SPOKE
Sector Partnership for Optical Knowledge and Education

SPOKE Framework for Staff: Student Ratios (SSR) benchmarking in Optical Education

Introduction

Standard 5.2 of the General Optical Council's Requirements for Approved Qualifications in Optometry or Dispensing Optics requires providers to demonstrate that there are "sufficient and appropriately qualified and experienced staff to teach and assess the outcomes." This includes an obligation to benchmark their staff: student ratios (SSR) to comparable providers "to determine if their SSR provides an appropriate level of resource for the teaching and assessment of the outcomes leading to the award of an approved qualification, leadership and research."

This document sets out to provide a benchmark that frames SSR expectations to support course teams in meeting standard 5.2, safeguard patient safety and high-quality learning experiences and support and maintain consistency of quality between programmes. It also attempts to address the balance between the demands of clinical learning and the need for a sustainable cost base, to enable optical education that is affordable but fit-for-purpose. It is not intended to address supervised practice and patient-facing activity (covered in the SPOKE Project 4 supervision guidance).

Risks

There are universal and considerable concerns across the sector, that increasing cost pressures on education providers coupled to a prolonged period of static funding will result in programmes either being under-resourced or closed due to the requirement for excessive cross subsidy. The changes invoked by ETR have required review and revalidation within institutions, and an ongoing process of renegotiation of resourcing for heads of subject or department, as the new courses roll out. Staffing forms by far the largest cost base and is also seen by providers as the only direct cost that can be readily flexed. As a consequence, staffing typically forms the nub of internal institutional funding conversations. At the time of writing, in early 2026, almost all UK FHEIs have a post freeze and/or a redundancy consultation underway. In the same year, the first delivery of the fourth year of many new ETR optometry programmes is due to commence, and whilst lower direct contact hours are required for students who are predominantly undertaking workplace learning, the staff time required for remote oversight and support should not be underestimated.

It is therefore imperative that this benchmarking exercise provides clarity of expectations around what is required to assure patient safety and the learning experience, without placing excessive expectations on provider resourcing.

Methodological challenges

Across UK further and higher education institutions (FHEIs), SSR reporting practices are highly variable. Significant differences exist in:

- Staff workload models, including maximum teaching hours permitted and leadership, administrative or assessment allowances
- Contractual expectations with regards to the proportion of teaching, research and administration undertaken including more than one kind of contract being in use within any one institution
- Management of the contributions of fractional, and part-time hourly-paid staff
- Deployment of non-registrants to deliver parts of the course relating to non-protected activities

Accordingly, there is a consensus that a return to a single mandatory numerical standard would be inappropriate. Instead, a risk-based framework, with indicative ranges aligned to the type of activities conducted in anyone session, is provided. This flexible but principled approach aims to protect patient safety and learner experience, whilst allowing HEIs to manage operational realities.

Risk-based SSR Framework

A risk based-framework benchmarking staff resource relating to the teaching of clinical skills and other relevant activities is provided in the table below.

It is expected that providers will determine what is necessary, and measure and explain how such ratios are resourced in with reference to their methods of teaching delivery as documented in module and course paperwork. This must be explained in the light of workload models used in their institution for their registrant staff, including reference to their expected contribution to teaching. This may include the contributions from suitably qualified fractional and part-time hourly-paid clinical teaching and technical registrant staff (as appropriate) but should not include staff whose workload model does not include a contribution to teaching.

Risk level	Examples	Ratio*
Low risk	Requires minimal direct oversight. Instructional and knowledge-based teaching. Practical work involving low risk skills, eg communications	1:12
Medium risk	Requires only intermittent direct oversight. Early years clinical skills teaching. Practical manipulative techniques (use of slit lamp, trial frame, measuring spectacle fit).	1:6
High risk	Requires continous observation for the duration of the task. Tasks which carry significant risk of injuries such as corneal abrasion, or require direct observation to determine student efficacy. Goldmann Applanation Tonometry, primary eye-care clinics, contact lens fitting, use of facial measurement gauges.	1:1 to 1:2 depending on context, whilst the task is taking place

*Ratio may well be 2-3 times higher, for low and medium risk tasks, where students are practicing on each other and taking turns to act as surrogate patients – especially where “patient” feedback is an important part of learning.

It should also be clear how the remaining learner hours are supported through deployment of both registrant and non-registrant staff, such that a judgement can be made, given cohort size, as to whether there is sufficient registrant input into didactic clinical teaching (lectures), and sufficient capacity and expertise for other teaching activities (non-clinical teaching, research projects, personal tutoring etc), assessment design, marking and documentation, and leadership and management of the team, including staff development. For example, a lecture to the whole cohort will only require one member of staff irrespective of class size, but personal tutoring will attract staff hours that match the expected 1:1 and small group contact time.

Alternatives

Simulation tools, including those based on AI, may also be used to derisk activities and increase teaching capacity, especially in relation to unusual patient types or conditions, but these should supplement not substitute for the need for properly supervise experience with real and surrogate patients. Simulation is also widely recognised to require significant investment and specialist expertise to deliver well.

Teaching group modalities can also impact the type and number of staff required to deliver specific learning. Use of station circuses and staging of activities, switching between risk levels, can both reduce requirement for continuous staff observation and input, and provide a more wholistic and varied experience for the learner, than sessions aimed at teaching an entire group to undertake one specific technique. However, it should be recognised that such approaches require significant planning, coordination of staff teams, and timely access to more diverse facilities, to enact, which can be challenging in the age of centralised timetabling.

GOC Education Visitor Panels, QAE and Standard 5.2

It is expected that the adequacy of the staff base, for patient safety and learning experience, is best judged in the light of testing the connections between the validated module documentation, the timetabled delivery schedule, and the staff contributions. This would allow EVPs to make judgements based on published teaching hours and workload allocations.