Northumberland, Tyne, and Wear Local Optometrist Committee

Response to the General Optical Council (GOC) Call for Evidence

Background

On the 28th of March 2022, the GOC, the regulator for all UK optical professionals, began a consultation process, inviting stakeholders to submit evidence relating to several proposed changes to the Opticians Act. This process was initiated as a response to the Department of Health's plan to review all healthcare regulator legislation. The call for evidence included proposed changes to which professionals can perform elements of the sight test, and whether the requirement to have had a sight test within the last two years prior to a contact lens fit was necessary.

The Northumberland, Tyne, and Wear Local Optometric Committee (NTW LOC), a body established by the NHS (Amendment) Act 1949, and the official representative body for all General Ophthalmic Service (GOS) contractors and performers working within the NTW area, felt it was appropriate to engage and gather evidence from their members, consisting of optical professionals working in the NTW footprint who had applied to join.

Data collection method

The author created a survey using the Ninja Forms WordPress plugin available through the NTW website and published on the NTW LOC website on 1st of July. A post with hyperlink was placed within the news section of the NTW website, all NTW LOC members were sent a survey link via email, two Facebook posts with hyperlinks to the survey were created within the members only NTW LOC group page, and several Twitter posts advertised the survey but did not contain the hyperlink. The intention was to make as many members as possible aware of the survey without attracting non-member input by restricting access to the link as much as possible. The survey was, however, made public and anonymous, so anyone with a link could complete it. This was intentional, as previous surveys which required members to log-in attracted complaints from members who were unable to do so, and the LOC wished to gather as much feedback as possible on this important matter.

The questions were broadly based on those asked by the Association of Optometrists (AOP) in a similar survey, and were follows:

Number	Question	Input Required?	Input options
1	To help us understand how our members differ in their views, please let us know which of the following most applies to you.	Yes	One of: Employer, Employee, Locum, Student/pre-reg, Other (please specify)
2	Please confirm your occupation	Yes	One of: Optometrist, Dispensing Optometrist, Contact Lens Optometrist, Other (please specify)
3	If you selected "Other" please specify your occupation	No	Textbox
4	Which CCG areas do you mainly work in? (select all)	Yes	Multiple-choice from: Newcastle Gateshead, North Tyneside, Northumberland, Sunderland, South Tyneside, Other (please specify)

5	If you selected "Other" please list the CCG areas	No	Textbox
6	What is your typical work setting	Yes	One of: A practice within a multiple chain, an independent practice, hospital, domiciliary, other (please specify)
7	If you selected "Other" please specify your typical work setting	No	Textbox
8	How many days are you currently practicing per week on average?	Yes	One of 1-2, 3-4, 5-7, N/A
9	Please let us know your age group	Yes	One of: 18-24, 25-34, 35-44, 45-54, 55-64, 65+
10	Do you agree with the idea that the refraction and health check elements of the sight test could safely be separated?	Yes	One of: Strongly agree, agree, neither agree nor disagree, disagree, strongly disagree
11	Briefly describe any scenarios you have encountered or foresee happening in relation to the separation of the refraction and health check elements	No	Textbox
12	Do you think that elements of the sight test could appropriately be delegated to another professional such as a DO?	Yes	One of: yes, elements can be delegated, yes, but only with strict guidelines, no, don't know
13	Please explain your views on the delegation of sight test elements	No	Textbox
14	There is currently a requirement to verify a patient's contact lens specification with the original prescriber if the original specification is not available (such as when supplying contact lenses online). The GOC is consulting over whether this requirement could safely be removed. Do you agree that it could be removed?	Yes	One of: Yes, No, Don't know
15	Briefly justify your opinion	No	Textbox
16	Does the GOC requirement to have had a sight test within the last 2 years, before contact lenses are fitted/refitted, help to protect patients?	Yes	One of: Yes, No, Don't know

17	Briefly describe any scenarios you have encountered or foresee happening in relation to these proposed changes to contact lens requirements	No	Textbox
18	Do you feel your clinics are back to pre-pandemic capacity levels	No	One of: Yes, above pre-pandemic capacity, yes, about the same as pre-pandemic levels, No a little below pre-pandemic capacity, no, significantly below pre-pandemic capacity, N/A
19	Are you struggling to obtain professional clinic cover?	No	One of: Yes, No, N/A
20	Have you heard about the NHS Eyecare Transformation Programme?	No	One of: Yes, I'm actively engaged, yes, but I don't know much about it, never heard of it
21	Have you heard about the Optometry First proposal?	No	One of: Yes, I'm actively engaged, yes, but I don't know much about it, never heard of it
22	Any additional feedback?	No	Textbox

The questions were categorised as follows:

- Questions 1-9: Understanding more about the demographic of the respondent.
- Questions 10-17, 22: Relating to the GOC consultation (adapted from the AOP survey).
- Questions 18-21: Relating to LOC engagement (these were deliberately optional questions and are not considered of further relevance. They are neither included nor analysed in this report.)

Engagement analysis

The following analytics tools were utilised to monitor and evaluate engagement:

- Google analytics (website activity)
- Facebook analytics (Facebook activity)

Twitter activity was not monitored as the tweets were made from private accounts which the LOC has no access to. Historically, Twitter engagement with LOC members has been extremely low, with the last (Electronic eyecare Referral System) survey in May 2022 having attracted single digit referral clicks from this platform.

On the day the survey was advertised, Google analytics reported a spike in visits, peaking at approximately four times the normal level of visitors to the site (figure 1). However, by the 3rd of July, the volume of traffic had dropped back to normal levels, suggesting that most survey data was obtained over the weekend. This is further indicated by the engagement time, which was significantly higher over the same period (figure 2); more engagement time would be required to complete the survey.

Figure 1. NTW LOC website visitors spiked on the 1st of July 2022

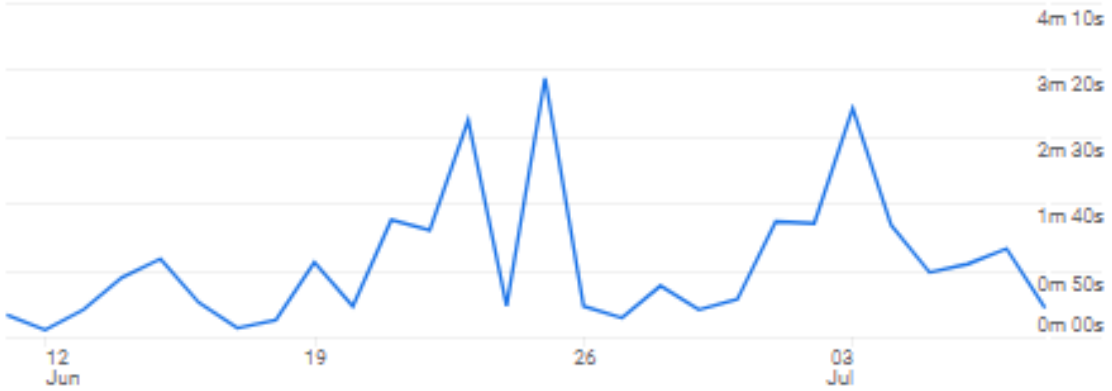

Figure 2. Engagement time reported by Google Analytics. Note that engagement time is prone to outliers when traffic is low.

The Facebook post was viewed by 68 members and was the fourth most engaged post within the last 28 days. Activity amongst members was perhaps slightly lower than usual during the survey period (figure 3) which might explain this.

Figure 3. Facebook NTW LOC group activity during the survey period.

	Page title and screen class	↓ Views	Users	New users	Views per user	Average engagement time	Unique user scrolls	Event count All events
	Totals	294 100% of total	197 100% of total	163 100% of total	1.49 Avg 0%	1m 26s Avg 0%	148 100% of total	1,098 100% of total
1	GOC call for evidence survey	125	95	83	1.32	2m 10s	71	438
2	(not set)	43	38	29	1.13	0m 11s	26	174
3	Referral Pathways	34	28	4	1.21	0m 39s	21	127
4	Applying for NHS Email	33	27	22	1.22	1m 04s	22	138
5	Committee members	7	7	6	1.00	0m 04s	4	28

Figure 4. The GOC survey was the most visited page during the survey period (1st-8th July).

Google analytics reported that the survey page was by far the most visited page during the period that the survey was carried out (figure 4), with an average engagement time of 2 minutes and 10 seconds. Each user on average viewed the survey 1.32 times, suggesting that some either attempted to complete the survey more than once, or completed the survey more than once. It is also possible that multiple submissions were made by different members from a single computer, a plausible scenario in a work environment. As the survey was anonymous, it is impossible to be certain if any members made multiple submissions, or if any non-members made a submission. However, the views-per-user metric for this page was broadly similar to other pages on the website (figure 5), the submission rate closely matched an inverse exponential distribution (figure 6), and that the total number of submissions (57) was in line with expectations; any attempt to sabotage the results of the survey were therefore likely to be insignificant.

	Page title and screen class	↓ Views per user
	Totals	1.49 Avg 0%
1	WOPEC training	2.50
2	Local Vacancies/Practices for sale	1.67
3	Public Eye Health concerns	1.50
4	GOC call for evidence survey	1.32
5	Applying for NHS Email	1.22
6	Referral Pathways	1.21
7	(not set)	1.13
8	Aims of the LOC	1.00
9	Care navigation	1.00
10	Children's Service	1.00

Figure 5. Views per user ranking of the NTW LOC website during the survey period (1st-8th July).

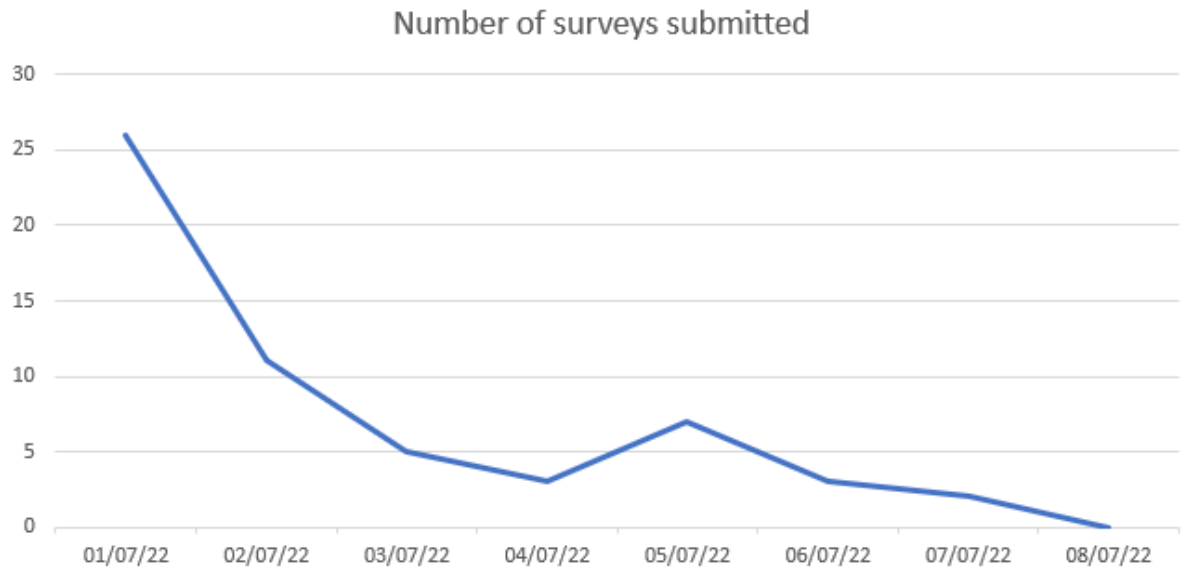

Figure 6. Count of submissions received for each date of the survey window.

Survey Data

Data Protection and Confidentiality

In view of current (GDPR) data protection legislation and confidentiality considerations, and to promote honest responses, the decision was taken to not capture information that could reveal the identity of any individual making a submission. However, the LOC is mindful that particularly with small datasets, there exists a risk of identifying individuals from their responses by cross-referencing these with other datasets and other methods including mosaics, rainbow tables, and triangulation. It is never, therefore possible to be completely confident that anonymity is preserved, but the LOC have considered other data sources (notably the GOC and GOS registers) and considered steps to reduce this risk using the 'motivated intruder' test. However, other than the redaction of practice information, it was decided that no further anonymisation nor pseudoanonymisation processes were required; the raw captured survey data has been computationally cleaned, sanitised, and practice information redacted, but has not been altered further.

Demographic Analysis

One of the concerns raised was that the survey data should represent the views of all its members regardless of their position within an organisation. The decision to email performer and contractor mailing lists, and the social media promotion appears to have attracted views from employers, employees, and locum groups (figure 7), though the vast majority of those who responded were optometrists (figure 8). The only other occupations declared were Contact Lens Optician (1) and undeclared (1). Survey responses were captured from across the NTW footprint, with each area well-represented (figure 9). Several practitioners work in multiple areas, though the majority were domiciliary providers and therefore work in all areas. Those working outside the NTW area were working in the adjoining areas south of the NTW footprint; Durham (7), Darlington (2) and Teeside (1).

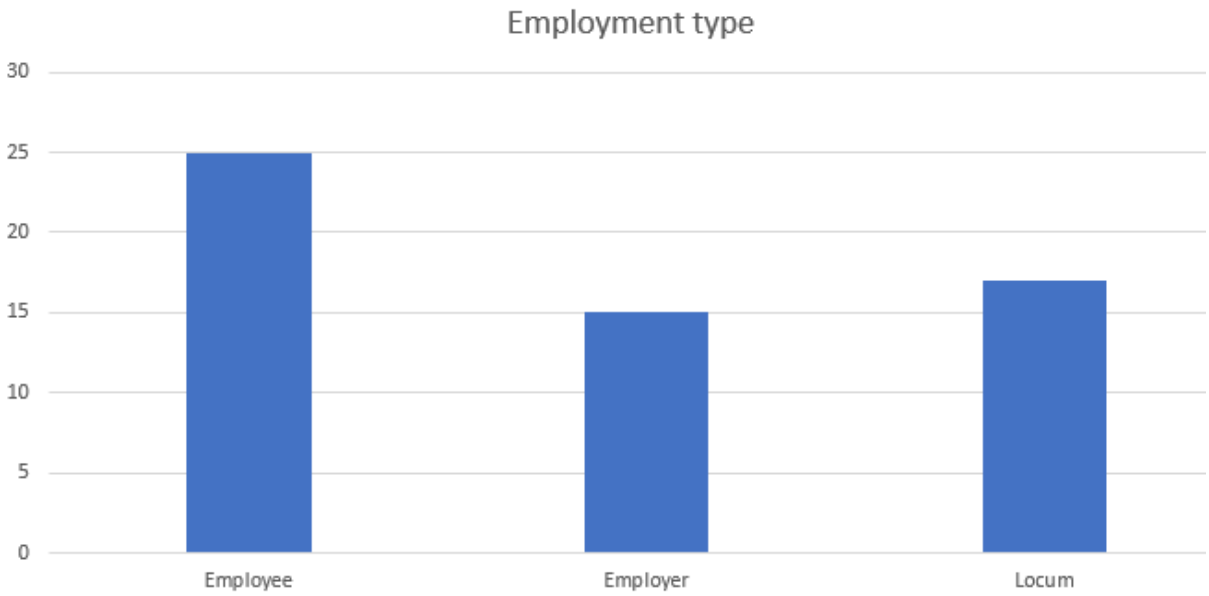

Figure7. Employees, Employers, and Locums were all well-represented in the survey results

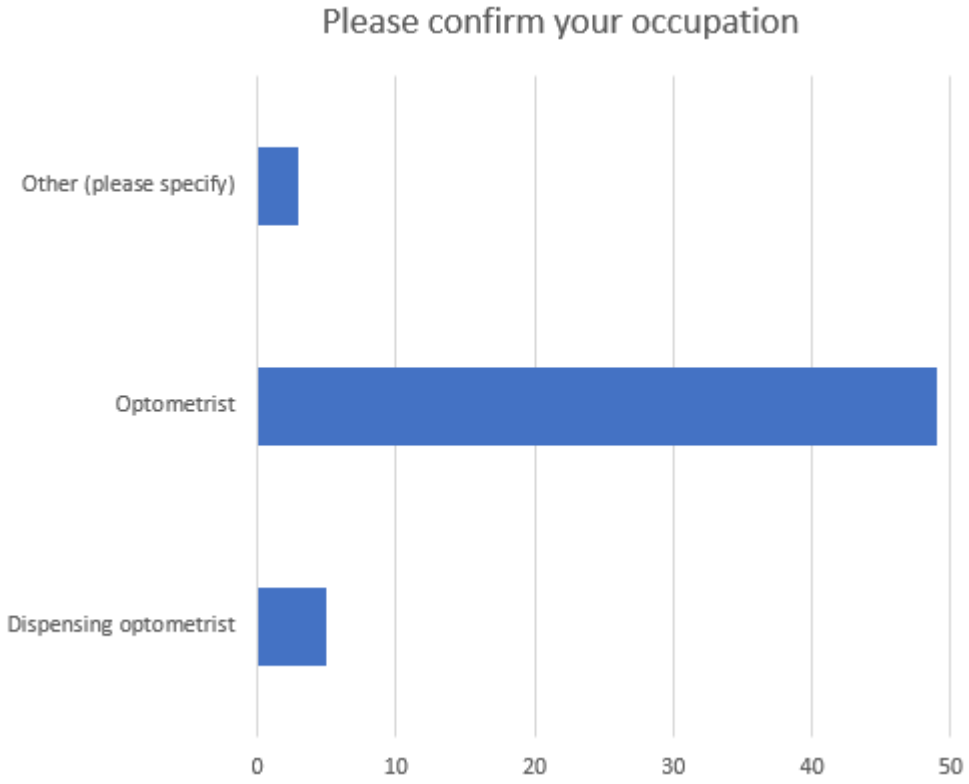

Figure 8. Most respondents were optometrists.

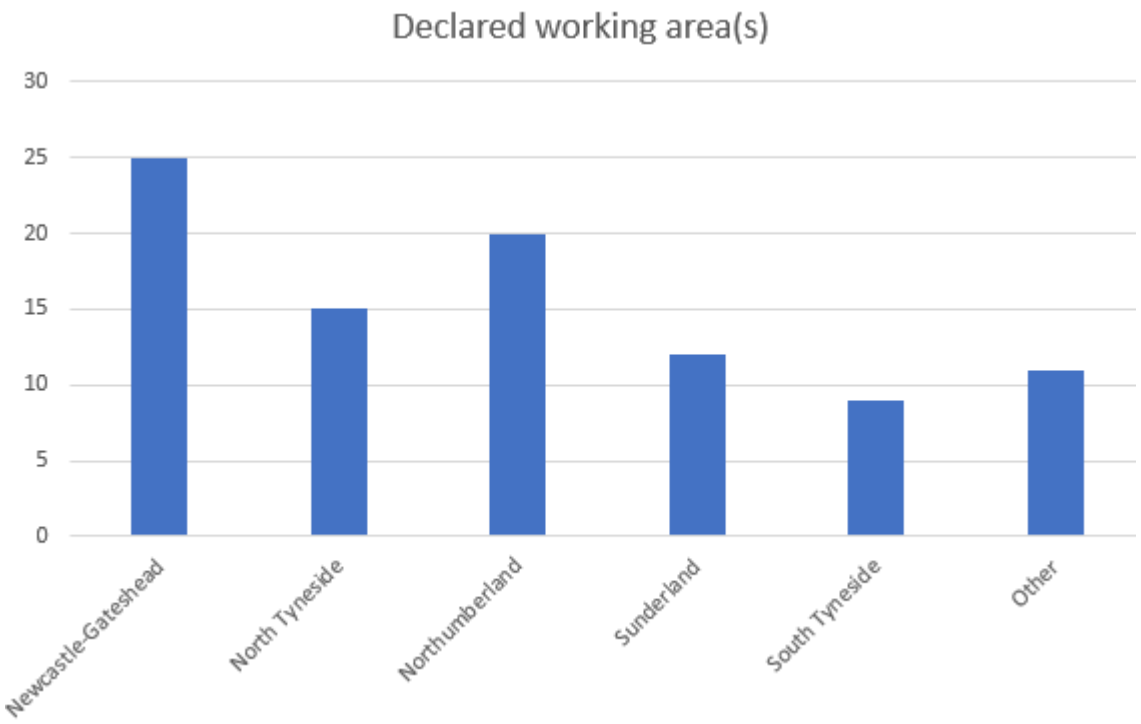

Figure 9. All NTW areas were represented in the survey responses.

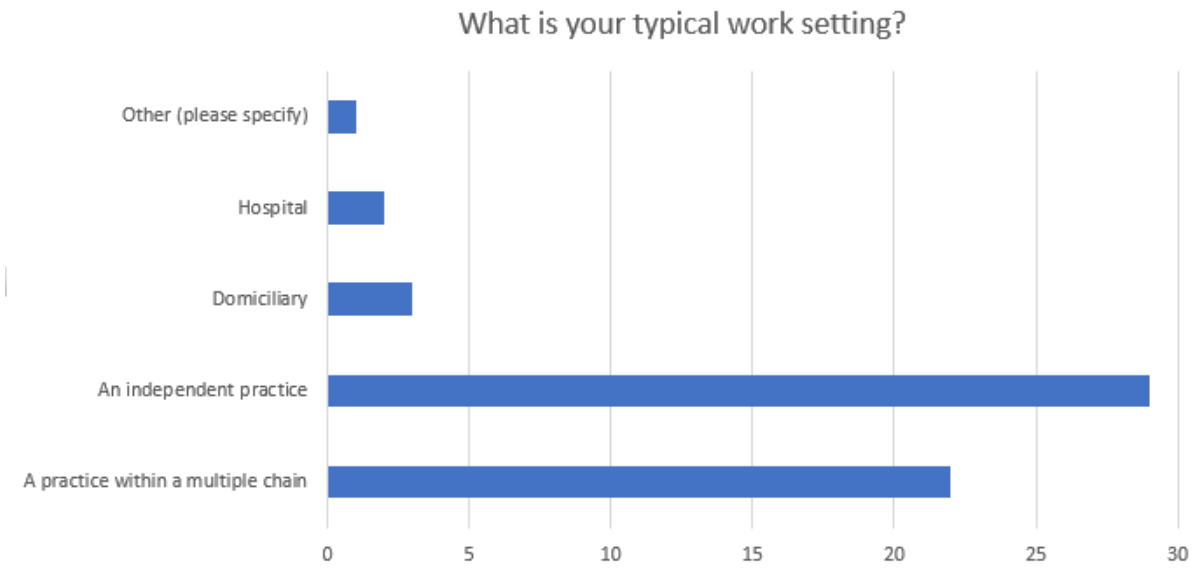

Figure 10. Most respondents work in independent or multiple settings.

The survey data has successfully captured the views of practitioners working in both independent and multiple practices (figure 10), though it is envisaged that the views of those working in multiples is under-represented in the survey data. The LOC feels that it has historically struggled to engage with employees working within multiple settings, and the survey responses seem to corroborate this. The single respondent who declared that they work in other settings splits their time between two of the work settings already listed. Domiciliary providers are known to be scarce in the NTW footprint, though with only three responses it is possible that this group is under-represented. The LOC were also interested in the views of those who don't work full time. The survey responses suggested that those working 3-7 days per week were well-represented, but not those working fewer days (figure 11). All age groups were well represented, though only two respondents were

aged 65 or older (figure 12). Whilst it is possible that there were fewer practitioners in this age category, other explanations – particularly the digital knowledge requirement to complete the survey – may have contributed to this under-representation.

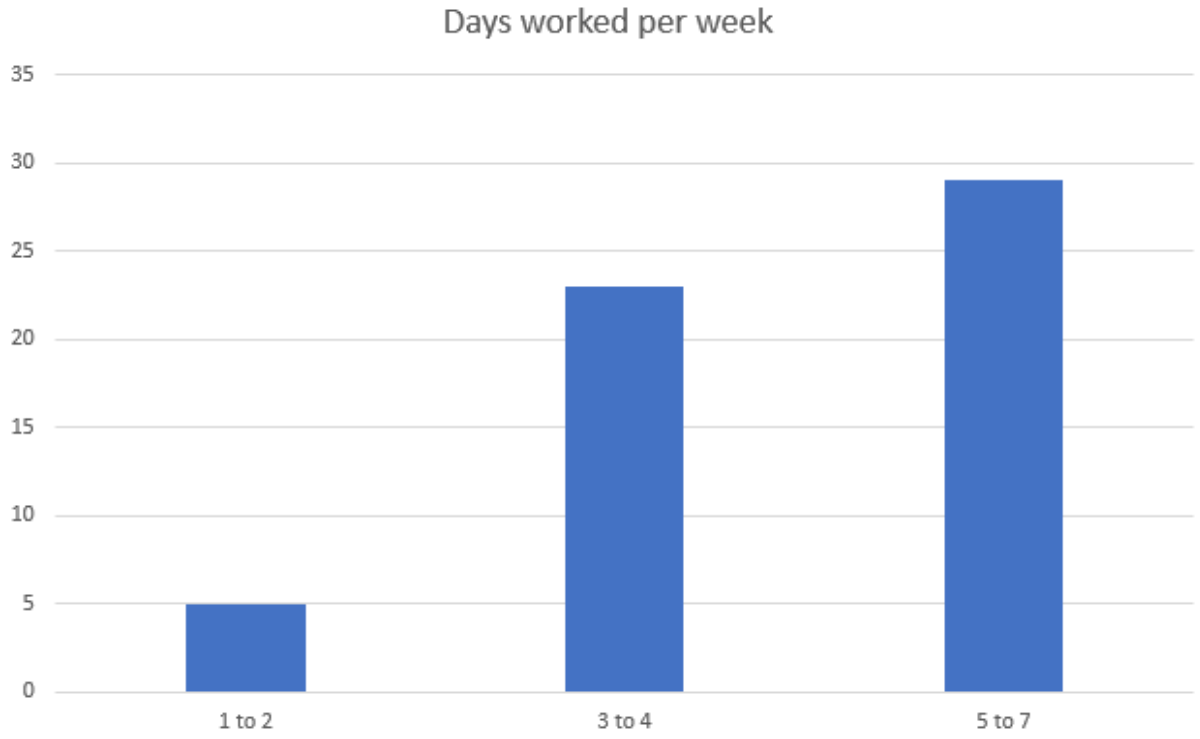

Figure 11. Most respondents work 3-7 days per week.

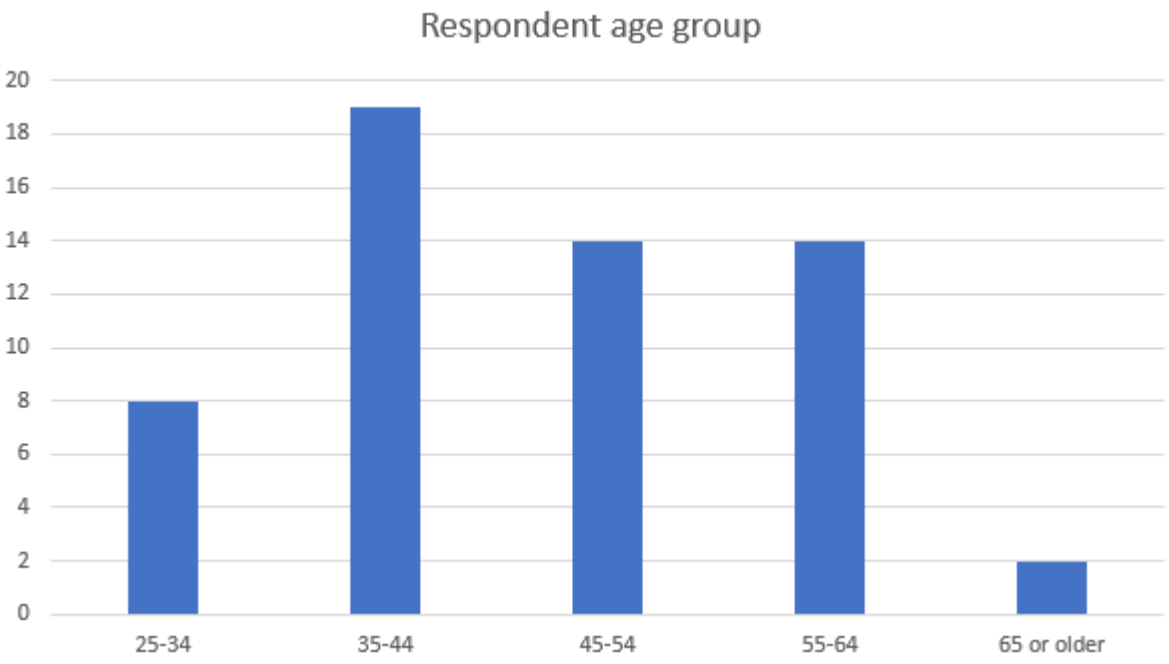

Figure 12. All age groups are well-represented except for those aged 65 or older.

In summary, the survey appears to have primarily captured the views of optometrists and not dispensing opticians or contact lens opticians. Most identified demographic groups seem well covered, apart for those working fewer than three days per week, those aged over 64, and those working in multiples and domiciliary environments.

GOC consultation question 1: "Do you agree with the idea that the refraction and health check elements of the sight test could safely be separated?"

Most respondents disagreed or strongly disagreed with this proposal (figure 13), with 51% adding comments to substantiate their argument (Appendix 1). Of the five dispensing opticians, one strongly agreed, one agreed, two disagreed, and one strongly disagreed. Looking at CCG areas, responses echoed the general trend except for Newcastle-Gateshead, where of the ten respondents, three strongly agreed, three agreed, and four strongly disagreed. Those who agreed or strongly agreed with this statement tended to be aged 35 and older, an employee working 3-7 days per week in a multiple, and work within Newcastle-Gateshead CCG.

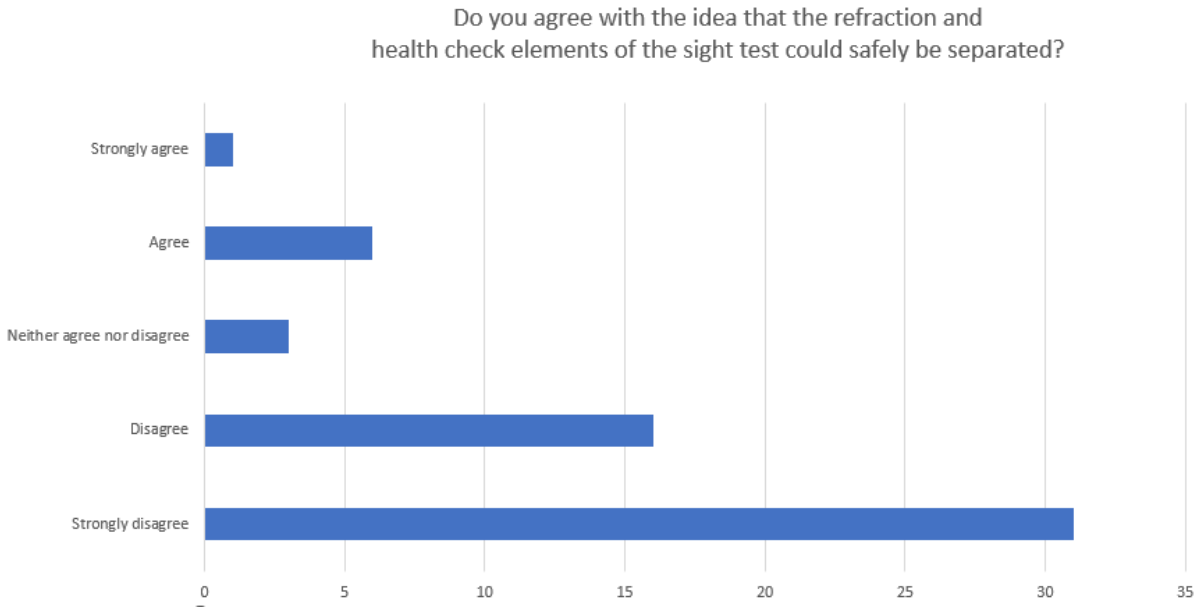

Figure 13. Responses to the question on separation of the refraction and health check

These follow several common themes (stated in the order of most popular to least popular):

Theme 1: The refraction and health check are inextricably linked

Once again, many respondents felt that changes in refractive error and stability can be indicative of health conditions such as diabetes, cataract, dry eye, and keratoconus that could be missed without an accompanying health check and could lead to inappropriate prescribing and delayed diagnosis and treatment. It was felt that a practitioner performing both aspects of the examination would be more likely to connect these findings, for example by detecting corneal irregularities during retinoscopy. Another concern was the assessment of binocular visual function which requires extensive knowledge of neurology and the oculomotor muscles and determines the prismatic element of the prescription. A common concern here was that poor visual acuity could easily be misattributed to amblyopia. The way that a patient reads the chart can indicate neurological disease and could be missed by a refractionist. If the proposal were to proceed, these patients would be at greater risk of sight loss.

Theme 2: Risk of the public neglecting the health aspect of the sight test.

Many respondents highlighted that many of their patients attend for a sight test seeking new glasses, and that many eye health conditions are symptomless (retinal tears, glaucoma, AMD, papillaoedema) or carry few symptoms that could easily be missed by a refractionist untrained in eye health. Another concern would be whether a patient referred for a health check by a

refractionist would attend this appointment. If the proposal were to proceed, these patients would be at greater risk of sight loss.

Theme 3: Risk of lesser qualified professionals identifying clinical signs and symptoms

Two respondents commented that they felt lesser qualified professionals would be more likely to miss important signs and symptoms; One of these being an optometrist who is also a dispensing optician, stating that they didn't feel the knowledge they had as a DO was sufficient to refract. There was also a concern raised about existing students who may enter a different profession to the one they expected when they qualify.

Theme 4: Improved efficiency

A single respondent claimed that more people could be seen by separating the refraction from the health check.

GOC consultation question 2: "Do you think elements of the sight test could appropriately be delegated to another professional such as a DO?"

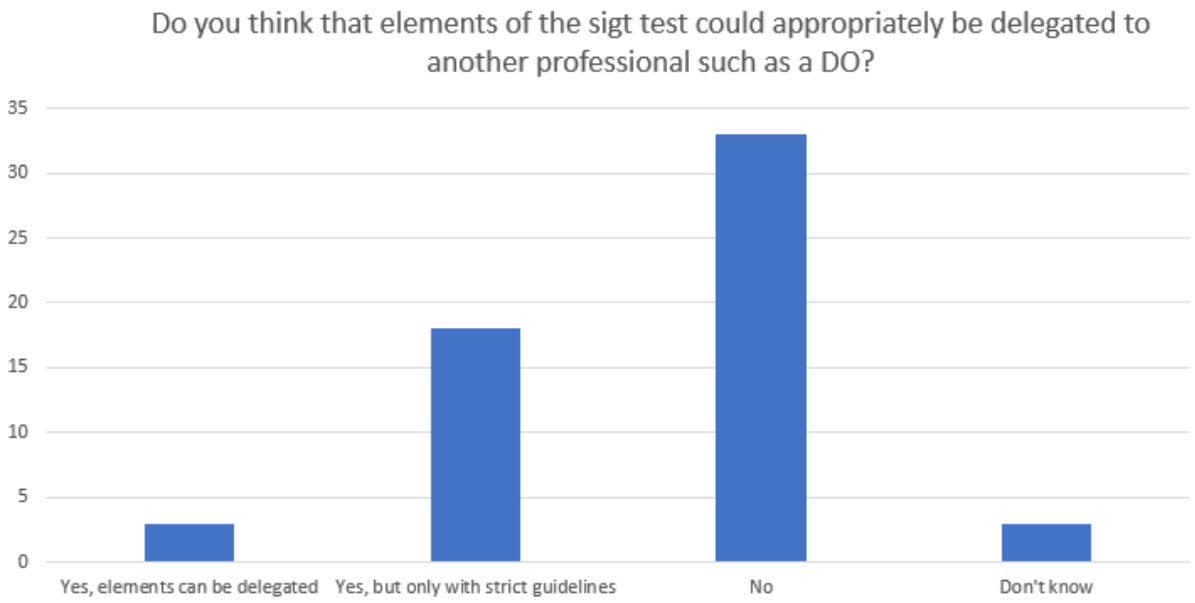

Figure 14. Responses to the question of whether elements of the sight test should be delegated.

Responses were mixed, with most respondents stating that they didn't think delegation was appropriate, but some feeling that it was appropriate, but only with strict guidelines in place (figure 14). Looking through the demographics, those working in multiples were more likely to answer yes to this question (figure 15). Age did not appear to be a factor, and neither did the answer provided for question 1 (figure 16).

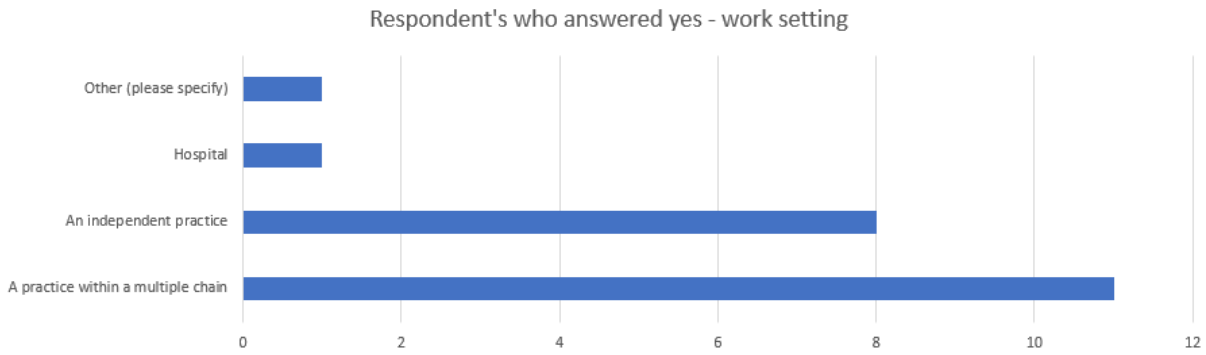

Figure 15. Despite the most frequent work setting being independent, those working in multiples were more likely to answer yes to this question.

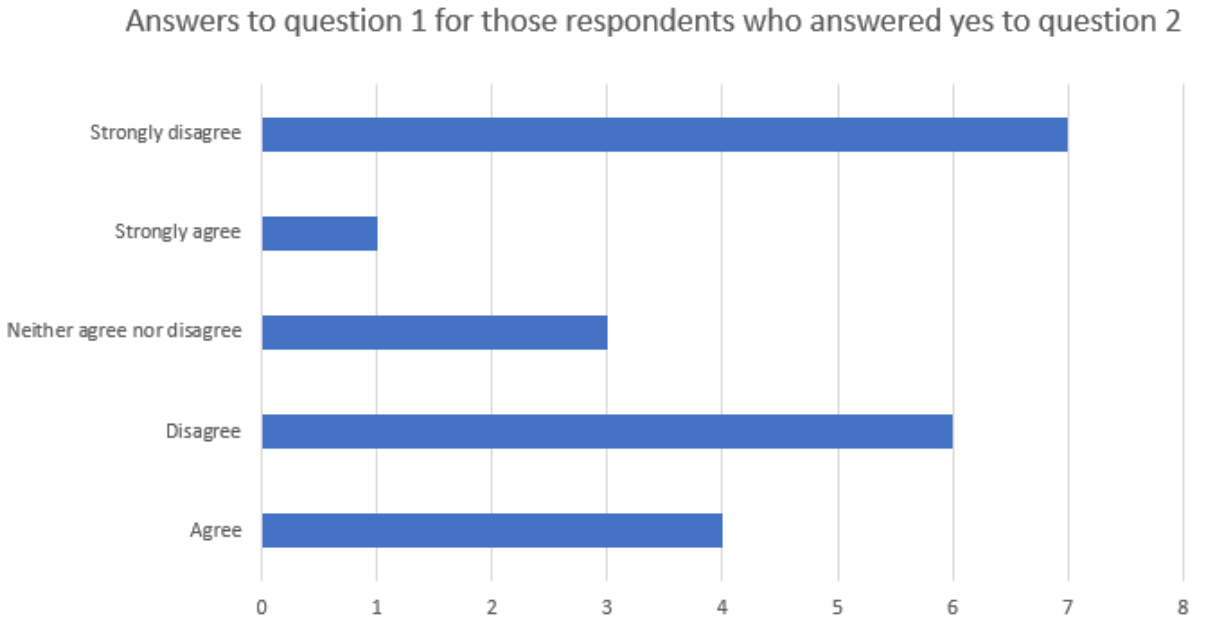

Figure 16. There was no clear correlation between answers to question 1 and 2.

Common themes discussed by respondents here (see Appendix 2) were:

Theme 1: Risk of failure to detect clinical signs/symptoms during delegated element

Like the arguments exhibited in the previous question, there were concerns raised about the capability of other professionals to detect and recognise important clinical signs and symptoms which would then be missed by the optometrist as they didn't perform the test. Several commented that they would only trust the tests they performed themselves as they have overall responsibility. There were mixed opinions on whether a DO/CLO can provide a competent refraction.

Theme 2: Some elements are already delegated, some can safely be delegated

Elements such as field assessment, tonometry, and image capture are already commonly delegated. Another stated that the Eye Refract system effectively delegates refraction already. One commented they would be happy for measurement of unaided visual acuity and visual acuity when wearing specs to be delegated. One commented that there is an important distinction between information gathering and information analysis. Another commented on the Honey Rose case and the potential risks of delegation. Several stressed the importance of proper training, personally reviewing and repeating delegated elements if in doubt.

Theme 3: Risk of missing the bigger clinical picture

Several respondents were concerned about the risk inherent with delegation, that they will miss important incidental clinical information. Similarly, delegated elements involving analysis may reach incorrect conclusions.

GOC consultation question 3: "Do you agree that the requirement to verify a contact lens specification with the original prescriber could be removed?"

The overwhelming majority of respondents answered 'no' to question 3. Of those that responded "yes" to question 3, three of the four respondents were employers, and one was a locum. There were no other clear differences between the other demographic factors or answers to other questions found.

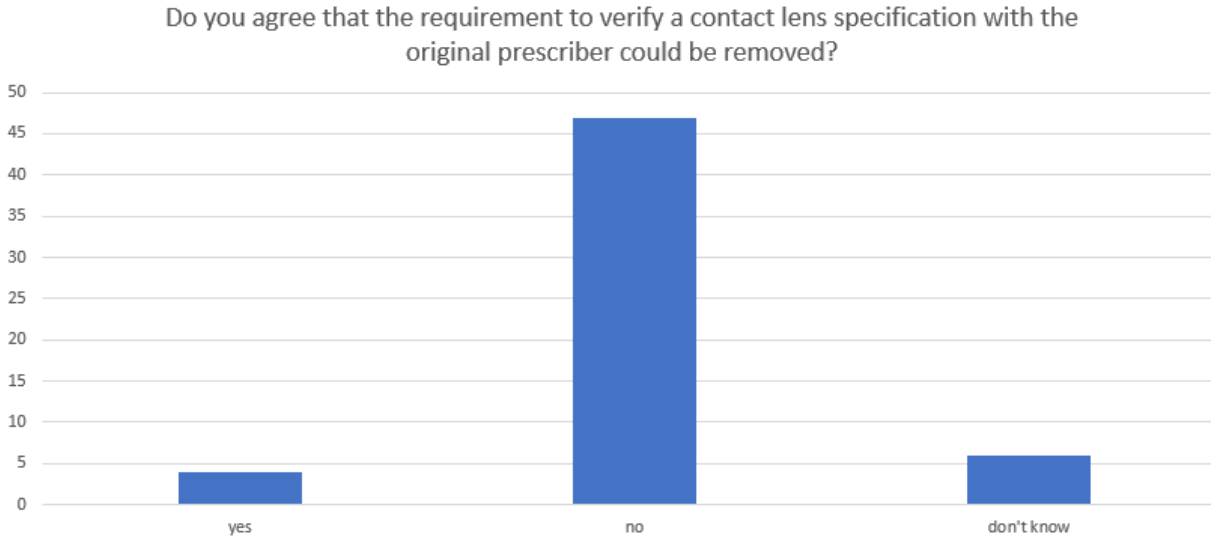

Figure 17. Most respondents did not agree with this proposal.

Themes identified (Appendix 3) were:

Theme 1: Some online sellers already don't request verification

Many respondents pointed out (some quite forcefully) that this is already the case for some online contact lens sellers. One mentioned that at least one online seller advertises this.

Theme 2: Ill-fitting contact lenses increase the risk of harm to the public

Many gave examples of infections, corneal neovascularisation, and undiagnosed glaucoma which were attributed to patient self-prescribing and/or lapsed aftercare. One practitioner commented that they had seen multiple patients wearing ill-fitting lenses with incorrect oxygen transmissibility to those previously prescribed. The consensus appears to be that these events are more likely if this requirement is removed.

Theme 3: Removing this requirement increases the risk of patient's forgoing their aftercare

Many were concerned that patients would be more likely to forgo aftercare, leading to an increased risk of poor vision and harm.

Theme 4: The public and online sellers are not aware of the reasons why a lens has been prescribed

Several respondents felt that the public perception of contact lenses is less driven by clinical requirements, and that patients may be less able to understand the clinical differences between

products, leading to self-prescribing and a primarily cost-driven purchase decision. One mentioned the importance of counselling for contact lens patients provided by the contact lens practitioner, particularly in relation to swimming and driving.

GOC consultation question 4: "Does the GOC requirement to have had a sight test within the last 2 years, before contact lenses are fitted/refitted, help to protect patients?"

The clear consensus was that yes, the GOC requirement stated in question 4 does help protect patients (figure 18). With such a small number of 'no' responses, no clear demographic factors were identified, and no clear trend was identified from the answers to previous questions.

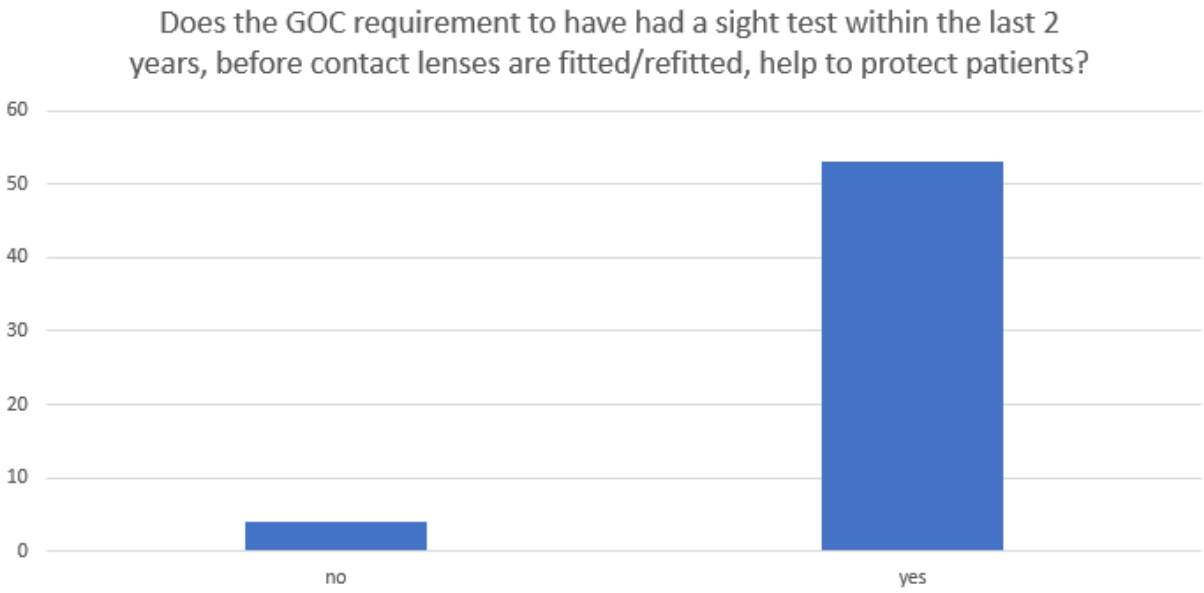

Figure 18. Once again, a clear consensus was reached.

Themes emerging from comments (Appendix 4) were:

Theme 1: Patient's perception of the health aspect of the sight test is undervalued

Many comments focused on the opportunity afforded by the sight test to detect pathology, and the unlikeliness of patients to value this if the requirement was removed. One disagreed and commented that patients should be able to make an informed choice in this regard.

Theme 2: This is already happening

A minority of patient's were reported to be self-prescribing or falsely declaring that they had a sight test when purchasing contact lenses online. One respondent had to refer a patient with corneal ulcer to hospital who had not had either a sight test or aftercare for some time.

Theme 3: The need for an up-to-date pair of glasses

Several commented that contact lens wearers still need a pair of glasses with the correct prescription for when they are not wearing their contact lenses. One respondent added that contact lenses can alter the refractive state over time.

Theme 4: The interdependence of the sight test and contact lens fit/aftercare

Knowledge of the results of a recent sight test was considered useful in contact lens work; one example given was the presence of pathology affecting visual acuity. The knowledge that the eye was healthy was seen as equally relevant, as was the presence of findings that contraindicated contact lens wear that would not otherwise have been known.

Appendix 1 – Comments made in response to "Briefly describe any scenarios you have encountered or foresee happening in relation to the separation of the refraction and health check elements"

1. I've had several asymptomatic retinal tears picked up when testing patients who only came for new glasses. Also, a choroidal melanoma on routine eye exam when the patient only attended as he'd broken his glasses.
2. Waiting times for 'sight test' will be reduced and practices will be able to see more people routinely and refer to an optometrist if any concerns regarding eye health.
3. The main thing that brings people to practice in my experience is that they want new glasses, or their vision has changed. I don't think the public understands the health of the eye being checked and the potential importance of this. If they can get their glasses/prescription done separately I don't think they will keep up to date with the health part. Also, many times a change in prescription can be indicative of a health issue going on. Both being done at the same time by the same practitioner means it can all be dealt with immediately without the need to send a patient to see someone else which has more potential to be a missed appointment or slip through the net and just not done at all.
4. Refraction is intrinsically linked to ocular diseases such as cataracts and diabetic changes.
5. If I can't improve vision with spectacles, why can't I improve it? It is due to cataracts? Glaucoma? Amd? Papillodema? If I delay knowing why I can't improve vision, will it impact their health? Will their vision be lost forever?
6. Certain pathologies require link between Rx change and ocular appearance.
7. Increase in sight loss due to clinical signs being missed by a lesser qualified professional. More chair time being required over all when a DO has to perform history and symptoms then an optometrist needs also to take h&s before the health check. There needs to be consideration to the students who have invested in their education and may qualify into a very different profession and pay scale to the one they envisaged.

8. If VA is reduced, Px would need to have a separate health check and may not come back for it as they only want the new prescription and don't understand the importance of the health check.
9. There are changes in refractive error which can indicate pathological problem which needs urgent referral and would be missed
10. Being able to accurately determine best corrected VA at the same time as assessing health issues has been extremely useful to me many times during my career. A simple example is when assessing the effect of PSC LO's, also when concerned with macula issues.
11. A change in refractive error due to early diabetes could be easily missed and without retinopathy the diabetes could remain undiagnosed
12. Problems with health problems being missed such as glaucoma. People not realising importance of health check and just getting spectacles.
13. There are patients where the findings from the health check and refraction need to be used in tandem to get the full picture. For example, keratoconic patients, latent hyperopes, malingerers, patients with severe dry eyes to name a few. I believe separating them between professionals will lead to a poorer experience for patients.
14. refraction change can sometimes indicate health issues, e.g., diabetes, cataract
15. Binocular function and neurology work up needs both. Refraction information pertinent to glaucoma risk and lens to use for visual fields
16. I am a DO as well as an Optom and do not believe I would have had the suitable experience to refract as a DO compared to what I know now
17. Without a health check unable to account for poor va
18. It's hard for me to see how you could do a refraction without a health check as one informs the other. What if a patient just came in for a refraction and their vision was down due to a

macula issue the went untreated- it could just be assumed amblyopia if there was no prior history. I think it just increases the risk of missing things. Or a patient who just attends for a refraction, but they have signs of glaucoma which wouldn't affect VA.

19. Conditions such as keratoconus (quite common) where disease process and refraction are intrinsically linked
20. More frequently than on a daily basis I use the refraction result to aid in diagnosis of pathology and vice versa. The most common is example of this is in Pxs with mild/moderate cataracts.
21. Poor visual acuity need to know cause
22. The two parts are linked. One often aids the diagnosis or referral pathways. For example, change in Rx in diabetes
23. The Ret can be a first line of examination that gives you clues for further in-depth examination Variable refraction due to health-related issues like diabetes or anterior segment/retinal problems. Separating will do the opposite of reassuring patients when managing expectations with respect to visual outcomes when they are linked to e.g., cataract. Likely to involve rechecks and discussion/stress that could be avoided if optometrist performs all elements
24. patient struggle to understand the health side of the sight test at the moment this would complicate things, people often as if 'they need new glasses' once the refraction is over before all the health checks have been completed. the design to prescribe needs to take all the factors into account.
25. Many occasions of normal visual acuity but pathology present, e.g., detachments, glaucoma
26. I think it is part of the general health check and can highlight underlying problems such as a small tropia, early diabetic changes, even the way in which the letters are read out can indicate hemifield sight loss following a stroke.
27. Refraction and acuity inter-relate, but are also affected by ocular conditions relating to cornea, lens, and retina
28. Many examples of patients having good visions or corrected visual acuity with sight and in some cases life threatening conditions. It’s obvious that separation of refraction from health check within the same appointment would result in poor outcomes for patients.
29. Many eye conditions are asymptomatic, and many problems found are incidental case finding in a routine EE. Many Pxs do not appreciate the health checks we perform, and I think those who most under appreciate our roles are least likely to present for separate refractions and health checks

Appendix 2 – Comments made in response to “Do you think elements of the sight test could appropriately be delegated to another professional such as a DO?”

1. It depends on what? Any tests what were done by a DO would in my opinion need to have the results checked by an OO anyway - and if I were the OO, I’d always feel happier doing a test myself that I had to check the results of.
2. Not knowing the reason for why we can't improve vision needs to be known, and the only way to find out is a full ocular examination which a DO would not be able to do, even if they were just to carry out a refraction, the whole picture needs to be pictured.
3. I only work with the information I've personally obtained.
4. Somebody could check the patients unaided VA and aided VA with current spectacles.
5. If a DO wants to refract they should study to be an optometrist.
6. Please see above comments
7. As stated above; I believe that this will mean that pathology is missed due to the lack of consistency of approach and simultaneous assessment.
8. Patients like continuity and this proposal drives a horse and cart through this. Secondly there is risk that supplementary results are lost / not brought to the attention of the optometrist.

It is stressful working in practices with ghost clinics and these suggestions will result in an unacceptable increase in the number of patients seen. There is more to optometry than profit

9. You need an awareness if how changes to What happens if patient only reads one half of the chart? Optoms would think about hemianopia, but a DO may not. Vision e.g., myopic changes interact with nuclear cataracts, management of phorias by adjusting the prescription.
10. I wouldn't trust not being given the correct results from the DO and that I turn could alter my opinion on pathology and referral
11. I am a DO as well as an Optom and do not believe I would have had the suitable experience to refract as a DO compared to what I know now
12. Why would you delegate certain sections of an eye examination? Who's funding this? Since deregulation in 1986. Optometrists have been subsidizing the industry. Their income since then hasn't kept up with inflation. The NHS payment in England is an embarrassment. You want to deregulate even more? You should be asking the GOC who's behind this, who's lobbying for this. They are not as squeaky clean as they make out. As proven during lockdown! How important is an eye examination? Important enough for it to be messed about with?
13. We already delegate fields, photos, OCT and tonometry. Some practices are already using Eye Refract. As long as overall responsibility is left with the optometrist then I don't see why the refraction element couldn't be undertaken by someone else.
14. DOs and CLOs are more than capable of providing a competent refraction; however, this doesn't mean refraction should be delegated. Optometrists often need refraction alongside all other tests as a diagnostic tool to enable the best management for the patient. Particularly true in more challenging tests/refractions, but still true for simple cases where you get an idea of what is best to prescribe from history and symptoms and the patient's subjective responses.
15. Image capture, OCT and VFA for example could be delegated but must be interpreted by the optom.
16. An overall view of sight test required; therefore, all aspects of sight tests need to be assessed by one practitioner.
17. Parts of the test such as VA's, field screening, tonometry, and digital image capture could be delegated but would need reviewing by the optometrist
18. Need to separate information gathering e.g., tonometer, fundus photography from information analysis
19. Within the context of an eye examination, oversight is with the optometrist/doctor
20. Pre-screening and additional tests such as fields when performed by trusted member of staff however I would always repeat the tests myself if I had any doubt
21. It's a slippery slope - if optometrists are to be held responsible legally then no elements should be delegated however we have already moved into this area with multiple optical practices. The Honey Rose case touched on some aspects of moral ethical hazard through delegation of fundus photography. We should be establishing a much more robust training and clinical qualification requirement for any sight test elements.
22. symptoms often could have variety of causes all these plus any refractive error need to be considered to make a decision.
23. I think reviews of prescription if a recheck is needed, adjusting powers for balance, spending additional time getting working distances correct.
24. I feel refraction could be performed by Dispensing Opticians

25. Refraction could be delegated with training on prescribing as exact refraction may not always give the patient the best prescription for their needs or binocular vision

Appendix 3 – Comments made in response to "Do you agree that the requirement to verify a contact lens specification with the original prescriber could be removed? "

1. Lots of illegal supply anyway via internet suppliers
2. I'm not sure why this is a question when there are so many online sellers NOT verifying details anyway. I think they should be verified but you're not upholding this requirement anyway.
3. A patient who has not been checked for a while may have neovascular changes which they might not know about
4. To keep the public safe verification must remain or else people will be able to purchase any lenses that may be ill fitting and the wrong prescription. Instead, the GOC needs to be accepting future changes such as virtual clinics and online sales but regulating them efficiently.
5. Those that do buy online are often abusing their use without it being easier
6. Purchasing on-line makes a farce of the current legislation anyway so maybe a change is needed.
7. I have seen many patients who do not even realise that they are wearing contact lenses with a different fit or oxygen transmissibility to those that they were originally prescribed. I have seen many examples of harm, for example infections (including very serious infections which required months of hospital treatment), or neovascularisation of the cornea. This is happening anyway and, in my opinion, would be much more frequent without the requirements.
8. There are many patients go online to avoid aftercare and renewal of contact lens details. Withdraw this requirement will result in the wrong lenses been supplied and an increase i sight threatening complications
9. The GOC is a farce when it comes to its utter failure to shut down online contact lens supply
10. It isn't checked much now but it does make patients think about going for a check
11. Too many factors that may have influenced initial fitting decisions not known to alternative suppliers
12. A contact lens patient attended for a review with me for the first time complaining of reduced vision. She had lost her inferior fields with glaucoma. She had not had an eye examination for 4 years
13. It's not checked now by many online companies, and I believe this needs addressed, not made easier
14. According to Vision Direct's latest online advertising "No Prescription verification required". What's the GOC going to do about that?
15. Incorrectly fitting lenses increase the risk of corneal damage and therefore infection
16. For patient safety all contact lenses should be checked by a professional. Removing this would surely allow easier access to contact lenses, which I believe is already too easy online for example.
17. Helps to ascertain that contact lens wearers are having regular health and contact lens checks. People may not attend contact lens checks if prescription is not required. Health problems and overwear issues may be missed
18. The GOC doesn't seem to apply these rules as many patients manage to get CLs supplied online without verification of prescription
19. Patients will not have aftercare, but clinicians remain legally responsible

20. there is a judgement call as to whether an Rx is near-enough, which could be by prescriber or dispenser
21. Already too deregulated anyway - patients already able to buy online without prescription through loopholes. Needs more regulation if anything
22. Ask the NHS ophthalmologists - we have been asked to council patients about the dangers of swimming or cleaning contact lenses due to the large increase in acanthamoeba keratitis... if there is a free for all with no regulation on the supply side how will this important function take place?
23. This helps to impress the importance of a professional having assessed their eyes at some point periodically, give an opportunity for contact lenses compliance/health information to be re-iterated and potential health issue to be found at early stages. There are many examples of people who have flouted the rules and needed up in EED due to CL's related issues as it is.
24. I have seen Px's with extremely incorrect self-prescribed or old prescriptions that are unsafe for driving. I have seen Px's with scarred corneas because of wearing inappropriate lenses.
25. We need to keep our patients buying for the practice and give best health care
26. The fitting and material supplied should math the optometrist's/contact lens fitter's specification
27. Need to know lens patient is wearing but may have difficulty obtaining previous Rx if over 2 years old
28. Because patients unfortunately can be an unreliable source. I have seen on many occasions where Pxs have tried to buy contact lenses that only look like what they usually wear, and at the incorrect Rx. This can be damaging to their eyes and sight. It could impact the wider public if a Px drives in incorrect Rx, imagine if they're a lorry driver.
29. It would increase self-prescribing, unsafe practice and increases in over wear or CL related complications if there's no proof of clinical oversight.

Appendix 4 – Comments made in response to "Does the GOC requirement to have had a sight test within the last 2 years, before contact lenses are fitted/refitted, help to protect patients?"

1. As with specs often the only incentive to get the patient in to have their eye health looked at is the fact that they can't have their contact lenses without it. Also, if they don't have to have this done then this would imply that their spec Rx isn't getting checked. And as we all know contact lens users should have up to date glasses in case of infection.
2. People who order their lenses from the Internet do not require an up-to-date CL specification, but at least if they have had an up-to-date eye examination, any issues can be picked up then.
3. Unidentified pathology
4. Change in Rx/ pathology.
5. Undiagnosed pathology has chance to be identified. Similar to ready readers, Pxs just buy gos then come in with end stage glaucoma which would have been picked up with checks.
6. Increase in the amount of pathology being missed.
7. So many people buy online and are never asked when their last aftercare was. It could be years overdue, and they still keep ordering.
8. Corneal/lid pathology.
9. Change in Rx or new pathology.
10. In theory yes but I have encountered many patients obtaining new c/ls whose Rx is older than 3 years.

11. I have seen a couple of patients over the last year who have bought online but are wildly out of date for ST and CLC, that I have had to refer to HES due to ulcers or abrasion that have gone unnoticed.
12. Seen patients wearing lenses for nine years without having eyes tested. Buying online.
13. Knowing the patient has an in-date sight test means you can refer to these findings when recommending contact lens options. If it has been years since their last sight test it will make fitting patients with contact lenses more complicated. Do they have ocular conditions affecting their VAs that should be picked up in a sight test? Has astigmatism changed meaning we could be fitting different contact lenses and improving their vision and contact lens experience?
14. Pathology could be missed but I believe patients could be allowed to make an informed choice on this.
15. Allows practitioner to know eyes healthy and no underlying problems before trying contact lenses. Patients may not have sight test if can have contact lens checks without this, meaning health checks can be missed. If an eye condition was developing but able to be picked up at routine contact lens check, would the practitioner be liable in anyway. Would the patient understand that certain eye conditions can't be found on a standard contact lens fit/check?
16. Yes, any early issues with CL wear should be picked up with regular examinations
17. Refractive changes induced by contact lenses or pathology would not be identified by cl aftercare only
18. Underlying risk factor can thereby be assessed/ managed
19. I have experienced examples of patients wanting to try contact lenses who were unknown to themselves to be contra indicated due to findings that could only be uncovered during a full eye examination involving ALL aspects of the test.
20. Patients misuse contact lens wearing, there must be some protection.
21. See above
22. A contact lens fitter during the aftercare appointment should be able to refer to an optometrist if eye exam needed and withhold supply of lenses if required
23. Ensure their eyes are healthy at the very least.
24. Need to verify a change in Rx