Optometry Scotland's Submission

Call for evidence on the Opticians Act and consultation on associated GOC policies

Submitted 18 July 2022

optometryscotland

About Optometry Scotland

Optometry Scotland (OS) is a non-profit making organisation established to develop and represent the views of the entire Optometry sector of Optometrists, Dispensing Opticians and Optical Bodies Corporate to the Scottish Parliament, the Scottish Government Health Directorates and other relevant stakeholders.

Formed in 2001, OS is the voice of the optical professions in Scotland, we work in close partnership with the Scottish Government Health Directorates, Health Boards, third sector organisations and other professional groups such as ophthalmology clinical leads.

OS is the first point of contact for eye health matters in Scotland and our objective is to continue to develop world class eye health care services for the people of Scotland.

We will achieve this aim by:

- Striving for the highest possible standards of professional competence and care within the optometric professions.
- Securing funding to enable Optometrists, Dispensing Opticians and their staff to provide high quality equitable services across Scotland and thereby
- Working to provide the highest standards of clinical care
- Support ongoing training and development
- Working towards the prevention of avoidable blindness through the early detection and appropriate management of eye disease
- Work with other relevant stakeholders, organisations, and the media, to raise awareness of the importance of regular eye examinations and extended specialist services provided within optometry practices.

Optometry Scotland is run by a Council including members from the independent sector, hospital optometry, multiple operator representatives, university representation and attendees from NHS Education Scotland.

In addition, members of the Association of Optometrists (AOP), The Federation of Dispensing Opticians (FODO), the College of Optometrists, the Association of British Dispensing Opticians (ABDO) support and attend Council meetings.

Optometry Scotland represents the interests of all GOC registrants across Scotland and promotes the professional development of optometrists and dispensing opticians through representation to the Scottish Government, NHS Scotland and responding to all relevant national consultations and reports.

Section One

Community Eyecare in Scotland

OS worked with the Scottish Government to develop a number of novel eyecare pathways and a review of General Ophthalmic Services (GOS) in the early years of this century.

The new GOS arrangements were introduced in 2006 establishing a step change in community eye care provision across Scotland.

The new GOS arrangements heralded an alternative, standardised, community based pathway for all eye care problems and identified optometrists as the 'first port of call' for all eye related matters.

The new GOS arrangements enabled community optometrists to manage a more extensive case load in the community.

This model is in place, in all NHS Health Boards across Scotland.
It has gradually evolved over time expanding the range and scope of care being delivered by optometrists.

This has delivered high quality care, effective triage, remote access for advice, remote consultations, face to face care leading to ongoing management in the community or effective, prioritised referral to secondary care.

It is now commonplace in most communities across Scotland for eye care issues to be directed to a community optometrist rather than attending a GP practice or presenting to pharmacy.

All NHS Boards also have facilities in place for direct electronic referral from optometry to secondary care, removing the administrative burden from General Practice teams. This SCI Gateway facility allows for added value to the referral, as visual field plots and digital images etc can be attached to the referral, improving the care journey for many patients.

Several NHS Boards have also given Emergency Care Summary and Clinical Portal access to community optometrists ensuring reliable clinical data can be accessed for individual patients during the eye examination without having to contact the GP.

This has also led to greater efficiencies within the system by avoiding duplication of processes, tests and ensuring more effective treatment plans.

Similarly, a number of NHS Boards have involved optometrists in 'Falls' and 'Stroke' pathways and by doing so have added a vital eye health check earlier in the patient journey.

Again this helps avoid duplication and speeds up the care process delivering more efficient treatment for patients.

Prevention – Early Diagnosis

GOS 2006 has helped delivered rapid and accurate diagnosis leading to prompt and effective treatment compared to the more cumbersome model in place prior to 2006.

A new examination structure was implemented in 2006 to help harmonise the level of care available in all communities across the country.

Crucial to this was the introduction of a new & novel concept – the GOS primary and supplementary eye examinations.

This established comprehensive, personalised initial assessment & examinations based on presenting signs and symptoms and the opportunity to repeat procedures to confirm initial findings. The supplementary examinations also allowed for follow up and review optometrists in the community, the outcome being ongoing management in the community or prioritised referral to secondary care.

Prior to 2006 approximately 25% of acute anterior eye problems were managed in the community, this has changed over the intervening years to a level where 80-90% of acute eye problems are managed safely in the community by optometrists. This has reduced the burden on GPs and reduced the number of patients needing referral to secondary care.

The added benefit of rapid access to an eye expert in the community is earlier diagnosis and treatment, reduced morbidity and prevention of more progressive disease.

Enhanced GOS

The model has been further developed in some NHS Board areas such as Lanarkshire and Grampian with enhanced protocols in place to manage a wider range of conditions. Lanarkshire has also employed patient group directives to allow more rapid supply of topical medication.

Independent Prescribing

Independent prescribing has facilitated greater access to treatment options for optometrists and there are approximately 400 IP optometrists across Scotland with a prescribing qualification.

Optometrists have the knowledge and equipment to allow an accurate diagnosis and safer prescribing of drugs.

The Scottish Government has plans to develop this further by introducing an additional supplementary process that will allow optometrists to manage a more complex case mix of anterior eye disease.

This new service will establish intra-referral between non-prescribing optometrists and independent prescribing optometrists for safer management of complex eye disease.

This will ensure further support for secondary care with optometry accepting responsibility for an extended range of eye conditions.

Eye care Statistics – Managing the Burden of Disease

Around 2.3 million GOS eye examinations are carried out by optometrists in Scotland each year, this is broken down to 1,763,659 Primary eye examinations and 579,945 supplementary eye examinations (year 2018/19).

Over 1.4 million cases of eye disease or disorder are managed within the primary eye examination service (This does not include specific paediatric or binocular vision cases as this is not recorded).

In addition over 500,000 people are treated for eye disease within the supplementary eye examination service.

This level of clinical activity being delivered in the community needs to be considered in the context that the total case load in all hospitals across Scotland is 450,000.

The implication is that if GOS was not available considerable additional resource would need to be made in secondary care or the service would grind to a halt.

As indicated above this has allowed hospital eye departments to manage caseloads more effectively.

Since 2007 to 2020 (no data recorded during Covid) attendance across all Scottish eye departments has increased by less than 3%.

This compares favourably with the 39% increase in eye attendances across England since 2006 to 2020 where the GOS model remains unchanged.

The accepted understanding is that much of the increased case load in Scotland has been managed within GOS 2006.

Delegated Care

During the Covid 19 crisis Scottish Government implemented a ‘shared care’ scheme in 2021 to help provide further support for secondary care eye departments, this led to the delegation of care by placement of many patients into the community to be managed by optometrists.

The setup varied slightly across the country, the principal case load was glaucoma and, in some areas, additional sub-specialties were sent out such as uveitis, oculo-plastics, medical retina and ocular surface disease cases.

This initiative allowed many thousands to be managed effectively in primary care. Most cases consisted of patients already attending eye clinics where the review appointment had been missed, but in some areas the shared care also led to novel referral refinement care models being established to help reduce waiting lists.

NHS Education for Scotland Glaucoma Award Training (NESGAT)

NES has established a new glaucoma qualification for optometrists – NES Glaucoma Award Training (NESGAT). This new qualification allows optometrists a greater role in the management of glaucoma cases, including discharge to the community, listing with named optometrists and the autonomous management of glaucoma by NESGAT qualified optometrists..

The Scottish Government are developing plans to implement NESGAT within NHS Boards in Scotland

Again, this will have a positive impact on secondary care capacity and allow closer collaboration and communication between optometry and GPs.

Section Two

GOS Impact Summary

GOS 2006 has resulted in significant benefits across the eyecare sector in Scotland with a positive impact on early intervention / prevention and shifting the balance of care to the community.

The following does give some perspective on this:-

- ✓ Around 2.3 million eye examinations per year
- ✓ Optometry established as the first port of call for all eye conditions
- ✓ Thousands benefit from early diagnosis of eye disorders
- ✓ 1.4 million eye disorders managed within the GOS primary eye examination service
- ✓ Over 500,000 cases managed within the supplementary eye examination service
- ✓ 4.1% of all cases given prioritised direct electronic referral to secondary care
- ✓ A standardised, uniform high quality care across Scotland
- ✓ 80-90% reduction in acute eye presentations to eye casualty and A&E
- ✓ Thousands of appointments released in secondary care by transferring chronic cases to the community
- ✓ 5-10% appointments released in GP surgeries by directing patients to community optometrists
- ✓ Over 5,000 HES appointments released by establishing low vision networks in the community
- ✓ Efficiency savings in care costs & drug budgets due to IP optometry uptake
- ✓ Potential for further management of complex cases in the community
- ✓ Potential for glaucoma discharge to the community

Consultation Questions and Responses

Q5[1]: Are these the right objectives for the GOC for legislative reform?

Yes

Optometry Scotland would support the GOC objectives as set out in page 6 of the document.

You will note from the statement above (Section One) that the eye care model in Scotland has evolved separately from the rest of the UK but the core principle underpinning safe care 'maintaining patient and public safety' is a common shared concept.

The GOS arrangements are universally available to all in Scotland and the evolving development of this novel care provision is founded on the key principles underpinning the Opticians Act.

The Opticians Act has allowed the profession to develop and build a care network with shared investment between the Scottish Government and the optical professions in human resources, equipment and estates.

The GOS examinations are available at no cost, removing a key barrier to care. The level of care is standardised and of a high quality.

As described in the opening paragraph in Section 14 of the document we would support the GOC contention that there is a lack of 'robust and compelling evidence' suggesting any change is required to the Opticians Act as it stands at present.

Q6. What activities should non-registrants be restricted/prevented from doing?

In our view, the existing restrictions work well and should be retained. We are not aware of any evidence that would indicate a need to alter the current legislative framework.

Q7. What activities do you think must be restricted to our registrants?

Please note our reply to Q6.

The activities that must be restricted are:

All aspects of the eye examination:

Eye health checks and assessment
Sight tests / eye examinations
Supply and sale of contact lenses and glasses
Supply and sale of low visual aids
Patients aged under 16

In a Scottish context this would also mean:

The general assessment of visual function and health of the visual system that might not necessarily involve refraction, should be restricted.

The term ‘eye examination’ as used in Scotland to differentiate a refraction from an overall eye health assessment, should be restricted.

We feel that the ‘eye examination’ better reflects the eyecare service that is delivered optometrists in Scotland. This avoids confusion between the term ‘sight test’ and ‘refraction’ and places a greater emphasis on the eye health aspects of the process. However, we do recognise the complications that this might create for other parts of the UK.

In Scotland, optometrists routinely and frequently assess unscheduled patients presenting with a range of acute eye emergencies as part of the ‘First Port of Call’ arrangements with General Ophthalmic Services – this should be restricted.

Q8. What are your views about continuing to restrict/prevent non-registrants from carrying out the following activities?

In the overall interest of public protection we suggest that:

Testing of sight: should be restricted

The fitting of contact lenses should be restricted.

Zero powered contact lenses should be restricted

Dispensing optical appliances to those under 16 should be restricted.

Q9. Are there any additional activities that you think should be restricted to registrants?

No

Please note our response to Q6, Q7 and Q8 above

Q10. 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)?

No

At present the GOC recognises higher qualifications in prescribing for optometrists and contact lenses for dispensing opticians.

Other organisations such as the College of Optometrists, ABDO, NHS Education for Scotland and GCU award higher qualifications for a variety of enhanced services. Any further extension would require further consideration.

The GOC would need to engage fully with all relevant stakeholders before considering the impact GOC accreditation might have.

There might be benefits to the public if higher qualifications are noted on the GOC register but this may have unintended consequences.

We advocate for continuous professional development and additional qualifications that may enhance skills however feel patients are protected under the current legislation.

We do not believe the GOC need to specifically recognise all qualifications awarded by other bodies or learned skills such as foreign body removal, as the Opticians Act should ensure that all registrants practice within their own skill set, competency and expertise. This is in keeping with 'The Rules Relating to Injury and Disease of the Eye (Sec 6)'.

A stated above, other professional bodies and organisations award additional qualifications in keeping with professional development. The GOC has specialist list for prescribing optometrists and contact lens dispensing opticians. There is no evidence to support an expansion of these categories, but it is important that 'The Opticians Act' permits the flexibility required to allow for appropriate professional development and increased scope of practice.

For example, in Scotland we have seen the development of Independent Prescribing for optometrists with over 400 qualified across all NSH Boards. The IP qualification led to the development of the NESGAT glaucoma qualification (see statement above) and the potential for optometrists to manage and monitor glaucoma patients in the community setting. The GOC should be aware of such developments to ensure that the 'rules' permit such development in the interest of public benefit and safety.

Conversely the Scottish Government has proposed the introduction of a national low vision service in Scotland. Despite low vision being a core competency for optometrists NES will deliver an accreditation process that optometrists and DOs will need to complete before participating in the new service as part quality assurance requirements.

OS fully supports the ongoing development of GOS and enhanced services in Scotland, the existing act has the flexibility to allow the accreditation of various types of enhanced clinical activity.

We would hope that the GOC monitor the evolving eyecare model in Scotland and ensure that due consideration is given accept to clinical developments and advances in the future

Q11. Does the basis for extension of business regulation outlined in our 2013 review of business regulation still apply?

Yes

It is important to retain the position of a responsible person who is required to be registered with GOC. This allows for any responsibility to be shared with the Optometrist and Owner/Senior Management.

Q12. 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

Some optical practices are 'lay owned' and not registered with the GOC. It would be beneficial to registrants and patients if such businesses were registered in some form with the GOC.

This would result in a more consistent and equitable regulatory landscape for all optical businesses.

It is important that any such development is not an additional financial burden to optical businesses.

Q13. Do you think the GOC could more effectively regulate businesses if it had powers of inspection?

No

Adequate provision of inspections is currently undertaken by Health Boards in Scotland and would be a duplication for both the businesses and GOC. Therefore, this is not a role required to be undertaken by the GOC.

Practice inspections in Scotland ensure that all practices meet a common minimal requirement to safeguard the public. This includes a minimum equipment list and other general requirements.

It would be helpful however, for the GOC to liaise with the Scottish Government and NHS Scotland to help ensure that any preferred GOC requirements are included in the inspection process.

Q14. Is there an alternative model of business regulation that we should consider?

Yes (other)

See response to Q12 above.

Q15. 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 – under the oversight of an optometrist or registered medical practitioner

It is our view that DOs should have the ability to undertake certain component parts of refraction within the scope of appropriate oversight by an optometrist. Component parts of refraction are within the ability of a DOs role and could positively impact optometrist time and resource.

In our view optometrist would retain responsibility for the overall health of the eye, assessment of the visual pathway, an internal eye examination and overall assessment of visual function.

The form in which oversight of any aspect of care should be applied would require further clarification.

We would not promote remote supervision as this is not in the best interest of the patient.

We would be concerned that remote supervision might lead to an unwanted separation of refraction and the eye health assessment. An optometrist should be on the premises to ensure they are able to step in if required otherwise this would put the patient at risk and be a threat to public health and safety.

Q16. 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.)

Case sharing by optometrists and DOs has the potential to increase capacity within practices, to allow optometrists to engage in more complex tasks. Careful consideration needs to be given to ensure patient safety is paramount.

In Scotland many optometrists are engaging in shared care and other enhanced services in support of secondary care and others within the primary care sector. This changing eyecare landscape could possibly lead to capacity pressures within optometry practices requiring the additional support of DOs and clinical assistants.

An obvious disadvantage would be a breakdown in communication between the DO and the optometrist when some underlying ocular disorder is missed and the patient suffers harm. Clear protocols need to be established to ensure that roles and responsibilities are clearly demarcated.

Q17. Does the sight testing legislation create any unnecessary regulatory barriers (not including refraction by dispensing opticians)?

No

Provision in Scotland allows for enhanced services and increased responsibility of optometrists in relation to sight examination. There is no evidence to suggest there are any unnecessary regulatory barriers.

As stated above the 'eye examination' in Scotland does not always involve a refraction, but it will always include a relevant assessment of visual function.

Separating the refraction / visual assessment from the eye health check is not logical and can only place the public at greater risk of undetected ocular morbidity.

The 'sight test' as defined within the Opticians Act ensures that a relevant health check is included with refraction. This provides an opportunity for an early detection of unknown or undiagnosed ocular morbidity and managing this appropriately. This benefit of this is evident when it is estimated that over 90% of glaucoma cases currently in eye clinics were initially detected in the community referred on by community optometrists.

Q18. 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 and equality, diversity and inclusion.)

The current sight testing legislation (adapted as a universal no cost eye examination in Scotland) is available to all, eliminating a key barrier to care and ensuring relatively equivocal access to a specialist eyecare resource in every community regardless of circumstances.

The GOS eye examination is described in detail above (section one and two) and delivers a significant public health benefit, keeping the population more able to participate in recreation activities, work comfortably and provides greater safety on the roads and reduces the risk of co-morbidity such as falls and accidents.

The current sight testing legislation as it stands provides a universal platform to enable the opportunistic detection of various eye conditions, for example glaucoma where this may otherwise go unnoticed.

OS has analysed various data relating to GOS that is published by Public health Scotland.

Q19. Do you have any data on the number/percentage of referrals that are made to secondary care following a sight test / eye examination?

Yes

There are approximately 2.3 million eye examinations carried out each year in Scotland (latest published data relates to year 2019/20, Public Health Scotland).

93.6% are retained in the community.
4.1% are referred to an eye clinic
1.4% are referred to a GP
0.8% are referred to care pathway
0.3% are referred to another optometrist.

The most interesting feature here relates to the large number of patients managed in the community.

Public Health Scotland publish various GOS data every year – last publication pre-covid and relates to year 2019-20.

Optometrists are asked to record if any patient is living with an eye disorder or disease and report this on the GOS forms. This is now recorded and submitted electronically.

For the year 2019-20:

The data would indicate that approximately 1.4million eye conditions were managed by optometrist during a primary eye examination.
In addition over 500,000 eye conditions were managed by optometrists during a supplementary eye examination

In the same year a total of 450,000 were seen in hospital eye clinics across the whole of Scotland.

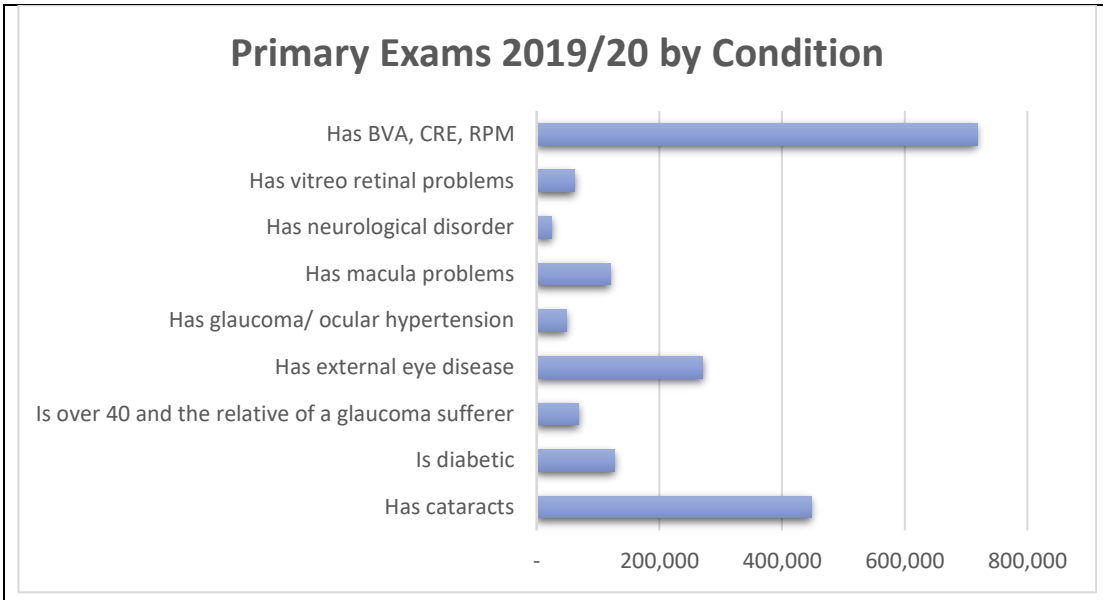
OS has analysed the various data sets and a conservative estimate would indicate that over 300,000 of the GOS managed cases would be referred prior to 2006.

As the HES is operating at capacity at present considerable investment would need to be made in staff, estates and additional services to meet such a demand or the HES would crash.

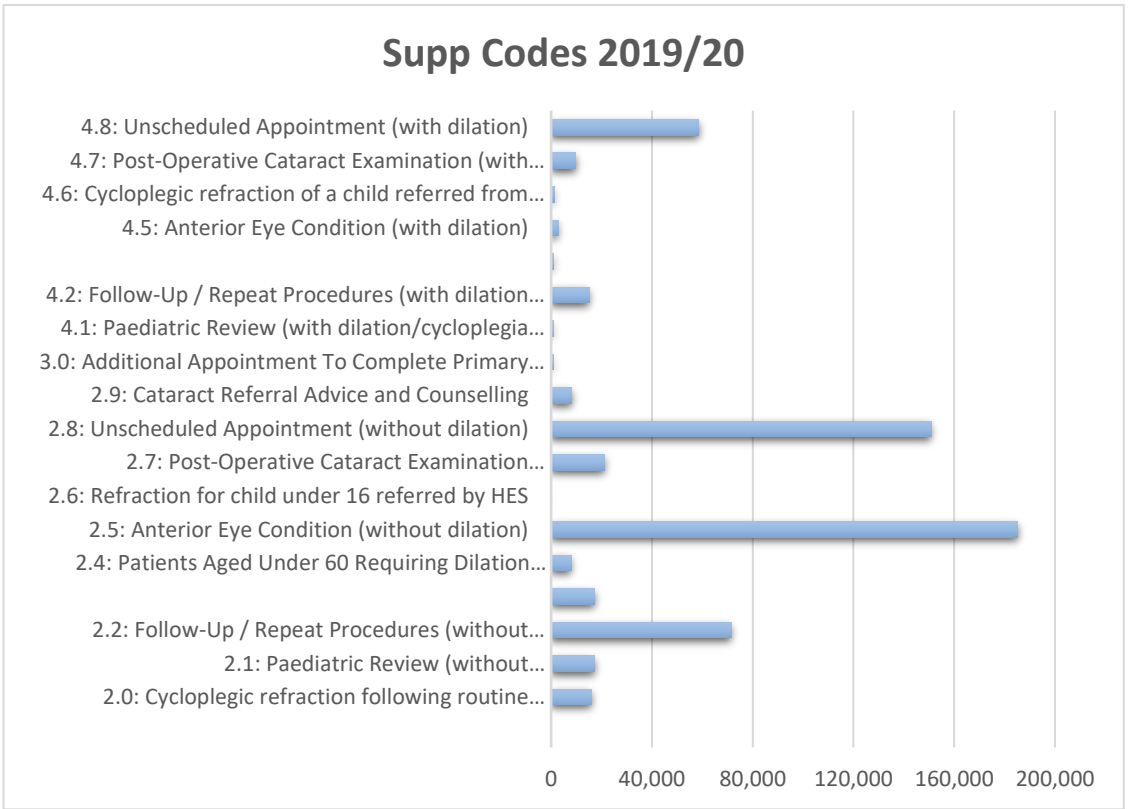
The bigger message here is the positive impact that the current Scottish eye examination service is having across the sector.

The greatest burden of ocular disease is being managed by community optometrists in Scotland.

This table demonstrates the range of conditions managed by optometrists carrying out primary eye examinations in the community with 4.1% of this total being referred to secondary care, the bulk of referral being for cataract, macular degeneration and glaucoma.



The is table below demonstrates the range of conditions managed within the supplementary eye examination service.



This model should be supported by retaining the current regulatory model that ensures a competent eye health / refraction / sight test.

The current GOS model illustrates the capacity for community optometry to deliver a wide raging preventative eye care service with the potential for early diagnosis, ongoing management or referral to secondary care as appropriate.

The current eye health landscape is indicating a greater need for community driven care models and the current sight test as defined in the Opticians Act is a fairly robust foundation for evolving care models such as exists in Scotland.

It is vital the GOC recognise the future demands on the sector that an increasingly aging population places greater demands on all aspects of eyecare services and help facilitate the new roles and responsibilities that registrants will need to absorb.

Q20. Are you aware of any data to support or refute the case for separating the refraction from the eye health check?

Please refer to the response for Q19.

There is no evidence to support separating refraction from the eye health check / assessment.

However, there is considerable evidence emerging in Scotland to maintain and develop the model to help better detect eye problems at an earlier stage.

Q21. Does the fitting of contact lenses legislation create any unnecessary regulatory barriers?

No

The public can easily access high quality professional contact lens care across the UK. The public can attend practices across the country, easily accessible in almost every conurbation with a wide choice of location and practice type.

We would contend that the fitting aftercare and management of this medical device is important and the professional care available in the UK will minimise the potential of harm for all contact lens wearers.

Q22. 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 impacts and equality, diversity and inclusion.)

The advantages of fitting of contact lenses legislation continues to ensure that appropriate contact lenses are ordered to suit each individual and that the patient can attend for routine aftercare.

In most cases this will allow the early detection of adverse effects relating to contact lens wear or contact lens products. It will also help to promote good compliance and regular health advice which could in turn decrease the risk of potential infections.

This will ensure that minor problems are dealt with speedily and that more serious sight threatening, ocular surface disease is detected early, and serious consequences are prevented from occurring.

The identification of eye disease, changes or issues is in the best interest of public protection.

A contact lens is a medical device that requires expert pre-assessment before fitting, precise fitting, and ongoing aftercare to provide the opportunity for the early detection of CL induced anterior eye disease before this results in painful ocular surface disease or loss of vision.

The evidence relating to contact lens related disease is sparse as in most case of mild adverse scenarios the matter is dealt with by substituting one product for something more appropriate.

Most cases of advances ocular surface disease, such as corneal ulceration will present in a hospital eye clinic and it is unlikely that the receiving ophthalmologist would enquire where the lens was sourced or purchased.

The record would state that the problem was contact lens related, no detail regarding online or illegal purchase.

Q23. Should the sale and supply of optical appliances be further restricted to certain groups of vulnerable patients?

Not sure

Intuitively it seems reasonable to offer additional support to people with any form of disability.

We would welcome further discussion on this point as it is an area of concern that we have tried to explore in Scotland.

A new supplementary GOS code was introduced in Scotland with the intention of allowing increased clinical time for vulnerable patients with a variety of disability issues.

The difficulty we found was when to implement the new code and how to adequately define what was a ‘reasonable’ level of disability to warrant the claim.

This matter continues to cause confusion despite numerous attempts at defining who could fit into this vulnerable group.

We considered people (adults and children) with moderate to profound physical and learning disability. We also included dementia cases.

We also found some resistance from patients and carers to be included in such a group.

Consideration was given to various patients who may have dementia however, without a patient’s voluntary disclosure, confirmation could not be guaranteed.

The principal challenges is defining who might fall into this vulnerable group, how they can be identified and how they can be mobilised.

Q24. 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.)

See response to Q23.

Q25. Do the general direction / supervision legislative requirements relating to the sale of prescription contact lenses create any unnecessary regulatory barriers?

No

We believe that the current legislative requirements are fit for purpose.

Q26. 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

Risks that could be considered if changes were made to the general direction/supervision requirements include missing general health checks, purchase of lenses using out of date prescriptions and/or lenses having a detrimental effect on the eye.

There are also potential public health risk with inappropriate contact lenses resulting in impaired vision that could result in a hazard whilst driving.

Reduced vision is also a recognised risk associated with falls.

Q27. Do the legislative requirements for verification of contact lens specifications create any unnecessary regulatory barriers?

No

Contact lenses should be fitted by a competent professional, normally an optometrist or a CLO.

Consideration is given to how the lens performs on the eye for optimum comfort and vision. This is a precise process requiring a range of skills and knowledge. Unfortunately some online suppliers ignore the rules and supply a substitute lens that might not perform as the prescribed specification of the original contact lens. It is important that substitution lenses used are comparable in performance, this remains in the best interest of public protection.

Q28. 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.)

Substitution of contact lenses can result in adverse effects for the wearer.

Where an identical lens is not available from a supplier, a suitable replacement may be supplied. The concern is where prescribed lenses are replaced by a lens which has very little resemblance to the lens prescribed. An example could be when a patient is prescribed with an oxygen transmissible silicone hydrogel lens and a lens of different material with lower oxygen transmission is supplied.

This can often cause various degrees of ocular hypoxia and ongoing ocular surface disease.

This can have a detrimental effect on the health of the eye and may go unnoticed by the wearer until there is a detrimental impact on the ocular surface.

Substitution should only be allowed where the lens issued has very similar material properties to the lens originally prescribed and this can only normally be achieved safely under the care of a competent clinician.

Q29. Do you think the Act should specify a definition of aftercare?

No

It is important to allow for a tailored aftercare approach determined on an individual basis.

This should be a clinical decision made at the time of the appointment based on the presenting scenario.

Raising awareness of the benefits of aftercare is another matter as is the importance of compliance with the overall care regime.

Q30. Does the zero powered contact lenses legislation create any unnecessary regulatory barriers?

No

It is in the best interest of public protection to ensure that lenses are appropriately fitted, and eye health is checked to ensure no detrimental effect.

The risk of adverse effects is the same with ‘zero’ powered contact lenses as it would be with any other contact lens.

People buying zero powered contact lenses online bypass the essential fitting stage and miss out on any aftercare.

Losing out on key information and advice regarding safe lens wear can only result in greater risk of complications and ensuing eye disease.
Such patients miss the vital opportunity for early detection of complications and detection of pathology.

Q31. Would there be a risk of harm to patients if the requirements relating to the sale of zero powered contact lenses change?

Yes

See response to Q 30.

In addition, poor quality lenses could be detrimental to eyes with the risk of sight loss and due to the opaque patterns on some cosmetic contact lenses could result in the loss of peripheral vision.

Q32. If you answered yes to the previous question, is legislation necessary to mitigate this risk?

Yes

Legislation should remain as it is with additional advice provided to patients on the use of zero powered contact lenses.

Q33. 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.)

It is important to ensure that patient eye safety and protecting eye health remains a priority.

Q34. 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?

No

Q35. If you answered yes to the previous question, what would be the risk on the consumer if these barriers were removed?

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Q36. Is legislation regarding the sale of optical appliances necessary to protect consumers (except restricted categories)?

Yes

Legislation currently exists and is necessary to ensure patient eye safety and health.

The current legislation provides the necessary safeguards for children and the visually impaired groups.

There is no evidence that this needs to change.

Q37. Is the two year prescription restriction on purchase of spectacles from non-registrants an unnecessary regulatory barrier?

No

A two-year prescription restriction is important as it provides an opportunity for the patient to attend for an eye examination / sight test.

In the absence of any other routine eyecare provision, this provides an opportunity to detect any underlying ocular morbidity.

This ensures maintenance of eye health and allows regular opportunity to identify any changes or the early onset of eye disease. The sight test/eye examination can be considered a crucial public health intervention important for public protection and road safety.

Q38. 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.)

There are no obvious advantages to altering this limit. There is no financial benefit as all get 'free' eyecare in Scotland and most people on reduced income can access the NHS spectacle voucher system to help with spectacle costs.

A stated above, the disadvantage would be the risk of not detecting ocular disease in a timely manner.

In Scotland, annual primary eye examinations are available to those over 60 and those living with diabetes in recognition of the increase prevalence of eye disease within this demographic.

We consider any changes a risk public wellbeing, protection and road safety.

Q39. 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.)

The current legislation remaining as it is currently ensures maintenance of eye health and allows regular opportunity to identify any changes or eye disease. This remains important for public protection and road safety.

Q40. Does the legislation in relation to the sale and supply of sportswear optical appliances for children under 16 create any unnecessary regulatory barriers?

No

We consulted with members on this matter and there was no evidence that this is a problem for children. In effect, many parents value the additional safety aspect of having such devises properly fitted and dispensed by a registrant

Q41. What would be advantages, disadvantages and impacts (both positive and negative) of children under 16 being able to buy sportwear optical appliances outside the supervision of a registrant / registered medical practitioner? (Impacts can include financial and equality, diversity and inclusion.)

Poor fitting sportwear optical appliances in children under 16 could have unintended consequences for developing eyes, by not providing the same level of vision correction or offering adequate protection.

Q42. 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.)

The legislation as it is currently ensures that appropriate checks and fitting are carried in the best interest of public protection.

Q43. Are there any other aspects of the sale and supply of optical appliances legislation that you think need changing or create unnecessary regulatory barriers?

No

Q44. 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.)

The current legislation ensures public protection and provides the appropriate balance where there is little room for unintended consequences.

Q45. 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

Much of the new technology recently introduced represents a range of labour-saving devices, there remains a need for robust clinical decision making in the interest of public health and safety.

Some of the new equipment that has come into use over the recent past, such as ocular coherence tomography, does represent a step change in clinical development, but again, requires expert interpretation of results and findings to ensure safe and consistent outcomes for patients.

There is awareness of remote refraction however this does not comply with the current Act as there is a risk that the eye health check might not take place as the patient might not require spectacles and decline to attend for a follow check. Any technological developments should be considered carefully to ensure that public protection remains a priority.

There is clear distinction between remote refraction and other modes of remote care where robust protocols are in place to ensure patient safety and wellbeing. There is mention of the proposed shared patient record being developed in Scotland, this will be built around robust information governance controls to ensure adequate protection of patient information.

During the Covid pandemic remote consultation was tested in various parts of Scotland, with mixed results. There was a predicted benefit in more remote and rural areas compared with larger communities.

Digital image case sharing was found to an advantage in certain circumstances. However, a basic telephone call without images left both the patient and clinician at a relative disadvantage regarding the accuracy of diagnosis.

The level of confidence in clinical decision making was considerably reduced in many circumstances. This was further evidenced with the increase in ocular morbidity due to misdiagnosis by telephone or other digital devices.

There is a role for remote consultation, but serious consideration should be given to how this is monitored and controlled.

Q46. Is there any evidence that increased use of technology or remote care may have an impact on patient safety or care in the future?

Not sure

This depends on the definition of remote consultation. In Scotland this normally means remote triage of some form or another. The technology employed provides varying degrees of success.

This is a new and emerging field that requires further evidence.

Q47. 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?

No

Most optical practices are progressive and despite the need to self-fund have consistently invested in eye care equipment, retaining and interest in new and novel developments.

Q48. 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?

Not sure

Please note our response to Q45 above.

We can see the potential benefits to remote triage and the use of effective IT for case sharing. We have considerable reservations regarding remote refraction which could result in patients missing out on a vital eye health assessment.

Q49. 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?

We would hope that the GOC give priority to patient safety and wellbeing at all times when faced with interests from a commercial operator willing to introduce changes without due consideration given to the need for adequate health assessment.

We would expect that any proposals around technical applications be given due consideration before being introduced to the UK.

There is a considerable difference to remote clinical triage and remote refraction and both should be considered within the prism of patient safety.

Q50. 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?

No

Q51. 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?

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Q52. 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)?

No

Q53. Are they any other gaps in regulation where you think legislative change might be required?

No

Q54. Are there any other policies or guidance that the GOC currently produces that should be reviewed or require amendments?

No

Q55. 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)?

No