Response to GOC's education strategic review call for evidence

1. Questions for consultation

1.1. Please respond to the following questions and provide evidence in support of your views as far as possible:

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

Consultation question 1 – How might the needs of patients requiring eye care change over the next 20 years?

In the UK, the proportion of persons aged 65 and over increased from 15% in 1985 to 17% in 2010 (ONS, 2012); by 2030 it is projected that those aged 65+ will account for 22% of the total population. In terms of individuals, 2010–30 projections suggest a 50% rise in people aged 65+ and 100% more aged 85+ (ONS 2010, 2015). The average cost of providing hospital and community health services for a person aged 85+ is around three times greater than for a person aged 65 to 74 years (Cracknell, 2010). This means that there will be a considerable increase in the number of patients with eye disease and various co-morbidities, such as dementia or diabetes. It is also follows that more patients are likely to be in care homes or confined to their own homes. This may lead to a greater need from domiciliary and low vision services and for help for those with sight loss living alone.

Changes in technology mean that patients may well be able to self-refract or use a handheld OCT, either at home using a smartphone or in a booth in practices or elsewhere in towns and cities. There are likely to be advances in online sales as well, and possibly 3D printing. This may lead to a reduced need for optometry and dispensing optician input in relation to sight testing.

Ref: Foresight Project Report A discussion of the potential impact of technology on the UK optical sector to 2030 by 2020health March 2016 Commissioned by The Optical Confederation & The College of Optometrists

There is also increasing evidence that the number of children with myopia will grow, and there will be more available interventions. This may lead to an increase in optometrists needing to be proficient in working with children and in the use of myopia control treatments.

Refs:

McCullough SJ, O'Donoghue L, Saunders KJ (2016) Six Year Refractive Change among White Children and Young Adults: Evidence for Significant Increase in Myopia among White UK Children. PLOS ONE 11(1): e0146332. doi: 10.1371/journal.pone.0146332

Katie M. Williams, Geir Bertelsen, Phillippa Cumberland, Christian Wolfram, Virginie J.M. Verhoeven, Eleftherios Anastasopoulos, Gabriëlle H.S. Buitendijk, Audrey Cougnard-Grégoire, Catherine Creuzot-Garcher, Maja Gran Erke, Ruth Hogg, René Höhn, Pirro Hysi, Anthony P. Khawaja, Jean-François Korobelnik, Janina Ried, Johannes R. Vingerling, Alain Bron, Jean-François Dartigues, Astrid Fletcher, Albert Hofman, Robert W.A.M. Kuijpers, Robert N. Luben, Konrad Oxele, Fotis Topouzis, Therese von Hanno, Alireza Mirshahi, Paul J. Foster, Cornelia M. van Duijn, Norbert Pfeiffer, Cécile Delcourt, Caroline C.W. Klaver, Jugnoo Rahi, Christopher J. Hammond, Increasing Prevalence of Myopia in Europe and the Impact of Education, Ophthalmology, Volume 122, Issue 7, July 2015, Pages 1489-1497, ISSN 0161- 6420.

Walline, J. J., Lindsley, K., Vedula, S. S., Cotter, S. A., Mutti, D. O., & Twelker, J. D. (2011). Interventions to slow progression of myopia in children. *The Cochrane Database of Systematic Reviews*, (12), CD004916. Advance online publication.

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

Capacity issues in hospitals are likely to worsen both because of the ageing population and new treatments, which means that more care will have to transfer to the community, be that in standard optometric practices or community clinics. Technological advances in optometry equipment may mean optometrists have more time to spend on cases which are transferred from the hospital eye service. There could also be benefits from inter-professional collaborations and the growth of polyclinics.

Ref: B Foot and C MacEwen, British Ophthalmological Surveillance Unit, The Royal College of Ophthalmologists, *Surveillance of sight loss due to delay in ophthalmic treatment or review: frequency, cause and outcome*, Eye (2017), 1-5

Barriers include:

IT – this is a significant challenge, as most optometry practices are not currently connected to hospitals and GP surgeries. This means that they cannot send data, or referrals, electronically and cannot easily receive feedback on data or referrals they send to the hospital eye service. This is a particularly significant problem in England, where the money has not been forthcoming to start this process. And although the Governments in the devolved nations have invested in IT, rolling it out is slower than had been hoped.

Governance - It is difficult to put clinical governance arrangements into community practices, as good clinical governance requires significant resources. The various elements of clinical governance (risk management, clinical audit, CPD, evidence-based care and effectiveness, patient involvement and staff management) require expertise, time and money to implement, manage and undertake. The current funding frameworks, particularly in England, do not support this and are heavily

reliant on commercial transactions to survive as a business.

Clinicians who work in hospitals can take advantage of institutional systems and of mentoring by more experienced colleagues.

CPD (specifically) – The current system takes a limited approach to CPD and does not lend itself to optometrists personalising their development and creating learning plans that relates directly to their own practice. In addition, because they do not have protected learning time and work in a commercial environment, it is not always easy for them to do as much CPD as they might need to ensure they keep up-to-date and develop their knowledge and skills.

At all levels, as qualifications are gained, it is important for health professionals to consolidate their new knowledge and skills through experience with patients, and to have access to a good supervisor or mentor, on whom they can model their practice, whatever their stage in their career, and who will review their work and give them feedback and encourage reflection. This is difficult in a small community practice.

Increase in part-time work and locums: It is difficult for those who work part-time, and particularly for locums who work in different practices, to take part in clinical governance and CPD. When roles become more clinical, there will need to be some kind of assurance mechanisms that work for locums.

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

Technology is likely to remove some of the activities that dispensing opticians and optometrists currently undertake on a regular basis, as will the increase in online sales. This is particularly true for dispensing.

For optometrists, this will mean that their roles will become more clinical, as low risk patients with eye health issues will be managed in the community. Training will need to include more critical thinking and clinical decision making skills as well as knowledge, skills and experience in more specialist areas.

There are likely to be more large corporate brands and fewer small independent practices.

Ophthalmologists may move into community practice, so there will be greater scope for interprofessional collaboration.

There is likely to be an increasing domiciliary and low vision workload, as well as scope for broadening public health surveillance and advice for general health conditions.The drivers, as stated above, will be the ageing population, the availability of new treatments and interventions, and an increased use of technology. Further

developments in globalisation, including the use of the internet, will also be a factor.

Ref: Foresight Project Report A discussion of the potential impact of technology on the UK optical sector to 2030 by 2020health March 2016 Commissioned by The Optical Confederation & The College of Optometrists

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

Core training at undergraduate level should integrate knowledge, skills and professional behaviours that are revisited over the duration of the course so that students build on what they have learnt and look at it in more depth as they gain experience. Situated learning should be embedded from the start and built up through the curriculum, so that students can see how what they learn translates into actual practice. How to plan learning, and reflection skills, should be embedded from the beginning, and a range of teaching techniques used, which will allow students to take increasing responsibility for their own learning and be confident that they will be able to direct their own learning throughout their careers.

There should be a period of supervised and assessed practice to allow newly graduated optometrists to gain experience and consolidate their skills in a managed environment.

Continuing professional development, which is tailored to their own practice, is essential for all optometrists so they can maintain and develop their practice throughout their careers. This should involve planning learning, undertaking CPD, reflection, and putting what is learned into practice.

Those who want to work at a more specialist level should take the relevant qualifications and be able to consolidate their learning under appropriate supervision by gaining appropriate patient experience.

The aim should be to build up skills, knowledge, behaviours and experience in a way that each part of training builds on the previous parts. This allows knowledge, skills and behaviours to be taught at a point where they will be consolidated through experience. It is important that skills are practised and kept up-to-date, for example, surgeons must undertake a minimum number of particular operations to be allowed to continue in that field.

Studies showing whether inter-professional learning has a significant impact on future collaborative healthcare have mixed results and further research is needed.

Ref: Reeves S, Perrier L, Goldman J, Freeth D, Zwarenstein M,

Interprofessional education: effects on professional practice and healthcare outcomes (update) (Review), 2013

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

It is anticipated that there will be a blurring of roles. That does not automatically mean, however, that there should not be distinctions between registrant groups, as they will have different levels of education, training and experience and undertake different ranges of activity. Optometrists will take on some work currently done by doctors, but this does not make them doctors. Similarly, dispensing opticians may take on some work currently undertaken by optometrists, but this will not make them optometrists.

GOC's approach to education

Consultation question 6 – What are your views on the GOC's approach to the accreditation and quality assurance of education programmes, including on whether this is an appropriate focus on outcomes and on the use of the competency model to set the standards of education?

We would prefer to see an outcomes model, as this is becoming the norm for other clinical disciplines. We acknowledge, however, that there is opposition in some quarters, where it is felt that outcomes based training reduces the thirst for education in the wider sense. However, clinicians have to be capable of undertaking their role with a limited time for training. We do not believe the current competency-based model works, as there are a large number of competencies ranging from the very small to the very broad. This encourages students to tackle the competencies separately, ticking them off, and not to look at them as part of a whole.

While we agree that an outcomes based approach is correct and institutions should have freedom to develop their own courses, we believe strongly that it is the role of the regulator to ensure that curricula and assessments are developed in line with modern methods of clinical education and that arrangements are in place to support students and teachers. The regulator's role is to verify that appropriate leadership is in place to ensure a good learning environment that allows students to meet the learning outcomes. Ensuring that newly qualified optometrists are fit to practise is the most important priority and measures must be put in place to ensure consistency of standards at that level.

We believe the GOC should put quality assurance and accreditation systems in place that allow for flexibility but that are clear, transparent and have good practice in clinical education and the safety of patients at their heart.

Ref: ASME, ed Tim Swanick, The Understanding Medical Education Text Book (2nd Edition), 2013

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

The College of Optometrists has accredited a broad range of service-specific higher qualifications. There are currently eight different qualifications being delivered by five providers. Over 700 certificates have been awarded. The qualifications are referenced in the NICE Glaucoma Commissioning Guidance and the Royal College of Ophthalmologists Common Clinical Competency Framework for non-medical ophthalmic healthcare professionals. We would suggest that we continue with this system and the GOC accredits us to do so, and, indeed, it has suggested this system to us in the past.

Content of education programmes

Consultation question 8 – What are the core skills, knowledge and behaviours which optometrists will need to have on first joining the register in the future?

The safety of patients is paramount and the education system should include the core skills, knowledge and behaviours to support this. This includes professional skills as well as clinical skills.

Students should be well supported so that they emerge competent, critical and reflective practitioners, confident in their abilities.

We believe that, as practice is likely to change rapidly, it is also important that students learn to direct their own learning from the beginning of their undergraduate course.

If the profession wants to grow, students also need to begin to develop leadership, mentoring and evaluative skills.

Core skills, knowledge and behaviours we suggest are:

Basic and clinical science

- Basic and clinical sciences to underpin their clinical decision making skills and help in dealing with patients with different needs. This needs to be integrated so students understand why this is important for their clinical practice from testing to prescribing drugs to advising patients.

Clinical and practical skills

- History taking.
- Clinical assessment skills such as ocular examination, visual function, analysis of

digital data, refraction (which will still needed for some time and will always be needed for some groups, for example those with learning difficulties or dementia)

- Critical thinking and problem solving to underpin clinical decision making skills, including which tests to undertake, interpreting results, diagnosis, management, prescribing drugs appropriately.
- Reflection skills.
- An ability to write clearly and concisely and with the information the recipient needs – no more and no less. This is particularly important for referrals.
- Communication skills: listening, explaining, and reassurance, involving patients in decision making
- Prescribing drugs appropriately but only in areas where they have the management expertise at registration. We believe it is really important that prescribing matches capability in terms of diagnosis and management and any higher level prescribing qualifications should be taken at the appropriate time after registration when the optometrist has the requisite experience and capability to diagnose and treat particular diseases. This is because skills must be practised regularly to avoid patient safety issues.
- Practical procedures that they need at the time of registration and continuing experience of doing them. So we believe that refraction is still important, and, by way of example, there is risk from students practising gonioscopy if they do not then go on to use it regularly.

Professional skills

- Information management from keeping accurate records, to writing clear and concise referrals, and finding and verifying information.
- Working in a multi-disciplinary team
- Understanding how to accept feedback, including negative feedback
- Working with patients
- Ethical principles and the law
- Equality and diversity
- Self-directed learning and reflection
- Clinical governance, including clinical audit to improve care.
- Understanding evidence and how to read a research paper critically
- Patient safety issues such as infection control and safeguarding.
- Public health, epidemiology and evidence based practice.
- Leadership skills and the ability to teach others.

Consultation question 9 – How should the content and delivery of optometry programmes change to ensure that students gain the skills, knowledge and behaviours that they will require for practice and for new roles in the future?

We would suggest that the content and delivery of optometry programmes should put patient safety and needs at the heart.

Outcomes based learning

We would commend the system of outcome-based education, which is now used in medicine and other health-related disciplines. This builds the curriculum around the optometrist who will emerge at the end of the course, and helps prepare the student by looking at what he or she will need to be able to do once qualified. It should be put in context, however, so that the student understands that registration is not the end of learning but a stage on the way.

References:

AMEE Education Guide to Outcome-based Education 1999

Experiential situated learning

Optometry students have little exposure to patients with different needs and conditions compared with other clinical students and we believe this needs to be increased significantly, beginning with simple contact so they begin to understand the needs of different types of patients and building to more complex clinical abnormalities and diseases so that they get a breadth of clinical experience. Situated learning, throughout the course, that makes an explicit link between what they learn at university and actual practice, is present for all other health professions students.

Professionalism

We believe professional skills such as communication with patients and colleagues, clinical decision making, critical thinking, governance, including audit, ethical and legal considerations, basic research skills, epidemiology and understanding evidence should be woven into the curriculum, and their relevance to each aspect of the curriculum explored. They should not be taught as a separate module. Integrating professionalism into all aspects of the curriculum will help students understand how to do the right thing in relation to everyday practice as well as in more ethically challenging situations.

Universities should treat optometry students differently from non-clinical students, requiring them to behave professionally and holding them to the GOC's standards for optical students.

Methods

There is a considerable amount of research into the effectiveness of clinical education and assessment.

Optometry schools should use a range of teaching methods that build students' confidence and gradually allow them to take responsibility for their own learning. This means more small group work, problem-based learning, where learning is structured around clinical situations, and a gradual transition from more classroom based teaching to more clinically based teaching, allowing students to experience a variety of different clinical situations.

We believe that training and assessment institutions should use modern methods of

clinical assessment and obtain permission for optometry courses to be run in the same manner as medicine and other health related courses. For example, we do not think all existing optometry courses use recognised methods of standard setting, as they are obliged to use the university pass mark. This is not appropriate for courses leading to registration as a health professional.

Scheme for registration

It is important that Pre-Registration trainees get the support they need from their supervisors. In some practices, the level of support may vary. A regulatory requirement for them to help trainees plan their learning, with regular review meetings, good feedback, case based discussions and a policy of inviting them to shadow the supervisor seeing patients with more complex conditions would help. The College has a supervisor competency framework which is designed to support supervisors through this period as well as help them develop professionally in the role. We would recommend this framework for all supervisors. We have also developed our own online training which is compulsory for all supervisors.

Consultation question 10 – How might post-registration training and registrable higher qualifications for optometrists need to change in the future?

Post registration training

Just as in any profession, optometrists will have different aspirations. However, we must assume that they will be working for many years, whichever path they decide to take. To provide the best care to patients, they must ensure they are fit to practise in their chosen career and that will involve continuing professional development (CPD) so that they consolidate their original learning, build on and learn from their experience and have the ability to learn new knowledge and skills as their profession develops.

The current CET system does not fulfil this function. It is possible for optometrists to approach this as a tick box exercise, meaning that it does little to improve their performance in their areas of work. It is also onerous for providers and has been known to prevent small but good providers from undertaking CET sessions.

Research shows that, to be effective, CPD needs to be linked with and relevant to individual learning needs within the context of the professionals' own practice, and the needs of their patients, so it needs to be planned. Learning with others and reflection are known to help, and active learning is regarded as useful. The impact of CPD is shown through positive changes in practice, knowledge acquisition and learner satisfaction.

Follow up through informal learning, by discussing issues from CPD with colleagues, is also felt to be effective by professionals.

It is difficult to balance a more personal approach to CPD with a quantifiable system,

but other professions are finding ways to tackle this. However, collecting a number of points can mean that the CPD does not improve practice but is an activity in its own right. Checking the effectiveness of CPD is a challenge, but imbuing an understanding of CPD is becoming more and more important now as the practice of registrants will change considerably through the life of their own careers. It is important that they know how to direct their own learning effectively to take responsibility for it and continue to provide good care for their patients.

Reference: https://www.college-optometrists.org/cpd-and-cet/plan-your-learning.html
http://www.aomrc.org.uk/wp-content/uploads/2016/07/Core_Principles_CPD_0716-2.pdf
Schostak, Jill et al, 2009, The Effectiveness of Continuing Professional Development, A report prepared on behalf of the College of Emergency Medicine, Federation of Royal Colleges of Physicians and Manchester Metropolitan University.
I Starke and W Wade, CPD Supporting Delivery of Quality Healthcare, Ann Acad Singapore. 2005
Karen J McConnell et al, The Impact of Continuing Professional Development versus traditional Continuing Pharmacy Education on Pharmacy Pracitce, The Annals of Pharmacotherapy, 22, 2010
Griseti O, Jacon J, Effectiveness of Continuing Education Programmes in Nursing: Literature Review, 2006, Blackwell Publishing Ltd
Woosung Sohn, DDS et al, Efficacy of Educational Interventions targeting Primary Care Provider's Practice Behaviours: An Overview of Published Systematic Reviews, Journal of Public Health Dentistry, 64, 2004
David A Davis et al, Changing Physician Performance A Systematic Review of Continuing Medical Education Strategies, JAMA, 274, 9, 1995
Bernard S Bloom, Effects of continuing medical education on improving physician clinical care and patient health: a review of systematic reviews, International Journal of Technological Assessment in Health Care, 21:3 (2005), 380-385
S Wallace and S A May, veterinaryrecord.bmj.com, 2016; 179: 551-520 doi:10.1136/vr.103862t

Higher qualifications

We believe that it is important that qualifications in particular areas of practice build on general experience and involve a period of supervised or mentored experience and relevant CPD to consolidate the learning from the qualification. Having a qualification without gaining experience by putting it into practice and keeping the knowledge and skills up-to-date can be dangerous for patients.

Putting in place a CPD system that requires a certain amount of experience and

evidence of keeping up-to-date would overcome this. For example, surgeons are required to undertake a certain number of particular operations if they are to continue undertaking them.

We believe that the three tier system of higher qualifications that we have developed in various specialist areas and accredit other institutions to deliver, works well. We involve all relevant professionals in developing the qualifications, for example ophthalmologists, orthoptists or dispensing opticians. These range from just above core competency (professional certificate) to specialist hospital work (diploma). We have a detailed system of accreditation that covers curriculum content, structure, assessment, guidance for teachers and trainers, clinical placements, student support and feedback and quality assurance. The Royal College of Ophthalmologists used it as a basis for its common clinical competency framework and uses our glaucoma qualifications in its glaucoma commissioning guidance (page 6 and table page 12). We understand some believe that the independent prescribing qualification contains sufficient learning about glaucoma to be equivalent to the College Diploma in Glaucoma. We believe that a comparison of the learning outcomes and indicative content for the two qualifications would show that this is not the case.

Consultation question 11 – What are the core skills, knowledge and behaviours which dispensing opticians will need to have on joining the register in the future?

We recognise that these will change, in the way that those for optometrists will change. ABDO is better placed to comment on the detail but we would be happy to work jointly with them, if that would be helpful.

Consultation question 12 – How should the content of dispensing programmes change to ensure that students gain the skills, knowledge and behaviours that they will require for practice and for new roles in the future?

We recognise that this will change, in the way that it will for optometrists. ABDO is better placed to comment on the detail but we would be happy to work jointly with them, if that would be helpful.

Consultation question 13 – How might post-registration training and registrable higher qualifications for dispensing opticians need to change in the future?

We recognise that this will change, in the way that it will for optometrists. ABDO is better placed to comment on the detail but we would be happy to work jointly with them, if that would be helpful.

Professionalism and consistent standards

Consultation question 14 – How can we ensure students have the professionalism needed to take on new roles, including through the admissions procedures used by

education providers, patient experience, supervision and embedding professional standards?

Students should be subject to a selection system to ensure that they have the appropriate characteristics for the role and know themselves that the profession is right for them. We believe that they should be asked to undertake work experience before applying so they can decide whether it is the right choice. Multiple mini interviews or group interviews would be a possibility for selecting people with the right aptitude and attitudes, and possibly an aptitude test, as it is important that they have the intellectual ability as well as the communication and ethical skills needed in the profession. There has been some research into this area, for example:

Ref: Identifying best practice in the selection of medical students (literature review and interview survey) Professor Jennifer Cleland Dr Jon Dowell Professor John McLachlan Dr Sandra Nicholson Professor Fiona Patterson, 2012

Professionalism needs to be embedded in the curriculum from the beginning, woven in so students understand that it is involved in every aspect from the legal aspects of practice, to working with patients and colleagues, prescribing drugs, research,and using evidence in practice etc.

Ref: https://www.college-optometrists.org/the-college/policy/professionalism-in-optometry.html

It is helpful if students see practitioners leading by example and acting as role models. However, care needs to be taken that the chosen role models are positive. In medicine, what is known as the hidden curriculum where teaching by humiliation sometimes occurs, is known to be a problem in some places.

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

It is important that appropriate assessment methods are used throughout the course **Ref: ASME, ed Tim Swanick, The Understanding Medical Education Text Book (2nd Edition), 2013**

Standards appear to differ across optometry schools. To ensure parity of standards at the point of registration, it is crucial that there is an independent assessment of all students after graduation and before entry to the register. This is currently done through the Scheme for Registration. The Scheme for Registration is a flexible programme and is being offered at the end of undergraduate courses as well as being incorporated into four year MOptom programmes. The Scheme allows students to have an extended period of situated learning to consolidate their skills while still under supervision.
Ref: College of Optometrists, The Scheme for Registration 2013-15, 2016

The General Medical Council has recently concluded that there has to be a comprehensive independent assessment of medical students at the point of graduation and doctors also have a period of supervised, assessed practice before entering the register.

Ref: https://gmc.e-consultation.net/econsult/

This ensures the best possible safety for patients and gives newly qualified clinicians the confidence they need to practise independently.

Barriers to change and other issues to consider

Consultation question 16 – What are the challenges and barriers to improving the system of optical education, including issues that may be outside the remit and control of the GOC, such as legislative change, workforce planning, the funding of education (including higher education, continuing education and training and continuing professional development) and the provision of student placements?

***University* funding**
To make the undergraduate curriculum work, it would be ideal if optometry could have funding for a clinical stage. However, we realise that this is unlikely in the current climate where this type of funding is being restricted. Alternatively, it might be possible for optometry students to be funded for clinical placements in the manner of allied health professionals.

Optometry schools' resources are very tight and staff-student ratios need to be increased. A newly designed course with more clinical and small group work, and modern clinical assessment methods, would cost considerably more to run. In addition, they may need more optometrists with current practical experience on the staff to help with clinical skills. The multiples might be in a position to help with this if partnerships could be formed between universities and employers. The College could

look at options for training the trainers so that practitioners had the necessary skills to undertake such a role.

Hospital placements
Hospital eye departments are well situated for students to to experience abnormalities and pathology that are too complex to be managed in community practice. However, placements are limited because the hospital departments have to accommodate medical students, junior ophthalmologists and other health professionals with an interest in eyes, as well as optometry students and trainees and those undertaking higher qualifications.

Funding for CPD and clinical governance activities
This is currently underfunded for optometrists. In addition, optometrists do not have protected time for CPD.

Practice funding
In England, particularly, optometry is funded by GOS and has to be heavily subsidised by the commercial aspects of optometry. This makes it difficult to allow space for training and professional development, and quality assurance. Contractual changes would be needed to enable those with the required skills level to pracise at the higher level and quality outcome measures would be needed.

Workforce planning
More optometrists are opting to work part-time or as locums. There is a danger that this would leave them outside any systems designed to assure the public that optometrists were safe to practise.

Ref: **https://www.college-optometrists.org/the-college/research/research-projects/optical- workforce-survey2.html**

Consultation question 17 – Are there any other issues that we should consider in carrying out our review? If so, please set out what they are.

Ultimately, the education of optometrists is about patient safety and the training should, therefore, be patient-centred at all stages.

The closing date for responses is **Thursday 16 March 2017**.
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