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

Response from the British and Irish Orthoptic Society

The British and Irish Orthoptic Society (BIOS) is the professional body for orthoptists and was founded in 1937. It is also a registered charity and a company limited by guarantee. BIOS is affiliated to the Allied Health Professionals Federation, a group made up of 12 bodies representing more than 158,000 workers in the UK. BIOS is also a member of the International Orthoptic Association and OCE. BIOS members in the UK are also automatically trade union members of the British Orthoptic Society Trade Union (BOSTU).

We welcome the opportunity to comment on possible future changes to the Opticians Act 1989. In particular, we agree that it is right that activities such as the testing of sight and the fitting of contact lenses should be restricted to regulated healthcare professionals, to ensure patient and public safety. However, where a regulated profession other than those registered with the GOC are able to show comparable competencies, they should not be restricted from doing these activities where there is a benefit to patients and eyecare services.

Given the overlap between the core competencies and training of orthoptists and optometrists, many of the activities currently restricted to GOC registrants could be extended to orthoptists, where this benefits patients, without any risk to public safety.

Objectives for reform

Q5 Are these the right objectives for the GOC for legislative reform?

a) Yes

We believe that these are appropriate objectives for the GOC, balancing patient and public safety with the need for flexibility, consistency and proportionality to ensure services are efficient and recusing health inequalities.

Protection of title, restricted activities and registers

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

It is right that activities such as the testing of sight and the fitting of contact lenses should be restricted to regulated healthcare professionals, to ensure patient and public safety. However, where a regulated profession other than those registered with the GOC are able to show comparable competencies, they should not be restricted from doing these activities where there is a benefit to patients and eyecare services.

Given the overlap between the core competencies and training of orthoptists and optometrists, many of the activities currently restricted to GOC registrants could be extended to orthoptists, where this benefits patients, without any risk to public safety.

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

As stated above, where healthcare professionals have appropriate skills and knowledge and are appropriately regulated, they should not be restricted from activities where there is a clear benefit to patients.

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

a) Testing of sight: should not be restricted
b) Fitting of contact lenses: should not be restricted
c) Selling optical appliances to children under 16 and those registered visually impaired: should not be restricted
d) Selling zero powered contact lenses: should not be restricted

Appropriately skilled and regulated eyecare professionals should not be restricted from doing any of these activities, where there is a clear benefit to patients. While it would be appropriate for orthoptists to carry out all of these activities, there is a particularly strong case for them to be enabled to carry out a sight test, particularly within a hospital setting, where there are currently needless delays due to the long waiting lists for refraction appointments.

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

The examination and management of ocular and ophthalmic disease should be restricted to those with the appropriate education and regulation to ensure high standards of care and avoid risk of harm to the public. Once again, this should be based on the specific skills and knowledge of the healthcare professional, rather than restricted purely to GOC registrants.

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)?

b) No

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

We are not aware of any evidence that there is a need for other post-registration skills, qualifications or training to be accredited by the GOC.

Qualifications and training should be accredited by the relevant regulator, in the case of orthoptists this would be the Health and Care Professions Council (HCPC), but recognised or approved by the appropriate accrediting organisation or professional body.

Testing of sight

CONSULTATION

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.)

a) Yes – with no restrictions

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

The 2013 GOC statement on refraction should be removed or amended to allow appropriately qualified eyecare professionals other than optometrists and medical practitioners to undertake refraction for the purposes of a sight test.

The consultation document rightly recognises the role that dispensing opticians could fulfil in alleviating the increasing pressures on ophthalmology departments, if, where appropriately trained, they were given the right to carry out refractions for the purposes of a sight test. Orthoptists are appropriately trained, refraction forms part of the core curriculum for all pre-registration orthoptics courses; all current HEI courses meet the HCPC standards, which specifically state refraction competency. Orthoptists could therefore could significantly reduce the strain on ophthalmology services if they were given the right to undertake refractions for the purposes of issuing a prescription. Indeed, within hospital eye services it is already common for orthoptists to carry out refractions, with the prescription signed off by an optometrist or ophthalmologist.

Many NHS hospitals have significant waiting times for refraction appointments, up to a year in some cases, while there are other available, skilled practitioners who could undertake this work and prescribe optical corrections, to avoid such dangerous waiting times. Many hospitals struggle to recruit Optometrists and the Ophthalmologist workforce is acutely understaffed with the problem expected to grow in future years.

The current restriction to non-GOC registrants is therefore extremely challenging to patient centred and time appropriate care. For example, orthoptists fit prisms to glasses to relieve double vision caused by strabismus. However, they are currently unable to prescribe prism glasses to the same patients, thus requiring that the patient is referred to an optometrist for refraction and the supply of glasses.

Similarly, in areas of advanced practice, such as paediatric ophthalmology, the ability of orthoptists to adequately care for patients is severely restricted, relative to other professionals, by the legislation. The Advanced Clinical Practice Course in paediatric ophthalmology at the University of Sheffield was set up for participants to relieve the work burden of ophthalmologists. The majority currently are Orthoptists who have already learnt refraction and passed assessments in this skill in their Bachelor's Orthoptic degree, and have now undertaken extensive further learning in paediatric retinoscopy, as part of their ACP Masters programme. The ACP students have to produce a Bland-Altman plot of the repeatability of their refraction results, yet they are not able to relieve the Ophthalmologist work burden, as the ACP workforce is envisioned to do. This leaves a situation of poor patient access, long waiting times and consequential delays in the supply of optical devices to patients, if their base profession is not Optometry. Those with Optometry base profession, will not face such a restriction, which means that the ACP workforce will be variable in output, despite a course designed for both professions.

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.)

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

There are a number of clear advantages to the removal of the 2013 statement on refraction, so that not just dispensing opticians but all appropriately qualified and regulated professionals can refract for the purposes of the sight test.

As we have shown in the examples in our answer to question 15, allowing orthoptists to perform refractions has the potential to improve patient care and reduce waiting times in a number of areas of eye care where they are the primary eye care professional seen by patients. Indeed, increasing the number of professionals able to refract increases the opportunity for patients to see a qualified professional.

The change would encourage a more holistic approach to care, avoiding a silo approach, were patients are referred between multiple professionals. For example, orthoptists are specialists in working with children and people with learning disabilities. These vulnerable patients would benefit from eyecare professionals who were able to provide the full range of options to support their vision.

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

a) Yes

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

The legislation as it stands produces regulatory barriers to the recognition and use of other professionals, such as orthoptists. By restricting activities to GOC registrants, it creates unhelpful silos within healthcare, undermining patient experience and increasing waiting times. Patients also suffer from a lack of continuity of care, as they are referred between professionals unnecessarily. This is particularly damaging for vulnerable people, such as children and adults with learning difficulties, who would benefit from developing a relationship with one trusted professional.

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.)

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

The disadvantage of sight testing legislation remaining as it is currently is the restrictions in places on dispensers and other health professionals from providing patient care. For example, were orthoptists able to refract within hospital eyecare services, this would have a significant impact on reducing waiting times and improving the service experienced by patients.

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

b) No

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

We do not have access to any data on this.

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

a) Yes
b) No
c) Not sure / no opinion

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

The numbers of hospital eye services where orthoptists are routinely carrying out refractions, which are then signed off by optometrists or ophthalmologists would demonstrate the strong case for the changes we have suggested. This could likely be obtained via an FOI to NHS organisations.

Other – sales:

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?

a) Yes

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

The legislation currently restricts the sale and supply of low vision aids, such as spectacle magnifiers and telescopes. There are a number of specialist orthoptists working in low vision, and their ability to provide appropriate aids independently is restricted in comparison to optometrists working with comparable competencies in the same field. This undermines their ability to work autonomously, providing an efficient service for patients. In hospital eyecare services, no restriction applies as suitably trained and regulated health care professionals such as orthoptists are already able to supply low vision aids.

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.)

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

The restrictions on orthoptists being able to supply low vision aids lead to a number if disadvantages. Services are less efficient, requiring patients to see a second professional to acquire certain aids. This causes delays for patients and is also more costly. In contrast, in hospital eyecare services, where no such restriction applies, orthoptists are able to supply these.

Remote care

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?

a) Yes

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

The expansion in the availability and use of telehealth, particularly since the start of the COVID-19 pandemic, would require the review of legislation to allow flexibility but ensure that sufficient regulation is in place to ensure patient safety.

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?

a) Yes – a mainly positive impact

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

There is as still a great deal of research required to ensure patient safety and care in remote consultations. However, evidence suggests that, if done appropriately, this can provide more prompt and flexible services for patients. For example, there are a number of orthoptists who use telemedicine to assess the stability of conditions, such as adult strabismus and those with prisms.

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?

a) Not sure / no opinion

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?

a) No

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?

a) Not sure / no opinion