FODO response to the Welsh Government consultation: Proposals to reform the ophthalmic services delivered in primary care in Wales

About us

The Federation of Optometrists and Dispensing Opticians (FODO) is the leading association for eye care providers in Wales.

Our members include individual GOC registrants, independent and regional practice owners, and national eye care providers who serve the population of Wales. Between them they provide the majority of primary eye care services in Wales, and as the main Welsh contractors, will be at the heart of ensuring these reforms are delivered successfully.

About our response

We would like to thank all for their hard work to date on this complex and wide-ranging set of proposed reforms.

In Principles and priorities from primary eye care we set out a future vision for eye care, sharing many goals with Welsh Government. FODO and our Welsh members therefore fully support Welsh Government plans to provide more care closer to home and stand ready to help deliver this successfully on behalf of the patients we all serve in Wales.

We welcome Welsh Government's recognition that the optimal option for meeting eye health needs is to expand access in primary eye care services, and its commitment to increase spending on primary eye care services by £30m per annum by 2024/2025, to correct historical underfunding of GOS and to establish new services to reduce pressure on hospital eye services.

As is the case with all complex reforms, there is still a lot to unpack, learn, respond to, and deliver on. We believe however that Wales is now in the home straight and, although we still have much to do, success will mean preventing sight loss due to delays in accessing hospital eye care services. We are committed to helping deliver this change fairly for all.

In our response, our focus is on our shared goal to meet eye health needs in a sustainable way for this and future generations in Wales. Our response supports proposals where we have full information and looks to support other proposals based on reassurances given to date but where details might be pending. In cases where Welsh providers have raised concerns and questions, we aim to support the Government with further information and in the hope we can by working constructively through an honest dialogue get things right for the population of Wales.

We provide feedback on the formal consultation response and would be happy to clarify any points and answer any questions Welsh Government might have.

Our response

Consultation Response Form

Question 01: Do you agree that optometric practices should be required to incorporate prevention and well-being advice as well as an individual patient management plan and patient self-care advice as part of the service they provide when providing an NHS sight test?

In brief

Our Welsh members deliver the vast majority of GOS and this will continue to be the case for WGOS1. Based on information and reassurances provided to date (please see detailed response below), our members support proposals to evolve WGOS1.

Detailed response

We have consulted FODO members in Wales, who support in principle the proposal based on information and reassurances provided to date by Welsh Government (WG) and Optometry Wales (OW).

This support is based on WG approved OW FAQs published in October 2022 and June 2023, the WG webinar 'Future Approach for Optometry in Wales' on 26 September 2022, further reassurances from OW about how WGOS1 should work when finalised and details set out in this public consultation with respect to WGOS1.

To date our members in Wales have been advised:

- WGOS1, will resemble the current sight test, plus will include a patient management plan, prevention and wellbeing and patient self-care advice (Reference: WG webinar of 26 September 2022)
- New requirements WGOS1 will not involve additional optometrist time. The focus will be on collecting and utilising data already collected (Reference: OW FAQs October 2022 and June 2023)
- Increased funding for WGOS1 is based on the existing time taken to perform a sight test. The correction in fees is to help practice sustainability and address longstanding underfunding of the GOS sight test (References: OW correspondence November 2022 and consultation document, including timings on page 11 of the Regulatory Impact Assessment)
- Additional elements of WGOS1 would include Making Every Contact Count (MECC) type support – e.g. targeted support and advice at an individual level to support patients with healthy lifestyle choices etc. This should be subject to professional direction by an optometrist or dispensing opticians but facilitated and delivered by non-clinical staff in the practice team (References: Future Approach for Optometry Services 2021, OW FAQs, WG webinar September 2022, and 2023 consultation documents).

Welsh eye care providers were previously advised that clinical manuals, setting out details, would be shared in December 2022 and changes would start to be implemented 1 June 2023, with services introduced gradually over the coming 18 months (Reference OW FAQs October 2022).

Unfortunately, clinical manuals are not yet published, otherwise our members would have been able to provide an unequivocal endorsement of plans for WGOS1 and other proposals but at this stage this must remain in principle while this detail is outstanding.

Our members are however reassured by:

- WG acknowledging that the only way to meet the eye health needs of people in Wales is to provide more care closer to home using primary eye care providers (Reference: WG opting for option 3 in the Regulatory Impact Assessment and recognising options 1 and 2 are not realistic or viable).
- WG recognising it must take full advantage of "the infrastructure and a highly qualified and motivated workforce across primary care, working collaboratively with secondary care to continue to ensure Wales' eye care services continue to be a triumph for devolution" (Page 5, main consultation document).

For many years FODO members in Wales have worked in a collaborative and positive way with WG and NHS Wales to provide more care closer to home. They stand ready again to build on joint successes to date. There is therefore support for WG leadership to get the details right in the clinical manuals, and we, as a sector, stand ready to help so that we do genuinely deliver world class eye care services in Wales. Provided reassurances given to date are honoured, there will be strong support for WGOS1.

Question 02: Do you agree that all optometric practices in Wales should offer an eye health examination to patients needing urgent attention or those at higher risk of eye disease?

In brief

Yes, based on information provided to date, we agree with the general proposal to include WGOS2 as part of the core service for fixed practice locations.

Our Welsh members deliver the vast majority of EHEW and this will continue to be the case for WGOS2.

However, there are some aspects of this proposal which our members in Wales believe are unworkable and have asked to be reconsidered. One issue is addressed in our response to question 12. The main issue however is the unintended impact on the sustainability of domiciliary services and how patients might be worse off if current proposals are pushed through without further collaborative work with the domiciliary eye care community in Wales to get the detail and phasing right (see our response to question 24).

It is our goal to work with Optometry Wales (OW) to get WGOS2 right for domiciliary patients and healthcare professionals that sustain these essential services. This will help achieve the Welsh Government (WG) goal of equality in access to care for those who depend on care at home.

Detailed response

We agree with the WG that the hospital eye care service cannot meet eye health needs alone, and reforms are necessary if we are to serve the population of Wales in a safe and sustainable way.

- "Moving the delivery of some eye care services from hospitals to primary care optometry, where there is a skilled workforce with the capacity to meet the predicted substantial increase in demand, represents the most viable and sustainable solution. The capacity to provide hospital services is increasingly limited due to a number of factors including availability of workforce and estates, the consequences of which are shown in the extent of current waiting lists which have been further exacerbated by the pandemic" (Reference page 8, main consultation document)
- "A key driver for the changes is the need to alleviate pressure on secondary care HES, through increasing the range of services delivered closer to home in primary care by eye care practitioners. We intend to further embed prevention and well-being across all optometry services, facilitating improved patient outcomes and reduced demand for General Practice (GP) services in primary care as well as specialist HES." (Reference, Page 7, main consultation document).
- Evidence on options as set out in the Regulatory Impact Assessment

We have been reassured by Optometry Wales (OW) and WG that WGOS2 will simply include existing EHEW services, transferred into the new contract and made mandatory rather than opt-in as now (Reference: OW FAQs, WG webinar 2022 and consultation documents).

As set out in Principles and priorities for primary eye care we support the principle of making WGOS2 part of the core primary care service provided this is structured in a way that is sustainable and responsive to patient needs once WGOS1 and WGOS3-5 are taken into account.

Specific feedback from Welsh eye care providers about proposals for WGOS2 includes:

- Based on the information shared to date, there is strong support to include WGOS2 as part of core primary eye care services for fixed premises locations.

- While we strongly support that all fixed premises locations should provide WGOS1 and WGOS2 as core services, there are operational concerns about mandating that WGOS2 should always be offered at the same clinical times as WGOS1 (see our response to question 12).

- There is strong support for tackling current inequalities in access by allowing domiciliary eye care providers to provide WGOS2 to patients who depend on care at home. There are however significant concerns about the feasibility of this for domiciliary providers in the short term and the limited engagement with specialist Welsh domiciliary eye care providers on these issues to date to get this right. This means this opportunity to enhance equality might be lost, and worse still we might see access for WGOS1 also decline unless concerns are addressed.

More positively, we believe it is possible to find ways forward that will massively improve access to WGOS2 at home by working with the domiciliary eye care community in Wales, to make minor changes to some proposals and address the barriers to delivering WGOS2 at scale.

We fully support WG in getting this right for patients and therefore set out more detail in our response to question 24.

Finally, while we note that the policy, legislative framework and regulation are set out at a high-level on pages 10-12 of the main consultation document, we would welcome sight of the draft regulations so that we can work in partnership with WG, OW and other sector partners to ensure the regulations will work on the ground as intended. We stand ready to work at pace and in confidence when WG is ready to share a draft with key stakeholders.

Question 03: Do you agree that all practicing practitioners in Wales must have a core standard of accreditation and training to enable them to provide the full range of core services including eye examinations?

WGOS1 and WGOS2 fall within the core competencies of GOC registered optometrists and some WGOS2 services are also within the scope of practice of GOC registered dispensing opticians. Historically, as the NHS started to offer more enhanced eye care services in primary care, GOC registrants have undertaken refresher courses to ensure their core skills remain up to date.

With a long history of providing enhanced primary eye care services, Wales starts this journey from a position of strength. This is why 95% of optometrists have already undertaken this training (page 10 main consultation).

With the plan to now make WGOS2 mandatory it is important to fund and allow time for other GOC registrants to undertake the necessary refresher courses so they too are up to date and can provide enhanced primary eye care services. We would ask that the following scenarios are considered and adequately planned for:

- A significant proportion of GOC registered optometrists are mobile and work across England and Wales. It is important that contractors in Wales do not lose access to this core group who might be on hand to cover WGOS1 clinics, freeing up time for Welsh resident optometrist to provide WGOS2-5.
- Some areas in Wales, especially North Wales, also depend on cover from locums that live in England. Again, it is important that where it is in patients' best interests, we continue to call on this workforce to deliver additional capacity to meet WGOS1 needs.
- Dispensing opticians that might be able to deliver aspects of WGOS2 should also be offered structured and funded training and support.

To address cross border issues, and to ensure there is a contingency in place, we would ask Welsh Government to consider an exemption for optometrists providing temporary cover for WGOS1 services, so that, for example, in a case where a practice needs urgent cover, it can call on a wider group of optometrists to meet clinical demand. If there are no contingency plans in place, we could see a

scenario in which clinics have to be cancelled with knock on effects across WGOS1 to WGOS5.

We also believe these reforms, if implemented as suggested, will make Wales one of the best places to work in optometry. We should therefore see more people seeking out optometry in Wales and to support this we would suggest there is some flexibility for newly qualified optometrists to establish themselves in providing WGOS1 and then evolve into delivering WGOS2. To facilitate this we would suggest that they are given six months after working in Wales to achieve this.

Question 04: Do you agree with the requirement to have these proposed nationally directed services in primary care to ensure consistent access to eye care services across Wales?

Yes we agree that LHBs should be required to make arrangements to ensure people across Wales have access to WGOS 3, 4 and 5.

Question 05: Do you agree that a practice who doesn't offer higher-level clinical services should be legally compelled to refer a patient to a nearby practice who does offer the necessary clinical services to meet the needs of the patient?

All GOC registrants must refer appropriately, and this will mean acting in each individual patient's best interest. Logically, this will mean a requirement – under existing professional duties and the proposed reforms – to refer to an appropriate WGOS 3, 4 or 5 service as necessary. We are therefore not convinced it is sensible to make this a further legal requirement. This is because:

- There are already existing regulatory standards to which all GOC registrants must adhere. CPD and reminding registrants of existing duties is likely to be more effective in the long run as registrants are more sensitive to their licensing conditions than the detail of contracts.
- Legally compelling a regulated healthcare professional to refer based on locality – e.g. nearby – is prone to run into significant issues. For example, one of the reasons primary eye care is so successful is that it meets patients' needs flexibly. People can access a GOS sight test anywhere in Wales, and then be seen closer to home or nearer to families, carers, network support, work etc for other services Defining nearby would require some significant thought if including it in a legal definition given the geography of Wales.
- We can imagine scenarios, especially for WGOS 4 and 5, where a patient might prefer to travel further to a specific provider and they should not be required to have a forced choice of a nearby provider only.
- Making a legal obligation to force a GOC registrant to refer the patient to a nearby service, whatever the definition, might also result in less responsive services – e.g. longer waits, risk of sight loss etc.

We would therefore favour GOC registrants being reminded of GOC standards, reinforced by education and enforcement options where there are concerns this is not being done.

In summary, GOC standards already require registrants to act in each patient's best interests and to refer appropriately in the light of that. A new legal obligation to refer

to 'nearby practice' is likely to result in legal complexities, cost and increased risk in the system.

Question 06: Do you agree that a duty should be placed on optometry practices to collaborate to ensure the eye health needs of the cluster area are addressed within primary care clusters?

We note the consultation sets out:

- "To ensure consistency of engagement across Wales we intend to establish Cluster Optometry Collaboratives with a duty for each optometry practice within the cluster to engage through participating in the Optometry Professional Collaborative meetings with a **maximum of 4 meetings per year**, for which the practice will be reimbursed" (page 16, our emphasis)

We agree that if this is to be imposed, there should be a maximum number of meetings, especially as practices will be busier than ever delivering a wider range of services across WGOS1 to WGOS5 and we do not want to recreate the operational system pressures and inefficiencies in primary care that are so prevalent in the hospital eye service.

As a rule, we do not believe imposing a duty to attend meetings of this type creates the culture and climate to foster genuine collaboration. We however understand and support Welsh Government's goal to make primary eye care an integral and integrated part of the wider NHS family and we support this goal.

To make this more sustainable, we would suggest that meetings are organised in a way to prioritise time for practices delivering WGOS4 and WGOS5, with practices delivering WGOS1-3 attending meetings less frequently but to ensure they stay informed of wider system changes, capacity pressures etc. It might therefore be that practices delivering WGOS1-3 attend a maximum of 2 meetings per year, and those delivering WGOS4 and 5 attend a maximum of 4.

It also goes without saying that meetings should be arranged at times which suit optical practices and practitioners and not in clinic hours.

We also think there is an opportunity to improve written communications to contractors, to aid dissemination, consistency, and collaboration. Written communication to all contractors can also help further minimise the risks associated with silo working.

Question 07: Do you agree it would be beneficial for LHBs to conduct an eye health needs assessment every three years to ascertain the specific needs of their communities, with a duty imposed on LHBs to do so to bolster this provision?

In brief

We fully support the need for good data and using this to help inform planning and decision-making at all levels. We however think a five-year window is sufficient, with more targeted ongoing work to compel LHBs to bolster capacity to meet population needs.

Detailed response

There is real merit in LHBs having up to date eye health needs assessments (EHNAs), but the primary research on the prevalence of eye diseases is not developing at pace to warrant this being done every three years.

Instead, we would suggest each LHB undertake a detailed EHNAs and perform a 5-year projection (minimum), and then only invest resource should new primary research emerge which would warrant a review of the data assumptions.

LHBs however should more regularly review capacity and waiting times and use this to ensure fixed location practices are supported to deliver additional capacity for WGOS 3, 4 and 5 and domiciliary services in general. This might for example include funding new providers to open up capacity or increasing funding to enable existing providers to invest in new capacity etc.

There are some aspects of care planning which can only be carried out at national level - e.g workforce and national investment planning. We feel it would also be good practice therefore for Welsh Government to carry out regular EHNAs. These would provide a helpful double check for local health needs assessments and a template against which to confirm to the Senedd that the reforms are working as intended.

FODO is also supporting the College of Optometrists and other sector bodies in a data project which will estimate the prevalence of a wide range of eye health conditions. We would be happy to share the outcome of this work with LHBs and Welsh Government.

Question 08: Do you agree with the introduction of one Ophthalmic List per LHB to reduce complexity?

We agree that wherever possible bureaucracy in the NHS should be minimised while ensuring safeguards remain effective.

- "To reduce bureaucracy, it is proposed LHBs should only be required to prepare one list split into two parts detailing those who have been approved by that LHB to either provide or assist in the provision of ophthalmic services." (Page 17 consultation document)

With respect to this particular proposal, we do not fully understand how one list in two parts is more efficient that two separate lists. We also think it would be helpful to consider the proposal to list Dispensing opticians here too.

We are not sure how the current system is administered but if the software used would reduce cost and complexity by having one core list split into several filters, then we would not object. Might it even be possible to have a list in three parts:

- fixed premises contractors and levels of WGOS they provide per LHB
- domiciliary providers and levels of WGOS they provide per LHBs
- optometrists, dispensing opticians, listed to practise in Wales

which the public could search?

Question 09: Do you agree with the proposal for LHBs to produce an additional administrative amalgamated list of all individual practitioners who are registered on their ophthalmic list and perform NHS ophthalmic services?

Please see our response to question 8.

Question 10: Do you agree with the proposal to include student optometrists registered with the GOC, within the supplementary ophthalmic list, to ensure appropriate oversight and governance arrangements are in place?

The UK governments have now published their response to the review of health care professions regulations. There is a clear intention for the GOC to cease holding a student register.

In addition, once ETR for optometrists is implemented in Wales, the pre-registration system as we currently know it will end. Students on placements will be regulated by universities.

We would therefore suggest it would not be wise to proceed with this particular proposal in its current form.

However, we do favour allowing early applications for professional listing in final academic year (as now for pre-regs) so that when graduates enter the GOC register after completing their course, there is no delay in their starting NHS practice in Wales.

We would also like to take this opportunity to flag that funding for the new system of undergraduate placements (long placements in two 22 week blocks towards end of course plus observational placements in earlier years) is not yet in place and it would be a positive development if Welsh Government starts working on this with Optometry Wales so the sector can also prepare accordingly.

Question 11: Do you agree with the proposal for LHBs to produce an administrative list of all dispensing opticians who provide NHS services in their area?

Please see our response to question 8.

Question 12: Do you agree that all NHS funded contractors / opticians, should offer core clinical hours as agreed between the contractor and by their LHB to ensure suitable access to patients?

As set out in our response to question 2, we support WGOS1 and WGOS 2 becoming core primary eye care services – although as we also set out, concerns have been raised about the practicality of this in domiciliary care in the short term which we address this in our response to question 24.

We understand that Welsh Government wants to ensure providers deliver WGOS1 and WGOS2, and not avoid, as some do at present, offering enhanced primary eye care services. However, we believe that making both WGOS1 and WGOS 2 mandatory (except for domiciliary care in the short term) will to a large extent resolve issues with the current opt-in system for enhanced services.

We also fully agree that when operating NHS services, a provider must not refuse to provide services on any basis which could be discriminatory or is otherwise unjustified (as set out on page 19 of the consultation document)

We also agree that contractors should inform LHBs of the hours when they will offer core services. It will then be for LHBs to discuss with contractors if these do not meet local needs and what, by collective agreement, can be done to address this.

However, we do not agree with the following proposal:

- The contractor must agree "hours during which the full range of service levels 1 and 2 will be available and will be agreed between the LHB and the contractor, and this will be advertised to the public to raise awareness" (page 18 main consultation document)

This rigid approach could result in significant inefficiencies, for example requiring providers to always block out slots for WGOS2, which in turn can increase marginal cost when this capacity is not utilised and potentially reduce capacity to provide WGOS3, 4 and 5 etc.

With more and more optometrists working part time, there are also challenges with workforce management. For example, a practice might be able to offer more WGOS2 capacity when a part-time optometrist who has childcare responsibilities is working as it can open up an additional room, and therefore over a period of one week they might in fact offer more WGOS2 capacity on specific days, but on some days only have capacity to prioritise WGOS1, with say one slot for WGOS2. We would advise that WGOS1 and WGOS2 are mandatory for fixed practice locations and providers must explain when they are provided, but that the requirement to always offer both simultaneously is removed.

Question 13: Do you agree with our proposal to remove the advance notice requirements that contractors must provide to Local Health Boards prior to undertaking mobile services?

In brief

Yes, we strongly support this. It is positive step forward and corrects a longstanding and unjustifiable inequality in access for people who depend on care at home from regulated eye care professionals. We congratulate the Welsh Government for leading the way on this in the UK.

Detailed response

We fully support the proposals to expand eligibility to improve access and to remove the unnecessary and discriminatory prior notification requirements (which simply create meaningless work for PSS and providers and delays for patients).

However sufficient domiciliary expertise does not seem to have been brought into feasibility thinking and cost analysis at the crucial stage. As a result, and despite the welcome changes on eligibility etc, conversely we have been advised the reforms if implemented without further engagement are likely to lead to an immediate and

significant reduction in domiciliary capacity and therefore worse outcomes overall across all levels.

For example, under current visiting fee proposals and strict response timelines, WGOS2 may not be viable for all domiciliary providers so, if not resolved before implementation, this might force some providers to cease offering local services.

Many mixed practices are also in this position and to avoid this risk until the system has settled down, specialist domiciliary providers in Wales have suggested that WGOS2 should be 'opt-in' initially so there is immediate take up by those who can but without losing those who cannot. This would be more in line with the 'evolutionary approach' envisaged in negotiating documents.

There are also other unconsidered risks in the consultation proposals which do not seem to have been fully weighed against the evidence. For example, the evaluation of the special schools 'proof of concept' exercise in England makes clear that the proposed fees and voucher values in Wales will be insufficient to deliver such a service safely. Please see our response to question 24 which sets out concerns raised by specialist domiciliary eye care providers in Wales.

Question 14: Do you agree with our proposal to expand further the provision of mobile eye care services to qualifying patients who are unable to receive care in an optometry practice?

Yes in principle we support improving equality in access for people who depend on mobile services. However domiciliary eye care providers in Wales have raised serious doubts about the feasibility of some proposals (see our response to question 13) and the modelling which led to them which may well result in a significant reduction in capacity.

Unless concerns are addressed, this could mean that, although on paper access may look to be improved for WGOS2, in reality patients will struggle for the first time in generations to access WGOS1 and may well not have anybody in their community able to deliver WGOS2 at home anyway. Pease see our response to question 2, 13, 21 and 24.

Question 15: Do you agree with the additional safeguarding measure proposed? We would welcome your views as to whether practitioners should register with and maintain annually the DBS Update Service or alternatively for practitioners to have a new DBS certificate every three years?

Contractors and practitioners in Wales take safeguarding very seriously and already comply with sector's own safeguarding guidance which was developed expressly for optical practices.

In our view the safest solution is for practitioners (optometrists and dispensing opticians) to have a DBS check when joining the ophthalmic list or administrative lists and also to sign up to the update service at the same time so that, with the registrant's permission, employers, engagers and the NHS can check on a clinician's status at any time. This is important given the increasing numbers of clinicians who

are opting for self-employment and therefore move more frequently from one practice to another.

We would however anticipate a transition and risk-based prioritisation system being put in place to avoid overwhelming practices with having to setup an update service at short notice at the same time as implementing other major changes set out in these proposals, as this could lead to unsafe gaps in clinical cover based on capacity to manage a peak in administrative tasks.

The only other feedback we would like to share, in case it is helpful in the planning stages, is that sometimes the update service is difficult to administer and can result in individuals dropping off and needing to restart the process.

Question 16: Do you agree with the proposal to impose a requirement on NHS contractors / opticians to use electronic referral methods where available to ensure timely access to eye care services?

Yes, but only when electronic referral methods are secure and fit for purpose.

Openeyes is far from rolled out universally beyond Cardiff and the Vale and experience from other parts of the UK do not yet provide foolproof systems.

It is also important to note that for electronic referral to work, and operate safely, we must design the system to avoid double keying and other operational inefficiencies which increase risk of human error and unsafe workarounds.

This will mean working with providers of practice management systems (PMS) to design risk out of all systems.

These PMS providers will have costly processes to undertake to update the relative small number of practices in Wales in order to deliver seamless connectivity. A coordinated, collaborative and pan-Wales- approach is called for to get this right. As set out in Principles and priorities for primary eye care we are fully committed to supporting sustainable IT connectivity, including e-referral systems. We would ask that Welsh Government work with the sector's Information and IT committee and subject matter experts in e-referral so we can get this right. FODO members in Wales (some of whom are PMS providers in their own right) would be very willing to work within such a partnership to ensure safe electronic referral, discharge, access to 'advice and guidance' and shared care can be delivered throughout Wales in the shortest possible timescales.

Question 17: Do you agree with the proposals to improve governance and quality standards for Optometry in Wales? Please elaborate if you think this is reasonable and proportionate. You are welcome to comment on each item in isolation (from a-d on the list on page 21) or provide a general response across the range of proposals.

We welcome this opportunity to provide feedback on whether proposals are reasonable and proportionate.

In our view, based on information available at the time of the consultation, current proposals need work with respect to the tests of reasonableness and proportionality. We hope the feedback below is helpful in this regard.

Context and factual accuracy

We would first like to address the statement that 'there is no formal Quality Improvement standards or templates to adhere to for Optometry in Wales'. We understand the statement but feel it risks confusing/misleading the lay reader and general public. It is clearly important not to risk misinforming the public and lay reader that there are quality concerns.

In fact there is a longstanding history of the sector having QI standards and templates – e.g. the sector produced Quality in Optometry in Wales, A toolkit for clinical governance in optometric practice, in 2007.

In addition, our members, who provide most primary eye care in Wales, are registered with the General Optical Council (GOC) and adhere to its standards. These include a regulatory requirement to have a system of clinical governance in place and other key criteria which are at the heart of quality assurance (QA) systems.

Our members do therefore already have quality assurance (QA) systems in place. This explains the high level of patient satisfaction, high levels of patient confidence and low level of complaints as evidence by the General Optical Council's own research and data. The fact that primary eye care doing so well and providing high standards of timely care, is the reason that these reforms are possible. We would therefore ask Welsh Government to recognise, embrace and build on these joint successes and the solid foundation we have created together as a sector with NHS Wales and Welsh Government over many years.

Comparisons with other sectors

We welcome evidence led discussions on QA and systems and controls to ensure patient safety and quality outcomes. Considering this we caution against drawing parallels between dentistry, pharmacy and optometry.

In both dentistry and pharmacy there is a risk of immediate death based on the use of medicines, anaesthetics and invasive surgery, which is materially different from the delivery of WGOS1, 2 and 3, while GOS 4 and 5 are likely to sit somewhere in between on a risk scale. We would therefore expect any Quality for Optometry (QO) toolkit to be reflective of this.

Quality for Optometry (QO)

QO is born out of Quality in Optometry (QiO) which was conceived and successfully executed as a joint enterprise in QA between ABDO, AOP, College of Optometrists and FODO. We, and the other partners will be very willing to work with OW and the Welsh Government to get this latest version right. Key for us, as with earlier versions, was practicality, simplicity, reasonableness and proportionality. We therefore assume:

- Providers only providing WGOS1, 2 and 3 will have proportionate core QO system
- Providers providing WGOS4 and 5 will have suitably tailored additional levels

We have extensive experience about reporting requirements across the UK, and annual filing would in our view be excessive for WGOS1, 2 and 3. A three yearly cycle might be more appropriate whereas an annual confirmatory filing may be appropriate for those providing higher risk services in WGOS 4 and 5 (except in cases where issues have shown that closer attention is needed for a while). Annual filings for all levels would seem excessive and create additional work for contractors and NHS alike out of proportion to risk.

Bronze and e-learning

At a Welsh Government webinar in September 2022 the sector was informed that bronze level service delivery would receive a £1,250 payment per quarter per contractor to cover the cost of all QA, of which e-learning is only one part.

Firstly, we welcome clarification that the e-learning course for all staff will be one-off and that practice employees will not be required to organise days off to attend in person.

The consultation document explains that every single member of staff that works at least one day per week will be required to complete an e-module once and in addition GOC registrants will access quality improvement training as a condition of CPD training grants.

- "All practice managers and employees involved in the provision of NHS ophthalmic services in Wales will complete the Optometry Improving Quality Together bronze level e-learning package. This must include anyone who works at least one day per week at the practice and includes both clinical and non-clinical staff members. This need only be done once for each member of staff"
- "Dispensing opticians and optometrists will access training in quality improvement as part of their performer CPD payment" (page 21 consultation document)

With respect to all employees having to do this training, there are some practices with more than 50 employees, and given the expansion of services and increased specialisation we predict large practice hubs will increase. Yet, the current bronze payment is fixed whether there are two or 100 employees, making the funding per employee wide ranging and potentially unsustainable for some practices.

With larger practices able to propose alternative operating models, with assurances, we would ask Welsh Government to also consider the option of 'train the trainer' for larger teams. This will ensure all team members are aware of e-learning content, but providers can opt to tailor training to more specific role/context, helping deliver system controls.

We assume that the established principle of CPD funding being for loss of practice time and that accruing to whoever is sustaining the loss, will be maintained. We further assume locums will be similarly required to use the CPD grant towards QI training and be able to evidence this to engagers, and that more detail about this will follow.

Welsh national workforce reporting system

We presume the intention for each contractor to complete the Welsh National Workforce Reporting System tool is to track workforce changes over time and for planning purposes, for example so that Welsh Government can fund more university or training places.

We understand, although the high-level consultation is not clear on this, that the requirement is for quarterly submissions but for three of these only changes rather than full submissions will be required?

This seems excessive and we would suggest that an annual workforce return would provide higher quality information, better compliance and be easier to analyse.

We would be interested to see on behalf of our members the analysis that concludes that quarterly data on the eye care workforce are required and the purposes for which they, rather than annual data, are necessary for Welsh Government purposes. Just because this is a requirement for other primary care professions, which may have different workforce profiles, pressures and needs, is not really a rational argument.

We assume the consultation referencing dispensing optician managers (management) and not dispensing opticians (clinical staff) is a typo. It would be helpful to also clarify how 'other professional staff' are defined and why they are included, and whether the census is in headcount or WTE terms?

We welcomed the Welsh Government goal to reduce bureaucracy (page 17 consultation document) and we believe this should also be applied to other aspects of data collection. For example, some proposals to collect workforce data may not only be excessive in terms of administrative time but also with respect to the principle of minimising personal data collected in the Data Protection Act 2018. Here we understand there are provisional plans to collect a GOC and national insurance number. The GOC number is a unique identifier and already in the public domain, and unlike an NI number, in the event of a data breach a GOC number does not expose an individual to an increased personal risk of their data being used for identity theft or other fraudulent purposes. We would therefore ask that any data reporting requirements across these proposed reforms avoid duplication and minimise personal data collection.

Audits

These current proposals are not in our view reasonable and proportionate, as three audits per year independently of which services are provided is excessive and will mean resources are directed to a more bureaucratic rather than learning system that is proportionate to complexity and risk.

We would think that it would be more proportionate and reasonable to establish a system where:

- Providers delivering WGOS1, 2 and 3 provide an annual audit
- Providers delivering WGOS 4 and 5 provide additional audits linked to the services they offer.

We also note the consultation states

- “the content [of audits] to be agreed with Welsh Government and LHBs” (page 21 consultation document)

Given WGOS1 and WGOS2 will form part of the core contract, it would seem more proportionate and reasonable to standardise these audits at a national level to aid rollout, education and training, and compliance, in a consistent way across all practices delivering similar/same services to the Welsh population.

WGOS3, 4 and 5 could have content agreed with the Welsh Government and LHBs as these services might be expanded on a more regular basis to further reduce pressure on hospital departments with the goal of reducing cases of avoidable sight loss due to delays in seeing an ophthalmologist for example. It is not yet clear what the process for agreeing these audits might be and what the routes of appeal are if practices consider requirement to be unreasonable.

Question 18: Do you agree that eligible patients should be entitled to a free optical appliance across all prescription ranges with a duty placed on contractors to support this free provision?

In brief

If voucher values had been proposed to stay at their current levels uplifted for inflation, with corrections made to underfunded prescription bands, the proposal to ensure providers ‘make available a basic pair of spectacles for those people who are eligible for a voucher towards the cost of spectacles’ would have been a policy our members would warmly support.

Equally if the proposed new voucher values had been fairly and correctly costed, the impact assessments in this consultation would have been accurate in claiming that a requirement to offer a basic pair of spectacles would in fact improve equality.

Unfortunately, the wrong vouchers have been cut and the impact assessment has confused what has and has not historically helped bridge the funding gap caused by the NHS underpaying for primary eye care services.

These errors in the initial premise have led to a misleading approach which is not good public policy.

To be clear, we fully support the wider reforms and the aims of improving equality in access and tackling health inequalities. It is because this element of the reform will fail to do this that we struggle to support it in its current form.

Firstly, our members already offer high quality options and a wide range of choice for children and adults on means tested benefits who depend on NHS support to access essential vision correction. The proposals to cut 99% of voucher values will make this offer very difficult to maintain.

In addition the proposal, if implemented based on a cost-plus analysis that the sector does not recognise, will result in challenges, concerns and patient complaints (as set out below in more detail).

We therefore cannot agree to the current proposal as set out by Welsh Government because the costing exercise for deriving voucher values is not sufficiently robust. While the Welsh Government may choose to impose this element of planned reforms on the sector, our main concern is the impact this will have on patients.

We are also concerned that providers who are close to the detail, understand costs and who have challenged working assumptions, have been told that any challenge risks the whole package all reforms being withdrawn by Welsh Government, leaving them nervous about sharing their knowledge openly and honestly in the interests of patients. We know however from Welsh Government's own goals to improve equality in access and quality outcomes, this is not the case.

We are hopeful that together, through open and honest dialogue about the potential implications of the current proposals for vouchers, we can find a solution that ultimately works better for the patients we all serve. We hope Welsh Government will encourage the sector to speak up and share views honestly about what they calculate will happen.

<u>Detailed response</u>

Challenges, concerns and complaints

It is concerning to providers that the Welsh Government has decided to cut 99% of patient vouchers claimed during a cost-of-living crisis and a period of high inflation.

It is without doubt that proposals, as they stand, will see those that rely most heavily on this patient benefit to access vision correction suffer less choice and reduced access to quality vision correction.

This means that families and adults on lower incomes will be most adversely affected by this proposed cut in patient benefits.

We note from the impact assessments, that patient groups, consumer organisations and even the children consulted as part of these reforms, have not been fully sighted on what these proposals to reduce spending on patient benefits by £4.8mwill means at a practical level for them.

We do not think it is factually accurate to frame this as an equity or equality enhancing step, nor to frame this as a progressive policy. It is in most cases likely to be regressive.

Under existing voucher values, there is a wide range of choice and access to vision correction which does not require a patient to contribute unless they wish to do so. Also where a patient picks vision correction for less than the voucher value, the NHS pays the lower fee so scarce NHS funds are not wasted.

However, the new proposals are likely to mean that parents will find they can no longer access the same quality of vision correction at no cost, and adults on means tested benefits will have limited choice and poorer quality or feel more compelled to pay towards essential vision correction contrary to the policy intention. We cannot believe this is what Welsh Ministers intended.

This proposal risks sending Wales back to the 1980s where people's income status could be differentiated based on the spectacles they wore, which is regrettable because, as a society, we have only recently tackled the stigma of wearing spectacles especially amongst children.

The feedback we have on this proposal is clear, that cutting 99% of existing vouchers claimed by children and adults on means tested benefits will reduce choice and access to quality vision correction.

If Welsh Government chooses to impose this policy without any revision to voucher values, it is important to note that for the first time as a sector we are likely to receive complaints from parents and people on means tested benefits about a lack of choice and spectacles more prone to breakages within two years of use.

We are also likely to see more parents and people on benefits feeling they must pay more to get access to the quality they have become used to with respect to vision correction which our members – who have always led the sector in terms of value – cannot accept is right or fair.

We note the consultation states

- "voucher values will be kept under review. This will ensure optometry practices are accurately and fairly remunerated for the work completed" (page 22 consultation document)

We are concerned, in the context of meeting needs and voucher values, that this approach risks missing the point. It is not about being paid for the work we do – important though that is – it is about being able to meet patients' needs in a quality way within voucher values.

We would ask Welsh Government work with Optometry Wales to ensure all sector feedback on this particular proposal is considered objectively and that proposals to cut this patient benefit are reviewed. Whatever the reason behind this political choice to cut patient benefits, we are not able to support the proposal because we do not think it is right for patients.

Cost-plus analysis

We have consulted members widely and they do not recognise the costing exercises that suggests the A, B, E and F vouchers be cut as proposed.

This is estimated to take £4.8m out of patient benefits which currently allow children and adults on means tested benefits to access quality vision correction, and as a result make it more difficult for this population to access the same quality of vision correction they currently use.

As such, we do have concerns about the inferences set out in the Regulatory Impact Assessment Document given these are based on a narrow review of dispensing essential vision correction to children (which require GOC registrant time) and adults on means tested benefits.

If Welsh Government opt to impose these new voucher values and require practices to "make available a basic pair of spectacles for those people who are eligible for a

voucher towards the cost of spectacles" (Page 22 consultation document), it is important to note basic will likely mean:

- Less choice
- Reduced quality relative to options accessible today
- Increased probability of breakages and repair costs for all parties (including consequential increases in dependence on repair vouchers at additional cost to the Welsh Government)
- Practices having to use clinical fees to fill the funding gap for spectacles - which will mean those seeing populations more likely to depend on vouchers being worse off (see affluent vs poorer areas below)
- A risk that for the first time since the 1980s, people will be able to identify a child or adult who depends on State benefits, simply by the vision correction they wear.

While we would support the obligation to provide basic spectacles within voucher value, which our members already do, we are not able to support the current proposal as we do not have confidence in the cost-plus analysis which underpins it. So little detail is available on how the model was constructed at national level, that, we have to assume it would benefit from further work.

If timescales prevent further analysis and reassessment at this stage, we would call on Welsh Ministers to maintain the existing system (uplifted for inflation which is already biting) to continue until such time as this detailed work can be carried out – possibly on the basis of survey of all providers in Wales which we would support – between Welsh Government and OW.

Disparities – affluent vs poorer areas

There are other issues with this proposal, which highlight why it needs to be reconsidered. We set this out below

- The Welsh Government is right that clinical fees have not reflected the cost of provision for a long time, and it is important this is now corrected to enable need to be met and pressure on hospitals to be reduced. Paying £43 for a WGOS1 eye examination, is aligned with other cost research and will mean that on average NHS Wales will finally be covering the actual cost of providing a sight test
- It is true that patients who pay for vision correction have historically helped fill the funding gap caused by the NHS not paying the cost of a sight test and that, as more customers shop online, it is important to address the NHS dependence on this cross subsidy
- It is factually inaccurate to suggest that patients who depend on A, B, E and F vouchers, and do not contribute towards the cost of an appliance, have historically been the population that has helped fill the funding gap caused by NHS sight test underfunding.
- The cross subsidy to offset underfunding of clinical fees by the NHS has historically therefore come from patients who pay privately for vision correction where there is a very wide range frame and lens types and of course brands, not populations that depend heavily on patient benefits. The cut in voucher will only hit the latter
- The proposal to fund the NHS sight test correctly is a positive and necessary step and will benefit all patients and all practices

- The proposal to cut £4.8m from the vouchers bands that cover 99% of existing claims, means most new voucher claims will not cover the cost of providing vision correction (appliances, professional fees and other overheads) and will therefore disproportionately impact on practices serving more children and a higher proportion of adults on means tested benefits,
- For example, a practice in a wealthy area will serve far fewer of this patient demographic and can more easily absorb the short fall from a smaller number of vouchers claimed, and in most cases parents for example will have the means and be willing to let their child choose. In contrast practices serving a higher proportion of mean-tested patients will make losses on this, struggle to offer a reasonable range within new voucher values for A, B, E and F, and even then have to fund at least part of any shortfall from clinical income
- The policy proposal is therefore not only regressive at an individual patient level, it is also regressive at a health system level.

We would be happy to discuss this in more detail but in case helpful, at this stage, running a scenario analysis on the data included in pages 11-14 of the Regulatory Impact Assessment Document will demonstrate that a practice on average will see an increase from WGOS1 fees but a reduction as a result of voucher cuts. As practices serving more affluent areas redeem fewer vouchers, it is clear practices serving more affluent communities will see a greater marginal increase in NHS income relative to those serving less well-off populations. To continue delivering vison correction to poorer communities, many practices will have to put a significant proportion of new WGOS1 income into funding the dispensing cost gap caused by new voucher values, further reducing their NHS position relative to practices that serve more affluent areas. In turn they will have relatively less cost covered for clinical care and have less to invest in the future to sustain practices that serve these communities.

Whichever way this is looked at this will push them back into underfunded clinical services. This effect will also apply to domiciliary providers.

Given that the logic driving these reforms was to no longer underfund clinical services, other things being equal, the proposals to cut vouchers, makes practices serving poorer communities less viable than those serving affluent communities, which demonstrates the fact that it was never the population depending on vouchers that were funding the NHS fees gap. The policy is therefore based on a flawed economic premise.

This is why the unintended consequences of proposals to cut vouchers are wide reaching and pose a challenge to the sustainability of practices serving the poorest communities in Wales and domiciliary providers.

It is our hope this consultation process will open a constructive and helpful dialogue so that this erroneous aspect of proposals can be revised and corrected in good time. It is also our view that, given statements made across the political, public health and NHS leadership in Wales, we are all aligned on protecting people through this cost-of-living crisis.

- First Minister Mark Drakeford has made clear that at a time "when people cannot buy food and they cannot afford to pay for energy", the Welsh Government

would not "take even more money out of their pockets" and doing so would never be "a choice a serious government would make here in Wales".
- Finance minister Rebecca Evans said the Welsh Government would "top up NHS funding and help vulnerable people through the cost-of-living crisis"
- Many across the NHS, including the Welsh NHS Confederation and Royal College of Physicians in a joint report have called on the Welsh Government and all parties to tackle widening health inequalities during the cost-of-living crisis, explaining that "Wales now has the worst child poverty rate of all the UK nations at 31%".
- Public Health Wales has called the cost-of-living crisis a public health emergency.

Taken together, we do sincerely believe there is a way to deliver all planned reforms while protecting this essential patient benefit. We understand the wish for Welsh Government to find some savings to help part fund the service expansion, and acknowledge the additional funding already committed, but this could be better achieved in our view by rephasing the new investment so as not to have to take from poorer patients. However, if Welsh Government proceeds to impose this cut on patient benefits, we ask it to acknowledge our objections as a leading association for eye care providers in Wales. Ultimately these are not practice benefits but essential support for the children and adults on means tested benefits we serve.

Question 19: Do you agree with the proposal to extend the eligibility criteria to certain prisoners on leave?

Yes. We welcome this development in Wales.

Question 20: Do you agree with the proposal to extend the eligibility criteria for under 18-year-olds who are care leavers or are in the care of a Local Authority?

Yes. We welcome this development in Wales.

Question 21: We would welcome your thoughts as to whether you think there are any other benefits or disadvantages not mentioned in the consultation? Please explain what these might be and provide evidence to support your response.

Overall, we think there are many advantages associated with planned reforms and we welcome the Welsh Government correctly identifying, and including in the Regulatory Impact Assessment Document, that using primary eye care is the only sustainable way to meet population needs in Wales.

We do however feel a few potential risks (disadvantages) have been missed in the consultation but these can still be addressed in partnership with Welsh Government and NHS Wales get things right for the patients we are all here to serve.

The main risks (disadvantages) not addressed in the consultation are:

- Manging cross border issues in a way that provides flexibility for Welsh practices to deliver on the shared goals set out in the consultation (see our response to question 3 as one example)

- The impacts on children and adults on means tested benefits if Welsh Ministers plan go ahead to cut 99% of patient benefits used to access essential vision correction (see our response to question 18)
- Domiciliary provision could reduce significantly as providers are forced to exit local provision because this element of the reforms has not yet been fully explored with a view to mitigating risks (see our response to question 24).

While the focus throughout the reform discussions have rightly been on primary eye care, a significant omission is any mention of parallel reforms in LHBs (apart from administrative functions) and NHS trusts (e.g. investment, training, IT roll out, reorganising departments and clinics and rostering staff) to support the new primary care services in return. A whole system approach is necessary, and we would hope to see a future parallel plan for hospital eye care and wider system reform in which OW is fully engaged so pathways can be streamlined in line with right care principles. Only then will we have a genuine eye care plan for Wales.

Question 22: The Welsh Government is committed to creating an environment where everyone will want to use the Welsh language. We would like to know your views on the effect the new legislation could have on the Welsh language, specifically on opportunities for people to use Welsh and on treating the Welsh language no less favourably than English. What effects do you think there would be? How could positive effects be increased, or negative effects be mitigated?

The advantage of care closer to home is that it is provided in the heart of communities across Wales, whereas hospital services tend to be more centralised away from where many people live.

Expanding access to care close to home means people are more likely to be seen by somebody who is a part of their community, and more likely to share a common preferred language. Therefore, the overall impact should be positive with respect to increasing the probability of a match between patient, provider and language.

Question 23: Please also explain how you believe the proposed legislation could be formulated or changed so as to have positive effects or increased positive effects on opportunities for people to use the Welsh language and on treating the Welsh language no less favourably than the English language, and no adverse effects on opportunities for people to use the Welsh language and on treating the Welsh language no less favourably than the English language.

Please see our response to question 22.

Question 24: We have asked a number of specific questions. If you have any related issues which we have not specifically addressed, please use this space:

We would like to thank Welsh Government, NHS Wales, the Optometry Wales Board and sector partners for all the work done to advance what is one of the most ambitious and wide-ranging set of eye care reforms the UK has seen for generations.

Without doubt, if clinical manuals turn out as hoped, then the benefits of these reforms will far outweigh any costs – as the impact assessment evidences.

It is however a natural part of any complex reforms process, for all of us to reflect on issues that arise only after we consult a wider range of subject matter experts and to design negatives out before implementation. It is far more costly for all parties to do so afterwards and that inevitably impacts on patients.

Finding we have not got all things right first time is in no way a criticism – in fact it is remarkable that the sector and Welsh Government have managed to get so much right, even prior to consultation, given the breadth and complexity of the proposals.

However, where we know things will not work it is sensible for all of us to come together and find solutions. There are broadly three areas that warrant urgent attention and agreed resolution prior to implementation:

- The proposal to cut patient benefits (which we set out our Welsh members views on in response to question 18)
- Proposals for domiciliary eye care services, which providers in Wales collectively tell us will have adverse effects on vulnerable patients (more below)
- Workforce planning (more below)

Getting these right will also help address cross border issues.

Domiciliary eye care is a specialist area with unique characteristics, cost drivers, and more complex patients than the average practice-based location.

For avoidance of doubt, the entire domiciliary eye care sector in Wales, fully supports:

- Offering people who depend on care at home WGOS1
- Offering people who depend on care at home WGOS2
- Opening up options to provide WGOS3, 4 and 5 at home based on clinical needs
- Removing the discriminatory notification period which only creates barriers to delivering care without due regard to the protected characteristics of people who depend on care at home.

The sector is fully behind the goal of improving equality in access and addressing historical issues in providing services to people who need mobile care.
There remain however some serious concerns and challenges with respect to the detail underpinning the proposals; these include:

- Welsh domiciliary eye care providers voices not being sought or being disregarded during and after the negotiations phase of the reforms
- Domiciliary eye care cost of service not being investigated in the same way as fixed practice services
- Changes to patient benefits not being investigated in the context of providing essential vision correction to those who need dispensing at home, and where the economies of scale and marginal cost are not the same as in practice locations.

Current proposals risk forcing some Welsh domiciliary eye care providers to give up providing those services which risks creating serious gaps in provision. This is the opposite of what we all hope to achieve.

These issues can be readily resolved and Welsh domiciliary eye care providers have written to Optometry Wales to ensure their concerns are shared with Welsh Government. The solution to the issues at hand are broadly as follows:

- Clinical fees per patient will not reflect the cost of provision. Whereas practices will see significant increases in the WGOS1 fee to help finally cover more of the cost of provision, those that provide care at home (as opposed to care in care homes to many patients on the same day) will not see fees corrected to reflect costs.
- Dispensing vision correction at home under new voucher values will result in significant losses as the proposed cost-plus analysis has not considered the unique cost drivers of providing care at home
- Given the misalignment of fees, and the geographically complexity of Wales, mandating WGOS1 and WGOS2 from the outset will make some services unsustainable.
- Ensure clinical manuals are evidence-based with respect to response times to ensure reforms reduce rather than increase risk – e.g. it is important to avoid non-evidence-based requirements in the clinical manuals which might require a provider to meet all WGOS2 needs within a certain window of time as this could conflict with a provider's duty to serve all patients best interests
- Work with domiciliary eye care providers to ensure that the new criteria for eligibility to care at home does not lead to unintended system pressures – i.e. the sector welcomes opening up access to care at home but this scarce capacity needs to be prioritised to those in greatest need and people who are able to should still visit their practice rather than call for a domiciliary visit.

FODO is supporting the sector domiciliary eye care committee (DEC) to ensure Welsh domiciliary provider concerns are considered and acted on where possible by Welsh Government. We would ask that Welsh Government allow time to work out the detail on domiciliary care, and in the interim reassure the sector's home care providers that WGOS2 will not be mandatory until issues raised by domiciliary care providers are reviewed.

Finally, the consultation document is understandably light on workforce issues, yet the reforms will naturally have significant implications for the optometric, dispensing and support workforce now and into the future. Representing the majority of employers and training practices in Wales, we view this challenge and opportunity to upskill positively. FODO has played a significant role in the General Optical Council's Education Strategic Review (ESR) where we have been strong advocates for reform.

Our Education and Training Requirement (ETR) Implementation Support Group is working with all universities to ensure we can meet the new requirements for undergraduate long and short training placements to ensure all students have a high-quality learning experience in practice. As set out in Principles and Priorities for Primary Eye Care, we are also looking at wider multidisciplinary team working, greater use of technology and new models of care as the nature and make-up of the workforce changes and will continue to change and take on expanded areas of practice.

Fortunately, there is already flexibility and mobility in the workforce and the positive direction set by the reforms will provide a clear framework for Welsh Higher Education, eye care practitioners and employers to plan and work together to meet future workforce needs, ambitions and aspirations.

Responses to consultations may be made public – on the internet or in a report. If you would prefer your response to be kept confidential, please tick here: ☐

We are happy for our response to be published.