GOC Review

ABDO response to the GOC's call for evidence and consultation on the Opticians Act and related policies

OBJECTIVES

5. Are these the right objectives for the GOC for legislative reform?

Yes	☑	No	☐

If no, please provide details

ABDO supports the eight objectives which the GOC has proposed to guide its approach to legislative reform, although we do not agree with the GOC's description of the objectives as 'non-hierarchical' as this suggests that all the objectives will carry equal weight.

The GOC notes that its overarching statutory objective is to protect the public and it would be helpful if this were reflected more clearly in its objectives for legislative reform rather than listing 'maintaining public and patient safety' as one of eight 'non-hierarchical' objectives. This might suggest that there could be trade-offs between public protection and other considerations.

Aside from this point, we agree that it is sensible for the GOC to focus on examining whether there is a need for targeted changes to legislation or associated policies in order to reflect developments in practice or wider society.

The UK's system of primary eye care continues to provide access to high quality eye care across all four nations, which is reflected in the absence of waiting lists, affordable eye wear and continuing innovation in the provision of diagnostic tests. Also, there continues to be a high level of patient satisfaction, with the GOC's latest public perceptions research (April 2022) showing 94 per cent of patients who had a sight test during the last two years were satisfied with the overall experience.

For future surveys, however, we request that the GOC reviews its methodology because asking respondents how confident or otherwise they are of receiving a high standard of care from a dispensing optician and giving the guidance that a dispensing optician, "could be the person who advises on, fits and supplies spectacles and low vision aids" will produce misleading findings. The reason for this is that the person who advises on, fits and supplies spectacles and low vision aids could be an unregistered optical assistant rather than a dispensing optician, particularly as there are approximately ten times as many optical assistants as there are dispensing opticians.

RESTRICTED ACTIVITIES

6. What activities should non-registrants be restricted/prevented from doing?

Please provide details

ABDO's view is that the overarching need to protect the public makes it necessary to continue to prevent non-registrants from:

- *testing sight*
- *fitting contact lenses*
- *selling optical appliances to children under 16, including sports eyewear*
- *selling optical appliances to people registered as visually impaired*
- *selling zero-powered contact lenses*

DISPENSING OF SPECTACLES TO CHILDREN

We would like to particularly highlight the issue of dispensing of optical appliances to children under 16. Non-registrants should certainly continue to be prevented from dispensing spectacles to children without supervision and we have concerns about the quality of paediatric dispensing, which suggest that further action is needed to protect the public.

In the course of the research carried out for her recently-completed PhD, ABDO's Director of Examinations, Dr Alicia Thompson, conducted a survey of registrants. The PhD research has not been published yet, but we would be happy to provide the GOC with a copy of her thesis.

The survey involved 699 registrants, of whom 95.5 per cent were actively involved in dispensing spectacles. One of the research findings was that 30 per cent of respondents rated the overall fit of children's spectacle frames as 'poor' or 'dreadful', with a further 45.6 per cent rating them as 'average'.

This finding provides cause for concern because if a child's spectacles do not fit correctly, they will not receive the required visual correction. A poor quality fit can arise if a child's pupils are not aligned with the centre of the lenses or the frames slide down the bridge of their nose, resulting in them looking over the top of the spectacles. This can have a serious impact on:

- their wellbeing;
- the development of their visual pathways, leading to poorer lifelong visual acuity, which could have the consequence of precluding access to certain careers, such as being a pilot or a professional driver;
- their educational development;
- their ability to enjoy sport and other leisure pursuits; and
- their behaviour, with uncorrected vision making it harder to pick up social cues.

FACTORS INFLUENCING THE QUALITY OF PAEDIATRIC DISPENSING

The quality of paediatric dispensing is influenced by a range of factors. Respondents to the aforementioned survey were asked for their views on how the fitting of children's spectacles could be improved and around 95 per cent of respondents rated the following factors as 'important' or 'essential': exposure to children, hands-on training, a wider range of frames and the ability to adapt frames. Around 80 per cent rated as 'important' or 'essential' the development of appropriate communication skills.

There is a need, therefore, to improve the range of frames that is suitable for children. Currently, the majority of paediatric spectacle frames are scaled down versions of frames designed for adults, which assumes that facial characteristics and proportions do not change with growth. This often results in an ineffective delivery of any refractive correction prescribed at a critical time in a child's development.

ABDO is working with frame manufacturers to improve the range of frames that are suitable for children, drawing on the findings of the aforementioned PhD research. Dr Thompson's thesis describes measurements of paediatric facial parameters that specifically relate to the design of spectacle frames.

Three-dimensional stereophotogrammetry was employed to capture images in a rapid, non-invasive manner. Fifteen paediatric facial measurements associated with spectacle frame parameters were measured using custom software in a sample of 1334 interactive images of children's faces observing differences in gender, ethnicity and Down's syndrome. The principal findings were that:

- The typically-developed White British children showed a definite emergence of the nasal bearing surface at a younger age compared to Chinese children and children with Down's syndrome from which all parameters surrounding the nose narrowed with age.
- A distinct nasal bearing surface emergence was not observed in either Chinese children or children with Down's syndrome therefore requiring larger spectacle parameters in terms of frontal and splay angles, distance between rims and apical radius.
- Chinese children and children with Down's syndrome have a lower crest height and a shorter front to bend compared to typically-developed White British children and differences were detected in head width and pupillary distance between these two groups. This translates into frame requirements of a lower bridge position and sides that are capable of being shortened and angled appropriately.
- Children with Down's syndrome are not wholly smaller or larger than typically-developed White British children but need their requirements to be incorporated into frame design to accommodate differences in facial development.

Percentiles were calculated for each of the largest study groups. This data, combined with the model of facial growth and inter-relationships between facial measurements presented in the thesis, will inform spectacle frame manufacturers on appropriate parameters and design features required to produce a more suitable range of paediatric frames that will enable a more stable and comfortable fit.

However, improving the range of spectacle frames that are suitable for children will not, in itself, improve the fitting of children's spectacles. Also required is expertise in dispensing spectacles to children, including the:

- ability to advise on and measure for the most appropriate paediatric frames, taking account of the facial characteristics of, for example, children at different ages and ethnicities;
- ability to communicate effectively with children and their parents and carers;
- ability to advise and measure for the most appropriate lens choice; and
- ability to fit, adjust and repair paediatric optical appliances.

The GOC competencies for dispensing opticians include a specific competency relating to paediatric dispensing, whereas there is no such competency relating to paediatric dispensing in the GOC competences for optometrists. As a result, most student optometrists do not gain the same level of expertise in dispensing spectacles to children and are less well-equipped to carry out and supervise paediatric dispensing. Once they have qualified, most optometrists focus on carrying out eye examinations and do not gain significant additional experience of paediatric dispensing and the expertise they have gained is likely to diminish.

This should not necessarily mean that the quality of paediatric dispensing suffers as the *GOC's Standards of Practice for Optometrists and Dispensing Opticians* provide:

- Be competent in all aspects of your work, including clinical practice, supervision, teaching, research and management roles, and do not perform any roles in which you are not competent (standard 5.1).
- Comply with the Continuing Education and Training (CET) requirements of the General Optical Council as part of a commitment to maintaining and developing your knowledge and skills throughout your career as an optical professional (standard 5.2).
- Recognise and work within the limits of your scope of practice, taking into account your knowledge, skills and experience (standard 6.1).
- Be sufficiently qualified and experienced to undertake the functions you are supervising (standard 9.1).
- Be on the premises, in a position to oversee the work undertaken and ready to intervene if necessary in order to protect patients (standard 9.3).

Similarly, the GOC's *Standards for optical businesses* require that a registered business:

- Makes staff aware that they must only work within the limits of their competence, and takes appropriate action where they do not (standard 3.2.5).
- Supports GOC registrants to meet their professional requirements, including Standards of Practice for Optometrist and Dispensing Opticians and Standards for Optical Students and continuing education and training (CET) requirements (standard 3.2.7).
- Ensures that only staff with sufficient levels of qualification and experience act as supervisors, and require them to be in a position to oversee the work undertaken and ready to intervene if necessary to protect patients (standard 3.3.1).

However, the aforementioned survey findings suggest that there is a need to improve the quality of paediatric dispensing skills and knowledge and/or the supervision of paediatric dispensing.

REQUIRED ACTION

We recommend, therefore, that the GOC take the following action:

- Consider developing guidance to define what constitutes good practice in relation to paediatric dispensing and the supervision of paediatric dispensing. ABDO would be happy to work with the GOC and other sector bodies to develop such guidance.
- Consider revising the standards of practice and standards for optical businesses to make explicit the fact that paediatric dispensing and the supervision of paediatric dispensing must be carried out by registrants with up-to-date skills and knowledge in this area.
- Carry out research to monitor the quality of paediatric dispensing and if necessary, consider pursuing legislative change to restrict paediatric dispensing to dispensing opticians and optometrists.

REQUIRED ADDITIONAL RESTRICTIONS ON DISPENSING SPECTACLES

As well as focusing on the quality of paediatric dispensing and how this can be improved, the GOC should seek legislative change to prevent non-registrants from dispensing optical appliances to patient groups that can be described as vulnerable, such as people with learning disabilities or people diagnosed with dementia, recognising that this requires enhanced skills and knowledge.

DISPENSING SPECTACLES TO ADULTS WITH LEARNING DISABILITIES

Fitting spectacles for adults with learning disabilities requires:

- expert communication skills, including the use of appropriate language and techniques and the ability to engage with and take into account the views and interests of both patients and carers;
- expert dispensing skills, including the ability to take into account head position and facial characteristics, such as the particular facial characteristics of people with Down's syndrome;
- an understanding of the sight problems that are likely to be experienced by people with learning disabilities; and
- an ability to gauge a patient's decision-making capacity and enable them to make their own decisions as far as possible, recognising the complexity involved in gaining valid patient consent and taking into account the GOC's guidance on consent, which provides that registrants must:
    - consider any disabilities, literacy or language barriers that may affect a patient's understanding and amend their communication approach to take account of this (paragraph 20); and
    - not make assumptions about the patient's level of knowledge or understanding (paragraph 21).

The dispensing of spectacles to children with learning disabilities must already be carried out by or under the supervision of a registrant. At least this same level of protection should be extended to adults with learning disabilities. However, given the particular expertise involved in dispensing spectacles to this patient group, in our view the GOC should consider restricting this to registrants only.

We note that children with learning disabilities are 28 times more likely to have a serious sight problem and only seven per cent will ever have had a community eye test or be able to access community services. To respond to this need, NHS England established the Special Schools Eyecare Programme and in developing the relevant care pathway specified that spectacles should be dispensed by a registrant, recognising the enhanced skills and knowledge required to dispense spectacles to this patient group. More information about this programme is available on the NHS England website: https://www.england.nhs.uk/learning-disabilities/improving-health/eye-care-dental-care-and-hearing-checks/eye-care/

DISPENSING SPECTACLES TO PEOPLE DIAGNOSED WITH DEMENTIA

According to research carried out by the Alzheimers Society, there are currently around 900,000 people with dementia in the UK. This number is expected to rise sharply in the coming years. This increase is driven by the ageing population, with the risk of developing dementia rising significantly with age. There are projected to be over 1 million people with dementia in the UK by 2025, with this figure projected to rise to nearly 1.6 million in 2040. The Alzheimers Society also found in 2018 that 70 per cent of people in care homes have dementia or severe memory problems. More information is available on the Alzheimers Society website: https://www.alzheimers.org.uk/blog/how-many-people-have-dementia-uk

FITTING SPECTACLES FOR PEOPLE WITH DEMENTIA REQUIRES:

- **Enhanced dispensing skills** – it is necessary to take into account factors such as head position, mobility and gait in order to optimise a patient's vision. This might involve considering whether they can safely wear spectacles with progressive lenses rather than having a pair for reading and a pair for distance. In making such a judgment, it will be important to bear in mind that patients with dementia find it more difficult to adjust to change.

- **Enhanced communication skills** – using appropriate language and techniques to enable patients to make their own decisions as far as possible recognising that they might have related conditions which affect their communication skills, such as aphasia, and taking account of the views and interests of both patients and carers.

- **An understanding of dementia as a medical condition and how this can affect vision and behaviour** – it is important to understand, for example, that a patient who is unable to see clearly despite a recent sight test may require a neurological referral rather than a need for their spectacles to be remade, and that a patient who orders three or four pairs of spectacles having in the past just ordered one might be doing so as result of their condition and would benefit from support and guidance. This video provides a useful insight into posterial cortical atrophy, which is a form of dementia that affects visual processing: https://www.youtube.com/watch?v=jekW8Z93LMw

- **An ability to judge a patient's decision-making capacity and enable them to make their own decisions as far as possible** – the GOC's guidance on consent recognises the complexity involved in gaining valid consent (as mentioned above) and there will often be questions about a patient's decision-making capacity when they have been diagnosed with dementia, particularly as the condition progresses.

There is a strong relationship between impaired vision in older people and both reduced quality of life and increased risk of accidents, particularly falls. The research literature suggests that those with low vision are about two times more likely to have falls than fully sighted people, and the annual UK cost of treating falls directly attributable to visually impairment is £128 million. The literature on the prevalence of undetected reduced vision in older people shows that between 20 and 50 per cent of older people have undetected reduced vision. The majority of these people have correctable visual problems, i.e. refractive errors or cataract: Evans, B.J.W. and Rowlands, G. (2004), Correctable visual impairment in older people: a major unmet need. Ophthalmic and Physiological Optics, 24: 161-180. https://doi.org/10.1111/j.1475-1313.2004.00197.x

The increased risk of accidents, particularly falls, as a result of impaired vision in older people is further reason to ensure that people diagnosed with dementia benefit from expert dispensing skills. Although some registrants might need to enhance their understanding of dementia and the implications for spectacle dispensing, they are required by the GOC's standards of practice to keep up-to-date with developments in research and carry out Continuing Professional Development (CPD) activity.

The number of people diagnosed with dementia, and the expected growth in this number, means that if they do not benefit from expertise in the dispensing of spectacles, the scale of harm could be substantial.

ACTION REQUIRED

We recommend that given the knowledge, skills and challenges involved in the dispensing of spectacles to people with learning disabilities and people diagnosed with dementia, these activities should be restricted to registrants and not be allowed to be carried out under supervision.

MYOPIA MANAGEMENT

We also wish to highlight the need for advice and treatment relating to myopia management to be restricted to registrants only.

Myopia (commonly referred to as short-sightedness) is one of the most common eye conditions seen in optical practice. Being myopic also brings an increased risks of other eye conditions that can have serious and potentially sight threatening repercussions in later life.

Myopia management is the name given to any type of intervention that intends to limit the level of myopia for a given patient. Interventions may be pharmacological, surgical and behavioural. They may also involve the use of spectacles lenses or contact lenses.

Myopia management does not remove the risk of becoming myopic or the chances that the level of myopia will increase; it is designed to try to control and reduce the increase in the level of myopia and therefore reduce the risk factors associated with higher degrees of myopia.

Treatment for myopia management:

- has the potential to reduce the risk of eye disease later in life, as well as slowing the development of myopia;
- is long-term and potentially expensive;
- may be of value to patients who are over 16;
- where this involves spectacles or contact lenses, is likely to involve a significant period of adaptation and the need for extended wear; and
- in the case of spectacle treatment of myopia, successful treatment is dependent on a stable, well-fitting spectacle frame.

Therefore, failure to provide appropriate clinical advice could have serious long-term consequences in that myopia could progress more than would otherwise be the case, with the potential for this to increase the risk of a sight-threatening condition in later life.

ABDO has produced clinical guidance on myopia management for its members and would be happy to share with the GOC any further information that might be helpful, including references to the relevant research literature.

While fitting contact lenses and spectacles for children under 16 is already restricted, there is evidence that myopia management can be of significant value to people aged 16-plus. This evidence is summarised in the following article: https://www.myopiaprofile.com/adult-myopia-progression/

It states that the developing consensus from the research to date is that 50 per cent of patients will stabilise by 15-16, with half of older teenagers and young adults still progressing. And one-fifth of myopes in their 20s will experience significant progression of at least one dioptre.

There are a number of conclusions drawn, including:

- Young adult myopia progression can and does happen, by up to one dioptre in 35% of adults in their early 20s.
- Every dioptre matters for lifelong disease risk, so some attempt at myopia control is worthy, although the same results as those seen in children cannot be guaranteed.

In our view, therefore, it is necessary to prevent non-registrants from providing advice on or treatment for myopia management to registrants, even under supervision. This area of practice involves complex solutions on which patients, and their parents/carers, need careful advice and guidance, including in relation to the ongoing commitment and costs.

ACTION REQUIRED

Recognising that legislative change could take some time, the GOC should revise its standards of practice and standards for optical businesses to make clear the need for specialist expertise in relation to dispensing spectacles to patient groups that may be described as vulnerable and giving advice and treatment in relation to myopia management and the importance of registrants operating within their individual scopes of practice.

We recognise as well that myopia management is an evolving area of practice and that there will be value in working with the GOC and other sector bodies to explore how best to promote good practice, including the role of regulation.

IMPACTS ON PARTICULAR PATIENT GROUPS

We also note that unlike in other sections of the call for evidence, there is no question in this section about the advantages, disadvantages and impacts of maintaining the current legislation. In our answer above, however, we have set out the disadvantages of maintaining the current legislation and the advantages of making the changes we have proposed.

In addition, we wish to note that maintaining the current approach to regulation would have a disproportionately negative impact on certain vulnerable patient groups, namely children, people with learning disabilities and people with dementia. In particular, where paediatric dispensing is not carried out or supervised by registrants with appropriate expertise, patient groups with facial characteristics that are different to white British children are likely to be even less well protected.

7. What activities do you think must be restricted to our registrants?

In order to protect the public, the following activities must continue to be restricted to registrants:

- testing sight;
- fitting contact lenses;
- selling optical appliances to children under 16, including sports eyewear;
- selling optical appliances to people registered as visually impaired; and
- selling zero-powered contact lenses.

However, it is also important to ensure that restricted activities are carried out and supervised by registrants who are operating within their individual scope of practice. In particular, as set out in our answer to question 6, we wish to highlight the importance of ensuring that the dispensing of optical appliances to children is carried out or supervised by a dispensing optician or optometrist with appropriate expertise.

In the course of the research carried out for her recently-completed PhD, ABDO's Director of Examinations, Dr Alicia Thompson, conducted a survey of registrants. The survey involved 699 registrants, of whom 95.5 per cent were actively involved in dispensing spectacles. One of the research findings was that 30 per cent of respondents rated the overall fit of children's spectacle frames as 'poor' or 'dreadful', with a further 45.6 per cent rating them as 'average'. The PhD research has not been published yet, but we would be happy to provide the GOC with a copy.

This finding provides cause for concern because if a child's spectacles do not fit correctly, they will not receive the required visual correction. A poor quality fit can arise if a child's pupils are not aligned with the centre of the lenses or the frames slide down the bridge of their nose, resulting in them looking over the top of the spectacles. This can have a serious impact on:

- their wellbeing;
- the development of their visual pathways, leading to poorer lifelong visual acuity, which could have the consequence of precluding access to certain careers, such as being a pilot or a professional driver;
- their educational development;
- their ability to enjoy sport and other leisure pursuits; and
- their behaviour, with uncorrected vision making it harder to pick up social cues.

The quality of paediatric dispensing is influenced by a range of factors. Respondents to the aforementioned survey were asked for their views on how the fitting of children's spectacles could be improved and around 95 per cent of respondents rated the following factors as 'important' or 'essential': exposure to children, hands-on training, a wider range of frames and the ability to adapt frames. Around 80 per cent rated as 'important' or 'essential' the development of appropriate communication skills.

There is a need, therefore, to improve the range of frames that is suitable for children. Currently, the majority of paediatric spectacle frames are scaled down versions of frames designed for adults, which assumes that facial characteristics and proportions do not change with growth. This often results in an ineffective delivery of any refractive correction prescribed at a critical time in a child's development.

However, improving the range of spectacle frames that are suitable for children will not, in itself, improve the fitting of children's spectacles. Also required is expertise in dispensing spectacles to children, including the:

- ability to advise on and measure for the most appropriate paediatric frames, taking account of the facial characteristics of, for example, children at different ages and ethnicities;
- ability to communicate effectively with children and their parents and carers;
- ability to advise and measure for the most appropriate lens choice; and
- ability to fit, adjust and repair paediatric optical appliances.

The GOC competencies for dispensing opticians include a specific competency relating to paediatric dispensing, whereas there is no such competency relating to paediatric dispensing in the GOC competences for optometrists. As a result, most student optometrists do not gain the same level of expertise in dispensing spectacles to children and are less well-equipped to carry out and supervise paediatric dispensing. Once they have qualified, most optometrists focus on carrying out eye examinations and do not gain significant additional experience of paediatric dispensing and the expertise they have gained is likely to diminish.

This should not necessarily mean that the quality of paediatric dispensing suffers as the GOC's *Standards of Practice for Optometrists and Dispensing Opticians* provide:

- Be competent in all aspects of your work, including clinical practice, supervision, teaching, research and management roles, and do not perform any roles in which you are not competent (standard 5.1).
- Comply with the Continuing Education and Training (CET) requirements of the General Optical Council as part of a commitment to maintaining and developing your knowledge and skills throughout your career as an optical professional (standard 5.2).
- Recognise and work within the limits of your scope of practice, taking into account your knowledge, skills and experience (standard 6.1).
- Be sufficiently qualified and experienced to undertake the functions you are supervising (standard 9.1).
- Be on the premises, in a position to oversee the work undertaken and ready to intervene if necessary in order to protect patients (standard 9.3).

Similarly, the GOC's *Standards for optical businesses* require that a registered business:

- Makes staff aware that they must only work within the limits of their competence, and takes appropriate action where they do not (standard 3.2.5).
- Supports GOC registrants to meet their professional requirements, including Standards of Practice for Optometrist and Dispensing Opticians and Standards for Optical Students and continuing education and training (CET) requirements (standard 3.2.7).
- Ensures that only staff with sufficient levels of qualification and experience act as supervisors, and require them to be in a position to oversee the work undertaken and ready to intervene if necessary to protect patients (standard 3.3.1).

However, the aforementioned survey findings suggest that there is a need to improve the quality of paediatric dispensing skills and knowledge and/or the supervision of paediatric dispensing.

REQUIRED ACTION

We recommend, therefore, that the GOC take the following action:

- Consider developing guidance to define what constitutes good practice in relation to paediatric dispensing and the supervision of paediatric dispensing. ABDO would be happy to work with the GOC and other sector bodies to develop such guidance.
- Consider revising the standards of practice and standards for optical businesses to make explicit the fact that paediatric dispensing and the supervision of paediatric dispensing must be carried out by registrants with up-to-date skills and knowledge in this area.
- Carry out research to monitor the quality of paediatric dispensing and if necessary, consider pursuing legislative change to restrict paediatric dispensing to dispensing opticians and optometrists.

RESTRICTING ADDITIONAL ACTIVITIES

See our answer to question 6

The following additional activities should be restricted to registrants only:

- dispensing optical appliances to patient groups that can be described as vulnerable, such as people with learning disabilities or diagnosed with dementia; and
- giving advice on and treatment for myopia management, including through the fitting and supply of spectacles and contact lenses.

8. What are your views about continuing to restrict/prevent non-registrants from carrying out the following activities?

	Should be restricted	Not sure / no opinion	Should not be restricted
Testing of sight	☑	☐	☐
Fitting of contact lenses	☑	☐	☐
Selling optical appliances to children under 16 and those registered visually impaired	☑	☐	☐
Selling zero powered contact lenses	☑	☐	☐

9. Are there any additional activities that you think should be restricted to registrants?

Yes ☑ No ☐

As stated in our answers to questions 6 and 7, the GOC should take account of developments in practice and society that have occurred since the legislation was last reviewed and restrict to GOC registrants the dispensing of optical appliances to patient groups that can be described as vulnerable, such as people with learning disabilities or dementia.

MYOPIA MANAGEMENT

An additional activity that should be restricted to registrants is advice and treatment relating to myopia management.

Myopia (commonly referred to as short-sightedness) is one of the most common eye conditions seen in optical practice. Being myopic also brings an increased risks of other eye conditions that can have serious and potentially sight threatening repercussions in later life.

ABDO response to the GOC's call for evidence and consultation on the Opticians Act and related policies (CONTINUED)

Myopia management is the name given to any type of intervention that intends to limit the level of myopia for a given patient. Interventions may be pharmacological, surgical and behavioural. They may also involve the use of spectacles lenses or contact lenses.

Myopia management does not remove the risk of becoming myopic or the chances that the level of myopia will increase; it is designed to try to control and reduce the increase in the level of myopia and therefore reduce the risk factors associated with higher degrees of myopia.

Treatment for myopia management:

- has the potential to reduce the risk of eye disease later in life, as well as slowing the development of myopia;
- is long-term and potentially expensive;
- may be of value to patients who are over 16;
- where this involves spectacles or contact lenses, is likely to involve a significant period of adaptation and the need for extended wear; and
- in the case of spectacle treatment of myopia, successful treatment is dependent on a stable, well-fitting spectacle frame.

Therefore, failure to provide appropriate clinical advice could have serious long-term consequences in that myopia could progress more than would otherwise be the case, with the potential for this to increase the risk of a sight-threatening condition in later life.

ABDO has produced clinical guidance on myopia management for its members and we would be happy to share with the GOC any further information that might be helpful, including references to the relevant research literature.

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There are a number of conclusions drawn, including:

- Young adult myopia progression can and does happen, by up to one dioptre in 35% of adults in their early 20s.
- Every dioptre matters for lifelong disease risk, so some attempt at myopia control is worthy, although the same results as those seen in children cannot be guaranteed.

In our view, therefore, it is necessary to prevent non-registrants from providing advice on or treatment for myopia management to registrants, even under supervision. This area of practice involves complex solutions on which patients, and their parents/carers, need careful and advice and guidance, particularly around the ongoing commitment and costs.

ACTION REQUIRED

Recognising that legislative change could take some time, the GOC should revise its standards of practice and standards for registered businesses to make clear the need for specialist expertise in relation to dispensing spectacles to patient groups that may be described as vulnerable and giving advice and treatment in relation to myopia management and the importance of registrants operating within their individual scope of practice.

We recognise as well that myopia management is an evolving area of practice and that there will be value in working with the GOC and other sector bodies to explore how best to promote good practice, including the role of regulation.

10. Is there any evidence that any other post-registration skills, qualifications or training need to be accredited or approved by the GOC (above and beyond the existing contact lens optician and prescribing qualifications)**?**

Yes ☐	No ☑

Given the GOC's overarching objective of protecting the public it continues to be appropriate for it to focus on the approval and quality assurance of programmes and qualifications leading to registration with the GOC. In this way it can ensure that practitioners entering the optical professions are able to meet the standards of practice for optometrists and dispensing opticians and are safe to practise. Once practitioners are registered with the GOC, they are required by the standards of practice to operate within their scopes of practice and ensure that they receive appropriate training before extending their roles.

The GOC also regulates continuing professional development (CPD) to ensure that practitioners keep their skills and knowledge up-to-date and encourage further professional development.

The accreditation or approval by the GOC of additional further qualifications would provide a further layer of regulation and we are not aware of any evidence that this is necessary to protect the public in order to, for example, address concerns about the quality of qualifications.

As a general rule, the GOC should only seek to add to the burden of regulation where this is necessary to protect the public and where this is the case, should choose the most proportionate form of regulatory intervention. Regulating additional further qualifications would increase costs for stakeholders, including qualification providers, employers, practitioners and ultimately patients.

We welcome the GOC's new focus on continuing professional development and having recently introduced a more flexible regulatory framework in this area, the GOC should avoid creating barriers to professional development and stifling the development and delivery of further qualifications.

BUSINESS REGULATION

11. Does the basis for extension of business regulation outlined in our 2013 review of business regulation still apply?

Yes	☑	No	☐

Please give your reasons and provide any evidence to support these.

Yes, there should be a consistent approach to business regulation, recognising that some activities are within the control of businesses as opposed to individual registrants, such as ensuring that:

- there is the right balance between clinical and commercial considerations;
- there are appropriate standard operating procedures that are consistent with the GOC's standards of practice and standards for optical businesses;
- equipment used in practice is maintained correctly and staff receive; and appropriate training

Therefore, all businesses carrying out restricted activities should be required to register with the GOC and comply with its business standards. Perpetuating a system where some businesses are not required to register creates a risk of downward pressure on business standards as unregistered businesses seek to gain a competitive advantage.

12. Are there any advantages, disadvantages and impacts (both positive and negative) of extending business regulation in addition to those identified in our 2013 review of business regulation? (Impacts can include financial and equality, diversity and inclusion.)

Yes	☑	No	☐

Please give your reasons and provide any evidence to support these.

As well as considering whether to extend business regulation to cover all businesses carrying out restricted activities, the GOC should review the technical registration requirements, notably the requirement to have a majority of registrant directors.

We recognise the important role which registrant directors play in promoting hight standards, but we think there would be value in reviewing whether it is proportionate to require a majority of registrant directors. This can lead to difficulties, including creating a barrier to business registration, encouraging businesses to have a single director and adding to administrative costs.

We have had a recent case of a member who was a sole director of a longstanding registered company being advised by NHS England to appoint another director to ensure the viability of the company in case anything should happen to them. After acting on this advice and appointing a non-registrant director, the member was contacted by the GOC to say that they were in breach of the business registration requirements and needed to appoint an additional registrant director. For a small business, the time and cost involved in meeting such administrative requirements are considerable and it is important to be sure that they are both necessary and proportionate.

13. Do you think the GOC could more effectively regulate businesses if it had powers of inspection?

Yes	No ✓	Unsure or no opinion

Please give your reasons and provide any evidence to support these.

When the GOC considered this question in 2013 it concluded that the risks associated with business practices did not warrant an inspection regime. Since then, the GOC has strengthened the system of business regulation by introducing more comprehensive business standards that make clearer its expectations.

In the absence of evidence that the risks associated with business practices have increased and analysis showing that it is necessary and proportionate to introduce an inspection regime, the case for doing so has not been made.

As a general rule, the GOC should think carefully before increasing the costs of regulation as these will ultimately be passed on to patients; it should ensure that the system of business regulation is proportionate and minimises costs.

14. Is there an alternative model of business regulation that we should consider?

Yes (please specify) ✓	No	Not sure / no opinion

Please give your reasons and provide any evidence to support these.

The GPhC model of a responsible pharmacist

In examining the model of regulation used in pharmacy and considering whether this would provide a superior model for eye care, it is important to look at the whole system of regulation, including the focus on regulating premises as well as the role of the 'responsible pharmacist'.

Arguably the focus on premises is not as 'future-proof' as the focus in the optical sector on regulating activities and the role of the 'responsible pharmacist' is a response to the primary focus of pharmacy regulation, which is the control of medicines within pharmacy premises.

There is a lower level of risk in relation to optical practices and introducing the 'responsible pharmacist' model would stand in the way of efficient practice management in line with the GOC's standards, without being justified by the risks involved.

Reinventing the system of regulation for optical businesses would also carry substantial transitional costs, making it even more important for there to be a clear, evidence-based case for change.

TESTING OF SIGHT

15. Should dispensing opticians be able to undertake refraction for the purposes of the sight test? (NB This would be possible only if the GOC were to amend or remove its 2013 statement on refraction.)

Yes - with restrictions ☐	Yes - under the oversight of an optometrist or registered medical practitioner ☑
No ☐	Not sure / no opinion ☐

Please give your reasons and provide any evidence to support these.

The GOC states in the call for evidence that, "dispensing opticians could undertake refraction for the purposes of the sight test if they are appropriately trained, competent, overseen and indemnified." It goes on to say that this would be possible only if it were to amend or remove its 2013 policy statement on refraction.

ABDO supports the GOC's view that dispensing opticians should be able to undertake refraction for the purposes of the sight test, subject to the stated conditions. Therefore, the GOC should amend its 2013 statement on sight-testing to enable this to happen, rather than perpetuating the current unwarranted restriction on the ability of dispensing opticians to extend their scopes of practice.

This change would in no way compromise patient safety and should not be controversial. A refraction carried out by a dispensing opticians for the purposes of the sight test would be under the oversight of an optometrist or medical practitioner. Therefore, an optometrist or medical practitioner would still have overall responsibility for the sight test and patients would continue to benefit from an eye health examination at the same time as a refraction. This is a major strength of the UK's system of eye care and enables eye and wider health issues to be identified and addressed at an early stage in line with the wider health policy focus on prevention.

Enabling dispensing opticians to support optometrists and medical practitioners in carrying out sight tests would simply enable patient care to be provided in a more flexible way, while upholding the principle that a sight test should involve a refraction and an eye health examination delivered during the same practice visit.

We note that survey data gathered by another optical body suggests concern among optometrists about delegation of elements of the sight test to other professionals such as dispensing opticians. However this is not relevant to the question of whether dispensing opticians should be allowed to carry out refraction under the oversight of an optometrist rather than as a delegated function, which would involve the optometrist discharging their responsibility for the refraction element of the sight test.

There should also be confidence in dispensing opticians' ability to carry out refraction accurately and safely, including flagging up any concerns about pathology or binocular vision for the optometrist or medical practitioner to consider:

- Dispensing opticians already learn to refract as part of their education, with Unit 9 of the current syllabus of ABDO's Diploma in Ophthalmic Dispensing covering 'The Assessment and Management of Refractive Errors' and including a module on binocular vision.
- The GOC's 2013 statement already allows dispensing opticians to refract outside of the sight test to, for example, verify a prescription.

We recently carried out a survey of our membership (June 2022) and received around 1350 responses, providing a representative sample of our membership and the profession as a whole. One of the findings was that 9 per cent of dispensing opticians (not including contact lens opticians) already carry out refraction. This equates to around 600 dispensing opticians, which is a large number of practitioners who could easily and quickly receive additional training and be accredited to safely carry out refraction as part of the sight test.

If the GOC decides to allow this, ABDO will provide training to enable members to ensure their skills and knowledge are up-to-date and gain accreditation to this effect.

The GOC's new *Outcomes for Registration for Approved Qualifications in Optometry or Dispensing Optics* (updated March 2022), which were developed with input from its expert advisory groups and subject to public consultation, state that both student dispensing opticians and student optometrists will need to be able to analyse visual function from a range of diagnostic sources and use data to devise a clinical management plan for a patient in areas that include refractive management and binocular vision (Outcome 3.4). Student dispensing opticians will therefore need to pass a practical examination to demonstrate their ability to carry out refraction.

It is not the case, therefore, that enabling dispensing opticians to carry out refraction as part of the sight test would present a risk to patients or the wider public. Dispensing opticians undertaking this task will have proven their ability to do so, including flagging up any concerns about pathology or binocular vision for the optometrist or medical practitioner to consider.

We note that survey data gathered by another optical body suggests concern among optometrists about whether it would be safe for the refraction element of the sight test to be separate from the eye health examination. However, such survey data should not carry any weight in deciding whether to amend the 2013 statement unless recipients of the survey were informed a) about the education and training which dispensing opticians currently and would in future receive in relation to refraction; and b) that the refraction would remain under the oversight of the optometrist. We also question whether all optometrists who have expressed concern about dispensing opticians carrying out refraction as part of the sight test will foreswear the use of auto-refractors in practice.

Enabling dispensing opticians to refract as part of the sight test would form part of the wider and positive trend towards a multi-disciplinary approach to delivering primary eye care. By optimising the use of the primary care workforce rather than seeking to maintain outmoded professional boundaries, we can help to relieve the strain on hospital eye departments and improve the quality of eye care which we provide for the UK public.

The sight test already involves a range of staff, such as optical assistants collecting data on visual fields or operating an auto-refractor. It would seem inappropriate for an optometrist or medical practitioner to be able to use the results of increasingly sophisticated subjective auto-refractors but not a refraction carried out by a dispensing optician, a healthcare professional registered by the GOC and trained to add more value to the sight-testing process by flagging up any concerns about pathology or binocular vision for the optometrist or medical practitioner to consider. A dispensing optician could also save time for an optometrist by carrying out the re-check needed if a patient returns to the practice following a sight test saying that their new spectacles have not corrected their vision as intended, and would be able to flag up any concerns about pathology for the optometrist or medical practitioner to consider.

CHANGING THE 2013 STATEMENT WOULD BE CONSISTENT WITH THE GOC'S OBJECTIVES FOR LEGISLATIVE REFORM, IN PARTICULAR:

- OBJECTIVE 1: maintaining patient and public safety – our primary objective in everything we do as a regulator
- OBJECTIVE 2: ensuring that legislation reflects current and future context of healthcare delivery and is more flexible to accommodate changes going forward
- OBJECTIVE 3: ensuring that our legislation is flexible enough to accommodate future workforce needs and does not unnecessarily restrict the development of different roles needed to deliver the eye care needs of the UK
- OBJECTIVE 7: reform should take the path of least resistance where this is appropriate, i.e. considering other regulatory levers, such as standards and guidance if these would be more effective than changing legislation

16. What would be the advantages, disadvantages and impacts *(both positive and negative)* of amending or removing our 2013 statement on refraction so that dispensing opticians can refract for the purposes of the sight test?

(Impacts can include financial impacts and equality, diversity and inclusion impacts.)

Enabling dispensing opticians to refract as part of the sight test under the oversight of an optometrist or medical practitioner would be a limited change to the GOC's 2013 statement on sight-testing. The statement already allows dispensing opticians to refract outside of the sight test, e.g. to check a prescription, meaning that some dispensing opticians already have experience of carrying out refraction.

Dispensing opticians already learn about refraction as part of their initial education and ABDO would provide additional training so members' skills and knowledge are up-to-date. The GOC's new outcomes for registration will ensure that future DOs are fully versed in refraction from the outset.

Enabling dispensing opticians to support optometrists and medical practitioners in carrying out sight tests would enable patient care to be provided in a more flexible way while upholding the principle that a sight test should involve both a refraction and an eye health examination at the same time.

17. Does the sight testing legislation create any unnecessary regulatory barriers?

(not including refraction by dispensing opticians)

Yes	No	Unsure or no opinion
☐	☑	☐

Please give your reasons and provide any evidence to support these. Please also include any advantages, disadvantages and impacts (both positive and negative) of any proposed changes.

In our view, the current sight testing legislation does not create unnecessary regulatory barriers. The legislation has served patients and the wider public well by enabling access to high quality primary eye care services throughout the four nations of the UK.

18. What would be the advantages, disadvantages and impacts *(both positive and negative)* of sight testing legislation remaining as it is currently?
(Impacts can include financial impacts and equality, diversity and inclusion impacts.)

Please give your reasons and provide any evidence to support these.

The GOC's public perceptions research shows a high level of public satisfaction with and confidence in the services provided by registrants. This is an important indication that the current system of primary eye care is serving patients and the public well by providing accessible, high-quality, affordable and innovative care. This is in contrast with other parts of the primary care system, where there is an ongoing struggle to meet patient demand.

In particular, patients benefit from a sight test that includes an eye health examination, which is consistent with the wider health policy focus on prevention.

19. Do you have any data on the number/percentage of referrals that are made to secondary care following a sight test / eye examination?

Yes	No	Unsure or no opinion
☐	☑	☐

If yes, please provide details of the evidence and where it can be obtained.

ABDO does not hold data on referrals to secondary care following a sight test. We are aware, however, that such data has been collected by FODO, the Association for Eye Care Providers.

It is important, in our view, to analyse such data carefully and to take account of the range of factors that can influence referral rates, including the level of experience of an optometrist and whether the NHS has commissioned enhanced diagnostic tests in the area in question, such as a glaucoma referral/refinement pathway.

It is also necessary to take into account the fact that referrals may also be to healthcare professionals in primary care, such as GPs and other optometrists.

20. Are you aware of any data to support or refute the case for separating the refraction from the eye health check?

Yes	No	Unsure or no opinion
☑	☐	☐

If yes, please provide details of the evidence and where it can be obtained.

As stated in our to question 15, the fact that patients benefit from a sight test that includes an eye health examination at the same time as a refraction is a major strength of the UK's system of eye care, enabling eye and wider health issues to be identified and addressed at an early stage in line with the wider health policy focus on prevention.

This benefit is recognised by the public as shown by the GOC's research, with its 2021 public perceptions survey showing that 93 per cent of UK adults agreed that a routine sight test could save someone's sight, 80 per cent knew that a sight test could detect issues such as cataracts and glaucoma and 61 per cent knew that wider health issues could be identified through a routine test.

Other models of eye care do exist, with many countries relying on optometrists or opticians to carry out refraction and eye health issues being the preserve of ophthalmologists. Care should be taken in making international comparisons as across Europe, for example, eye care professionals receive very different levels of education and training, with many optometrists and opticians being educated to a level equivalent to that of a UK dispensing optician. There are also significant variations in the number of qualified eye care professionals, with, for example, approximately twice as many ophthalmologists per person in France and Germany compared with the UK.

FITTING OF CONTACT LENSES

21. Does the fitting of contact lenses legislation create any unnecessary regulatory barriers?

Yes	No	Unsure or no opinion
☐	☑	☐

Please give your reasons and provide any evidence to support these. Please also include any advantages, disadvantages and impacts (both positive and negative) of any proposed changes.

Contact lenses are regulated medical devices and wearing contact lenses can lead to discomfort and at worst, serious complications, including sight loss.

ABDO's view is that in order to minimise the risks to the public it is necessary to maintain the current requirement that contact lenses can be fitted only by a contact lens optician, optometrist or medical practitioner.

This system does not involve any unnecessary regulatory barriers, instead striking an appropriate balance between a) protecting patients against the risks associated with poorly fitted contact lenses and poor compliance with aftercare advice, and b) the benefits of competition in terms of quality, choice and value for money.

22. What would be the advantages, disadvantages and impacts *(both positive and negative)* of fitting of contact lenses legislation remaining as it is currently?

(Impacts can include financial and equality, diversity and inclusion.)

Please give your reasons and provide any evidence to support these.

As stated in our answer to question 21, there are significant advantages to maintaining the current legislation in relation to the fitting of contact lenses.

The fitting of contact lenses should continue to begin before the re-examination date specified in a valid prescription, i.e. a prescription dated no more than two years previously, but we would advise going further than this to ensure that the fitting of contact lenses is completed before the expiry of a valid prescription. The fitting process will often involve the patient trying different lenses and having a number of appointments. This may lead to the patient being supplied with lenses after the prescription has expired.

Removing the current requirements would lead to an increase in the number of patients experiencing serious complications and an increased number of emergency referrals to hospital eye departments.

23. Should the sale and supply of optical appliances be further restricted to certain groups of vulnerable patients?

Yes	No	Unsure or no opinion
☑	☐	☐

Please explain which group(s), give your reasons and provide any evidence to support these.

GOC should seek legislative change to prevent non-registrants from dispensing optical appliances to patient groups that can be described as vulnerable, in particular people with learning disabilities or people diagnosed with dementia, recognising that this requires enhanced skills and knowledge.

DISPENSING SPECTACLES TO ADULTS WITH LEARNING DISABILITIES

Fitting spectacles for adults with learning disabilities requires:

- expert communication skills, including the use of appropriate language and techniques and the ability to engage with and take into account the views and interests of both patients and carers;
- expert dispensing skills, including the ability to take into account head position and facial characteristics, such as the particular facial characteristics of people with Down's syndrome;
- an understanding of the sight problems that are likely to be experienced by people with learning disabilities; and
- an ability to gauge a patient's decision-making capacity and enable them to make their own decisions as far as possible, recognising the complexity involved in gaining valid patient consent and taking into account the GOC's guidance, which provides that registrants must consider any disabilities, literacy or language barriers that may affect a patient's understanding and amend their communication approach to take account of this (paragraph 20) and not make assumptions about the patient's level of knowledge or understanding (paragraph 21).

The dispensing of spectacles to children with learning disabilities must already be carried out by or under the supervision of a registrant. At least this same level of protection should be extended to adults with learning disabilities. However, given the particular expertise involved in dispensing spectacles to this patient group, in our view this activity should be restricted to registrants only.

We note that children with learning disabilities are 28 times more likely to have a serious sight problem and only seven per cent will ever have had a community eye test or be able to access community services. To respond to this need, NHS England established the Special Schools Eyecare Programme and in developing the relevant care pathway specified that spectacles should be dispensed by a registrant, recognising the enhanced skills and knowledge required to dispense spectacles to this patient group. More information about this programme is available on the NHS England website: https://www.england.nhs.uk/learning-disabilities/improving-health/eye-care-dental-care-and-hearing-checks/eye-care/

DISPENSING SPECTACLES TO PEOPLE DIAGNOSED WITH DEMENTIA

According to research carried out by the Alzheimers Society, there are currently around 900,000 people with dementia in the UK. This number is expected to rise sharply in the coming years. This increase is driven by the ageing population, with the risk of developing dementia rising significantly with age. There are projected to be over 1 million people with dementia in the UK by 2025, with this figure projected to rise to nearly 1.6 million in 2040. The Alzheimers Society also found in 2018 that 70 per cent of people in care homes have dementia or severe memory problems. More information is available on the Alzheimers Society website: https://www.alzheimers.org.uk/blog/how-many-people-have-dementia-uk

Fitting spectacles for people with dementia requires:

- **Enhanced dispensing skills** – it is necessary to take into account factors such as head position, mobility and gait in order to optimise a patient's vision. This might involve considering whether they can safely wear spectacles with progressive lenses rather than having a pair for reading and a pair for distance. In making such a judgment, it will be important to bear in mind that patients with dementia find it more difficult to adjust to change.
- **Enhanced communication skills** – using appropriate language and techniques to enable patients to make their own decisions as far as possible, recognising that they might have related conditions such as aphasia, and taking account of the views and interests of both patients and carers.
- **An understanding of dementia as a medical condition and how this can affect vision and behaviour** – it is important to understand, for example, that a patient who is unable to see clearly despite a recent sight test may require a neurological referral rather than a need for their spectacles to be remade, and that a patient who orders three or four pairs of spectacles having in the past just ordered one might be doing so as result of their condition and would benefit from support and guidance. This video provides a useful insight into posterial cortical atrophy, which is a form of dementia that affects visual processing: https://www.youtube.com/watch?v=jekW8Z93LMw
- **An ability to judge a patient's decision-making capacity and enable them to make their own decisions as far as possible** – the GOC's guidance on consent recognises the complexity involved in gaining valid consent and there will often be concerns about a patient's decision-making capacity when they have been diagnosed with dementia, particularly as the condition progresses.

There is a strong relationship between impaired vision in older people and both reduced quality of life and increased risk of accidents, particularly falls. The research literature suggests that those with low vision are about two times more likely to have falls than fully sighted people, and the annual UK cost of treating falls directly attributable to visually impairment is £128 million. The literature on the prevalence of undetected reduced vision in older people reveals that between 20 and 50% of older people have undetected reduced vision. The majority of these people have correctable visual problems, i.e. refractive errors or cataract. [Evans, B.J.W. and Rowlands, G. (2004), Correctable visual impairment in older people: a major unmet need. Ophthalmic and Physiological Optics, 24: 161-180. https://doi.org/10.1111/j.1475-1313.2004.00197.x

The increased risk of accidents, particularly falls, as a result of impaired vision in older people is further reason to ensure that people diagnosed with dementia benefit from expert dispensing skills. Although some registrants might need to enhance their understanding of dementia and the implications for spectacle dispensing, they are required by the GOC's standards of practice to keep up-to-date with developments in research and carry out Continuing Professional Development (CPD) activity.

The number of people diagnosed with dementia, and the expected growth in this number, means that if they do not benefit from expertise in the dispensing of spectacles, the scale of harm could be substantial.

ACTION REQUIRED

We recommend that given the knowledge, skills and challenges involved in the dispensing of spectacles to people with learning disabilities and people diagnosed with dementia, these activities should be restricted to registrants and not be allowed to be carried out under supervision.

As also explained in our answer to question 6, research to monitor the quality of paediatric dispensing should be carried out and if there is not significant improvement, the GOC should consider pursuing legislative change to restrict paediatric dispensing to dispensing opticians and optometrists and make clear that registrants must carry out this activity only if it is within their individual scope of practice.

24. If you answered yes to the previous question, what would be the advantages, disadvantages and impacts *(both positive and negative)* of further restricting the sale and supply of optical appliances to certain groups of vulnerable patients? (Impacts can include financial and equality, diversity and inclusion.)

Please give your reasons and provide any evidence to support these.

See our answers to questions 6, 7 and 23.

In summary, dispensing optical appliances to children, people with learning disabilities or who have been diagnosed with dementia, requires enhanced skills and knowledge, including:

- highly-developed communication skills;
- expert dispensing skills;
- an understanding of medical conditions, such as dementia;
- an ability to judge the decision-making capacity of a patient.

Enabling more vulnerable patient groups to benefit from enhanced dispensing skills would promote more equal treatment and increase inclusion.

Maintaining the current approach to regulation would have a disproportionately negative impact on vulnerable patient groups, namely children, people with learning disabilities and people with dementia. In particular, where paediatric dispensing is not carried out or supervised by registrants with appropriate expertise, patient groups with facial characteristics that are different to white British children are likely to be even less well protected.

25. Do the general direction / supervision legislative requirements relating to the sale of prescription contact lenses create any unnecessary regulatory barriers?

Yes	No	Unsure or no opinion
☐	☑	☐

Please give your reasons and provide any evidence to support these.

ABDO's view is that this legislation is required to protect the public and does not create any unnecessary regulatory barriers.

The current approach strikes an appropriate balance between protecting patients against the risks associated with wearing contact lenses and enabling patients to secure the benefits of competition in terms of quality, choice and value for money.

However, we think it would be helpful for the GOC to clarify its approach to enforcing the legislation relating to the supply of contact lenses. We appreciate that following the consultation on its revised illegal practice protocol, the GOC will be developing a wider illegal practice strategy. As part of this work, it would be helpful to clarify how the legislation applies to suppliers who are registered overseas, but operate from the UK.

26. Would there be a risk of harm to patients if the general direction / supervision requirements relating to the sale of prescription contact lenses changed?

Yes	No	Unsure or no opinion
☑	☐	☐

Please give your reasons and provide any evidence to support these.

If the general direction or supervision requirements relating to the sale of prescription contact lenses were changed, there would be a risk of harm to patients. The involvement of a registrant in the supply of prescription contact lenses continues to provide an important safeguard, given the risks associated with wearing contact lenses. In particular, the risk of complications increases significantly if patients do not wear and look after their contact lenses in line with professional advice and registrants play a key role in ensuring that patients have check-ups at appropriate intervals and in communicating and reinforcing aftercare advice.

27. Do the legislative requirements for verification of contact lens specifications create any unnecessary regulatory barriers?

Yes	No	Unsure or no opinion
☐	☐	☑

Please give your reasons and provide any evidence to support these.

There is not a straightforward 'yes' or 'no' answer to this question. There should continue to be verification that a patient has a valid in-date specification before being able to buy contact lenses. This ensures that a patient has contact lens check-ups at appropriate intervals rather than being able to buy contact lenses on an open-ended basis.

What is worth exploring, however, is how the verification of the specification should be undertaken and by whom. For example, it is arguable that a patient should be able to provide an electronic copy of their in-date contact lens specification without the need for this to be separately verified with the supplier of the specification, provided it can be read clearly. This would enable a patient to supply a picture of their specification taken on their smartphone.

However, we do not agree with the GOC's view that the requirement to verify the particulars of a specification should be removed entirely as this would potentially enable contact lenses to be sold without a patient having an in-date specification and therefore without receiving appropriate aftercare.

28. What would be the advantages, disadvantages and impacts *(both positive and negative)* of removing the requirement to verify a copy of or the particulars of a contact lens specification? (Impacts can include financial and equality, diversity and inclusion.)

Please give your reasons and provide any evidence to support these.

Removing the requirement for specifications to be verified would be detrimental to patients as it would enable contact lenses to be purchased without a valid in-date specification and thus avoid the need for regular aftercare appointments and without receiving professional aftercare advice.

The GOC states that the requirement for verification of both electronic copies and particulars of specifications is outdated and that the risks associated originally with this requirement may have changed. It is hard to comment on this assertion without understanding why the GOC believes that the requirement is outdated or that the risks may have changed. Certainly, it would be premature to draw any conclusions from the relaxation of this requirement during the COVID-19 pandemic. We also question the GOC's assumption that because it is not aware of any detrimental effects caused by this relaxation, that no such effects occurred.

Furthermore, as we said in our answer to question 27, it is important to draw a distinction between a patient supplying a legible copy of a specification and a patient supplying the particulars of a specification. Relying on the particulars supplied by a patient without verification would enable contact lenses to be supplied on an open-ended basis without regular check-ups or professional aftercare advice.

29. Do you think the Act should specify a definition of aftercare?

Yes	No	Unsure or no opinion
☐	☑	☐

If yes, please specify what you think the definition of aftercare should be.

ABDO is of the view that what constitutes 'appropriate aftercare' should be defined, although we suggest that the GOC should explore whether this needs to be specified in legislation rather than in a policy statement that could be reviewed and updated more easily. However, it would be important to ensure that such a statement would be binding on all suppliers of contact lenses. This issue should be addressed, therefore, in conjunction with extending business registration to all businesses carrying out restricted activities. This would give a policy statement on aftercare 'teeth' in that the GOC's standards for registered businesses would require all such businesses to comply with relevant policy statements.

An important issue that would need to be covered in such a policy statement is what should be the maximum time that can be recommended prior to an aftercare appointment.

As we said in our response to the GOC's consultation on its illegal practice protocol, it is also necessary to explore how with sector bodies to raise patient awareness of the need to have regular contact lens check-ups and how to wear and look after contact lenses safely. This is particularly important given that online suppliers who are based overseas will not have to register with the GOC and comply with UK law.

30. Does the zero powered contact lenses legislation create any unnecessary regulatory barriers?

Yes	No	Unsure or no opinion
☐	☑	☐

Please give your reasons and provide any evidence to support these. Please also include any advantages, disadvantages and impacts (both positive and negative) of any proposed changes.

No, the legislation governing the supply of zero-powered contact lenses does not create any unnecessary regulatory barriers. Requiring such lenses to be supplied by or under the supervision of a registrant is an important safeguard, given that people wanting to wear zero-powered contact lenses at, for example, Halloween or a fancy dress party, might not be regular contact lens wearers with an understanding of how to wear and look after contact lenses safely.

We note that the MHRA has recognised that zero-powered contact lenses carry similar risks to prescription contact lenses if, for example, they are worn when showering or worn overnight, and intends, therefore, to classify them as medical devices.

31. Would there be a risk of harm to patients if the requirements relating to the sale of zero powered contact lenses change?

Yes	No	Unsure or no opinion
☑	☐	☐

Please give your reasons and provide any evidence to support these.

Yes, there would be a risk of harm to patients if the legal restrictions on the supply of zero-powered contact lenses were changed, presumably by removing them. Patients without necessarily any experience of wearing contact lenses would be able to obtain zero-powered contact lenses without receiving any professional advice on how to wear them safely.

32. If you answered yes to the previous question, is legislation necessary to mitigate this risk?

Yes	No	Unsure or no opinion
☑	☐	☐

Please give your reasons and provide any evidence to support these.

Yes, legislation is necessary to mitigate the risk of patient harm as in the absence of such legislation, zero-powered contact lenses could be supplied by businesses, such as hairdressers or market stalls, that would not be registered with the GOC and therefore, not required to follow GOC policy statements.

33. What would be the advantages, disadvantages and impacts *(both positive and negative)* of zero powered contact lenses legislation remaining as it is currently?
(Impacts can include financial and equality, diversity and inclusion.)

Please give your reasons and provide any evidence to support these.

Zero-powered contact lenses would be fitted correctly and people buying such lenses would receive professional advice on how to wear and look after them. They would be less likely to experience complications as a result.

Zero-powered contact lenses would still be readily available to the public but would be supplied in way that recognises their status as medical devices, the wearing of which can lead to patient harm, particularly if professional advice on how to wear and look after them is not followed.

34. Are there any unnecessary regulatory barriers in the Act that would prevent current or future development in the sale of optical appliances or competition in the market?

Yes	No	Unsure or no opinion
☐	☑	☐

If you answered yes, please give details, including your reasons and provide any evidence to support these.

Not applicable

35. If you answered yes to the previous question, what would be the risk on the consumer if these barriers were removed?

Please give your reasons and provide any evidence to support these. Please also include any advantages, disadvantages and impacts (both positive and negative) of any proposed changes.

Not applicable

36. Is legislation regarding the sale of optical appliances necessary to protect consumers (except restricted categories)**?**

Yes	No	Unsure or no opinion
☑	☐	☐

Please give your reasons and provide any evidence to support these.

The current legislation regarding optical appliance is necessary to protect the public. Optical appliances are medical devices and where they are not being supplied by registrants the patient should at least have a valid prescription, demonstrating that they have had a recent sight test, including an eye health examination to identify any concerns and enable appropriate intervention.

37. Is the two year prescription restriction on purchase of spectacles from non-registrants an unnecessary regulatory barrier?

Yes	No	Unsure or no opinion
☐	☑	☐

Please give your reasons and provide any evidence to support these.

Requiring that non-registrants should supply optical appliances only with a written prescription issued within the previous two years continues to be necessary to protect the public.

The suggestion that 'some patients' are not happy with this requirement does not provide evidence of the need for change, particularly when the GOC's public perceptions research shows high levels of satisfaction and confidence in optical professionals.

While some patients might not appreciate that a sight test involves an eye health examination and therefore, appreciate the benefit of having a sight test every two years, this approach is a successful example of preventative health care. Early identification and treatment of eye disease reduces the risk of sight loss.

A sight test can also enable the early identification and treatment of other health conditions, such as high blood pressure or diabetes.

38. What would be advantages, disadvantages and impacts *(both positive and negative)* of patients being able to purchase spectacles from non-registrants without a prescription dated in the previous two years? (Impacts can include financial and equality, diversity and inclusion.)

Please give your reasons and provide any evidence to support these.

Being able to purchase spectacles from non-registrants without a prescription dated in the previous two years would be disadvantageous to patients.

Patients would miss out on eye health checks at the interval recommended by an optometrist, with this recall period being based on clinical guidance and tailored to the individual taking into account ocular and family history and the information gathered during the sight test.

The fact that the sight test includes an eye health examination means that there are public health benefits in line with the wider health policy focus on prevention.

Patients would potentially not have their refractive error fully corrected if the nature of this error had changed in the period between buying the spectacles and a sight test carried out more than two years previously. This could mean that they failed to meet vision standards for driving, with risks to themselves and the wider public, or could be more at a greater risk of falls, leading to a need for NHS and social care.

Removing the requirement in question would not lead to a significant cost saving. 70 per cent of sight tests in UK are NHS-funded, with this rising to 100 per cent in Scotland. Privately funded tests are widely available for a below cost charge and some employees may be able to reclaim the costs from their employer.

Sight tests are also available without any significant waiting time in contrast with other parts of primary care system, meaning that removing this requirement would not speed up access to care.

39. What would be advantages, disadvantages and impacts *(both positive and negative)* of the legislation remaining as it is currently? (Impacts can include financial and equality, diversity and inclusion.)

Please give your reasons and provide any evidence to support these.

The current system working well, with high levels of satisfaction and confidence in optical professionals.

Overall, eyecare is accessible and affordable, with the current system having improved equality of service provision and therefore, increased inclusion.

Outside of the legislative requirements relating to the sight test, the legislation does not prevent practitioners from expanding their scopes of practice where they are trained and competent to do so.

What determines whether dispensing opticians and optometrists are able to provide enhanced eye care services to their patients is the extent to which such services are commissioned by the NHS.

40. Does the legislation in relation to the sale and supply of sportswear optical appliances for children under 16 create any unnecessary regulatory barriers?

Yes	No	Unsure or no opinion
☐	☑	☐

Please give your reasons and provide any evidence to support these.

No, the legislation relating to the sale and supply of sports eye wear for children under 16 does not create any unnecessary regulatory barriers.

The current restrictions on the supply of sports eye wear to children under 16 are necessary to protect the public. Sports eyewear is fitted not only to ensure optimum vision but to afford protection to the wearer and, for contact sports, to other participants. As a result, it is more rather than less complex to fit, requiring detailed questioning about usage and enhanced dispensing skills to ensure a safe, optimum fit.

41. What would be advantages, disadvantages and impacts *(both positive and negative)* of children under 16 being able to buy sportswear optical appliances outside the supervision of a registrant / registered medical practitioner? (Impacts can include financial and equality, diversity and inclusion.)

These restrictions are necessary to protect the public and should be maintained. We disagree with the GOC that the fitting process for such sportswear is 'not as complex' as for spectacles or contact lenses. Sports eyewear is fitted not only to ensure optimum vision but to afford protection to the wearer and, for contact sports, to other participants. Therefore, it is more rather than less complex to fit, requiring detailed questioning about usage and enhanced dispensing skills to ensure a safe, optimum fit.

The call for evidence also suggests that the restrictions might be unnecessary because sportswear is 'usually only worn for short periods'. While diving masks , swimming goggles or sport goggles can be worn for short periods, they can also be worn over an extended length of time. In any case, if such optical appliances have not been fitted correctly and/or appropriate advice has not been given, there is clearly an increased risk of harm if a child is unable to see clearly under water or is wearing a poorly fitting pair of rugby goggles. This could also result in harm to team members or competitors.

42. What would be advantages, disadvantages and impacts *(both positive and negative)* of the legislation remaining as it is currently? (Impacts can include financial and equality, diversity and inclusion.)

Please give your reasons and provide any evidence to support these.

The advantage of maintaining the current legislation would be that children would continue to benefit from well-fitting sports eye wear which optimises their vision and protects them and, in the case of team sports, their fellow participants.

Sports eyewear would remain readily available and support the enjoyment of sporting activities by children, while ensuring that the risk of harm is minimised.

43. Are there any other aspects of the sale and supply of optical appliances legislation that you think need changing or create unnecessary regulatory barriers?

Yes	No	Unsure or no opinion
☐	☑	☐

If yes, please give your reasons and provide any evidence to support these.

44. What would be the advantages, disadvantages and impacts *(both positive and negative)* of the sale and supply of optical appliances legislation remaining as it is currently? (Impacts can include financial and equality, diversity and inclusion.)

Please give your reasons and provide any evidence to support these.

Not applicable

45. Do you have any knowledge or experience of areas of technological development that the GOC should be aware of when considering changes to the Act?

Yes ☑	No ☐	Unsure or no opinion ☐

If you answered yes, please give details, including your reasons and provide any evidence to support these.

ABDO worked with sector partners to commission the Foresight Report (2016), which the GOC has referred to in the call for evidence, and tracks technological developments closely to inform our advice and guidance to members and our strategic planning. We would be happy to present to GOC members and staff our analysis of the latest developments and their implications for optical practice and patient care.

The Opticians Act has not prevented the rollout of technologies to enhance patient care and the UK model of primary eye care has encouraged and enabled this innovation. However, the need to ensure that technology is used safely in practice strengthens the case for a consistent and comprehensive approach to business regulation.

Achieving this reform will enable the GOC to ensure through its standards for optical businesses that businesses ensure:

- technology is maintained and working effectively
- effective operating procedures are in place
- all relevant staff are trained appropriately
- they comply with other relevant regulation, such as complying with MHRA requirements in relation to the need for assurance that software, including artificial intelligence, produce reliable and equitable outcomes for patients

We also encourage the GOC to be precise in its use of language when referring to technologies as the risk of patient safety issues will vary depending on the particular type of technology under consideration. For example, equality concerns in relation to the application of artificial intelligence will not apply to other forms of technology.

46. Is there any evidence that increased use of technology or remote care may have an impact on patient safety or care in the future?

Yes – a mainly positive impact ☑	Yes – a mainly negative impact ☐
No ☐	Not sure / no opinion ☐

If you answered yes, please give details, including your reasons and provide any evidence to support these.

The use of technology in optical practice raises different issues to the application of remote care so this is a difficult question to answer and there would be value in breaking it down further.

The use of technology in practice in line with legislative requirements and GOC standards is likely to continue to enhance patient care by, for example, improving the diagnosis of eye disease and wider health issues.

The use of remote care has the potential to increase the risk to patients if it is not carried out by offshore business that are not bound by UK legislation and without the involvement of GOC registrants.

47. Are there any unnecessary regulatory barriers in the Act that would prevent any current or future technological development in the eye care sector or restrict innovative care delivery or competition in the market?

Yes	No	Unsure or no opinion
☐	☑	☐

If you answered yes, please give details, including your reasons and provide any evidence to support these.

Not applicable

48. Are there any gaps within the Act or GOC policy relating to the regulation of technology or remote care that present a risk to patients?

Yes	No	Unsure or no opinion
☑	☐	☐

If you answered yes, please give details of what these are, including your reasons and provide any evidence to support these.

As more hybrid models of care evolve, potentially with optometrists working remotely, there is a risk that this affects their ability to carry out effective supervision of other staff in practice.

The Topol Review highlighted the need for healthcare professionals to be equipped to use technology confidently and adapt as it evolves: https://topol.hee.nhs.uk/

49. If you answered yes to the previous question, do you have any suggestions about how these gaps in the regulation of technology or remote care could be addressed?

Please include your reasons and any evidence or impacts of your suggestions.

The GOC should review is policy statement on supervision to reflect developments in the delivery of eye care, including hybrid models. It should also ensure this is enforced effectively.

The GOC should consider further how it might promote technological literacy through, for example, its education requirements, standards of practice, business standards and CPD scheme.

50. Are there any gaps in the Act or GOC policy relating to the regulation of online sales of optical appliances that present a risk to patients?

Yes	No	Unsure or no opinion
☑	☐	☐

If you answered yes, please give details of what these are, including your reasons and provide any evidence to support these.

The GOC lacks statutory powers of investigation and enforcement, which means that it not able to take effective enforcement action. Based on the GOC's research into the risks associated with illegal practice, this presents a risk to patients.

We accept that dealing with illegal practice is not a core function of the GOC, but as a matter of policy, it has taken an unnecessarily narrow view of what activities it is able to carry out in line with its overarching objective of protecting the public.

We note that the Professional Standards Authority has questioned previous activity to raise public awareness of the risks associated with illegal practice, such as supplying contact lenses online without ensuring that a patient has an up-to-date specification. However, it is possible for the GOC to explain its reasoning and seek to persuade the PSA to take a different view. The PSA's disapproval should not be used as an excuse for inaction.

51. If you answered yes to the previous question, do you have any suggestions about how these gaps in the regulation of online sales of optical appliances could be addressed?

Please include your reasons and any evidence or impacts of your suggestions.

The GOC should seek statutory powers of investigation to enable it to take more effective action to deal with the online sales of optical appliances. It should also give more priority to related activities, such as liaising with trading standards departments, the Advertising Standards Authority, the Competition and Markets Authority and with overseas organisations responsible for regulation and enforcement. It would not be appropriate for significant additional activity in this area to be funded by registrants so the GOC should seek public funding for this work.

The GOC should work with sector bodies to develop a code of practice for the online supply of optical appliances and services, building on previous work to develop a code of practice for the online supply of contact lenses and the joint regulatory statement setting out High level principles for good practice in remote consultations and prescribing (November 2019). NB This statement no longer appears to be available on the GOC's website.

The code of practice should be accompanied by a public awareness campaign to signpost the public to online suppliers who comply with the code of practice. This would circumvent the challenge posed by suppliers based overseas in that such suppliers would have incentive to sign up to the code or face losing business to those which did.

52. Are there other areas of our current legislation that you think need to be amended? (Recognising that the Department of Health and Social Care review will cover our core functions)

Yes	No	Unsure or no opinion
☐	☑	☐

If you answered yes, please give details, including your reasons and provide any evidence to support these.

Not applicable

53. Are they any other gaps in regulation where you think legislative change might be required?

Yes	No	Unsure or no opinion
☐	☑	☐

If you answered yes, please give details, including your reasons and provide any evidence to support these.

Not applicable

54. Are there any other policies or guidance that the GOC currently produces that should be reviewed or require amendments?

Yes	No	Unsure or no opinion
☐	☑	☐

If you answered yes, please give details, including your reasons and provide any evidence to support these.

See our answers to questions 6 and 7.

The GOC should review its standards of practice and standards for optical business to make clearer the expectation that registrants must operate within their individual scope of practice in relation to paediatric dispensing and the supervision of paediatric dispensing.

55. Are there any other impacts of our legislation that you would like to tell us about, including financial impact or impact on those with protected characteristics under the Equality Act 2010? (i.e. age, sex, race, religion or belief, disability, sexual orientation, gender reassignment, pregnancy or maternity, caring responsibilities)

Yes	No	Unsure or no opinion
☐	☑	☐

If you answered yes, please give details, including your reasons and provide any evidence to support these.

Not applicable