
1.2 Manages desired health outcomes of patients, taking into consideration any relevant medical, family and social history of the patient, which may include personal beliefs or cultural factors.	Provides advice that directly conflicts with patient's desired outcomes Acts in a way that clearly makes the patient uncomfortable Does not meet legal requirements in relation to data management. Does not meet legal requirements in relation to equality.
1.3 Protects patients' rights; respects the choices they make and their right to dignity and privacy.	
1.5 Commits to care that is not compromised because of own personal conscious and unconscious values and beliefs.	
4.9 Complies with equality and human rights' legislation, demonstrates inclusion and respects diversity.	
4.12 Complies with legal, professional and ethical requirements for the management of information in all forms including the accuracy and appropriateness of patient records and respecting patient confidentiality.	
1.6 Obtains and verifies continuation of valid consent from adults, children, young and vulnerable people and their carers and records as appropriate.	Repeatedly fails to establish consent (or meet legal requirements re consent).
4.4 Applies the relevant national law and takes appropriate actions i) to gain consent and ii) if consent cannot be obtained or is withdrawn.	
2.1 Conducts communications in a sensitive and supportive manner adapting their communication approach and style to meet	Communicates in an unprofessional or misleading manner

the needs of patients, carers, health and care colleagues and the public.	
3.1 Undertakes safe and appropriate ocular examinations using appropriate techniques and procedures to inform clinical decision-making within individual scope of practice.	Safety of patient compromised requiring assessor intervention
4.8 Complies with health and safety legislation.	Compromised safety of patient or self, without making attempt to correct.
5.5 Applies infection prevention control measures commensurate with the risks identified.	Poor hygiene or infection control potentially impacting patient safety Unsafe disposal of clinical waste
5.7 Able to risk assess i) patient's clinical condition and ii) a situation in clinical practice and make appropriate clinical decisions.	Safety of patient compromised requiring assessor intervention

Learning-related core outcomes

GOC Outcome	SPOKE indicative guidance
7.1 Evaluates, identifies, and meets own learning and development needs. (DOES)	Analyses and responds to own learning and development needs. Prepares and follows a personal development plan, utilising appropriate learning opportunities.
7.4 Engages in critical reflection on their own development, with a focus on learning from experience, using data from a range of information sources (such as clinical audits, patient feedback, peer review and significant event analysis) and identifying and addressing their new learning needs to improve the quality and outcomes of patient care. (DOES)	Assesses own learning needs and engages in self-directed learning to maximise potential and improve outcomes. Critically reflects on own practice, and participates in multi-disciplinary service and team evaluation formulating and implementing strategies to act on learning and make improvements. Actively engages in peer review to inform own practice, formulating and implementing strategies to act on learning and make improvements. Demonstrates how audit can contribute to improvement in the quality and/or efficiency of patient care.

Assessment visits

How assessment visits are organised

Assessment visits are organised roughly every 9 – 12 weeks of the placement. The student usually has the visit within the set window for the assessment and will need to be ready in terms of all the visit prerequisites and training. Within this schedule, there is scope to arrange for students to have the visit later in the assessment window if required.

There will be one remote and one face-to-face visit in each of the two CLiP parts, so four assessment visits in total:

CLiP 1R – CLiP Part 1 remote visit

CLiP 1F – CLiP Part 1 face-to-face visit

CLiP 2R – CLiP Part 2 remote visit

CLiP 2F – CLiP Part 2 face-to-face visit

A different Assessor will be assigned to each visit.

General visit requirements

Students and supervisors can review the detailed logbook requirements for each visit later in this document and/or in separate guidance on the College website.

The general requirements for all visits are that the student:

- Is ready to start on time.
- Has photo ID ready to show at the start.
- Is ready to share in-practice patient records.

For remote visits, the student will need to have in-practice patient records corresponding to their logbook entries both:

- fully anonymised and;
- open and ready to share on their computer.

For remote visits, the student can be at home or in the workplace but must have a reliable internet connection and be in a room where they are alone and will not be interrupted.

For face-to-face visits, the Practice Lead supervisor must be available during the visit. The Assessor will need to be able to access the CLiP Portal during the visit so the student must have the WiFi details ready to share.

Preparing for assessment visits

The student needs to have all logbook requirements for the visit prepared and approved a week in advance of the visit. If there are any gaps in the requirements, the Assessor will have to award a fail result for the relevant task and the student will need to re-take it. As such, it is very important that students and supervisors check the logbook and ensure that the student is ready for the visit in time.

The dashboards in the CLiP Portal and the visit guidance with logbook checklists can be used to carry out checks. Student guidance has been prepared for each visit and is available on the Assessment visits area of the College website. We advise Supervisors and students to start preparing with this separate guidance. These include preparation checklists for each visit and we recommend starting checks 4-5 weeks ahead of the visit at the latest.

Quality assurance tasks

Most tasks within each visit are assessed, but each visit ends with a 'Quality assurance of setting and supervision' task to make sure the student is being properly supported in their placement. The Assessor can also discuss the student's progress on the placement, focussing on areas of the risk profile where the student is not at the expected level, for example. The outcome of such a discussion could be that the need for additional support is identified.

Preparing in-practice patient records

For some assessment tasks, there are requirements to select an in-practice patient record for the Assessor to review. Patient records used for the assessment visit must:

- be original;
- be contemporaneous (completed at the time of the patient consultation);
- comprise the written record only – fields and scans are not required;
- include a note that the patient gave consent for them to be used for assessment purposes (e.g. VCG / verbal consent given); and
- not be altered in any way, other than being anonymised.

On a face-to-face visit, it is expected that students will be able to show the original records to the Assessor on a practice computer. On a remote visit, they will probably be using their own computer at home to share records. For data protection purposes, the student will therefore need to anonymise and copy all records before they transfer them.

The process for anonymising records for use on remote visits is:

- Supervisor approves the record as one the student can use in assessment.
- Student duplicates the record, in the practice.

- Student anonymises the duplicated record, in the practice, using electronic editing tools or black marker for a paper record.
- Student edits to remove view of patient name, address, date of birth, GP details, telephone number and any other information which could be used to identify the patient.
- Student does not make any further changes to the record: all details of the patient consultation must remain unchanged.
- Supervisor checks the record.
- Student copies record to their computer.
- Student uses the Patient ID as filename for the record, for easy cross-reference with the CLiP Portal logbook entry.
- When supervisor approves the logbook entry, this confirms they have checked and approved any accompanying anonymised record.

In-practice patient records are not uploaded to the CLiP Portal. The student needs to have the anonymised records open and ready to share, on their device, before the visit starts.

Service Evaluation Project

In CLiP 1, the student needs to submit material for the Project at both the remote and face-to-face visits. Planning for the project is discussed at CLiP 1R (with the 'planning' sections of the template submitted in advance of the visit) and the final project is submitted along with other logbook entries for CLiP 1F ('workbook' sections and all references and data provided).

More information about the Service Evaluation Project is provided below and in separate guidance available on our Assessment visits area.

Assessment visit schedule

See below.

Month	Week	CLiP Model A (January start)	CLiP Model B (July start)
Jan	1	Earliest placement start date	CLiP Part 2 start
	2		
	3		
	4		
Feb	1	Latest placement start date	CLiP 2R: Part 2 remote visits
	2		
	3		
	4		
March	1		
	2		
	3		
	4	CLiP 1R: Part 1 remote visits	
	5		CLiP 2F: face-to-face visits
April	1		
	2		
	3		
	4		
May	1		
	2		
	3	CLiP 1F: face-to-face visits (and submission of Service Evaluation Project)	
	4		
	5		End of placement
June	1		
	2		
	3		
	4	End of CLiP Part 1	
July	1		Earliest placement start date
	2		
	3		
	4		
August	1	CLiP Part 2 start	Latest placement start date
	2		
	3		
	4		
	5	CLiP 2R: Part 2 remote visits	
Sept	1		
	2		
	3		CLiP 1R: Part 1 remote visits
	4		
Oct	1		
	2		
	3		
	4	CLiP 2F: face-to-face visits	
	5		
Nov	1		
	2		CLiP 1F: 1 face-to-face visits (and submission of Service Evaluation Project)
	3		
	4		
Dec	1		
	2		
	3		
	4	End of placement	End of CLiP Part 1

Assessment visit requirements and special circumstances

Visit prerequisites

It is the student's responsibility to ensure that they have logged all the prerequisite evidence and arranged for their Supervisor to approve it prior to the assessment visit deadline, which will normally be one week in advance.

Any task that does not have the full complement of prerequisite evidence logged by the deadline will be treated as failed, unless there are approved exceptional circumstances.

Visit attendance

Students who present themselves for assessment at the visit will be treated as declaring themselves fit-to-sit the assessment. Only in exceptional cases will circumstances declared after the assessment visit has taken place be considered for mitigation. For example, the student was hospitalised and unable to notify us of absence on the day of the visit.

If students or the practice are not ready to start the assessment visit on time, visits can be started late, provided at least one hour of the allotted time remains. However, only the tasks that can be completed in full, in the remaining allowed time, will be assessed.

Students who do not present themselves for the assessment visit will be considered to have failed unless there are documented and approved exceptional circumstances relating to lateness or absence.

Students who have a valid reason for absence must provide this, together with appropriate evidence, by email to education.admin@college-optometrtsists.org. Notification of absence must take place as soon as possible, ideally before the visit is due to start. If evidence is provided after the visit, the reason for delay must also be evidenced.

Failing and re-sitting

At the assessment visit, the Assessor will log a Pass or Fail result for each task.

Where a task consists of a number of sub-tasks, the student will need to pass all the sub-tasks to pass that task. In the event that they fail any sub-task, they would need to take and pass the entire task again.

If a student passes a number of tasks in the visit but fails others, they will only need to take and pass the tasks which they failed again.

Whether the result for each task is Pass or Fail, the Assessor will be able to write comments to give the student feedback.

The Assessor’s judgement is final and the College will not accept challenges made on the basis that the student does not agree with the assessment decision.

If the result for any task is a Fail, the Assessor will identify the GOC outcome, bullet-point indicator or SPOKE indicative guidance point which the student did not meet. Free-text commentary will also be recorded.

Students will be given two attempts at completing each task. Where a student fails a task, the College will usually arrange a separate assessment visit within the following weeks for the student to attempt it again. The only exception to this in CLiP 1R, in which some outcomes are assessed again at the CLiP 1F visit. As such, if a student fails any part of CLiP 1R Task 3, they do not need to re-take these elements as the outcomes are tested again at CLIP 1F.

If any task has not been successfully completed by the end of CLiP 1 or CLiP 2, then that part of CLiP must be repeated in full, to ensure time and experience to consolidate and improve the relevant clinical skills.

The student will be allowed one more attempt to complete the CLiP Part in full. If they fail any tasks on this second attempt at the whole part, they will be given the opportunity to attempt each task again a second time if required.

As a result, the maximum number of times any task can be attempted is four, provided no exceptional circumstances are taken into account.

Preparing to resit tasks

Students who need to resit elements of an assessment will have a new visit date arranged and will need to re-sit the failed task(s) only.

Provided the Assessor did not give specific feedback on the logbook entry used for the task, the same logbook entry or entries can be used for the resit. If a student uses the same logbook entry, the corresponding patient records **must not** be amended or changed.

If feedback was given to change or replace a logbook interaction, the student can do this and a supervisor will need to confirm and approve prior to the resit.

Exceptional circumstances

Where a task, visit or missed submission deadline is subject to approved exceptional circumstances, that element will be postponed and rescheduled, without penalty, to a date set by the College in the light of the circumstances.

Should the circumstances prevent progress or attendance over a prolonged period, such that the student will be unable to:

a) accrue 22 weeks patient-facing activity before the start of CLiP Part 2; or
b) accrue 44 weeks of patient-facing activity before the end of CLiP Part 2; or
c) be unable to complete CLiP Part 1 assessment within the 22 weeks; or
d) be unable to complete CLiP Part 2 assessment before the end of their placement;

…then they may be required to restart the relevant section of CLiP (1 or 2) at the next start point. Typically, this would apply for circumstances that last more than three weeks total, depending on other leave taken.

No additional fees will be charged for this, and the College will support students to find an alternative placement if their employer is unable to extend the placement period.

Applications for exceptional circumstances

Exceptional circumstances postponements will only be awarded in response to an application made to the College, with supporting evidence, sent to education.admin@college-optometrtsists.org. Where supporting evidence will be available at a later date, this must be indicated. Prolonged or complex exceptional circumstances will require more substantial evidence of impact and may also require University approval and trigger other support processes.

The following table shows a non-exhaustive list of potential exceptional circumstances and forms of evidence that might be provided, alongside some examples of circumstances that would not qualify as exceptional:

Exceptional circumstances

Circumstance	Examples that would normally be approved	Evidence	Examples that would not normally be approved
Ill health, including mental health	Illness that would warrant not attending work	Formal letter or document from a health professional	Claims for illness after the visit has taken place
Bereavement	Loss of close family member	Death certificate or funeral arrangements Employer-approved compassionate leave	Loss of a distant relative, unless evidence is provided of impact such as caring responsibilities for of from the student
Caring responsibilities	Serious injury or illness in a close family member such as parent, spouse, partner, sibling or child	Medical records	Expected childcare responsibilities such as school holidays. Caring for family members with minor illness such as coughs and colds
Pregnancy and maternity	Serious complications in pregnancy or maternity	Medical records	Being pregnant with no complications (although students may apply for reasonable adjustments)
Job loss / Placement disruption	Redundancy, or long-term /permanent closure of practice Loss of access to practice records	Employment termination records Employer-provided evidence	Misconduct or other termination reasons.
Leave	Maternity, paternity, adoption or compassionate leave	Employer records of maternity, adoption or compassionate leave	Holidays
Assessment disrupted	Fire alarm, mystery patient sickness, assessor prevented from attending, unavoidable practice closure	Assessor report	Minor interruptions of less than five minutes

Reasonable adjustments

Reasonable adjustments approved by the student's University will be applied to CLiP assessments as follows:

Approved Adjustment	Assessment	Application to CLiP
Extra time	Visit	Visit will be extended by percentage required. However, clinical tasks which are conducted so slowly, in the view of the assessor, as to cause the patient risk or discomfort will be failed, even if completed within the extended time period.
Extra time	Service evaluation project submission dates	These must be completed by the visit date. The visit will be scheduled for the last week of the allotted (three-week) window.
Breaks	Visit	Rest breaks as specified will be provided.
Use of one eye for retinoscopy (e.g. for Amblyopia)	Visit – Direct observation tasks	Will be permitted but must use recognised technique (e.g. Barrett) to good effect.

All other adjustments will be implemented in the light of discussions between the College and the University Link Tutor.

Where workplace adjustments have been provided by the employer for students with disabilities, or with relevant temporary conditions, these will normally be permitted during the face-to-face assessment. These must be notified at the start of CLiP, or as soon as requested by the student, to the College. Where there is any question that such adjustments would impact the validity of outcome or conduct of assessments, the student's University will determine what is acceptable for use in CLiP.

Where concerns remain on either side that performance standards may be impacted through implementation of any specific adjustment, or equality legislation may be breached if not enacted, the GOC will be approached for final decision.

Appeals

Students who believe that an administrative mistake has been made by the College should contact clip@college-optometrists.org as soon as possible to ask for it to be rectified. Students must follow the appeals process of their own University in relation to any other concerns about the outcome of CLiP assessments.

Misconduct during assessment

Where professional or academic misconduct is suspected or identified during assessment, the Assessor will report, including available evidence, to the College. The College will notify the University, and the Lead Assessor will instigate further investigation and provide the outcome to the University for decision.

Fitness to train

On receipt of evidence that indicates that the student's fitness-to-train may be impaired, the College will inform the University for action. Where the impairment may present an immediate concern for the welfare of the student, patients, colleagues or others the College will take such action as is deemed appropriate to protect those involved.

Understanding the assessment information

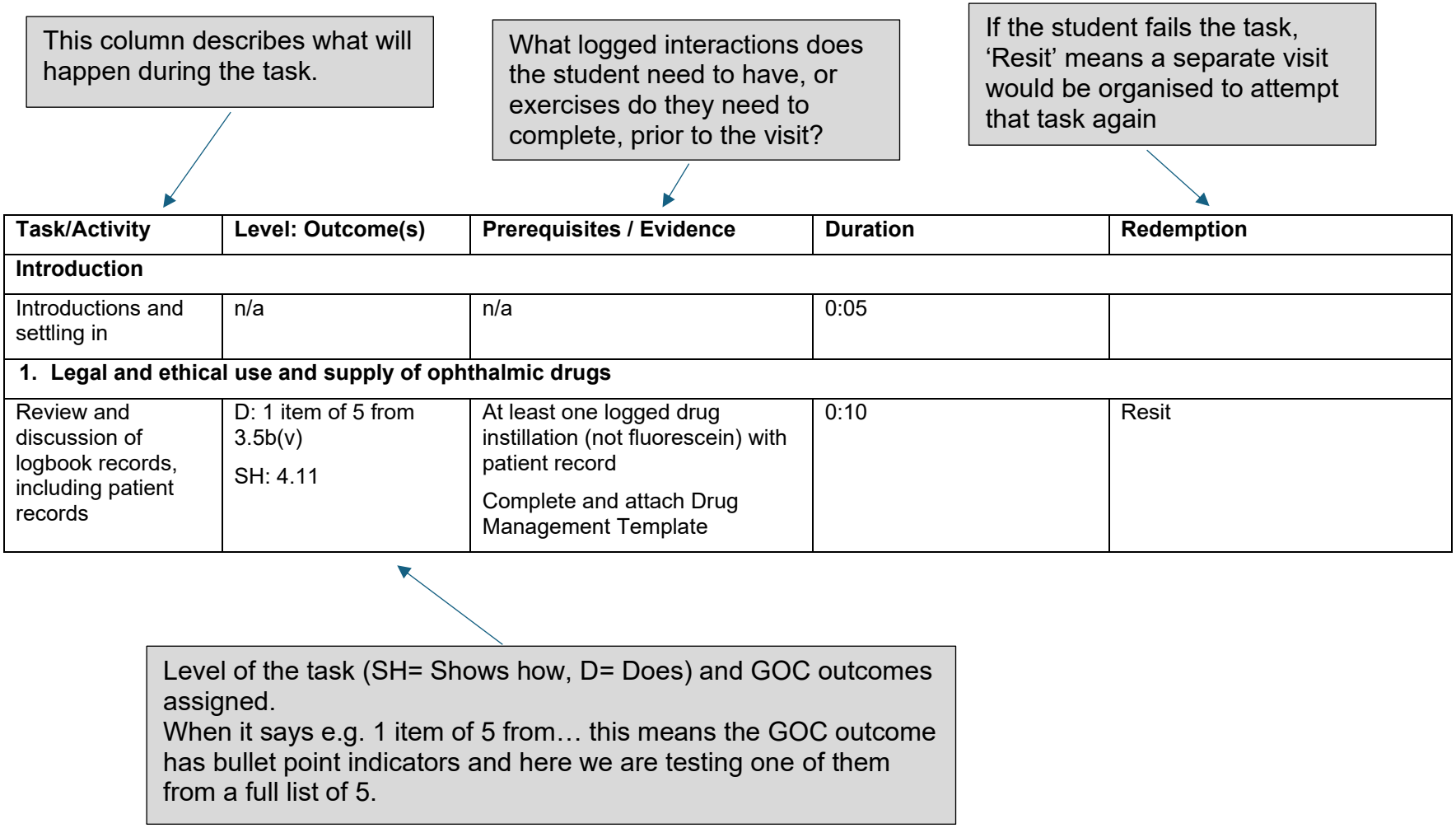
Information for each visit

This Handbook contains a separate section for each of the four visits. The sections are divided into:

- Summary page: outlines the timing of the visit, the tasks and where the student is expected to be in terms of their risk profile and dashboard.
- Task prerequisites and timing: the table shows the prerequisite tasks the student needs to complete or the number and type of logbook entries they need to make available in advance of the visit. It also details the time for each task and the re-sit opportunity.
- Instructions, learning outcomes and marking criteria: a short narrative section summarises the nature of each task. The table shows the learning outcomes and SPOKE indicative guidance associated with each task and sub-task, alongside the marking criteria.

This is the only guidance which contains marking criteria and, as such, we do suggest that students and Supervisors refer to the sections below in advance of each visit. However, we recommend that they start with the **Student guidance** for assessment visits which you can find on our Assessment visits pages.

Using the ‘Task prerequisites and timing’ tables



Task/Activity	Level: Outcome(s)	Prerequisites / Evidence	Duration	Redemption
Introduction				
Introductions and settling in	n/a	n/a	0:05	
1. Legal and ethical use and supply of ophthalmic drugs				
Review and discussion of logbook records, including patient records	D: 1 item of 5 from 3.5b(v) SH: 4.11	At least one logged drug instillation (not fluorescein) with patient record Complete and attach Drug Management Template	0:10	Resit

Level of the task (SH= Shows how, D= Does) and GOC outcomes assigned.
When it says e.g. 1 item of 5 from… this means the GOC outcome has bullet point indicators and here we are testing one of them from a full list of 5.

Using the learning outcome and marking criteria tables

The GOC outcomes being assessed in this task, with level, together with any of the bullet point indicators being tested.

SPOKE indicative guidance is often absent for Section 3 Clinical practice outcomes, which have extensive bullet point indicators.

Some tables include some text in bold font and the meaning of this this is explained in the narrative above each table.

GOC Outcome	**SPOKE indicative guidance**	**Indicative success criteria**	**Example failing performance**
From 3.4 Analyses visual function from a range of diagnostic sources [~~*and uses data to devise a clinical management plan for a patient*~~] in areas that include the following: • Refractive management • Anterior eye and contact lenses (DOES)	Applies normative data in the interpretation of results of visual function tests. Uses clinical data to formulate a management plan across a range of ocular conditions. Analyses clinical data in the light of presenting signs and symptoms. Demonstrates effective management across the specified range of patients	Develops rapport with patient Ensures consent is established and maintained Uses required range of appropriate techniques effectively	Failure to establish and maintain consent Inappropriate or unsafe use of equipment Hurts the patient by hitting/poking them with equipment or pulling hard on eye structures

Where text is bracketed and struck out, that element is being tested in another task.

Assessors will use these criteria to determine whether the student has met the standard required.

Other guidance and documentation

We have produced guidance for students about each visit, complete with a logbook checklist which shows exactly what they need to record in their logbook to meet the prerequisites. Supervisors or other colleagues may find this guidance helpful as a simpler introduction than this Handbook content. However, the student guidance does not include the full marking criteria set out in the sections below. It can be found on our CLiP web pages.

CLiP Part 1 remote visit (CLiP 1R)

Summary

When: Approximately 9-12 weeks from starting the CLiP placement

Where: Online, in practice or at another location

Duration: 2 hours

Task outline

The visit will consist of five overarching tasks:

1. Legal and ethical use and supply of ophthalmic drugs
2. Health and safety legislation
3. Patient relationships
    a. Consent
    b. Patient care (privacy, dignity, equality, inclusivity)
    c. Communication skills
    d. Information management
4. Service Evaluation Project (project orientation)
5. Quality assurance of setting and supervision (for support purposes)

Student risk profile

We expect all low and medium interaction items (except visual needs) should be amber by the time of this assessment visit. High risk items and the medium risk 'Visual needs' items can be red. If there are some red items at the time of the visit, this should be included in the 'Quality assurance of setting and supervision' discussion with the Assessor.

Task prerequisites and timing

Task/Activity	Miller's Level: GOC Outcome(s)	Prerequisites / Evidence	Duration	Redemption
Introduction				
Introductions and settling in	n/a	n/a	0:05	
1. Legal and ethical use and supply of ophthalmic drugs				
Review and discussion of logbook records, including in-practice patient records	D: 1 item of 5 from 3.5b(v) SH: 4.11	At least **one** logged drug instillation (not fluorescein) with anonymised in-practice patient record to be presented, but not uploaded to the Portal Complete and attach Drug Management Template	0:15	Resit
2. Health and safety legislation				
Student presentation	SH: 4.8	Presentation uploaded to the Portal and used to deliver presentation to Assessor: guide time 5 minutes, max. 7, then follow-up questions and discussion. Identifies and explains risks, mitigation and reporting procedures for each of **five** different categories of potential hazard in own practice: fire, hygiene, physical (trip/falling etc), chemical, electrical. One slide per category, 2 examples/images per slide	0:10	Resit
3. Patient relationships (1 hour total, to be split across the sub tasks)				
a. Consent – review and discussion of logbook records	SH: 1.6, 4.4	At least **one** logged interaction linked to outcome 1.6 and at least **one** linked to 4.4 for **each** of: • Adult • Under 12 • Vulnerable • Carer present with attached policies (safeguarding, chaperone etc) where applicable The same logbook entries may be used more than once but with no more than two learning outcomes per entry.	Indicative 0:15	CLiP 1F

b. Patient care (privacy, dignity, equality, inclusivity) – review and discussion of logbook records	SH: 1.3, 1.5, 4.9	At least **two** logged interactions for **each** outcome, linked to 1.3, 1.5 and 4.9 (six total), uploading policies where relevant. No more than two learning outcomes per entry.	Indicative 0:15	CLiP 1F
c. Communication skills – review and discussion of logbook records in relation to communication with patients and other healthcare professionals, including review of anonymised in-practice patient record involving a referral	SH: 2.1	At least **two** logged interactions linked to outcome 2.1, for **each** of: • Adult patient • Patient under 12 • Supervisor • Another colleague • External professional (at least one of these two logged interactions must include the anonymised record of a referral to be presented, but not uploaded to the Portal). The same records may be used more than once but no more than two learning outcomes per entry.	Indicative 0:20	CLiP 1F
d. Information management – review and discussion of logbook records, including patient records	SH: 4.12	**Five** logbook entries with interactions linked to outcome 4.12 with redacted patient records to be presented, but not uploaded to the Portal, and attached policies (safeguarding, chaperone etc) where applicable. NOTE: logbook entries used for other GOC Outcomes can be used here, but no more than two learning outcomes per entry.	Indicative 0:10	CLiP 1F
4. Service Evaluation Project (project orientation)				
Project orientation	D: 7.1, 7.4	Completed Service Evaluation Project planning tool	0.15	n/a
5. Quality assurance of setting and supervision (for support purposes)				
QA survey	n/a	Completed QA survey (student)	0.15	n/a

Instructions, learning outcomes and marking criteria

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Task 3 – Patient relationships – total time 1 hour 50
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3b. Patient care (privacy, dignity, equality, inclusivity) (Indicative: 15 minutes) 51
3c. Communication skills (Indicative: 20 minutes) 53
3d. Information management (Indicative: 10 minutes) 54
Task 4 – Service Evaluation Project (project orientation) (15 minutes) 55
Task 5 – Quality assurance of setting and supervision (15 minutes) 57

Task 1 – Legal and ethical use and supply of ophthalmic drugs (15 minutes)

The student will be questioned about at least one interaction in which a drug has been used (student must have patient record available to share on screen), exploring processes and protocols used by the student to ensure legal compliance and safe, appropriate use.

GOC Outcome	SPOKE indicative guidance	Evidence	Indicative success criteria	Example failing performance
From 3.5b(v) Adheres to legal requirements for the use and supply of common ophthalmic drugs. • Uses common ophthalmic drugs, safely to facilitate optometric examination and the diagnosis / treatment of ocular disease. (DOES)	See GOC Outcome column, left, for bullet point indicators. (There is no SPOKE indicative guidance here because the GOC clinical learning outcomes (Section 3) include indicators expressed as bullet points).	Logbook and patient record (not uploaded to the CLiP Portal but ready to present)	Uses appropriate drug (could list, P, GSL and POM), explains indication(s) for use and observes guidance for use of POMs.	Uses POM when not appropriate (e.g. occ. 1% chloro) Doesn't adhere to College Guidance for Professional Practice (GfPP)
4.11 Adheres to the ethical principles for prescribing and to legislation relating to medicines management. (SHOWS HOW)	Applies the regulations regarding the use, storage, and disposal of ophthalmic drugs used in ophthalmic practice. Respects the limitations in prescribing and treating yourself and others close to you. Shows how to report incidents of adverse reactions to medical devices or medicines using the appropriate reporting schemes. Maintains appropriate knowledge regarding the drugs administered in the practice, especially contraindications and side effects, and understands how to access the relevant information relating to the medicines used.	Drug Management Template	Observes relevant sections of College GfPP Awareness of Yellow card scheme and Medical Devices reporting form. Understands the indications and contraindications for drug use and potential side effects. Understands and applies best practice in terms of the legal aspects of access, use and supply. Makes appropriate selection of drug/s and uses safely. Understands the indications/contraindications/legal aspects	Uses ophthalmic drugs without due care and attention to indications and potential side effects such as: • drug allergies • dilating without checking VH and IOPs

	Explains the requirement to register with the MHRA under specific circumstances, and identify the products regulated as class 1 medical devices. Takes appropriate measures when delegating the instillation of ophthalmic drugs		for use and supply of mydriatic/cycloplegic drugs.	

Task 2 – Health and safety legislation (10 minutes)

Over the course of a five-minute presentation, using slides, the student must identify and explain risks, mitigation and reporting procedures for each of five different categories of potential hazard in their own practice: fire, hygiene, physical (trips/falls or other), chemical, electrical. The presentation should include one slide for each category, with two examples with images on each slide. The student will have worked from the presentation assessment brief.

The student must include images in the presentation which show them in their practice and consulting room – they need to be able to demonstrate that images used are recent and their own work. The Assessor will ask checking questions at the end to cover any areas that require additional evidence.

GOC Outcome	SPOKE indicative guidance	Evidence	Indicative success criteria	Example failing performance
4.8 Complies with health and safety legislation. (SHOWS HOW)	Applies current health and safety legislation and professional body guidance to their practice environment. Demonstrates appropriate infection control procedures. Considers both personal and environmental hygiene when dealing with patients and colleagues.	Presentation (5 mins)	Adequate presentation and ability to respond to questions on a sample of topics. Knowledge of reporting procedures. Demonstrates a proactive approach to Health and Safety issues such as identifying hazards, risk assessment, first aid, etc., in order to produce a safe environment for staff and patients alike. Demonstrates appropriate approach to personal hygiene, cleanliness of the practice, hygiene relating to instrumentation, contact lenses, disposal of clinical waste, etc. Infection control: College Guidance	Incorrect/outdated information Missing and/or ambiguous information Evidence of basic lack of awareness or engagement with health and safety responsibilities

Task 3 – Patient relationships – total time 1 hour

3a. Consent (Indicative: 15 minutes)

The student will provide, in advance of the visit, logbook evidence of interactions in which they needed to obtain consent, including an adult, a child under 12 and a vulnerable patient or interaction with carer present. The Assessor will lead a conversation exploring the student's understanding of the relevant policies and how they apply them in practice.

GOC Outcome	SPOKE indicative guidance	Evidence	Indicative success criteria	Example failing performance
1.6 Obtains and verifies continuation of valid consent from adults, children, young and vulnerable people and their carers and records as appropriate. (SHOWS HOW)	Adheres to legal requirements when gaining consent. Applies the various policies that a practice is required to have on display or on file including safeguarding children and adults, chaperone policy, complaints and data management.	Logbook (1.6)	Obtain valid consent before examining a patient, providing treatment or involving patients. For consent to be valid it must be given: • Voluntarily. • By the patient or someone authorised to act on the patient's behalf. • By a person with the capacity to consent. • By an appropriately informed person. Aware of GOC Guidance and standards 3.1 and 3.3 Ensure that the patient's consent remains valid at each stage of the examination or treatment and during any research in which they are participating.	Unable to explain the need for consent, when consent is required or how to obtain it Doesn't understand capacity to consent Does not understand difference between implied and explicit consent Displays lack of knowledge of policy, or fails to follow correctly.
4.4 Applies the relevant national law and takes appropriate actions i) to gain consent and ii) if consent cannot	Evaluates the appropriateness of different types of consent to clinical tests, dispensing, delegated functions, triage and release of information. Applies the principles of consent to clinical situations and evaluates situations when implied and implicit consent are required, including appropriate recording.	Logbook (4.4)	Applies principles of 1.6 to specific clinical scenarios/situations. Is aware of National Law requirements, in the student's jurisdiction, in relation to mental capacity Can explain implications of power of attorney (or equivalent in the student's jurisdiction)	Incorrect application of law and guidance

be obtained or is withdrawn. (SHOWS HOW)	Establishes if a patient has the capacity to consent and if they are unable to consent, who is able to give consent on their behalf. Recognises that lack of capacity to consent may be temporary or may be withdrawn, describe examples of these situations and the actions that should be taken. Applies the current legislation on data protection, confidentiality, and consent with respect to sharing information with patient's relatives or carers. Is able to explain clinical tests and referrals, together with the risk and benefits in a way the patient is able to understand in order to obtain informed consent. Reflects on different situations from the student's own practice regarding consent.		Awareness of relevant sections of College GfPP (Consent) Gillick competence Follows policy across specified range of patient characteristics	

3b. Patient care (privacy, dignity, equality, inclusivity) (Indicative: 15 minutes)

Assessor instructions

The Assessor and student will discuss the logbook entries and attached policies, focussing on each outcome as they talk through the logged interactions. One or more examples may be evaluated per outcome.

GOC Outcome	SPOKE indicative guidance	Evidence	Indicative success criteria	Example Warning Flags
1.3 Protects patients' rights; respects the choices they make and their right to dignity and privacy. (SHOWS HOW)	Follows relevant frameworks	Logbook (1.3)	Describes appropriate patient interaction(s) to assessor. Is aware of relevant associated legislation.	Inappropriate interaction selection and/or inappropriate action.

1.5 Commits to care that is not compromised because of own personal conscious and unconscious values and beliefs (SHOWS HOW)	Develops an awareness of differing values and belief structures and seeks to care inclusively, with attention to the potential impact of own beliefs on patient care.	Logbook (1.5)	Describes appropriate patient interaction(s) to assessor. Is aware of relevant associated legislation. Follows points listed in SPOKE indicative guidance column	Inappropriate interaction selection and/or inappropriate action.
4.9 Complies with equality and human rights' legislation, demonstrates inclusion and respects diversity. (SHOWS HOW)	Acts in line with equality and human rights legislation in the context of patient care and the workplace. Demonstrates compassionate and professional behaviour, delivers patient centred care and an inclusive and fair approach towards patients and colleagues. Recognises the potential impact of their own attitudes, values, beliefs, perceptions and bias (conscious and unconscious) on individuals and groups and identifies personal strategies to mitigate this. Appreciates the importance of handling sensitive personal information and responding to any information divulged by the patient in a sensitive and unbiased fashion. Maintains confidentiality and respects an individual's dignity. Gives consideration to any equality, diversity and fairness issues from the outset when assessing a patient, particularly for groups of people who share protected characteristics.	Logbook (4.9)	Describes appropriate patient interaction(s) to assessor. Is aware of relevant associated legislation. Follows points listed in SPOKE indicative guidance column	Inappropriate interaction selection and/or inappropriate action.

3c. Communication skills (Indicative: 20 minutes)

Assessor instructions

The student and Assessor will discuss the examples of logged interactions demonstrating communication skills. The Assessor will suggest alternative scenarios and audiences and ask the student to demonstrate how they would manage the communication in those situations. The student will be asked to respond to at least three situations, to address effectiveness at handling different audiences, content, sensitivities and situations. They will also need to evidence methods for assuring they understand the patient, including accommodating to additional needs.

If the student fails to communicate clearly in the initial scenarios the assessor will ask for their reflections on this, and if the student can identify how to address shortfalls (further scenarios can be used for confirmation) this is acceptable to pass at the 'Shows how' level.

The uploaded written referral is discussed with reference to accuracy, completeness and appropriate use of technical language. Again, the student will be given the opportunity to offer solutions where shortcomings are identified.

GOC Outcome	SPOKE indicative guidance	Evidence	Indicative success criteria	Example failing performance
2.1 Conducts communications in a sensitive and supportive manner adapting their communication approach and style to meet the needs of patients, carers, health and care colleagues and the public. (SHOWS HOW)	Demonstrates effective communication using verbal, non-verbal, and written skills. Seeks and communicates relevant information from and to patients in an effective and appropriate manner. Ensures the effective implementation of individual management plans, checking patient understanding by actively adapting their communication approach.	Logbook (2.1)	Deploys verbal and non-verbal skills Modifies language and communication style appropriately for different audiences – responding to cues and summarising and reiterating as necessary Acknowledges patient concerns and is empathetic and but not patronising. Reassures the patient where appropriate. Checks the patient has understood the information provided. Makes the patient aware of all options available to them, if necessary, supplementing with written materials to aid comprehension.	Lacks confidence and/or is very hesitant and/or illogical to the point where the patient would lose confidence in the practitioner. Speech difficult to comprehend. Unprofessional/overly casual. Wrong level of technical language for audience.

			Employs a patient-centred approach to understand the patient's perspective. Produces, clear, accurate and comprehensive written information using technical language correctly, when communicating with other professionals.	Inappropriate language and communication style for the patient. Incorrect or unsafe information provided Frightens unnecessarily and/or confuses the patient.

3d. Information management (Indicative: 10 minutes)

The Assessor will review at least two of the five in-practice patient records, and policies where available, and discuss these with the student. If there are any omissions, errors, or examples of lack of clarity, these will be explored to determine if the student is able to recognise what needs to be improved. In such cases, students will be encouraged to explain how they will change their future record-keeping practice to meet good practice expectations and ensure compliance with policies, to demonstrate achievement at 'Shows how' level.

GOC Outcome	SPOKE indicative guidance	Evidence	Indicative success criteria	Example failing performance
4.12 Complies with legal, professional and ethical requirements for the management of information in all forms including the accuracy and appropriateness of patient records and respecting patient confidentiality. (SHOWS HOW)	Keeps clear, accurate, and contemporaneous records, understanding the GOC's and professional bodies' advice and guidance in relation to record keeping. Produces records which are accessible, and contain all relevant patient details and history, measurements and details of assessment findings, consent obtained, referrals made, and advice. Ensures that records contain the name of any staff undertaking delegated tasks/functions. Demonstrates a systematic understanding of the principles of data protection and freedom	Logbook (4.12)	Knowledge of GDPR requirements (Data Protection Act 2018). Knowledge of relevant Subject Access Request protocols. Logbook completed at least weekly (i.e. no more than 7 days from appointment to log) Case history shows full exploration of symptoms. Results from key tests recorded. Management/advice fully recorded.	Unsound knowledge of key legislation Logbook maintenance does not meet requirements Omissions from case history e.g. full exploration of symptoms, responses to key questions not recorded.

	of information legislation in relation to the use and disclosure of health data. Grants, where appropriate, a patient's Right to Access their health data, and demonstrates a detailed knowledge of the Subject Access Request (SAR) protocols relevant to ophthalmic practice.		Practice policies used effectively.	Results from key tests not recorded. Management/advice given not recorded. Practice policies poorly understood or not used correctly.

Task 4 – Service Evaluation Project (project orientation) (15 minutes)

The purpose of the task is to ensure that the student has understood the requirements of the Service Evaluation Project and has a plan for completing each of the required elements. The plan should include milestones, with deadlines, and some initial ideas about how the work will be properly connected to the student's own practice.

This is a formative task so will not be assessed with a Pass/Fail outcome. However, the Assessor will refer to the learning outcomes during the discussion, to foster development towards self-led Personal Development Planning.

GOC Outcome	SPOKE indicative guidance	Evidence	Indicative success criteria	Feedback Points
7.1 Evaluates, identifies, and meets own learning and development needs. (DOES)	Analyses and responds to own learning and development needs. Prepares and follows a personal development plan, utilising appropriate learning opportunities.	Service Evaluation Project planning tool	All sections completed Plans well connected to setting and practice Clear understanding of requirements Reference to external frameworks/evidence base/peer-reviewed literature	Any missing sections Plans that indicate lack of understanding of task Evidence of copy/paste or AI approach Use of unevidenced source material
7.4 Engages in critical reflection on their own development, with a focus on learning from experience, using data from a range of information sources (such as clinical audits, patient feedback, peer review and significant event analysis)	Assesses own learning needs and engages in self-directed learning to maximise potential and improve outcomes. Critically reflects on own practice, and participates in multi-disciplinary service and team evaluation formulating and implementing strategies to act on learning and make improvements.			

and identifying and addressing their new learning needs to improve the quality and outcomes of patient care. (DOES)	Actively engages in peer review to inform own practice, formulating and implementing strategies to act on learning and make improvements. Demonstrates how audit can contribute to improvement in the quality and/or efficiency of patient care.			

Task 5 – Quality assurance of setting and supervision (15 minutes)

The student's answers to the QA questionnaire will be discussed, with signposting to further information and support if required. The Assessor will raise a concern with the College team for action if there are concerns which cannot be addressed at the visit. If the student has not met the expected risk profile in the summary dashboard for this stage of the placement, the Assessor should ensure there is a plan in place to address this.

This task is for support purposes and will not be assessed with a Pass/Fail outcome.

CLiP Part 1 face-to-face visit (CLiP 1F)

Summary

When: Approximately 18-20 weeks from starting the CLiP placement

Where: In the student's practice

Duration: 3 and a half hours (with an additional 15 minutes for Assessor to carry out patient consultation)

Task outline

The visit will consist of nine overarching tasks:

1. Clinical examination fundamentals
    a. History and symptoms
    b. Clinical examination
    c. Management plan
    d. Record keeping
    e. Health and safety including infection control
    f. Clinical decision-making
2. Dispense and verification
    a. Dispensing
    b. Verification
3. Communication and consent
4. Patient care
5. Safety and risk
6. Diagnosis and decision-making
7. Record-keeping
8. Service Evaluation Project (submission and verification)
9. Quality assurance of setting and supervision (for support purposes)

Student risk profile

All interaction items are expected to be amber or green. If any are red this does not prevent the assessment visit from going ahead, but the student and Assessor should discuss any red items as part of the 'Quality assurance of setting and supervision' discussion.

Task prerequisites and timing

Task/Activity	Miller's Level: GOC Outcome(s)	Prerequisites / Evidence	Duration	Redemption
Introduction				
Introductions and settling in	n/a	n/a	0:05	n/a
1. Clinical examination fundamentals				
a. History and symptoms – observation	D: 1.1, 1.2	No task-specific documentary evidence Pre-presbyope or presbyope contact lens wearing patient will be provided by the College Direct observation will be used as evidence	1:20	Resit
b. Clinical examination – observation i. CL over refraction ii. Evaluation of lens in situ iii. Subjective and objective refraction iv. Slit lamp examination (external eye and related structures) (must include staining) v. Indirect ophthalmoscopy vi. Pupil assessment vii. Binocular vision	D: 2 items of 9 from 3.4, 4.4, 1.6			
c. Management plan, inc. CL Spec/aftercare, and any additional tests – observation	D: 2 items of 9 from 3.4, 2 items of 11 from 3.5b(ii) and outcome 2.1			
d. Record-keeping – observation	D: 4.12			
e. Health and safety including infection control – observation	D: 4.8, 5.5			
f. Clinical decision-making – observation and discussion	D: 3.1, 5.7	No task-specific documentary evidence.	0:15	

2. Dispense and verification				
a. Dispensing – observation: dispensing advice, measurements and fitting on a simulated patient provided by the practice	D: 1 item of 9 from 3.4, and 1 item of 11 from 3.5b(ii)	No task-specific documentary evidence. A practice colleague (not another student) should be available to act as the patient.	0:15	Resit
b. Verification – observation	D: 1 item of 11 from 3.5b(ii)	No task-specific documentary evidence.	0:05	Resit
3. Communication and consent				
Discussion based on logbook records, seeking evidence of consistent good practice across a range of interactions to supplement the observation. Students will be asked to show in-practice patient records to supplement this discussion.	D: 1.1, 1.2, 1.6, 2.1, 1 item of 4 from 3.5b(i) and outcome 4.4	At least **three** logged interactions for outcomes 1.1, 1.2, 1.6, 2.1 and 4.4 (no more than two outcomes to be used per entry). Must include examples of the following, with history, examination and management, including consent: • patient with carer • patient with difficulty communicating • child under 7 years old • significant family history • significant social/cultural factor Student needs to have corresponding in-practice patient records ready and available to view.	0:15	Resit
4. Patient care (privacy, dignity, equality, inclusivity)				
Discussion based on logbook entries, seeking evidence of consistent good practice across a range of interactions to supplement the observation. Students will be asked to show in-practice patient records to	D: 1.3, 1.5 and 4.9	At least three logged interactions for outcomes 1.3, 1.5 and 4.9 (no more than two outcomes to be used per entry). Student needs to have corresponding in-practice patient records ready and available to view.	0:10	Resit

supplement this discussion.				
5. Safety and risk				
Discussion based on logbook entries, seeking evidence of consistent good practice across a range of interactions to supplement the observation. Students will be asked to show in-practice patient records to supplement this discussion.	D: 4.8, 5.5 and 5.7	At least three logged interactions for outcomes 4.8, 5.5 and 5.7 (no more than two outcomes to be used per entry). Student needs to have the corresponding in-practice patient records ready and available to view.	0:10	Resit
6. Diagnosis and decision-making				
Discussion based on logbook entries, seeking evidence of consistent good practice across a range of interactions to supplement the observation. Students will be asked to show in-practice patient records to supplement this discussion.	D: 3.1, 2 items of 9 from 3.4 and 4 items of 11 from 3.5b(ii)	All low and medium categories (except visual needs) must be green in the summary risk profile and a sample of these will be reviewed. At least five logbook entries with contact lens interactions. To include: • 3 entries in which the student undertakes application and removal • a replaceable lens where a CL aftercare has been carried out and an adjustment has been made to the specification (not power alone) • a toric fitting • a multifocal fitting • A CL teach that includes a care regime Student needs to have the corresponding in-practice patient records ready and available to view.	0:25	Resit
7. Record-keeping				
Discussion based on logbook entries, seeking evidence of consistent good practice across a range of interactions to supplement the observation.	D: 4.12	No specific examples – assessors will observe the approach to record management displayed during the assessment visit.	n/a	Resit – 15 minutes, can be remote visit

Students will be asked to show in-practice patient records to supplement this discussion.				
8. Service Evaluation Project				
Project verification	D: 7.1 and 7.4	Final draft Service Evaluation Project workbook with all sections completed	0:15	n/a
9. Quality assurance of setting and supervision (for support purposes)				
Discussion of student experience	n/a	QA surveys (student and Supervisor)	0:15	n/a

Instructions, learning outcomes and marking criteria

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Task 1 – Clinical examination fundamentals (1 hour and 35 minutes)

Note: 1 hour and 20 minutes to complete the clinical examination with the patient and an additional 15 minute discussion with the Assessor for Task f 'Clinical decision-making'

A 'mystery shopper' patient will be arranged who is pre-presbyope, or presbyope, and a contact lens wearer. The patient will have a specified ocular health and prescription range. Prior to the assessment start, the Assessor will need to review the mystery shopper questionnaire (Rx, history etc.) and conduct SLE for basic ocular health. 15 minutes should be allowed as part of the visit for this activity.

The evidence for this task will be directly observed at the assessment visit, with the student completing a record template rather then creating a record in the practice system. The student will need to successfully complete and pass each sub-task because some of the learning outcomes can only be met across multiple sub-tasks. If the student makes minor mistakes or omissions during the 'clinical examination' in Task 1b, the Assessor may use additional scenario-based questions, to determine whether the student meets the competence standards.

Contact lens elements of Task 1 will be carried out on one eye only.

The parts of outcomes which cannot be assessed by direct observation (such as handling carers in 1.1) will be addressed during the record review tasks 3 – 6.

At this stage, the student's techniques should be in place and correctly performed, but may not yet be fully refined. Where the student is uncertain during the clinical examination, it may be appropriate for them to recognise the need to consult with a Supervisor. It is more important for the student to recognise the limits of their capability than to be fully independent.

1a. History and symptoms

GOC Outcome	SPOKE indicative guidance	Indicative success criteria	Example failing performance
1.1 Actively listens to patients and their carers to ensure patients are involved in and are at the heart of decisions made about patient's care. (DOES)	Effectively communicates with patients and carers to obtain all relevant history and symptoms using a combination of verbal, non-verbal, and written skills. Actively seeks confirmation of patient understanding and involves patient in decisions made regarding their own healthcare.	Asks appropriate questions to obtain a full history. This includes the following: • RFV, vision and symptoms • OH and FOH • GH, medication and FGH • symptom check • driving • lifestyle/ work • CL history and current wear habits • smoker Asks appropriate follow on questions when appropriate. Uses appropriate strategies to understand patients' needs e.g. not interrupting, summarising and checking understanding Maintains a friendly and professional communication style throughout	Omits to question any of the following categories (and can be verified by clarification): • general health • ocular health • medication • family history • lifestyle / work Does not ask any follow-on questions related to symptoms if indicated and/or fails to illicit correct information Does not ask regarding other symptoms. This may include not asking about: • Headaches • Flashes and floaters • Diplopia • Pain • Redness Interrupts on numerous occasions or does not check patient understanding coupled with poor communication techniques Demonstrates a rude, poor or patronising questioning technique
1.2 Manages desired health outcomes of patients, taking into consideration any relevant medical, family and social history of the patient, which may include personal beliefs or cultural factors. (DOES)	Recognises the importance and significance of family history, signs, and symptoms. Recognises patients' physical, emotional, intellectual, and cultural background and adapts care and communication appropriately. Adheres to relevant aspects of the Equalities Act.		

1b. Clinical examination

GOC Outcome	SPOKE indicative guidance	Indicative success criteria	Example failing performance
From 3.4 Analyses visual function from a range of diagnostic sources [~~*and uses data to devise a clinical management plan for a patient*~~] in areas that include the following: • Refractive management • Anterior eye and contact lenses (DOES)	Applies normative data in the interpretation of results of visual function tests. Uses clinical data to formulate a management plan across a range of ocular conditions. Analyses clinical data in the light of presenting signs and symptoms. Demonstrates effective management across the specified range of patients	Develops rapport with patient Ensures consent is established and maintained Uses required range of appropriate techniques effectively	Failure to establish and maintain consent Inappropriate or unsafe use of equipment Hurts the patient by hitting/poking them with equipment or pulling hard on eye structures
1.6 Obtains and verifies continuation of valid consent from adults, children, young and vulnerable people and their carers and records as appropriate. (DOES)	Adheres to legal requirements when gaining consent. Applies the various policies that a practice is required to have on display or on file including safeguarding children and adults, chaperone policy, complaints and data management.	**i. Contact lens over refraction** Accurately assesses vision with the contact lenses and makes any necessary adjustment **ii. Evaluation of lens in situ** Is able to correctly assess the fit of lens using a variety of techniques Assesses the condition of the lens	**i. Contact lens over refraction** Does not carry out over refraction or uses inappropriate technique **ii. Evaluation of lens in situ** Inaccurate assessment of fit/condition of lens Fails to evaluate fit or assess condition of the lens
4.4 Applies the relevant national law and takes appropriate actions i) to gain consent and ii) if consent cannot be obtained or is withdrawn. (DOES)	Evaluates the appropriateness of different types of consent to clinical tests, dispensing, delegated functions, triage and release of information. Applies the principles of consent to clinical situations and evaluates	**iii. Subjective and objective refraction** Fits trial frame appropriately including pd measurement and maintains throughout Static fixation retinoscopy correctly undertaken, or if a student prefers or needs to use one eye only then they must use a valid and appropriate technique for	**iii. Subjective and objective refraction** Unable to maintain fit of trial frame appropriately Does not use an appropriate retinoscopy technique

GOC Outcome	SPOKE indicative guidance	Indicative success criteria	Example failing performance
	situations when implied and implicit consent are required, including appropriate recording. Establishes if a patient has the capacity to consent and if they are unable to consent, who is able to give consent on their behalf. Recognises that lack of capacity to consent may be temporary or may be withdrawn, describe examples of these situations and the actions that should be taken. Applies the current legislation on data protection, confidentiality, and consent with respect to sharing information with patient's relatives or carers. Is able to explain clinical tests and referrals, together with the risk and benefits in a way the patient is able to understand in order to obtain informed consent. Reflects on different situations from the student's own practice regarding consent.	monocular viewing e.g. Barrett Method or Near Fixation retinoscopy. Uses appropriate methods of checking e.g. +1.00Ds blur or use of pinhole **iv. Slit lamp examination** Must include staining Demonstrates a full slit-lamp routine for the assessment of the external eye and related structures in a logical sequence. Examines: • the external eye and adnexa • lids • lashes • Anterior Chamber Angle Uses a range of illumination techniques, appropriate brightness and magnification Chooses appropriate instrumentation and uses correct and safe methods to assess tear quantity and quality Demonstrates a safe technique Detects significant lesions **v. Indirect ophthalmoscopy** Uses a technique which allows an appropriate view of the fundus, including thorough & systematic scanning in all 9 positions of gaze	Illogical subjective technique Fails to ask appropriate questions and act appropriately on response to establish correct Rx. Fails to demonstrate adequate control of accommodation **iv. Slit lamp examination** Fails to stain (despite a prompt) or does not detect, identify or record significant corneal staining when present Fails to view the external eye in four positions of gaze in both eyes Fails to detect, identify or record a significant abnormality Fails to examine the tear film or chooses an unsafe, incorrect or inappropriate method to assess the tear film Omits elements **v. Indirect ophthalmoscopy** Does not use an appropriate technique to view the fundus Fails to view fundi in the nine positions of gaze in both eyes Fails to view lens and media

GOC Outcome	SPOKE indicative guidance	Indicative success criteria	Example failing performance
		vi. Pupil assessment Uses appropriate technique with correct ambient Illumination and light source to assess pupil reactions **vii.Binocular vision** Undertakes objective tests (including cover) using suitable targets, and assessing deviation accurately to include: • direction of latent or manifest deviation • speed of recovery • size • concomitant/incomitant Undertakes subjective tests using suitable targets, as appropriate to patient including motility	**vi. Pupil assessment** Fails to assess pupils appropriately or incorrectly records pupil findings **vii. Binocular vision** Fails to perform cover test Incorrect technique when performing cover test, in either the target chosen or cover technique Not interpreting the movement seen on cover test correctly Incorrect interpretation of any tests chosen Fails to perform motility or uses a very poor technique that would not identify incomitance

1c. Management plan

GOC Outcome	SPOKE indicative guidance	Indicative success criteria	Example failing performance
From 3.5b(ii) Completes an informed clinical assessment of individual patients' need and uses this to dispense, fit and advise on the safe and effective use of spectacles, contact lenses, low-vision aids and other ophthalmic appliances. • Identifies, recommends and fits soft or rigid contact lens as appropriate to support and enhance individual patients' vision, lifestyle and eye health and provides ongoing care.	See GOC Outcome column, left, for bullet point indicators. (There is no SPOKE indicative guidance here because the GOC clinical learning outcomes (Section 3) include indicators expressed as bullet points).	Uses the clinical data obtained from the clinical examination and the presenting symptoms of the patient to formulate an appropriate management plan. Understands the relationship between vision and Rx and symptoms and Rx through making an appropriate prescribing and management decisions based on the refractive and oculomotor status Gives factually relevant information in a clear and understandable way, avoiding jargon and technical terminology.	Makes inappropriate prescribing and management decision Gives the patient incorrect or misleading information and persists in using jargon and technical terminology
• Instructs and advises patients in handling soft or rigid lens as appropriate, and how to wear and care for their fitted lenses. (DOES)		**i. Contact lens specification** Writes an appropriate specification for appropriate soft lens following aftercare	**i. Contact lens specification** Inappropriate choice of soft lens parameters Poor understanding of the range of soft lens materials and designs available. Fails to make an appropriate choice of lens design and materials for the patient. Note, patient choice and lens availability should be taken into account.
		ii. Contact lens aftercare Makes appropriate adjustment of the lens to result in the best fit if required Demonstrates an understanding of soft lens adaptation and aftercare issues and how to manage them i.e. providing advice:	**ii. Contact lens aftercare** Fails to adjust the lens if appropriate to do so Fails to provide advice on one or more of the following:

GOC Outcome	SPOKE indicative guidance	Indicative success criteria	Example failing performance
		• addressing presenting complaint, communicating cause and remedy of complaint including action to be taken and review date. • advise need of any other examination if not up-to-date e.g. next eye exam etc. • complying with appropriate lens handling, care regimes and hygiene requirements throughout • advise on the management of common CL complications	• Complying with appropriate lens handling, care regimes and hygiene requirements throughout • Advise on the management of common CL complications if needed Provides advice that is confusing or inaccurate Fails to advise the patient of any other examination required if not up- to-date e.g. next eye exam etc. Provides advice to the patient that would be considered dangerous
From 3.4 [~~*Analyses visual function from a range of diagnostic sources and*~~]-uses data to devise a clinical management plan for a patient in areas that include the following: • Refractive management • Anterior eye and contact lenses (DOES)	Applies normative data in the interpretation of results of visual function tests. Uses clinical data to formulate a management plan across a range of ocular conditions. Analyses clinical data in the light of presenting signs and symptoms. Demonstrates effective management across the specified range of patients	**iii. Advice and additional tests** Understands limitations of knowledge, referring patients for advice when necessary Maintains a professional and friendly communication style throughout Recognises and documents need for any further clinical investigations such as visual fields, IOPs	**iii. Advice and additional tests** Fails to refer the patient if necessary Fails to identify the need for further investigations.
2.1 Conducts communications in a sensitive and supportive manner adapting their communication approach and style to meet the needs of patients, carers, health and care colleagues and the public. (DOES)	Demonstrates effective communication using verbal, non-verbal, and written skills. Seeks and communicates relevant information from and to patients in an effective and appropriate manner. Ensures the effective implementation of individual management plans, checking patient understanding by		

GOC Outcome	SPOKE indicative guidance	Indicative success criteria	Example failing performance
	actively adapting their communication approach		

1d. Record keeping

GOC Outcome	SPOKE indicative guidance	Indicative success criteria	Example failing performance
4.12 Complies with legal, professional and ethical requirements for the management of information in all forms including the accuracy and appropriateness of patient records and respecting patient confidentiality. (DOES)	Keeps clear, accurate, and contemporaneous records, understanding the GOC's and professional bodies' advice and guidance in relation to record keeping. Produces records which are accessible, and contain all relevant patient details and history, measurements and details of assessment findings, consent obtained, referrals made, and advice. Ensures that records contain the name of any staff undertaking delegated tasks/functions. Demonstrates a systematic understanding of the principles of data protection and freedom of information legislation in relation to the use and disclosure of health data. Grants, where appropriate, a patient's Right to Access their health data, and demonstrates a detailed knowledge of the Subject Access Request (SAR) protocols relevant to ophthalmic practice.	Fully and accurately records all the information related to the patient regarding findings and management plan. Is able to produce records which are legible and contain all relevant patient details, measurements, results and advice.	Fails to accurately and fully record the advice and management plan Have not recorded details of several tests performed Recorded results of tests which were not carried out Records information that was not given to the patient

1e. Health and safety including infection control

GOC Outcome	SPOKE indicative guidance	Indicative success criteria	Example failing performance
4.8 Complies with health and safety legislation. (DOES)	Applies current health and safety legislation and professional body guidance to their practice environment. Demonstrates appropriate infection control procedures. Considers both personal and environmental hygiene when dealing with patients and colleagues.	Consistently demonstrates appropriate infection control relating to instrumentation and own hand hygiene Safe disposal of clinical waste	Poor hygiene demonstrated consistently Poor infection control potentially impacting patient safety Safety of patient compromised requiring assessor intervention
5.5 Applies infection prevention control measures commensurate with the risks identified. (DOES)	Safely applies appropriate measures to minimise risk of infection, applying relevant current guidance. Identifies risk of person-to-person transmission and transmission via object. Identifies appropriate measures to minimise risk of infection, including: hand hygiene, surface disinfection, use of PPE, use of disposable items, (e.g. tonometer heads), where possible, decontamination of tonometer heads/diagnostic contact lenses etc., proper treatment of open bottles of contact lens solutions/saline. Uses appropriate methods to deal with disposal of controlled, clinical and offensive waste, including both non-hazardous and hazardous waste. Carries out a risk assessment, applying appropriate principles.		

1f. Clinical decision-making

NOTE: 15 minutes allotted for this task following the 1 hour and 20 minute clinical examination.

Discussion of a-e above, covering decision-making, ensuring awareness of minor failings, and approach to improving practice.

GOC Outcome	SPOKE indicative guidance	Indicative success criteria	Example failing performance
3.1 Undertakes safe and appropriate ocular examinations using appropriate techniques and procedures to inform clinical decision-making within individual scope of practice. (DOES)	Justifies the choice of clinical procedures used on appropriate techniques for clinical investigations. Has an awareness of own limitations to conduct clinical examinations, and work within limits of competence. Appraises the risk balance of clinical techniques used to examine patients. Ensures patient and practitioner safety during all clinical processes and procedures.	Able to explain decision-making and contextualise in light of relevant frameworks, tasks undertaken, and patient needs.	Unclear about or unable to articulate purpose of tasks undertaken, or meaning of results obtained
5.7 Able to risk assess i) patient's clinical condition and ii) a situation in clinical practice and make appropriate clinical decisions. (DOES)	Uses a range of established techniques to initiate and undertake critical analysis of information, and to propose solutions to problems arising from that analysis Applies knowledge of the subject and techniques in a routine manner to evaluate and formulate management plans and solutions to problems and issues in clinical practice. Applies underlying concepts and principles outside the context in which they were first studied and applies symptom-appropriate tests.	Integrates risk management into clinical decision making Reflects on own performance, identifies areas for improvement, suggesting actions that could be taken to improve practice.	Fails to consider impact of decision-making on patient. Unable to identify mistakes when prompted. Unable to formulate actions to improve practice.

GOC Outcome	SPOKE indicative guidance	Indicative success criteria	Example failing performance
	Understands and applies the principles of clinical reasoning and evidence-based practice and the steps in problem solving.		

Task 2 – Dispense and verification

2a. Dispensing (15 minutes)

The student will advise, measure and fit a practice colleague (but not another student) for spectacles, using a prescription and scenario supplied by the Assessor. The evidence for this task is direct observation throughout.

GOC Outcome	SPOKE indicative guidance	Indicative success criteria	Example failing performance
From 3.4 Analyses visual function from a range of diagnostic sources and uses data to devise a clinical management plan for a patient in areas that include the following: • Dispensing of optical appliances (DOES)	See GOC Outcome column, left, for bullet point indicators. (There is no SPOKE indicative guidance here because the GOC clinical learning outcomes (Section 3) include indicators expressed as bullet points).	Demonstrates knowledge of lens characteristics including lens form, design, materials, coatings and tints, availability and blank sizes. Makes appropriate frame choice by considering the following: size, materials, and relationship between frame, lenses and face. Can discuss appropriate frame adjustments	Insufficient knowledge of lenses to advise patient Insufficient knowledge of frames available or frame fitting
From 3.5b (ii) Completes an informed clinical assessment of individual patients' need and uses this to dispense, fit and advise on the safe and effective use of spectacles, contact lenses, low-vision aids and other ophthalmic appliances.	See GOC Outcome column, left, for bullet point indicators. (There is no SPOKE indicative guidance here because the GOC clinical learning outcomes (Section 3)		

• Interprets and dispenses a prescription using appropriate lenses, frame choice and accurate facial and frame measurements (DOES)	include indicators expressed as bullet points).		

2b. Verification (5 minutes)

The Assessor will provide a pair of progressive addition spectacles, together with an appropriate template, for verification of one lens only. Evidence is direct observation throughout.

GOC Outcome	SPOKE indicative guidance	Indicative success criteria	Example failing performance
From 3.5b (ii) Completes an informed clinical assessment of individual patients' need and uses this to dispense, fit and advise on the safe and effective use of spectacles, contact lenses, low-vision aids and other ophthalmic appliances. • Measures and verifies optical appliances in line with relevant standards, guidelines and evidence (DOES)	See GOC Outcome column, left, for bullet point indicators. (There is no SPOKE indicative guidance here because the GOC clinical learning outcomes (Section 3) include indicators expressed as bullet points).	Marks up, measures and verifies that a pair of lenses have been produced to a given prescription within BS tolerances. Accurate results to within: • ± 0.25DS/DC for dioptric measurements • Axis appropriate to cylinder power 0 ≤ 0.50DC ± 9° 0 > 0.50DC ≤ 0.75DC ± 6 ° 0> 0.75DC ≤ 1.50DC ± 4 ° 0 > 1.50DC ± 3 ° • Centres – 1mm tolerance. Must demonstrate a knowledge of actual tolerances.BS EN ISO 21987:2017. Verifies that all aspects of the frame or mount have been correctly supplied. Measures and verifies that the lenses are correctly positioned in the spectacle frame/mount within BS tolerances.	Inaccurate use of focimeter to verify lenses to British standards Unable to mark up lenses using template

		Choice of instrumentation could include: manual or semi-automated focimeter (Fully automated focimeter e.g. Eye refract VX40 is not acceptable)	

Note on Tasks 3 – 6

The purpose of tasks 3 to 6 is to determine that:

a. the student is able to demonstrate the connection between their clinical experience and the relevant GOC outcome(s);
b. the student is undertaking complete, accurate and appropriate record-keeping (where this is not the case, it would trigger a fail result in Task 7);
c. clinical experiences entered in the logbook were actually undertaken by the student, by requesting and reviewing samples of in-practice patient records.

This is in order to determine whether those outcomes have been fully met at 'Does' level, meaning that the student is carrying out the activities to the required standard consistently in their day-to-day practice. These tasks complement the direct observation undertaken in tasks 1 and 2.

For these tasks, the Assessor will use the assessment visit dashboard to select from a range of logbook entries linked to the relevant learning outcomes, and will discuss these with the student. They will be looking for evidence that the student is meeting these outcomes consistently in their daily practice. The Assessor is not restricted to the items the student has selected and may also use search terms or filters (such as 'carer' or 'disability') to look for evidence which has not been present in the direct observation.

Enquiry is used to establish that the student:

- Is able to empathise with patient's perspective, and identify how that might differ from own experiences and preferences.
- Actively considers the potential impact of different perspectives when formulating management plan
- Pays attention to overt and implied patient desires, acknowledges alternative perspectives, and their impact on patient management and care.
- Demonstrates awareness of, and actively addresses legal requirements
- Relevant frameworks may include: GDPR; safeguarding; Trust and practice data and patient management policies

The marking criteria for these tasks, which focus on the review of logbook entries and in-practice patient records, are different to other tasks in the CLiP assessment framework. The Assessor will not use the 'Indicative success criteria' and 'Example failing performance' columns for these tasks. The 'Evidence' of the range of records is the main indicative success criteria, and the

SPOKE indicators can also be used as indicators of the student passing each outcome. The significant absence of records or evidence of actions contrary to the SPOKE indicators could be examples of failing performance.

Task 3 – Communication and consent (15 minutes)

The Assessor and student will focus, for this task, on the items **marked in bold** in the table below. This is because some elements of the learning outcomes have already been assessed elsewhere in the CLiP assessment framework.

GOC Outcome	SPOKE indicative guidance	Evidence
1.1 Actively listens to patients and **their carers** to ensure patients are involved in and are at the heart of decisions made about patient's care. (DOES)	Effectively communicates with patients **and carers** to obtain all relevant history and symptoms using a combination of verbal, non-verbal, and written skills. Actively seeks confirmation of patient understanding and involves patient in decisions made regarding their own healthcare.	Logbook entries linked to learning outcomes: 1.1,1.2, 2.1, 1.6, 4.4 Must include enquiry into: Patients with range of needs as below (history, examination, management including consent) • carer • difficulty communicating • children under 7 years old • significant family history • significant social/cultural factor • capacity is not established • consent is withdrawn • managing sensitive information
1.2 Manages desired health outcomes of patients, taking into consideration any relevant medical, **family and social history of the patient**, which may include personal beliefs or **cultural factors.** (DOES)	Recognises the importance and significance of **family history, signs, and symptoms.** Recognises patients' **physical, emotional, intellectual, and cultural background and adapts** care and communication appropriately. Adheres to relevant aspects of the **Equalities Act.**	
2.1 Conducts communications in a sensitive and supportive manner **adapting their communication approach and style** to meet the needs of patients, carers, health and care colleagues and the public. (DOES)	Demonstrates effective communication using verbal, non-verbal, and written skills. Seeks and communicates relevant information from and to patients in an effective and appropriate manner. Ensures the effective implementation of individual management plans, checking patient understanding by actively adapting their communication approach.	
From 3.5b (i) Acts as a first point of contact for patients for their eye health needs by investigating, diagnosing and managing individuals' functional and developmental visual conditions, including those related to age. • **Takes a relevant history from [*~~individual patients and~~*] any other**	See GOC Outcome column, left, for bullet point indicators. (There is no SPOKE indicative guidance here because the GOC clinical learning outcomes (Section 3) include indicators expressed as bullet points).	

appropriate person involved in their care (relatives/carers and others). (DOES)		
1.6 Obtains and verifies continuation of valid consent from **adults, children, young and vulnerable people and their carers** and records as appropriate. (DOES)	Adheres to legal requirements when gaining consent. Applies the various policies that a practice is required to have on display or on file including safeguarding children and adults, chaperone policy, complaints and data management.	
4.4 Applies the relevant national law and takes appropriate actions i) to gain consent and ii) **if consent cannot be obtained or is withdrawn.** (DOES)	Evaluates the appropriateness **of different types of consent** to clinical tests, dispensing, delegated functions, triage and release of information. Applies the principles of consent to clinical situations and evaluates situations when implied and implicit consent are required, including appropriate recording. **Establishes if a patient has the capacity to consent and if they are unable to consent, who is able to give consent on their behalf.** **Recognises that lack of capacity to consent may be temporary or may be withdrawn, describe examples of these situations and the actions that should be taken.** **Applies the current legislation on data protection, confidentiality, and consent with respect to sharing information with patient's relatives or carers.** **Is able to explain clinical tests and referrals, together with the risk and benefits in a way the patient is able to understand in order to obtain informed consent.** **Reflects on different situations from the student's own practice regarding consent.** **Appreciates the importance of handling sensitive personal information and responding to any information divulged by the patient in a sensitive and unbiased fashion. Maintains confidentiality and respects an individual's dignity.** **Gives consideration to any equality, diversity and fairness issues from the outset when assessing a patient, particularly for groups of people who share protected characteristics**	

Task 4 – Patient care (privacy, dignity, equality, inclusivity) (10 minutes)

GOC Outcome	SPOKE indicative guidance	Evidence
1.3 Protects patients' rights; respects the choices they make and their right to dignity and privacy. (DOES)	Follows relevant frameworks	Logbook entries with Interactions linked to learning outcomes 1.3,1.5 and 4.9, together with commentary which explains why the Interaction addresses the learning outcome.
1.5 Commits to care that is not compromised because of own personal conscious and unconscious values and beliefs (DOES)	Develops an awareness of differing values and belief structures and seeks to care inclusively, with attention to the potential impact of own beliefs on patient care.	
4.9 Complies with equality and human rights' legislation, demonstrates inclusion and respects diversity (DOES)	Acts in line with equality and human rights legislation in the context of patient care and the workplace. Demonstrates compassionate and professional behaviour, delivers patient centred care and an inclusive and fair approach towards patients and colleagues. Recognises the potential impact of their own attitudes, values, beliefs, perceptions and bias (conscious and unconscious) on individuals and groups and identifies personal strategies to mitigate this.	

Task 5 – Safety and risk (10 minutes)

GOC Outcome	SPOKE indicative guidance	Evidence
4.8 Complies with health and safety legislation. (DOES)	Applies current health and safety legislation and professional body guidance to their practice environment. Demonstrates appropriate infection control procedures. Considers both personal and environmental hygiene when dealing with patients and colleagues.	Logbook entries with interactions linked to 4.8, 5.5 and 5.7, together with commentary explaining why the Interaction addresses the learning outcome.
5.5 Applies infection prevention control measures commensurate with the risks identified. (DOES)	Safely applies appropriate measures to minimise risk of infection, applying relevant current guidance. Identifies risk of person-to-person transmission and transmission via object. Identifies appropriate measures to minimise risk of infection, including: hand hygiene, surface disinfection, use of PPE, use of disposable items, (e.g. tonometer heads), where possible, decontamination of tonometer heads/diagnostic contact lenses etc., proper treatment of open bottles of contact lens solutions/saline. Uses appropriate methods to deal with disposal of controlled, clinical and offensive waste, including both non-hazardous and hazardous waste. Carries out a risk assessment, applying appropriate principles.	
5.7 Able to risk assess i) patient's clinical condition and ii) a situation in clinical practice and make appropriate clinical decisions. (DOES)	Uses a range of established techniques to initiate and undertake critical analysis of information, and to propose solutions to problems arising from that analysis Applies knowledge of the subject and techniques in a routine manner to evaluate and formulate management plans and solutions to problems and issues in clinical practice. Applies underlying concepts and principles outside the context in which they were first studied and applies symptom-appropriate tests. Understands and applies the principles of clinical reasoning and evidence-based practice and the steps in problem solving.	

Task 6 – Diagnosis and decision-making (25 minutes)

GOC Outcome	SPOKE indicative guidance	Evidence
3.1 Undertakes safe and appropriate ocular examinations using appropriate techniques and procedures to inform clinical decision-making within individual scope of practice. (DOES)	Justifies the choice of clinical procedures used on appropriate techniques for clinical investigations. Has an awareness of own limitations to conduct clinical examinations, and work within limits of competence. Appraises the risk balance of clinical techniques used to examine patients. Ensures patient and practitioner safety during all clinical processes and procedures.	Assessor to review a minimum of **three** logbook entries covering a range of pathology and further investigative techniques (selecting from logbook drop-downs), with a focus on decision-making. Must include records where further investigations have been made to diagnose and manage ocular pathology. Approach to limits of scope of practice to be explored (may include logbook interactions which included 'Referral – consult')
From 3.4 Analyses visual function from a range of diagnostic sources and uses data to devise a clinical management plan for a patient in areas that include the following: • Dispensing of optical appliances • Refractive management (DOES)	Applies normative data in the interpretation of results of visual function tests. Uses clinical data to formulate a management plan across a range of ocular conditions. Analyses clinical data in the light of presenting signs and symptoms. Demonstrates effective management across the specified range of patients.	Assessor to review a minimum of **five** logbook entries covering a range of prescription and dispense interactions. Must include where refraction routine, and/or dispense has been adapted depending upon individual circumstances such as amblyopia, visual impairment, age, physical characteristics, lifestyle or personal preference.
From 3.5b(ii) Completes an informed clinical assessment of individual patients' need and uses this to dispense, fit and advise on the safe and effective use of spectacles, contact lenses, low-vision aids and other ophthalmic appliances. • Interprets and dispenses a prescription using appropriate	See GOC Outcome column, left, for bullet point indicators. (There is no SPOKE indicative guidance here because the GOC clinical learning outcomes (Section 3) include indicators expressed as bullet points).	

lenses, frame choice and accurate facial and frame measurements • Measures and verifies optical appliances in line with relevant standards, guidelines and evidence (DOES)		
From 3.5b(ii) Completes an informed clinical assessment of individual patients' need and uses this to dispense, fit and advise on the safe and effective use of spectacles, contact lenses, low-vision aids and other ophthalmic appliances. • Identifies, recommends and fits soft or rigid contact lens as appropriate to support and enhance individual patients' vision, lifestyle and eye health and provides ongoing care. • Instructs and advises patients in handling soft or rigid lens as appropriate, and how to wear and care for their fitted lenses. (DOES)	There is no SPOKE indicative guidance here because the GOC clinical learning outcomes (Section 3) include indicators expressed as bullet points – see GOC outcome column for bullet point indicators.	Assessor to review at least **five** logbook entries with contact lens interactions. To include: • **Three** entries in which the student undertakes application and removal • A replaceable lens where a CL aftercare has been carried out and an adjustment has been made to the specification (not power alone) • A toric fitting • A multifocal fitting • A contact lens teach that includes a care regime Student needs to have the corresponding in-practice patient records ready and available to view.

Task 7 – Record-keeping (no additional time)

There is no specific activity for the Assessor to carry out with the student in Task 7; this is based on what the Assessor has observed in tasks 3 – 6.

GOC Outcome	SPOKE indicative guidance	Evidence
4.12 Complies with legal, professional and ethical requirements for the management of information in all forms including the accuracy and appropriateness of patient records and respecting patient confidentiality. (DOES)	Keeps clear, accurate, and contemporaneous records, understanding the GOC's and professional bodies' advice and guidance in relation to record keeping. Produces records which are accessible, and contain all relevant patient details and history, measurements and details of assessment findings, consent obtained, referrals made, and advice. Ensures that records contain the name of any staff undertaking delegated tasks/functions. Demonstrates a systematic understanding of the principles of data protection and freedom of information legislation in relation to the use and disclosure of health data. Grants, where appropriate, a patient's Right to Access their health data, and demonstrates a detailed knowledge of the Subject Access Request (SAR) protocols relevant to ophthalmic practice.	Overarching approach to records management displayed during assessment visit

Task 8 – Service Evaluation Project verification (15 minutes)

Using the submitted work as a guide, the student will give the Assessor a tour of the practice and/or information systems to explain and demonstrate the in-practice processes / pathways covered by the Service Evaluation Project (SEP). They also need to explain how the benchmarks and data were sourced and filtered. The Assessor will ask questions to verify the information provided.

The Assessor will not need to judge the quality of the student's project as part of this task, it is just about making sure that the information provided does relate to the practice where the student is working and that the student has undertaken the auditing and data evaluation described. In line with the self-development and reflection learning outcomes linked to this task, the student is expected to reflect on the experience of developing the SEP as part of this verification exercise.

This is a verification activity so will not be assessed with a Pass/Fail outcome. However, any indication that the work is not wholly that of the student, or that the material presented is not genuine will trigger further investigative processes.

GOC Outcome	SPOKE indicative guidance	Example positive verification markers	Example markers of concern
7.1 Evaluates, identifies, and meets own learning and development needs. (DOES)	Analyses and responds to own learning and development needs. Prepares and follows a personal development plan, utilising appropriate learning opportunities.	Student provides a narrative on the development of the work. For each section of the final SEP project workbook, student can describe how practice systems have influenced their findings. Student is able to explain their thinking for each section of SEP.	Report or narrative do not appear to be specific to student clinical practice and placement setting. Student is unable to explain content from the report.
7.4 Engages in critical reflection on their own development, with a focus on learning from experience, using data from a range of information sources (such as clinical audits, patient feedback, peer review and significant event analysis) and identifying and addressing their new learning needs to improve	Assesses own learning needs and engages in self-directed learning to maximise potential and improve outcomes. Critically reflects on own practice, and participates in multi-disciplinary service and team evaluation formulating and implementing strategies to act on learning and make improvements. Actively engages in peer review to inform own practice, formulating and implementing		

the quality and outcomes of patient care. (DOES)	strategies to act on learning and make improvements. Demonstrates how audit can contribute to improvement in the quality and/or efficiency of patient care.		

Task 9 – Quality assurance of setting and supervision (15 minutes)

Assessor instructions

Assessor will discuss (with each separately) the student's and the Supervisor's answers to the QA questionnaire and, where appropriate, signpost further information and support. The Assessor will be able to raise a concern with the College team for action if there are concerns which cannot be addressed at the assessment visit. If the student has not met the expected risk profile in the summary dashboard for this stage of the placement, the Assessor should ensure there is a plan in place to address this.

This task is for support purposes and will not be assessed with a Pass/Fail outcome.

CLiP Part 1 Service Evaluation Project

This section is not related to the CLiP 1F visit, but is included here to provide an overview of the Service Evaluation Project (SEP) as it will need to be submitted and externally marked at the end of CLiP 1.

The full instructions and templates for the Project are published separately on our Assessment visits pages.

SEP Summary

A service evaluation looks at how well a service is meeting its goals and aims to improve the experience for people using that health service. For this project, students need to carry out an enquiry-based audit that checks how the current service compares to the standards in the practice. For example, students could review how quickly patients are seen after referral or whether staff are following safety guidelines. They also suggest ways to make the service better, such as improving appointment scheduling or adding extra support for patients.

Each student will need to decide on their own focus for the project: it will help to identify a sub-set of patients, clinical activities, or conditions to study retrospectively. Students should think about what interests them in clinical practice, and what standards are associated with that area. This could be (for example) in one of the following areas:

- Referrals
- Dispensing
- Record Keeping
- Additional tests
- Recalls

The project will seek to find out if the practice is providing the appropriate service delivery that meets the standards associated with that service, and if that service can be improved in any way.

Preparing and submitting the project

Students are provided with a planning workbook and workbook template (including guiding questions and timelines) to guide them in developing an enquiry-led project. This leads them through the required areas they should cover, with a section of the workbook provided to write about each, including:

- evaluation of the current state of play (audit)
- opportunities for and risks of change
- proposals for value maximisation and risk mitigation

The Project will also include consideration of ways of improving patient experience and patient outcomes (Learning outcomes 6.1, 6.3, 7.3) through:

1. Personal and team behaviours (Learning Outcome 1.4)
2. New technology and services (LO 3.3)
3. Practice environment review and change (LO 1.4)
4. Referrals and navigation of commissioning frameworks (external environment) (LO 4.14)

The student will also consider what adaptations would be required for the proposed improvements to be applied in other environments.

In the CLiP 1F assessment visit, the Assessor will ask verification questions to ensure that the output is genuinely grounded in the practice and owned by the student. The final submission date for the written project will be the submission date for CLiP1F (one week in advance of the visit).

Following the visit, the work will be assessed by an assigned College marker and feedback will be provided. Work that does not meet the standard may be revised and re-submitted once only.

GOC Outcome	SPOKE indicative guidance
1.4 Ensures high quality care is delivered and puts into place adaptative measures as needed for different environments (such as domiciliary, prisons and special schools). (SHOWS HOW)	Adapts own practise to ensure appropriate care of all patients. Recognises when environmental factors should be adapted to accommodate individual patient needs.
3.3 Engages with technological advances in eye health and broader healthcare delivery and the significance of specific developments for enhancing patient outcomes and service delivery. (DOES)	Uses new technologies in diagnosis, treatment and management of ocular conditions. Uses appropriate technology in consultation, referral and clinical data exchange. Keeps abreast of emerging technologies and their potential application in clinical practice.
4.14 Applies eye health policies and guidance and utilises resources efficiently to improve patient outcomes. (DOES)	Demonstrates a working knowledge of shared care schemes, glaucoma triage, pre and -post- cataract referral schemes and other locally-commissioned Enhanced Optical Services (EOS). Refers patients appropriately to optometry-led triage services or secondary care to improve patient care and outcomes, whilst reducing unnecessary delays. Navigates service commissioning and care information effectively, in order to establish and refresh knowledge of local health and other relevant systems when changing location, and over time. Accesses public health information and campaigns (e.g. smoking cessation) for the benefit of patients. Takes account of national guidance e.g. NICE, the College of Optometrists Clinical Management Guidance. Appropriately distinguishes between patients who require referral and those who can be monitored effectively in practice.
6.1 Undertakes efficient, safe and effective patient and caseload management. (DOES)	Conducts responsibilities in a timely manner, prioritising urgent and important tasks to ensure safe practice. Acts in a responsible and considered way to ensure safe practice when services are under pressure.

	Applies best-practice techniques to promote own health and wellbeing in the workplace.
6.3 Engages with clinical governance requirements to safeguard and improve the quality of patient care, including through contributing to service evaluation and development initiatives. (KNOWS HOW)	Demonstrates a systematic understanding of the components of clinical governance. Recognises the need to adhere to local and national clinical governance guidelines. Evaluates own practice, and participates in multi-disciplinary service and team evaluation. Is able to articulate an understanding of the impact of own and team practice on service function, effectiveness, and quality.
7.3 Gathers, evaluates and applies effective patient and service delivery feedback to improve their practice. (SHOWS HOW)	Demonstrates a systematic understanding of how audit of clinical practice can improve clinical outcomes. Actively seeks and is open to feedback on own practice by colleagues to promote ongoing development. Undertakes effective reflection and analysis of feedback. Proactively formulates and implements strategies to act on feedback and make improvements to practice.

CLiP Part 2 remote visit (CLiP 2R)

Summary

When: Approximately 5 weeks from starting CLiP 2

Where: Online, in practice or at another location

Duration: 2 hours and 30 minutes

Task outline

The visit will consist of seven overarching tasks:

1. Low vision
2. Paediatrics and vulnerable patients
3. Non-tolerance and contact lens complications
4. Use of drugs to aid refraction and assessment of the fundus
5. Multidisciplinary collaboration, communication and leadership
    a. 360° review
    b. Coaching exercise
6. Personal Development Plan discussion (for support purposes)
7. Quality assurance of setting and supervision (for support purposes)

Student risk profile

All interaction items should be green, possibly with some amber in high-risk categories. Students **must** be green on low vision, paediatric, vulnerable, non-tolerance and use of drugs.

Task prerequisites and timing

Task/Activity	Miller's Level: GOC Outcome(s)	Prerequisites / Evidence	Duration	Redemption
1. Low vision				
Review and discussion of logbook entries, with in-practice patient records	D: 1 item of 9 from 3.4 and 4 items of 11 from 3.5b(ii)	At least **two** interactions (which include advice and at least **one** dispense of an LV aid) with patients with vision that meets the specified LV definition*, with anonymised patient records to be presented, but not uploaded to the Portal.	0:15	Resit
2. Paediatrics and vulnerable patients				
Review and discussion of logbook entries, with in-practice patient records	D: 2 items of 9 from 3.4, 1 item of 11 from 3.5b(ii) and outcome 4.15 SH: 4.3	At least **two** logged interactions for children aged 7 or under, including: • **One** aged 4 and under • **One** dispense for a child aged 4 or under • **One** with a BV anomaly that has been managed (which may include referral) by the student Each logbook interaction must include, in the 'Consultation notes' section, an explanation of how safeguarding might be handled if there were concerns about the patient during the consultation. Anonymised in-practice patient records for these patients to be presented, but not uploaded to the Portal. Uploaded certificate for Paediatric clinic online HES course with reflection. If possible, include a logged interaction and prepare anonymised record for patient under 2. At least **two** logged interactions of patients with disabilities, including: • At least one with a disability that impacts communication • At least one with a disability that impacts mobility Anonymised in-practice patient records to be presented, but not uploaded to the Portal.	0:45	Resit

3. Non-tolerance and contact lens complications				
Review and discussion of logbook entries, including in-practice patient records	D: 1 item of 11 from 3.5b(ii)	At least **three** logged interactions, including at least **one** example of each of the following circumstances: • Non-tolerance to new Rx due to dispensing issues • Non-tolerance to new Rx due (i) incorrect Rx issued to suit px needs or (ii) Other reasons • Symptomatic CL complications that require management Anonymised in-practice patient records to be presented, but not uploaded to the Portal.	0:20	Resit
4. Use of drugs to aid refraction and assessment of the fundus				
Review and discussion of logbook entries, including in-practice patient records	D: 4 items of 5 from 3.5b(v)	At least **three** logged interactions, with rationale for use, of at least one example of use of each of the following drug types: • Mydriatic • Cycloplegic • Local Anaesthetic Anonymised in-practice patient records to be presented, but not uploaded to the Portal.	0:10	Resit
5. Multidisciplinary collaboration, communication and leadership				
a. 360° Review – discussing reflections on feedback	D: 2.3 SH: 6.2	Completed 360° Review: With input from one patient, one Supervisor, one other colleague **One** logbook reflection outlining points for action or development.	0:15	Resit
b. Coaching exercise – simulated scenarios	D: 4.7 SH: 7.2	No task-specific documentary evidence. Direct observation and discussion will be used as evidence	0:15	Resit
6. Personal Development Plan discussion (for support purposes)				
Discussion and feedback on draft PDP	D: 7.1 and 7.4	Draft copy of Personal Development Plan	0:15	n/a
7. Quality assurance of setting and supervision (for support purposes)				
Discussion of student experience	n/a	Completed QA survey (student)	0:15	n/a

* A person with low vision is one who has an impairment of visual function for whom full remediation is not possible by conventional spectacles, contact lenses or medical intervention and which causes restriction in that person's everyday life. *Low Vision Services Consensus Group. A framework for low vision services in the United Kingdom*. London: Royal National Institute for the Blind, 1999. Both eyes

6/12 or worse (binocular) and/or N6 (with +4 dioptre reading addition) or severely restricted fields (that are consequence of clinical condition). WGOS

Instructions, learning outcomes and marking criteria

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Task 1 – Low vision (15 minutes)

The Assessor and student will discuss two logged interactions in which low vision aids have been advised. The assessor may also select other suitable logbook entries to support discussions, if required.

GOC Outcome	SPOKE indicative guidance	Evidence	Indicative success criteria	Example failing performance
From 3.4 Analyses visual function from a range of diagnostic sources and uses data to devise a clinical management plan for a patient in areas that include the following: • Low Vision/visual impairment (DOES)	Applies normative data in the interpretation of results of visual function tests. Uses clinical data to formulate a management plan across a range of ocular conditions. Analyses clinical data in the light of presenting signs and symptoms. Demonstrates effective management across the specified range of patients.	Logbook with LV patient entries	Assesses vision and adapts refraction routine depending on circumstances, for example, age, amblyopia, visual impairment. Knows when the use of specialist charts is beneficial to fully understand visual function and is able to interpret the results, differentiate normal from abnormal. eg Peli Robson and logMar Demonstrates ability to link clinical findings to the presenting problem and manage appropriately for patients with a range of ocular conditions that may cause visual impairment. e.g. maculopathy, retinitis pigmentosa, media opacities, severe visual field loss such as hemianopia, quadrantanopia, severe altitudinal loss or central scotoma Assesses visual function considering a range of relevant clinical findings such as acuity, visuals fields and binocular vision. Adapts refraction routine appropriately for each patient circumstance. e.g age, amblyopia, reduced acuity, field defect	Unable to interpret results e.g. not aware of how LogMar relates to Snellen acuity or unable to score LogMar. Unable to demonstrate appropriate management based on patient needs and clinical findings.
From 3.5b(ii) Completes an informed clinical assessment of individual patients' need and uses this to dispense, fit and advise on the safe and effective use of spectacles, contact lenses, low-vision aids and other ophthalmic appliances	See GOC Outcome column, left, for bullet point indicators. (There is no SPOKE indicative guidance here because the GOC clinical learning outcomes (Section 3) include indicators	Logbook with LV patient entries	Takes relevant history including social history and full task analysis to identify patient needs and visual requirements Conducts appropriate low vision assessment demonstrating adaptations to routine to accommodate the needs of patients with visual impairment Demonstrates understanding of principles of magnification, field of view and working distance in relation to different aids by dispensing appropriate low vision aid:	Fails to identify patients who could benefit from low vision aids Does not understand principles of magnification and the implications of this when advising and managing patients

• Identifies and advises patients who could benefit from simple or complex low-vision aids • Conducts a low-vision assessment, including through full history-taking and evaluation of visual requirements • Evaluates the clinical findings of low-vision assessments, applying knowledge of low-vision optics to dispense appropriate simple and complex low-vision aids and provide relevant advice • Advises on accessing and makes appropriate referrals to low-vision services, in line with patients' best interests (DOES)	expressed as bullet points).		- Justifies choice of aid including type of aid and magnification required - Discusses correct use of aid – to include correct WD, lighting, how to maximise FOV, spectacles required. - Records acuity with aid provided - Aware of other options available and aware of pros and cons Able to give additional advice to visually impaired patients including use of non-optical aids, use of contrast and lighting Aware of criteria and process for registration and certification Aware of how to access local and national low vision services and support including help from social services, low vision clinics and support groups	Unable to justify choice of low vision aid Inappropriately advises patient regarding suitable low vision aids e.g options available, magnification required, lighting Unable to advise patient correctly on the use of low vision aid No understanding of criteria and process for registration and certification No understanding of local low vision services and how to access these

Task 2 – Paediatrics and vulnerable patients (45 minutes)

In the discussion of logged interactions relating to outcomes 3.4, 3.5b(ii) and 4.15 the Assessor will discuss each of the entries with the student, referring to other logged interactions where required, and asking follow-up questions ("why…", "what if…") to explore understanding, rationale and the student's ownership of their decision-making.

In each case, the student should demonstrate they have maintained professional boundaries, made an informed clinical assessment of individual patients' needs and used a range of diagnostic sources, while formulating a clinical management plan – always adapting their approach to the specific needs of the patients in the light of the specified characteristics.

In the discussion of logged interactions relating to outcome 4.3, the Assessor will discuss the student's approach to, and ability to navigate mechanisms for, safeguarding.

GOC Outcome	SPOKE indicative guidance	Evidence	Indicative success criteria	Example failing performance
From 3.4 Analyses visual function from a range of diagnostic sources and uses data to devise a clinical management plan for a patient in areas that include the following: • Paediatrics • Patients with learning disabilities and complex needs (DOES)	Applies normative data in the interpretation of results of visual function tests. Uses clinical data to formulate a management plan across a range of ocular conditions. Analyses clinical data in the light of presenting signs and symptoms. Demonstrates effective management across the specified range of patients.	Logbook with paediatric, vulnerable and disability entries.	Asks appropriate questions during symptoms and history to identify risk factors and understands when there is a need to follow up on history given (e.g. onset and nature of diplopia). Adapts approach to identified needs of patient. Carries out appropriate clinical tests to investigate symptoms and/or presenting risk factors Demonstrates use of a range of assessment strategies according to the age and ability of the patient – including appropriate assessment of vision, OMB, stereopsis. Knows the expected norms for different ages and applies knowledge when interpreting results and managing paediatric patients including infants under 2 Understands the use of vision testing equipment for infants and non communicative	Fails to carry out appropriate clinical tests to investigate presenting symptoms Unable to choose appropriate testing strategies relevant to the patients age and ability Unable to adapt technique according to patient's capabilities Unaware how to establish full cycloplegia Makes inappropriate prescribing and/or management decisions

GOC Outcome	SPOKE indicative guidance	Evidence	Indicative success criteria	Example failing performance
			patients, for example, preferential looking, optokinetic nystagmus. Demonstrates an awareness of the need to be flexible in approach to examination, amending and adapting techniques and communication appropriately. Understands when cycloplegic examination is indicated and how to check it has had the desired effect on visual function Identifies and manages significant heterophoria, strabismus and amblyopia in children. Understands different types of management including refractive, orthoptic, prismatic and surgery. Considers OMB tests and symptoms when deciding on appropriate management. Demonstrates knowledge of referral processes and hospital waiting list times locally. Can discuss management of young Myopic patients (c/f College guidelines)	Fails to give adequate advice to young myopic patients
From 3.5b(ii) Completes an informed clinical assessment of individual patients' need and uses this to dispense, fit and advise on the safe and effective use of spectacles, contact lenses, low-vision aids and other ophthalmic appliances.	See GOC Outcome column, left, for bullet point indicators. (There is no SPOKE indicative guidance here because the GOC clinical learning outcomes (Section 3) include indicators expressed as bullet points).	Logbook with paediatric, vulnerable and disability entries.	Respects and cares for all patients and their carers in a caring, patient, sensitive and appropriate manner. Identifies patients with additional needs and adapts clinical assessment to meet individual needs Applies knowledge of the Disability and Equality Act (2010) and ensures the patient environment is safe, inviting and user- friendly in terms of access and facilities	Fails to adapt practice and decision -making to needs of specific patient characteristics (appropriate to GOC outcome) Fails to demonstrate appropriate frame or lens selection to suit patient needs/requirements

GOC Outcome	SPOKE indicative guidance	Evidence	Indicative success criteria	Example failing performance
• Manages and dispenses appropriate spectacles for paediatric patients and for patients with complex or additional needs, including by adapting the practice environment and practice activity in line with individuals' needs. (DOES)			Explains and justifies management options for different scenarios, allowing for specified patient characteristics e.g. What if px was hyperopic rather than myopic? What if px had mobility issues? What if frame chosen did not fit well? etc Able to advise on potential dispensing solutions to control myopia When appropriate, dispensing advice should be clearly recorded, and a range of dispensing options should have been considered to meet the patient's needs. Demonstrates understanding of dispensing frames covering the following: size, materials, relationship between frame, lenses and facial features. Demonstrates the appropriate lens and frame selection and justification (bearing in mind patient's age disability and lifestyle requirements) Dispenses a range of lens forms to include complex lenses and high corrections and advises on their application to specific patients' needs. Demonstrates appropriate frame adjustments to meet patient needs. If appropriate, discusses and dispenses contact lenses. Orders appropriate material and lens parameters. Gives adequate advice for safe contact lens wear with appropriate follow up	Fails to demonstrate appropriate contact lens knowledge to fit and manage patient needs/requirements

GOC Outcome	SPOKE indicative guidance	Evidence	Indicative success criteria	Example failing performance
4.15 Maintains professional boundaries with patients and others taking into consideration the additional needs of vulnerable people and specific requests/requirements. (DOES)	Recognises the boundaries between patient and clinician, both within and outside the workplace. Communicates appropriately with and respects the needs of vulnerable people and those with specific requests/requirements. Demonstrates interpersonal behaviours showing sensitivity to a range of physical, emotional, and protected characteristics in individuals. Maintains acceptable professional boundaries within the testing room and during an eye examination. Where appropriate, uses chaperones and adopts professional boundaries with children and vulnerable adults. Maintains a professional distance between the practitioner and the patient, understanding that using social media can blur personal and professional boundaries	Logbook with paediatric, vulnerable and disability entries.	Able to discuss boundaries between patient and clinician, and how to maintain these boundaries both within and outside the workplace Recognises emotion in patients and is able to respond to fears, anxieties and concerns in an empathetic way even when the outcome is not what the patient hoped for.	Fails to understand and/or maintain professional boundaries
4.3 Understands and implements relevant safeguarding procedures, local and national guidance in relation to children, persons with disabilities, and other vulnerable people. (SHOWS HOW)	Identifies and applies, where necessary, national safeguarding protocols relating to healthcare professionals working in primary or secondary care. Identifies and applies local protocols in place to support healthcare professionals in managing instances of safeguarding issues, such as: • Local safeguarding team's role in providing advice, training	Logbook (4.3)	Aware of national safeguarding protocols relating to healthcare professionals working in primary or secondary care. Aware of local protocols in place to support healthcare professionals in managing instances of safeguarding issues Can discuss common signs of maltreatment, abuse, and neglect of children and vulnerable adults.	Fails to implement relevant safeguarding procedures Fails to identify people that are at a higher risk of experiencing safeguarding issues

GOC Outcome	SPOKE indicative guidance	Evidence	Indicative success criteria	Example failing performance
	opportunities, and their contact details to the local healthcare professionals • Role of the 'designated' safeguarding doctor or nurse in the local area. Explains the common signs of maltreatment, abuse, and neglect of children and vulnerable adults. Recognises their responsibilities in ensuring the non-registered staff in their practice understand their responsibilities in relation to safeguarding. Demonstrates detailed knowledge of internal and external protocols regarding the recording and safe referral of safeguarding issues. Demonstrates an understanding of the groups of people that are at a higher risk of experiencing safeguarding issues, including but not limited to: 'Looked after children', elder abuse, domestic abuse, adults with learning disabilities. Explains the minimum requirements of an effective chaperone policy and its role in safeguarding children and vulnerable adults.		Explains internal and external protocols regarding the recording and safe referral of safeguarding issues.	

Task 3 – Non-tolerance and contact lens complications (20 minutes)

The assessor will review and discuss the logbook entries to explore the student's choices, investigations and actions taken to remedy each situation. The Assessor can ask follow-up questions and use other logged interactions if required.

GOC Outcome	SPOKE indicative guidance	Evidence	Indicative success criteria	Example failing performance
From 3.5b(ii) Completes an informed clinical assessment of individual patients' need and uses this to dispense, fit and advise on the safe and effective use of spectacles, contact lenses, low-vision aids and other ophthalmic appliances. • Manages cases of non-tolerance (DOES)	See GOC Outcome column, left, for bullet point indicators. (There is no SPOKE indicative guidance here because the GOC clinical learning outcomes (Section 3) include indicators expressed as bullet points).	Logbook with non-tolerance patient entries	Identifies and addresses the needs of the patient carrying out appropriate task analysis when a patient presents with suspected non tolerance Explores issues when problems occur by undertaking appropriate investigations Uses appropriate communication for all cases of non-tolerance e.g. explaining to patient suggested course of action and obtaining their agreement and arranging follow-up if necessary. Manages cases of non-tolerance to spectacles Manages cases of non-tolerance to contact lenses Understands possible causes of non-tolerance to low vision aids to ensure effective management should these present Demonstrates an understanding of the designs and materials available in Contact lenses including toric and multifocal contact lenses to be able to recognise when this may be the cause of non-tolerance Demonstrates an understanding of soft lens adaptation and aftercare issues and how to manage them by addressing the presenting complaint, communicating a cause and remedy including the action to be taken and review date. Gives advice on the management of common CL complications	Provides advice that is confusing or inaccurate Provides advice to the patient that would be considered unsafe CLs: fails to provide appropriate advice on the management of common CL complications Fails to address patient concerns

Task 4 – Use of drugs to aid refraction and assessment of the fundus (10 mins.)

The Assessor will review and discuss the drug entries in the student's logbook to explore the student's rationale and precautions for use, using follow-up questions and reference to other logged interactions where required.

GOC Outcome	SPOKE indicative guidance	Evidence	Indicative success criteria	Example failing performance
From 3.5b (v) Uses common ophthalmic drugs, safely to facilitate optometric examination and the diagnosis / treatment of ocular disease. • Appraises the appropriate use of common ocular drugs to aid refraction and assessment of the fundus • Obtains individual patients' informed consent to use common ophthalmic drugs to aid investigation, examination, diagnosis and treatment, including by advising on the potential side effects and associated risks of specific drugs • Administers common ocular drugs appropriately, effectively and judiciously, exercising caution to ensure patient safety. • Recognises the indications and contraindications of commonly-used ophthalmic drugs and responds in light of these to uphold patient care and safety (DOES)	See GOC Outcome column, left, for bullet point indicators. (There is no SPOKE indicative guidance here because the GOC clinical learning outcomes (Section 3) include indicators expressed as bullet points).	Logbook entries for drug instillations with anonymised in-practice patient record	Provides accurate records with all relevant drug details to include drug name and dose, patient consent and any advice given Uses all ocular drugs appropriately: - Can justify drug choice and aware of alternative options - Carries out appropriate checks before and after drug instillation - Safe instillation of drug used Understanding of mode of action of mydriatics, anaesthetics and cycloplegic drugs Can discuss contraindications and side effects of drug used and manage appropriately Can discuss legal aspects of access, use and supply	Incomplete record keeping Inappropriate use of chosen drug No understanding of mode of action of common ocular drugs Unaware of contraindications of common ocular drugs Unsafe management of contraindications and side effects Inappropriate supply of local anaesthetic

Task 5 – Multidisciplinary collaboration, communication and leadership

5a. 360° review (15 minutes)

In advance of the visit, colleagues and patients will be asked for feedback on the student by completing a form. In this task, the Assessor will explore the feedback with the student (and with one of the student's colleagues, for verification). The Assessor may present alternative scenarios and ask the student to demonstrate how they would respond. This will allow the Assessor to probe the student's ability to communicate and respond to feedback across different practice interactions. The purpose is not to measure performance based on the feedback of others, but to gauge how the student responds to it and reflects on their impact on team behaviours.

GOC Outcome	SPOKE indicative guidance	Evidence	Indicative success criteria	Example failing performance
2.3 Communicates effectively within a multi-disciplinary healthcare team and works collaboratively for the benefit of the patient. (DOES)	Recognises the diverse contributions of both clinical and non-clinical colleagues including those from other professions, and adapts own communication methods, style and content to ensure the delivery of effective patient care. Recognises the varying roles of other allied health and medical professionals and their contribution to person centred care.	360° review	Able to articulate the roles and relationships found in practice Values contributions and specialisms of different roles Has an awareness of the importance of team cohesion to patient experience	Unable to describe different contributions Not engaged with understanding wider contributions of different professions
6.2 Works collaboratively within healthcare teams, exercising skills and behaviours of clinical leadership and effective team-working and management in line with their role and scope of practice. (SHOWS HOW)	Critically evaluates appropriate theoretical frameworks of leadership and management. Demonstrates the application of theoretical perspectives of multi-professional team working to own practice. Proactively constructs and develops effective relationships, fostering clarity of roles within teams, to encourage productive working and to positively influence practice		Uses appropriate terminology to describe practice roles and relationships Is able to connect feedback to their own behaviours, and the perceptions of others. Considers their contribution to team performance. Can give examples where they have role modelled Able to rationalise approach to differences of opinion	Is dismissive of poor performance in themselves or others Fails to recognise impact of own behaviour on others Is unable to offer means of achieving consensus

5b. Coaching exercise (15 minutes)

The Assessor will supply clinical data and the student will be asked to review and feed back as if the Assessor was a colleague who had conducted the tests. The Assessor will introduce complexity to the task by introducing factors such as the colleague displaying anxiety, resistance, lack of knowledge, lack of respect or other shortcomings, and discuss the student's management of the scenario afterwards.

GOC Outcome	SPOKE indicative guidance	Evidence	Indicative success criteria	Example failing performance
4.7 Demonstrates the fulfilment of professional and legal responsibilities in supervising unregistered colleagues undertaking delegated activities. (DOES)	Delegates appropriate activities to unregistered colleagues, applying relevant legislation, standards and guidance. Monitors knowledge and skills of unregistered colleagues, including adequate training and assessment for regulated activities. Demonstrates appropriate supervision of unregistered colleagues.	Discussion and observation	Takes responsibility for delegated activities Takes steps to determine cause of failings Provides clear instructions on remediation. Checks comprehension and follows up	Fails to recognise or describe the shortcomings objectively Is uninterested in establishing root cause Is unable to communicate what changes are required Fails to establish impact of feedback
7.2 Supports the learning and development of others, including through acting as a role model and mentor. (SHOWS HOW)	Demonstrates the skills required to contribute to the teaching and training of students and other healthcare colleagues. Demonstrates awareness of teaching and learning theories and models in healthcare. Understands future position as Supervisor and mentor.	Discussion and observation	Provides feedback firmly but sensitively – ensuring that they have a receptive audience Can articulate the approach they took, and rationale for it Recognises that learning goes beyond instruction	Does not customise approach to situation and audience Cannot describe importance of supervision of delegated activities Displays no awareness of own leadership style

Task 6 – Personal Development Plan discussion (15 minutes)

The Assessor will review the PDP document and discuss this with the student. The discussion can incorporate feedback from other tasks in the visit and refer to the learning outcomes to help the student develop a holistic approach to personal development planning. They should discuss any perceived gaps in the PDP or any lack of alignment between the student's performance and the action plan with a view to supporting the student in developing their approach ready for the final CLiP 2F assessment visit.

If there are aspects of the learning outcomes where the assessor has some concerns, but the student is able to demonstrate that they have engaged with the task and attempted to identify their own learning needs in areas of shortfall, this is adequate to meet expectations at this visit.

This is a developmental exercise to allow the student to evidence progression by the end of CLiP 2F.

GOC Outcome	SPOKE indicative guidance	Evidence	Indicative success criteria	Example failing performance
7.1 Evaluates, identifies, and meets own learning and development needs. (DOES)	Analyses and responds to own learning and development needs. Prepares and follows a personal development plan, utilising appropriate learning opportunities.	Draft PDP, prior and current visit feedback.	Identifies own learning needs based on multiple sources which may include: • reflection on clinical experience to date • case discussions during assessment • prior visit feedback • input from colleagues, including Supervisor(s) • peer discussion • objective assessment methods (e.g. audit) Prepares a coherent plan with actions that connect to needs Is able to articulate how they will measure success	Is unable to draw upon a range of sources Fails to complete all sections of template with relevant material Does not connect needs with actions
7.4 Engages in critical reflection on their own development, with a focus on learning from experience, using data from a range of information sources (such as clinical audits, patient feedback, peer review and significant event analysis) and identifying and addressing their new learning needs to improve the quality and outcomes of patient care. (DOES)	Assesses own learning needs and engages in self-directed learning to maximise potential and improve outcomes. Critically reflects on own practice, and participates in multi-disciplinary service and team evaluation formulating and implementing strategies to act on learning and make improvements. Actively engages in peer review to inform own practice, formulating and implementing strategies to act on learning and make improvements. Demonstrates how audit can contribute to improvement in the quality and/or efficiency of patient care.			

Task 7 – Quality assurance of setting and supervision (15 minutes)

The student's answers to the QA questionnaire will be discussed, with signposting to further information and support if required. The Assessor will be able to raise a concern with the College team for action if there are concerns which cannot be addressed at the assessment visit. If the student has not me the expected risk profile in the summary dashboard for this stage of the placement, the Assessor should ensure there is a plan in place to address this.

This task is for support purposes and will not be assessed with a Pass/Fail outcome.

CLiP Part 2 face-to-face visit (CLiP 2F)

Summary

When: Approximately 13 weeks from start of CLiP 2

Where: In the student's practice

Duration: 3 hours (with an additional 10 minutes for Assessor to carry out patient consultation)

Task outline

The visit will consist of five overarching tasks:

1. Complete eye examination
    a. History and symptoms
    b. Refraction
    c. Eye health assessment
    d. Binocular vision assessment
    e. Management plan (incl. supplementary tests)
    f. Record-keeping
2. Specialist dispense
3. Diagnosis: management and referral
4. Learning and development
5. Quality assurance of setting and supervision (for support purposes)

Student risk profile

All items are expected to be green before the assessment visit takes place. This will ensure that the student has enough evidence for the Assessor to use in task 3.

Tasks and prerequisites

Task/Activity	Miller's Level: GOC Outcome(s)	Prerequisites / Evidence	Duration	Redemption
1. Complete eye examination				
a. History and symptoms - observation	D: 3 of 9 items from 3.4 and all 4 items from 3.5b(i) Core clinical Outcomes	No task-specific documentary evidence Presbyope patient will be provided by the College Direct observation will be used as evidence	1:00 (50 minutes for eye exam and 10 mins. to discuss with Assessor)	Resit
b. Refraction – observation				
c. Eye health assessment – observation				
d. Binocular vision assessment – observation				
e. Management plan (incl. supplementary tests) – observation				
f. Record-keeping – observation				
2. Specialist dispense				
Student to provide advice on different dispensing scenarios	D: 2 of 9 items from 3.4 and 1 of 11 items from 3.5b(ii)	No task-specific documentary evidence	0:30	Resit
3. Diagnosis: management and referral				
Discussion based on logbook entries and in-practice patient records	D: 8 of 8 items from 3.5b(iii), 2 of 5 items from 3.5b(iv), 1.7 and 1.8	In summary risk dashboard, student must be green on all logbook categories. In-practice patient records must be available for all logged interactions.	1:00	Resit
4. Learning and development				
Discussion of PDP (including response to feedback on draft)	D: 7.1 and 7.4	Finalised PDP document	0:20	Resit
5. Quality assurance of setting and supervision (for support purposes)				
Discussion of student experience	n/a	Completed QA surveys (student and Supervisor)	0:10	n/a

Instructions, learning outcomes and marking criteria

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Task 1 – Complete eye examination (1 hour)

Note: 50 minutes to complete the eye examination and an additional 10 minute discussion with the Assessor

A 'mystery shopper' patient will be arranged who is presbyope, with a specified ocular health and prescription range. Prior to the assessment start, the Assessor will need to review the mystery shopper questionnaire (Rx, history etc.) and conduct SLE for basic ocular health (this is a 10 minute addition to the overall visit time but not included in the assessment time).

The evidence for this task will be directly observed at the visit. The student will need to successfully complete and pass each sub-task because some of the learning outcomes can only be met across multiple sub-tasks. If the student makes minor mistakes or omissions during the clinical examination, the Assessor may use additional scenario-based questions to determine whether the student meets the competence standards.

Clinical core outcomes apply throughout clinical activities – although they have already been specifically assessed in CLiP1. Accordingly, any action which could lead to patient harm, breaches the law or GOC standards, or represents a major failing on a core outcome, may result in failure of the assessment. The clinical core outcomes have been mapped to examples of failing performance which can be found in **bold** in the table below as part of the relevant task, to enable integration with the visit-specific outcomes.

1a. History and symptoms

GOC Outcome	SPOKE indicative guidance	Indicative success criteria	Example failing performance
From 3.5b (i) Acts as a first point of contact for patients for their eye health needs by investigating, diagnosing and managing individuals' functional and developmental visual conditions, including those related to age.	There is no SPOKE indicative guidance here because the GOC clinical learning outcomes (Section 3) include indicators expressed as bullet points – see GOC outcome column for bullet point indicators.	Asks appropriate questions to obtain a full history. This includes the following: • RFV, vision and symptoms • OH and FOH • GH, medication and FGH • symptom check • driving • lifestyle/ work	Omits to question any of the following categories: • general health • ocular health • medication • family history • lifestyle / work Does not ask any follow-on questions related to symptoms if indicated and/or fails to illicit correct information

• Takes a relevant history from individual patients [~~*and any other appropriate person involved in their care (relatives/carers and others).*~~] (DOES)		• CL wear • smoker Asks appropriate follow-on questions if needed. Uses appropriate strategies to understand patients' needs e.g. not interrupting, summarising and checking understanding Maintains a friendly and professional communication style throughout	Does not ask regarding other symptoms. This may include not asking about: • Headaches • Flashes and floaters • Diplopia Interrupts on numerous occasions or does not check patient understanding coupled with poor communication techniques **Fails to note critical information provided by patient** **Demonstrates a rude, poor or patronising questioning technique** **Communicates in an unprofessional or misleading manner**

1b. Refraction

GOC Outcome	SPOKE indicative guidance	Indicative success criteria	Example failing performance
From 3.4 Analyses visual function from a range of diagnostic sources and uses data to devise a clinical management plan for a patient in areas that include the following: • Anterior eye [~~*and contact lenses*~~] • Ocular and systemic disease (DOES)	Applies normative data in the interpretation of results of visual function tests. Uses clinical data to formulate a management plan across a range of ocular conditions. Analyses clinical data in the light of presenting signs and symptoms.	Appropriate retinoscopy technique that achieves accurate results • accurate results for retinoscopy within +/- 1.00 DS/DC (determined using a power cross) and axis appropriate to cylinder. (Static fixation retinoscopy is the expected technique, but if a student prefers or needs to use one eye only then they must use a valid and appropriate technique for monocular viewing e.g. Barrett Method or Near Fixation retinoscopy.) Accurate end point subjective results • accurate results for subjective within +/- 0.50 DS/DC (determined using a	Does not use an appropriate retinoscopy technique The accuracy of the retinoscopy result is out of tolerance The accuracy of the end point subjective results is out of tolerance Fails to establish appropriate near add(s) to meet the needs of the patient **Repeatedly fails to establish consent (or meet legal requirements re consent).** **Acts in a way that clearly makes the patient uncomfortable** **Does not meet legal requirements in relation to equality.** **Compromised safety of patient or self, without making attempt to correct, or requiring assessor intervention.**

GOC Outcome	SPOKE indicative guidance	Indicative success criteria	Example failing performance
	Demonstrates effective management across the specified range of patients.	power cross) and axis appropriate to cylinder if patient VA 6/9 or better Near add and range appropriate to needs Uses appropriate methods of checking IF NEEDED e.g. +1.00Ds blur or use of pin-hole Understands the relationship between vision and Rx and symptoms and Rx making an appropriate prescribing and management decisions based on the refractive and oculomotor status.	**Poor hygiene or infection control potentially impacting patient safety. Unsafe disposal of clinical waste.**

1c. Eye health assessment

GOC Outcome	SPOKE indicative guidance	Indicative success criteria	Example failing performance
From 3.4 Analyses visual function from a range of diagnostic sources and uses data to devise a clinical management plan for a patient in areas that include the following: • Anterior eye [~~and contact lenses~~] • Ocular and systemic disease (DOES)	Applies normative data in the interpretation of results of visual function tests. Uses clinical data to formulate a management plan across a range of ocular conditions. Analyses clinical data in the light of presenting signs and symptoms.	Assesses anterior and posterior eye, and neurological health. Selects and uses appropriate techniques competently, in a comprehensive and logical manner Uses a range of illumination techniques, appropriate brightness and magnification Examines: • the external eye and adnexa • lids (including lid eversion in white and blue light) • lashes	Omits core parts of the examination Misses obvious pathology such as: Lens opacity, red eye, significant corneal staining, abnormal tear film or obvious lesions Fails to view the external eye in four positions of gaze in both eyes Hurts the patient by hitting/poking them with equipment or pulling hard on eye structures Does not use an appropriate technique to view the fundus Fails to view fundi in the nine positions of gaze in both eyes Inappropriate or unsafe use of equipment

GOC Outcome	SPOKE indicative guidance	Indicative success criteria	Example failing performance
	Demonstrates effective management across the specified range of patients.	• all parts of the cornea in both eyes (white and blue light) • bulbar conjunctiva • palpebral conjunctiva • Anterior Chamber Angle • Lens and media • Tear film • Pupil Reactions • Fundus (inc. thorough and systematic scanning) Detects any significant lesions Differentiates normal from abnormal	Fails to examine the tear film or chooses an unsafe, incorrect or inappropriate method to assess the tear film Fails to assess pupils appropriately or incorrectly records pupil findings **Repeatedly fails to establish consent (or meet legal requirements re consent).** **Acts in a way that clearly makes the patient uncomfortable.** **Does not meet legal requirements in relation to equality.** **Compromised safety of patient or self, without making attempt to correct, or requiring assessor intervention.** **Poor hygiene or infection control potentially impacting patient safety. Unsafe disposal of clinical waste.**

1d. Binocular vision assessment

GOC Outcome	SPOKE indicative guidance	Indicative success criteria	Example failing performance
From 3.4 Analyses visual function from a range of diagnostic sources and uses data to devise a clinical management plan for a patient in areas that include the following: • Binocular vision (DOES)	See GOC Outcome column, left, for bullet point indicators. (There is no SPOKE indicative guidance here because the GOC clinical learning outcomes (Section 3) include indicators expressed as bullet points).	Undertakes objective tests (including cover) using suitable targets, and assessing deviation accurately to include: • direction of latent or manifest deviation • speed of recovery • size –small, moderate or large • concomitant / incomitant	Fails to perform cover test Incorrect technique when performing cover test, in either the target chosen or cover technique Not interpreting the movement seen on cover test correctly Incorrect interpretation of any tests chosen Fails to perform motility or uses a very poor technique that would not identify incomitancy **Repeatedly fails to establish consent (or meet legal requirements re consent).**

GOC Outcome	SPOKE indicative guidance	Indicative success criteria	Example failing performance
		Undertakes subjective tests using suitable targets, as appropriate to patient including motility	**Acts in a way that clearly makes the patient uncomfortable.** **Does not meet legal requirements in relation to equality.** **Compromised safety of patient or self, without making attempt to correct, or requiring assessor intervention.** **Poor hygiene or infection control potentially impacting patient safety. Unsafe disposal of clinical waste.**

1e. Management plan (incl. supplementary tests)

GOC Outcome	SPOKE indicative guidance	Indicative success criteria	Example failing performance
From 3.5b (i) Acts as a first point of contact for patients for their eye health needs by investigating, diagnosing and managing individuals' functional and developmental visual conditions, including those related to age. • Interprets the results of history-taking and the examination of the refractive and ocular motor status and ocular health of individual patients to inform clinical decision-making and	See GOC Outcome column, left, for bullet point indicators. (There is no SPOKE indicative guidance here because the GOC clinical learning outcomes (Section 3) include indicators expressed as bullet points).	Gives factually relevant information in a clear and understandable way, avoiding jargon and technical terms. Uses appropriate supporting material, for example, diagrams or leaflets, and uses a range of different explanations where required to avoid repetition. Understands limitations of Knowledge and understanding, referring the patient for advice where necessary Maintains a friendly and professional communication style throughout Recognises and documents need for any further clinical investigations such as visual fields, IOPs	Gives incorrect information Fails to refer or manage appropriately where necessary Articulates information in a confusing way, using lots of jargon and technical term Fails to identify the need for further investigations. Records findings that were not actually carried out or advice that was not given to the patient **Provides advice that directly conflicts with patient's desired outcomes.** **Does not meet legal requirements in relation to equality.** **Communicates in an unprofessional or misleading manner**

GOC Outcome	SPOKE indicative guidance	Indicative success criteria	Example failing performance
care management plans. • Accepts responsibility and accountability for professional decisions and actions as a first point of contact, including in responding to individual patients' needs, managing risk, and making appropriate referrals. (DOES)			

1f. Record-keeping

GOC Outcome	SPOKE indicative guidance	Indicative success criteria	Example failing performance
From 3.5b (i) Acts as a first point of contact for patients for their eye health needs by investigating, diagnosing and managing individuals' functional and developmental visual conditions, including those related to age. • Records all aspects of the consultation, the findings of all tests	See GOC Outcome column, left, for bullet point indicators. (There is no SPOKE indicative guidance here because the GOC clinical learning outcomes (Section 3) include indicators expressed as bullet points).	Produces records which are legible and contain all relevant patient details, measurements, results and advice	Omits details of tests performed Recorded information that was not carried out Inaccurate or illegible records **Does not meet legal requirements in relation to data management.**

GOC Outcome	SPOKE indicative guidance	Indicative success criteria	Example failing performance
and relevant communications with patients, their carers and colleagues, ensuring that records are accurate, legible, dated, signed, concise, contemporaneous and securely stored. (DOES)			

Task 2 – Specialist dispense (30 minutes)

The student is required to provide dispensing advice for specialist needs. The assessor will present scenarios involving two separate fictional patients: one with specialist occupational needs and one needing contact lens dispense. The Assessor will select these requirements at random from a wide choice of patient needs, combining variants of background/occupation/hobby with corrective requirement and dispense type. The Assessor will ask follow-up questions where required.

GOC Outcome	SPOKE indicative guidance	Indicative success criteria	Example failing performance
From 3.4 Analyses visual function from a range of diagnostic sources and uses data to devise a clinical management plan for a patient in areas that include the following: • [~~*Anterior eye and*~~] contact lenses	See GOC Outcome column, left, for bullet point indicators. (There is no SPOKE indicative guidance here because the GOC clinical learning outcomes (Section 3) include	Demonstrates a working knowledge of the relevant standards for VDU users, drivers and patients requiring occupational and vocational correction. Understands and is able to identify common ocular hazards and common or sight threatening leisure activities and occupations and advises the patient accordingly	Fails to demonstrate appropriate frame, lens or contact lens selection to suit patient needs/requirements

GOC Outcome	SPOKE indicative guidance	Indicative success criteria	Example failing performance
• Occupational optometry (DOES)	indicators expressed as bullet points).	Is able to identify a patient's vocational needs and perform visual task analysis Chooses and advises appropriate optical appliances for patients with specific visual requirements (spectacles, contact lenses and other visual aids)	
From 3.5b(ii) Completes an informed clinical assessment of individual patients' need and uses this to dispense, fit and advise on the safe and effective use of spectacles, contact lenses, low-vision aids and other ophthalmic appliances. • Prescribes, advises and dispenses appropriate vocational and special optical appliances, in accordance with personal eye protection regulations and relevant standards (DOES)	See GOC Outcome column, left, for bullet point indicators. (There is no SPOKE indicative guidance here because the GOC clinical learning outcomes (Section 3) include indicators expressed as bullet points).		

Task 3 – Diagnosis: management and referral (1 hour)

This task is based on review and discussion of logbook entries and in-practice patient records, supplemented by assessor toolkit images and simulated scenarios.

The Assessor will select and discuss **five** conditions from those listed below (including at least **one** from each of categories 1, 2 and 3) by searching and filtering from the full logbook (rather than from the assessment visit dashboard).

1. Anterior eye
    a. Cataract
    b. Red eye
    c. Dry Eye
    d. Blepharitis
2. Posterior eye
    a. Glaucoma
    b. Diabetic or hypertensive retinopathy
    c. Suspect retinal detachment
    d. Maculopathy
3. Neurology and fields

During the exploration of the five conditions, at least three with referrals must be considered, and compared and contrasted with similar cases in which a referral was not made, to explore decision-making. For each entry, the student will be asked to explain the findings and their own decision-making, in a style appropriate to communicating with another healthcare professional.

The review should be augmented with Assessor Toolkit images (of pathologies not already covered by the logbook entries) to assure differential diagnosis outcomes, presenting the student with at least **one** from each category (Anterior, posterior, neurology and fields) including:

- **three** images of common ocular conditions: e.g cataract, diabetic retinopathy, hypertensive retinopathy, age-related maculopathy, retinal detachment, tilted disc, red eye, conjunctivitis

- **two** images of less common conditions: e.g retinitis pigmentosa, anisocoria, BCC, corneal ulcer, endothelial dystrophy, ONH swelling, uveitis, angle closure glaucoma
- **one** image of visual fields

For each case the assessor will ask the student to

a. describe what is seen in language that could be used in a referral letter to another health care professional
b. give a provisional diagnosis
c. outline any further tests that would be helpful before deciding on management
d. decide on best management giving appropriate urgency, and pathway, if onward referral is required.

Role play should be used at least **twice** during the assessment to explore how the student would approach communicating the findings to patients or carers.

GOC Outcome	SPOKE indicative guidance	Indicative success criteria	Example failing performance
From 3.5b(iii) Makes informed decisions on the treatment and management of ocular abnormalities and disease • Investigates and interprets individual patients' presenting symptoms and risk factors and identifies the clinical signs of potential abnormality and disease • Selects and deploys appropriate methods of clinical examination • Analyses the results of an examination to make a differential diagnosis • Advises individual patients on the implications and care options arising from the detection of common ocular abnormalities and disease, making referrals in line with professional guidance and local	See GOC Outcome column, left, for bullet point indicators. (There is no SPOKE indicative guidance here because the GOC clinical learning outcomes (Section 3) include indicators expressed as bullet points).	**Overall** Manages all aspects of anterior, posterior, neurological disease and abnormalities, including those indicative of systemic disease, making timely and effective referrals where necessary. **Clinical decision-making and follow-up** Recognises a significant risk factor during history taking. Investigates appropriately, interprets the results and manages the patient accordingly. Recognises significant signs and symptom(s) including those that could relate to a neurological condition or indicative of systemic disease, and	**Clinical decision-making and follow-up** Fails to recognise common ocular conditions Fails to manage common ocular condition appropriately Fails to recognise and act upon significant symptoms or signs that could indicate ocular disease Selects inappropriate tests.

GOC Outcome	SPOKE indicative guidance	Indicative success criteria	Example failing performance
pathways, when in patients' best interests so that they receive timely, efficacious care. • Designs and implements an appropriate management plan arising from a clinical examination and differential diagnosis, in line with individual patients' clinical need and preferences • Assesses and evaluates signs and symptoms of neurological significance • Manages patients presenting with a range of anterior and/or posterior ocular conditions. • Detects the ocular manifestations of systemic disease and advises and refers in line with individual patients' need (DOES)		• asks appropriate and relevant questions • carries out appropriate additional investigations to follow up presenting symptom(s). Interprets the results to differentiate normal and abnormal Understands the significance and relative importance of the findings. Designs and implements appropriate management plan, recognising when limit of scope of practice requires referral. **Service and Systems knowledge** Refers patients with ocular abnormalities to appropriate practitioner with due regard to urgency Demonstrates awareness of referral systems and pathways appropriate to the conditions discussed Able to navigate referral systems to ensure timely care, Able to determine and rationalise whether referral is necessary, and the level of urgency and pathway that should be used	Unable to interpret results effectively. Fails to recognise limitation of knowledge/clinical expertise, or urgency, when managing ocular conditions Unable to recognise likely cause/location of visual field defect and manage appropriately Unable to rationalise referral choices, including decision not to refer. **Service and Systems knowledge** Uncertain about service choices or mechanisms Unable to provide patient with information about next steps
From 3.5b(iv) Accurately identifies patients' conditions and their potential need for medical referral in a timely way, including when urgent or emergency attention is required. • Appraises the need for and urgency of making a patient referral, using relevant local protocols and national professional guidance, and acts accordingly • Recognises the clinical signs of sight- and life-threatening conditions that require immediate treatment and takes appropriate action (DOES)	See GOC Outcome column, left, for bullet point indicators. (There is no SPOKE indicative guidance here because the GOC clinical learning outcomes (Section 3) include indicators expressed as bullet points).		

GOC Outcome	SPOKE indicative guidance	Indicative success criteria	Example failing performance
1.7 Demonstrates effective clinical decision making, diagnosis, evaluation and makes appropriate and timely referral, where this is needed to meet a patient's needs. (DOES)	Demonstrates an awareness of referral pathways and can accurately refer when appropriate. Recognises their scope of practice and the role of referral in effective person-centred care. Designs and implements an appropriate management plan, in line with individual patients' clinical needs and preferences.	Aware of local low vision services and RNIB pathway Understands the criteria and process for RVI/CVI registration, the use of the LVL and the difference between certification and registration. **Communications (Patient and HCP)** Conveys and communicates information in a way that the patient understands, ensuring a patient centred approach throughout. Advises patients on the implications and care options to suit their needs, identifying and responding appropriately to patients' fears, anxieties and concerns about their visual welfare Ensures patient knows how to access (or is given) supplementary information in a format that is suitable for their needs When referring, provides comprehensive persuasive and clear written evidence, in a format and style that meets framework requirements.	**Communications (Patient and HCP)** Fails to adapt style and use of technical language to audience. Gives factually incorrect or irrelevant information Fails to recognise, or is unable to manage, patient anxiety Uses a rude, patronising tone and /or demonstrates a lack of empathy Omits key information. Written referral does not meet systems expectations
1.8 Refers and signposts as necessary to sight loss and other relevant health services. (DOES)	Advises on accessing and makes appropriate referrals to low-vision services, in line with patients' best interests. Is able to direct to relevant health and social care services for patients at risk.		

Task 4 – Learning and development (20 minutes)

This task will involve discussion of the submitted PDP and the student reflecting on progress throughout CLiP and their degree. If gaps remain in the learning needs analysis or actions planned, the Assessor should explore the student's ability to suggest appropriate amendments to improve their PDP.

<table>
<tr><th>GOC Outcome</th><th>SPOKE indicative guidance</th><th>Indicative success criteria</th><th>Example failing performance</th></tr>
<tr><td>7.1 Evaluates, identifies, and meets own learning and development needs.
(DOES)</td><td>Analyses and responds to own learning and development needs.
Prepares and follows a personal development plan, utilising appropriate learning opportunities.</td><td rowspan="2">Identifies own learning needs based on multiple sources which may include
• reflection on clinical experience to date
• case discussions during assessment
• prior visit feedback
• input from colleagues, including Supervisor(s)
• peer discussion
• objective assessment methods (eg audit)
Prepares a coherent plan with actions that connect to needs
Is able to articulate how they will measure success
Where gaps are identified, student makes responsive and appropriate suggestions for improving their PDP.</td><td rowspan="2">Is unable to draw upon a range of sources
Fails to complete all sections of template with relevant material
Does not connect needs with actions</td></tr>
<tr><td>7.4 Engages in critical reflection on their own development, with a focus on learning from experience, using data from a range of information sources (such as clinical audits, patient feedback, peer review and significant event analysis) and identifying and addressing their new learning needs to improve the quality and outcomes of patient care.
(DOES)</td><td>Assesses own learning needs and engages in self-directed learning to maximise potential and improve outcomes.
Critically reflects on own practice, and participates in multi-disciplinary service and team evaluation formulating and implementing strategies to act on learning and make improvements.
Actively engages in peer review to inform own practice, formulating and implementing strategies to act on learning and make improvements.
Demonstrates how audit can contribute to improvement in the quality and/or efficiency of patient care.</td></tr>
</table>

Task 5 – Quality assurance of setting and supervision (10 minutes)

Assessor will discuss (with each separately) the student's and the Supervisor's answers to the QA questionnaire and, where appropriate, signpost further information and support. The Assessor will raise a concern with the College team for action if there are concerns which cannot be addressed at the assessment visit.

This task is for support purposes and will not be assessed with a Pass/Fail outcome.

Appendix I – GOC outcome mapping

Key
Outcome to be assessed by HEI
Assessed by HEI during or after CLiP
Outcome to be assessed by College
Outcome not required by GOC at this level

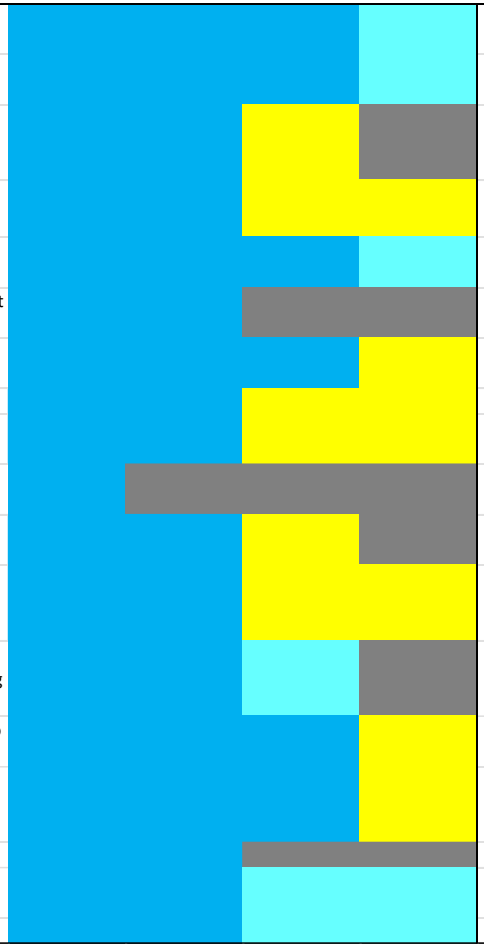
RV	Remote visit, meeting with assessor carried out online
F2F	Face-to-face visit with assessor attending at the student's practice
SEP	Service Evaluation Project, written element of CLiP Part 1
Core	Elements that should be central to students' practice and behaviours

						CLiP 1			CLip 2	
Outcome / Level	**Knows**	**Knows how**	**Shows how**	**Does**	**Task reference (TBC)**	**RV**	**F2F**	**SEP**	**RV**	**F2F**
1. Person centred care										
O1.1 Actively listens to patients and their carers to ensure patients are involved in and are at the heart of decisions made about patient's care.							✓ (D)			
O1.2 Manages desired health outcomes of patients, taking into consideration any relevant medical, family and social history of the patient, which may include personal beliefs or cultural factors.							✓ (D)			
O1.3 Protects patients' rights; respects the choices they make and their right to dignity and privacy.						✓ (SH)	✓ (D)			
O1.4 Ensures high quality care is delivered and puts into place adaptative measures as needed for different environments (such as domiciliary, prisons and special schools).								✓		
O1.5 Commits to care that is not compromised because of own personal conscious and unconscious values and beliefs.						✓ (SH)	✓ (D)			
O1.6 Obtains and verifies continuation of valid consent from adults, children, young and vulnerable people and their carers and records as appropriate.						✓ (SH)	✓ (D)			
O1.7 Demonstrates effective clinical decision making, diagnosis, evaluation and makes appropriate and timely referral, where this is needed to meet a patient's needs.										✓
O1.8 Refers and signposts as necessary to sight loss and other relevant health services.										✓

2. Communication									
O2.1 Conducts communications in a sensitive and supportive manner adapting their communication approach and style to meet the needs of patients, carers, health and care colleagues and the public.					✓ (SH)	✓ (D)			
O2.2 Acts upon nonverbal cues from patients or carers that could indicate discomfort, a lack of understanding or an inability to give informed consent.									
O2.3 Communicates effectively within a multi-disciplinary healthcare team and works collaboratively for the benefit of the patient.								✓	
O2.4 Critically reflects on how they communicate with a range of people and uses this reflection to improve interactions with others.									
3. Clinical Practice									
O3.1 Undertakes safe and appropriate ocular examinations using appropriate techniques and procedures to inform clinical decision-making within individual scope of practice.						✓ (D)			
O3.2 Engages with developments in research, including the critical appraisal of relevant and up-to-date evidence to inform clinical decision-making and improve quality of care.									
03.3 Engages with technological advances in eye health and broader healthcare delivery and the significance of specific developments for enhancing patient outcomes and service delivery.							✓		
O3.4 Analyses visual function from a range of diagnostic sources and uses data to devise a clinical management plan for a patient in areas that include the following:									
• Dispensing of optical applicances						✓			
• Low vision/visual impairment								✓	
• Refractive management						✓			
• Anterior eye and contact lenses						✓			✓
• Ocular and systemic disease									✓
• Binocular vision									✓
• Paediatrics								✓	
• Patients with learning disabilities and complex needs								✓	
• Occupational optometry									✓

03.5 Meets the following clinical practice outcomes for registration either as a dispensing optician or an optometrist.							
03.5b (i) Acts as a first point of contact for patients for their eye health needs by investigating, diagnosing and managing individuals' functional and developmental visual conditions, including those related to age.							
• Takes a relevant history from individual patients and any other appropriate person involved in their care (relatives/carers and others).				✓			✓
• Interprets the results of history-taking and the examination of the refractive and ocular motor status and ocular health of individual patients to inform clinical decision-making and care management plans.							✓
• Records all aspects of the consultation, the findings of all tests and relevant communications with patients, their carers and colleagues, ensuring that records are accurate, legible, dated, signed, concise, contemporaneous and securely stored.							✓
• Accepts responsibility and accountability for professional decisions and actions as a first point of contact, including in responding to individual patients' needs, managing risk, and making appropriate referrals.							✓
03.5b (ii) Completes an informed clinical assessment of individual patients' need and uses this to dispense, fit and advise on the safe and effective use of spectacles, contact lenses, low-vision aids and other ophthalmic appliances.							
• Interprets and dispenses a prescription using appropriate lenses, frame choice and accurate facial and frame measurements				✓			
• Measures and verifies optical appliances in line with relevant standards, guidelines and evidence				✓			
• Prescribes, advises and dispenses appropriate vocational and special optical appliances, in accordance with personal eye protection regulations and relevant standards							✓
• Manages and dispenses appropriate spectacles for paediatric patients and for patients with complex or additional needs, including by adapting the practice environment and practice activity in line with individuals' needs						✓	
• Manages cases of non-tolerance						✓	
• Identifies and advises patients who could benefit from simple or complex low-vision aids						✓	
• Conducts a low-vision assessment, including through full history-taking and evaluation of visual requirements						✓	
• Evaluates the clinical findings of low-vision assessments, applying knowledge of low-vision optics to dispense appropriate simple and complex low-vision aids and provide relevant advice						✓	
• Advises on accessing and makes appropriate referrals to low-vision services, in line with patients' best interests						✓	
• Identifies, recommends and fits soft or rigid contact lens as appropriate to support and enhance individual patients' vision, lifestyle and eye health and provides ongoing care.				✓			
• Instructs and advises patients in handling soft or rigid lens as appropriate, and how to wear and care for their fitted lenses.				✓			

03.5b (iii) Makes informed decisions on the treatment and management of ocular abnormalities and disease							
• Investigates and interprets individual patients' presenting symptoms and risk factors and identifies the clinical signs of potential abnormality and disease							✓
• Selects and deploys appropriate methods of clinical examination							✓
• Analyses the results of an examination to make a differential diagnosis							✓
•Advises individual patients on the implications and care options arising from the detection of common ocular abnormalities and disease, making referrals in line with professional guidance and local pathways, when in patients' best interests so that they receive timely, efficacious care.							✓
• Designs and implements an appropriate management plan arising from a clinical examination and differential diagnosis, in line with individual patients' clinical need and preferences							✓
• Assesses and evaluates signs and symptoms of neurological significance							✓
• Manages patients presenting with a range of anterior and/or posterior ocular conditions.							✓
• Detects the ocular manifestations of systemic disease and advises and refers in line with individual patients' need							✓
03.5b (iv) Accurately identifies patients' conditions and their potential need for medical referral in a timely way, including when urgent or emergency attention is required.							
• Interprets the results of history-taking and clinical findings (i.e. a recognition of abnormality and correct interpretation of common investigative tests) to formulate an appropriate management plan, recognising and acting when a referral is appropriate							
• Identifies the signs of disease progression or change in individual patients' clinical status and adapts and advises on their management plan in line with this							
• Appraises the need for and urgency of making a patient referral, using relevant local protocols and national professional guidance, and acts accordingly							✓
• Recognises the clinical signs of sight- and life-threatening conditions that require immediate treatment and takes appropriate action							✓
• Detects adverse ocular reactions to medication and advises, manages and refers in line with individual patients' need.							
03.5b (v) Uses common ophthalmic drugs, safely to facilitate optometric examination and the diagnosis / treatment of ocular disease.							
• Adheres to legal requirements for the use and supply of common ophthalmic drugs				✓			
• Appraises the appropriate use of common ocular drugs to aid refraction and assessment of the fundus						✓	
• Obtains individual patients' informed consent to use common ophthalmic drugs to aid investigation, examination, diagnosis and treatment, including by advising on the potential side effects and associated risks of specific drugs						✓	
• Administers common ocular drugs appropriately, effectively and judiciously, exercising caution to ensure patient safety.						✓	
• Recognises the indications and contraindications of commonly-used ophthalmic drugs and responds in light of these to uphold patient care and safety						✓	

4. Ethics and Standards						
O4.1 Upholds the values and demonstrate the behaviours expected of a GOC registrant, as described in the GOC Standards of Practice.						
O4.2 Acts openly and honestly and in accordance with the GOC Duty of Candour guidelines.						
O4.3 Understands and implements relevant safeguarding procedures, local and national guidance in relation to children, persons with disabilities, and other vulnerable people.					✓	
O4.4 Applies the relevant national law and takes appropriate actions i) to gain consent and ii) if consent cannot be obtained or is withdrawn.		✓ (SH)	✓ (D)			
O4.5 Recognises and works within the limits of own knowledge and skills. Seeks support and refers to others where appropriate.						
O4.6 Understands the professional and legal responsibilities of trainee and student supervision and of being supervised.						
O4.7 Demonstrates the fulfilment of professional and legal responsibilities in supervising unregistered colleagues undertaking delegated activities.					✓	
O4.8 Complies with health and safety legislation.		✓ (SH)	✓ (D)			
O4.9 Complies with equality and human rights' legislation, demonstrates inclusion and respects diversity.		✓ (SH)	✓ (D)			
O4.10 Understands the patient or carers' right to complain without prejudicing the standard of care provided.						
O4.11 Adheres to the ethical principles for prescribing and to legislation relating to medicines management.		✓				
O4.12 Complies with legal, professional and ethical requirements for the management of information in all forms including the accuracy and appropriateness of patient records and respecting patient confidentiality.		✓ (SH)	✓ (D)			
O4.13 Manages situations under which patient confidentiality may be breached in order to protect a patient or the public, in line with relevant guidance on disclosing confidential information and/or with the patient's consent.						
O4.14 Applies eye health policies and guidance and utilises resources efficiently to improve patient outcomes.				✓		
O4.15 Maintains professional boundaries with patients and others taking into consideration the additional needs of vulnerable people and specific requests/requirements.					✓	
O4.16 Understands the role of carers and the power of attorney.						
O4.17 Complies with legislation and rules concerning the sale and supply of optical appliances.						
O4.18 Provides clarity on services available and any associated payments.						

5. Risk						
O5.1 Recognises when their own performance or the performance of others is putting people at risk and takes prompt and appropriate action.						
O5.2 Knows how to manage complaints, incidents or errors in an effective manner.						
O5.3 Address any health and safety concerns about the working environment that may put themselves, patients or others at risk.						
O5.4 Applies due process for raising and escalating concerns, including speaking-up and protected disclosure if all other routes have been pursued and there is reason to believe that patients or the public are at risk.						
O5.5 Applies infection prevention control measures commensurate with the risks identified.		✓ (D)				
O5.6 Understands the importance of maintaining their own health to remain healthy and professionally effective.						
O5.7 Able to risk assess i) patient's clinical condition and ii) a situation in clinical practice and make appropriate clinical decisions.		✓ (D)				
6. Leadership and Management						
O6.1 Undertakes efficient, safe and effective patient and caseload management.			✓			
O6.2Works collaboratively within healthcare teams, exercising skills and behaviours of clinical leadership and effective team-working and management in line with their role and scope of practice.				✓		
O6.3 Engages with clinical governance requirements to safeguard and improve the quality of patient care, including through contributing to service evaluation and development initiatives.			✓			
O6.4 Recognises and manages adverse situations, understanding when to seek support and advice to uphold patients' and others' safety.						
O6.5 Takes appropriate action in an emergency, providing care and clinical leadership within personal scope of practice and referring or signposting patients as needed, to ensure their safe and timely care.						
O6.6 Engages with population and public health initiatives and understands how population data should inform practice and service delivery.						
7. Lifelong Learning						
O7.1 Evaluates, identifies, and meets own learning and development needs.	✓	✓	✓	✓	✓	
O7.2 Supports the learning and development of others, including through acting as a role model and mentor.				✓		
O7.3 Gathers, evaluates and applies effective patient and service delivery feedback to improve their practice.			✓			
O7.4 Engages in critical reflection on their own development, with a focus on learning from experience, using data from a range of information sources (such as clinical audits, patient feedback, peer review and significant event analysis) and identifying and addressing their new learning needs to improve the quality and outcomes of patient care.	✓	✓	✓	✓	✓	

Appendix II – Templates for student visits

Documents available in Assessment visits area

All

QA of setting and supervision questionnaire: Supervisor (CLiP 1F and 2F only)

CLiP 1R

Drug Management Template

Health and Safety presentation briefing

Service Evaluation Project workbook

CLiP 1F

Record card

Service Evaluation Project workbook

Service Evaluation Project

Service Evaluation Project workbook

CLiP 2R

360° Review

Personal Development Plan

CLiP 2F

Record card

Personal Development Plan

Document version	Date	Update
1.1	01/07/2025	First version
1.2	04/08/2025	Updates to CLiP 1F section
1.3	12/09/2025	Updates to CLiP 2R and 2F
1.4	17/10/2025	Risk framework amendments and added definitions
1.5	21/10/2025	Header changed in pre-req tables (Miller)
1.6	31/10/2025	Single vision added
1.7	05/12/2025	1R details updated
2.1	05/01/2026	Text update with new sections and content
2.2	20/01/2026	Updates to CLiP 2R; logbook sections; updates to ‘Meeting visit requirements’

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