Temporary changes to our Optometry Handbook and Supervision policy

Consultation Report

19 August 2020

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Introduction

Following representations from education providers and stakeholders regarding how students might achieve clinical experience during the pandemic, the GOC sought to identify temporary changes to its education standards/requirements which would protect patients, students and the public and maintain the quality of clinical experience, and enable new and innovative approaches. On 15 July 2020 Council agreed to delegate approval of temporary changes to a subgroup, subject to the outcomes of a short consultation. The subgroup met on 7 August 2020 and considered the responses to the consultation as well as this, the consultation outcome report. Having carefully considered these documents, the subgroup approved the following changes to our Optometry handbook and the Supervision policy and requested that a post-implementation review would be completed in the next 6-12 months.

Executive Summary

We ran a consultation on proposed temporary changes to our Accreditation and Quality Assurance Handbook for Optometry and our Supervision policy as a result of the COVID-19 pandemic.

The focus of this consultation was to seek views on the proposed changes to ensure that students' ability to continue to practise safely and enter our fully qualified register is maintained.

It was a swift two-week targeted consultation, which we believe was in the best interests of the sector. The consultation opened on **23 July 2020** and closed on **6 August 2020.**

We asked organisations or individuals who objected to the two-week timeline to submit their notice to object and a brief rationale to the GOC before the consultation closes. We received no objections.

We are very grateful for the support received from the sector who made many efforts to respond within the timeframe. We received **71** responses.

Scope of the proposed temporary changes:

The scope of proposed temporary changes to our Accreditation and Quality Assurance Handbook 'Routes to Registration in Optometry' ('Optometry handbook') education standards and requirements were as follows:

- For the proposed temporary changes affecting undergraduate education; from 1 September 2020 for the 2020/21 academic year only.
- For the proposed temporary changes affecting the College of Optometrists' Scheme for Registration or other registrable qualification: for this year's (Autumn 2020) incoming cohort of students/trainees only. Due to the nature of the Scheme for Registration enrolment, we have since decided that these changes will apply

to anyone who enrols onto the Scheme for Registration between September 2020 and 31 May 2021.

In our consultation we acknowledged that, due to the structure of their courses, for the current cohorts undertaking clinical experience in the University of Bradford's BSc Optometry (Accelerated Route) and University of Hertfordshire's Master of Optometry students, these changes may need to be applied retrospectively. We have offered to consider an application to recognise experience (which meets our new temporary criteria, once finalised and approved) from 21 March 2020 from these providers.

Summary of Findings and Recommendations

Stage 1 – Patient Episodes/Experience

	Total	Percent
Fully support	32	**45%**
Partially support	30	**42%**
Do not support	9	**13%**
I do not have a view	0	**0%**
Not Answered	0	**0%**

The majority of respondents supported our proposed changes to Stage 1 patent experience, with many academic and professional body respondents submitting drafting corrections or questions of clarification.

Key reasons for support included:

- Many providers were grateful for the more flexible approach during this challenging time. They commended the flexibility that these proposals will bring to provision in academic year 2020-21, *which is more pedagogically sound than the current approach.*
- One respondent commented that '*the proposed changes outlined in the consultation document provides a pragmatic solution that should maintain education standards and clinical experience for students in these unprecedented times.'*
- The approach was perceived as moving in the direction of modern health care regulation.
- Another respondent commented that as the proposed changes are to be entrusted on an education provider such as universities '*I have no doubt that trainees will be just as well prepared, if not better prepared, as previous cohort of trainees. This is because university settings and real clinics provide the perfect environment for learning and enforcing knowledge.'*
- *'There is a need to have in place sufficient numbers in the workforce to support the challenges of rising patient demand with the aging population demographic.'*

Key concerns included:

- Some respondents commented that it is patient numbers that create the experience, and without the numbers the experience cannot be achieved.

- There was concern that too much responsibility was on the provider to set out breadth and quality of experience, which was open to misuse and misinterpretation – which needs to be appropriately managed and monitored.

Summary of changes made post-consultation: As a result of the feedback we received we have made some very minor grammatical corrections to our original proposals along with clarifying some of the language and phrasing we use. We have also further defined patient:student ratios for primary care episodes and dispensing, and permitted observation with formal reflection to be counted as patient experience.

Certificate of Clinical Competence (GOC stage 1)

Temporary extension	**Total**	**Percent**
Fully support	59	**83%**
Partially support	6	**8%**
Do not support	3	**4%**
Do not have a view	3	**4%**
Not Answered	0	**0%**

There was extremely strong support (83%) to grant the temporary extension to the GOC Stage 1 Certificate of Clinical Competence.

Whilst there was slightly less support for permanently removing this GOC requirement in its entirety, the proposal to permanently remove this requirement was still well supported. Respondents cited that this seemed reasonable as long as education providers had adequate policies in place to consider individual cases and that providers will apply a time limit to ensure that the individuals' skills and knowledge are sufficiently up to date.

The GOC also considered whether it appropriate as a regulator to continue to be involved in a provider's enrolment processes.

Permanent removal of GOC requirement	**Total**	**Percent**
Fully support	35	**49%**
Partially support	14	**20%**
Do not support	15	**21%**
Do not have a view	5	**7%**
Not Answered	2	**3%**

Summary of changes made post-consultation: The final proposal remains the same; the intention is to progress with granting the temporary extension and work towards permanently removing this GOC requirement in its entirety.

Stage 2 – Patient Episodes/ Experience

	Total	Percent
Fully support	38	**54%**
Partially support	18	**25%**
Do not support	11	**15%**
Do not have a view	4	**6%**
Not Answered	0	**0%**

The proposed changes were supported by most respondents, with many citing it to be proportionate to the current circumstances and in line with the direction of travel of modern regulation.

Key concerns were about how it would be assured that the students attain an appropriate breadth of experience which is not driven by commercial demands. Ensuring an appropriate breadth of experience will be the responsibility of the College of Optometrists. GOC will request reports regarding attainment of the clinical experience through its quality assurance processes.

Some respondents called for a greater level of prescription. However, as the majority of students progress through the College of Optometrist's Scheme of Registration, the College of Optometrists will retain oversight of trainees' breadth of experience and will be required to provide support to make up any shortcomings.

Summary of changes made post-consultation: The final proposal is similar to our original proposal; eligibility has been clarified and a review date has been added.

Supervision Policy

	Total	Percent
Fully support	54	**76%**
Partially support	9	**13%**
Do not support	7	**10%**
Do not have a view	1	**1%**
Not Answered	0	**0%**

The proposal to broaden supervision was well supported by respondents, including the College of Optometrists, the AOP, the Optometry Schools Council, and by all 11 respondents who work in Hospital Eyecare Services (8 fully, 3 partially supported).

Key reasons for support included:

- It will help expand the scope of practice among optometry students and improve the quality of learning. In particular optometry students will also learn the reality of primary and emergency care and what happens to their referrals that follow that route which may change their practice to take more responsibility for themselves.
- Other health care professionals such as orthoptists can give a different perspective on clinical investigation and management. A qualified orthoptist

will know more about binocular vision than an optometrist, a qualified dispensing optician will know more about dispensing than an optometrist, etc.

- There was a view that this suggested a growing maturity across different health care regulators in that assurance in relation to orthoptists is provided to the GOC by virtue of regulation by the HCPC. This approach was welcomed and seen to be proportionate.
- It should also increase the feasibility of practices providing placements and reduce the supervisory burden on individual practitioners
- It should have professional development benefits for both individual trainees and those contributing to their supervision, as well as for MDT working and therefore patient care.

The main risks/concern was regarding whether the supervisor could be signing off core competencies without being a GOC-registrant. In response to this, it must be noted that the primary role of a supervisor is to advise and mentor students whilst maintaining oversight and responsibility of the patient in order to ensure public safety whilst a student is with a patient.

The role of a supervisor is not to assess and/or sign off the student, although a supervisor might also be an assessor and be able to sign off competencies etc. It is not always the case that a) a supervisor can assess b) a supervisor is required to assess. It is therefore not envisaged that professionals from other regulators will ever be in a position to sign off the achievement of core competencies.

It will be for the education provider to manage this to ensure that their application of the GOC supervision policy is safe, clear and appropriate for all the supervision of patient experience, competency sign off and assessments.

Summary of changes made post-consultation: The final proposal remains the same as the original, with very minor grammatical corrections.

Next steps

Following Council's delegated decision, we have included the agreed temporary changes into a Temporary Optometry Handbook and Supervision policy, and we will publish these online alongside our permanent handbooks. In publishing both handbooks, we will clearly differentiate between each version, marking the temporary version as temporary and clarifying the scope of each document.

We will contact all education providers and professional bodies to ensure that they are aware of the changes and will review the outstanding notification forms received, whilst inviting new notifications from any other provider wishing to make a change to their programme. These will be processed and recorded in our normal way. We will also update our COVID-19 Education Statement to reference the outcome of this decision.

Analysis

Total respondents: **71**

The respondents were asked to select which of the following categories applied to them:

	Total	Percent
I am a student optometrist	7	**9.72%**
I am a student dispensing optician	1	**1.39%**
I am an optometrist	35	**48.61%**
I am a dispensing optician	9	**12.50%**
I am a member of the public / patient	2	**2.78%**
I am a member of staff on a GOC-approved optometry programme	26	**36.11%**
I am a member of staff on a GOC-approved ophthalmic dispensing programme	7	**9.72%**
I work as an assessor for the College of Optometrists	9	**12.50%**
I am an optical employer	3	**4.17%**
I am a supervisor in practice	3	**4.17%**
I work in a Hospital Eye Service department	11	**15.28%**
I am a GOC Education Visitor Panel member	6	**8.33%**
I am a GOC Advisory Panel member	4	**5.56%**
I am a healthcare professional regulated by another regulator (e.g. HCPC, GMC etc.)	0	**0%**
Other	9	**12.50%**
Not Answered	0	**0%**

* Some GOC registrants identified that they were also patients. We have considered these henceforth in their role of a registrant.

Organisations that responded and consented to being named included:

- Association of Optometrists (AOP)
- College of Optometrists (College)
- FODO
- Glasgow Caledonian University
- Hospital Optometrists Committee
- Optometry Schools Council (representing GOC-approved optometry programmes)
- University of Manchester
- University of Plymouth
- Ulster University

Within the responses there were some queries related to our current standards. These have not been addressed as part of this consultation. Should anyone have queries about our current standards, they are welcome to ask our team on education@optical.org

1) GOC Optometry Stage 1 – Patient Experience/ Episodes

Summary: We proposed various changes to the handbook wording to move from a 'minimum number of patient episodes' to 'an appropriate breadth of patient experience'. This is to enable clinical experience to be delivered differently in light of the limitations that the COVID-19 pandemic has put on clinical practice.

Our view was that this approach will enable clinical experience to be delivered in a safe and practical way and contribute to preparing students for the new world of practice brought about by the pandemic.

	Total	Percent
Fully support	32	**45%**
Partially support	30	**42%**
Do not support	9	**13%**
I do not have a view	0	**0%**
Not Answered	0	**0%**

Summarised feedback:

The majority of respondents supported the proposed changes, with numerous academic and professional body respondents submitting drafting corrections or clarification questions.

Key reasons for support were:

- Many providers were grateful for the more flexible approach during this challenging time. They commended the flexibility that these proposals will bring to provision in academic year 2020-21, *which is more pedagogically sound than the current approach.*
- One respondent commented that '*the proposed changes outlined in the consultation document provides a pragmatic solution that should maintain education standards and clinical experience for students in these unprecedented times.'*
- The approach was perceived as moving in the direction of modern health care regulation.
- Another respondent commented that as the proposed changes are to be entrusted on an education provider such as universities '*I have no doubt that trainees will be just as well prepared, if not better prepared, as previous cohort of trainees. This is because university settings and real clinics provide the perfect environment for learning and enforcing knowledge.'*
- *'There is a need to have in place sufficient numbers in the workforce to support the challenges of rising patient demand with the aging population demographic.'*
- There was a consistent view was that obtaining an arbitrary number of records was tedious, with support for focusing on quality of experience.
- Respondents were pleased to see other ocular professionals being deployed in making assessments of optometry students.
- The change from 'minimum episodes' and 'specified patient types' to 'breadth of experience' and 'range of patient types' was welcomed. This gives greater

flexibility during COVID-19 and is more pedagogically sound than the current approach.'

Key concerns were:

- Some respondents commented that it is patient numbers that create the experience, and without the numbers the experience cannot be achieved.
- There was one singular view that postponing a year of education should be considered in order to maintain the same standards.
- There was concern that too much responsibility was on the provider to set out breadth and quality of experience, which was open to misuse and misinterpretation – which needs to be appropriately managed and monitored.

Summary of changes made post-consultation: As a result of the feedback we received we have made some very minor grammatical corrections to our original proposals along with clarifying some of the language and phrasing we use. We have also further defined patient:student ratios for primary care episodes and dispensing, and permitted observation with formal reflection to be counted as patient experience.

Detailed commentary

Temporary change

Consultation responses	**GOC response**
The change of emphasis towards the breadth of clinical experience was welcomed by most respondents, but there was the view/concern that it may be difficult for the GOC to justify the existing minimum number when we revert back following these temporary changes.	**Accepted,** this is a risk of making any temporary changes. These changes will be regularly monitored for impact and changes may be pursued if needed.
There was a call to make it clear in the documentation that the temporary arrangements articulated in the proposed document are an acceptable alternative, but where elements of the current handbook can be safely delivered by programmes that this is also valid and meets regulations.	**Accepted,** amended accordingly.
One education provider sought to understand if they were still able to submit changes for approval that sit outside these changes. They stated that they would value a statement which said that these temporary proposals could be extended, without consultation for 2021-22, subject the GOC approval should circumstances dictate this is appropriate."	**Partially accepted,** the statutory role of approval of standards means that whilst providers are able to submit changes for approval which sit outside of these changes, we would normally consider that such changes to our standards would apply to our all providers, not

	just a single provider (unless there was a robust rationale). These are temporary changes to enable students to gain clinical experience throughout the pandemic. We expect all providers to assume that the current handbook requirements would be back in force as soon as feasible.

Language used

Consultation responses	**GOC response**
There was some concern over the use of the word 'sufficient', 'range of', 'appropriate breadth', 'some experience' etc. because they are subject to interpretation. It would be important to ensure that expectations are clear.	**Partially accepted,** during times when innovation is required, it is important not to stifle this with prescription. We are committed to working collaboratively to ensure that any areas of confusion are identified early. One way we do this is through our notification process, whereby providers must alert us to changes that they are making before they happen, which provides an opportunity to discuss their proposals.
Page 3 The word 'categorised' has been changed to 'delineated'. Given that 'categories of experience' (A-F) still exist we suggest that categorise is a more appropriate term.	**Accepted,** proposal reverts to the original word, categorised.
The word 'master' does not add anything extra to the text.	**Accepted,** removed.
There is inconsistency in the wording between 'certificate of clinical competence' to 'certificate of professional competence'.	**Accepted,** this has been rectified to 'certificate of clinical competence.'
There is inconsistency between the use of the word 'episode' and 'experience', and many respondents had a preference with using 'experience'.	**Accepted,** amended.

Others suggested using "appropriate patient encounter" with the clarity as to the meaning e.g. the inclusion remote consultations, simulation and case scenarios, which are already stated. We wholeheartedly welcome the inclusion of these as appropriate encounters.	
There was a call to be clearer to indicate which quantitative/numerical measures relating to patient experience, 'real patient' numbers and student:patient rationale are indicative only, and which are mandatory	**Accepted,** this has been rectified.
There was a query regarding what the GOC mean by the term 'significant' in that 'significant deviations to the numerical measures are fully justified.'	**Partially accepted,** the GOC would expect the provider to use its professional judgement to decide whether their programme revisions constituted significant deviations. Significant can be in prevalence (e.g. the number of students a lower number would apply to) and/or that the clinical experience required is lower than set out. We have sought to clarify this.

Student: patient ratio

Consultation responses	**GOC response**
It was felt by many that the proposed approach of stipulating 'low student:patient ratio' was unclear. Some respondents explained that the purpose of patient experience at Stage 1 is to allow students to begin to develop independent thought to become independent practitioners and that it would be much more challenging for students to develop this without a 1:1 basis. Others suggested that some guidance on the meaning of this phrase might be useful to assist providers, avoid misunderstanding, and provide additional assurance from a perspective of the protection of the public. Some dispensing optician respondents who worked in the academic setting did not believe that it was appropriate to lose the 1:1 patient to student ratio for ophthalmic dispensing interaction such that students only carry out part of the dispense. It was viewed that ophthalmic dispensing patients are not in short supply in	**Accepted**, we have clarified minimum student:patient ratios where most appropriate.

the same way as, perhaps, patients with active pathology are.	

Types of Experience

Consultation responses	**GOC response**
Whilst the documentation indicated that certain types of experience are not suitable for all categories of episodes e.g. grand rounds is not suitable for primary care, dispensing or contact lenses (especially fitting), there were a few respondents who believed that it should be clearer what is allowed under each category.	**Not accepted,** we believe that the education providers are capable of assessing which types of experience are suitable for which categories. We will monitor this as part of our quality assurance processes.
It was noted that there was a view within the responses that confidence is greatly gained in honing your craft by repetition. It gives the clinician, and as a result the patient, greater confidence and sets the basis for better communication and a slicker experience.	**Noted.** This is important development and providers are expected to ensure that their students are well prepared.
There was concern that there is no real substitute for face to face patient examination to develop clinical skills and if the COVID pandemic stretches past the academic year 2020/1 and pre-registration, the students may have less face to face experience than their predecessors, which could impact on their readiness.	**Noted.** We recognise that clinical experience must include working with real patients in order to best prepare students for entering the fully qualified register. During COVID-19, any opportunities to provide better and more varied clinical experience will help someone's development and would not make them less competent. Robust assessment remains and this is important for giving confidence to the profession about those students going through their education and training at this stage.
There was a strong view amongst academic respondents that observation, with discussion/reflection, does enable students to attain quality clinical experience and that this should be allowed, particularly when	**Accepted,** we agree that observation, combined with active / reflective exercises

Consultation responses	GOC response
scenario-based experience which will have no 'patient interaction' can count as well. It was a consensus view amongst academics that there is much to be gained from active observation/reflection and in some cases the learning gain could be greater than participation (for example observing an experienced practitioner or analysing the performance of peers). With regards to student:patient ratio for these types of episodes, the case was made that a number of students can observe such an examination and with sufficient de-briefing, those episodes are good learning experiences for more than one student, which supported that observations should be able to count in general and not be limited to a 1:1 ratio. Multiple students in a small group can participate in such an examination and minimise exposure to at risk patients. With sufficient de-briefing these episodes should count as patient episodes for more than one student.	have great pedagogic value and could be considered as part of clinical experience.
The proposed new introductory material on "Types of patient episodes" (page 8) includes a statement that "Experience must enable individual students to develop their professional independence" – it is not clear what this means in isolation, but we understand from discussion with the GOC that it relates to experiences with a higher student-patient ratio than 1:1. It would be helpful to spell this out. We question whether the development of 'professional independence' at undergraduate level protects patients when students/graduates are entering a supervised placement, not entering independent practise. We would suggest 'experience must enable individual students to develop to the point of entering a supervised pre-registration placement'.	**Partially accepted,** amended. We do not believe we need to define this further to accommodate the different stages of the route to registration as this is implicit.
The document says that grand rounds may be used as 'part of the student's face-to-face experience'. Please clarify what this refers to.	**Partially accepted,** removed as this sentence does not add value.

<u>45% real patient experience</u>

Consultation responses	GOC response
It was strongly welcomed by optometry education providers that the GOC would allow simulation and scenarios to count towards patient experiences.	**Noted.**

Consultation responses	GOC response
Clarity was requested about whether the stipulation of 45% of experience being with real patients applied to overall or within each category	**Accepted,** amended – within each category.
Clarity over the rationale behind the 45% was also requested to enable education providers to explain their own rationale which they would need to provide to the GOC. Whilst the majority of respondents believed that 45% of patient experience being with real patients was sufficient in the circumstances, there were concerns that this would not be comparable to the experience achieved in training as a dispensing optician and that simulation cannot replace the 'real' patient contact experience with the anomalies that they throw into the situation	**Noted.** The GOC expects as much safe, real patient experience to be achieved as possible. This is the absolute minimum considering the COVID pandemic.
Clarity was also sought regarding if the GOC would have the option to amend the 45% requirement if the situation changes in the next few months.	**Noted.** The GOC will review our temporary requirements periodically as part of our quality assurance activity.

<u>Patient and student welfare:</u>

Consultation responses	GOC response
Concern was raised regarding patient welfare during COVID-19 pandemic, citing the length of time that patients will be exposed to close contact with the student and the supervisor (often supervising two students at a time), which overall supported less patient contact during this time. There were a range of views presented regarding the safest approach including, if two students were able to examine one patient, to enable closer supervision, particularly with PPE and other infection control measures. This may also reduce the time for the patient to be exposed. The converse was also suggested as the safest approach. There was a suggestion that the GOC set a requirement for evidence that the student has undergone COVID awareness training, in order for them to carry out a local risk assessment for where they are working.	**Partially accepted,** patient welfare and safety is our primary concern. The purpose of these changes is to minimise risk to patients whilst enabling students to gain appropriate clinical experience. We would expect the education providers and supervisors to already be supporting their students to understand their responsibilities when working during a pandemic. This would fall into our existing requirements regarding facilities and health and safety. We have added

	in a sentence in the introduction to reflect that we expect government guidelines to be followed.
There was also a suggestion to amend the proposed wording slightly to read 'It is expected that opportunities for students to examine real patients are maximised *within the constraints of patient safety'.*	**Accepted**, rephrased.

Quality and breadth of experience management

Consultation responses	**GOC response**
It was asked who is responsible to ensuring that students have the opportunity to experience a wide range of clinical conditions and that they gain experience with as broad a range of patients as possible.	**Noted.** It is the provider's responsibility to meet the GOC requirements and providers will be expected to oversee and manage the patient experience to ensure their students are adequately prepared. The GOC will seek updates from providers to assess how they are managing it.
One education provider disagreed that the bank of cases for teaching needs to be quality assured stating that it was essential for assessments but given the limited teaching resources that we have in many Departments and the time it takes to create good quality teaching scenarios we will need to rely on students to not share with others after completing cases. In our experience, students fully understand this is required as part of their learning. With regards to ensuring that the scenarios do not become known to the students, one respondent questioned whether this is a problem, explaining that even if scenarios do 'become known' students will still receive the appropriate teaching with regard to the scenario in question. For example, knowing that a patient scenario may involve macular degeneration does not then negate the value of the learning experience. Case scenarios is about the process, not about a student knowing an answer. Using a bank of cases does not jeopardise the learning experience of a	**Partially accepted,** we believe that all learning material should go through a quality assurance process. We have amended the requirement for the scenarios to not become known to reflect that we expect there to be a wide variety of case scenarios available, including for the same conditions.

Consultation responses	GOC response
student. We would suggest that this limitation is being removed.	
There was one view that a student's patient record may not be scrutinised other than by their supervisor. One proposed mitigation was suggested to ensure that a spot check on record keeping by the assessor took place.	**Noted.** We agree that this is a good idea. It is the responsibility of the providers to manage this and be satisfied that the student has achieved the appropriate level of record keeping and that the patient log is accurate and well-presented. We therefore do not propose amending the standards any further on this matter.
Achieving a "Master record" raised some concern - although this is relative straightforward in the university and primary care setting it will be very difficult in a hospital environment to gain a master list of all appointments and how students move quickly between patients if called upon by ophthalmology staff keen for them to view an interesting case. An alternative of a reflective statement by the student/trainee was suggested.	**Partially accepted,** it remains important that the student has sufficient and appropriate evidence of the clinical experience they have undertaken. We have removed the word 'master'.

Annex F

Consultation responses	GOC response
The respondents welcomed: • the potential for providers to add to this list of types of experience ('it is not exhaustive'). • that all of the types of experience described could contribute, as appropriate, to each of the categories A-F.	**Noted.**
There was strong voice from the academic community to suggest that the GOC should allow active/reflective observation to be accepted as clinical experience, as long as the provider has a clear rationale for this. Pedagogically it was argued that there is much to be gained from active observation/reflection and in some cases the learning gain could be greater than participation (for example observing an experienced practitioner or analysing the performance of peers).	**Accepted,** we have set out provision for active and reflective observation (which is supported by formal, recorded reflection/discussion).
It was felt that the draft new material for the Handbook on patient experience categories A – F should be amended	**Accepted,** this has been amended and

Consultation responses	GOC response
to clarify the minimum requirements for each category of experience, to avoid confusion and inconsistency. There was call to remove the requirement to have 'clinically trained' member of staff acting as a patient.	the 'clinically trained' requirement has been removed.
Clarity was sought in category A (page 11) it is also not clear how the 18 "episodes" differ from the 8 "complete eye examinations", given that the first paragraph of this section says experiences must constitute all components of a sight test. There was concern that given the potential of a second wave or localised lockdowns that may require University clinics to close, it is likely that 18 complete eye examinations may be unachievable and may need to be revised.	**Accepted**, amended. We will review our amendments if the situation dramatically changes.
Binocular vision and paediatrics Numerous education provider responded that the wording for Binocular Vision and Paediatric experience has been changed from specifically allowing observation, to specifying 'experience of examining children' which gives less, rather than more flexibility and is unlikely to be feasible.	**Accepted,** we have reverted to the meaning of our current handbook, and rephased this.
"Providers should ensure that students are exposed to a range of common and uncommon ocular pathologies. This experience can take place in ophthalmology clinics at NHS or private hospital eye departments or clinics hosted by the provider." It would be both pragmatic and pedagogically sound to broaden this statement as follows; "....This experience can take place in ophthalmology clinics at NHS (including virtual clinics) or private hospital eye departments or clinics hosted by the provider or real case discussions led by an ophthalmologist".	**Accepted,** amended.
"a student examining another optometry student or clinically trained member of staff …" It is not clear why this patient needs to be 'clinically trained' for the student to gain suitable experience.	**Accepted,** amended.
Page 12 (Appendix F, Contact Lens Experience): 'Indicative safe patient episodes: 12 episodes, to include complete fitting appointments, aftercare appointments, and clinical decision making episodes.' We do not understand what is meant by a 'clinical decision making episode'; all such episodes will include decision making. - Please note that there is no legal distinction between contact lens 'fitting' and 'aftercare' – all aftercare necessarily includes a 'fitting' of a contact lens. We	**Accepted**. Whilst we recognise that all experience would include clinical decision-making, this is included to ensure that the experience is sufficiently clinical. We have rephrased this slightly.

Consultation responses	GOC response
support the overall increase in flexibility that edits in this section provide.	
Page 15 (Appendix F, Spectacle Dispensing Experience): The provider must ensure that the student has experience of dispensing a range of frame and lens types, including some experience of dispensing for children and low vision patients.' The way it is worded (i.e. the "must") means that all students should have experience of dispensing a low vision patients, which is very challenging to ensure in the current context. We would suggest to re-word as "…and lens types, which could include experience of dispensing for children and low vision patients."	**Not accepted**: It is very important that students get experience of dispensing to a low vision patient.
Page 39 abnormal eye conditions: Generally the changes to reduce the number of hours and that this experience does not have to take place in a hospital environment was welcomed, particularly as concern was raised over the availability, nature and volume of placement provision (and the delivery of eye care services), which then may require alternative experience to be accepted, such as remote hospital cases. One respondent who has offered training on a grand rounds private hospital setting to optometric undergraduates over recent years felt that 7 hours may be too little to enable small groups to gain broad experience. Although another suggested remove the arbitrary 7 hours and allowing alternative experience. It was also pointed out that category F no longer includes any reference to clinic experience being supplemented by other types of experience. Given the importance of training in abnormal eye conditions, and the likely limitations on clinical placements in hospital during the pandemic, it is important that providers offer supplemental experience of this type.	**Noted.** **Partially accepted.** We have reduced the hours in consideration of COVID-19 however we do not believe a full reduction is suitable, considering the variety of experience that could contribute to this – including remote experience. Hospital experience is a critical part of an optometrists development as a clinician and as part of the wider healthcare team. We have reinstated the supplementary experience.
Page 11 (Appendix F, Primary Care Experience): We support this change including flexibility on the number of 'complete' eye examinations and student:patient ratio.	**Noted.**
Page 14 (Appendix F, Specialised Clinic Experience): 'The provider must ensure that students experience a range of specialist techniques including ocular imaging / further investigative techniques, examining patients with additional needs, and at least one low vision assessment.' The way this is worded means that all students must have experience of imaging, further techniques, and patients with additional needs – that's	**Not accepted:** We appreciate that this may be difficult however, it is very important that students experience a wide range of specialist techniques.

Consultation responses	GOC response
very challenging to ensure in the current context. We would suggest to re-word as "…must ensure that students experience a range of specialist techniques, which could include…"	

Comparison to other qualifications

Consultation responses	GOC response
There were concerns about the discrepancy between the patient experience required to be an Optometrists against that to become a Dispensing Optician or Contact Lens Optician.	It is not the intention of this piece of work to consider differences/similarities across different handbook – rather to consider the temporary changes that need to be made to enable student optometrists to progress through their education and training and achieve the appropriate experience to be safe practitioners.

2) Validity of Certificate of Clinical Competence for Optometry (Stage 1)

Summary: We propose to extend the validity of the Stage 1 certificate of clinical competence for students who graduated in summer 2018 to 31 December 2020.

We also propose removing this requirement entirely as of January 2021, so that any decisions to the currency of learning forms part of a provider's enrolment/admissions policy (such as the enrolment policy for the College's Scheme for Registration).

Summarised feedback
There was extremely strong support (83%) to grant the temporary extension to the GOC Stage 1 Certificate of Clinical Competence.

Whilst there was slightly less support for permanently removing this GOC requirement in its entirety, the proposal to permanently remove this requirement was still well supported. Respondents cited that this seemed reasonable as long as education providers had adequate policies in place to consider individual cases and that providers will apply a time limit to ensure that the individuals' skills and knowledge are sufficiently up to date.

The GOC also considered it to no longer be appropriate for a regulator to be involved in a provider's enrolment processes.

Summary of changes made post-consultation: The final proposal remains the same; the intention is to progress with granting the temporary extension and work towards permanently removing this GOC requirement in its entirety.

a) To grant the temporary extension

	Total	Percent
Fully support	59	**83%**
Partially support	6	**8%**
Do not support	3	**4%**
Do not have a view	3	**4%**
Not Answered	0	**0%**

b) To remove the 2-year validity limit permanently

	Total	Percent
Fully support	35	**49%**
Partially support	14	**20%**
Do not support	14	**21%**
Do not have a view	5	**7%**
Not Answered	2	**3%**

Detailed commentary

Consultation responses	GOC response
It was felt that the language needed to be consistent. The certificate of clinical competence, is already referred to by differing names in GOC documentation e.g. clinical competency.	**Accepted,** we have amended the terminology to reflect this feedback.
Respondents sought clarification over the timing of making this a permanent change when changes from the ESR are imminent.	**Noted.** It is more appropriate that an education provider manages their own admissions policy rather than having regulator involvement. For example, the education provider will be able to form a judgement as to the appropriateness of their admittance or whether they need to do further preparatory work first. If the provider identifies that only a little additional support is required for the student, the education may choose to enrol them but would be expected to provide the additional support to the student. We have suggested that this is a permanent change because of the minimal public protection risk (as all students are supervised) and the opportunity to ensure a more appropriate arrangement, recognising that COVID-19 is likely to increase the number of queries about this. The GOC is not resourced to consider individual cases regarding this and it is more appropriate that an education provider incorporates this as part of their enrolment processes. For ESR, the current proposal does not have a time limit, although we would expect a student to graduate and then register with the GOC without delay in order to meet their statutory obligations. Failure to register would mean that the individual is required to restore to the register.
Those not in favour of permanent removal of this requirement were much more comfortable with simply extending the timeframe to allow some flexibility whilst continuing to maintain a reduction of misuse of the	**Partially accepted,** we agree that the currency of knowledge skills and behaviour is important. We would ensure that the Scheme for Registration's enrolment policy appropriately addresses this in accordance with our Recognition of Prior Learning guidance. Removing this as

Consultation responses	GOC response
policy and minimising the opportunity to lose currency of knowledge.	a GOC requirement means that the decision on an individual case by case basis can be appropriately decided by the education provider. The statutory student registration requirement means that students must be working towards an optical qualification to be registered, and the verification checks that we do with education providers, will mean that an individual cannot take an extended period and then just restart – they would need to restore to the register and would only be able to do this if they meet the entry requirements of the provider. If they do not meet the entry requirements of the provider, they would need to retrain (as per normal arrangements). It is more appropriate for providers to decide what entry requirements need to be in place for their own programme(s) and by removing the GOC requirement, it allows providers to decide exactly what is appropriate. Providers may use similar criteria, such as a 2 year timeframe in which to assess potential candidate knowledge and ability. Some respondents suggested that if the 2-year validity needs to be removed, there must be accompanying clarity in the RPL policy.
Many respondents supported the temporary change, in light of the current pandemic, but were cautious about the implications of removing the time limit completely and felt that this would be perceived as 'indefinite' and leave it too open for individuals to take advantage of the open time frame, potentially enabling a large gap between when they graduate and when they enter the scheme for registration.	**Accepted,** it is not intended that the requirement will be removed without putting in place other mechanisms in which to manage and monitor the concerns raised. In order to remove this requirement, there must be appropriate mitigating mechanisms in place which clearly state the parameters. The provider will be responsible for creating and implementing such mechanisms, but these will still need to be quality assured by the GOC as per usual procedure.
Students having taken long periods away may come into practice unable to examine patients which will cause a huge burden on supervisors who may not be equipped or prepared to teach them. Potential mitigation could	**Noted.** It is the responsibility of the education providers to enrol students who meet their entrance criteria which should be appropriate to ensure that the students are ready for the demands of their programme. This mitigation is something

Consultation responses	GOC response
include creating bubbles at the university of students for them to practice on.	that the sector could consider as part of any retraining required. Currently there are GOC-approved retraining programmes available.
It was asked how will this change affect integrated programmes?	**Noted.** We have not identified any impact on integrated programmes.

3) GOC Optometry Stage 2 - Patient Episodes

Summary: We propose reducing the total number of patient episodes for GOC stage 2 by 10% and removing the categorised patient episode numbers for GOC Stage 2.

Instead, the provider must ensure that the student achieves an appropriate breadth of experience, and also set and justify its level of any minimum experience in specific areas of practice.

	Total	Percent
Fully support	38	**54%**
Partially support	18	**25%**
Do not support	11	**15%**
Do not have a view	4	**6%**
Not Answered	0	**0%**

The proposed changes were supported by most respondents, believing it to be proportionate to the current circumstances and in line with the direction of travel of modern regulation.

Key benefits include:

- *'While Covid-19 is obviously creating extremely difficult circumstances for optometry practice, changes arising from or being expedited by the pandemic should also provide positive opportunities for trainees' learning and development. Less intense patient throughput and a greater emphasis on taking a risk-based/needs-led approach to meeting patient care needs should enable trainees to develop their competence and prepare for registered practice. A stronger emphasis deriving learning from reflecting on experience should further enhance trainees' professional development (Gibbs, 1988)'.*
- *'Of prime importance is that trainees gain a breadth of experience across patient groups and conditions that reflects changes in optometry practice, models of care and service delivery. Our [The College of Optometrists'] changes to Scheme requirements include that trainees' experience is shaped/defined by a minimum set of mandatory patient encounters.'*

Key concerns were about how it would be assured that the students attain an appropriate breadth of experience which is not driven by commercial demands. Ensuring an appropriate breadth of experience will be the responsibility of the College of Optometrists. GOC will request reports regarding attainment of the clinical experience through its quality assurance processes.

Some respondents called for a greater level of prescription. However, as the majority of students progress through the College of Optometrist's Scheme of Registration, the College of Optometrists will retain oversight of trainees' breadth of experience and will be required to provide support to make up any shortcomings.

Summary of changes made post-consultation: The final proposal is similar to our original proposal; eligibility has been clarified and a review date has been added.

Detailed commentary

Eligibility

Consultation responses	GOC response
Many students entering the pre-registration year will not do so until January 2021, whereas some will have started their year in Summer 2020 (as well as those students from the Universities of Bradford and Hertfordshire already named in the documentation as having had their experience affected since March 2020). It is important that the inclusion and exclusion criteria are clearly specified, and account is taken of students/trainees who might have their experience particularly delayed or interrupted. We believe that the disruption caused by COVID-19 is very likely to extend beyond one year and suggest that these changes should apply for longer.	**Accepted,** we have now confirmed the exclusion/inclusion criteria.

Temporary change

Consultation responses	GOC response
It was expressed that the new draft material (page 18) says it is "the responsibility of the provider and/or the supervisor" to make alternative arrangements if it proves difficult for a student to achieve the required patient experience. The use of "and/or" here does not provide clear responsibility or accountability. Given the likely challenges of arranging patient experience during the pandemic, we think it is important for accountability on this to be clear.	**Accepted,** we have clarified this to be the provider's responsibility.
It was requested that the GOC review this decision after a set period of time, to include engaging with those students and employers on their experiences of the reduction, and any negative aspects they have noticed.	**Accepted,** we will ensure this is completed

10% reduction

Overall, this was supported by the majority of respondents.

Consultation responses	GOC response
There was the full range of views regarding the 10% reduction – One respondent suggested that the number should be reduced further or removed completely at this time, especially since the reduction in patients coming in for	**Noted,** due to the limited number of providers delivering GOC Stage 2 patient experience/core

Consultation responses	GOC response
sight tests are much more than 10%, another suggested that the focus should be output rather than input driven. However, the College of Optometrists was satisfied that students could obtain the breadth of experience without the 10% reduction. An alternative to set a minimum number or % of face to face consultations at a lower level than currently set was also proposed. Those who did not support the changes or partially supported the changes cited concerns about how breadth would be ensured if the GOC did not set clear minimum or proportions for the different types of experience– for example, there was concern that pre-registration students would get disproportionately more experience in dispensing than refracting, or that they would get given many less contact lens patients. One respondent raised concerns about the impact on students who are facing lengthy localised lockdowns or those within different regions of the country are likely to face different restrictions (such as those in Northern Ireland or Wales when compared to England) or may be subject to shielding. Students will be adversely affected by this arbitrary threshold for adequate patient encounters. Adjustments should be able to be considered by the College of Optometrists (with guidance from the student's Assessors) in relation to adequate patient encounters and the level of skill of the student given their individual circumstances. There was also the view that the numbers at present are not excessive and reducing them further will reduce the experience each trainee receives and that this goes against the direction of travel presented in the ESR.	competencies, there will be consistency with the levels achieved as they will be mainly monitored by the College of Optometrists. The GOC will request regular updates to ensure that breadth is being obtained.
Others welcomed the in definition of each clinical interaction and highlighted that it must still be recorded and validated as now, preferably by external assessors, citing that the current system is working well and gives the trainees a good framework and targets to aim for.	**Accepted,** the sign off must remain appropriate.
Some viewed that experience and repetition were extremely important and any reduction in the numbers could reduce the quality of experience achieved and ultimately lower the competence of students.	**Noted,** there are no proposals to reduce the rigour of the formative and summative assessments and certainly the GOC maintain a close view on the progression information.

Consultation responses	GOC response
There was a request that the minimum experience for student optometrists who are already qualified and registered as dispensing opticians or contact lens opticians can be exempted.	**Noted.** The GOC already has a policy for Recognising Prior Learning; it is the provider's responsibility to assure the GOC that their approach is appropriate and in line with our policy.

Comparability with peers:

Consultation responses	GOC response
There were concerns about the discrepancy between the patient experience required to be an Optometrists against that to become a Dispensing Optician or Contact Lens Optician.	**Noted.** It is not the intention of this piece of work to consider differences/similarities across different handbook – rather to consider the temporary changes that need to be made to enable student optometrists to progress through their education and training and achieve the appropriate experience to be safe practitioners.
There was concern that Stage 2 students may have quite different experiences if the minimum number of contact lens experiences, refractions, paediatric experiences, and dispenses are set by the provider. One respondent raised the point that dispensing spectacles correctly is also an imperative skill all Optoms should be able to do and therefore this skill should also be maintained. In many high street practices, a registrant is still required to be on site until closing for dispensing high risk groups and therefore this knowledge has important value. The scheme for registration is an excellent platform for graduate Optometrists to transition into safe practitioners, based on the 75 core competency based programme and using expert assessors to implement this Since the need for infection prevention and control measures during the pandemic may create commercial	**Noted.** At present the vast majority of students go through the Scheme of Registration who would retain oversight of the breadth or experience that the students were getting and would support them to make up any shortcomings. As part of our quality assurance activities, the GOC would request regular updates from the College and other

Consultation responses	GOC response
pressures for pre-reg students to spend less time on sight testing than at present, it was thought to be important for the GOC to make suitable monitoring arrangements to ensure that this cohort of pre-reg students obtains a properly balanced range of clinical experience.	relevant providers to understand the effectiveness of their policies and processes in ensuring that breadth is achieved.

Patient volume

Consultation responses	GOC response
It was stated that patient volume is crucial for fundamentals of Optometry. A student/newly qualified must be capable of assessing volumes of patients as well as breadth of pathology.	**Noted.** We have considered this as part of the College of Optometrists' response who are committed to ensuring that trainees should be supported to develop clinical efficiency and the ability to manage a realistic caseload safely and with efficacy.

Patient safety

Consultation responses	GOC response
There was concern that patient safety is not made clear enough - that even those episodes that are going ahead must be subject to government prescribed safety procedures, and students are not permitted to go ahead without, and this includes supervisors, and premises where episodes may take place.	**Accepted,** we have made this clearer in the temporary handbook.

Quality management:

Consultation responses	GOC response
It was suggested that any witness testimony completed should also signed by another GOC or non GOC registrant to reduce bias. The importance of assessors being able to view patient records was also put forward by one respondent.	**Noted.** The education provider is responsible for ensuring that its assessment procedures are robust and fit for purpose, in line with our standards.

Consultation responses	GOC response
There was some concern from one respondent that hospital placements are an imperative part of the pre-registration period. An on-line module is a very poor substitute for seeing live the range of pathologies necessary to be a good clinician.	**Noted.** The education provider is responsible for ensuring varied experience which is sufficient for the learning needs of the student, and must be able to robustly justify its approach.

Additional support available

Consultation responses	GOC response
Reduction of clinical experience may be mitigated by allowing students and pre-registration optometrists to access DOCET courses (or similar online clinical education) during this period.	**Noted.**

4) GOC Supervision policy

Summary: We propose permitting non-GOC fully-qualified registrants to supervise students, if they meet our supervision criteria, are regulated, only supervise tasks that are within their professional scope of practice, and the education providers ensure that all other supervision requirements are met – including clarity about any role in patient episode or core competency 'sign off' that these supervisors may have.

For example, this change would mean that HCPC-registered orthoptists (who have 2 years HCPC continuous registration) could supervise student optometrists conducting a binocular vision examination.

	Total	Percent
Fully support	54	**76%**
Partially support	9	**13%**
Do not support	7	**10%**
Do not have a view	1	**1%**
Not Answered	0	**0%**

The proposal to broaden supervision was well supported by respondents, including the College of Optometrists, the AOP, the Optometry Schools Council, and by all 11 respondents who work in Hospital Eyecare Services (8 fully, 3 partially supported).

Key reasons for support included:

- It will help expand the scope of practice among optometry students and improve the quality of learning. In particular optometry students will also learn the reality of primary and emergency care and what happens to their referrals that follow that route which may change their practice to take more responsibility for themselves.
- Other health care professionals such as orthoptists can give a different perspective on clinical investigation and management. A qualified orthoptist will know more about binocular vision than an optometrist, a qualified dispensing optician will know more about dispensing than an optometrist, etc.
- There was a view that this suggested a growing maturity across different health care regulators in that assurance in relation to orthoptists is provided to the GOC by virtue of regulation by the HCPC. This approach was welcomed and seen to be proportionate.
- It should also increase the feasibility of practices providing placements and reduce the supervisory burden on individual practitioners
- It should have professional development benefits for both individual trainees and those contributing to their supervision, as well as for MDT working and therefore patient care.

The main risks/concern was regarding whether the supervisor could be signing off core competencies without being a GOC-registrant. In response to this, it must be noted that the primary role of a supervisor is to advise and mentor students whilst maintaining oversight and responsibility of the patient in order to ensure public safety whilst a student is with a patient.

The role of a supervisor is not to assess and/or sign off the student, although a supervisor might also be an assessor and be able to sign off competencies etc. It is not always the case that a) a supervisor can assess b) a supervisor is required to assess. It is therefore not envisaged that professionals from other regulators will ever be in a position to sign off the achievement of core competencies.

It will be for the education provider to manage this to ensure that their application of the GOC supervision policy is safe, clear and appropriate for all the supervision of patient experience, competency sign off and assessments.

Summary of changes made post-consultation: The final proposal remains the same as the original, with very minor grammatical corrections.

Detailed commentary

Consultation responses	**GOC response**
Whilst many respondents reacted positively to this proposal, some concerns were raised about how this approach to supervision would be audited or quality assured.	**Noted.** This is for the education provider to manage to ensure that appropriate mechanisms are in place to manage, monitor and check how this adaptation is being applied.
It was questioned why this temporary change is seen as necessary in response to the COVID emergency?	**Noted.** We have proposed this change to reduce pressure on services by opening up those who can supervise GOC-registered students safely.
The main concern was raised by Optometrists/Dispensing Opticians was that they were worried about the competence of the other healthcare professionals and that they would have no experience of the GOC requirements and expectations. For example, citing that orthoptists work under an Ophthalmologist and cannot practice or prescribe unsupervised. They are not trained to identify ocular disease or perform complete eye exams, although they can provide Binocular Vision expertise. Another raised concerns that the training of orthoptists may not be of sufficient breadth to supervise all of the required areas of binocular vision practice e.g. non-strabismic disorders of vision however they suggested that as long as the supervision is limited to the scope of practice of the supervisor that overlaps with optometric practice, this should be appropriate. Another respondent	**Noted.** The education provider would be expected to manage what is deemed suitable for non-GOC registrants to supervise which would be limited to the individual's knowledge and experience. See below our response regarding a supervisor's role in signing off competencies / safe episodes. In addition, it would be unlikely that another healthcare registrant would agree to supervise something that is outside of their scope of practice.

Consultation responses	GOC response
who, in their experience, had seen that others would not be prepared to supervise unless competent.	
Implementation challenges were cited, such as the need for the provider to take care to ensure that the HCPC was aware of College management guidelines rather than their own professional guidelines if they differ.	**Noted.** This is for the education provider to manage to ensure that their application of the GOC supervision policy is safe and appropriate. The education provider will be expected to notify the GOC of any changes to its supervision policy which the GOC will review to seek assurance that the provider is managing this change responsibly and appropriately.
Whilst many respondents recognised the benefits of cross profession training, allowing the student/trainee to be exposed to other ways of practising etc., it was felt strongly that non-GOC registrants should not be the final arbiter of any student/trainees education or assessment. Many respondents felt that it was not appropriate to have non-GOC registrants signing off competencies or patient episodes/experience. This related to those individuals not being fully aware of the assessment criteria and or what knowledge Optometrists need to have. From a DO perspective, it was believed that a Dispensing Optician can help with training and perhaps supervising a delegated function, but the responsibility should still remain with the main Optometrist supervisor.	**Noted.** The primary role of a supervisor is to advise and mentor students whilst maintaining oversight and responsibility of the patient in order to ensure public safety whilst a student is with a patient. The role of a supervisor is not to assess and/or sign off the student, although a supervisor might also be an assessor and be able to sign off competencies etc. It is not always the case that a) a supervisor can assess b) a supervisor is required to assess. Therefore it is not envisaged that professionals from other regulators will ever be in a position to sign off the achievement of core competencies. It will be for the education provider to manage this to ensure that their application of the GOC supervision policy is safe, clear and

Consultation responses	GOC response
	appropriate for all patient experience, competency sign off and assessments.
Concern was raised that by expanding supervision, it may have an impact on the breadth of experience that an individual obtains as they may frequently repeat the same type of experience. It was suggested that the GOC limit the number of days/experience that can be supervised in this way.	**Not accepted.** The breadth of experience would be considered by the education provider in the above proposals, rather than in the supervision proposal.
There was a view across some responses that welcomed making explicit that supervision does not have to be from a GOC registrant but can include other registrants such as Orthoptists (HCPC) and Ophthalmologists (GMC) but went on to say that this was not regarded as a change. This is because many providers already use other registered healthcare professionals in the delivery of their course and have been explicit about this during GOC visits.	**Noted.** Whilst the use of other registered healthcare professionals is already used in the delivery of many courses, this is in relation to the teaching and delivery of the content and ensures multi-disciplinary learning. This does not extend to supervising student/trainee optometrists whilst practising with patients.
Some queried who else this could apply to and that this should also be applicable to primary care medical practitioners such as GPs, A&E doctors, Physician Associates and Pharmacists.	**Noted.** This would be acceptable as long as the GOC supervision policy criteria were met.

Annex 1: Revised proposed amendments

In the temporary handbook there will be the following introductory statement:

As a result of COVID-19 and further to the short consultation which ran from 23 July to 6 August 2020, we have approved the following temporary changes to enable clinical experience to be delivered in a safe and practical way in light of the limitations that the COVID-19 pandemic has put on clinical practice. Where elements of the current substantive handbook can be safely delivered by programmes, the superseded requirements can apply as well, as they will continue to meet our standards.

Patient safety is our top priority, and it is important that government and health and safety guidelines are followed at all times during this pandemic.

These temporary changes to our Accreditation and Quality Assurance Handbook 'Routes to Registration in Optometry' ('Optometry handbook') education standards and requirements are applicable as follows:

- **Temporary changes affecting undergraduate education are applicable from 1 September 2020 for the 2020/21 academic year only.**
- **Temporary changes affecting the College of Optometrists' Scheme for Registration or other registrable qualifications are applicable to this year's (Autumn 2020) incoming cohort of students/trainees only. Due to the nature of the Scheme for Registration, these changes will apply to students/trainees enrolling onto the Scheme for Registration between 1 September 2020 and 30 May 2021.**

We acknowledge that for the current cohorts currently undertaking clinical experience on the University of Bradford's BSc Optometry (Accelerated Route) and University of Hertfordshire's Master of Optometry, due to the structure of their courses, these changes may need to be applied retrospectively. We have offered to consider an application to recognise experience (which meets our criteria, once finalised and approved) from 21 March 2020 onwards from these providers.

GOC Stage 1 – Patient Episodes

Current wording of GOC Handbook for Optometry	Original proposal of temporary changes to GOC Handbook	Revised proposal (changes from current handbook wording highlighted in bold)
Section 1.4 Page 4 Practical experience Achievement of a minimum number of patient episodes covering a specified range of patient types and clinical procedures conducted under close supervision and assessment within a controlled environment, followed by completion of a period of supervised pre-registration training (undertaken in an external placement). The pre-registration placement practical experience can be integrated within the degree programme or completed separately with an alternative GOC approved provider.	Practical experience Achievement of **an appropriate breadth of patient experience** covering **a range** of patient types and clinical procedures conducted under close supervision and assessment within a controlled environment, followed by completion of a period of supervised pre-registration training (undertaken in an external placement). The pre-registration placement practical experience can be integrated within the degree programme or completed separately with an alternative GOC approved provider.	Practical experience Achievement of **an appropriate breadth of patient experience** covering **a range** of patient types and clinical procedures conducted under close supervision and assessment within a controlled environment, followed by completion of a period of supervised pre-registration training (undertaken in an external placement). The pre-registration placement practical experience can be integrated within the degree programme or completed separately with an alternative GOC approved provider.
Section 3.4 Page 13 • Patient episodes are clearly categorised into the different types of patient experience outlined in the handbook (attached at Appendix F) • The visitor panel is provided with a print-out of the total number of safe patient episodes for the full	• Patient **experience is** clearly **delineated into the different categories as** outlined in the handbook (attached at Appendix F) • The visitor panel is provided with a **copy of the Provider's master record** of the **total**	• Patient experience is clearly categorised into the different types as outlined in the handbook (attached at Appendix F) • The visitor panel is provided with a **copy of the provider's record** of the **total patient experience,**

cohort of students who attended the final year of the course (the last academic year)	**patient experience, including clear delineation of categories and safe episodes within each,** for the full cohort of students who attended the final year of the course (the last academic year)	**including clear delineation of categories and safe episodes within each,** for the full cohort of students who attended the final year of the course (the last academic year)
Section 4.1 Page 21 Any clinical activity or element of practice-based learning must be carried out under the supervision of a GOC registered and approved supervisor that meets the requirements outlined in Appendix I	Any clinical activity or element of practice-based learning must be carried out under the supervision of **an appropriately** registered and approved supervisor that meets the requirements outlined in Appendix I	Any clinical activity or element of practice-based learning must be carried out under the supervision of **an appropriately** registered and approved supervisor that meets the requirements outlined in Appendix I.
Section 4.6 Page 28 4.6.1 Patient Experience The provider must demonstrate that each student has achieved the appropriate range and number of patient episodes under close supervision to ensure competence in practice and skills to enable the award of the certificate of clinical competence at Stage 1 and Stage 2. A full definition of what constitutes a patient episode for each individual patient experience category (A-F) is given in the table attached at Appendix F. The figures specified in the table	4.6.1 Patient Experience The provider must demonstrate that each student has achieved **an appropriate breadth of patient experience** under close supervision to ensure competence in practice and skills to enable the award of the certificate of **professional** competence at Stage 1 and Stage 2. A full definition of what constitutes **appropriate patient experience for each individual category (A-F)** is given in the table attached at Appendix F. The figures specified in the table	4.6.1 Patient Experience The provider must demonstrate that each student has achieved **an appropriate breadth of patient experience** under close supervision to ensure competence in practice and skills to enable the award of the certificate of clinical competence at Stage 1 and Stage 2. A full definition of what constitutes **appropriate patient experience for each individual category (A-F)** is given in the table attached at Appendix F. The figures specified in the table

state the *minimum* number of safe patient episodes the student must achieve for each patient experience category prior to starting a pre-registration placement. • Only episodes which are certified as safe by the supervising registrant can be counted towards the minimum required number of patient episodes. The provider must have an effective system in place to ensure each student has access to a sufficient range and volume of patients under each category of experience. Volunteer patients may be used to contribute to some of the required episodes to enhance the student's range of experience by providing access to unusual pathologies and a mixture of patient types. If an exceptional circumstance leads to a variation below the minimum number of patient episodes, the provider must notify the GOC Education Committee of the proposed alternative learning experience offered to the student to	state the *minimum* safe patient episodes the student must achieve for each category prior to starting a pre-registration placement. • Only episodes which are certified as safe by the **supervisor** can be counted towards the minimum required patient **experience**. The provider must have an effective system in place to ensure each student has access to a sufficient range and volume of patients under each category of experience. **Simulated patients and scenarios** may be used to contribute to some of the required **experience** to enhance **the student's access** to unusual pathologies and a mixture of patient types**. The balance of simulated patients and/or scenarios relative to real patient experience for each student must be justified by a clear rationale.** If an exceptional circumstance leads to a variation below the minimum **required**	state the *minimum* safe patient **experiences** the student must achieve for each category prior to starting a pre-registration placement. • Only **experience** which **is** certified as safe by the **supervisor** can be counted towards the minimum required patient **experience**. The provider must have an effective system in place to ensure each student has access to a sufficient range and volume of patients under each category of experience. **Simulated patients and scenarios** may be used to contribute to some of the required **experience** to enhance **the student's access** to unusual pathologies and a mixture of patient types**. The balance of simulated patients and/or scenarios relative to real patient experience for each student must be justified by a clear rationale. This rationale must demonstrate how the balance of experience between real and simulated patients and/or scenarios achieves the clinical experience required to meet the relevant competencies.**

enable achievement of the appropriate learning outcome. The Committee will determine if the proposal meets the Handbook requirements.	patient episodes, the provider must notify the **GOC** of the proposed alternative learning experience offered to the student to enable achievement of the appropriate learning outcome. The **GOC** will determine if the proposal meets the Handbook requirements.	If an exceptional circumstance leads to a variation below the minimum **required** patient **experience**, the provider must notify the **GOC** of the proposed alternative learning experience offered to the student to enable achievement of the appropriate learning outcome. The **GOC** will determine if the proposal meets the Handbook requirements.
Page 29	Page 29	Page 29
4.6.2 Core Competencies The graduate must, on completion of their route to registration have demonstrated achievement of all elements of the GOC Core Competency Framework (Stage 1 and Stage 2) in order ensure they are fit to apply to the GOC Register. • Portfolios demonstrating clear assessment and achievement of each core competency element and the required patient episodes	4.6.2 Core Competencies The **student** must, on completion of their route to registration, have demonstrated achievement of all elements of the GOC Core Competency Framework (Stage 1 and Stage 2) in order **to** ensure they are fit to apply to the GOC Register. • Portfolios demonstrating clear assessment and achievement of each core competency element and the required patient **experience.**	4.6.2 Core Competencies The **student/graduate** must, on completion of their route to registration, have demonstrated achievement of all elements of the GOC Core Competency Framework (Stage 1 and Stage 2) in order **to** ensure they are fit to apply to the GOC Register. • Portfolios demonstrating clear assessment and achievement of each core competency element and the required patient **experience.**
Page 30	Page 30	Page 30

4.6.3 Certificate of Professional Competence Stage 1
• The student must demonstrate that they have achieved a *Certificate of Professional Competence at Stage 1* in order to begin their external supervised pre-registration placement
• A *Certificate of Professional Competence at Stage 1* can only be issued if the following requirements are satisfied:
  • The student must have been taught and assessed as competent against each of the Stage 1 core competencies (attached at Appendix G)
  • The student must have acquired the minimum amount of real patient experience with each patient group (attached at Appendix F)
  • The student must hold a certified portfolio containing a record of both their patient experience and achievement of all core competency elements;
  • This record must evidence how and when each individual element of competence was achieved by the individual student
	4.6.3 Certificate of Professional Competence Stage 1
	• The student must demonstrate that they have achieved a *Certificate of Professional Competence at Stage 1* in order to begin their external supervised pre-registration placement
	• A *Certificate of Professional Competence at Stage 1* can only be issued if the following requirements are satisfied:
	  • The student must have been taught and assessed as competent against each of the Stage 1 core competencies (attached at Appendix G)
	  • The student must have acquired **an appropriate breadth of patient** experience **within each category** (attached at Appendix F)
	  • The student must hold a certified portfolio containing a record of both their patient experience and achievement of all core competency elements;
	  • This record must evidence how and when each individual element of competence was achieved by the individual student
		4.6.3 Certificate of **Clinical** Competence Stage 1
		• The student must demonstrate that they have achieved a *Certificate of **Clinical** Competence at Stage 1* in order to begin their external supervised pre-registration placement
		• A *Certificate of **Clinical** Competence at Stage 1* can only be issued if the following requirements are satisfied:
		  • The student must have been taught and assessed as competent against each of the Stage 1 core competencies (attached at Appendix G)
		  • The student must have acquired **an appropriate breadth of patient** experience **within each category** (attached at Appendix F)
		  • The student must hold a certified portfolio containing a record of both their patient experience and achievement of all core competency elements;
		  • This record must evidence how and when each individual element of competence was achieved by the individual student

• The portfolio must contain a case record for each individual patient episode contributing to the minimum requirements
• The portfolio must evidence development of the students professional judgment through critical thinking and reflection
 	
Stage 2
• Upon completion of the pre-registration placement the provider is required to certify to the GOC that the student has achieved professional competence at Stage 2 before granting an award approved by the GOC as entitling entry to the GOC Register of Optometrists
• A *Certificate of Professional Competence at Stage 2* can only be issued if the following requirements are satisfied:
  • The student must have been taught and assessed as competent against each of the Stage 2 core competencies (attached at Appendix H)
  • The student must have acquired the minimum amount of patient experience with each patient
	• The portfolio must contain a **record of patient experience** for each individual patient episode contributing to the minimum requirements
	• The portfolio must evidence development of the student's professional judgment through critical thinking and reflection
	
	Stage 2
	• Upon completion of the pre-registration placement the provider is required to certify to the GOC that the student has achieved professional competence at Stage 2 before granting an award approved by the GOC as entitling entry to the GOC Register of Optometrists
	• A *Certificate of Professional Competence at Stage 2* can only be issued if the following requirements are satisfied:
	  • The student must have been taught and assessed as competent against each of the Stage 2 core competencies (attached at Appendix H)
	  • The student must have acquired **an appropriate breadth of patient** experience **within each**
		• The portfolio must contain a **record of patient experience** for each individual patient episode contributing to the minimum requirements
		• The portfolio must evidence development of the student's professional judgment through critical thinking and reflection
		
		Stage 2
		• Upon completion of the pre-registration placement the provider is required to certify to the GOC that the student has achieved professional competence at Stage 2 before granting an award approved by the GOC as entitling entry to the GOC Register of Optometrists
		• A *Certificate of **Clinical** Competence at Stage 2* can only be issued if the following requirements are satisfied:
		  • The student must have been taught and assessed as competent against each of the Stage 2 core competencies (attached at Appendix H)
		  • The student must have acquired **an appropriate breadth of patient** experience **within each category** (attached at Appendix F)

category (attached at Appendix F) • The student must hold a certified portfolio containing a record of both their patient experience and achievement of all core competency elements; • This record must evidence how and when each individual element of competence was achieved by the individual student • The portfolio must contain a record for each individual patient episode contributing to the minimum requirements • The portfolio must evidence development of the students professional judgment through critical thinking and reflection	**category** (attached at Appendix F) • The student must hold a certified portfolio containing a record of both their patient experience and achievement of all core competency elements; • This record must evidence how and when each individual element of competence was achieved by the individual student • The portfolio must contain a record for each individual patient episode contributing to the minimum requirements • The portfolio must evidence development of the student's professional judgment through critical thinking and reflection	• The student must hold a certified portfolio containing a record of both their patient experience and achievement of all core competency elements; • This record must evidence how and when each individual element of competence was achieved by the individual student • The portfolio must contain a record for each individual patient episode contributing to the minimum requirements • The portfolio must evidence development of the student's professional judgment through critical thinking and reflection.
<u>Appendix B</u> - Description of terms used in the Handbook Pages 33-34	ADD: **<u>Remote consultation</u>** **Consultations undertaken with real patients using telephone, video or other virtual means, to address the patient's needs and concerns including suitable remote examination (as appropriate), advice and management** **<u>Simulated patients and scenarios</u>**	ADD: **<u>Remote consultation</u>** **Consultations undertaken with real patients using telephone, video or other virtual means, to address the patient's needs and concerns including suitable remote examination (as appropriate), advice and management** **<u>Simulated patients and scenarios</u>**

	Simulated patients may be used for some of the experience to enhance the student's access to unusual pathologies **and refractive errors** and a mixture of patient types. **Where actual patients carrying the pathology(s) cannot be found, these may be substituted for prepared clinical case scenarios appropriately demonstrating the required clinical signs**	**Simulated** patients may be used for some of the experience to enhance the student's access to unusual pathologies **and refractive errors** and a mixture of patient types. **Where actual patients carrying the pathology/pathologies cannot be found, these may be replaced by prepared clinical case scenarios appropriately demonstrating the expected clinical signs and symptoms.**
Appendix F Page 39 onwards	**Types of patient episodes:** Below is a non-exhaustive list of the types of experience which could contribute to the achievement of A-F patient episodes. These should be selected on suitability of the activity for attaining quality experience and may not be appropriate for some of the A-F categories. **The provider is expected to ensure that students have the opportunity to experience a wide range of clinical conditions and that they gain experience with as broader range of patients as possible.**	**Types of patient episodes:** Below is a non-exhaustive list of the types of experience which could contribute to the achievement of A-F patient episodes. These should be selected on suitability of the activity for attaining quality experience and may not be appropriate for some of the A-F categories. **The provider is expected to ensure that students have the opportunity to experience a wide range of clinical conditions and that they gain experience with as broad a range of patients as possible.**

	Experience must enable individual students to develop their professional independence. **It is expected that opportunities for students to examine real patients are maximised and that the provider sets a minimum amount of real patient episodes to provide assurance that students will achieve real patient experience. It is recommended that at least 45% of the patient experience is with real patients.** Patient episodes could include, but are not limited to: • real patients attending for a **face-to-face consultation** • grand rounds • simulated scenarios that form the basis of case-based discussion which enable individual students to demonstrate their understanding and/or ability to do • clinical audit to include case discussion of specialist techniques and evaluation of patient outcomes • **simulated patients enacting a pre-determined clinical case scenario**	**Experience must enable individual students to develop their professional independence, particularly when working at a higher student:patient ratio than 1:1.** **It is expected that opportunities for students to examine real patients are maximised, whilst maintaining patient safety at all times. Providers must set a minimum volume of real face-to face or remote patient experience for each category (45% is recommended) to provide assurance that students will achieve sufficient experience with real patients.** Patient **experience** could include, but are not limited to: • real patients attending for a **face-to-face consultation** • grand rounds • simulated scenarios that form the basis of case-based discussion which enable individual students to demonstrate their understanding and/or ability to do • clinical audit to include case discussion of specialist techniques and evaluation of patient outcomes

	• **patients undergoing telephone or video consultation which involves remote assessment and management of the patient** • a student **examining** another optometry student **or clinically trained member of staff** and completes a patient record.	• **simulated patients enacting a pre-determined clinical case scenario** • **patients undergoing telephone or video consultation which involves remote assessment and management of the patient** • a student **examining** another optometry student **or member of staff,** complet**ing** a patient record.
Stage 1 Patient Experience It is a requirement that students record their patient episodes as the different types of patient experience categories outlined in the following table under A-F.	**GOC expectations regarding patient experience** Stage 1 Patient Experience • It is a requirement that students record their **patient experience against the different categories** outlined in the following table under A-F. • **The provider must demonstrate that its clinical experience model enables students to gain appropriate patient and clinical experience to successfully achieve the relevant Core Competencies and be prepared to progress to the next stage. This means that patient episodes must not be trivial and should always**	**GOC expectations regarding patient experience** Stage 1 Patient Experience • It is a requirement that students record their **patient experience against the different categories** outlined in the following table under A-F. • **The provider must demonstrate that its clinical experience model enables students to gain appropriate patient and clinical experience to successfully achieve the relevant Core Competencies and be prepared to progress to the next stage. This means that patient episodes must not be trivial and should always**

	support clinical and professional learning. • **The quantitative/numerical measures related to patient experience and student:patient rationale are indicative only (unless specified). We would expect a provider to ensure that significant deviations to the numerical measures are fully justified.** • **Student:patient ratio must ensure effective learning and the provider is required to have an appropriate rationale for its ratios and numerical requirements.** • The provider is **required to demonstrate that any group sizes are** appropriate for the activity being undertaken (e.g. for the learning experience and patient safety and comfort). • **The provider is expected to ensure that students have the opportunity to experience a wide range of clinical conditions and that they gain experience with as**	**support clinical and professional learning.** • **The quantitative/numerical measures related to patient experience and student:patient rationale are indicative only (unless specified). We expect providers to ensure that significant deviations (to the numerical measure, or the number of students this applies to) are fully justified.** • **Student:patient ratio must ensure effective learning. The provider must apply an appropriate rationale for its choice of student:patient ratios and numerical requirements, with consideration given to enabling individual students to develop their professional independence.** • The provider is **required to demonstrate that any group sizes are** appropriate for the activity being undertaken (e.g. for the learning experience and patient safety and comfort).

	broader range of patients as possible. • **It is expected that opportunities to work with a real patients (face-to-face or remotely) are maximised and that the provider sets a minimum amount of real patient episodes to provide assurance that students will achieve real patient experience. It is recommended that at least 45% of the patient experience is with real patients.** • Patient **experience must** be carried out with appropriate student:patient ratios **(including for simulated case based discussion) in order to enable individual students to develop their professional independence.** • **In clinical examinations, where the student:patient ratio is more than 1:1**, students must not count episodes they have **only** observed (without any patient interaction), although this can be used to enhance learning through reflective practice.	• **The provider is expected to ensure that students have opportunity to experience a wide range of clinical conditions and that they gain experience with as broad a range of patients as possible.** • **It is expected that opportunities for students to examine real patients (face-to-face or remotely) are maximised, whilst maintaining patient safety at all times. Providers must set a minimum volume of real face-to face or remote patient experience for each category (45% is recommended) to provide assurance that students will achieve sufficient experience with real patients.** • **Students may only count experience they have observed if it is accompanied by formal, recorded discussion and reflection. Observation without discussion and reflection may be used to enhance learning through informal reflective practice.**

	• **When a student examines another optometry student or clinically trained member of staff, it is expected that they always complete a patient record. For the majority of these encounters, it is expected that these 'patients' have a clinical condition (e.g. refractive need, BV etc) to ensure that the episode provides experience of clinical conditions.** • **Mechanisms need to be in place to ensure that case scenarios are quality assured and selected from a bank such that they do not "become known" to the student cohort.**	• **When a student examines another student or member of staff, it is expected that they always complete a patient record. For the majority of these encounters, it is expected that these 'patients' have a clinical condition (e.g. refractive need, BV etc) to ensure that the episode provides experience of clinical conditions.** • **Mechanisms need to be in place to ensure that case scenarios are quality assured, and it is expected that there are a wide variety of case scenarios available, including for the same conditions.**

A. Primary Care Experience The experience must follow a normal optometric eye examination as closely as possible and constitute all components of a sight test as defined in the Opticians Act 1989 (amended 2005). The provider must ensure that access is given to patients with a range of refractive errors and common eye conditions. **Minimum number of safe patient episodes:** 18 complete eye examinations **Type of patients:** Patients attending for an eye examination or eye-care service. A student practicing on another student can only count if the student is booked in, treated and recorded as an actual patient. **Type of experience:** All primary care episodes must be on a 1:1 (student: patient) ratio with the student as practitioner. *Patient episodes should be designed to fully replicate the complete patient experience when attending for an eye examination.* Students must not gain multiple primary care episodes with the same patient.	A. Primary Care Experience The experience must follow a normal optometric eye examination as closely as possible and constitute all components of a sight test as defined in the Opticians Act 1989 (amended 2005). The provider must ensure that access is given to patients with a range of refractive errors and common eye conditions. **Indicative** safe patient episodes**: 18 episodes, which should include at least 8 complete eye examinations at a low student:patient ratio.**	The experience must follow a normal optometric eye examination as closely as possible and constitute all components of a sight test as defined in the Opticians Act 1989 (amended 2005), **where possible**. The provider must ensure that access is given to patients with a range of refractive errors and common eye conditions. **Indicative** safe patient **experience: 18 episodes, of which at least 8 must be complete eye examinations with a (mandatory) 1:1 student:patient ratio.**

B. Contact Lens Experience The provider must ensure that the student has experience of a range of patient episodes relating to contact lens fitting and aftercare. **Minimum number of safe patient episodes:** 12 episodes **Type of patients:** Patients attending for a contact lens assessment, fit, and aftercare. A student practicing on another student can only count if the student is booked in, treated and recorded as an actual patient requiring a contact lens assessment. **Type of experience:** Patient episodes may be carried out on a 2:1 ratio (student: patient), however, both students must interact with the patient (for example, a pair of students might examine one eye each or take responsibility for different stages of an examination ensuring they each gain sufficient experience as the practitioner). Students must not count patient episodes they have observed (without any patient interaction) in their final patient numbers, although this can be used to enhance learning through reflective practice.	**B. Contact Lens Experience** The provider must ensure that the student has experience of a range of **contact lens fitting and aftercare episodes.** **Indicative** safe patient episodes**:** 12 episodes, **to include complete fitting appointments, aftercare appointments, and clinical decision making episodes**.	**B. Contact Lens Experience** The provider must ensure that the student has experience of a range of contact lens fitting and aftercare **experience.** **Indicative** safe patient **experience:** 12 episodes, **to include complete fitting appointments involving clinical decision making.**

C. Binocular Vision, and Paediatric Experience The provider must ensure that the student has experience of patients with anomalies of binocular vision and those undergoing orthoptic assessment and/or treatment. **Minimum number of safe patient episodes:** 8 episodes including at least 3 paediatric patients, one of which must be a child under 7 years. **Type of patients:** Patients attending for a binocular vision assessment and/or an anomaly of binocular vision. **Type of experience:** Students may observe the assessment and treatment of patients with binocular vision anomalies and those undergoing investigation for suspected binocular vision anomalies individually or in small groups. Students should have the opportunity to assess individuals with binocular vision anomalies either individually or in small groups of up to 4 students (maximum). Students must not gain multiple episodes with the same patient. The provider will be required to demonstrate that the group size is appropriate for the activity being undertaken.	**C. Binocular Vision, and Paediatric Experience** The provider must ensure that the student has experience of **examining children,** patients with anomalies of binocular vision and those undergoing **orthoptic treatment.** **Indicative** safe patient episodes**:** 8 episodes including at least **two** paediatric patients **one of which** must be a child **aged** under 7 years.	**C. Binocular Vision, and Paediatric Experience** The provider must ensure that the student has experience of patients with anomalies of binocular vision and those undergoing **orthoptic treatment, as well as children.** **Indicative** safe patient **experience:** 8 episodes including at least **two** paediatric patients **one of which** must be a child **aged** under 7 years.

D. Specialist Clinic Experience The provider must ensure that students attend a range of clinics in which specialist techniques are being used, such as Low Vision clinics, Imaging / Further Investigative Techniques clinics and Paediatric / Special Needs clinics. **Minimum number of safe patient episodes:** 12 episodes **Type of patients:** Patients requiring specialist clinical services. These experiences should normally be gained through the providers' clinical services and hospital visits. Grand rounds may be used as part of the student's experience. **Type of experience:** Students may work in small groups of 4 (maximum), observing and participating in the provision of specialist services as appropriate for the learning experience and patient safety and comfort. Students must not gain multiple episodes with the same patient. The provider will be required to demonstrate that the group size is appropriate for the activity being undertaken.	**D. Specialist Clinic Experience** The provider must ensure that students **experience** a range of specialist techniques **including ocular imaging / further investigative techniques, examining patients with additional needs, and at least one low vision assessment.** **Indicative** safe patient episodes**:** 12 episodes.	**D. Specialist Clinic Experience** The provider must ensure that students **experience** a range of specialist techniques **including ocular imaging / further investigative techniques, examining patients with additional needs, children, and at least one low vision assessment.** **Indicative** safe patient **experience:** 12 episodes.

E. Spectacle Dispensing Experience The provider must ensure that the student has experience of dispensing a range of frame/lens types, including some experience of dispensing for children and low vision patients. **Minimum number of safe patient episodes:** • 6 initial selection and facial/frame measurements • 6 prescription verification • 6 fit and adjustment of spectacles These three stages can be completed on stages at least six times. **Type of patients:** Patients requiring a spectacle dispense. **Type of experience:** Patient episodes must be on a 1:1 ratio (student: patient). The provider should endeavour to provide some experience of the same or multiple patients. However, the student must see a minimum of six different patients and complete all three dispensing a range of frame/ lens types for children and low vision patients.	**E. Spectacle Dispensing Experience** The provider must ensure that the student has experience of dispensing a range of frame **and** lens types, including some experience of dispensing for children and low vision patients. **Indicative** safe patient episodes**:** • 6 initial selection and facial/frame measurements • 6 prescription/**appliance** verifications • 6 fit and adjustment of spectacles These three stages can be completed on the same or multiple patients. However, the student must see a minimum of six different patients **(combination of real and simulated) and there should be a low student:patient ratio.**	**E. Spectacle Dispensing Experience** The provider must ensure that the student has experience of dispensing a range of frame **and** lens types, including some experience of dispensing for children and low vision patients. **Indicative** safe patient episodes**:** • 6 initial selection and facial/frame measurements • 6 prescription/**appliance** verifications • 6 fit and adjustment of spectacles These three stages can be completed on the same or multiple patients. However, the student must see a minimum of six different patients **with a (mandatory) 1:1 student:patient ratio.**

F. Abnormal Eye Conditions This experience should take place in hospital eye clinics and must include attendance at ophthalmology clinics. An effective feedback mechanism must be in place to record the student's patient experience gained during hospital attendance, for example, through a portfolio/record of all patients and conditions seen by the student supported by a reflective commentary. **Minimum number of safe patient episodes:** 12 hours of experience in clinics **Type of patients:** Typically, patients attending for a hospital eye appointment. It is the responsibility of the provider to ensure that students are exposed to a range of patient types and conditions. To ensure exposure to common ocular pathologies, in addition to the hospital placement, supplementary experience may be gained through: • specialist clinics (within the university) offering additional exposure to less common conditions • grand rounds (case and management demonstrations incorporating real patients, video or images to highlight key pathology) ensuring the student has observed common conditions • directed study using a range of media	**F. Abnormal Eye Conditions** **Providers should ensure that students are exposed to a range of common and uncommon ocular pathologies. This experience can take place in ophthalmology clinics at NHS or private hospital eye departments or clinics hosted by the provider.** An effective feedback mechanism must be in place to record the student's patient experience gained, for example, through a portfolio/record of all patients and conditions seen by the student supported by a reflective commentary. Minimum **experience required: 7** hours of experience in clinics.	**F. Abnormal Eye Conditions** **Providers should ensure that students are exposed to a range of common and uncommon ocular pathologies. This experience can take place in ophthalmology (including virtual) clinics at NHS or private hospital eye departments or clinics hosted by the provider, or real case discussions led by an ophthalmologist.** An effective feedback mechanism must be in place to record the student's patient experience gained, for example, through a portfolio/record of all patients and conditions seen by the student supported by a reflective commentary. Minimum **experience required: mandatory 7** hours of experience in clinics. **To ensure exposure to common ocular pathologies, in addition to the hospital placement, supplementary experience may be gained – please see types of experience.**

Type of experience: Students may attend these clinics in small groups of up to a maximum of 4 students, the provider will be required to demonstrate that the group size is appropriate for the activity being undertaken.		

Validity of Certificate of Clinical Competence for Optometry (Stage 1)

Summary: We propose to extend the validity of the Stage 1 certificate of clinical competence for students who graduated in summer 2018 to 31 December 2020.

We also propose removing this requirement entirely as of January 2021, so that any decisions to the currency of learning forms part of a provider's enrolment/admissions policy (such as the enrolment policy for the College's Scheme for Registration).

Current wording of GOC Requirements on website: https://www.optical.org/en/Education/What_to_study_and_where/index.cfm	**Original proposal of permanent change**	**Revised proposal (changes from current wording highlighted in bold)**
To enter a pre-registration placement trainees must have gained a degree in optometry from an institution recognised by the GOC at 2:2 or above and have a valid Certificate of Clinical Competency, which is awarded on graduation. **The Certificate of Clinical Competency is valid for two years from either the date of graduation or the date of last period of supervised practice**.	To enter a pre-registration placement trainees must have gained a **GOC approved qualification in optometry** at 2:2 or above and have a valid Certificate of Clinical Competency, which is awarded on graduation.	To enter a pre-registration placement trainees must have gained a **GOC approved qualification in optometry** at 2:2 or above and have a valid Certificate of Clinical **Competence**, which is awarded on graduation.

GOC Stage 2 - Patient Episodes

Summary: We propose reducing the total number of patient episodes for GOC stage 2 by 10% and removing the categorised patient episode numbers for GOC Stage 2.

Instead, the provider must ensure that the student achieves an appropriate breadth of experience. The provider must also set and justify its level of minimum experience in specific areas of practice.

- **Temporary changes affecting the College of Optometrists' Scheme for Registration or other registrable qualifications are applicable to this year's (Autumn 2020) incoming cohort of students/trainees only. Due to the nature of the Scheme for Registration, these changes will apply to students/trainees enrolling onto the Scheme for Registration between 1 September 2020 and 30 May 2021.**

Current wording of GOC Handbook for Optometry	**Original proposal for a temporary change to GOC Handbook**	**Revised proposal (changes from current handbook wording highlighted in bold)**
Stage 2 Patient Experience On completion of the period of supervised practise-based training, the student must demonstrate achievement of the **total number of refractions, dispenses and contact lens patients to the provider. The *minimum* patient numbers required for GOC Registration:** **Refractive examinations: 350** **Dispenses: 200** **Contact Lens Patients: 30** Patient experience must be recorded in a reflective portfolio with each activity	Stage 2 Patient Experience On completion of the period of supervised practise-based training, the student must demonstrate achievement **of 520 patient encounters.** **The patient encounters must ensure that a breadth of experience is achieved, with an appropriate level of encounters with real patients.** **The provider must set out the minimum amount of contact lens experience (to include new fits), refractions and**	Stage 2 Patient Experience On completion of the period of supervised practise-based training, the student must demonstrate achievement **of 520 patient encounters.** **The patient encounters must ensure that a breadth of experience is achieved, with an appropriate mix of encounters with real patients.** **The provider must set out the minimum amount of contact lens experience (to include new fits), refractions, dispenses, low vision and paediatric**

certified by the supervisor and returned to the provider. The completed portfolio must be validated by the provider responsible for overseeing the period of practise-based experience. If difficulty occurs in enabling the student to achieve the required patient experience, it is the responsibility of the supervisor to make alternative arrangements, such as an external placement, to ensure the student has access to the required number and range of patients.	**paediatric experience, which is appropriate for gaining proficiency.** **The provider must have an appropriate mechanism in place to ensure that sufficient breadth and quality of experience is achieved.** Patient experience must be recorded in a reflective portfolio with each activity certified by the supervisor and returned to the provider. The completed portfolio must be validated by the provider responsible for overseeing the period of practise-based experience. If difficulty occurs in enabling the student to achieve the required patient experience, it is the responsibility of the **provider and/or** supervisor to make alternative arrangements, such as an external placement, to ensure the student has access to the required number and range of patients.	**experience appropriate for gaining proficiency.** **The provider must have an appropriate mechanism in place to ensure that sufficient breadth and quality of experience is achieved.** Patient experience must be recorded in a reflective portfolio with each activity certified by the supervisor and returned to the provider. The completed portfolio must be validated by the provider responsible for overseeing the period of practise-based experience. If difficulty occurs in enabling the student to achieve the required patient experience, it is the responsibility of the **provider** to make alternative arrangements, such as an external placement, to ensure the student has access to the required number and range of patients.

GOC Supervision policy

Current GOC Supervision policy wording	**Original proposal for a temporary change to GOC Supervision policy**	**Revised proposal (changes from current policy wording highlighted in bold)**
Supervision requirements It is a requirement for those supervising trainees or those undertaking delegated activities to be able to demonstrate to the GOC that the supervision is *adequate*. We define 'adequate supervision' as provided by a registrant who: • is sufficiently qualified and experienced to themselves undertake the functions they are supervising; • is not only on the premises but in a position to oversee the work undertaken and to intervene if necessary in order to ensure protection of the patient; • must retain clinical responsibility for the patient; • must ensure that no untoward consequences to the detriment of the patient can arise from the actions of a person who is being supervised; • must ensure compliance with all legal requirements governing the activity. Additional requirements for supervision of trainees undertaking practice based learning	Supervision requirements It is a requirement for those supervising **students** or those undertaking delegated activities to be able to demonstrate to the GOC that the supervision is *adequate*. We define 'adequate supervision' as provided by a registrant who: • **who holds a qualification in an eyecare related field and is sufficiently** experienced to undertake the functions they are supervising; • i**s a fully qualified statutorily registered health care professional with at least two years continuous registration;** • comply with the GOC code of conduct **(and/or equivalent regulator's conduct standards)** in their professional practice; • is not only on the premises but in a position to oversee the work undertaken and to intervene if necessary, in order to ensure protection of the patient; • must retain clinical responsibility for the patient;	Supervision requirements It is a requirement for those supervising **students** or those undertaking delegated activities to be able to demonstrate to the GOC that the supervision is *adequate*. We define 'adequate supervision' as provided by a registrant who: • **holds a qualification in an eyecare related field and is sufficiently** experienced to undertake the functions they are supervising; • **is a fully qualified statutorily registered health care professional with at least two years continuous registration;** • compl**ies** with the GOC code of conduct **(and/or equivalent regulator's conduct standards)** in their professional practice; • is not only on the premises but in a position to oversee the work undertaken and to intervene if necessary, in order to ensure protection of the patient; • must retain clinical responsibility for the patient;

Current GOC Supervision policy wording	**Original proposal for a temporary change to GOC Supervision policy**	**Revised proposal (changes from current policy wording highlighted in bold)**
Trainees undertaking practice-based learning must practice under the supervision of an appropriately qualified, registered and approved supervisor. To supervise you must: • Have at least two years recent and relevant post qualification practical experience; • Have maintained a minimum of two years continuous GOC registration; • Comply with the GOC code of conduct in their professional practice; • Ensure that your students are registered with the GOC; • Meet the approval criteria of Providers; • Provide continuous personal supervision, i.e. be in the practice when the student is in professional contact with patients and be able to intervene as necessary; • Support, observe and mentor; • Provide a sufficient and suitable learning environment; • Ensure the student has access to the appropriate equipment to meet the requirements of the Route to Registration;	• must ensure that no untoward consequences to the detriment of the patient can arise from the actions of a person who is being supervised; • must ensure compliance with all legal requirements governing the activity. • ensure that **their** students are registered with the GOC; • meet the approval criteria of providers; • provide continuous personal supervision, i.e. be in the practice when the student is in professional contact with patients and be able to intervene as necessary; • support, observe and mentor; • provide a sufficient and suitable learning environment; • ensure the student has access to the appropriate equipment to meet the requirements of the Route to Registration; • be familiar with the assessment requirements, guidelines and regulations of the Route to Registration; • ensure that when the student is in professional contact with patients they are clearly identified as a **student** under supervision and that the identity of the	• must ensure that no untoward consequences to the detriment of the patient can arise from the actions of a person who is being supervised; • must ensure compliance with all legal requirements governing the activity. <u>Additional requirements for supervision of **students:**</u> **<u>The supervisor:</u>** • ensure**s** that **their** students are registered with the GOC; • meet**s** the approval criteria of providers; • provide**s** continuous personal supervision, i.e. is in the practice when the student is in professional contact with patients and be able to intervene as necessary; • support**s**, observe**s** and mentor**s**; • provide**s** a sufficient and suitable learning environment; • ensure**s** the student has access to the appropriate equipment to meet the requirements of the Route to Registration;

Current GOC Supervision policy wording	**Original proposal for a temporary change to GOC Supervision policy**	**Revised proposal (changes from current policy wording highlighted in bold)**
• Be familiar with the assessment requirements, guidelines and regulations of the Route to Registration; • Ensure that when the student is in professional contact with patients they are clearly identified as a trainee under supervision and that the identity of the supervisor is also made clear to the patient.	supervisor is also made clear to the patient.	• **is** familiar with the assessment requirements, guidelines and regulations of the Route to Registration; • ensure**s** that when the student is in professional contact with patients they are clearly identified as a **student** under supervision and that the identity of the supervisor is also made clear to the patient.
(All other GOC requirements related to supervision will remain the same. For example this includes, but is not limited to, the requirement to have effective supervision procedures in place, comprehensive supervisor guidance and training.)	N/A	N/A

Annex 2: Individual responses

This document contains the responses where respondents gave their consent for publication.

Organisational respondents overview:

Organisation	Stage 1	Cert of CC - temp	Cert of CC- perm	Stage 2	Supervision
AOP	Partially	Fully	Fully	Partially	Fully
FODO	Fully	Fully	Fully	Fully	Fully
College of Optometrists	Fully	Fully	Fully	Fully	Fully
OSC (Optometry education providers)	Partially	Fully	Fully	Fully	Fully
Glasgow Caledonian University	Partially	Fully	Fully	Partially	Fully
Hospital Optometrists Committee	Fully	Fully	No	Fully	Partially
University of Manchester	Partially	Fully	Fully	Partially	Fully
University of Plymouth	Partially	Fully	Fully	Fully	Fully
Ulster University	Partially	Fully	Partially	Fully	Fully

Consultation responses (verbatim)

GOC Stage 1 – Patient Episodes **Summary:** We propose various changes to the handbook wording to move from a 'minimum number of patient episodes' to 'an appropriate breadth of patient experience'. This is to enable clinical experience to be delivered differently in light of the limitations that the COVID-19 pandemic has put on clinical practice. This approach would enable clinical experience to be delivered in a safe and practical way and contribute to preparing students for the new world of practice brought about by the pandemic.
Fully support
A general comment: most welcome proposals, the practicality of which I leave to my clinical colleagues to judge. However, I am pleased to see other ocular professionals being deployed in making assessments of optometry students. I am disappointed to see the use of the word 'appropriately' scattered throughout. If I was a provider I would be left confused. I understand why that term is used, but give some examples, so the range of appropriateness is more obvious. Otherwise you are leaving yourselves open! (EVP member)
Broadly in support, but I suggest requirement for evidence that the Student has undergone COVID awareness training, in order for them to carry out a local risk assessment for where they are working. (Individual, dispensing optician and GOC Advisory Panel member)
I hope that this will continue beyond COVID-19 - if it safe now it will remain safe in the future and current rules are too prescriptive. One negative action is the requirement for a "Master record". Although this is relative straightforward in the university and primary care setting it will be very difficult in a hospital environment to gain a master list of all appointments and how students move quickly between patients if called upon by ophthalmology staff keen for them to view an interesting case. I wonder if a reflective statement by the trainee could help alleviate this requirement? (Individual, DO, academic, GOC Advisory Panel)
If the proposed changes were to be entrusted on a educational provider such as universities, I have no doubt that trainees will be just as well prepared ,if not better prepared, as previous cohort of trainees. This is because university settings and real clinics provide the perfect environment for learning and enforcing knowledge. If however, these changes are entrusted on employers in work, it is likely that trainees will have a significant reduction in experience and confidence in comparison to the previous cohort of trainees. Allowing Universities and hospitals to run stage 2 qualification will help bridge any gaps in experience and knowledge that this current cohort of trainees might have ,that previous cohorts did not, as a result of the reduction in requirements. (Individual, Student optometrist)
It may be difficult for the GOC to justify the existing minimum number when we revert back following these temporary changes. (EVP member)
Obtaining an arbitrary number of records was tedious at the best of times, I think it is right to focus of quality of experience over mindless number crunching (Individual, dispensing optician, and student optometrist)

There is some potential risk to public safety in temporarily lowering the standards required for entry to the profession. This has to be managed and mitigated bearing in mind the need to have in place sufficient numbers in the workforce to support the challenges of rising patient demand with the aging population demographic. (Organisation, Hospital Optometrists Committee)
This would give an opportunity to explain best action vs. Pragmatic approach taken. (Individual, student dispensing optician)
We fully support these proposals and believe they will have positive benefits on education and will not cause negative impacts. However, on detail, it would be helpful to make clear in Section F that abnormal eye conditions exposures could be achieved via remote or virtual clinics or simulations. This would be a useful way to expand the range of education and training opportunities for students who might otherwise not have access to a clinical caseload with significant ocular pathology/complications. In 4.6.1 it would be helpful to change 'patients' to 'patient experience' as elsewhere – viz "The provider must have an effective system in place to ensure each student has access to a sufficient range and volume of patient experience under each category." (Organisation, FODO)
We support the proposed changes set out in question 7 for GOC Stage 1. We believe that the changes will create a more flexible approach to students' engagement in patient episodes and would suggest the application of the same principles as we have set out for a different approach to patient episodes, or encounters, in Stage 2 (i.e. as set out in our original proposal and, in brief, below). (Organisation, College of Optometrists)
Partially support
Appendix F - the observation of specialist episodes (observing Orthoptist carrying out BV examination/Ophthalmologist seeing patients) Allowing students to count virtual episodes does give them breadth or experience over seeing a set number of patients who could all be relatively straight forward. (Individual, dispensing optician)
Appendix F A. Primary Care Experience Indicative safe patient experience: 18, which must include complete eye examinations. This statement is unclear if all 18 experiences require complete eye examinations or only a proportion? This lack of clarity could negatively impact on the student's ability to meet the required number of experiences. Given the potential of a second wave or localised lockdowns that may require University clinics to close it is likely that 18 complete eye examinations may be unachievable. I suggest this could be managed by revising the statement to ensure there is clarity regarding the required proportion of complete eye examinations and ensure that this number is achievable given the unpredictability of the academic year. Appendix F F. Abnormal Eye Conditions. Minimum experience required; 7 hours of experience in clinics

Given the current requirements for social distancing and efforts to minimise infection risk to patients and staff it is highly likely that students will be unable to gain adequate or any experience "in clinics". Many ophthalmology clinics will be unable to offer remote/virtual clinics due to the technological limitations, GDPR, practitioner/consultant time etc. This will negatively impact on a student's ability to fulfil this requirement. It is suggested that the arbitrary 7 hours should be removed and suitable alternatives to the "in clinic" experience should be allowed. (Individual, optometry academic)
Comments numbered below and suggestions provided... (1) We would like it to be clear in the documentation that the temporary arrangements articulated in the proposed document are an acceptable alternative, but where elements of the current handbook CAN be safely delivered by programmes that this is also valid and meets regulations. (2) Appendix F,- GOC expectations regarding patient experience, Stage 1 Patient Experience: We would suggest a rewording of the following statement; “In clinical examinations, where the student:patient ratio is more than 1:1, students must not count episodes they have only observed (without any patient interaction), although this can be used to enhance learning through reflective practice.” Based on the wording of the current handbook, we believe this this statement should read; “In primary eye care face-to-face experiences, where the student:patient ratio is more than 1:1, students must not count episodes they have only observed (without any patient interaction), although this can be used to enhance learning through reflective practice.” In the current handbook, it is ONLY the primary care episodes which are mandated to have a 1:1 student:patient ratio. The CL and other clinical experiences allow for more than one student to observe a patient episode (BV, paediatrics Handbook 2015 Appendix F, Section C “Students may observe the assessment and treatment of patients with binocular vision anomalies and those undergoing investigation for suspected binocular vision anomalies individually or in small groups”) and for two students to examine a CL patient (Handbook 2015 Appendix F, Section B, “Patient episodes may be carried out on a 2:1 ratio (student: patient), however, both students must interact with the patient”. (3) Appendix F – Category F Abnormal Eye Conditions "Providers should ensure that students are exposed to a range of common and uncommon ocular pathologies. This experience can take place in ophthalmology clinics at NHS or private hospital eye departments or clinics hosted by the provider.” It would be both pragmatic and pedagogically sound to broaden this statement as follows; "....This experience can take place in ophthalmology clinics at NHS (including virtual clinics) or private hospital eye departments or clinics hosted by the

provider or real case discussions led by an ophthalmologist". (4) Appendix F - "a student examining another optometry student or clinically trained member of staff …" It is not clear why this patient needs to be 'clinically trained' for the student to gain suitable experience. We would suggest this could be reworded "…another optometry student or volunteer." (Organisation, Ulster University)
Concerns - preregs having inadequate experience to become competent in examining the general public Their patient records will not be scrutinized other than by their supervisor. Concern - they will not know how to keep accurate, competent and contemporaneous records Management - find a way for a spot check if record keeping by the assessor to take place (Individual, optometrist, supervisor and College assessor)
I do not understand why observations cannot count towards the student experience (Individual, optometrist, academic)
I largely support the changes however would have the following concerns: 1. The purpose of patient experience at Stage 1 is to allow students to begin to develop independent thought to become independent practitioners. Without stipulating 1:1 student:patient ratios for encounters, students will not be able to develop this. Stating "low student:patient ratio" is not clear enough and I feel an actual figure out to be stipulated. There is otherwise a real risk of incredibly variable experiences for students across different institutions 2. Certain types of experience are not suitable for all categories of episodes e.g. grand rounds is not suitable for primary care, dispensing or contact lenses (especially fitting) - I think it should be clearer what is allowed under each category 3. The stipulation of 45% of experience being with real patients - is this overall or within each category? I would support the latter (EVP member)
I welcome the change of emphasis towards the breadth of clinical experience, but caution reducing the number of cases significantly on a permanent basis past Covid-19. It shouldn't be underestimated how much confidence is gained by honing your craft by repetition. It gives the clinician, and as a result the patient, greater confidence and sets the basis for better communication and a slicker experience. (Individual, dispensing optician)
In general, I support most of the changes proposed and welcome the added flexibility. I would query a few items listed below: • In clinical examinations, where the student:patient ratio is more than 1:1, students must not count episodes they have only observed (without any patient interaction), although this can be used to enhance learning through reflective practice- this appears to be a tightening of the requirement as for certain categories previously, observations could be counted as episodes F. Abnormal Eye Conditions: it is unclear if the 'clinics hosted by the provider' can be routine optometry clinics in which patients with abnormal conditions

attend, or if they should be secondary care clinics. Access to hospital clinics may not be possible through no fault of the providers.

F. Binocular Vision and Paediatric Experience: ‘The provider must ensure that the student has experience of examining children, patients with anomalies of binocular vision and those undergoing orthoptic treatment. Indicative safe patient episodes: 8 episodes including at least two paediatric patients one of which must be a child aged under 7 years.’
This requirement may be difficult in the ongoing COVID situation as arranging experience with such a large number of young patients may not be possible, depending on how long we operate in the amber phase. (Individual, optometry academic)

Overall our team appreciates the changes that have been suggested for the academic year 2020-21 which allow flexibility in the challenging times ahead.

Page 28: the use of experience and episodes is confusing, we suggest using experience throughout.

Appendix B: we welcome the addition of 'remote consultations’ and ‘simulated patients and scenarios’ as some patient types may be difficult to recruit in light of COVID-19.

Appendix F: There are lots of options for what counts as a patient episode although observation does not count. We could argue that dicussion with an experienced clinician where a case management plan is decided by the student would be equally as beneficial to their clinical experience and decision making. Observations of an experienced clinician or critical review of a peer could have more valuable learning than participation. Multiple students in a small group can participate in such an examination and minimise exposure to at risk patients. With sufficient de-briefing these episodes should count as patient episodes for more than student. (Organisation, Academic Institution)

Appendix F p39 please state what "significant deviations to the numerical measures" are.

Page 39 Binocular vision and paediatrics: The change requiring students to ‘examine’ rather than ‘observe’ children will be extremely difficult achieve in light of COVID-19 where it will not be safe for groups of students to be in close contact examining a child rather than observing.

Page 39 abnormal eye conditions :
Availability, nature and volume of placement provision (and the delivery of eye care services) is at present uncertain; Realistically we think we need a suggestion of what would be a suitable replacement for patient episodes. Would case studies or silmulators be acceptable if there is a second lockdown or other hindrance to progression?
We suggest observations of remote hospital cases should count towards the 7 hours hospital experience. We welcome the reduction of hours required. (Organisation, GOC-approved education provider)

Overall we welcome the temporary changes outlined in the consultation document and the flexibility that they will bring to provision in academic year 2020-21. Please see below for specific comments.
Page 3 We welcome the change from ‘minimum episodes’ and ‘specified patient types’ to ‘breadth of experience’ and ‘range of patient types’. This gives greater flexibility during COVID-19 and is more pedagogically sound than the current approach.
Page 3 The word ‘categorised’ has been changed to ‘delineated’. Given that ‘categories of experience’ (A-F) still exist we suggest that categorise is a more appropriate term. The word ‘master’ does not add anything extra to the text.
Page 19 We welcome the making explicit that supervision does not have to be from a GOC registrant but can include other registrants such as Orthoptists (HCPC) and Ophthalmologists (GMC) but we do not regard this as a change. Many providers already use other registered healthcare professionals in the delivery of their course and have been explicit about this during GOC visits.
Page 4 and elsewhere
- It is unclear what the change from ‘certificate of clinical competence’ to ‘certificate of professional competence’ is meant to signify and, more importantly, what consequences on changes to training and teaching it might entail.
We would also suggest that a consistent use of this terminology is applied throughout.
-It is confusing to replace the word ‘episode’ with ‘experience’ in the handbook and then reintroduce the word ‘episode’ again (e.g. ‘A full definition of what constitutes appropriate patient experience for each individual category (A-F) is given in the table attached at Appendix F. The figures specified in the table state the minimum safe patient episodes…….’). We suggest using the term ‘experience’ throughout.
Page 4/5 and elsewhere
-We welcome allowing simulation and scenarios to count towards patient experiences for the reasons outlined in the proposal the OSC sent to the GOC on 3/7/2020. We understand the need for a ‘clear rationale for the balance of simulated patients and/or scenarios relative to real patients’ but it appears that within the document the recommendation that the balance should be at least 45% ‘real patients’ is not backed-up. This lack of evidence makes it difficult for institutions to provide a justified rationale for their balance.
Page 4: Section 4.6 Page 28, point 4.6.1, second paragraph:
‘The figures specified in the table state the minimum safe patient episodes the student must achieve for each category prior to starting a pre-registration placement.’ “Minimum" needs to be replaced by “indicative" to be consistent with the wording “indicative” in the table.
Pages 7 (Appendix B) We welcome the addition of ‘remote consultations’ and ‘simulated patients and scenarios’
Page 7 & 8 (Appendix F, Added text)
-We welcome that there is potential for providers to add to this list of types of experience (‘it is not exhaustive’). We also welcome the fact that all of the types of experience described could contribute, as appropriate, to each of the categories A-F.
-We question whether the development of ‘professional independence’ at undergraduate level protects patients when students/graduates are entering a

supervised placement, not entering independent practise. We would suggest 'experience must enable individual students to develop to the point of entering a supervised pre-registration placement'.
-'It is expected that opportunities for students to examine real patients are maximised…' This expectation should to be qualified as 'maximised within the constraints of patient safety'.
-'a student examining another optometry student or clinically trained member of staff and completes a patient record.' We do not understand why the staff member has to be 'clinically trained' – suggest replace with 'member of staff'.
Page 10 (Appendix F, Stage 1 Patient Experience):
-'In clinical examinations, where the student:patient ratio is more than 1:1, students must not count episodes they have only observed (without any patient interaction), although this can be used to enhance learning through reflective practice.' This represents a tightening of the current rules where students can count observation as an episode in some categories (e.g. Binocular Vision). This may make this experience harder/impossible to attain. We think it inconsistent that a student could count a scenario based experience which will have no 'patient interaction' but could not count an observation. Pedagogically we would argue there is much to be gained from active observation/reflection and in some cases the learning gain could be greater than participation (for example observing an experienced practitioner or analysing the performance of peers). It isn't clear why/ how the 1:1 ratio makes a difference. We would argue that direct observation of an experienced clinician examining a patient is just as valuable an experience as taking part in a case discussion. A number of students can observe such an examination and with sufficient de-briefing, those episodes are good learning experiences for more than one student. We therefore think that it is important that observations should be able to count in general and not be limited to a 1:1 ratio.
-'Mechanisms need to be in place to ensure that case scenarios are quality assured and selected from a bank such that they do not "become known" to the student cohort.' For assessments, this is entirely reasonable but in the context of experience we question whether this is a problem. Even if scenarios do 'become known' students will still receive the appropriate teaching with regard to the scenario in question. Case scenarios is about the process, not about a student knowing an answer. Using a bank of cases does not jeopardies the learning experience of a student. We would suggest that this limitation is being removed.
Page 11 (Appendix F, Primary Care Experience): We support this change including flexibility on the number of 'complete' eye examinations and student:patient ratio.
Page 12 (Appendix F, Contact Lens Experience):
-'Indicative safe patient episodes: 12 episodes, to include complete fitting appointments, aftercare appointments, and clinical decision making episodes.' We do not understand what is meant by a 'clinical decision making episode'; all such episodes will include decision making.
-Please note that there is no legal distinction between contact lens 'fitting' and 'aftercare' – all aftercare necessarily includes a 'fitting' of a contact lens. We support the overall increase in flexibility that edits in this section provide.
Page 13 (Appendix F, Binocular Vision and Paediatric Experience): 'The provider must ensure that the student has experience of examining children, patients with anomalies of binocular vision and those undergoing orthoptic

treatment. Indicative safe patient episodes: 8 episodes including at least two paediatric patients one of which must be a child aged under 7 years.' The change requiring students to 'examine' rather than 'observe' children (current handbook) will be extremely difficult to comply with in the COVID-19 emergency, where we do not think it will be viable for groups of students to be in close contact with a child examining rather than observing. We welcome the fact that the numbers are indicative but would argue for the wording to be changed to 'observe' from 'examine'. Page 14 (Appendix F, Specialised Clinic Experience): 'The provider must ensure that students experience a range of specialist techniques including ocular imaging / further investigative techniques, examining patients with additional needs, and at least one low vision assessment.' The way this is worded means that all students must have experience of imaging, further techniques, and patients with additional needs – that's very challenging to ensure in the current context. We would suggest to re-word as "…must ensure that students experience a range of specialist techniques, which could include…" Page 15 (Appendix F, Spectacle Dispensing Experience): We welcome the increased flexibility the minor edits give. 'The provider must ensure that the student has experience of dispensing a range of frame and lens types, including some experience of dispensing for children and low vision patients.' The way it is worded (i.e. the "must") means that all students should have experience of dispensing a low vision patients, which is very challenging to ensure in the current context. We would suggest to re-word as "…and lens types, which could include experience of dispensing for children and low vision patients." Page 16 (Appendix F, Abnormal Eye Conditions): We welcome the fact that the number of hours has been reduced and the fact that this experience does not have to take place in a hospital environment. We also welcome the fact that all of the different types of experience, as appropriate, at the beginning of the Appendix F edits can be included in this category. 'Providers should ensure that students are exposed to a range of common and uncommon ocular pathologies. This experience can take place in ophthalmology clinics at NHS or private hospital eye departments or clinics hosted by the provider.' The availability of such placements is out of our hands and to remain flexible, we would like this to be amended to "…ophthalmology clinics at NHS (including virtual clinics) or private hospital eye departments or clinics hosted by the provider or real case discussions led by an ophthalmologist". (Organisation, Glasgow Caledonian University)
Overall we welcome the temporary changes outlined in the consultation document and the flexibility that they will bring to provision in academic year 2020-21. Please see below for specific comments: Appendix F (Binocular Vision and Paediatric Experience): The change requiring students to 'examine' rather than 'observe' children (current handbook) will be extremely difficult to comply with in the COVID-19 pandemic, where we do not think it will be viable for groups of students to be in close contact with a child examining rather than observing. Observing with a discussion can be a great learning experience. (Organisation, GOC-approved education provider)
The Optometry Schools Council represent the collective views of UK Optometry Schools (www.optometryschoolscouncil.org)

Overall we welcome the temporary changes outlined in the consultation document and the flexibility that they will bring to provision in academic year 2020-21. Please see below for specific comments.
Section 1.4, Page 4. We welcome the change from ‘minimum episodes’ and ‘specified patient types’ to ‘breadth of experience’ and ‘range of patient types’. This gives greater flexibility during COVID-19 and is more pedagogically sound than the current approach.

Section 3.4, Page 13. The word ‘categorised’ has been changed to ‘delineated’. Given that ‘categories of experience’ (A-F) still exist we suggest that categorise is a more appropriate term. The word ‘master’ does not add anything extra to the text.

Section 4.1, Page 21. We welcome the making explicit that supervision does not have to be from a GOC registrant but can include other registrants such as Orthoptists (HCPC) and Ophthalmologists (GMC) but we do not regard this as a change. Many providers already use other registered healthcare professionals in the delivery of their course and have been explicit about this during GOC visits.

Section 4.6, Page 28.

-We don’t understand the rationale for the change from ‘certificate of clinical competence’ to ‘certificate of professional competence’. The two names seem to be used interchangeably in the document.

-It is confusing to replace the word ‘episode’ with ‘experience’ in the handbook and then reintroduce the word ‘episode’ again (e.g. ‘A full definition of what constitutes appropriate patient experience for each individual category (A-F) is given in the table attached at Appendix F. The figures specified in the table state the minimum safe patient episodes…….’). We suggest using the term ‘experience’ throughout.

-We welcome allowing simulation and scenarios to count towards patient experiences for the reasons outlined in the proposal the OSC sent to the GOC on 3/7/2020. -‘The figures specified in the table state the minimum safe patient episodes the student must achieve for each category prior to starting a pre-registration placement.’ The word ‘indicative’ needs to be inserted in this text if the numbers are not absolute.

Page 29. Both the word ‘student’ and ‘graduate’ may be appropriate here depending on the route taken. We do not see how this edit relates to the COVID-19 emergency and would suggest that the GOC does not make general edits during this time.

Page 30. We agree with the minor edits in this section

Appendix B, Pages 33-34. We welcome the addition of ‘remote consultations’ and ‘simulated patients and scenarios’

Appendix F,Page 39 (Added text).

-It is not clear why some of the text is in bold and some is not in the first section as this all appears to be new.

-We welcome that there is potential for providers to add to this list of types of experience ('it is not exhaustive'). We also welcome the fact that all of the types of experience described could contribute, as appropriate, to categories A-F.

-We question whether the development of 'professional independence' at undergraduate level protects patients when students/graduates are entering a supervised placement, not entering independent practice. We would suggest 'experience must enable individual students to develop to the point of entering a supervised pre-registration placement'.

-'It is expected that opportunities for students to examine real patients are maximised…' This expectation needs to be qualified as 'maximised within the constraints of patient safety'.

-The document says that grand rounds may be used as 'part of the student's face-to-face experience'. Please clarify what this refers to.

-'a student examining another optometry student or clinically trained member of staff and completes a patient record.' We do not understand why the staff member has to be 'clinically trained' – suggest replace with 'member of staff'.

Appendix F, Stage 1 Patient Experience.

-'The quantitative/numerical measures related to patient experience and student:patient rationale are indicative only (unless specified). We would expect a provider to ensure that significant deviations to the numerical measures are fully justified.' Please define significant and state exceptions to the numbers being 'indicative' in this paragraph.

-'In clinical examinations, where the student:patient ratio is more than 1:1, students must not count episodes they have only observed (without any patient interaction), although this can be used to enhance learning through reflective practice.' This represents a tightening of the current rules where students can count observation as an episode in some categories (e.g. Binocular Vision). This may make this experience harder/impossible to attain. We think it inconsistent that a student could count a scenario based experience which will have no 'patient interaction' but could not count an observation. Pedagogically we would argue there is much to be gained from active observation/reflection and in some cases the learning gain could be greater than participation (for example observing an experienced practitioner or analysing the performance of peers). We therefore think that observations should be able to count as part of clinical experience as long as the provider has a clear rationale for this.

-'Mechanisms need to be in place to ensure that case scenarios are quality assured and selected from a bank such that they do not "become known" to the student cohort.' For assessments this is entirely reasonable, but in the context of

experience we question whether this is a problem. Even if scenarios do 'become known' students will still receive the appropriate teaching with regard to the scenario in question. For example knowing that a patient scenario may involve macular degeneration does not then negate the value of the learning experience. Appendix F, Primary Care Experience. We support this change including flexibility on the number of 'complete' eye examinations and student:patient ratio. Appendix F, Contact Lens Experience. -'Indicative safe patient episodes: 12 episodes, to include complete fitting appointments, aftercare appointments, and clinical decision making episodes.' We do not understand what is meant by a 'clinical decision making episode'. If this relates to remote consultation or scenario based experience then this can be removed as it is made clear earlier in the document that these can be used as appropriate. -Please note that there is no legal distinction between contact lens 'fitting' and 'aftercare' – all aftercare necessarily includes a 'fitting' of a contact lens. We support the overall increase in flexibility that edits in this section provide. Appendix F, Binocular Vision and Paediatric Experience. 'The provider must ensure that the student has experience of examining children, patients with anomalies of binocular vision and those undergoing orthoptic treatment. Indicative safe patient episodes: 8 episodes including at least two paediatric patients one of which must be a child aged under 7 years.' The change requiring students to 'examine' rather than 'observe' children (current handbook) will be extremely difficult to comply with in the COVID-19 emergency, where we do not think it will be viable for groups of students to in close contact with a child examining rather than observing. We welcome the fact that the numbers are indicative. Appendix F, Spectacle Dispensing Experience. We welcome the increased flexibility the minor edits give. Appendix F, Abnormal Eye Conditions. We welcome that the number of hours has been reduced and that this experience does not have to take place in a hospital environment. We also welcome the fact that all of the different types of experience, as appropriate, at the beginning of the Appendix F edits can be included in this category. We suggest that remote observation of hospital clinics should be able to count towards the 7 hours of experience. (Organisation, Optometry Schools Council)
The proposed changes are broadly sensible to enable delivery during the pandemic, but there are some areas that need clarification. The draft new material for the Handbook on patient experience categories A – F should be amended to clarify the minimum requirements for each category of experience, to avoid confusion and inconsistency. For instance:

• The references to “a low student-patient ratio” in category A (primary care experience, page 11) and category E (spectacle dispensing experience, page 15) are open to interpretation. The GOC should ensure that there is a clear understanding of expectations between it and providers as to the acceptable ratios to avoid misunderstanding. • The proposed new introductory material on “Types of patient episodes” (page 8) includes a statement that “Experience must enable individual students to develop their professional independence” – it is not clear what this means in isolation, but we understand from discussion with the GOC that it relates to experiences with a higher student-patient ratio than 1:1. It would be helpful to spell this out. • In category A (page 11) it is also not clear how the 18 “episodes” differ form the 8 “complete eye examinations”, given that the first paragraph of this section says experiences must constitute all components of a sight test • It is not always clear when the required quantity of patient experience in a category is a hard minimum which requires the involvement of real patients. o For instance, we understand from discussion with the GOC that the 7 hours’ clinic time in category F (abnormal eye conditions, page 16) is intended to be a hard minimum requirement, which cannot be partially replaced by other types of experience such as simulated scenarios, but this is not clear from the proposed new text on page 8, which implies that only 45% of experience need be with real patients. o The reference to “at least two” patients in category C (binocular vision and paediatric experience, page 13) does not make it clear whether these must be real patients o Category F also no longer includes any reference to clinic experience being supplemented by other types of experience. Given the importance of training in abnormal eye conditions, and the likely limitations on clinical placements in hospital during the pandemic, it is important that providers offer supplemental experience of this type, and we think this should be made clear in the Handbook. (Organisation, Association of Optometrists (AOP))
The proposed changes outlined in the consultation document provides a pragmatic solution that should maintain education standards and clinical experience for students in these unprecedented times. We are in full support of the consultation response submitted by the Optometry school’s council which highlights edits that we feel the document would benefit. (Organisation, University of Plymouth)
There is some ambiguity in the term "provider". Is this an independent body such as the College or an employer? It needs to be the former • The provider is expected to ensure that students have the opportunity to experience a wide range of clinical conditions and that they gain experience with as broader range of patients as possible Would the gatekeeper have a responsibility to ensure this, or should this be for the supervisor, employer and trainee to sort out? What constitutes a "normal" sight test now? We are to some extent finding out at

the moment. And whatever it is, is 18 enough? Abnormal eye conditions (Individual, optometrist and College assessor)
These changes strike me as proportionate. The move towards requiring providers to ensure an 'appropriate breadth of patient experience' combined with guidance is in line with the direction of modern health care regulation. My only concern is with the requirement of a 'low student:patient ratio'. Some guidance on the meaning of this phrase might be useful to assist providers and provide additional assurance from a perspective of the protection of the public. (EVP member)
Unfortunately there is no substitute for face to face patient examination to develop clinical skills. There may not be a better alternative to that proposed but consideration should be give to the fact that if the COVID-19 pandemic stretches past academic year 2020/1 and pre-registration students are required to have less face to face experience then there will inevitably be a less competent and less safe cohort of optometrists who have experienced this. (Individual optometrist, who works in Hospital Eye Services)
We are pleased to see the proposed changes, and thank the GOC for demonstrating flexibility in these challenging times. We also fully support the OSC submission to the consultation. Patient Experience: The wording needs to be clearer. We would suggest a standardised approach using "appropriate patient encounter" with the clarity as to the meaning e.g. the inclusion remote consultations, simulation and case scenarios, which are already stated. We wholeheartedly welcome the inclusion of these as appropriate encounters. We do not understand why the staff member has to be ‘clinically trained’. There also seems to be some inflexibility here, a student observing another student is not permitted, whereas appropriate discussion of a patient who is not actually present is. As an institution will will find it very difficult to provide any actual paediatric patient experience. It is also unknown whether we will be able to allow our students to attend hospital placements as currently we are not being permitted by the hospitals that provide our placements. The certificate of clinical competence, is already referred to by differing names in GOC documentation e.g. clinical competency. We would prefer a standardised approach using Clinical Competence. Professional Competence is appropriate to the SfR. We would prefer greater consistency of terminology to ensure students on registrable degrees are covered. We would also like clearer reassurance that institutions are still able to submit changes for approval that sit outside these changes. We would also value a statement that says these changes could be extended, without consultation for 2021-22, subject the GOC approval should circumstances dictate this is appropriate. (Organisation, GOC-approved education provider)
We support comments made by the Optometry Schools Council (Organisation, University of Manchester)

Do not support
As an experienced Optometrist and College Assessor and OSCE Examiner, it is imperative that all our trainees receive adequate clinical experience, performing full eye exams and consultations, in order to develop into competent and confident practitioners. The current numbers should not be reduced. Most trainees have these numbers achieved in 8 months, when they sit their stage 2 practical exam, so a flexible approach on the time frame for achieving this, would be a better proposal. Dispensing spectacles correctly is also an imperative skill all Optoms should be able to do and therefore this skill should also be maintained. In many high street practices, a registrant is still required to be on site until closing for dispensing high risk groups and therefore this knowledge has important value. The scheme for registration is an excellent platform for graduate Optometrists to transition into safe practitioners, based on the 75 core competency based programme and using expert assessors to implement this. (Individual, Optometrist and College assessor)
I do not support the level of simulated patients for both stage 1 and stage 2 competencies, there is a risk to patient safety will be at risk due to the lack of true patient experience. Although simulations do have their place in training, they cannot replace the 'real' patient contact experience with the anomalies that they throw into the situation less than 50% patient episodes being 'real' patients is unacceptable for regulated healthcare profession that is currently upskilling in clinical practice. (Individual, dispensing optician)
px numbers are what create the experience, without the numbers the experience cannot be achieved.....in my opinion..... (Individual, optometrist)
Using soft language like "appropriate" "range" etc is subject to interruption by individuals and therefore subject to abuse How can a non GOC registered person supervise ? they would have no personal knowledge of GOC standards required Experience could be from just being told about rather than doing/watching themselves No Appendix I added so cant check that Who defines "appropriate breath" - role play does not equate to good learning with real patients This will / could lead to lowering of standards achieved by pre reg optometrist and npt give them the tools to deal with real life once qualified - this could lead them to fall foul of regulations etc and put themselves in a position to be subject to FTP and patients have a poor experience I do not see the need to reduce patient episodes - pre re Optometrists will have been in practice since at least September 2019 if not August 2019 and therefore I would expect all would have already met the numbers required to be seen by the time fo lockdown (Individual, DO)
you need to have as much clinical experience as is possible despite a global pandemic. We cannot afford for future optometrists to be examining patients with limited exposure to clinical situations in their training because of cover 19. If we have to wait an extra year to maintain high standards then thats what we should aim to retain! (Individual, optometrist)

GOC Stage 1 – Validity of Certificate of Clinical Competency for Optometry

Validity of Certificate of Clinical Competency for Optometry (Stage 1)

Summary: We propose to extend the validity of the Stage 1 certificate of clinical competency for students who graduated in summer 2018 to 31 December 2020.

We also propose removing this requirement entirely as of January 2021, so that any decisions to the currency of learning forms part of a provider's enrolment/admissions policy (such as the enrolment policy for the College's Scheme for Registration).

2 years is not a long time given uncertain times and if examinations are fit for purpose then what does it matter if it takes a few months or a year or two longer? At present people who have unfortunate life experiences such as bereavement, ill-health, loss of job etc are thrown on the scrap heap or have to go back to university when they should be perfectly capable of catching up once mental health and personal circumstances are back on an even keel. I'd favour a system for optometry like that for DOs / CLOs where you have 7 years from joining the course to get through and even then extenuating circumstances should be possible. (Individual, dispensing optician, academic, GOC Advisory Panel)
A temporary extension is completely understandable in these current circumstances, however a proposal to change the terms of the handbook for this would indicate a more permanent change and that is most definitely not supported. A time limit is required.(Individual, dispensing optician)
Concerns - students will come into practice unable to examine patients A huge burden on supervisors who may not be equipped/ prepared to teach them Manage - create bubbles at the university of students for them to practice on (Individual, optometrist, supervisor and College assessor)
I believe that if this is removed entirely it will be very difficult to then decide to admit someone into Stage 2 training knowing that they have basic clinical skills. (Individual, optometrist and College assessor)
I support these changes but they highlight that it is vital that the provider's 'enrolment and admissions policy' adequately and appropriately cover the issue of current competence. It needs to be emphasised that the removal of the two year validity limit necessitates the taking on of the responsibility to ensure current competence by providers. (EVP member)
I think for this years enrolment affected by COVID it would be reasonable to allow for 3 years. I think the condensed 2 years is required!! (Individual, optometrist)
I'm not sure how the change to remove the 2-year validity limit will affect integrated programs. Why propose this as a permanent this change now? Why not also make this temporary for now? (EVP member)
Lockdown will only have impacted for a few months so an extension is all that is required and the two year limit remains appropriate By removing a limit students could "take their time" to pass etc and lose their

knowledge making them less competent and able to pass their pre-reg year (Individual, DO)
Only seems fair at this time, once things are back to normal perhaps re introduction (Individual, dispensing optician, and student optometrist)
Optometry is changing both from the development of technology and external effects of COVID or similar pandemics. With the proposed change what is to stop someone taking an extended period (say 10 yrs) and then coming back with obsolete knowledge and skills? How would a potential employer know if the trainee was safe to employ? (Individual, optometrist and College assessor)
pre reg students will be duly unprepared for what is ahead of them. Lack of clinical experience will only result in possible litigation issues in the future. How this can be managed in the current climate I am unsure of. (Individual, optometrist)
Removing the 2 year validity limit is dependent on wider ESR review should be part off a different full consultation. (Organisation, Hospital Optometrists Committee)
Some concern that clinical competence may not be maintained if there has been no opportunity to practise a technique since achieving the certificate. However, it is unclear how long competence could reasonably be expected to endure under such circumstances, so any time period imposed may be arbitrary. (Individual, optometry academic)
Temporary extension - if the student can show some form of continuing development such as a job within the practice then they can prove their skills are still current. Remove - This would mean you could graduate and not work within an Optometric setting for several years - then start pre-reg. having worked with students who have attempted this but had to return to gain an up to date certificate of clinical competence they have generally lost skills and have to be taught from the beginning. This is too much to ask educational establishments to carry out in the short term course this is offered on, practice supervisors would not have the time (and in many cases the teaching ability) to get them up to speed in a safe manner. (Individual, dispensing optician)
The purpose of the Stage 1 certificate of clinical competency is to assure employers and pre-registration supervisors of the quality of a graduate. This is essential to ensure the safety of patients and protect the public. I do not fully support the proposed changes until the provider's enrolment/admissions policy (such as the enrolment policy for the College's Scheme for Registration) is published to ensure that it is adequate to ensure patient safety and practitioner quality when entering the Scheme for Registration. (Individual, optometry academic)
The two year limit needs to be extended during the Covid-19 pandemic but it cannot be open ended, there needs to be a limit such as 5yrs or additional information in the recognition of prior learning (RPL) policy to account for the unlimited timeline. What if a trainee come in 10 yrs after graduation to start the pre-reg period, is that acceptable? The 2-year validity needs to be removed but there has to be accompanying clarity in the RPL policy. (Organisation, GOC-approved education provider)
There needs to be some element of "expiration" of the certificate otherwise this can be taken as indefinite, meaning students potentially entering the Scheme for

Registration many years after graduating and therefore being completely out of touch with knowledge, skills and requirements (EVP member)
We believe the temporary extension will have only positive benefits. We believe removing the 2-year validity limit will have positive benefits. We do not believe the changes will cause negative (Organisation, FODO)
We support the proposals to create more flexibility for optometry graduates' progression from their degree to the Scheme for Registration, for both the immediate- and longer-term. We believe that this greater flexibility is needed in the current climate (particularly the inevitable delays to graduates being able to progress in their pre-registration education and the knock-on impact of this on their peers' opportunity for progression). We also do not believe that it will erode individuals' quality of learning and development, providing that they are supported to engage critically in this process. We are taking steps to strengthen our support for new graduates in this way. We will be pleased to discuss further with the GOC how we plan to implement these arrangements, including to address issues of the currency of individuals' learning, development and competence if they do have a substantial gap between stages in their optometry education and progression. (Organisation, College of Optometrists)
We would like further information on the rationale behind the permanent change and the need for such a change in the context of the ESR. What are the scenarios that are being covered by such a change? (Organisation, Ulster University)

GOC Stage 2 - Patient Episodes

Summary: We propose reducing the total number of patient episodes for GOC stage 2 by 10% and removing the categorised patient episode numbers for GOC Stage 2.

Instead, the provider must ensure that the student achieves an appropriate breadth of experience, and also set and justify its level of any minimum experience in specific areas of practice.

Fully support

Fully support on a temporary basis. (Organisation, Hospital Optometrists Committee)
I hope the minimum experience for student optometrists who are already qualified and registered as dispensing opticians or contact lens opticians can be relaxed so they can be exempt from one or other or both of the dispensing and contact lens episodes depending on what constitutes their day job. If a full time CLO that never dispenses than exemption from CLO only, but if do both as part of day job should be exempt from both or required to reflect on their day job episodes from the start of the course? If such an individual found themselves at FTP on a CL or dispensing related matter they would be tried as a qualified registrant not as a student so the same should apply to their studies and they be given exemption. (Individual, DO, academic, GOC Advisory Panel)
I support these changes which I believe are proportionate to the current circumstances and in line with the direction of travel of modern regulation. (EVP member)
I would like to see this reviewed after a set period of time, to include engaging with those students and employers on their experiences of the reduction, and any negative aspects they have noticed. (Individual, dispensing optician)
If anything the number should be reduced further or removed completely at this time, especially since the reduction in patients coming in for sight tests are much more than 10%. This makes it harder for pre reg students and less attractive for employers to offer places (Individual, dispensing optician and student Optometrist)
If trainees are exposed to fewer patient episodes will that be recorded on their transcripts, as less experience is obviously not as valuable as more. Presumably we can be reassured that we will revert to the normal expectation as soon as practical. Is is made clear enough that even those episodes that are going ahead MUST be subject to government prescribed safety procedures, and students are not permitted to go ahead without, and this includes supervisors, and premises where episodes may take place. (EVP member)
It is difficult currently for students to obtain sufficient HES experience. This is likely to become more difficult at present. (Individual, optometrist who works in Hospital Eye Services)

Reduction of clinical experience may be mitigated by allowing students and pre-registration optometrists to access DOCET courses (or similar online clinical education) during this period (Individual, who works in Hospital Eye Services)
We have proposed a shift to a focus on 'patient encounters' in how GOC patient number requirements are framed, and therefore support this proposal to a focus on patient episodes (although we would see that the 'encounter' and 'episode' as having different connotations; see below). Of prime importance is that trainees gain a breadth of experience across patient groups and conditions that reflects changes in optometry practice, models of care and service delivery. Our planned changes to Scheme requirements include that trainees' experience is shaped/defined by a minimum set of mandatory patient encounters. We included a list that we believe usefully defines this breadth of experience for all trainees. Our use of the term 'patient encounters' refers to the following: - Interactions with individual patients (and their carers) - Patient interactions through face-to-face and remote consultations - Provision of patient services and/or to assess patients' eye health status - Provision of patient and carer advice in response to presenting problems or issues (underpinned by history-taking and the exercise of clinical-reasoning) - Appropriate referrals, in accordance with individual patient needs. To expand further, patient encounters should comprise a broadening range of episodes of patient care to provide a complete, specific service or to address a specific problem or condition during a set time period. This acknowledges that telephone triage, telephone contact lens care and telephone dispensing as Covid-19 measures are services with important outcomes in their own right, as are enhanced services for minor eye conditions (MECs), ocular hypertension monitoring (OHT) or glaucoma referral refinement (GRR) as relevant to the local need. Our planned changes to the GOC also covered the points outlined below. We believe that these would ensure that the GOC proposals are met. - Trainees should continue to meet the GOC's current total for patient experience requirements, but through activity that reflects contemporary optometry services (rather than just in relation to refraction, dispensing and contact lens care) - Elements of refraction in supervised practice should be recognised, while there should be an increased emphasis on contact lens care and enhanced optometry roles and less emphasis on dispensing - Trainees should gain exposure to clinical variation in terms of the age profile of patients, presenting conditions, and types of optometry practice and service delivery - Involvement in telephone triage and remote consultations should be recognised within trainees' supervised practice, in line with changing models of care and taking a risk- and needs-based approach to meeting patient needs - Trainees should be supported to engage in critical reflection on their patient encounters, as well as the practice environment created by Covid-19 - Trainees should be supported to develop clinical efficiency and the ability to

manage a realistic caseload safely and with efficacy. Trainees, including those who may secure part-time placements in the current context, should fulfil GOC number requirements, if the focus is on patient encounters. As an illustration, trainees would need to accrue an average of 12 patient encounters per each week of supervised practice over 12 months (allowing for four weeks not in practice). Within our planned changes, assessors would continue to monitor individual trainees' accrual of patient experience. They would continue to use structured action plans to support trainees (and supervisors) to identify specific areas of practice in which they need to gain more experience to develop their competence. While Covid-19 is obviously creating extremely difficult circumstances for optometry practice, changes arising from or being expedited by the pandemic should also provide positive opportunities for trainees' learning and development. Less intense patient throughput and a greater emphasis on taking a risk-based/needs-led approach to meeting patient care needs should enable trainees to develop their competence and prepare for registered practice. A stronger emphasis deriving learning from reflecting on experience should further enhance trainees' professional development (Gibbs, 1988). Our planned changes focus on trainees being supported to do the following: - Engage in 'deliberate practice' and 'rational testing'; i.e. to think critically about their knowledge and skills acquisition, and ensure they have a clear rationale for each test procedure that they undertake (Brabeck, 2010; Duvivier, 2011; Kumar, 2017; Morgan, 2014). - Record their patient encounters in a reflective portfolio and distil and articulate their learning from their experience - Build a conscious understanding of their evolving competence as their range of patient encounters increases. Under our planned changes, trainees will record their patient encounters in a reflective portfolio and distil and articulate the learning that they gain from the encounters and their engagement in 'deliberate practice'. This should develop their conscious understanding of their evolving competence as their range of patient encounters increases (Helyer, 2015). (Organisation, College of Optometrists)
We strongly support these changes which will deliver a system which is more quality driven and more trusting of education providers which are already highly regulated. (Organisation, FODO)
Will there be a similar change to the pre-reg period hours/tasks/numbers for the dispensing trainees? (Organisation, GOC-approved education provider)
Partially support
Whilst the changes are pragmatic, and to be supported, I believe that the student should be additionally assessed on their situational judgement ability to manage the patient through COVID protocols (Individual, dispensing optician and GOC Advisory Panel member)

Whilst I support a reduction in the number of patient encounters, a 10% reduction is arbitrary. This blanket approach to a reduction in episode numbers does not allow adequate flexibility required by the current situation. Some student's are likely to face lengthy localised lockdowns, students within different regions of the country are likely to face different restrictions (such as those in Northern Ireland or Wales when compared to England) or may be subject to shielding. Students will be adversely affected by this arbitrary threshold for adequate patient encounters. Adjustments should be considered by a panel from the College of Optometrists (with guidance from the student's Assessors) in relation to adequate patient encounters and the level of skill of the student given their individual circumstances. (Individual, optometry academic)
We think the proposed 10% reduction in patient episodes for GOC stage 2 is a reasonable temporary measure in response to the pandemic. And, we welcome the new reference to paediatric experience in this section of the Handbook. There are some points in the wording of the revised standards which we think need attention: • The new draft material does not make any minimum provision for refractive examinations, dispenses or contact lens patients, unlike the current Handbook. Since the need for infection prevention and control measures during the pandemic may create commercial pressures for pre-reg students to spend less time on sight testing than at present, it will be important for the GOC to make suitable monitoring arrangements to ensure that this cohort of pre-reg students obtains a properly balanced range of clinical experience. • The new draft material (page 18) says it is “the responsibility of the provider and/or the supervisor” to make alternative arrangements if it proves difficult for a student to achieve the required patient experience. The use of “and/or” here does not provide clear responsibility or accountability. Given the likely challenges of arranging patient experience during the pandemic, we think it is important for accountability on this to be clear. (Organisation, Association of Optometrists (AOP))
We support the College of Optometrists' response to the consultation regarding this section. (Organisation, GOC-approved education provider)
We did not have the opportunity to fully review this part but are in broad agreement with a reduction in patient encounters. We are not in a position where we could comment with high confidence on the details of the reduction. We understand that the College will submit detailed feedback on this and we support their views. (Organisation, Glasgow Caledonian University)
This depends on "the provider" being independent of any commercial influence. It needs to be the College or similar independent entity. rather then an employer Also, why is it the responsibility of the provider to arrange external placement? Isnt that down to the supervisor, employer and trainee? (Individual, optometrist and College assessor)
This could end up with a dispensing heavy pre-registration year - especially may be an issue in large multiple practice. It would be better to ensure a minimum number or % of face to face consultations at a lower level than current to remove this possibility. The wording is quite open to interpretation and could easily result

in students with poor experience. (Individual optometrist, who works in Hospital Eye Services)
Some concern that Stage 2 students may have quite different experiences if the minimum number of contact lens experiences, refractions, paediatric experiences, and dispenses are set by the provider (Individual, optometry academic)
Patient volume is crucial for fundamentals of Optometry. A student/newly qualified must be capable of assessing volumes of patients as well as breadth of pathology. (Individual, optometrist)
I support this but the 10% reduction is necessarily a guess. It's perfectly possible, likely even, that students will not achieve 90% of the current (pre-covid) numbers. What flexibility, if any, is present in the proposed temporary changes to accommodate a situation where the number of episodes is well below (>10% below) what is normally expected? In other words is the 10% reduction realistic? (EVP member)
I agree with reducing the overall numbers due to the reduction in patients being seen in practice due to COVID - a hopefully temporary situation However, taking out the specifics means there is no requirement for them to carry out any dispenses during pre-registration. For contact lenses - who is determining how many episodes are appropriate? This is too open for abuse by practices to reduce the workload and speed them through (Individual, dispensing optician)
Ensure any witness testimony they complete if possible can be also signed by another GOC or non GOC registrant to reduce unconscious bias. To use universal language and change Reflective Accounts to Reflective Learning. (Individual, optometrist, dispensing optician, College assessor, employer)
‘For the changes affecting the College of Optometrists’ Scheme for Registration or other registrable qualifications, these changes would apply to this year’s (Autumn 2020) incoming cohort of students/trainees only.’ Many students entering the pre-registration year will not do so until January 2021, whereas some will have started their year in Summer 2020 (as well as those students from the Universities of Bradford and Hertfordshire already named in the documentation as having had their experience affected since March 2020). It is important that the inclusion and exclusion criteria are clearly specified, and account is taken of students/trainees who might have their experience particularly delayed or interrupted. We believe that the disruption caused by COVID-19 is very likely to extend beyond one year and suggest that these changes should apply for longer. ‘On completion of the period of supervised practice-based training, the student must demonstrate achievement of 520 patient encounters. The patient encounters must ensure that a breadth of experience is achieved, with an appropriate level of encounters with real patients. The provider must set out the minimum amount of contact lens experience (to include new fits), refractions and paediatric experience, which is appropriate for gaining proficiency.’

We don't understand the rationale for reducing the numbers by 10%. Rather than any absolute number (520) it would seem more logical for providers to be required to facilitate clinical experience which allows the achievement of the stage 2 competencies (i.e. output rather than input driven). Different absolute final numbers would be enable stage 2 competencies to be achieved (depending on the patient mix) and this approach would provide for greater flexibility during COVID-19. 'Paediatric experience' has been added to the text and 'dispensing' has been removed. We do not understand the rationale for this or how it relates to flexibility during COVID-19. (Organisation, University of Manchester)
Do not support
The numbers at present are not excessive, even with reduced volume, due to Covid 19 and reducing them further will reduce the experience each trainee receives. A change in definition of each clinical interaction is a better approach, but must still be recorded and validated as now, preferably by external assessors. This system is working well and gives the trainees a good framework and targets to aim for. We must assume Covid 19 will pass, hopefully early next year, with vaccine development and implementation, so patient numbers will again increase, providing more experience and opportunities for trainees to resume full eye exam consultations. Hopefully the hospital placements will also resume, as this is also an imperative part of the pre-reg. An on-line module is a very poor substitute for seeing live the range of pathologies necessary to be a good clinician. Cutting down the volume will not produce good Optometrists and is a step backwards. (Individual, Optometrist and College assessor)
experience can only be achieved by number of px episodes, this new system could result in a fully qualified optometrist who has never seen a contact lens px but has it all in theory or not done v many dispenses or lots of dispenses and v few refractions: quantification is required to aid with compliance: these numbers are only a minimum, without this minimum, the px experience would not be achieved...in my opinion (Individual, optometrist)
I don't believe that removing the need to complete a minimum number of eye examinations will help the student become a better Optometrist.....quite the reverse. Allowing the student to modify their routine so that they can still see patients within sensible time limits would enhance their skills and improve their usefulness to Optometry. I worry that this change will reduce the competence of the students. (Individual, optometrist, employer, and supervisor)
The removal of the categorised patients can only lead to variation in standard of graduates. With so much reliance on the provider to determine much of these patient episodes, one candidate may undertake a plethora of real patient experience including paediatrics, LV and AOC The reduction by 10% and the inclusion of simulated experience would mean that only 234 real patients could be accepted in comparison to the 580 all candidates have had to undertake previously. When the drive of the ESR is to increase clinical experience for optometrists, this very much goes against this belief. (Individual, dispensing optician)

If the assessors cannot view the patient records you are dependent on supervisors to certify this THis will result in inadequate experience and incompetence for some preregs. It will depend a lot on how good a supervisor they have (Individual, optometrist, supervisor and College assessor)
By saying have to see 520 patients and not specifying how many of each as previous means that Some practices will give the pre-reg eye examinations only and the bare minimum Contact lens px - this will lead to a reduction in competence in contact lens fitting and therefore reduction in confidence and capability An Optometrist once qualified can fit contact lenses with no further training - so to allow a pre-reg to qualify having only seen / watched /experienced only 8 episodes is not safe for patients - you would not allow a CLO to qualify after fitting only this low number and their course is much more intense plus they have experience gained from dispensing prior to becoming a CLO To reduce numbers needed for dispensing - particularly reducing numer of paediatrics is again making the optom unsafe as their experience will be minimal but they can then supervise childrens dispenings? Patient safety is an issue here As is Optom confidence and capability (Individual, DO)
I do have concern with leaving the requirement of 520 open for providers to determine the balance; I can see a real possibility that most students will have more than 50% of this experience relate to non-refraction / sight test activities, which I do not feel would represent adequate experience for registration as an optometrist. Whilst I completely understand the rationale for loosening this requirement and being less prescriptive, I wonder whether this could be amended such that 50% of the 520 episodes should relate to "testing of sight"? In essence it would still lower the requirement from 350 currently, to 260, which is quite significant. Otherwise there is a real risk that students will potentially be registering as optometrists having had more experience in dispensing than in sight testing, and no real experience in contact lenses (EVP member)

GOC Supervision Policy

Summary: We propose permitting non-GOC fully-qualified registrants to supervise students, if they meet our supervision criteria, are regulated, only supervise tasks that are within their professional scope of practice, and the education providers ensure that all other supervision requirements are met – including clarity about any role in patient episode or core competency 'sign off' that these supervisors may have.

For example, this change would mean that HCPC-registered orthoptists (who have 2 years HCPC continuous registration) could supervise student optometrists conducting a binocular vision examination.

Fully support

We would like to know why this temporary change is seen as necessary in response to the COVID emergency? Many institutions have orthoptists and ophthalmologists supervising patient experiences and this practice has been explicit during revalidation visits. We would caution against using these temporary changes in response to COVID to edit the current handbook in ways that aren't directly related to the emergency. (Organisation, Ulster University)

We support the proposed changes to the GOC's Supervision Policy. We support retention of the requirement that a named optometrist (qualified for at least two years)
remains accountable for each trainee's supervisory arrangements, while enabling other suitably qualified members of practice teams to be able to contribute to trainees' supervision. This includes other registered optometrists, dispensing opticians, and wider members of the multi-disciplinary team (MDT).

The rationale for proposing more flexible supervision arrangements is as follows:
- It should increase the feasibility of practices providing placements and reduce the supervisory burden on individual practitioners
- It should have professional development benefits for both individual trainees and those contributing to their supervision, as well as for MDT working and therefore patient care.

We also plan to modify the College's requirements for trainee supervision, so that registered optometrists can supervise more than one trainee at a time. This reflects changing circumstances in optometry practice/service delivery and reduced placement availability. It should be offset by the proposal that other members of a practice team can contribute to individual trainees' supervision (but with the retention of a named optometrist remaining accountable for arrangements).

Our underpinning concern, that underpins all the above, is that all supervisory arrangements should be
- Relevant, safe and comply with legislation
- Appropriate for individual trainees' specific areas of competence development at any point in time and in relation to specific patient need and area of practice
- Defined by how trainees can contribute safely to patient care/service delivery at any one time. (Organisation, College of Optometrists)

This makes a lot of sense - a qualified orthoptist will know more about binocular vision than an optometrist, a qualified dispensing optician will know more about dispensing than an optometrist, etc. (Individual, optometry academic)
This is a great idea, since other health care professionals such as orthoptists can give a different perspective on clinical investigation and management. Care would have to be taken to ensure that the HCP was aware of College management guidelines rather than their own professional guidelines if they differ. (Individual, who works in Hospital Eye Services)
This change suggests a growing maturity across different health care regulators in that assurance is provided to the GOC by virtue of regulation by the HCPC. I believe that this is proportionate and should be welcomed. (EVP member)
The qualification should include primary care medical practitioners such as GPs, A&E doctors, Physician Associates and Pharmacists. The GOC's own research shows that well over of half of patients waking with an eye problem would visit one of these practitioners rather than an optometrist. There may be concern as to the competence of these practitioners however in my experience they would not be prepared to supervise unless competent. Optometry students would also learn the reality of primary and emergency care and what happens to their referrals that follow that route which may change their practice to take more responsibility for themselves. It may be worth limiting this to a certain number of days. For example working within a large pharmacy or walk-in centre it is perfectly possible to spend the whole day dealing with eye problems - hayfever, dry eye, blepharitis, eye infections, eye-related medicine review complications etc however the system should ensure they don't carry too much weight. (Individual, DO, academic, GOC Advisory Panel)
Provided the above criteria are met, this can only enhance the availability of high-quality supervision. Exposure to other types of clinician is also good experience in itself. We therefore support the proposed changes and have no concerns. (Organisation, FODO)
Please see comments relating to this in question 1 - (Organisation, Optometry Schools Council)
It may be useful to consider other health care professions such as GP's, Pharmacists and Physician's associate who also see a lot of eye related conditions. For example, during hay fever season, the pharmacists will get lots of patient asking for advice and an optometry trainee could spend a session working at the pharmacy counter giving specific eye related advice under a pharmacists supervision. Research has shown that patients with eye problems seek out GP or pharmacists more than optometrists so spending time in such clinics would be useful for the trainee. (Organisation, GOC-approved education provider)
I think will allow much better interaction with colleagues in an inter-disciplinary manner (Individual, dispensing optician)
As a temporary measure this is a good idea and will help expand the scope of practice among Optometry students and improve the quality of learning (Individual, dispensing optician and student optometrist)

Partially support

Could you simply wave the GOC fee and include them during the pandemic? This would maintain the continuity of having the student supported by a registrant with GOC membership. (Individual, student dispensing optician)
There is of course benefit in integrated training across professions, however competence sign off should remain with GOC registered professionals who have a clear understanding of syllabus and competency requirements. (Individual, dispensing optician)
It is more appropriate that where possible the training of optometrists should be supervised by optometrists or medical practitioners. (Organisation, Hospital Optometrists Committee)
Do not support
In most training practices, the Optometrist should be the only person responsible for the supervision aspects, as no other related colleagues understand our role and responsibilities. A Dispensing Optician can help with training and perhaps supervising a delegated function, but the responsibility should still remain with the main Optom supervisor. This proposal sounds very complicated and likely to have problems. Diluting down supervision responsibilities is confusing and unhelpful. Orthoptists work under and Ophthalmologist and cannot practice or prescribe unsupervised. They are not trained to identify ocular disease or perform complete eye exams and apart from providing Binocular Vision expertise, have little knowledge on the services we provide. (Individual, optometrist and College assessor)
I cannot support a pre reg optometrist being supervised by a non GOC registered person - they would have no experience of the GOC requirements and expctations This could lead to dumbing down of quality for now and the future This is also unnecessary as most student optoms have only missed a few months and this experience can be "caught " up of there is an extension to the pre reg year (Individual, DO)
NO! Too wooly and dangerous. This will be abused and students will not gain the knowledge required! (Individual, optometrist)