



Together ABDO, AOP, the College and FODO represent over 12,000 optometrists, over 5,600 dispensing opticians and optical businesses in the UK who provide high quality and accessible eye care services to the whole population.

Thank you for giving us a chance to comment on your proposals for revalidation. We note that the consultation document is a proposed outline of your revalidation scheme based on a preliminary report of the GOC's Revalidation Workstream Group.

We have commented on each section of the document in turn.

### **Licence to practise**

1. As we said in our response to your previous consultation, we believe that licences should be granted to those who practise if the Register also contains the names of those who do not practise. This will make it more meaningful to the public.
2. To avoid unnecessary administrative costs, the licence should be by means of an annotation of the Register, verifiable on-line, rather than a paper licence.
3. The method chosen for granting licences to registrants who are returning to practice after a significant break must be fair and proportionate. We believe that 'significant break' should be defined in numbers of years. If the break is less than the six year cycle, practitioners should be permitted to present evidence from the years when they were working in the cycle. This reflects the current arrangements for continuing education and training. Those who have had a break which extends beyond the six-year revalidation cycle may be required to demonstrate that they would have support when returning to work and they may require a shorter revalidation cycle. This would align with the principle of equality (Principle 7: Department of Health Non-Medical Regulation Working Group).

### **Profiling risk**

4. As practitioners' livelihoods are at stake, it is important that any form of risk-profiling has a solid evidence base. It is of concern that you state that risk-profiling will be evidence based *wherever possible* (our italics). There is a danger that there will be a two-tier relicensing system. It should be sufficient for practitioners to demonstrate that they are up-to-date and fit to practise in relation to the scope of their work through whatever evidence they deem appropriate from pre-defined list of sources of evidence.

5. Risk should be considered across the healthcare professions. Optical practitioners should not be required to provide more evidence (and perhaps less) than those in higher-risk professions with wider clinical scope (in terms of the impact of competency failure for patient health and safety).
6. Implementing a national peer assessment programme would be fraught with difficulty and we would, therefore, like further information on what you mean by peer assessment. If failure in an assessment could mean a practitioner's livelihood was at stake, an assessment provider would have to demonstrate that the assessment was reliable (that is the results should be reproducible in a test on a different occasion) and not affected by variables such as question difficulty, examiner performance, equipment and simulated patients. The provider would also have to demonstrate the validity of the process. Consideration would also have to be given about how to equate assessments from different providers.
7. Success in an assessment/examination in a procedure on a particular day might not mean that the practitioner could transfer that competence to his or her actual practice with a variety of different patients over the next six years. He or she might not attempt that procedure again for three years. Providing reliable and valid assessments is expensive and resource intensive. If the purpose of revalidation is to confirm that the registrant is **practising** in accordance with the regulator's professional standards<sup>1</sup>, it is more appropriate for practitioners to provide evidence from their actual practice. Where practitioners have failed to provide sufficient evidence through other means, it might be appropriate to offer them the opportunity to provide further evidence by passing a valid and reliable assessment. This would be consistent with proposals from other regulators such as the GDC. The Non-Medical Revalidation Working Group Principle 10 states that the structures and processes of revalidation should be effective in confirming fitness to practise.
8. We believe that peer assessment can be used as part of the evidence set the optical practitioner provides, if he or she so wishes, but that a formal assessment process every six years is inappropriate, unrealistic and counter to the philosophy behind the revalidation process.

## Competencies

9. We agree that it would not be practical or proportionate for each and every registrant to be required to demonstrate that they continue to meet each and every competency. We believe that practitioners should describe their scope of practice and provide evidence that they remain up-to-date and fit to practise within that scope. We recommend that the description of the practitioner's practice should accompany the folder of evidence as this will allow the practitioner to describe any changes there have been to his or her practice throughout the six year period and submit appropriate evidence for each area of practice.

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<sup>1</sup> Principles for Revalidation: Report of the Working Group for non-Medical Revalidation, Department of Health, 2008

10. We agree that all practitioners should provide evidence in terms of professional conduct and communication as these are generic core skills. However, we do not believe that all practitioners should provide evidence that they can carry out the functions reserved in law unless these areas form part of their scope of practice. For example, practitioners who never fit contact lenses should not have to provide evidence that they are up-to-date and fit to practise in this area. Indeed, to require such a practitioner to demonstrate competence in that area might actually be dangerous for patients. Conversely those working in an area of special interest would have to provide evidence that they were up-to-date and fit to practise in that area even if it were above core competence. This would be a proportionate way forward and effective in confirming fitness to practise. Practitioners know that they must work within the limits of their competence.

### **Evidence**

11. We reiterate our comments in relation to *Profiling risk*. It is tempting to assume that an assessment or examination is a robust form of evidence but this is not always the case. Practitioners should offer assessment results only as part of a set of evidence if they feel it is appropriate. Formal assessment should not be the primary means of gathering evidence.
12. We would suggest that evidence of output based continuing professional development<sup>2</sup> that might include a reflection on the impact that piece of work has had on the practitioner and his or her practice and patients, together with evidence of clinical audits and appraisals, patient records, peer discussions or valid and reliable multi-source feedback (from colleagues and patients) would be better evidence of fitness to practise on an on-going basis. It would show that practitioners were keeping up-to-date in order to maintain the highest standards of practice.

### **Intensity and frequency of revalidation in relation to risk**

13. We agree that the six year revalidation period should be shortened if the process identifies concerns.
14. We agree that the cost of remedial action should be met by the registrant, but stress that this should not be prohibitive.

### **Key points**

- The system of revalidation should be simple and easy for practitioners to use, as well as easy and cost-effective for the regulator to administer.
- Licences to practise should be granted if the Register contains the names of those who practise and those who do not.

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<sup>2</sup> To include continuing education and training

- Those who have had a significant break of less than six years should be able to provide evidence from the time they were working during the six year cycle. Those with a longer break should return to supported practice and may require a shorter revalidation cycle.
- Practitioners should provide evidence from their scope of practice. The level of evidence required should not be different for practitioners working in different contexts.
- The system should be in line with that used by other professions, and optical practitioners should not be required to submit a higher level of evidence than professions where competency failure is more significant in terms of patient safety.
- Formal assessment should not be the primary source of evidence. This goes against the philosophy behind revalidation and would be too expensive and resource intensive to be effective. Evidence should be from actual practice.
- The only competencies for which all practitioners should be required to provide evidence are generic competencies such as communication and professional conduct. To require evidence of a skill that a practitioner does not use day to day would give a false impression of capability to patients and could be dangerous.
- The representative optical bodies would not be able to support a system of revalidation without adequate funding for practitioners from the Department of Health. As with compulsory CET, and particularly in a time of recession, the profession will expect some central contribution to the considerable costs of undertaking a revalidation process. Any system of remedial action should be cost-effective and costs should not be excessive.
- Any pilot should be undertaken using a cross-section of the professions.
- We wish to re-state a fundamental principle; a revalidation exercise is not requalification. By definition, the vast majority of the workforce is safe and competent and revalidation should reflect this. So the average, competent optical practitioner should be able to undertake revalidation, and pass, without doing any special revision. If they cannot, then the hurdle is too high.

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