

Revalidation Stakeholder Events Summary

March 2010

Introduction

The White Paper 'Trust, Assurance and Safety' set out the Government's proposals to ensure that all the statutorily regulated health professions establish suitable systems for revalidation of their registrants.

The GOC is committed to ensuring that the revalidation scheme to be established for optometrists and dispensing opticians will be risk-based, targeted, proportionate and which sustains, improves and assures the professional standards of optometrists and dispensing opticians, as well as identifying and addressing poor practice or bad behaviour

As part of this work, and supporting the GOC's broader programme of stakeholder engagement, the GOC organised five stakeholder events around the United Kingdom in February 2010. This paper provides a summary of the discussions at the events.

Purpose of the events

The GOC launched its initial proposals and consultation on Revalidation in March 2009. The consultation closed in September 2009. Department of Health funded research was subsequently conducted on the areas of risk profiling and employer appraisal. The stakeholder events sought input from GOC registrants, patient groups, professional bodies, regulatory bodies and members of the public on the following key issues:

- Profiling the Risks in the Optical Profession – what does it tell us about the focus of revalidation?
- Employer Appraisal – can it be used in revalidation?

Event programme

Each event was based around two presentations and interactive group sessions, which were led by an independent facilitator. Events were held in Cardiff, Manchester, London, Edinburgh and Belfast (the event schedule is attached as Annex 1). Delegate numbers ranged from 7 to 50.

The events were publicised in the optical press, GOC newsletter and website. Each event was attended by a senior GOC staff member, research consultants and other GOC staff.

The programme for each of the events was:

- Introduction from GOC Registrar/Deputy Registrar
- Overview of Revalidation work to date
- Profiling the Risks in the Optical Profession – what does it tell us about the focus of revalidation? (Presentation from Deborah Kelly – Europe Economics)
- Group discussion on risk profiling
- Feedback from groups on main issues
- Employer Appraisal – can it be used in revalidation? (Presentation from David Moore)
- Group discussion on the use of appraisal in revalidation
- Feedback from groups on main issues
- Next steps

Methodology

It was made clear to attendees at the start of each event that no plans or scheme for revalidation had been agreed and the purpose was for the GOC to listen to views and ideas about the research and scheme. As a result it was difficult to give answers to specific questions, i.e. cost of the scheme. The issues of the scheme being proportion and risk based were also stressed to participants

The rooms were set up in cabaret style to help facilitate and encourage interaction between the attendees. The tables had a mix of attendees to enable a broad range of discussion and feedback. At the group discussions, each table was given flip chart pads and different coloured post-it notes to write down and group together any areas of the reports that they liked and also had issues with. Attendees were also asked to suggest ideas and criteria for a model scheme for revalidation.

No one event was identical in the issues that were raised and the facilitation had to be and was flexible to take into account the different concerns and themes that were discussed. The summary aims to draw out as many of the issues discussed, whether written or spoken, though inevitably it won't cover every aspect at all the events. The majority view has been presented when considering the feedback wherever possible, though numbers of comments and a statistical representation are not provided.

Issues outside of scope

Several issues arose across the events that concerned issues outside the scope of the events. These concerned:

1. CET funding for Dispensing Opticians
2. Regulation of dispensing
3. Contracting issues

Many issues centred around the contents of the report, scope and methodology of the risk research and others around the implementation of the scheme. There was a vast amount of data to compile which was complex and difficult to extract every single issue or concern. As a result it will be difficult to do real justice to every point raised from the events and therefore the report focuses on the consistent and key themes. The issues, questions and concerns that were raised at each event can be found at Annex 2. There is duplication of issues and views in the headings in the annex they follow the theme of good points and then issues with the research/concept and then views on a model scheme for revalidation. Some views cut across different headings and may appear in both the good points and issues sections.

The GOC would like to thank all those who participated and contributed at the stakeholder events and the data gathered in annex 1 will be considered as the scheme for revalidation moves forward. The key messages from the events will help inform the direction of the GOC's scheme for revalidation.

Consistent themes about the benefits of the research and model scheme also arose across the events and these have been consolidated below to give a broad view of the issues and views that were either repeated or consistently raised and discussed as the most important to the implementation of a scheme for revalidation. The headings do not state whether they are good or bad points as there was often debate around the benefit and problems with each area. The breakdown of themes is not in any particular order of priority.

Risk Profiling

- Risk level - The profession is seen as low risk and no main risk areas were identified in the research. Risk assessments of individuals were generally seen as a good idea.
- Interaction - There was common consensus around the use of and need for peer review, assessment by peers and learning with other clinicians. Although the majority of CET points are gained through distance learning, most attendees supported the idea of peer interaction.
- Training – Many attendees agreed that targeted training and flexibility in the mode of delivery will be beneficial in delivering an effective scheme for revalidation. The existing CET scheme should be built on and developed. Training should be focussed across key competencies. Professionals should take responsibility for their training and this should be easy to fit into working life. Most attendees felt that there should be no exams and that revalidation should not be re-qualification.
- Existing Schemes - It would be beneficial to examine what is being undertaken in Scotland and Wales.
- Proportionality - The report differentiates between optometrists and dispensing opticians and is proportionate to risk. It was felt that any

scheme needs to be proportionate to the risks involved and identified. The majority of attendees felt that the conclusions recommended in the research report were proportionate.

- Report - The research and report was conducted by a researcher outside of the optical profession which was seen as a positive approach. The report also included contextual factors which was beneficial as well as by way of consulting with lots of different stakeholders.

Issues

- Cost and resources. The cost and impact of the scheme and who will fund it is one of the primary issues that arose at all the events.
- Points system – Attendees felt that a points driven system maybe too inflexible. This raised the question of whether the current CET is not already enough. If this approach was taken it would require more work for CET outside of working hours.
- Dispensing Opticians – Dispensing Opticians agreed that there is a disproportionate requirement on them for CET. It was also felt that the report is primarily based on risks by optometrists and not on dispensing opticians
- Research – It was felt that the research did not link insurance claims to modes of employment. It was also felt that some of the conclusions are not supported by evidence and there is a lack of data from litigation and FTP cases.
- Isolated practice - A full and proper definition of isolated practice is required before a scheme is outlined or introduced. This led to the issue of whether revalidation should be for all, and raised the question as to what is happening with the licence to practice option and how would bad practice be identified.
- Training – It was felt that the GOC should not over specify CET and that training should be up to the profession to decide. It was also felt that peer assessment is and would be difficult to set up.
- Patients – Patient representatives felt that the research did not address their perspective. Although the report may not define some issues as high risks they are perceived as high risks by patients.
- Evaluation – It was felt by some attendees that the report presents a static view of practice and that future developments were not considered.

Appraisal in Revalidation

- Use - Employer appraisal in its current state should not be used, though it could contribute to evidence towards revalidation and used as part of a menu of options for revalidation.
- Standards - If appraisal was to be used there would need to be a nationally agreed standard and funding. There is a lack of consistency for appraisal therefore it is currently unworkable for revalidation.
- Locums - They are portrayed badly in the research. This may be due to employer feeling and not proof of bad practice.
- Research - The report was very comprehensive and it was good that it was carried out independently and considered different employers

Issues

- Accreditation – The majority of attendees felt that it would be difficult for appraisals to be accredited. One of the issues with appraisals is there can often be conflicts of interest when they are carried out.
- Use - Most attendees felt that appraisals that are too commercially focused and have no place in a scheme for revalidation. It was also agreed that it would be extremely difficult to accredit appraisal schemes due to the amount of different schemes in use and also because many small businesses don't use appraisal systems. If appraisals were to be used there would need to be a standardised and consistent appraisal system.
- Research - The report highlighted the diversity of the profession and why appraisals couldn't be used as a source of evidence for revalidation on their own.
- Training - The majority of attendees felt that appraisal training would be a real issue and appraisals can only really work in a large organisation where there are checks in place.
- Assessment - It is and would be difficult for non-clinicians to assess clinical competence.

What would a Model Scheme look like?

- Existing Schemes – The existing CET scheme should be enhanced using mixed modes of training. CET should be modified to cover core aspects of practice and points should be acquired across the

competency range. Appraisal could be used to support and develop high risk registrants.

- Peer review - Interaction should make up part of the scheme for revalidation. This should include direct observation and a demonstration and assessment of clinical skills. Reflective practice should also be included as well as assessment of communication skills. A portfolio approach using CET, CPD, Peer review, workshops, appraisal, case records etc using different modalities could be utilised.
- Proportionality – The scheme should be proportionate to the level of risk and scope of practice. The scheme needs to focus on healthcare and patient safety, not commercial aspects. The scheme needs to be light touch. The cost and time involved needs to be reasonable and the scheme should be fair to everyone. The focus of the scheme should be on the scope and context of practice.
- Time - A 6 yr cycle was seen as an appropriate and realistic timescale by the majority of attendees.
- Evaluation – There should be clarity in the outcome of the scheme and a definition of what a successful scheme will look like. There is a need for clear outcome measures and what constitutes a successful revalidation process communicated to registrants.

Next Steps and further work

The summary was presented at and discussed by the GOC's revalidation workstream group on 4th March 2010. The workstream meets again on 20th May 2010 to further discuss progress on revalidation.

The GOC Standards Department met with the Department of Health on 8th March to discuss progress on the scheme for revalidation and the associated implications for legislative change. A separate piece of research on patient feedback and complaints handling is being commissioned with an expected completion date of August 2010.

A consultation document on Licence to Practice will be issued shortly after publication of the summary report. Meetings with Optometry Wales and Optometry Scotland are being arranged to discuss GOS schemes. We will communicate proposals and decisions on the scheme for revalidation on our website. A copy of this summary will also be sent to those attendees that provided their details.

Annex 1 – Event Schedule and GOC attendees

Location, Date, Time	People
<p>Cardiff – Monday 8 February 2010, 10.00 – 3.45pm</p> <p>Venue: Wales Millennium Centre Cardiff Bay Cardiff CF10 5AL</p>	<p>Dian Taylor (Registrar) – Welcome and presentation Jon Levett (Deputy Registrar) Grahame Tinsley (Assistant Director of Standards) – Presentation Deborah Kelly Europe Economics, Presentation on Risks David Moore, Presentation on appraisal Lindsay Mitchell (Facilitator)</p>
<p>Manchester - Wednesday 10 February 2010, 10.00 – 3.45pm</p> <p>Venue: Britannia Hotel Portland Street Manchester M1 3LA</p>	<p>Jon Levett (Deputy Registrar) – Welcome and Presentation Grahame Tinsley (Assistant Director of Standards) – Presentation Deborah Kelly Europe Economics, Presentation on Risks David Moore, Presentation on appraisal Lindsay Mitchell (Facilitator)</p>
<p>London – Tuesday 16 February 2010, 10.00 – 3.45pm</p> <p>Venue: Park Crescent Conference Centre 229 Great Portland Street London W1W 5PN</p>	<p>Jon Levett (Deputy Registrar) – Welcome and Presentation Grahame Tinsley (Assistant Director of Standards) – Presentation Simon Grier, Communications Officer Linda Kenneough, Director of Education Deborah Kelly Europe Economics, Presentation on Risks David Moore, Presentation on appraisal Lindsay Mitchell (Facilitator)</p>
<p>Edinburgh – Thursday 18 February 2010, 10.00 – 3.45pm</p> <p>Venue: Caledonian Hilton Hotel Princes Street Edinburgh EH1 2AB</p>	<p>Jon Levett (Deputy Registrar) – Presentation Grahame Tinsley (Assistant Director of Standards) – Presentation Deborah Kelly Europe Economics, Presentation on Risks David Moore, Presentation on appraisal Lindsay Mitchell (Facilitator)</p>
<p>Belfast – Friday 19 February 2010, 10.00 – 3.45pm</p> <p>Venue: Pharmaceutical Society of Northern Ireland (main meeting room) 73 University Street Belfast, BT7 1HL</p>	<p>Jon Levett (Deputy Registrar) – Welcome and Presentation Grahame Tinsley (Assistant Director of Standards) – Presentation Deborah Kelly Europe Economics, Presentation on Risks David Moore, Presentation on appraisal Lindsay Mitchell (Facilitator)</p>

Annex 2 – Views and issues raised at each stakeholder event

Cardiff Event - 8th February 2010

Risk Profiling

Good points/views about the research

1. Good to have contextual factors in the report
2. Low risk / no main risk areas / low incidence of misdiagnosis
3. If risk is low why profile individuals?
4. Value of peer review / assessment by peers
5. Targetted training / mode of delivery
6. Learning with other clinicians
7. Study outside optics / good research
8. Look at what is used in Scotland / Wales
9. Differentiates between Optometrists / Dispensing O's and proportionate to risk
10. Conclusion recommended is proportionate / training oppossed to exams
11. Build on good and exisiting CET practice
12. Easy to fit into working life
13. Professional should take responsibility
14. Lots of stakeholders consulted
15. Training focussed across all core competencies
16. Risk assessment of individuals
17. Proportionate scheme to risk
18. No exams

Issues/views about the research

1. Static view of practice
2. Contract issues
3. Points driven system maybe too inflexible
4. What about remediation systems?
5. No clear process expressed
6. Research didn't link insurance claims to mode of employment
7. Conclusions not supported by evidence
8. Few risks associated with dispensing properly / superficial analysis
9. Lack of clear governance strategy
10. Revalidation may be too difficult to continue registration
11. Who decides the risk profile for each practitioner?
12. How to handle dispensing done by none registered persons.
13. Cost and resources – who funds?
14. What about future developments?
15. Perception of losing career if not competent in everything
16. Transparency of the process
17. IS CET not already enough
18. Definition of isolated practice / occasional practice – obligation to participate
19. Revalidation for all?

20. DO's – why bother – unregistered assistants – disproportionate requirement on DO's for CET
21. Patient point of view
22. Use of FTP cases – not rigorous/ lack of information / hearings used
23. No bias to different practitioners i.e. lone practitioners – might be perception of risk rather than actual risk
24. Business aspect should not override health and safety
25. Low risk is wrong message
26. No mention of audit
27. How to identify bad practice?
28. Overspecification of CET – up to profession to decide.
29. CET too broad – not directed to core competencies
30. Peer assessment difficult to set up
31. Who would do appraisals?
32. Who controls revalidation – GOC/College
33. Should risk profiling be ignored - it may be valid / lack of evidence
34. Administrative burden
35. To patients they are big risks
36. Under qualified operators may be working
37. Did not relate risk of optometry to other health profession
38. Based on OO's not DO's fully.
39. No mention of unqualified DO's – higher risks
40. Glaucoma – lack of NHS funding / does risk link to funding rather than poor performance.
41. More work would be involved for CET – outside working hours
42. Communication issues
43. Costs - who will fund / will PCTs be involved / Time costs
44. Minimum number of days in practice
45. Should everyone be revalidated – for all?
46. Over specification of CET/over prescription/up to profession to decide
47. Unqualified optical assistants – Dos (why bother due to unregistered OAs)
48. No bias to different practitioner groups
49. Funding issue for Glaucoma testing
50. Targeted CET for Lone practitioners/Locums
51. Proper evaluation of risk – practising groups
52. How would bad practice be identified?
53. Disproportionate requirement for Dos
54. Linking appraisal to CET
55. Lay member – how do they know OO/DO has met minimum standard?

Appraisal in Revalidation

Good points/views about the research

1. Portfolio approach using CET, CPD, Appraisal, Case records, post grad courses
2. Portfolio but using different modalities dependent on background i.e. NHS, DO etc.
3. Guidelines including weighting of different elements
4. Look at other examples to look at what works elsewhere i.e. Europe

5. Rolling system – not a fixed period like CET
6. CET modified to cover core aspects of practice / CL practitioners to do comp CET
7. Need for clear outcome measures and what constitutes a successful revalidation process / communication to registrants
8. Hospitals are best placed to clinically appraise / employers are interested in commercial factors
9. Random audit of individuals portfolios
10. Pilot scheme / review and audit
11. Evidence based and can audit it with ease
12. Mandatory CPD in varying aspects of optometry i.e dispensing
13. DO scheme similar to optom scheme but proportionate to level of risk and scope of practice.
14. Pleased that appraisal is seen as poor validity
15. Good summary of situation
16. PEER review
17. Good if done by line manager/of same profession
18. Good research was done independently
19. Good presentation
20. Who would appraise the appraisers/or principal optometrist
21. What is the difference between appraisal and performance review?
22. Peer review may be open to bias – this is on self selection i.e. bringing own papers to review

Issues/views about the research

1. Should not be used in its current state but could contribute to evidence
2. Periodic audits could be used as a basis for appraisal (including locums)
3. Who should audit e.g. College assessor
4. Encourage/support for employers to do appraisal
5. There needs to be a nationally agreed standard – and funding (training every 3 years)
6. Presentation said they didn't work and we agree
7. They can be good if your employer sees you regularly
8. Good report – independent / considered different employers
9. Lack of consistency for appraisal – therefore unworkable for revalidation
10. Locums portrayed badly in the research – need to remember this is employer feeling not proof of bad practice.
11. Build on CET / mixed modes / limit carry over
12. May lose registrants
13. Equipment
14. User opinions?
15. Locums's could fall through the cracks
16. Lack of evidence of risks
17. Need professional integration / Isolated practice
18. Communication
19. Insufficient data for evidence
20. Locums – no risk in evidence
21. Self selection of mode / context should be more well rounded
22. More rigorous assessment / checks for CL optoms

23. Patient involvement in research
24. Risks of fraud / over prescribing
25. What if competence called into question
26. Difficult to get them accredited
27. Conflict of interest with appraisal
28. Consistency
29. Tackle distance selling
30. Appraise locum's
31. Non optical appraisals
32. No place in revalidation
33. Appraisal should be one of a number of sources of evidence / optional alongside other sources
34. Used as part of a menu of options for revalidation
35. Appraisals that are too commercially focused must not be used
36. Smaller practices would welcome some structure of appraisal they could implement
37. Difficulties in making use of different schemes
38. Can employers be audited / revalidated too?
39. There has been much work into the KSF system which would be sad to lose this if it could work
40. Report highlights the diversity of the profession and why appraisals couldn't be used alone
41. Report didn't address who will appraise employers who are registrants
42. Employers are not best placed to be involved in the revalidation process / a clinician should be able to use evidence from this environment to support evidence of their competence BUT amongst other methods of competence
43. Appraisal training would be a real issue
44. Extra revalidation required for extra qualification i.e. examiners
45. Revalidation workshops at CET events – learning with others with witness testimonies
46. Continuous audit of hospital referrals to identify weaker clinicians (plus give constructive feedback for all)
47. Build a better relationship between hospital and high street
48. Not all distance revalidation
49. Appraisals not effective and should be replaced by Audits, PEER review (similar to College Assessor for pre-regs)
50. In order to create a blame free arena the focus should be on improvement of service rather than punitive measures.
51. Appraisal can only work in a large organisation where there are checks in place.
52. Commercial interests can influence appraisal
53. Appraisal is the worst form of revalidation
54. Public would have confidence on eyecare professionals
55. Personalities get in the way
56. Not keen on responsible officers – could be perceived as GOC police.
57. Professional performance is an integral part of what should be assessed by an employer
58. Who would train the appraisers so that there would be a level playing field
59. Would be inappropriate for locums / sole practitioners = who would appraise them?

60. Would need a standardised consistent appraisal system
61. How can appraisal work for the self employed / practice owner
62. How often would appraisal be undertaken with a cycle of revalidation?
63. Do appraisers have time to do this and do they want to?
64. On-line assessment is good
65. Too many variables
66. Not specific enough to optics
67. Stengthen CET
68. PEER review – yes
69. Multi-source portfolio
70. How and who would you appeal to?
71. Personalities influences
72. PEER review – valued in CET but difficult
73. Confusion between performance and appraisal
74. Difficult to assess clinical competence by a non-clinician
75. Risk of holding employers to ransom
76. Shows limitations of appraisals / not viable
77. Good idea in theory
78. Would need to be done so not pay-linked
79. Will everyone be treated the same?
80. PEER review time consuming and open to bias
81. Appraisal by NHS too complex and irrelevant in general practice
82. Independent appraiser training
83. Research very negative with respect to clinical appraisal
84. Many small businesses don't run appraisal systems
85. Employers commercial interests will over-ride revalidation interests.
86. Observation in practice – is it the gold standard? How consistent will this be?
87. How would you police this and also the decision that has been made?
88. Regulation and consistency – across all registrants
89. Limitation of independent practices
90. Appeal process
91. Additional pressures
92. Difficult to get CET points for PEER review – bureaucratic hoops
93. What registrants do want to happen?
94. Certain elements of appraisal may be useful – i.e. records
95. LOCUMs - no evidence to suggest that they are high risk.

Model Scheme

1. Use mystery shoppers / patient involvement
2. Use appraisal to support and develop high risk registrants
3. No CET funding for DO's
4. Needs to focus on healthcare / patient safety not commercial aspects
5. Light touch scheme
6. Points acquired across competency range / abd range of modalities
7. Build assessment process into end of lecture
8. Points for those who deliver CET
9. On-line synchronised discussions / case reviews / forums
10. Additional points for IP etc

11. Multi-layered scheme – GOC role – new development
12. CPD – define – keeping ahead/keeping up-to-date
13. Protected time (funded) and linked to risk
14. Challenge to change culture
15. 6 yr cycle – but not last minute / milestones / CET
16. Focus on scope of practice
17. Use all sources i.e. records / case discussions
18. Continuous audit of hospital referrals – identifying weak practitioners
19. CET events – learning with others
20. Blame free – should not be punitive – developmental focus
21. Clarity of outcome – what is a successful revalidation?
22. Review CET accreditation
23. Who audits CET quality?
24. Funding
25. Reflective time on clinical strengths and weaknesses
26. Evidence that keeping up to date in scope of practice
27. Should include assessment of communication skills
28. Cost and time need to be reasonable
29. Peer review part of scheme / direct observation / demonstrate skills by peer appraisal / assessment of clinical skills / reflective practice
30. Must be fair to everyone
31. Electronic portfolio that can be verified
32. Workshop based

Manchester – 10th February 2010

Risk Profiling

Good points/views about the research

1. Skills/CET – building on existing practice
2. Modality of CET
3. Based on CET/different modes
4. Peer review
5. Practitioner contact with each other
6. Skills based – concern about cost

Issues/views about the research

- Remediation not defined
- Must be Relevant/accessible and cheap
- Risk low – therefore revalidation must not be onerous
- Risk profiling – restructure of current contract in England
- Governance – no evaluation and a lack of clinical governance
- All practitioners should be revalidated regardless of the environment.
- Time off for conferences
- Paying for CET
- CET – isn't skills based
- Practitioners may not be happy having their skills tested

- Different tiers in profession
- Costs of tests
- Huge challenge if employers take more control of Locums
- What about outliers?
- Flexibility in modality
- Bureaucracy in timescale and modality
- Peer review of records
- Appraisal

Employer Appraisal

Good points/views about the research

1. Objectives of organisations should be looked at for appraisal
2. It could form part of portfolio
3. If used it can't be onerous
4. Restricted to restricted functions

Issues/views about the research

1. Locums – not consistent and equitable across profession. Enhanced CET scheme = practical sessions / PEER review. What if clinical skills aren't up to scratch?
2. PEER review – geography – on-line discussion forums, for those who can't get out to do the work. Discussion needs to be flexible.
3. Appraisal unworkable – model scheme – DO/CLO's no CET payment therefore lite touch.
4. CET to cover a range of competencies – structure and variety are needed.
5. Patient aspect as opposed to PEER review.
6. 1-2-1 for poor performers i.e. those with high risk factors. Target those who are high risk – look at all core competencies which then identifies poor performers (as a supportive measure)
7. Enhanced CET could be a good idea i.e. people using other results, but also to improve the deficiencies
8. Can we change CPD. Assessed on an annual basis. On-line can be plagiarised / moe mandatory workshops / participations.
9. Yearly flow of points.

London – 16th February 2010

Risk Profiling

Good points/views about the research

1. Definition of scope of practice required
2. What about those who do not integrate?
3. Could workshops be linked to BCLA/Optrafair?

4. Linking geographical areas to demographic areas
5. Are locums high risk?
6. Risk profiling
7. How does patient know if OO/DO has done something wrong clinically?
8. Small number of high risk issues. High number of low level risks – perception of risks
9. Over dispensing – are these conduct issues
10. Narrow view of risks in presentation – lack of real risk
11. If setting standards this needs to be cost proportionate
12. More than just clinical competencies and more into managerial risks.

Issues/views about the research

1. Low risk / no major risks
2. Targetting major risks
3. Proportionate to risks
4. Contextual factors brought in i.e. quality of equipment
5. Appropriate to scope of practice
6. Modality of CET looked at
7. Simple risk profiling
8. GOC steer on revalidation with stakeholders
9. Attempt at finding out best practice
10. Costs have to be proportionate
11. Existing systems to be utilised
12. Enhance CET
13. Isolated practice – peer review
14. Communication should be an important part of CET.
15. Lack of evidence on risk/insufficient data
16. FTP/insurance data
17. Locum's – no evidence that they present a greater risk than an employed OO/DO.
18. How are they integrated into a practice
19. DO's – not much in the report.
20. Dislike the emphasise on CET not CPD – some reflective element in what registrants are doing to get well rounded practitioners/
21. Is risk the right approach?
22. Do we understand the risks? Does the profession understand risk? i.e. building revalidation on sand
23. Everything delegated back to a clinician in a practice.
24. Should revalidation revolve around competencies or GOC code of conduct?
25. OO's doing CLO practice – should be more than just a refresher – should all CLO practitioners be on a separate register?
26. Weighting of scope /context of practice
27. No patient involvement
28. How transparent is the process? – how will patients see this.
29. Static view of practice – where is it going?
30. Not a tick box exercise / how do you make this robust?
31. Isolated practice – those who work on their own
32. Narrow view of risk – morbid blood pressures etc

33. Fraud / dispensing to children i.e. life threatening / everyday.
34. How to meet with LOCs?
35. CLOs – Oos don't need to wait 6 yrs to be able to carry on.
36. Risks from commercial side – time pressures
37. GOS fee too low / who will pay for this?

Employer Appraisal

Issues/views about the research

1. Not useful for revalidation – useful for employee/employer
2. Could be linked to LOC assessment
3. PCT practice audits – these could be extended – they check equipment and record cards
4. Optical advisors could be utilised more
5. More use of HES referrals – is this a plus/minus issue
6. Patient feedback
7. Ideal model – patient feedback
8. All have CET – attendance at CET events.
9. College workshops – revalidation workshops at CET events/interactive events.
10. Learning with others.
11. Witness testimonys
12. Revalidation logbooks – to demonstrate experience.

Issues/views about the research

1. Appraisal couldn't be used on its own, but as a folder of evidence.
2. As part of revalidation – series of audits/this would include locums.
3. Audit – who would conduct audit/similar to college assessor.
4. Appraisal as part of a wider package – smaller employers would then be encouraged to appraise.
5. Nationally agreed model of appraisal and funding at a national level.
GP/PCT appraisal could be used as a model – once per 3 years.

Model Scheme

1. Standard appraisal – audit trail across appraisers.
2. Multi-layered form of revalidation – GOC to steer to emerging practice – CPD – everyone to do a mixture of modalities – funded protected time to do this.
3. Difficult to change culture – build on habit i.e. 3 yr milestone for CET. 6 yr cycle is fine with milestones along the way – i.e. targetted on scope and context.
4. Use case records / discussions. PCT audits of practice.
5. Continuous audit of HES referrals – constructive feedback needed.
6. Revalidation workshops at CET events
7. Improvements of service rather than punitive measures.
8. Clear outcomes/measures on what a successful programme is.
9. EU based schemes looked at.

10. What does a portfolio prove? Random audit of portfolios.
11. Look at CET – how it currently works. Too much focus on clinical aspects.
12. Who audits whether CET points / events are any good.
13. Revalidation of Body corporates? Currently no plans to revalidate BC's.

Edinburgh – 18th February 2010

Risk Profiling

Good points/views about the research

1. Risk low therefore low cost
2. If there wasn't a route – to maintain patients then risk may be higher.
3. Rights may be taken away from OO's due to NICE guidelines
4. Linked up communication between OO/DO's and HES for patients
5. Reflective practice
6. Revalidation for all
7. No blame culture – feedback from patients.
8. Proportionate
9. Patients not always about misdiagnosis – not always the best for patient care.
10. What about the future – higher risk profession.
11. Concepts are achievable
12. Training targetted around PEER review.
13. Interaction between others.
14. Scotland – have clinical pathways. If everyone signed up this would be a good thing.
15. Modes of delivery.
16. Learning alongside other clinicians / reflective practice
17. No blame culture / risk can't be eliminated
18. Not 1 strike and you're out. Other people should learn from mistakes.

Issues/views about the research

1. Scotland is different – receive funding and protected time.
2. Quality of referrals to HES/Ophthalmologists
3. Isolated practice – independent may not be high risk – down to interaction
4. Training – exposure to hospitals – included in pre-reg.
5. Need for hands on PEER interaction.
6. Is CET not enough?
7. Who does it / resources for it
8. Transparency – know what is expected in advance
9. Minimum level – getting those to training who normally don't get involved.
10. Isolated practice – definition needs to be clear cf: geography/personal isolation.
11. Non-practicing – those who dip and in and out of practicing

Employer Appraisal

Good points/views about the research

1. CPD – Where does this fit in?
2. PDP – was this considered?
3. Organise english model based as in Scotland / workshop tests.
4. Appraised and reviewed by College of Optometrists
5. Ensure minimum standard
6. Based more on audit/on record cards.
7. Using audit of GOS
8. How would you get a standardised system
9. Who would do appraisals?

Model Scheme

1. Fair to all modes of practice
2. Direct observation
3. Model scheme to have responsible officers
4. Consistent and include a testing element
5. Registered OSCE's
6. PEER review – colleagues sharing experiences around a table / broad spectrum of training.
7. Problem with distance learning. Make this compulsory and change CET mindset.
8. Scottish model has raised the bar.
9. Not all by distance learning and compulsory in certain areas.
10. Pastoral concern – tuition before the assessment
11. Basic level – continually rising.
12. Build on CET scheme – mix of modalities
13. Locums should be appraised
14. Limit CET carry over points each year.

Belfast – 19th February 2010

Risk Profiling

Good points/views about the research

1. No major risk areas
2. Risk adverse – optometrists risk adverse
3. Practitioner feed into risk/reflective
4. Regular process – appears good / 6 yearly interval / workshop with PEERS
5. Training with assessment built in
6. Building on current CET scheme
7. Proposal that looking what is in place at present is very important.
8. Building / taking account of current systems
9. 6 year cycle
10. not re-qualification
11. regularity of process
12. no major risk areas
13. low risk

14. training with assessment built in
15. Peer review / not paper based
16. CET / familiarity
17. aware of contracting difficulties
18. optom's knowing what they need to do
19. 2 way learning – new students with experienced practitioners

Issues/views about the research

1. Self selection – is an issue / reliance on practitioner honesty / not sure practitioners can do this
2. Are all practitioners safe to practice in all areas?
3. Peer review – who does it / will it be in CET workshop?
4. Improving CET scheme - issues with distance learning
5. Risk profiling – will it be linked effectively with revalidation / outcomes will result in onerous revalidation
6. Fairness / equity / robust
7. Must have engagement with profession so it is not just a box ticking exercise / motivating / finding good practice and done properly.
8. Risk and good practice – visual fields not the norm / pressures / GOC contract link
9. Necessary tests and use of equipment – difference between practice of doctors and optometrists / consistency / link to NICE guidelines
10. Reassurance to public - how will GOC do this / GOC project on patient feedback
11. License to Practise route – what could this mean / cost? How often? Separate registers? Revalidate all on register?
12. What about disengaged practitioners? How do you motivate them?
13. Self selection
14. reliance on practitioner honesty
15. practitioners have to be confident in all areas therefore revalidation has to be broad
16. more referral between professionals – if sole practitioner doesn't know the whole scope
17. all practitioners need to be safe and competent to practice
18. who does the PEER review?
19. Must be fair, practical and robust.
20. What's in it for the profession?
21. Repeating pressures isn't the norm and should be paid for.
22. Links between good practice and GOS contracting
23. GOC and AOP role in defending someone who is guilty
24. Necessary tests / equipment for visual fields cf: optometry v ophthalmologists
25. Cost of licence to practice / who gets one and why
26. European registrants – what will happen to them?
27. Disengaged practitioners

Employer Appraisal

Issues/views about the research

1. Too difficult/too many to accredit
2. Too onerous to accredit each scheme
3. Not fit for purpose – not valid for GOC requirements
4. Part of evidence in portfolio
5. Relevance to mode of practice – excellent concept for staff if the appraisal system is seen to be relevant to the current mode of practice.
6. GOC could create a model appraisal scheme
7. Appraisals often irrelevant i.e. don't link to risk / doubtfulness of use (yellow)
8. Room for bias – depends on personal relationships
9. QA – appraisers potentially an issue. How does the GOC ensure that the appraisers are suitable for task and are performing the task suitably? Who appraises the appraiser? What quality assurance mechanisms would be in place?
10. It could be useful if management were interested in developing and delivering consistently better clinical care.
11. Too difficult to standardise
12. Too many schemes / too difficult
13. Should be part of evidence in a portfolio
14. Good if relevant to mode of practice
15. Not fit for GOC purposes
16. Could GOC create model appraisal scheme
17. Must be relevant / appraisals are often irrelevant
18. Must have independent relationship with appraiser
19. working in a team / health and safety
20. how are appraisers appraised? Re: Quality assurance
21. practicality of appraisals
22. Must be confidential
23. Must be used to improve clinical care cf: management may want commercial issues raised
24. Evidence from appraisal maybe a good idea

Model Scheme

1. Improved CET scheme – targeting competencies / workshops encouraging peer interaction / less distance learning / focus on the core competencies
2. Different core competencies for revalidation? Must be relevant / standards for entry to the register
3. Code of conduct –
4. Scope for more reflection / professionalism – must validate relevant clinical skills and competencies – could validate ability to reflect on and learn from clinical experiences
5. Opportunity for more positive approach – peer review / case scenario / share case records
6. Reaffirmation of Competence

7. Must be fit for purpose i.e. enhances GOC's public protection role – improve public perception and awareness
8. Scheme must be fair, valid and reliable – must also be flexible
9. Need internal mechanism for measuring effectiveness within GOC
10. Can the GOC work with PCTs / practice visits / advisers not seen as facilitative
11. Risk areas – domiciliary – no one checking / contact lens – already more targeted in CET
12. Scheme should focus on basic standard not specialisms / needs to be kept broad
13. Portfolio of evidence – can GOC come up with a model portfolio
14. Change CET profile – needs to have required mix – not only distance learning and must have working with others / different modes / targeted CET with scope of practice and some sort of spread of topics / spread over time / application to practice
15. Learn from Scottish accreditation schemes – peer review workshops / practitioners must be confident in applying what they've learned / who would carry out peer audit?
16. No additional cost to registrant
17. Rule out – interview by anonymous professional practicing 100 miles away
18. Improved CET scheme
19. Code of conduct could be used – re: reflective practice – be aspirational with its use.
20. PEER review needs direction
21. Must validate relevant current knowledge / clinical standards / contemporaneous standard
22. Reflective practice
23. Positive spin / reaffirmation
24. Enhances GOC's public protection role
25. Keep adequate records and refer appropriately
26. Scrutinise records more
27. Can GOC work with PCTs to look at records
28. Public awareness of optometry
29. Identifying scope and context of practice – work with PCTs to identify for GOC their scope of context – link this into practice visits.
30. Domiciliary may need more scrutiny
31. Contact lens – more targeted already for CET
32. Should focus on basic standard – not specialist areas
33. Reliability of the process
34. Impact analysis of policy – but quality assurance via external audit
35. Weighting of evidence in portfolio – speed of cultural change
36. Targetted CET with scope of practice
37. CET could be targeted over certain areas i.e. children/glaucoma
38. Workshop participation
39. Scrutiny of referral patterns
40. Are workshops being fed back into practice with patients?
41. PEER assessment – how would it work / what would it look like.