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Another busy year passes
I know everyone says that years go by much quicker the older you get, but 2014 must be some sort of record.

It hardly seems possible that we are fast approaching Christmas and the festive season. The ABDO team has been working at full pelt throughout the year with many additional hours worked, often unsung and unrecorded, but greatly appreciated by both the ABDO board and myself.

In CET, social media and marketing, as well as general membership support, we have had the busiest year ever. At ABDO College we have seen a significant rise in the number of students enrolling on our existing courses and we are looking forward to further increasing course options in the future.

I am personally most grateful to all the staff at both the Association and the College for their huge contribution to the continued success of both organisations. However, none of what has been achieved would have been possible without the constant support and encouragement from you – our members.

So a very big thank you to every member for your loyalty and commitment. And on behalf of the whole team may I wish you a very happy and peaceful festive season and a prosperous and productive new year.

Tony Garrett ■

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Considering ocular motor balance in dispensing

By Stephen Freeman BSc (Hons), MCOptom, FBDO(Hons), Cert Ed

Ocular motor balance (OMB) can be regarded as the relative alignment of the visual axes in relation to the achievement of binocular single vision (BSV). As defined by the GOC core competencies for Dispensing7.1.5, the dispensing optician should “understand the investigation and management of patients with an ocular motor imbalance” – and competency 4.1.1 “identifies anomalies in a prescription and implements appropriate course of action – offers solutions for example, aniseikonia, anisometropia”. (This wording is exactly the same as for Optometry 4.1.1)².

This article, using case studies, aims to remind readers of some basic binocular vision theory and its relevance to dispensing.

During a routine eye examination, although the exact format and content will be determined by professional judgement and minimum legal requirements, an assessment of habitual OMB is regarded among the list of what a full eye examination should include³. However, more detailed attention may be given to measure a patient’s OMB with regard to certain symptoms, but also to refractive changes that might bring about a change in the OMB, whether due to subtle chronic changes (e.g. myopic shift in nuclear cataract) or often more sudden changes due to cataract surgery and implant, where the refractive change may be greater but ‘permanent’.

With an ageing population there are more patients with refractive changes due to incipient cataract, and by definition more ‘successful’ cataract extraction and implants are performed. Increasingly perhaps, only one eye has been operated on, and the criteria for the second eye may mean a considerable period of time where a large anisometropia is present. The optical dispensing options may now, even more, need that expertise knowledge that has been rigorously tested in professional qualifying examinations.

Binocular single vision (BSV) and heterophoria

The perceptual co-ordination to produce BSV that takes place in the brain is primarily the ability to fuse slightly dissimilar retinal images, which itself requires to be maintained through vergence eye movements. When a pair of eyes are viewing an object, the visual axes are maintained due to the desire for BSV – and this driver is stronger than the desire for visual clarity. This is brought about by the six pairs of oculorotary muscles and constant feedback via the three pairs of cranial nerves devoted only to this...
function. The fusional reflex can be considered to maintain the visual axes; hence the eyes are in an active position. Disrupting fusion will cause the eyes to take up their passive position.

The concept of orthophoria, where the active and passive positions are the same is an ideal rather than the norm. The combination of the position of the eyes and viewing objects at different distances and positions in space means that the visual axes show a tendency to deviate requiring constant adjustments. As this motor imbalance tends to occur, if BSV is mostly achieved then the imbalance is a heterophoria and measurable. The direction of the deviated eye from fixation allows a classification of heterophoria (Table 1). Although 80 per cent of the population exhibit some degree of horizontal heterophoria, and Table 2 shows the values considered to be within normal limits, i.e. present but not necessarily causing symptoms.

The presence of heterophoria may be caused entirely by, or be exacerbated by, a number of factors, both anatomical (large PD, specific oculorotary muscle weakness, neurological defects) and uncorrected or poorly corrected ametropia and, of course, anisometropia, where an increasing differential prismatic effect may be encountered as the eyes view away from the optical centres of a pair of spectacles. However, patients often are symptom free as their fusional reserves are adequate for the visual tasks undertaken (Table 3).

The fusional reserves are the maximum amount the eyes can converge (positive fusional reserves, measured with base out prism) or diverge (negative fusional reserves, measured with base in prism) while still maintaining BSV. As the image doubles, the break point is reached. Note from Table 3, both positive and negative reserves are greater for a near object and as convergence also stimulates accommodation, an image may become out of focus but still single (blur point). The vertical values shown in Tables 2 and 3 are much smaller, suggesting a vertical differential prismatic effect is more likely to cause problems than a horizontal differential prism.

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### Table 1: Classification of Heterophoria

<table>
<thead>
<tr>
<th>Deviation</th>
<th>Axis</th>
<th>Classification</th>
<th>Angle &gt; near</th>
<th>Angle &gt; distance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Temporal</td>
<td>Vertical</td>
<td>Exophoria</td>
<td>Convergence</td>
<td>Divergence</td>
</tr>
<tr>
<td>Nasal</td>
<td></td>
<td>Esophoria</td>
<td>Convergence</td>
<td>Divergence</td>
</tr>
<tr>
<td>Upwards</td>
<td>Horizontal</td>
<td>Hyperphoria</td>
<td>Tend not to differ much on viewing distance</td>
<td>but may be more noticeable for critical tasks</td>
</tr>
<tr>
<td>Downwards</td>
<td></td>
<td>Hypophoria</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wheel rotation temporally</td>
<td>Sagittal</td>
<td>Incyclphoria</td>
<td>Tend to be rare</td>
<td></td>
</tr>
<tr>
<td>Wheel rotation nasally</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Table 2: Muscle Balance within normal limits

<table>
<thead>
<tr>
<th>Distance</th>
<th>Exo</th>
<th>Eso</th>
<th>Vertical</th>
<th>Cyclo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Near</td>
<td>Exo 4∆</td>
<td>Eso 4∆</td>
<td>Vertical 1∆</td>
<td>Cyclo 0∆</td>
</tr>
<tr>
<td></td>
<td>Exo 8∆</td>
<td>Eso 4∆</td>
<td>Vertical 1∆</td>
<td>Cyclo 0∆</td>
</tr>
</tbody>
</table>

### Table 3: Fusional Reserves

<table>
<thead>
<tr>
<th>Direction</th>
<th>Fixation</th>
<th>Blur Point</th>
<th>Break Point</th>
<th>Recovery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Convergence (base out)</td>
<td>Distance</td>
<td>4∆</td>
<td>20∆</td>
<td>12∆</td>
</tr>
<tr>
<td></td>
<td>Near</td>
<td>8∆</td>
<td>30∆</td>
<td>20∆</td>
</tr>
<tr>
<td>Divergence  (base in)</td>
<td>Distance</td>
<td>8∆</td>
<td>4∆</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Near</td>
<td>15∆</td>
<td>8∆</td>
<td></td>
</tr>
<tr>
<td>Vertical</td>
<td>Both</td>
<td>4∆</td>
<td>2∆</td>
<td></td>
</tr>
</tbody>
</table>
Fusional reserves can easily be measured in the test room using a rotary prism (often incorporated as part of a phoropter) or with a prism bar (Figure 1). Fusional reserves can often be modified (increased) in younger patients with orthoptic-based exercises, but also can be affected (decreased) by advancing age, general well-being, medication, alcohol and drugs. Add to this a changed refractive state and/or increasing the amount of certain critical tasks, e.g. increasing use of hand-held electronic devices such as tablets and smartphones, it is not surprising that some patients symptoms are directly related to a heterophoria present.

The role of fusion during OMB measurement
Different values of deviation can be obtained for the same patient depending on the way fusion is prevented in the clinical environment. Perhaps the most obvious way to prevent fusion, i.e. cause dissociation, is to cover one eye with an occcluder (the cover test). The occcluder is held in front of each eye in turn and watching the recovery movement of the eye when uncovered in terms of direction, speed and magnitude. This can be measured accurately using a prism cover test, or estimated just by observation. This will also differentiate between a heterophoria (latent deviation) and heterotropia (manifest deviation).

The assessment of the speed of recovery movement is often a clue as to whether it is likely to be symptomatic and would be repeated with the patient viewing a distant and near object, or any relevant working distance. Further dissociating tests to obtain a measurement could include a Maddox Rod, high power prism or Maddox Wing (for near only), which dissociate by distortion, displacement or dissimilar object respectively (Figure 2).

BSV is based on corresponding retinal points and fusion, however, flexibility within the system allows for slightly disparate images to be fused providing they fall within Panum’s fusional areas. In heterophoria, advantage may be taken of this fixation disparity (FD) or ‘retinal slip’ to give partial relief by allowing one eye to deviate slightly from the position of accurate fixation. There are methods to measure this by partial rather than complete dissociation techniques, which usually reveal a smaller deviation in the same individual.

One example of this type of test is the Mallett Unit presented along with a distance test chart and a self-contained version used for near (Figure 3). This has orthogonally polarised targets and is viewed through a compatible polarising filter; other ways to achieve partial dissociation may include red and green targets and filters. This measured value of prism can represent the uncompensated amount of a total deviation and may be termed the ‘associated heterophoria’.

Generally, if there is no measurable fixation disparity despite a measured latent deviation, it is described as ‘compensated’, even if the
dissociated value is greater than ‘normal’ limits, and if this is the case, the patient is likely to be symptom free. If a patient does have symptoms, the value of the aligning prism is often the amount of prism that might be prescribed in spectacles, again rather than the full amount of the heterophoria present. The International Standards Organisation (ISO) has proposed that the term ‘aligning prism’ is adopted rather than using either ‘FD’ or ‘associated heterophoria’ as although their values may correlate, they are not strictly all describing the same entity.

**Dispensing**

Often the symptom-relieving amount of prism is so small that it is regarded as a subjective result verses an objective result – the subjective result being the smaller amount of prism considered to prescribe. As described above, there are various factors that might mean a previously compensated heterophoria is becoming (or has become) decompensated, especially with certain symptoms, e.g. frontal headaches, asthenopia, blurred vision, refocusing difficulties and, of course, even manifest diplopia, especially when associated with certain visual tasks.

In analysing the patient’s prescription, there are different areas that might challenge the conventional spectacle dispensing process. A really obvious issue was identified with the following patient. A 75-year-old male had a successful left cataract extraction and the patient is likely to be symptom free. If a patient does have symptoms, the value of the aligning prism is often the amount of prism that might be prescribed in spectacles, again rather than the full amount of the heterophoria present. The International Standards Organisation (ISO) has proposed that the term ‘aligning prism’ is adopted rather than using either ‘FD’ or ‘associated heterophoria’ as although their values may correlate, they are not strictly all describing the same entity.

His new spectacle prescription was now R -5.00/-1.00x85 6/9 L+1.00/-1.75x90 6/6 Add 2.50 each eye (R&L N5). The left eye was previously myopic as evidenced in his current unchanged bifocal spectacles. With approximately six dioptries of newly created anisometropia but an otherwise binocular patient who would prefer to continue with multifocal lenses, a pair of flat top 28mm bifocals were dispensed, the right lens as a bi-prism (Figure 4) (see also Case Study 3 below).

Three further case scenarios to present that represent the following:

1. Where a decompensated heterophoria has been identified and relieving prisms have been prescribed.
2. Changing (or introducing) a spectacle prescription, without regard to the patient’s OMB.
3. Where a prescription reveals an unwanted differential prismatic effect (especially vertical), that is now causing (or is likely to cause) symptoms due to either a change in the prescription itself, or a change to the viewing tasks of the patient (or both).

These are all based on real patients that have been seen in a university eye clinic setting in the last academic year.

**Case Study 1**

**Patient A: a 62-year-old retired female.**

Routine eye examination, patient finding their separate spectacles increasingly frustrating as they are finding they now prefer to use their distance spectacles for TV, but enjoys knitting and some other close work related activities while doing this, and now using a tablet for patterns, etc. Previously they just managed their near task using their single vision readers and looking over the top for distance. As the patient had not been seen in the clinic before, their current spectacles were focimeted and optical centres (OCs) noted.

Current spectacles from two years ago:

- **R +1.00/-0.25x95 L +1.25/-0.50x85 OCs 62, good condition. S/V plastic lenses**
- **R +3.00/-0.25x95 L +3.25/-0.50x85 OCs 52 S/V plastic lenses, scratched**

Of note was the ‘apparent’ difference between the OCs in the reading spectacles and the patient’s measured pupillary distance (PD) and near centration distance (NCD), which were 62 and 58 respectively. This effectively meant there was nearly 1.00a base in each eye at the NCD, so could this be an error in the making of these spectacles. The clue was they were (and still are) reasonably satisfactory from a visual point of view and the OMB findings.

As often happens, more of her latent hypermetropia has become manifest, hence the reason she now appreciates the small distance correction more. Her most recent findings are:

- **R +1.25/-0.25x90 6/6 L +1.50/-0.50x85 6/6 Small exophoria on CT but no aligning prism on Mallett Unit**
- **R +3.50/-0.25x90 N5 L +3.75/-0.50x85 N5 large exophoria on CT 1.50A IN for each eye aligning prism on Near Mallett Unit**
- **Near range checked for habitual working distance**

So it seems that the centration distance was probably correct, and that the base in prism was intentional, although the patient did not remember being told that ‘prisms’ were included when the spectacles were supplied. The simplest dispensing solution here would be to continue...
with separate pairs with the prism provided in the near pair only. But this would not satisfy the improved distance vision and allow the patient to carry out the prolonged near tasks simultaneously.

Solutions in bifocal format to include prism in the segment would be:
• Glass Solid Round 30mm Prism Controlled (prism segment) but no longer available
• Resin handmade bifocal (e.g. Presto from Norville)
• Franklin Split bifocal. This could be a solution for any of these scenarios but has the distinct disadvantage of comnisis, time to manufacture and cost
• Increase inset using large flat top bifocal (e.g. 40 or 45mm segment diameter)

For this last solution, the total inset would be combination of the NCD requirement and the amount required to produce 1.5∆ with the add power being of +2.25D, i.e. 2 + 6.67 = 8.67mm. Since there is also a very small amount of base out prism due to the distance portion, increasing to 9mm inset. As this uses conventional lenses, price could be a factor and it can be readily supplied in reasonable time. Patient A, having had the pros and cons of the various solutions explained, did opt for this one.

Case Study 2
Patient B: a 47-year-old male lecturer.
Early eye examination as the patient feels their spectacles seem ‘too strong’. Supplied as their first pair for near, having previously been aware that near tasks had become more difficult and was using +1.00DS ready-mades. Had been back to original supplier but was told that spectacles were ‘correct’, requiring reading spectacles was ‘normal’ for their age and that they just needed to ‘get used’ to them. The patient had reverted to their off-the-shelf readers, which they felt more comfortable with for most of their tasks apart from close fine detail.

Current spectacles from approximately six months ago:
• R +1.75/-0.25x95 6/6.5 L +1.50DS OCs 60, good condition. S/V plastic lenses with coatings

Current findings:
• R +0.25/-0.25x90 6/5 L -0.25DS 6/5 PD/NCD 64/60 Amplitude of accommodation 2.00D

Using half amplitude in reserve, and based on 40cm working distance, an add of 1.50 would be an appropriate starting point, subjectively refined, and range checked, which is so similar to the ‘rejected’ spectacles. Sometimes patients are not aware of the consequences of a near addition and the artificial far point created, unless informed. But with a 1.50DS add, as in this case, the artificial far point (i.e. the focal length of the add power) would be 67cm, and so should not be the issue, although often becomes a problem with higher adds.

The OMB status of this patient revealed a near exophoria with the correction in place but absent without, using an accommodative target. The extra accommodative effort and associated convergence using the +1.00DS ready readers was providing the relief for the exophoria, and when the new increased add is used, the reduced accommodative effort meant the heterophoria was becoming symptomatic even though the actual print was clearer at the closest working distance the patient might use.

The two options in this case were:
• Give the full add and prescribe base
  prism
• Give slightly reduced add (the patient needed some increase) and recommend appropriate orthoptic exercises (e.g. pen to nose type) aiming to improve positive fusional reserves

The second option was undertaken with a recommendation to review in three months’ time. Some research suggests that the efficacy of eye exercises reduces with age, but other studies have shown success even within the presbyopic age group.

Obviously, this patient will lose more of their accommodation with time but if the eye exercises do improve the OMB then the prism option may not necessarily be inevitable. The dispensing ‘issue’ was only that the patient was a non-tolerance, but the only action of a DO in this case would be to refer to a prescriber since the spectacles were found to be correct.

Case Study 3
Patient C: a 71-year-old retired female.
This patient was happily wearing bifocal spectacles supplied 18 months ago, but was noticing deterioration in vision in their right eye for some time. Distance vision almost seemed clearer now without spectacles. Prolonged reading has proved tiring for some time. Current spectacles from last examination:
• R +2.25/-1.00x30 L +3.00/-0.50x135

Add 2.50 R&L. OCs 58, reasonable condition, left lens scratched. Flat top 28mm bifocal lenses with coatings

VA’s with current spectacles: R 6/12 and N6. L 6/9 N5. Calculating the vertical lens powers using the concept of notional power F sin² Ø (where F is the cylinder power and Ø is the angle between the axis and the meridian in question). This gives an approximate value but is very useful as an indicator (R +1.50 using ¾ of the cyl power, L +2.75 using ½ cyl power) at 10mm below the distance OCs would have a vertical differential of around 1.25∆ up LE. Could this be part of the near fatiguing from before? New Rx: R +1.50/-1.25x45 6/7.5
L +2.50/-0.50x120 6/7.5 Add 3.00 N5 R&L.

Ocular examination showed advancing nuclear cataract (cortical) especially of the right eye. This was causing a typical myopic shift, however, the patient really appreciated the improvement in distance vision especially with the right eye with the new prescription. The change would also increase the differential vertical prismatic effect to at least 1.50∆, further exacerbating the prolonged near problem.

Vertical differential prismatic effect
Many patients who technically have amounts of vertical differential prism in their spectacles due to their anisometropia that exceed 1∆, report no problems with their multifocals. This may be because their own vertical fusional reserves are above average, or often the visual acuity in one eye is reduced or the image is suppressed to the extent that fusion is irrelevant.
One way to explore whether the calculated differential prismatic at the NVP needs to be resolved, would be to place the patient’s reading prescription in a trial frame along with a plano prism equal to the differential placed before one eye. Using a Near Mallet Unit (or similar), ask whether the markers are stable and aligned, and get the patient to undertake a typical near vision task for a number of minutes and check their subjective visual comfort (Figure 5). Repeat the near vision task without the prism and compare. Those reporting a subjective difference are more likely to benefit from some consideration of the problem.

Although there are a number of solutions to eliminate (or at least reduce) the vertical differential prismatic effect, some lend themselves better to certain types of prescriptions, assuming multifocal lenses are preferred. Different size round segment bifocals. The segments exert base down prism at the NVPs. This works well with +ve distance Rx, small differential prism and high adds. Calculating the difference in segment sizes using:

\[ \text{d}1 - \text{d}2 = \left( \frac{2 \times \text{diff Pvs}}{\text{Add}} \right) \]

where \( \text{d}1 - \text{d}2 \) is the difference in segment diameters in cm, would give segment sizes of 10mm to completely eliminate the differential prism. Just using a difference of 5mm would reduce the differential to less than 1∆ and be barely noticeable in appearance. The larger segment for the left to neutralise the unwanted base up. This would be a really good option but the patient was already wearing flat-top bifocals and it was considered the introduction of jump each time the visual axes crossed the dividing line might be an added complication.

Slab-off (Bi-prism). This is available for both bifocals and progressive power lenses. Traditionally, slab-off removes base down prism in the lower part of the lens, so works well with +ve distance Rx, removing the unwanted base down from the more negative lens (Figure 4). However, this would be difficult in a +ve lens, so the process could be applied the surface mould, so when the mould creates the lens surface it effectively adds base down to the lens surface (this could be called ‘slab-on’ or ‘reverse slab-off’), and would be applied to the more positive lens.

The patient was ordered a pair of CR39 flat-top 28mm bifocals as a bi-prism with 1.5∆ base down added. The transition created across the lens surface looks more like a faint horizontal crease than a solid line. Using freeform technology, the prism can now be added as well as subtracted to quite small amounts (less than 1.5) and with a blended division making the transition unnoticeable, and using different lens designs, forms and materials. Sometimes shorter corridor progressive lens designs can be considered for small amounts of differential prism to help keep the amount of prism encountered at the near visual point to a minimum.

Conclusion

Sometimes, and inevitably, most problems only manifest themselves in the form of a returning patient, having recently purchased their new spectacles, to complain that something is not right. Occasionally, the patient may not return to you but go elsewhere in the hope that some resolution is available, but probably not being very complimentary of their recent experience. Either way, it can be difficult at the point of dispensing to foresee a problem when perhaps that problem should have been identified during the prescribing process.

A skilled practitioner, whether normally working in or outside of the consulting room, should certainly be able to recognise the issue of differential vertical prism when it arises, and at least consider its possible effect. Careful questioning in terms of previous spectacles and symptoms, having identified a potential problem, it would be perfectly acceptable (and recommended) that it is explored further during the dispensing process.

Some studies have shown that 60 per cent of anisometropic patients benefit from some form of prism compensation, and that does not mean that the other 40 per cent would not notice the difference. Being able to offer alternatives to just ‘separate pairs’ and knowing the status of a patient’s OMB can prove invaluable when trying to find reasons for non-tolerance. The role of the optical detective is both rewarding for patient and practitioner alike.

References


Stephen Freeman is a lecturer in optometry at Plymouth University and teaching faculty member of the Vision Care Institute. He is an ABDO practical examiner and theory paper marker, and a College of Optometrists examiner and assessor. He also works in practice in South Devon. ■
Multiple choice questions (MCQs)
Considering ocular motor balance in dispensing by Stephen Freeman

1. How many pairs of cranial nerves innervate the ocular motor muscles?
   a. 6
   b. 3
   c. 4
   d. 2

2. Which statement best describes the term ‘orthophoria’?
   a. It is where only one eye deviates when occluded
   b. It is said to exist when all negative fusional reserves have been used up
   c. The active and passive positions of the visual axes coincide
   d. A term synonymous with decompensation in heterophoria

3. Which statement is UNTRUE?
   a. For myopic presbyopes with anisometropia, base down prism can successfully be removed from the more negative lens to avoid vertical diplopia
   b. Where an eye deviates nasally it indicates esophoria may be present
   c. It is possible for slightly different retinal images to be fused if they still fall within Panum’s fusional areas
   d. If a patient experiences no problems with vertical differential prism of 2∆ their vertical fusional reserves may be below average

4. Complete the sentence with the correct option. The term ‘positive fusional reserves’ in binocular single vision refers to…
   a. the maximum amount the eyes can converge measured with base out prism
   b. distance vision only
   c. hypermetropes who are able to converge to read without difficulty
   d. how much the eyes can diverge before the image doubles

5. A first-time bifocal wearer has the prescription: R: +1.25/-1.00 x 180, L: +0.75/-2.75 x 180 Addition +2.75DS. Visual acuities are 6/6 R and L and N5 just managed. Which of the following would provide the best dispensing option to control vertical anisometropia?
   a. R R25 and L R40 segments
   b. R and L R28 segments as acuities are the same
   c. R R40 and L R25 segments
   d. R S45 and L S28 segments

6. Which statement is UNTRUE?
   a. Digital surfacing techniques now enable relatively small amounts of prism to be worked on a spectacle lens
   b. Fusional reserves may be increased by orthoptic exercises even where presbyopia exists
   c. 8 prism dioptres of esophoria may be present for near but unlikely to cause symptoms
   d. Deviation of an eye from fixating when occluded may be made worse by extrinsic muscle weakness

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Christine Barker - Sanford Opticians

Much improved access to intermediate vision and without compromise of distance.
T Newman - Conway Opticians
Multiple choice answers:
Heads you win, tails you lose by Andrew Keirl

1. Which statement is correct?
   a. The back vertex power of a contact lens for a particular patient will always be equal to the patient’s ocular refraction
   b. RGP contact lenses are optically useful when fitting patients with irregular corneas
   c. When fitting a patient with an RGP contact lens, a positive tear lens will be produced if the back surface of the contact lens and the front surface of the cornea have the same radius of curvature
   d. When fitting a myopic patient with a hydrogel contact lens, the back vertex power of the contact lens will be greater than the patient’s spectacle refraction
   
   b is the correct answer. RGP contact lenses are better for correcting astigmatism induced by irregular corneas than other forms of optical correction. Irregular corneas can occur in patients with keratoconus, keratoplasty and in patients who have undergone refractive surgery. When fitted with a RGP contact lens, the tear lens that is formed between the back surface of the contact lens and the front surface of the cornea ‘fills in’ the irregularities of the corneal surface producing a more regular refracting surface.

2. An over-refraction is performed following the fitting of a patient with an RGP trial contact lens. The result of the over-refraction is -0.50DS more than the expected value. Which statement is correct?
   a. The over-refraction indicates that the lens is too steep and a lens with a BOZR 0.10mm flatter than the trial lens should be considered
   b. The over-refraction indicates that the lens is too flat and a lens with a BOZR 0.10mm steeper than the trial lens should be considered
   c. The over-refraction indicates that the lens is too steep and a lens with a BOZR 0.20mm flatter than the trial lens should be considered
   d. Based on the over-refraction result alone, the result indicates that the fit of the contact lens is correct

   c is the correct answer. Even though the thicknesses of both the RGP contact lens and the tear lens are small compared to the thickness of the spectacle lens, the steep curves involved mean that the spectacle magnification produced is significant.

3. Which statement is correct?
   a. The size of the retinal image formed in an eye corrected by a contact lens will always be the same as the size of the retinal image formed in the same uncorrected eye
   b. Spectacle magnification is the ratio of the retinal image size in the corrected ametropic eye compared with the retinal image size in the standard emmetropic eye when for a given distant object
   c. The tear lens formed when an RGP contact lens is placed on an eye can affect spectacle magnification produced
   d. The power factor is of no consequence when calculating the spectacle magnification produced by contact lens/tear lens system

   a is the correct answer. Compared to correction with spectacles, myopic subjects will require more accommodation and convergence when corrected with contact lenses compared to hypermetropes, but there will be annular area around the lens periphery where objects will be seen in diplopia.

4. Which statement is correct?
   a. The term ‘real field of view’ relates to the field of view produced by an empty spectacle frame
   b. Hypermetropic subjects benefit from an increase in field of view compared to myopes, and there will be an area around the edge of a lens from which no light can enter the eye
   c. Myopic subjects suffer from a decrease in field of view compared to hypermetropes, but there will be an area around the lens periphery where objects will be seen in diplopia
   d. A contact lens with a small overall diameter, or small diameter optic zone, can potentially affect the field of view experienced by a contact lens wearer

   d is the correct answer. A contact lens with a small overall diameter or small diameter optic zone can potentially affect the field of view experienced by a contact lens wearer.

5. Which statement is correct?
   a. Compared to correction with spectacles, myopic subjects will require more accommodation and convergence when corrected with contact lenses
   b. A positive spectacle and/or contact lens correction can be helpful in cases of a near exophoria
   c. A negative spectacle and/or contact lens correction can be helpful in cases of a near esotropia
   d. Prismatic correction cannot be incorporated into contact lenses

   a is the correct answer. Compared to correction with spectacles, myopic subjects will require more accommodation and convergence when corrected with contact lenses.

6. Which statement is correct?
   a. In cases of anisometropia, contact lenses reduce aniseikonia only if the anisometropia is axial in origin
   b. In cases of anisometropia, contact lenses reduce aniseikonia only if the anisometropia is refractive in origin
   c. Contact lenses reduce aniseikonia in all forms of anisometropia
   d. Refractive anisometropes are not likely to achieve their best binocular visual acuity and stereovisuality when wearing contact lenses as opposed to spectacles

   c is the correct answer. In axial anisometropia, spectacles are theoretically better if the anisometropia is axial as aniseikonia will be less and binocular vision will be more comfortable. The opposite is true if the anisometropia is refractive as correction with contact lenses will result in the right and left retinal images being the same size. However, this theoretical prediction was disproved by research that revealed that contact lenses reduce aniseikonia in all forms of anisometropia.
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See better. Look perfect.
Welcome to the intersection of technology and eyewear. Not that both lenses and frames aren’t already digital and high-tech, but the rapidly emerging field of wearable technology has set sights on smart glasses and electronic eyewear.

Technology and eyewear are inextricably linked, after all the average computer or mobile device user is online at least a third of their day, some as much as 10 hours. That puts special demands on having the right eyewear. In fact, eMarketer (Aug 2013) states that, “the average adult will spend over five hours per day online on non-voice mobile activities or with other digital media this year. Daily TV time will actually be down slightly this year (to 4:31 hours), while digital media consumption will be up 15.8 per cent.”

The article went on to say: “The most significant growth area is on mobile devices. Adults will spend an average of two hours and 21 minutes per day on non-voice mobile activities, including mobile internet usage on phones and tablets – longer than they will spend online on desktop and laptop computers, and nearly an hour more than they spent on mobile devices last year.”

Think about the viewing distances of mobile devices and the demands it puts on accommodation and convergence. In fact, it turns out that some PPL wearers no longer want better intermediate vision but in fact prefer better near because of the amount of time and ‘up close’ demand of their mobiles. Therefore, what is ‘normal’ is changing again. It’s not surprising that many consumers want to combine their mobile device with something that they are already wearing, giving rise to the term ‘wearables’ when referring to technology integrated into clothing and accessories.

Rise of the ‘wearables’

There are some who expect that by 2020 smartphones will be replaced by smart contact lenses, eyewear, watches and in-ear audio plugs that communicate with wearable computers (Figure 1). Emmanuel Lund is a tech industry analyst and has described how the combination of technologies will enhance the wearer’s abilities. There will be an estimated 1.6 billion smartphones shipped by 2018 and in the same period 112 million wearables are expected. Therefore the numbers of wearables will be substantial and doctors, opticians and optometrists need to understand how to think about them.

It is expected that glasses and contact lenses will deliver a rich variety of augmented information, which suggests a much larger audience of consumers. Consumers are already contacting eyecare practitioners about vision-enhanced wearables and ‘smart glasses’ and that’s an opportunity.

Wearable technologies are growing fast. Some may have read about the Explorer’s experiences with Google Glass; many have seen the Recon products that add GPS and measure speed to snow goggles. MetaPro Vuzix, Google, EPSON, Recon and others will open a variety of new doors to the way that eyewear is thought about. In each case, these glasses make mobile computing accessible through eyewear.

There are, at present, three broad categories in this arena: smart glasses, augmented eyewear and virtual eyewear (though over time, the differences might become more blurred). However, it’s a good way to describe their differences to customers, and then help them acquire their prescription for each.

Smart eyewear is set to be part of an estimated US$30bn market (Figure 2) affecting both the lifestyle, health/fitness and entertainment wants of consumers. However, prescription glasses have their own unique characteristics that can...
complicate the effective use of smart eyewear. Therefore, with knowledge of wearables and the eyecare practitioners’ knowledge of prescription eyewear, the practitioner is best suited to adopt and deliver smart glasses to the public. What can opticians and optometrists do uniquely in their practices to fuel consumer satisfaction and practice growth with smart eyewear? The first step is to understand the categories.

**Category 1: smart glasses and goggles**

Smart glasses are eyewear that includes a wearable computer and heads-up display (HUD). They may or may not be able to accept prescription lenses as part of the basic frame or as a convenient add-on; as well as audio and phone connectivity. Google Glass is an example of smart glasses that includes these features. The HUD visually delivers a screen that can contain many of the same items as your mobile computing device or smartphone. Location, text, directions, photos, videos, live chat and other activities make smart glasses an integrated part of day-to-day activities.

Examples of HUD glasses are Google Glass, Samsung’s Gear Blink and Vuzix M100 (see Table 1 overleaf and Figure 3). In the sports eyewear side of the business, Recon Jet and Oakley Airwave, amongst others, add an HUD to snowboarding goggles. In this way, the user has instant access to speed, performance stats, airtime, altitude, music and smartphone connectivity.

**Category 2: augmented reality eyewear**

Augmented reality is a live, direct or indirect view of the real world. One might think that smart glasses are also augmented reality but the distinction is that augmented is a display that is embedded within the lens rather than a separate attached HUD (Figure 4). As Atheer Labs describes: “See-through displays allow for 3D digital content to be positioned exactly where it needs to be to seamlessly blend in with the real world objects.”

Any variety of things can be seen or information delivered in an augmented lens. For example, that might be an application for nursing where the glasses deliver the real view of the patient with name and vital signs displayed, medications prescribed, when administered, allergies, etc. Bluetooth delivers this information wirelessly to the display screen embedded in the lenses. A jet engine mechanic using the same technology could consult a manual, supervisor or manufacturer in another country in real time. You might be walking on the street in Quito, Ecuador, and have a craving for Ceviche (a South American seafood dish). If there is connectivity with the internet, just consult your glasses as the Innovega website videos describe.

Table 1 summarises the augmented reality offerings. This list is ‘a snapshot in time’ of availability in the US so consult your UK supplier for an up-to-date list.

**Category 3: virtual reality eyewear**

The third category is virtual reality eyewear. Virtual reality is defined as “…immersive multimedia, in a computer-simulated environment that simulates a physical presence in places in the real world or imagined worlds”[2]. In this eyewear, the outside world is excluded. This gives the wearer the sense of a new environment. Examples of virtual reality eyewear are Oculus Rift, Zeiss Cinemizer and Avegant Glyph. The opportunity to be immersed in a virtual world is exciting to a gamer. Watching a film without outside distractions is a new experience, more 3D-like, without the discomfort that some have with 3D.

**Dispensing considerations**

Like every product that involves vision, there is a complex set of requirements needed to fit every person successfully. Prescription, lens surface design, centration and fitting characteristics all affect the resulting vision. As a result, there are some not-so-good side effects of smart glasses. Eyecare professionals report a variety of visual maladies similar to other digital devices like the digital eyestrain from tablets and smartphones. They include, but are not limited to, eye fatigue, eye strain, difficulty re-focusing at far distances and unavoidable blur in lenses.

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Table 1

<table>
<thead>
<tr>
<th>Category</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category 1: smart glasses and goggles</td>
<td>Google Glass, Samsung’s Gear Blink and Vuzix M100</td>
</tr>
<tr>
<td>Category 2: augmented reality eyewear</td>
<td>Recon Jet and Oakley Airwave</td>
</tr>
<tr>
<td>Category 3: virtual reality eyewear</td>
<td>Oculus Rift, Zeiss Cinemizer and Avegant Glyph</td>
</tr>
</tbody>
</table>

Figure 3: Vuzix M100 smart glasses: an Android-based wearable computer, enhanced with a wearable monocular display and computer, recording features and wireless connectivity capabilities.

Figure 4: EPSON Moverio BT-200. Smart glasses with GPS and Bluetooth capabilities for movies and augmented reality apps.
In many cases, smart glasses require a particular line of gaze and the resulting prismatic effects and off-axis aberrations that exist in some lenses create problems. This is especially true in single vision lenses with high powers and/or oblique cylinders and progressives, especially with front surface and non-optimised designs. These aberrations can contribute to dissatisfaction with smart glass performance.

For example, Figure 5 shows the effects of prescription on the resulting progressive delivered to a patient. It can be seen how distance, near and peripheral vision are compromised with power, cyl and axis. The successively darker zones are areas of increasing blur. As it turns out, prescriptions in traditional front surface progressives (even the most expensive) corrupt the clear fields of view.

Now, consider the centration requirements for good optics through eyewear, as well as eye positions required to best utilise smart eyewear, and there is a potential problem. New optimised and customised lenses reduce the off-axis effects in single vision and progressives. Digital measurements of the position of wear can further refine the delivered Rx but the resulting design must match the positioning demands of the eyewear.

**Prescription smart glasses**

Smart glasses bring data and internet access to a heads-up display (HUD). It shifts vision from a computer screen, tablet or smartphone to a wearable device and places the screen image in the field of vision. That means that looking at a GPS while walking does not require taking one’s eyes off the road. However, if a prescription is worn, the lenses may compromise vision through to the HUD. Figure 6 shows that different prescriptions can affect vision in the upper quadrant where access to the screen image is needed.

The Mail Online reported on 19 May 2014: “…Users have complained of headaches and sharp pains caused by the device, which places a small screen at the top right of the user’s field of vision. Google’s medical adviser

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Table 1: Smart, augmented and virtual reality eyewear

<table>
<thead>
<tr>
<th>NAME</th>
<th>SOURCE</th>
<th>FUNCTION</th>
<th>BENEFITS/APPLICATION</th>
<th>RX/FILTER</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Smart Glasses</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Google Glass</td>
<td>Available</td>
<td>Personal</td>
<td>Simple Easy User Interface</td>
<td>Various/RX/Safety Shields</td>
</tr>
<tr>
<td>Vuzix M100</td>
<td>Available</td>
<td>Enterprise/Prosumer</td>
<td>Work unit for enterprise</td>
<td>Various/RX/Safety Shields</td>
</tr>
<tr>
<td>Recon Jet</td>
<td>Available</td>
<td>Sport</td>
<td>Track time/Speed/ Receive information</td>
<td>Special Screens</td>
</tr>
<tr>
<td>Skully Helmets</td>
<td>Available</td>
<td>Motorcycle</td>
<td>GPS/Rearview camera</td>
<td>Special Screens</td>
</tr>
<tr>
<td>Samsung Gear Blink</td>
<td>Anticipated March 2015</td>
<td>Personal</td>
<td>Google Glass Rival</td>
<td>Various/TBD</td>
</tr>
<tr>
<td>Epiphany</td>
<td>Released</td>
<td>Personal</td>
<td>Notifications/Photos</td>
<td>Various/RX</td>
</tr>
<tr>
<td>Pivothead</td>
<td>Available</td>
<td>Personal/Sport</td>
<td>Video Glasses</td>
<td>Various/RX</td>
</tr>
<tr>
<td>Oakley Airwave</td>
<td>Available</td>
<td>Sport</td>
<td>Speed/Analytics/ Navigation</td>
<td>Special Screens</td>
</tr>
<tr>
<td>Ion</td>
<td>Available</td>
<td>Personal</td>
<td>Notifications</td>
<td>Various/RX</td>
</tr>
</tbody>
</table>

| **Augmented Reality**|          |                        |                      |                 |
| Epson Moverio BT-200 | Available| Enterprise/ Entertainment/Office | Full AR with binocular screens/3D | Varies/RX/VR Shield |
| Golden-I          | Available| Enterprise              | Full AR/Monocular    | RX/Safety Shields |

| **Virtual Reality**|          |                        |                      |                 |
| Epson Moverio BT-200 | Available| Enterprise/ Entertainment/Office | Full AR with binocular screens/3D | RX/VR Shield |
| Oculus Rift       | Available| Personal/Gaming         | Full VR/3D           | RX |
| Zeiss Cinemizer   | Available| Personal/Gaming         | VR/3D                | RX |
| Meta              | Available| Personal                | VR/3D                | RX |
| Atheer One        | Available| Enterprise              | Full VR/3D           | RX |
| Avegant Glyph     | Available| Consumer/ Mobile Theatre | Full VR/3D & Stereo Sound | RX |
| Innovega Optik    | Available| Consumer                | VR/3D                | RX |
says the problem is because of the placement of the screen, and warned new users to ‘take it easy’ as they adjust.”

‘Take it easy’ is step two: step one is to anticipate any prescription issues before the eyewear is delivered. In the optical business, new products often have prescription limitations. That typically slows the adoption of the product and may cause disappointment to the patient at some point in the process. If the blur from lenses can be anticipated, then optimisation of design can produce prescription lenses that work.

To address the problem, lens designs specifically for smart glasses have been developed which provide individual prescription adjustment for the upper right corner of both lenses, and the adjustments are unique to each eye. These Glasses Optimised Lens Designs (GOLD) are available in the UK. The optimisation of the lens design considers fitting requirements and the prescription so the visual experience is enhanced for wearers of smart eyewear, including Google Glass, Epson and Vuzix.

**Digital manufacturing**

Digital manufacturing delivers production accuracy of both design and prescription far beyond the capabilities of conventional prescription fabrication. This technology delivers an optimised prescription over the entire lens surface, calculated and cut in ±0.01D increments. That ensures that the lens power is correct for the moving eye especially in the HUD access zone. Each right and left lens is calculated separately considering prescription, axis, lens size and shape and the patient’s fitting measurements required. Lens design, Rx and material availability can be obtained from UK suppliers, but there is a wide Rx range.

**Conclusion**

Almost two thirds of the adult population requires some form of vision correction, and that same population accesses a mobile device daily, some nearly every waking hour. With all the functionality and usability of smart glasses, it is expected that many consumers will want to combine the need for prescription eyewear with the functionality of a mobile device. Without corrective lenses for these devices, many users won’t experience their full potential. However, the right corrective lenses can make a difference. Smart glasses require smart solutions.

**Websites to explore**

- Google Glass: www.google.com/glass
- Vuzix M100: www.vuzix.com/smart-glasses
- Recon Jet: www.reconinstruments.com/products/jet
- Skully Helmet: bit.ly/1pdpHdG
- Samsung Gear Blink: bit.ly/1pdjONs
- Microsoft: on.wsj.com/1pda3s1
- Epiphany: www.epiphanyeyewear.com
- Pivothead: www.pivothead.com
- Oakley Airwave: www.oakley.com
- ION: bit.ly/1sAtNwI
- GlassUp: www.glassup.net
- EPSON Moverio: bit.ly/1pdqkm0
- Golden-t: www.mygoldeni.com/
- Laforge: www.laforgeoptical.com
- Oculus Rift: www.oculusvr.com
- Zeiss Cinemizer: www.zeiss.com/cinemizer-oled
- Meta Pro Superglasses: www.spaceglasses.com
- Atheer Labs: www.atheerlabs.com
- Avegant Glyph: avegant.com
- Innovega Optik: innovega-inc.com/index.php;
- Sony Morpheous: bit.ly/1pdnTkU;
- InfinitEye: vrwiki.wikispaces.com/InfinitEye+V2

**References**


Bob Forgan is the managing director of Waterside Laboratories, which is the UK partner of independently-owned Rochester Optical, New York, USA, and the sole supplier of Rochester’s smart frames and smart GOLD lens designs in the UK.

This feature was adapted from an article by Mark Mattison-Shupnick, ABOM and Brad Main, ABOC, FNAO.
Have you thought about volunteering, or do you volunteer already? Many dispensing opticians are involved in a wide variety of voluntary work, from running a scout group to fundraising in practice, being a trustee for a charity to putting their optical skills to good use outside their usual job. In this article, find out more about volunteering opportunities and what to do if you want to share some of your time to help others.

Up to seven in 10 people volunteer once a year, and around three in 10 volunteer every month. Cabinet Office statistics show that more people are volunteering too, coming together to drive improvements in society. Events like the Olympics and the Commonwealth Games have created new volunteering opportunities, and encouraged a new generation to join in. Volunteering can make a difference to your own life and the lives of those around you.

There are opportunities that are specifically for those with optical experience, and other which can contrast with your day-to-day work. The National Council for Voluntary Organisations (NCVO) brings together all sorts of voluntary organisations to ensure that anyone thinking about giving their time can find a volunteering opportunity that is right for them, whether it’s supporting a victim of crime or helping out at a local sports club. Read on to find where to look for a volunteering opportunity to suit you.

Making a start
Volunteer centres are local organisations that provide support to volunteers and the organisations that involve them. If you want to find an opportunity in your local area, this can be an ideal place to start. Use the Volunteer Centre Finder at www.volunteering.org.uk to locate your nearest centre. Do-it is the national database of volunteering opportunities. You can search volunteering opportunities by interest, activity or location and apply online. Ivo is a social network for the community minded, connecting people and organisations that want to make their worlds a better place. It allows you to search through volunteering opportunities and jobs available in the not-for-profit sector. CharityJob is the UK’s busiest site for charity jobs and volunteering opportunities. They regularly have voluntary, internship and trustee positions.

For volunteering opportunities specific to opticians, Vision Aid Overseas offers short and long-term placements for optical professionals. Over recent years, the charity has refocused to ensure that volunteers help people from the country they are visiting to develop optical skills that will remain in the country and ensure better eyecare for many years to come. You could find yourself supporting student eyecare workers, developing a Vision Centre where local people are trained to glaze and dispense spectacles, or assisting local eyecare providers to reach patients.

Vision Care for Homeless People offers optical care for homeless people at regular weekly clinics in London, Birmingham, Brighton and Manchester. It uses optical professionals and general volunteers to help supply eyecare and eyewear to this vulnerable sector of the population. It also links up with the Crisis at Christmas Clinic, which runs throughout Christmas.

Beyond committing your time, charities are always grateful for help with fundraising and spreading the word. Even if you only have a few minutes to spare, why not contact a charity that is relevant to you, to practice staff members or to the local area. Ask what you can do to help. It may be something as simple as having a poster for the charity’s events in your practice, putting a collection box by reception, or hosting a coffee morning. If everyone takes action in a small way, opticians can make even more of a contribution to improve society.
Case study: assigned with VAO

Julie Heaney is a dispensing optician at Framed Opticians in Manchester. She has taken part in three assignments with Vision Aid Overseas (VAO). She says: “I was studying for a customer service NVQ and had a placement at Specsavers, which started my interest in optics. That was 15 years ago, and almost every practice I have worked in since then has collected old specs for VAO. I signed up as a member of the charity and made a donation every year, but I hadn’t thought about getting more involved until I attended my first ABDO conference at Brighton in 2009.”

Julie spoke to members of the VAO team staffing their stand at the conference. The charity holds training days a couple of times a year for people who want to find out more about the work it does, and after hearing about them Julie booked her place. She recalls: “The training day was superb. It was very thorough. I learnt about previous assignments and I heard a lot more about what to expect on an assignment, and the kind of assignments there are.

“All the information put my mind at rest. I signed up and it didn’t take long before I was offered a project. I had basic lab experience as well as my dispensing skills so I was invited to be part of a team opening a brand new vision centre in Uganda. My role was to explain simple things like how to understand a prescription, how to choose and fit a frame, and go through simple customer service skills.”

Every team member contributes to the cost of the expedition. Julie explains: “I did all sorts of fundraising to fund the trip. I did a skydive, applied to ABDO for a bursary, I did a bingo evening, a charity boxercise class, all sorts. I was aiming to raise £1,500, and got to £3,500. Fundraising was easier than I thought when I got started. The extra funds I raised all went towards the same project.”

Julie spent two weeks in Uganda. She says: “I felt very well prepared by VAO. It wasn’t a huge shock when we got there, and the accommodation was comfortable. On a day-to-day basis it was harder work than my usual work in practice. Sometime we had to build the clinic before we could start. I was well supported though, as there is a team leader and deputy on every trip who has loads of experience.

“The highlights of my trip were meeting the people, and then seeing what we were leaving behind. When we arrived there was no-one in the town who made affordable glasses to order. Specs would be far out of the reach of people financially, and those that existed were poor quality. If a child was short sighted, they just wouldn’t be able to see at school. Now, they can get glasses and if they have to pay, it is affordable. Everyone in the town has access to eyewear and eye health checks from trained optometrists.”

Since then, Julie has completed two further assignments with visits to Zambia and Ethiopia as well. She says: “These were outreach projects, travelling to health clinics in rural areas, setting up and providing eye tests and glasses if needed. We would take optometry students from the town nearby, so once they were qualified they would know how to do a rural clinic, as well as gaining valuable practical experience.”

Julie has the following advice for anyone considering volunteering with VAO: “Go to a training day, hear about other people’s experiences and you can decide if it is for you. Since my assignments, I’ve been to training days to talk to people and answered questions. It’s a great place to start. There are lots of other things you can do to support VAO too.

“After my first assignment one of the programme directors, Alison Guthrie, encouraged me to stay involved and I have done talks to rotary clubs to raise donations. That really boosted my personal confidence as I never imagined myself standing up and doing a talk, but it was easier speaking about my own visit, and the work of the organisation I’m passionate about. You can fundraise for VAO in any way you see fit, and the VAO website has lots of ideas. An easy way to start is to become a member, and start a practice spectacle collection.”

Summing up, Julie says: “I get job satisfaction every day dispensing new specs, helping someone to see better and look great, but to be able to do that for someone who has been uncorrected all their life outweighs anything that I’ve ever done. Working with VAO, I’ve made friends for life and developed new confidence.”

Helping children to see clearly

- CharityJob www.charityjob.co.uk/Volunteer-Jobs
- Crisis, www.crisis.org.uk, has volunteering opportunities all year round as well as at Christmas
- Do-It www.do-it.org.uk
- ivo: ivo.org
- NCVO: www.ncvo.org.uk
- Vision Aid Overseas www.visionaidoverseas.org/volunteer
- Vision Care www.visioncarecharity.org
- Volunteer Centre Finder www.volunteering.org.uk


Successfully and professionally managing the patient handover can dramatically increase patient loyalty and improve bottom line profits, but how many practices really understand the power of the handover? There’s a direct correlation between conversion or capture rates and bottom line profits. Get the handover right and a mediocre practice can transform its prospects overnight. Get it wrong, or just ignore this stage in the patient journey and you’ll limit your prospects.

Qualified dispensing opticians are a vital part of practice life, however, their level of importance and influence is further enhanced when working in close harmony with the optometrist. Even when a prescription is stable (never use the term ‘no change’ as this suggests to the patient that they need not spend with you) there may well be opportunities for the patient to upgrade their spectacles or consider new lenses to accommodate their lifestyle needs.

The more an optometrist spends time educating, informing and recommending, the greater the conversion rate, which inexorably leads to an increase in bottom line profits. It’s not enough, however, for the optometrist just to make recommendations to the patient in the chair; these should be repeated when handing over to the dispensing optician thereby validating the work the DO has to do.

Managing the handover
Psychologically, the handover has more impact if this takes place in the consulting room rather than in the body of the practice; the question is how best can that be managed? The objective is to ensure that when the optometrist is concluding the clinical part of the process, having discussed perhaps lens options and the patient’s lifestyle dispensing needs, the dispensing optician miraculously appears for the handover.

In a busy practice there can be challenges in getting the timing right so the best system should be sought out, agreed and adhered to. Some practices use a discrete buzzer system, which the optometrist uses to alert the dispensing optician when the clinical session is coming to a conclusion in time for them to knock and enter the consulting room. But this method won’t work for everyone.

At the point where the DO joins the discussion, the verbal handover should be brief but succinct. The optometrist needs to explain to the DO that they have made dispensing recommendations to the patient and at this point turn to the patient and say of the DO, “Of course [X] is our expert in this area and I will leave it to him/her to ensure you are made aware of all the most appropriate options suitable for your needs”.

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Paul Surridge highlights the power of the optometrist to DO handover in building loyalty and custom.
In the patient’s mind, not unlike GPs, optometrists are seen as respected professionals and their advice is valued and respected. If the optometrist subsequently deports to the knowledge and expertise of the DO, this too can have a positive psychological effect on the patient, and quite rightly builds the professionalism and status of the DO as a clinical adviser rather than a person selling appliances. The outcome is that patients are far more likely to respect and follow the advice of the DO, which ultimately serves the patient well in terms of seeing well and as a result builds practice revenue.

Sending the value message
The next question of course is how do we get patients to understand value when the marketing message on the High Street is all about price? We often make the mistake of thinking that patients really do consider price to be the number one consideration when purchasing eyecare and eyewear – but is that really true?

Of course, for a percentage of the population, price will be the only determining factor but surprisingly we’re told they are in a minority. Most people want their appliances to allow them to see well (an obvious requirement!) and in terms of frames they want them to suit their look, feel comfortable, and importantly want to be treated well throughout the practice journey. Oh, and of course they want value for money. There are other considerations of course but these are the fundamentals.

So what’s value for money? It doesn’t mean they want to buy the cheapest. Value for money means different things to different people irrespective of how much they spend. This is a very important point. In simple terms, no one wants to be knowingly over-charged. Put crudely, if you said to a patient: “We always over-charge for the spectacles and lenses we recommend. Is that OK?” The likelihood is that 99.9 per cent of patients would say: “No that’s not OK!”

Value for money as we understand it is bound up in the individual perception of worth. The perception of worth takes account of a host of practical, logical and illogical judgements all bound up in one’s personal experience of life and circumstance. One person’s value placed on an item could be an outrageous cost to another.

The key is a better understanding of the mind-set of the purchaser and building value through service and communication. We cannot underestimate the power of building long-term trusted relationships with those we seek to serve. People will often not remember what you said to them six or 12 months ago; they’re unlikely to remember what you did for them, but they will remember how you made them feel.

Dispensing opticians have a big and important job to do. I say that because I think qualified DOs have not been fully recognised over the years, and I’m delighted ABDO is constantly crusading for greater recognition for its members and rightly so. As a businessman who has visited and consulted with more than 2,000 independent practices since joining Sight Care 17 years ago, I see how important the role of the DO is in everyday practice life, so much so, that I believe the success of a practice can often be attributed to the individual contribution they make.

As technology drives change, and consumer buying habits mirror those changes, we must constantly seek ways of delivering added value to eyecare delivery to ensure people want to come and see us long into the future. It might be cheaper and more convenient to buy online, and let’s be honest we all do it, but that online experience is devoid of human interaction – the key ingredient at the heart of humanity.

Paul Surridge is chief executive of Sight Care Group. To learn more about successful handovers or discuss any aspect of improving the patient journey email paulsurridge@sightcare.co.uk

Medal of Excellence for ABDO stalwart
Area 11 chairman and ABDO stalwart, Ian Anderson, was presented with the ABDO Medal of Excellence by ABDO president, Peter Black, at the Association’s board and trustees dinner on 8 October.

Having registered with the GOC in 1974, Ian has been an ABDO member since 1969. A regular contributor to Dispensing Optics, Ian has worked as a locum DO, a dispensing practice visitor since 2008 and a dispensing examiner, as well as helping out at the annual graduation and prize giving ceremony.

Commenting on his award, Ian said: “What I thought was going to be a usual meeting with the ABDO board of directors and trustees turned into a huge surprise when I was honoured with the ABDO Medal of Excellence. My long association with the London Area started when my then manager, John Baker, told me that if I wanted to get on in the company then I had best get interested in the ADO, as it was then. That was many years ago, in which time I have been a committee member, treasurer and now chair.

“In being on the committee has its challenges but the best bit of all is meeting members, new and old, as well as colleagues from other areas in optics; it is like one big family, all helping and supporting each other. I have also got involved with other activities within ABDO because I am passionate about dispensing optics and its future. Receiving this award is a huge honour,” Ian concluded.
The majority of people consider their sight to be the most important sense, and over the years there have continued to be major campaigns to encourage people to go for an eye examination for healthcare purposes and visual correction. Luckily, most people will leave their opticians with nothing more than a prescription for glasses or contact lenses. For some – and it’s not a small number – the outcome is much more serious.

Age-related macular degeneration (AMD), for example, is the biggest cause of sight loss in the UK affecting more than half a million people. The distress it causes can be astounding. Shock, disbelief, anger and even suicidal thoughts are all part of the emotional impact1. Being told that you are losing your sight is life-changing.

Whilst great progress is being made with treatments to slow the progression of AMD, what about prevention? Oxidation is considered to be a major contributor to eye disease, and a good diet has been shown to offer protection2. Most practices will recommend a healthy diet with specific nutrients being highlighted, but this is usually in the form of a leaflet. Compare this to the comprehensive advice that is given out to patients suffering with dry eyes, which also has dietary implications, and you’ll see that a leaflet is woefully inadequate.

What causes AMD?
Whilst the exact causes of AMD are not fully understood, it is clear that oxidative damage is a major contributor2. Oxidation is a process that happens when oxygen interacts with chemical compounds of any type – such as an apple turning brown when exposed to air. Our bodies metabolise oxygen very efficiently, but a very small percentage of molecules turn into free radicals as they lose a critical electron, which causes damage throughout the system.

We have our own in-built antioxidant defence system and we can also receive antioxidants from our diet. When the defence system is working correctly in removing these free radicals, we have a healthy system. Certain external toxins from pollution and lifestyle choices, such as smoking, cause excessive free radical formation and tax our defences further. Not only that but as we age, our defence system weakens – just as everything from our muscles to our bone density do – and we may then require more dietary antioxidants to stay healthy.

The use of supplements for eye health is not new. There are many products that are available, which have specific antioxidant combinations to help with AMD. Studies show their efficacy at reducing the amount of visual loss with patients already suffering from the disease3. Unfortunately, these products are usually only recommended to patients who already have visual loss, and their use as a preventative is diminished.

Prevention: better than cure
With current treatments like anti-VEGF injections, the progression can be slowed. But multiple injections are needed every year, which is not only costly for our healthcare system, but time consuming for the patient. Some epidemiological studies show that diets high in antioxidants – specifically polyphenols – can protect against AMD and other retinal conditions like proliferative vitreoretinopathy (PVR)4.

Polyphenols are chemicals found in certain food and drinks such as tea, coffee, fruits, vegetables and nuts. They act as antioxidants and often have strong anti-inflammatory effects. It is thought that polyphenols help reduce the oxidative stress at the retinal pigment epithelium (RPE) – the cell layer responsible for providing structural and nutritional support to keep the retina healthy. The polyphenols in grapes, for example,
have been shown in some studies to reduce diabetic retinopathy due to their anti-inflammatory effects, along with their antioxidant protection, making them useful for many pathological conditions5.

Sources of polyphenols
Polyphenols are present in certain foods and drinks. They can also be obtained through supplementation, although risks have been associated with supplementing certain antioxidants like vitamin E and beta carotene, which may make dietary intervention the safer option. Anyone looking to increase their intake through supplementation should seek advice from a healthcare professional proficient in nutrition.

Increasing the consumption of foods and drinks containing these polyphenols is not only safer but also gives the insurance of a wide-range of antioxidants for overall protection. Some of the best sources include:

- Dark chocolate
- Red wine
- Fruit especially berries
- Vegetables especially kale and spinach
- Nuts
- Seeds
- Tea especially green tea
- Spices especially garlic and turmeric
- Coffee

Most would expect green tea and kale to be good sources, but some of the foods that are highest in antioxidant polyphenols are often considered as treats – red wine (in moderation) and dark chocolate especially5. Increasing the intake of these should not be a hard sell. If a patient centred approach was adopted – where the patient takes part responsibility for their own care – then the use of good nutrition could be implemented. Although the specific advice would be aimed at reducing the risks of ocular pathology, the patient may reduce their chances of other diseases in the process.

Implementing change
With all the research supporting the protective effects of dietary antioxidants, it is surprising that we do not do more training in the field of nutrition as dispensing opticians and optometrists. If we were more knowledgeable, it would be possible to give sound advice to patients on ways to protect their eyes. This could be especially important for patients with a family history or early signs of disease. Advice from an optometrist in the consulting room – much like the comprehensive dry eye advice – would certainly have more weight than a simple and impersonal, mass produced leaflet. Mentioning dark chocolate and red wine would be an easy way to get the patient’s attention!

If we can prevent, or at the very least delay, macular degeneration then we would prevent so much suffering for our patients. The impact that loss of vision has to the individual and their family is nothing short of disastrous. Anyone who has worked in a macular clinic will appreciate this fact – so even making a one per cent difference would be a worthwhile effort.

References

Iain Johnson BSc (Hons) FBDO has qualifications in both nutrition and dispensing optics. He has worked in practices throughout the North West for 13 years and provides nutritional and lifestyle consultations as well as writing for various publications. ■

Red wine and dark chocolate are good sources of polyphenols
Delegates at NOC 2014 were urged to harness the skills of their dispensing colleagues, reports Chris McGachy

DOs must have ‘frontline role’

Dispensing opticians have the skills, relationships, enthusiasm and dedication needed to help transform the NHS through a more preventative approach to healthcare delivery, NHS chiefs were told at the 2014 National Optical Conference (NOC), held at the Hilton Birmingham Metropole on 23 and 24 October. Delegates at this year’s event, organised by the Association of Optometrists (AOP) on behalf of LOCSU and the Optical Confederation, included a growing number of DOs involved in LOCs.

Profession “vastly underutilised”

During the conference, the message was made clear that DOs have the clinical knowledge, relationship-building opportunities and specialised experience of low vision and paediatric screening to make them key players in the health reforms outlined in Simon Stevens’ Five Year Forward View, launched the same day as the NOC. “DOs have pathology as a core competency, are the first and last contact with the patient in the practice and are trained to give eye health advice,” Elaine Grisdale, ABDO head of professional services and international development, told an expert panel of ‘enablers’ discussing the Call to Action.

“I firmly believe that the skills of DOs are a vastly underutilised asset and their ability to contribute with advice is underestimated,” Elaine said as part of a heavyweight panel including representatives from commissioning, ophthalmology and optometry discussing workforce as a key driver of reform in the forthcoming primary health strategy. “DOs don’t seem to be on anybody’s radar – yet they could be key actors in the holistic approach,” she added.

Keynote speaker Taryn Harding, strategy lead for NHS England, had earlier told delegates that the NHS was primed for radical transformation and High Street optical practices were well placed to deliver a primary care-led health transformation. LOCSU managing director, Katrina Venerus, agreed on the need to value the skills of all professionals in the practice to help deliver the new vision of out-of-hospital care. “Optical practices, along with pharmacies and dentists, have the clinical skills, the equipment, the High Street presence and, most importantly, the willingness to provide high quality care in the local community where patients want it delivered and, as such, are well placed to support GP surgeries,” Katrina said.

Continuity of care highlighted

The enablers panel agreed that the skills and training of all optical staff would be needed to drive the reforms. Alongside Elaine on the panel were Dr Graham Mennie, commissioning lead at Gloucestershire CCG, David Parkins, president of the College of Optometrists and chair of the London Local Eye Health Network, Richard Smith, consultant ophthalmologist and clinical lead for informatics (Buckinghamshire Healthcare NHS Trust), and Trevor Warburton, chair of LOCSU’s Clinical Advisory Group, along with discussion chair, Katrina Venerus.

Elaine told the audience that DOs were interested in developing a wider involvement with public health
What DO delegates thought...

Dave Stevens, Walsall LOC chair

“My overall impression of the NOC was that optics has got itself fairly well organised and is being led by people who are knowledgeable, organised and capable. There is an awful lot of change happening, which opens up unique opportunities to affect change for the better of patients and practices.

“At present I am leading on procuring community services. We have helped put together specifications for repeat IOP, pre and post cataract and a Pears scheme, and I have to thank colleagues from other areas who help with advice and examples from schemes already up and running. The NOC conference showed me there is a wealth of talent that I am able to draw upon, and helped me appreciate how much I still have to do and learn.

“Following the theme of changes within the NHS the conference has made me appreciate that we cannot sit in isolation and hope for things to be okay. As a profession, we have to go and contact other providers, health groups and commissioners, so that optical practices are seen as the first port of call for any eye problems and not just as retailers of spectacles. These changes will only happen if eye health professionals interact at a local level to affect change.

“The conference set out the principles for change but they have to be worked on at a local level to have a real chance of making a difference. I came away thinking that change was possible and now is the time to act. Having talked to many at the conference, it has made me realise that the members of LOCSU represent a vast library of knowledge that they are happy to share.”

Penny Heath, communications and engagement lead and treasurer, Oxfordshire LOC

“Some years ago, as a dispensing optician I was rather surprised to receive an email from ABDO requesting DOs to participate in their LOC. I have always had an interest in the changing role of optics and this seemed like a perfect opportunity to be at the forefront of those changes. I already knew most of the committee so it wasn’t too difficult fitting in and very soon I found myself being dispatched to my first NOC event as both the chair and treasurer were unable to attend.

“My aim on that occasion was to take copious notes and report back to the committee. It turned out to be an eventful NOC with the development of LOCSU urging optometrists and opticians to get together and prepare the path for enhanced services commissioning. The challenge began. I have recently been promoted to the joint role of communications and engagement lead and treasurer. My interest in attending the recent NOC was to better understand what the roles entail, expand my contacts, interact with people in similar roles on other LOCs and find out how things are done across the country, to prepare with an open mind for the tasks ahead.

“The first speaker who attracted my attention was Sarah Wrixon, director of Salix & Co., who gave a very informative talk on communications issues looked at by Pharmacy Voice. The Call to Action has been a very inspiring move towards integration of services to make best use of the skills within the network and therefore improve the care we can offer to those requiring it. Taryn Harding from NHS England spoke of the responses currently being analysed to develop action plans within the NHS. Dr Graham Mennie gave an inspiring talk on his work helping to promote early detection of eye disease, working together with integrated services in the area to give greater patient choice and satisfaction.

“Some of the statistics on obesity, especially in children leading to a huge rise in Type 2 diabetes were very disconcerting. We learned how the NHS works within dentistry from John Milne. Getting these groups together was very revealing and I believe extremely helpful to working together towards the necessary changes within the services provided. The Local Eye Health Networks Call to Action results are currently being analysed to enable us to make an impact beyond optics, especially in reaching out to hard to reach groups of people with learning difficulties, people with dementia and children’s eyecare. Parallel sessions ran throughout the conference allowing for smaller discussion groups to get together.

“As a long serving dispensing optician over the years I have seen many changes in optics, however, I feel the current changes are perhaps the most important to the future of optics in the community. If you feel as a dispensing optician you would like to get involved, I urge you to contact your LOC and be a part of influencing the future.”

Julien Nelson, clinical governance lead, Norfolk and Waveney LOC

“I attended the NOC in my role as clinical governance lead. The Call to Action theme was very timely as the presentations were able to discuss some of the early findings from the sector responses. This flowed neatly to a further session, which was a debate on the enablers between representatives of different bodies and perspectives. A big ‘well done’ to Elaine Grisdale for the backing she gave by explaining the wide range of roles that can be played by the dispensing optician.

“I attended with a view to learning more about my new role. Whilst the presentations were packed full of information, I would have enjoyed more detailed discussion looking at existing services rather than pitching it for LOCs, which are just starting out with new services. The NOC has an important part to play in bringing together LOC Company roles once a year to trade ideas and methods. The lectures were always conscious of time and I would have preferred the sessions to have been longer.

“Within the LOC, there are many tasks available to the qualified dispensing optician, with the help of LOCSU and ABDO, if you are willing to put the time in. After all, remember that ‘LOC’ stands for local optical committee, which includes both opticians and optometrists.”
outcomes and that they could specifically help in the treatment of low vision and in children’s screening. “ABDO members are qualified and comfortable with the management of low vision in practice,” she said. “Some even go on to specialise to be key players in the holistic approach we heard about. When we talk about low vision we think about elderly and vulnerable people. It’s a shame they have to go into a hospital setting when they can be seen in the High Street practice.

“Continuity is also important for those vulnerable people. They don’t often see the same person in the hospital setting whereas creating a relationship with the patient is key in community practice and it enables us to provide a better quality service for the patient in addition to achieving patient compliance,” Elaine added. Two other areas where Elaine said DOs could be useful were paediatrics and public health. “John Milne was talking about dental care for the young this morning,” she continued. “It is vitally important to get children into optical practices before seven to start them off on a healthy journey.

“As well as being skilled in paediatric dispensing and dealing with children’s eye problems, many DOs are interested and engaged in the concept of healthy sight and signed up for Darren Shickle’s public health course last year. With appropriate training and accreditation, I think DOs should be frontline actors in screening children to make sure they don’t slip through the net where they may be disadvantaged later.”

Elaine reminded delegates that half the contact lenses in the UK were fitted by CLOs who were skilled at using slit lamps and detecting anterior eye anomalies. “So that is another part of the DO family you can be using,” she said. “Don’t overlook the skills, enthusiasm and geographical coverage of dispensing colleagues,” Elaine told the NOC.

Speaking to Dispensing Optics after the NOC, Katrina Venerus said: “Radical change is definitely in the air and we need all the skills, enthusiasm and dedication of the whole sector if optical practices and LOCs are to play a central role in the NHS of the future. I would urge DOs to develop their professional skills outlined by Elaine, join the LOC and play their part in helping grasp the opportunities that the NHS reforms offer us.”

Chris McGachy is communications manager for LOCSU.

Proud moment for award winners

Lesley Oglethorpe took home the title of Dispensing Optician of the Year at this year’s AOP Awards, held during a black tie dinner at the Hilton Birmingham Metropole on 23 October, and hosted by broadcaster and columnist, Julia Hartley-Brewer.

Sponsored by ABDO, the award recognises a dispensing optician who is dedicated to keeping informed of new innovations in frames and lenses and a leader within the practice, supporting colleagues and promoting eye health. Lesley entered the profession in 1985 as a receptionist before qualifying in 1990 as a dispensing optician. She has since served as a LOCSU facilitator and ABDO examiner, and today works as a dispensing optician at GT Harvey & Partners in Newcastle.

Lesley told Dispensing Optics: “The award was a great honour and I am humbled but extremely proud. I am lucky to work with a fantastic team at GT Harvey & Partners and we all support each other. Working closely with suppliers gives a vast pool of knowledge and expertise to call upon when challenges come along and I am grateful to Lumley Optical, Hoya and Nikon for their constant support.

“Dispensing optics has given me a diverse and rewarding career but I am particularly proud of being an examiner for ABDO and working with a great team of people. Dispensing opticians are a hugely underutilised resource and I will continue to promote our expertise and skills to ensure we are involved in the future of optics,” Lesley added.

There was another accolade within the profession when Spescavers CLO, Suzanne Czerwinskiwas, was named Contact Lens Practitioner of the Year. Sponsored by CooperVision, this award recognises an individual who actively promotes contact lens wear within the practice and beyond – particularly focusing on groups such as teenagers and the elderly.

Having begun her optical career as a part-time optical assistant at a Spescavers branch in Plymouth, a job she took while studying psychology at university, Suzanne is now the only CLO in a team of 80 at the Nottingham Spescavers practice. Commenting on her award, she said: “Being recognised for such a prestigious award is, without doubt, the highlight of my career to date and I would like to thank everyone who voted for me.”

During the awards ceremony, Donald Cameron received a Special Lifetime Award, while the late Keith Holland was honoured with a Special Recognition Award. To see all the award winners, visit www.optometry.co.uk.
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Always closer
Nicky Collinson talks to Optical Confederation chairman, Chris Hunt, about the recent NHS England Call to Action and opportunities for DOs

**Revolutionary times ahead**

**NC:** Why is the Call to Action so significant for the sector?

**CH:** The Call to Action (CTA), and the eye healthcare professions’ response to it, is incredibly significant because it is the first time that the sector has been invited to have a say about how primary healthcare services are delivered. It is revolutionary but also a major challenge because it requires an entirely new way of thinking where everyone involved is working together in a joined up way. This, of course, calls for old prejudices to be put aside so we can capture this wonderful opportunity.

The Optical Confederation [OC] has done a fantastic job in putting eyecare on the government's healthcare agenda, as until now all the focus has been on general medical services, then dentistry then pharmacy. It will be an acid test for the sector in how we pick up the challenges and address them – as everyone in the NHS is watching. It is our one chance to significantly change the face of optics for the better.

**NC:** How will proposed changes impact on everyday eyecare practitioners?

**CH:** The results of the CTA, along with the findings from the CTAs for general practice, pharmacy and dentistry that took place over the past year, will be used by NHS England to help it shape its primary care commissioning strategy, which is expected to be published by the end of the year. We expect there will be a brand new model for primary care and this will impact on everyone in optics. Practitioners must ensure they have the right training and skills set to expand their roles. It is also likely that quality of service provision will be constantly monitored.

**NC:** What challenges will there be alongside opportunities?

**CH:** Optics has a wonderful opportunity to work together as a single service of providers, whilst being mindful of what NHS England may want to achieve nationally. Local relationships between contractors and suppliers will be more complex – but the ‘NHS family’ is about people relationships and if anyone is good at the people approach then it’s the optics sector. But we also have to recognise that we are working within a framework that is strapped for cash. So we need to demonstrate that using our skills sets can provide better quality of care for patients whilst being more cost-effective for the NHS.

The money is there in the secondary care sector and it will find its way to those practices that can demonstrate increased productivity. There are, of course, the cost implications of further training, especially for DOs, but hopefully, the debate on funding will widen in the future and lead to a more positive outcome. We must also be mindful that technological advances already are, and will, continue to provide increased opportunities for improving efficiencies and lowering costs.

**NC:** What will be the benefits to patients of improved/changed eyecare pathways?

**CH:** The potential impact on the patient is obvious: they will receive better, more timely care with eyecare practitioners better placed to pick up conditions at an earlier stage before they become a major problem. Detection and monitoring throughout the healthcare journey is required so that the patient has consistency of care.

**NC:** What part does the DO have to play in this new landscape?

**CH:** Dispensing opticians need to recognise that they are part of a community of 19,000 eyecare practitioners carrying out 13 million sight tests per year, and work to find a place within this structure. DOs have got to stop being apologetic for their position in optics, be proud of their skills and work with optometrist colleagues to fully exploit these new opportunities. Some in the sector feel there is a question mark over whether all registered practitioners will want to get
on board with the changes, but I genuinely believe the current enthusiasm far outweighs any apathy.

NC: What next for the OC and in your role as chair?

CH: Much of our feedback to the CTA has been incorporated into the Clinical Council for Eye Health Commissioning response. The CTA will change the landscape of optics, and part of the process is surely going to be a closer look, by those commissioning, at better matching skill set to requirement. I see real opportunity for the sector if we can be genuinely and effectively unified and ultra progressive in our thinking.

We also need to do a better job of promoting ourselves. This has always been our weakness, so we really need to look at ourselves and ask: do we need to change? The key is to work together. The OC needs to be brave and discuss the sensitive issues of the day and demonstrate what its remit is for the future. As chair I will be striving to keep the energy going and ensure the desire to communicate is alive and progressive. As the ‘Y generation’ grows to become the voice of the sector, root and branch, I would urge them to be asking not “Why can’t we?” but “Why don’t we?”

Interview

With a general election fast approaching in May 2015, the Optical Confederation (OC) reports that it is continuing to make groundwork with key national and local decision makers in order to ensure that the optical professions and the sector are heard and well understood by policy makers. This follows a productive year for the OC public affairs team, during which they continued to engage with parliamentarians, general election candidates, councillors and other primary care organisations informing them about the expanding role of optometrists and dispensing opticians in the community delivering high quality eyecare.

OC makes its voice heard nationally

‘Deal-of-the-day’ website, Groupon, recently withdrew an offer for £4.99 ‘Eye Spy Coloured Contact Lenses’ after being contacted by ABDO president, Peter Black.

Peter contacted the company after seeing an advertisement for the lenses, citing the proposed sale as illegal in the UK as it contravened the Opticians Act 1989 (as amended 2005) and the associated Rules of Council. He requested that the company cease and desist making the offer, or any other contact lens offer not involving a consumer having a valid specification/prescription issued by a registered contact lens practitioner.

Peter also requested that Groupon cancel and refund any outstanding orders as yet unfulfilled, adding that ABDO would “do all in its power to assist the General Optical Council in any prosecution to prevent illegal supply of contact lenses via Groupon in the future”. Groupon subsequently removed the deal from its website and agreed not re-run it, thanking Peter for bringing the matter to its attention.

Peter told Dispensing Optics: “I am obviously very pleased that Groupon has withdrawn its offer on coloured contact lenses and undertaken not to promote contact lenses without a valid specification in the future. I have successfully achieved similar undertakings from other retailers in the past and, in the main, have discovered that they are simply unaware of the law on supply of contact lenses and as soon as they are made aware of the Rules most companies seek to comply.

“Of greater concern remain those online retailers that continue to knowingly break the law by supplying contact lenses without a valid prescription, and without checking whether the lenses are for use by a child or person who is registered as visually impaired. Additionally there are many examples of illegal supply of spectacles via online and High Street retailers that we aim to tackle going forwards,” Peter added.

ABDO president alerts Groupon to illegal contact lens offer

OC deputy head of public affairs, Ben Cook, with Lord Hunt, Shadow Lords Health Spokesperson, at the Labour Party Conference

With a general election fast approaching in May 2015, the Optical Confederation (OC) reports that it is continuing to make groundwork with key national and local decision makers in order to ensure that the optical professions and the sector are heard and well understood by policy makers.

This follows a productive year for the OC public affairs team, during which they continued to engage with parliamentarians, general election candidates, councillors and other primary care organisations informing them about the expanding role of optometrists and dispensing opticians in the community delivering high quality eyecare.
Area meeting will be on 25 February.

Area 12 (Scotland): Interaction and special offers
Report by Fiona Anderson, chairman
Area 12 was involved within SCLOSS (Scottish Contact Lens & Ocular Surface Society) last month when it hosted its inaugural annual conference at the five-star Radisson Blu Hotel in Glasgow City Centre on Sunday 23 November. The event provided 15 interactive points over a range of competencies for IP, OO and CLOs by the combination of three lectures, four hands-on workshops, a discussion workshop and dedicated peer review session per track.

On Sunday 18 January at the Hilton Hotel, Glasgow, there will be two ABO lectures within the Eyecare by Perceptive conference that are free for all Area 12 members to attend. There will also be special offers for Area 12 members from Perceptive to be confirmed.

Area 5 (Midlands): 2015 plans afoot
Report by Ian Hardwick, vice chairman
Area 5 is pleased to report that we are currently in the process of putting together the programme of speakers for our next CET day taking place on Monday 2 March at the Riverside Centre, Derby.

Area 5 (North East and Isle of Man): The big chill
Report by Lorraine Wallbank, vice chairman
On 5 October, Area 3 hosted a full CET day event at the indoor skiing and snowboarding venue, the Chill Factore in Manchester. As an Area we enjoy trying to find unusual or different venues to add that extra quirkiness. Registration was at 8.30am to allow delegates to enjoy a hot drink while embracing the exciting and chilly atmosphere of the venue.

The day was filled by interesting yet informative discussion workshops by Ted Moffatt, Stephen Golding, Joanne Abbott and Lyndon Taylor. We would like to thank all of our sponsors – OWP, Menrad, Eyewear Company, Continental Eyewear, William Morris London, Eyespace and Safilo, without whom these events wouldn’t be such a success. The feedback from this event has been very positive and we will be informing you very soon about next year’s plans.

Eye defining lenses
Johnson & Johnson Vision Care has launched its “iris inspired design” contact lenses, 1-Day Acuvue Define, said to offer all the benefits of 1-day Acuvue Moist whilst giving “greater depth, dimension and brightness to the eyes”.

The lenses are available in Natural Sparkle or Natural Shimmer, which work using translucency and opacity to create blending, definition and contrast, accentuating the original iris patterns and enhancing contrast between the limbal ring and the sclera. The design also uses the company’s patented Beauty Wrapped in Comfort, eliminating contact between the pigment and ocular surface. Contact your Acuvue account manager for POS and free trial kits.
Black arts

In recent weeks at a variety of events, I have had the opportunity to compare notes with opticians and optometrists from several dozen countries around the world at the European Council of Optometry and Optics, the International Opticians Association, and the UK Four Nations meeting. It seems everywhere, in the developed world at least, eye healthcare faces the same challenges, yet England, in my opinion, seems to have somehow developed the worst of all worlds: a system that neglects patients, fails to reward eyecare practitioners and creates perverse financial incentives within secondary care to ensure progress cannot be made.

NHS GOS in England: a danger to public health?

The rest of the UK has moved on to a greater or lesser extent, but in England we have a 1950s system of General Ophthalmic Services (GOS) struggling to cope with 21st century eyecare needs. It also fails to recognise that optometry has progressed enormously over the years, with much improved standards of examination, equipment and record keeping. Despite several tests being done by support staff in a pre-screening environment, eye examinations now take 25 to 30 minutes compared to 10 to 20 minutes 25 years ago. This typical 30 per cent loss in capacity per optometrist day has been accompanied by simultaneous increases in the cost of equipment, space and pre-screening staff. The cost of delivering a sight test, relative to the price practices are forced to take from the NHS, has approximately doubled over that time.

The sector has done its duty, screening patients regularly for eye disease, to the extent that many patients attend more regularly for routine eye health checks dutifully responding immediately to their reminder rather than waiting until their vision has deteriorated (perhaps irreversibly). And here lies the rub: the ‘conversion rate’ has declined from around 80 per cent 25 years ago to less than 60 per cent today.

Until fairly recently, the cross-subsidy of NHS eyecare patients by private vision correction purchases is now reaching crisis point, as most opticians not only lose money on every NHS sight test, they lose their most lucrative patients to refractive surgery and the internet. The cross-subsidy of NHS patients by private eyewear purchases is now unsustainable.

Research by the Ophthalmic Public Health unit at Leeds has already shown that in areas where lucrative private patients are in short supply, namely the most deprived areas, optometric practices, if they ever existed, have simply disappeared. If we are to tackle preventable sight loss as a country, at-risk patients must be screened at appropriate intervals. Community optometric practices are the obvious candidates to carry out this role, but it must be economically viable for them to do so in deprived areas and elsewhere if they are to actively engage patients who do not purchase prescription eyewear.

Increased involvement of community practices is vital because hospital based secondary eyecare is now at breaking point. The ageing population, with the baby-boomers just round the corner, means demand for services such as cataract surgery, glaucoma treatment and the management of diabetic eye disease, is steadily rising. This is nothing compared to the demand for new treatments for macular disease which is about to increase by as much as 70 or 80 per cent.

The last thing hospital eye departments need is unnecessary referrals from ‘better safe than sorry’ optometrists who only refer because their practices can’t get paid for follow-up appointments or to manage eye conditions in-house.
Is there a better way?

GOS in Scotland rewards contractors adequately so that they can afford to provide eyecare to all patients whether they wear spectacles or not, and allows repeat procedures and follow-up visits within the GOS contract. Innovative shared care and enhanced services initiatives relieve pressure on secondary eyecare by improving referral quality and dealing with many conditions in the community at a much lower cost to the NHS and at much greater convenience to the patient.

In Aberdeenshire, routine eye emergencies are successfully directed to their optometrist not the A&E unit. In Fife, emailing photographs to a consultant ophthalmologist for determination before referral resulted in an audited 37 per cent drop in hospital appointments. In South Glasgow, the introduction of Level 2 optometry, with independent prescribing, came to fruition in 2014 with the first practitioners receiving their NHS prescription pads, and will enable an estimated 70 per cent of eye problems to be managed in primary care.

In England, the community opticians practices who contract to the NHS to provide GOS receive £21.10 for each eye examination their performers carry out. Not only is this fee uneconomic, there is also no incentive for optometrists to conduct follow-up appointments if they feel it is necessary because usually there is no fee available for doing so. Hence, children requiring cycloplegia, adults who are borderline glaucoma suspects, and many other groups of patients whose conditions require follow-up or longer term monitoring, are routinely, and often unnecessarily, referred.

Intuitively, one might suppose that offering optometric practices fees for repeat eye examinations to allow follow-up in the community would be a good thing. Certainly it would reduce the burden on secondary care and the cost of marginal referrals that subsequently turn out to be unnecessary. Of course, in most cases it would also be more convenient to the patients and cost-effective to the NHS. But what of the practice concerned?

Recently a business savvy optometrist, a director of a multimillion pound English practice that had wholeheartedly embraced the new enhanced services in his area, reported that in the preceding 12 months these services contributed £250,000 to practice turnover. But they added £300,000 in practice costs. Why would anybody want to be a part of that?

So, at current rates of remuneration, community NHS optical contractors are unlikely to wish to take on any new patient, or monitor any existing patient who does not require optical correction and at least give them a chance of the sale of an optical appliance. As a consequence, optometrists are likely in many areas to continue to make expensive and unnecessary referrals into secondary care because they feel it is better to play safe than be sorry but are not prepared to take on patients for repeat care or monitoring if it is uneconomic to do so.

The model in Scotland shows that an integrated eyecare system not only rewards optometric practices adequately, it also relieves pressure on secondary eyecare services and saves the NHS millions of pounds by dealing with many conditions in the community at a lower cost to the NHS and much greater convenience to patients.

So is GOS in England a danger to ophthalmic public health? Well, close to a million people living with sight loss that could have been prevented is hardly a ringing endorsement of our current eyecare system, and the under-funding of GOS is certainly part of the problem. A new GOS, akin to Scotland, that substantially eliminates cross-subsidy from product sales could well be the solution.

Furthermore, it could also be improved upon. The inclusion of DOs and CLOs in some schemes including smoking cessation referral, minor eye injuries, special school services and low vision are very welcome indeed and it is hoped can be extended across the UK. National commissioning of standardised enhanced services and shared care initiatives at nationally agreed rates would make sense. Not only would it save local optical committees and commissioners wasting time and money re-inventing the wheel 210 times across England, it would more importantly remove the postcode lottery of locally commissioned services.

A nationally commissioned enhanced GOS would make sense for patients, for practitioners, for contractors and for the NHS. A little extra investment in community opticians could pay large dividends going forward in terms of reduced visual impairment and downstream savings in social care, falls prevention and improved mental health. This seems to me to be common sense, but it seems common sense has no place in the NHS.

Peter Black

* Please turn to page 42 for a clarification from Peter Black regarding comments he made in his October column, under the heading ‘Graduates in demand’.

Optician Index - September 2013 summary

- Total practice turnover is three per cent lower than last month at 164 Index points and third quarter results are one per cent lower than the same quarter in 2013
- Total number of eye examinations is two per cent lower than September 2013 at 96 Index points and third quarter results are also one per cent lower than the same quarter in 2013
- Turnover per eye examination is £8 higher than last September at £181
- New contact lens fits shows one per cent improvement for the third quarter of 2014 over the same quarter last year
- Through the course of 2014 both the percentages of lenses treated with anti-reflective coatings and photochromic lenses have increased compared with 2013

The full August 2014 Optician Index was published in the 31 October issue of Optician
New Year makeover for Dispensing Optics

January 2015 will see the launch of a newly redesigned Dispensing Optics, with glossy laminate covers, a more modern and reader-friendly format and a more strategic approach to providing ABDO members with the latest news, information, CET and features relevant to everyday dispensing practice.

“Having continued with the same format for a number of years, we felt it was time to move the journal forwards with a fresh, dynamic design coupled with more relevant and targeted editorial content,” said Michael Potter, ABDU head of marketing and communications. “Come January 2015, the all-new Dispensing Optics will be a more attractive, vibrant, contemporary journal that, we believe, will create greater affinity with ABDO members and the wider optical profession.”

As always, send your feature proposals, letters and comments to managing editor, Nicky Collinson, at ncollinson@abdo.uk.com.

Thomas the Tank brings Christmas cheer

Oliver Sansum of Olivers Opticians has decided to train his staff in more ways than one this Christmas, by suspending a floor from his practice ceiling and placing a train track with Thomas the Tank Engine and a carriage full of presents on it.

The track covers the lower reception area and can be viewed from the designer frame gallery upstairs, as well as from the practice front windows. “Thomas the Tank Engine says he is very pleased to have the opportunity to check his susceptibility to vertigo ready for his trip to help Santa up the snowy mountains in Lapland,” joked Oliver. “He will obviously check his eyesight before leaving.”

Oliver, who will be 60 in January, has four-year-old and 10-week-old grandsons, who inspired his jolly festive venture. “My four-year-old grandson helped me test the train on his birthday in November ready for all the children in Chalfont St Peter to enjoy seeing the train running on their way past the practice to and from school. Of course, the practice will be able to run on time as usual as the display is not in the way,” added Oliver. “So long as no leaves blow in and onto the track….”

Journal readership prizes

Congratulations to Louise Stainer and Dave Wright, who were presented with this year’s Dispensing Optics readership prizes at last month’s President’s Consultation Day held at Aston University in Nottingham. Louise received the Dispensing Optics readership prize for ‘Best CET article’ for her two-part article on ‘Refractive surgery options’ published in March 2013. Dave Wright received the Dispensing Optics prize for the ‘Best contribution from an ABDO member’. Dave said: “It was a lovely surprise to hear I had won the award, and to have my musings recognised by my peers at ABDO – a real honour.”

Retention fees to rise by £20

The General Optical Council (GOC) has set its registration fee for 2015/16 at £310. This is an increase of £20 for optometrists, dispensing opticians and bodies corporate. The low income fee, for registrants earning under £12,000, will be £210 (maintaining the £100 discount) and the fee for students will be frozen at £25.

Gareth Hadley, GOC chair, said: “This year’s increase is partly down to inflation but it also reflects the work we are doing to protect the public and be fair to registrants. In common with most of the other healthcare professional regulators, we have again seen a significant increase in the number of FTP complaints we receive. It is absolutely imperative that this increase does not stand in the way of our continued efforts to speed up the FTP process, in the interests of patients and registrants alike.

Gareth added that the Council would be conducting more research into the views of registrants and of patients, be investing in its IT infrastructure and moving to a new, more modern office. “We hope too that whoever forms the next government after the general election passes the Law Commissions’ draft Bill on the future of healthcare regulation,” he added.
The first collection of Barbour International ophthalmic and sunwear, the original authentic motorcycle brand, is now available from Norville.

Optical workforce project initiated

ABDO is taking part in a joint project with other stakeholders from the optical sector to gain a clearer picture of the optical workforce.

Led by the College of Optometrists, the Optical Workforce Survey was launched last month and runs to January to gather quantitative data from a randomised sample of 4,000 optometrists and dispensing opticians. It will also include interviews with a wide range of professionals and stakeholders and explore what data already exists, to develop “a clear picture of the issues shaping the profession”.

The findings will be disseminated in spring 2015, and will include information about the specific workforces in England, Scotland, Wales and Northern Ireland. Further information is available at www.college-optometrists.org/research.

Ebola advice given

The College of Optometrists and Association of Optometrists have issued advice for eyecare practitioners on Ebola virus disease, which can be viewed in chapter A3 of the College’s Code of Ethics and Guidelines for Professional Conduct at www.college-optometrists.org.

DO comes full circle for new sales role

It’s full circle for dispensing optician Julian Boysen as he joins Stepper as part of its nationwide sales team to work with accounts in Yorkshire and North East England.

Julian has more than 20 years’ experience in optics. His formative ‘optical’ years were spent in branch management in the Blackpool area, before relocating to Yorkshire and subsequently working in the lens sector. After a spell back in branch, he decided his real passion was in providing “superb support services” to customers.

“This is an exciting opportunity for me,” said Julian. “I have watched the development of Stepper over recent years and feel I can offer a valuable contribution to this dynamic company.” Stepper MD, Richard Crook, added: “Julian is a most valuable addition to the Stepper team. He is well respected in the industry, and understands the Stepper business philosophy.”

Beat the winter steam-up woes

Rodenstock is running a half price promotion until the end of the year on its FogFree display, which contains 10 boxes with three cloths in each box.

Rodenstock FogFree is said to provide an anti-fog effect for the company’s premium coating, Solitaire Protect Plus, but is also suitable for other lens types. Each cloth comes in a re-sealable envelope, and can be used 20 times.

Opticians can order a Rodenstock FogFree display, single boxes containing three cloths or single cloths with a lens order of Solitaire Protect Plus coated lenses via WinFit Reference. There is also a FogFree Demonstrator, and a humidifier to demonstrate the fog-free effect in the practice.

Biker chic eye styles

The first collection of Barbour International ophthalmic and sunwear, the original authentic motorcycle brand, is now available from Norville.

The new range of men’s and women’s eyewear follows the trends of the Café Biker scene of the 1950s and 60s, highlighting strong masculine shapes in dark tones and contrast ladies’ models in small cute cats eyes. The company said the collection would complement the fast-growing range of international biker-inspired clothing sold in independent stand-alone stores, as well as most leading department and fashion retailers.

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All roads lead to Munich

More than 23,000 trade visitors from Germany and abroad are expected to attend Opti 2015, to be held in Munich from 7-11 January.

Some 500 companies, including new exhibitors RVS, Victoria Beckham, Aprospectacles, Marni and Prolens, are promising a host of product premieres. Frame companies will be showcasing their new styles in what the organisers promise will be a “spectacular new way”.

This new design will feature floating presentation levels made of glass to present frame designs made from acetate, wood and titanium. The optiBar and lounge area will encourage visitors to relax and enjoy this new production of the “Stars of the industry”. Find out more and register at www.opti.de.

Independent practitioners ‘stayin’ alive’

The immortal words of the Bee Gees classic, Stayin’ alive, provided the theme tune for the 2014 AIO conference held in Oxford in October.

Some 160 independent dispensing opticians and optometrists gathered at the one-day event to update their skills and knowledge – but not before dancing the night away to a Bee Gees tribute band at the AIO’s gala dinner on the Saturday night after a trip to nearby Blenheim Palace.

Opening the 24 CET point study Sunday was Henrietta Alderman, Association of Optometrists (AOP) chief executive, who enlightened delegates on the responsibilities of the AOP. The 10 speakers were split into five sessions, each with its own AIO ‘chairman’. Subjects included the clinical audit, OCT and myopia control.

The 12 parallel workshops covered paediatric dispensing with ABO president, Peter Black, OCT in action, corneal topography, a VRICS discussion group and peer discussion. In addition, delegates were able to have a one-to-one with AEL accountant, Marc Bennett – plus discover new products in the exhibition rooms. The 2015 AIO conference is from 12-15 October in Nottingham.

Protection from harmful blue light

Seiko SuperReducedBlue (SRB) lenses are designed to offer protection for today’s modern electronic world where devices such as computer screens, TVs and mobiles can emit large quantities of blue light, and cause discomfort for the wearer in the form of flickering and glare.

The new Seiko SuperReducedBlue range of thinner and lighter lenses has been developed to provide long-term comfort for wearers who are frequently exposed to modern devices such as computer screens. It achieves this by filtering the blue light emitted by the screen.

Available from this month, SuperReducedBlue will be offered on all Seiko prescription lenses.

Business experts on hand

Business services experts will be on hand at 100% Optical, to be held from 7-9 February at London ExCel, to provide visitors with advice, insight and training.

An ‘Ask an expert’ forum will focus on day-to-day practice matters and business growth with specialists from across the industry including: Dean Waugh of Volt Creative; Garry Kousoulou of Loving Social Media; Imran Hakim of the Hakim Group; Patrick Myers of Myers La Roche; Paul Surridge of the Sight Care Group; and Marc Bennett of AEL Partners.

*Sight for Sight has been named as the official charity partner for 100% Optical, www.100percentoptical.com
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100percentoptical.com
EUROPE’S HOT NEW OPTICAL SHOW
The British Contact Lens Association (BCLA) is calling for submissions for scientific abstracts, and case reports in poster format, to be presented at its 2015 conference from 29-31 May at the ACC Liverpool, by the deadline of 16 January.

Scientific abstracts are considered on any topic related to contact lenses and/or the anterior eye, and authors can choose between ‘poster only’ and ‘poster/oral presentation’ at the point of submission. Clinical case studies may also be submitted in this category, along with the option of ‘poster only’ or ‘poster/oral presentation’.

Research papers accepted for publication in the Association’s journal, Contact Lens & Anterior Eye, within a year of the 2015 conference will be awarded a voucher of £100 redeemable towards any future BCLA fee-paying event. Visit www.bcla.org.uk, email events@bcla.org.uk or call 020 7580 6661 for more information on how to make a submission.

* A brand new BCLA app can now be downloaded for free from the Apple and Google Play stores. The app will be built up in the coming months to feature a full programme for #BCLA2015, with the ability to create a personalised schedule, access interactive maps of the venue and exhibition, send private messages, share activities on social media, take part in polls and make notes.

Bradford building has the ‘wow’ factor

‘Wow!’ is how one student has described the new multi-million pound David Hockney Building at Bradford College, which is now home to the college’s Ophthalmic Dispensing section.

“The building is open plan with natural light and extensive views of Bradford, and provides an innovative and technology rich learning environment,” said Julie Lees, lecturer and curriculum team leader.

Named after the internationally acclaimed artist and alumnus of Bradford College, the David Hockney Building has a large leading edge lecture theatre. Ophthalmic Dispensing is located on the top floor with state-of-the-art facilities. “It’s a really exciting time at Bradford College for both students and tutors,” Julie added.

‘Iconic’ new colour and progressives

Developed under a patented colour technology, new Transitions Graphite Green from BBGR is described as “a new iconic colour that maintains natural colour perception and enhances contrast”.

Transitions Signature VII lenses combined with a BBGR UV anti-reflective coating guarantee the highest level of UV protection, said the company. All Transitions lenses with Neva+ UV and Neva Max UV provide an E-SPF 25 index. Launched across a wide range of design and materials in Rx, stock lenses in 1.5 and 1.6 will be available from January 2015.

Also new from BBGR are the progressive lenses, Sirus Plus and EasyWork, specifically designed for screen users. “Designed with a revolutionary and newly patented technology, Sirus Plus will provide patients with stable vision when moving and comfortable vision at all distances,” said a company spokesperson. Sirus Plus was awarded the Silmo d’Or in the Vision category at the recent exhibition in Paris.

Northern homecoming for leading CLO

ABDO member and 2012 Optician Awards Contact Lens Optician of the Year, Nick Howard, has joined Skipton-based Benjamin Opticians as a specialty contact lens practitioner, working alongside David Benjamin. David, who’s been fitting contact lenses for some 40 years at the practice, said: “It will be a privilege to work alongside Nick. His reputation and experience speak volumes and I’m sure he will continue the Benjamin’s ethos of providing first class eyecare to our patients”.

BCLA calls for papers and posters

The British Contact Lens Association (BCLA) is calling for submissions for scientific abstracts, and case reports in poster format, to be presented at its 2015 conference from 29-31 May at the ACC Liverpool, by the deadline of 16 January.

Scientific abstracts are considered on any topic related to contact lenses and/or the anterior eye, and authors can choose between ‘poster only’ and ‘poster/oral presentation’ at the point of submission. Clinical case studies may also be submitted in this category, again with the option of ‘poster only’ or ‘poster/oral presentation’. Research papers accepted for publication in the Association’s journal, Contact Lens & Anterior Eye, within a year of the 2015 conference will be awarded a voucher of £100 redeemable towards any future BCLA fee-paying event. Visit www.bcla.org.uk, email events@bcla.org.uk or call 020 7580 6661 for more information on how to make a submission.

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Silhouette is offering customers a chic and festive Christmas window display for their practice if they purchase four frames from its current luxury collections before 8 December.

As an added seasonal incentive, the company is also offering the prize of an exclusive Fortnum and Mason Christmas hamper (worth £150) to the customer that posts the best Silhouette Christmas window dressing photograph on Twitter (using the hashtag #silhouettechristmas). The competition closes on 15 December and the winner will be notified on 16 December.

* Silhouette has confirmed its presence at Optrafair next April after a six-year absence from UK trade events. “Optrafair has a long heritage in the optical industry and is the perfect launch pad for our exciting new collections of handmade SPX+ full-rims and revolutionary rimless eyewear,” said UK MD, David Chalmers.

The General Optical Council (GOC) has set out its strategy for tackling illegal practice in the optical sector, such as online contact lens sales that do not comply with UK law, the unlawful supply of cosmetic contact lenses and the misuse of protected titles.

The GOC will take a proactive, multi-pronged approach to reducing public harm through its new strategy. These actions include: raising awareness among contact lens wearers of the need to follow aftercare advice and have regular check-ups; developing a code of practice for online contact lens suppliers; acting on complaints in line with its prosecution protocol; and strengthening its collaboration with other bodies with a role in enforcement and promoting public health.

Alistair Bridge, GOC director of policy and communications, said: “The independent research we commissioned before devising this strategy showed that certain types of illegal practice can cause significant risks to public health. We will now be developing a multi-pronged approach to tackling illegal practice.

“We are particularly concerned about the unlawful supply of contact lenses and as well as dealing with complaints, we want to raise awareness among consumers of how to gain the benefits of wearing contact lenses without compromising the health of their eyes. This will require coordinated action with stakeholders, combining our collective resources and insight.”

The GOC is also setting up a stakeholder group to help implement the strategy, chaired by Dr Rob Hogan. Former Boots Opticians director, Richard Edwards, has been appointed as a consultant to advise on the delivery of the strategy.

Read the full strategy at www.optical.org

Spectrum Thea Pharmaceuticals’ latest innovation in dry eye – Thealoz Duo – is described as a unique hypotonic solution that harnesses the dual benefits of trehalose (three per cent) and hyaluronic acid (0.15 per cent) to both protect and hydrate the ocular surface, providing increased lubrication and longer lasting relief for patients.

Thealoz Duo also benefits from the unique ABAK delivery system resulting in a completely preservative and Phosphate free product that will last up to 3 months after opening. It delivers a calibrated and measured dose making it easy to use for all patients.

The launch is supported with information launch packs, patient leaflets, posters and POS materials. Telephone 0845 521 1210 or email thealozduo@spectrum-thea.co.uk

Shamir Power Mirrors is a new mirror treatment from Shamir that comes in a range of six high-density, highly reflective colours. The Power Mirrors collection is available in silver, gold, green, blue, red and orange. The outer layer of the Power Mirror coating features advanced hydrophobic and oleophobic properties, so they clean quickly and easily, said the company. The hydrophobic properties ensure the lenses repel water, and so resist stains and water-marking, while the oleophobic properties means the lenses repel grease, so that fingerprints wipe off easily. The result, says Shamir, are prescription sun lenses in a deep coloured, high-end mirror finish.
It’s been a rollercoaster ride of a year for former ABDO vice president, Kevin Gutsell

Fantastic challenges ahead

So it’s been quite an eventful year to say the least. Who would have believed at the end of 2013 where I would finish 2014, and the journey I would take. I must admit to beginning this year with some trepidation and some fear as to what the future might hold for me and how, where and when I would start a new career and challenge. Yet I also felt a degree of excitement – the kind that comes from not knowing what might be lying just around the corner.

Sometime before the New Year, I had spoken with many friends and colleagues and without exception all helped me considerably, either directly or indirectly, in finding work. This may have been short-term or part-time work, but believe me it was extremely useful. I’m not going to embarrass anyone by naming them, but they know who they are…

During the latter part of last year and through the early stages of 2014, I was fortunate enough to spend some time in practice, working at several locations for an independent group in the South East and a high quality single practice in Kent. At both companies, providing premium eye examinations and optical products, together with the provision of enhanced community eyecare services, is very much central to their belief as to how a modern practice can thrive and survive.

I certainly learned a lot from these experiences, and worked with some great people who really know their stuff. For someone who hadn’t worked in practice for a few years, I can say it was an enlightening experience. I could finally see how well the thoughts and ideas I ‘preached’ over the years worked or not, in practice, as the case may be.

Education and training forays

On a number of occasions during my 30 years in the optical business, I have been fortunate enough to lecture and present to professionals and colleagues in other countries. This may have been in a marketing capacity or to detail the workings of complex lens designs. So little persuasion was needed when the principal of ABDO College, Jo Underwood, asked if I could go to Chennai in India to teach optics, ophthalmic lenses and dispensing to a number of optometry students.

This was a fantastic experience and it was refreshing to see these students really wanting to learn about the skills that turn a prescription into a quality optical appliance, including different lens types and frame fitting. It may have been for just a week, but I managed to get a small insight into how optometry and ophthalmology works in India. I was shown around a very busy eye hospital in Chennai which, in addition to accident and emergency, ran very busy clinics covering paediatrics, low vision and for those suffering diabetic retinopathy (an increasing threat to eye health). During this past year, this wasn’t my only foray into education and training and besides carrying out a number of CET-approved lectures and discussion workshops for ABDO and the Association of Optometrists, I have been privileged to be involved in teaching the Optical Technicians Course years one and two, writing a number of CET peer discussions and assisting in training for a leading spectacle frame manufacturer’s sales team; my sincere thanks to the Worshipful Company of Spectacle Makers, Positive Impact and Silhouette for these opportunities. I certainly hope to continue to be asked to train, educate and lecture. Whether I will have the time is another matter!

ABDO College, which continues to go from strength to strength, lost head of operations, Michelle Derbyshire, earlier this year to the attraction of owning and running her own practice. I was asked to help manage the department in the busy time of collating reports back from the tutors and recording marks in preparation for the exams department. Swiftly following this was the important task of carefully checking applications and ultimately arranging tutors and coursework for the students.

It was great to be working closely with Jo and her team, and get an understanding of how the relationship works with Canterbury Christ Church University.

I feel like I have relived my whole optical career on a rollercoaster ride this year, but I am fortunate in that the
last 30 years have given me the experience both to be asked, and subsequently take up, the short-term projects that I have enjoyed so much.

Exciting new path
This just about brings me up to date and it was with huge pride and excitement when on 29 September, I walked in to the Federation of Manufacturing Opticians, at 199 Gloucester Terrace, as their new chief executive. Malcolm Polley, whose expertise I am pleased we retain, has done a great job since 2006 and I will do my utmost to keep taking the FMO forward and ensure it continues to play an important role within the Optical Confederation.

Undoubtedly, I have big shoes to fill and a steep learning curve lies ahead of me – but what a fantastic challenge and opportunity. As well as updating aspects of the FMO, I intend to make sure that the benefits package offered is relevant, up-to-date and fully usable to the members. FMO organises Optrafair and the members provide products and services into practices and hospitals, which are utilised by ophthalmologists, optometrists and opticians alike.

When approached to write this article for Dispensing Optics I was asked if I would like to include a ‘farewell to ABDO’. Well I’m really sorry to disappoint some of you (including the editor) but I have no intention of saying goodbye! On my appointment to the FMO, I had to resign my position on the ABDO board and as vice president – so I would like to take this opportunity to wish the new vice president, Fiona Anderson, and the ABDO board the best of luck for the future. I am remaining as an ABDO College trustee for the rest of my term, as part of the Journal Advisory Committee, the ABDO representative on BSi, an ABDO College tutor, and as Area 9 chairman as well.

I am looking forward to a more settled 2015, although I know it will be very busy and exciting. I hope to see many of you at Optrafair at the NEC in Birmingham next April, if not before. So Season’s Greetings and a healthy and prosperous New Year to all.

Kevin Gutsell FBDO (Hons) SLD is the chief executive of the Federation of Manufacturing Opticians.

Frequently asked questions

Out-of-date contact lenses

A member recently raised a query with me in person at a CET event, and she asked that I share my answer with readers in case not everyone had come across it. The query was: how long before the expiry date on a pack of contact lenses may you issue the lenses to a patient?

Firstly, I think you have to establish some facts. The expiry date on the box is a ‘use by’ date not a ‘sell by’ date. Technically, it’s the seal that might fail and thus compromise the safety of the product. The next fact to establish is: for what purpose are the lenses being supplied? Is it a five-lens strip to be used over the following week to check on the fitting and comfort of the lens, or a 90-pair pack to be used as and when the patient wishes?

Immediately, you can see the problem: one answer doesn’t suit all. It would be my view that the ‘use by’ date is checked at the point of issue to ensure that the date will not be exceeded for the expected use, and add a bit. This is not scientific, certainly, but common sense. I know some practitioners say a clear 12 months before the ‘use by’ date when issuing contact lenses, to be doubly sure.

A regular wearer using lenses most days, discarding generally on time, will use a three-month supply in a little over three months, so the ‘use by’ date should be six months beyond the date of supply to satisfy all contingencies. Also, perhaps consider where the patient might store their lenses; cool and dark is best, not in the handbag that sits next to the radiator in the office, as one patient of mine confessed to!

If patients abuse their contact lenses, and many do so regularly, it does not look good when we say: “Don’t do that but it’s ok to use the lenses past their use by date”. Patients generally take your lead; if you take extra trouble with their lenses and care then so will they. It all comes back to the ‘putting the welfare of the patient before all other considerations’. What is the best action from the patient’s perspective?

There is another problem, which was raised at the CET event, of how to dispose of the out-of-date stock of diagnostic lenses. The official advice is to use the ‘non-hazardous healthcare waste’ route, which involves placing in tiger bags and disposing of as ‘offensive waste’. It was suggested that there is a real danger of such lenses being retrieved from the waste bags and sold on in car boot fairs or down the pub.

Many of those in the audience that night commented that they opened these out-of-date lens packets before discarding, to prevent such sales. It would be nice to think this wasn’t necessary, but sadly I expect it is something we should all do.

Kim Devlin is chair of ABDO’s Advice and Guidelines Working Group.

answered by Kim Devlin FBDO (Hons) CL
Letters to the Editor

Merit in the ‘old school’ view

I read with interest Peter Black’s item in your November issue and felt the need to put graphite on vellum. I will no doubt be branded as ‘old’ by the very things I say and I have now been enjoying dispensing for nearly 35 years, however, there is merit in some of the old school.

Recently I had an idea for a book, modelled on 1984 by George Orwell and the prophetic school of dystopian societies: in my world there is no help for those with binocular vision anomalies such as anisometropia and uncorrected hyperopia and there develops an underclass of people, Deltas and Epsilons, who cannot achieve stereopsis and binocular vision. Lacking an appreciation of three-dimensional space has consigned them to a future where they cannot get a well-paid job because all the best jobs use 3D apps and computer simulations.

What a shock to read Peter’s article where he suggests that the optical profession has been colluding with the establishment to create just such an underclass! I have always believed that the majority of ‘lazy eyes’ are avoidable and we just need to make the parents and children aware of the potential future limitations and damage so that they have the tools to avoid this: we spend millions of pounds a year on avoidable blindness by cataracts in developing countries so why can’t we get this one right in ours?

The current system, whereby it is easy for parents to be confused as to the qualifications of the person dealing with their children, is not a positive one – but it is one we are now saddled with. We, as dispensing opticians, can do our bit by advertising ourselves by name badge or word of mouth, by educating the public to call for the DO not accept the girl off the make-up counter. We as dispensing opticians must be the best we can; we must remember how we were taught at college and keep learning and revisiting the skills.

This is the ‘old’ bit: we were taught at college to take all the measurements that would allow a frame to be made and fit perfectly first time. Most students leave the viva exam and forget all they have learnt because they don’t perceive its usefulness – but every time you see a child you can use all those skills. This year, ABDO has been championing paediatric dispensing and I applaud its work. The news video telling about the paediatric heads is great.

Like Peter I worry that avoidable amblyopia will lead to litigation through us not demonstrating a duty of care. I know this includes orthoptists, ophthalmologists and optometrists but if you own the business, it’s even more important. We need to be advising patients/parents about the importance of the corrections, the possible ramifications of poor compliance and to note that advice as being given.

You can make a whole article about the effectiveness of spectacle wearing and binocular vision development, but I have spent most of this year encouraging my optometrists and dispensing opticians to discuss contact lenses with much younger children – as they ‘stay up’ and provide a better peripheral lock for vision development.

David Bridle FBDO Hons
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Clarification on remarks

A number of members have contacted me directly with regards to comments I made in October’s Black Arts under the paragraph headed ‘Graduates in demand’, which some people thought were inappropriate.

Whilst I am very sorry if I have caused any offence, it was simply my intention to highlight the fact that studying to be a dispensing optician via blended learning allows one to ‘earn while one learns’ and does not come with the crippling debts associated with studying other subjects.

The accusation was also raised that I had implied that ‘unless students undertook the dispensing course through ABDO, they were unlikely to find employment at the end of their course’. Working to a tight deadline, and in less than ideal circumstances on a train, I could perhaps have worded this better. I believe dispensing opticians are currently more in demand than ever before, and I am glad the individual on £16,000 per year finally took the plunge to move on to a better employer who pays a more appropriate salary for a registered eyecare professional.

Whether you studied via blended learning, day release or full time, at ABDO College, Anglia Ruskin University, Bradford College, City & Islington College or Glasgow Caledonian University, all dispensing opticians are equally employable and equally welcome as members of ABDO, and I’m sorry if I implied otherwise.

Peter Black MBA, FBDO
ABDO president

We welcome contributions to our Letters to the Editor page, which we reserve the right to edit. If you would like to air your views please email ncollinson@abdo.uk.com
VAO honours members and trustees

Vision Aid Overseas recognised the exceptional commitment and achievement of its volunteers and members at its AGM dinner and trustees Awards Ceremony on 4 October.

VAO chairman, David Scott-Ralphs, presented two Honorary Life Membership Awards: the first to Michele de Vaal, for outstanding volunteer work to raise eyecare standards in Ethiopia as programme manager; and the second to Kath Stott, for her pioneering work in Ghana and in Sierra Leone’s poor Eastern Province, as country director.

Trustee Awards, made to volunteers who give up their time to offer exceptional service, support and care to the charity, were presented to: Margaret Lawrence, retired optometrist; David Mwitumwa, volunteer Zambia; Ian Bowers, volunteer Zambia, Ethiopia and Botswana; Jeremy Jalle, VAO development director (Special 10 year Recognition); and Howard Payne, VAO warehouse freight and equipment manager (Special 10 year Recognition).
Access a pathway to become a DO

Access Courses
An opportunity towards a career as a dispensing optician

ABDO College’s Access Courses are designed to help prospective dispensing optician students to meet the necessary entry requirements. They are also a useful refresher for those who have been out of education for a while. The entry requirements for the ABDO College Level 6 Fellowship Dispensing Diploma (FBDO) and Foundation Degree/BSc (Hons) courses are five GCSEs at grade c or above, which must include English, mathematics and a science subject. Each Access course is considered the equivalent of one GCSE. The Access Courses are available in the five key subjects of English, Mathematics, Optics and Dispensing, Human Biology and General Science.

- Courses commence: February 2015
- Method: Distance learning
- Candidates should ideally be educated to GCSE standard and possibly have already attained some of the GCSEs required for enrolment to dispensing courses
- Duration: Approximately 20 weeks

Application deadline:
January 2015

For further information and application forms for these and other courses, or to request a copy of the ABDO College Prospectus, please contact the ABDO College Courses Team on 01227 738 829 (Option 1) or email info@abdocollege.org.uk

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