LEARNING DOMAINS

CLINICAL PRACTICE

SPECIALTY: CONTACT LENS OPTICIANS

PROFESSIONAL GROUPS

Dispensing opticians — CPD PROVIDER — General Optical Council

Optometrists — CPD PROVIDER — General Optical Council

Contact lens opticians — CPD PROVIDER — General Optical Council

CPD CODE: C-109798

MCQs AVAILABLE ONLINE: Thursday 2 January 2025

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This CPD session is open to all FBDO members and associate member optometrists. Successful completion of this CPD session will provide you with a certificate of completion of one non-interactive CPD point. The multiple-choice questions (MCQs) are available online from Thursday 2 January 2025. Visit **abdo.org.uk**. After member login, scroll down and you will find CPD Online within your personalised dashboard. Six questions will be presented in a random order. Please ensure that your email address and GOC number are up-to-date. The pass mark is 60 per cent.

CPD CODE: C-109798

Scope of practice

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This CPD article will explore the concept of 'scope of practice', specifically in relation to the healthcare professions of dispensing opticians (DOs) and contact lens opticians (CLOs). First though, we need to have an understanding of what scope of practice means, which may not be as simple as it seems.

Globally, within the healthcare professions, there is no universally agreed definition of scope of practice[1]. This can be seen in eyecare in the UK where currently neither the Association of British Dispensing Opticians (ABDO) nor the General Optical Council (GOC) provide a definition of scope of practice. However, the College of Optometrists does – and in 2022 undertook a consultation to support its members regarding expanding scope of practice. The College of Optometrists, therefore, defines scope of practice as: *'The limit of your knowledge, skills and experience in which you can practice safely, effectively and lawfully[2]'.*

This is a good place for us to start, and this definition is similar to other healthcare organisations, which state what scope of practice means to them. For example, the Health and Care Professions Council states: *'Your scope of practice is the limit of your knowledge, skills and experience and is made up of the activities you carry out within your professional role. As a health and care professional, you must keep within your scope of practice at all times to ensure you are practising safely, lawfully and effectively. This is likely to change over time as your knowledge, skills and experience develop'[3].*

The second part of this statement introduces some of the areas we will consider in this article, namely that scope of practice is not a static concept. Both of these organisations' statements can be seen to align about specific elements of scope of practice:

LIMIT: this implies that one should practise within a defined boundary or set criteria. Limit is also referred to in the GOC's Standards of Practice for Optometrists and Dispensing Opticians[4]: Standard 6: Recognise, and work within, your limits of competence 6.1: *'Recognise and work within the limits of your scope of practice, taking into account your knowledge, skills and experience'.*

YOUR: this implies individual scope of practice as opposed to a profession's scope of practice.

KNOWLEDGE, SKILLS AND EXPERIENCE: these are the building blocks that go towards creating the individual's scope of practice. These will come from initial pre-qualification training as well as continuing professional development (CPD), which may include additional qualifications, accreditation or certification as necessary. In-practice supervision and/or mentoring may also be part of gaining essential patient experience.

SAFELY: Safe practice must be the first consideration in all that we do. For eyecare professionals, this is clearly set out in the GOC's Standards of Practice for Optometrists and Dispensing Opticians[4]. Safe practice needs to take into consideration both the patient and the practitioner, and should include risk assessment and management, including infection control measures.

LAWFULLY: all practise must be conducted within the legal framework of the country where the practise is taking place. For eyecare in the UK, one of the main pieces of legislation we need to adhere to is the Opticians Act 1989[5]. **Box 1** provides a summary of relevant professional functions that are limited by law. However, other legislation also needs to be considered in day-to-day eyecare practice, such as the Data Protection Act 2018[6], the Equality Act 2010[7] and the Human Medicines Regulations 2012[8].

EFFECTIVELY: in the context of these statements, the implication is that if you are not practising within your scope of practice, then your care may be ineffective, and so there must be the consideration of why it would be conducted. Additionally, there should be appropriate clinical governance in place to ensure the practise being conducted is effective for its purpose – as well as legal and safe. Clinical audits should be undertaken to enable a measure of care quality and highlight areas for improvement.

PROFESSION vs. INDIVIDUAL SCOPE OF PRACTICE

It is generally perceived that scope of practice relates to a profession rather than an individual but, actually, they co-exist. A profession's scope of practice is set initially by the knowledge and skills that are required to enter the profession, i.e. to be demonstrated to pass the professional qualification[1]. For DOs, this is the final theoretical and practical examinations to enable registration with the GOC.

The learning outcomes that need to be demonstrated to obtain this qualification have been agreed with the GOC and define what is considered necessary for an individual to practise in the professional DO role in the UK. The learning outcomes are distilled into the qualification syllabus, which is then used by the educational institutes that train individuals, to enable them to be ready to pass the qualification and go on to practise the profession.

It is at this point that a 'profession's' and an 'individual's' scope of practice start to become more complicated. Let's consider specifically DOs. Following the GOC's recent Education Strategic Review, new learning outcomes for all professions that the GOC regulates were created through sector working groups. This led to the creation of new syllabi, and for those entering training to be a DO and examined by ABDO, entry from September 2023 onwards meant they would follow the new Diploma in Ophthalmic Dispensing Syllabus 2023[11].

Assuming qualification in 2026, these 2023 trainee DOs will be demonstrating they that have the knowledge and skills to achieve the learning outcomes covered in the 2023 syllabus. However, these learning outcomes are not all the same as the 2015 syllabus[12], nor the previous ones, or the ones before that. Although there are considerable consistencies in subsequent syllabi, there are marked differences. These differences have developed as the required scope of practice of the profession of DO changes with the needs of eyecare practice in the UK. Therefore, one could say that a newly qualified DO has a more relevant professional scope of practice than a DO who qualified 20 years ago – if we *only* considered knowledge and skills at the point of entering the register. The reality should be that the DO who qualified 20 years ago has been adjusting their scope of practice to fit the current needs of eyecare, and this is where CPD comes to the fore.

Professional functions regulated by the Opticians Act 1989 BOX 1

The testing of sight, as defined in the Opticians Act 1989 Section 24 (Testing of sight) and 26 (Duties to be performed on sight testing) and in the Sight Testing (Examination and prescription) (No 2) Regulations 1989:

- Testing of sight is restricted to a registered optometrist or medical practitioner

The fitting of contact lenses (Section 25 of the Opticians Act 1989):

- Fitting contact lenses is restricted to a registered optometrist, appropriately qualified dispensing optician or medical practitioner

The dispensing of spectacle prescriptions of a kind that unqualified persons are not permitted by law to dispense (Section 27 of the Opticians Act 1989):

- There are restrictions on dispensing to persons under 16 years of age, or to those who are registered severely sight impaired or sight impaired
- The method of supply of all optical appliances including ready-made reading spectacles, on the premises of a registered optician or enrolled body corporate.

Exceptions are in place for some regulated functions for those engaged on approved training programmes and are under the supervision of an appropriate registered practitioner, when these are being undertaken in the course of obtaining practice experience.

CPD, STANDARDS OF PRACTICE AND SCOPE OF PRACTICE

The changes made by the GOC when moving from CET (continuing education and training) to CPD now require GOC registrants to truly consider their current scope of practice and their potential future scope of practice[13]. In the former CET scheme, all registrants were required to undertake lifelong learning in all areas of their profession's 'core competencies'. The specifics of these were directly related to the skills and knowledge required to pass their original qualifying examinations. This meant that all registrants needed to focus at least some of their continuing professional education on the basics of their profession, rather than development and expansion.

The GOC CPD scheme now requires all registrants to define their individual scope of practice up front, which enables individuals to reflect on what knowledge and skills are relevant for them to have to safely and effectively conduct *their individual role in their professional setting*. A DO based in a hospital eye service (HES) will have some different clinical requirements to one who is based in a suburban, independent practice. These, in turn, will be different for the DO who works as a locum across a range of multiple practices in the centre of London, and again different for the DO who works for a third sector organisation delivering services to low vision patients.

The GOC CPD scheme requires all registrants to take *professional responsibility* for understanding their

individual scope of practice, making sure that they are not undertaking tasks they are not competent to perform or not legally allowed to perform. There is also the responsibility to consider confidence and experience to perform the task. Two examples of individual and changing scope of practice can be found in **Box 2**.

The GOC Standards of Practice for Optometrists and Dispensing Opticians is an important document for registrants to consider when reflecting on their individual scope of practice and the professions' scope of practice. For example, **Standard 5: Keep your knowledge and skills up to date** 5.1 states[4]: *'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'.*

This highlights the professional responsibility registrants have to limit their practice when they are not competent in specific clinical areas. However, this requires personal reflection by the registrant to decide whether they are competent or not; competency should not be assumed. The remainder of Standard 5 should feed into this reflection and any required action[4]:

- *5.2 Comply with the Continuing Professional Development (CPD) 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'*
- *5.3 Be aware of current good practice, taking into account relevant developments in clinical research and practice, including digital technologies, to inform the care you provide'*
- *5.4 Reflect on your practice and seek to improve the quality of your work through activities such as reviews, audits, appraisals or risk assessments. Implement any actions arising from these'*

One other consideration the GOC Standards of Practice bring to scope of practice is where a skill or responsibility in the profession's scope of practice must also always remain in the individual registrant's scope of practice. One example of this is the duty to refer, which can be found in: Standard 6: Recognise, and work within, your limits of competence 6.2[4]: *'Be able to identify when you need to refer a patient in the interests of the patient's health and safety, and make appropriate referrals'.* Also in **Standard 7 Conduct appropriate assessments, examinations, treatments and referrals**[4]: *7.2 'Provide or arrange any further examinations, advice, investigations or treatment if required for your patient. This should be done in a timescale that does not compromise patient safety and care';* **and, Standard 12. Ensure a safe environment for your patients**[4]**:** *'12.4 In an emergency, take appropriate action to provide care, taking into account your competence and other available options. You must: 12.4.1 Use your professional judgement to assess the urgency of the situation. 12.4.2 Provide any care that is within your scope of practice which will provide benefit for the patient. 12.4.3 Make your best efforts to refer or signpost the patient to another healthcare professional or source of care where appropriate'.*

Examples of individual and changing scope of practice

BOX 2

EXAMPLE 1:
DO working in a hospital eye service

It is expected a DO working in a HES will be required to develop knowledge and skills related to supporting patients with a range of pathologies to make the most of their vision – likely far beyond that which they had on the day of entering the register. They may do this through work-based mentoring and training, CPD and gaining hands-on experience, as well as possible further qualifications.

Compared to a DO based in a High Street practice setting, their competence and confidence in managing patients with glaucoma, cataract, age-related macular degeneration and a range of other conditions and co-morbidities is likely to be high.

However, if this hospital is set in a large city, it is quite possible that children do not come into their service, as they are seen instead at a dedicated children's hospital. This DO then needs to consider how their knowledge and skills to support paediatric patients will diminish, and at which point they could no longer be considered competent and confident to work with these patients: *it has fallen out of their individual scope of practice.*

Should the DO choose to move to work in an alternative setting, they would need to consider if they would be expected to work with children. They are qualified to do this and so it would be legal for them to do so; but to adhere to the GOC Standards of Practice and practise safely and effectively, they may need to undertake CPD to bring themselves back up to the required levels of knowledge and skills to be able to manage this patient group.

EXAMPLE 2:
CLO providing dry eye clinics

Diagnosing and managing dry eye can be considered within the remit of the CLO. However, it would be expected that, post-qualification, additional knowledge and skills would be obtained through CPD and specific product training to support this practice.

In this example, let's consider a CLO who has undertaken extensive training in dry eye and now works exclusively delivering a dry eye service in practice. Their knowledge and skills in relation to investigating and managing a range of anterior eye pathologies would be expected to be very high. However, the CLO will need to consider the knowledge and skills relating to contact lens fitting and management that they no longer use, and at what point they are no longer competent or confident to do this.

This may be fairly specific; they could be fitting therapeutic contact lenses and be skilled in this area, but no longer seeing paediatric patients or fitting contact lenses to manage presbyopia.

It may be they then choose to change their practise and again deliver regular contact lens clinics. They will not have lost their skilled use of the slit lamp or how to obtain patient history and symptoms, but they will likely be behind in their knowledge of the latest contact lens materials and designs. They may also need to consider sourcing CPD to support how they manage certain patient groups with contact lenses.

As the GOC Standards of Practice apply equally to both optometrists and DOs, all GOC registrants have a duty to refer. Anecdotally, some DOs report that they never need to consider referring a patient, as they never work in practice without an optometrist present. It is certainly true that there will be some DOs working in large practices who have never worked a day without an optometrist colleague present. However, this does not stop the DO still having the requirement to personally undertake referral of a patient should circumstances require. Therefore, a DO in this practice situation must maintain their knowledge and skills on referral even if they are not putting them into practice regularly.

It should also be noted here that referrals may occur both externally and internally, for example, DO to optometrist. Therefore, it is expected that in this situation a DO *is* referring, such as when triaging a patient, even if they have not identified this action as a referral.

QUALIFICATION, ACCREDITATION, CERTIFICATION AND TRAINING

When expanding scope of practice beyond the profession's requirement to enter the GOC register, there is a need to consider what may be officially required to do this. We have already covered how qualification is required to practise in a specific registrable eyecare profession, and how additional training, which may be in the form of CPD, can support expansion of scope of practice.

It should be noted that where certification of training is not automatically provided, as it is with CPD, a record of the training should be maintained, even if this is just undertaken in a practice setting. Records should include the date/timeframe the training that took place, what was undertaken, and who the trainee and trainer were, including their relevant credentials. It would always be expected that the trainer is appropriately qualified and experienced in the relevant practice to be able to train.

An example of expansion of scope of practice that doesn't require additional qualification or accreditation would be a CLO learning to fit patients with scleral contact lenses (**Figure 1**). These lens types are included in the theory elements of the current and previous Level 6 Diploma in Contact Lens Practice syllabi, but are not practically examined outside possible inclusion in a viva discussion. Therefore, there is a need to gain practical experience on fitting and aftercare with scleral lenses to be able have the necessary skill and confidence to consider it to be within scope of practice. This could be conducted in practice through mentoring with a colleague or other appropriate professional. Some experience could also be gained by attending a practical CPD course on scleral contact lenses. Evidence of the knowledge and skills gained by the latter would be provided as a CPD certificate on completion, and the former could be submitted to the GOC as self-directed learning CPD, with a corresponding reflective learning statement and training record.

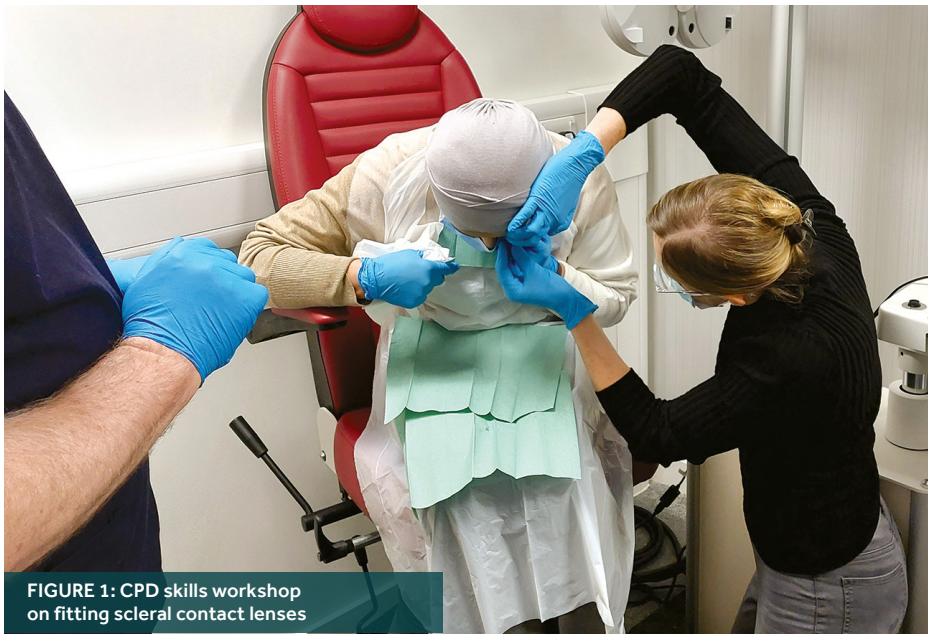

FIGURE 1: CPD skills workshop on fitting scleral contact lenses

Staying with CLOs, let's consider an example where accreditation is required, such as the ability to perform as an extended services CLO (ESCLO) in a minor eye conditions service (MECS)[14]. To ensure that CLOs are equipped and recognised to be able to work within a local MECS, an extended services course has been developed by a range of stakeholders, including ABDO and the Wales Optometry Postgraduate Education Centre (WOPEC), with the latter playing a key part in MECS accreditation for optometrists.

MECS for CLOs is strictly limited to the anterior eye, as it is not within the remit of any CLO to be managing posterior eye conditions; these should be referred to an optometrist or into the HES. However, ESCLO training does include some learning about posterior eye conditions. Although most of the extended services course content is already within the knowledge of the qualified CLO, it takes this to a more in-depth level – including training in glaucoma repeat monitoring and foreign body removal, which are not included in CLO entry qualification examinations.

It should also be noted that the ESCLO accreditation provides a measurable reassurance to other professionals involved in delivering local MECS pathways, such as ophthalmologists and commissioners. Such requirements may be necessary to enable new ways of multi-disciplinary working to serve specific patient needs.

SUPERVISION AND DELEGATED FUNCTIONS

When considering expanded scope of practice, it is necessary to understand which tasks are performed under supervision and which are performed as a delegated function. This dictates the need to understand the meaning of both terms.

SUPERVISION

Box 1 identifies that there are certain restricted functions, which can be performed 'under supervision'. The person supervising must themselves have the appropriate qualifications, knowledge and skills to undertake the restricted functions[4].

Examples of delegated functions and expanding scope of practice

BOX 3

Box 1 has informed us that fitting contact lenses is a restricted function, according to the Opticians Act 1989. Part 4, Section 25 (5b) of the Act, informs us that the person who fits contact lenses to an individual must[5]: *'provide the individual with instructions and information on the care, wearing, treatment, cleaning and maintenance of the lens'.*

In optical practice, this is commonly referred to as a 'contact lens teach', and in many practices is conducted by someone other than the optometrist or CLO who undertook the fitting. This may be an optical assistant (OA) or a DO. Although the 2023 and previous ABDO Ophthalmic Dispensing syllabi have required the trainee DO to write about the contact lens fitting process and either remove a contact lens under supervision or observe this being done, they have not been required to conduct a contact lens teach or be examined on this[11,12]. Therefore, a DO who does perform contact lens teaches has expanded their scope of practice, but is performing this task *under delegation*.

The registrant who fits the patient with contact lenses retains clinical responsibility for the patient and, therefore, should be satisfied that the DO (or OA) undertaking the teach has the relevant knowledge and skills to perform this function. This may not always be fully considered in practice, particularly where locums are being used or there are new staff in place; this applies to both the person delegating and the person being delegated to.

Ideally, there would be a standard operating procedure (SOP) in place in the practice, that all parties can agree on and refer to. Additionally, it is human nature for bad habits to creep in. Therefore, revisiting the SOP to check that the practice conforms, observation and audits are all useful tools to ensure the delegated function is still being appropriately conducted.

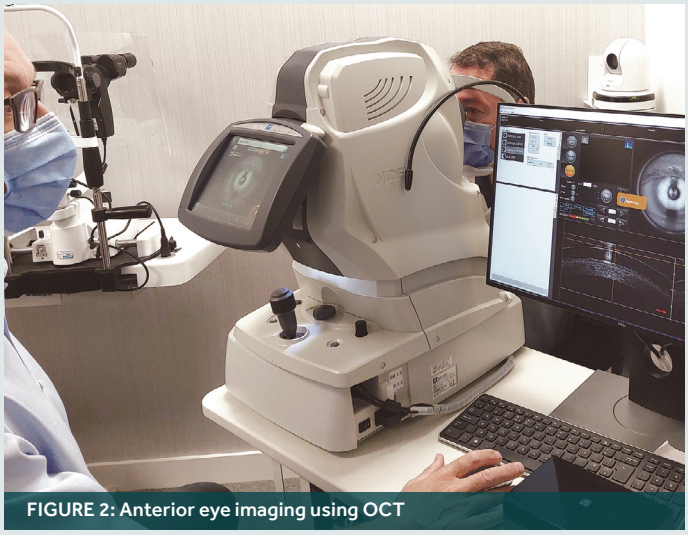

FIGURE 2: Anterior eye imaging using OCT

EXAMPLE 2: Clinical imaging

Similar to the contact lens teach, it is commonplace in optical practice for clinical imaging such as OCT (optical coherence tomography) and fundus photography to be delegated by an optometrist (**Figure 2**). This is may be delegated to an OA or a DO, and conducted as routine 'pre-screening' before an eye examination.

Like contact lens teaches, clinical imaging is not within the qualifying scope of practice of a DO. Therefore, if they are trained to undertake a clinical imaging task, they have expanded their scope of practice – but in High Street practice they are performing this as a *delegated function.*

There may be times when clinical imaging is undertaken by a DO instead as part of a triage process, for example, when referring to a HES as an emergency to support the prioritisation of the patient by the hospital team. A DO should only consider taking images for this purpose if they are appropriately trained to do so, and they are still limited to capturing the images as opposed to interpreting them. That is, although they may be able to recognise specific pathology, they are not able to make a diagnosis as this is outside their scope of practice and would not be based on the results of an image alone.

EXAMPLE 3: Instillation of drops

In the clinical field of myopia management, a DO can use a biometer to measure and monitor axial length, if they have been trained and, therefore, this skill is within their scope of practice. However, if the practice does not have a biometer, another way is to estimate axial length. One way this can be done is to perform a cycloplegic autorefraction.

A DO can instil cycloplegic drops and obtain measurements using an autorefractor for this purpose as a delegated function; again, if they are appropriately trained and so it is within their scope of practice and all other governance is in place for this to happen.

An example relating to a function restricted by the Opticians Act 1989 would be dispensing to a person under the age of 16[5]. Registered DOs and optometrists are able to legally perform this function and able to be the practice education lead (PEL), the new term for the lead supervisor, for a trainee DO as long as they conform to all other relevant criteria[15]. According to the GOC Standards of Practice 9: Ensure that supervision is undertaken appropriately and complies with the law: *'the responsibility to ensure that supervision does not compromise patient care and safety is shared between the supervisor and those being supervised[4]'.*

And, amongst other considerations, the supervisor must: *'9.3 Be on the premises, in a position to oversee the work undertaken and ready to intervene if necessary in order to protect patients. 9.4 Retain clinical responsibility for the patient. When delegating you retain responsibility for the delegated task and for ensuring that it has been performed to the appropriate standard[4]'.*

DELEGATED FUNCTIONS

There is little difference between delegating a function and supervising a function. Ultimately, both fall under Standard 9 of the GOC Standards of Practice, and clinical responsibility for the patient remains with the delegator. One difference is that delegated functions are

often delegated in routine practice as opposed to in relation to supervising a trainee.

Another way to consider the difference between a delegated task and supervision is the level of supervision. Delegation of a task means there is a certain level of autonomy and responsibility, (though it is still the delegator's and the person performing the task's responsibility to ensure it is within their scope to practice), but supervision requires direct, regular advice, support and feedback on performance.

Functions may be delegated to both registered and non-registered practice staff members, depending on the need and the skills, knowledge and competence of the person being delegated to. All other requirements of Standard 9 need to be in place/considered. **Box 3** provides three examples of how a DO may expand their scope of practice but perform these expansions as a delegated function owing to relevant legal restrictions.

INSURANCE

It is important that all eyecare practitioners consider their professional indemnity insurance and whether this is suitable for the tasks they are undertaking[16]. Standard 12 of the GOC Standard of Practice, provides information on insurance requirements, specifying that the registrant *'must have adequate indemnity insurance'*[4].

When entering the register as a DO, or the speciality register as a CLO, indemnity insurance is available that provides cover for the profession's scope of practice. It is only as an individual's scope of practice expands that there is a need to confirm if their current insurance will cover the new tasks being performed.

Insurance requirements are considered by the providers as practice develops. For example, a CLO who holds indemnity insurance with ABDO would be able to train to fit punctal plugs and this practise would now be covered by their insurance. CLOs successfully accredited as an ESCLO must increase their insurance to cover this practise.

There is also a need to consider if a task is being performed as a GOC registrant or outside of the GOC's remit and, therefore, if the practice is relevant to the indemnity insurance held for this purpose. One example here would be performing as a diabetic retinopathy screener or screener grader. A DO may be able to undertake this role, but they would require a qualification outside of that regulated by the GOC – and would usually be performing the task within an NHS contact, which would include indemnity insurance[17].

SUMMARY

Scope of practice can be confusing at times, but it is necessary for all GOC registrants to reflect on their current scope of practice and consider their future path. Optical practice is continuously changing and developing, and there are many opportunities for DOs and CLOs to consider how they may expand their scope of practice. However, this needs to be done legally and safely.

The ABDO teams in Membership, Examinations and CPD – and the ABDO clinical lead – are all available to contact with queries from members relating to scope of practice. Visit the ABDO website for more information and contact details.

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REFERENCES

References can be found when completing this CPD module. For a PDF of this article with references email, abdocpd@abdo.org.uk

LEARNING OUTCOMES FOR THIS CPD ARTICLE

DOMAIN: Clinical Practice

5.1, 6.4: *Reflect on your personal-professional scope of practice to ensure you are competent in all aspects of your work, and are not practising beyond the legal, safe and effective limits of your scope of practice.*

5.4: *Reflect on your practice and seek to improve the quality of your work through activities such as reviews, audits, appraisals or risk assessments. Implement any actions arising from these including furthering your scope of practice to support the care you provide your patients.*

6.2, 7.2: *Understand your professional duty to refer a patient in the interests of the patient's health and safety, and reflect on your ability to do this both internally and externally from the practice in a timescale that will not compromise patient safety and care.*

6.3: *Ensure that you have the required knowledge, skills and qualifications relevant to your practice.*

DOMAIN: Contact Lens Speciality

Reflect on your personal-professional scope of practice to ensure you are competent and not practising beyond the legal, safe and effective limits of your scope of practice. Reflect on where you may extend your scope of practice to support the care you provide your patients.

CLINICAL PRACTICE

SPECIALTY: CONTACT LENS OPTICIANS

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