Education and training requirements for specialist entry to the GOC register (additional supply, supplementary prescribing and independent prescribing)

Is there anything in the criteria in the 'Outcomes for Approved Qualifications for Specialist Entry to the GOC Register (AP, SP and IP)' that is missing or should be changed?

We welcome the move to an outcomes-based approach (key proposal f) and support that this is strongly aligned with the Royal Pharmaceutical Society's (RPS) Competency Framework for all Prescribers (2021). In fact, we would suggest that it would be preferable to seek complete alignment with the RPS framework. The use of Miller's pyramid to define outcome levels will assist in determining what forms of assessment are relevant to determining whether outcomes have been met (key proposal g).

However, there may be significant logistical and financial challenges to developing and delivering assessment regimes that are proportionate, but that address the full range of outcomes with sufficient rigour and consistency, including those that require observation of the trainee in clinical practice. Further evaluation of the outcomes to determine whether they should all be assessed at level 7/11, and whether existing trusted, rigorous and efficient forms of assessment such as the Therapeutic Common Final Assessment might continue to have validity in determining whether outcomes have been met, would be beneficial.

A more specific definition of the scope of "arrangement of aftercare" in the introduction to outcome three would also be useful. We would also suggest that further review of the level of the outcomes should be undertaken to ensure that programmes can be responsive to the changing needs of patients and the profession, and evolving eye care pathways, and to encourage the deployment of modern and innovative approaches to assessment. Given that prescribing is a form of advanced practice in optometry, we would also suggest that some outcomes might be better aligned with higher level descriptions such as the "is trusted" concept described in Cate et al (https://pubmed.ncbi.nlm.nih.gov/33060399/). We note that O1.4 and O4.1 currently lack a Miller's level.

It is of some concern that, although defining and adhering to personal scope of practice is a central tenet of independent prescribing qualifications, it is only referred to in a single learning outcome (O7.5) and is not strongly visible in the standards as presented. Given the potential for trainees to undertake clinical practice in a wide range of environments, including primary, secondary, community and non-NHS environments, it would be appropriate to pay more attention to developing and understanding trainee scope of practice, perhaps by stipulating a core level of diversity of clinical experience that might be required. Alternatively, guidance for trainees and providers that provides examples of how scope of practice may be defined and developed, recognising the diversity of optometric practice in the UK, would be of benefit. Some consideration of support mechanisms for extending scope of practice post-qualification as services evolve and patient needs change would also aid in future-proofing the new requirements. The College is currently working on developing high level principles to support optometrists in defining their scope of practice and developing this over time and we would be happy to support further work in this area.

Is there anything in the 'Standards for Approved Qualifications for Specialist Entry to the GOC Register (AP, SP and IP)' that is missing or should be changed?

It is appropriate that the qualifications are offered at this level, and that a single provider takes responsibility (key proposals a and b).

We have significant concerns, which were echoed by our survey respondents, that the levels of clinical experience and expertise of newly qualified optometrists will be insufficient to underpin the judgements and outcomes required of IP practitioners, if the two-year post-registration experience requirement is removed (key proposal h). This post registration period provides time and experience that allows consolidation of knowledge and working practices, and development of the self-assurance, that is key to the judgement and decision-making required of IP practitioners. It is notable that the route to qualification is typically five or more years in countries, such as New Zealand, that already allow concurrent qualification as an optometrist and therapeutic prescriber. Given that the current IP qualification typically requires around 60 credits of student effort, plus independent preparation for the TCFA, it is not clear how the whole of the proposed IP qualification can be accommodated at level 7/11 of the new undergraduate courses.

Even if the new master's level registration qualification routes were able to be designed to include the full IP learning, self-development and assessment regime, within the four years, over the top of the registration qualification requirements, these degrees will not be producing new registrants until at least 2027. It is not clear how the transition period in this case might be managed. For comparison, it should be noted that even pharmacists, whose entire degree focuses on the use and effects of regulated drugs, are not expected to achieve prescribing rights until they have completed five years of pharmacy education and training, prior to registration. Indeed, integration of IP qualification with the route to initial registration as a pharmacist has only recently been introduced by GPhC, and so has yet to be demonstrated to be successful in practice.

In contrast, it is not clear where the risk to patients would lie if the 2-year post registration requirement was retained, given the large numbers of more experienced optometrists who might readily be trained as IP optometrists if funding were available.

We would suggest that the minimum duration of study and credit volume SHOULD be specified to ensure that IP-specific learning opportunities and time for learning are clearly documented and identified (key proposal c) and developed to a consistent standard by all providers.

Whilst increased flexibility of location and setting for trainees to undertake clinical experience is to be welcomed, it should be overtly recognised that some settings may focus on services for specific types of conditions and thus offer a more restricted range of clinical experiences. The diversity of cases observed may impact the trainees' scope of practice at qualification, and thus care should be taken to ensure that the range of experiences obtained are clearly defined and documented. It is also currently not clear what limits if any there might be on location. Could a trainee undertake clinical experience outside of the UK, for example, in a practice on Jersey, or even whilst volunteering with UK charities abroad?

We strongly support the extended range of professionals who may act as supervisors and as DPP (key proposal d, S4.5). However, the amount of experience required to be appointed as a DPP, and the location of the responsibility for training and support for would benefit from more clarity and detail. In addition, S4.6 indicates that the primary supervisor is listed as responsible for "coordinating" supervision and may have little direct oversight of the

trainee, but it is not clear how non-DPP supervisors are selected and supported. A minimum standard for oversight of the whole of the trainee's development, including expectations around supervisor training and the number of trainees per supervisor, should be included.

The proposals indicate (key proposal d, S2.6) that it is for the trainee to identify their DPP before applying to the course. However, it is the responsibility of the provider to assure and manage this relationship. This appears to be contradictory.

The involvement of a wide range of stakeholders in the design of programmes is to be commended. (key proposal e, S4.7)

It is not clear how RPL (key proposal h, S2.5) might be deployed for trainees who have part completed the existing regime, in a way that does not disadvantage them financially or require them to repeat elements of study.

It is also not clear that AS and SP qualification retain relevance in modern optometric practice, and it seems likely therefore that providers will focus on the single IP qualification. The continuing inclusion of, and reference to AS, and SP qualifications throughout the proposed text of the new standards and outcomes reduces clarity to little benefit. If AS and SP are to be retained, then the clinical placement time should be scaled (as is the case currently) to reflect the differing breadth and depth of experience required.

Is there anything in the 'Quality Assurance and Enhancement Method for Specialist Entry to the GOC Register (AP, SP and IP)' that is missing or should be changed?

Current qualification standards are subject to the Therapeutic Common Final Assessment, and this assures consistent outcomes in IP registrants. It is not clear how EVPs will be enabled to ensure this level of consistency is maintained when assessment methods may vary significantly by provider? Equally, how will EVP members acquire the specialist understanding required for undertaking IP accreditation?

The QAE method and course management requirements (Standard 4) make almost no reference to partnership or collaborative provision, despite the likelihood of this model being preferred by some providers to enable delivery of integrated academic and clinical provision.

To what extent do you agree with our proposal to replace our handbook for independent prescribing optometrists and related policies with the proposed 'Outcomes for Approved Qualifications for Specialist Entry to the GOC Register (AP, SP and IP),' 'Standards for Approved Qualifications for Specialist Entry to the GOC Register (AP, SP and IP)' and 'Quality Assurance and Enhancement Method for Specialist Entry to the GOC Register (AP, SP and IP)'?

The handbook should be replaced for the reasons outlined in the consultation documents.

To what extent do you agree with our proposal that at the point of retention, registrants in the additional supply, supplementary prescribing and/or independent prescribing categories will no longer need to supply details of prescribing decisions undertaken in the previous 12 months?

We are broadly supportive of this, given that currency should be assured via specialist CPD requirements. It is, however, not clear whether there will be an expectation that qualified practitioners will need to undertake some revalidation if not actively prescribing for an extended period, or how practitioners might best be supported to extend their scope of practice as service requirements develop.

Is there anything else you would like to tell us about the education and training of future independent prescribing optometrists?

We consider that the proposals represent a welcome update to the IP qualification, with some reservations. In particular, the location of responsibility for approval and training of the DPP needs enhanced clarity. Equally, mechanisms should be outlined to ensure that the learning experience of trainees is of sufficient length and diversity to develop and establish both confidence in prescribing and appropriate scope of practice in new IP registrants. Methods for increasing scope of practice in more experienced IP Optometrists would also add value. Finally, further consideration of means to ensure that ALL potential specialty registrants are enabled to access training to support enhanced models of care, and that the changes do not inadvertently privilege post ESR graduates or reduce access through increased costs. Overall, it would be a positive addition to foreground patient needs and patient safety more strongly throughout the documentation, with assurance of these being the prime driver for resolution of queries or doubt.

This response was prepared in consultation with College members via our website, and an online panel discussion and Q&A in town hall meeting format.

Section 2: Impact of our proposals

We would like to ask everyone the following questions on impact of our proposals.

Do you think any of the proposed changes will impact – positively or negatively – on any other individuals or groups (for example, trainees, patients and the public, current providers of approved qualifications, placement providers, employers and devolved nations)?

Please describe the impact and the individuals or groups concerned. We are particularly keen to understand further any financial or other impacts we haven't considered in our accompanying impact assessment.

More clarity is required on how "teach out" will be managed for those who have already started their IP training, to avoid them being disadvantaged.

We have concerns that current and potential providers will struggle to devote the capacity to develop the new qualifications effectively in time for approval in 2022, given that those same course teams are, over the same period, developing their new undergraduate qualifications.

In addition, many Universities are still working on post COVID changes to teaching and assessment arrangements and this will continue to be a significant source of challenge for course teams.

Equally, it is not clear whether the geographical distribution of IP qualified optometrists who could supervise IP trainees has been considered in sufficient detail to determine whether specific regions or nations may be relatively disadvantaged. It is clear that there is an ongoing and increasing need for IP qualified optometrists to meet workforce requirements to prevent sight loss, but the means to deliver appropriate placement experiences in sufficient quantity, with additional quality assurance and assessment requirements is not clearly established. The settings in which complex cases are currently found are already suffering from a shortage of training capacity and this presents a bottleneck for IP training. This could be further exacerbated if new registerable qualifications are designed to incorporate IP education in parallel with the undergraduate degree. This in turn may lead to a shortage of placements, and perhaps even of standalone courses, for more experienced optometrists wishing to undertake postgraduate IP training. Placement availability was by far the greatest source of concern from respondents to the College's survey on the GOC consultation, and measures to address this should be considered as a matter of urgency.

The new integrated route to IP qualification is also likely to require a significant increase in funding. A conservative estimate for the clinical learning elements (based on typical charges for clinical observation sessions in hospital clinics) is of the order of £3000 for 90 hours. When this is laid alongside the rather expensive assessment methods typically expected for "Does" learning outcomes (direct observation, OSCE etc) and the current cost of delivering the academic learning, it would be unsurprising if course fees were to rise to more than £20k per trainee. This may significantly reduce access to and enrolment on the IP qualification.